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Female genital mutilation in Europe from a child right’s perspective

Els Leye and Annemarie Middelburg

1. Introduction

Female Genital Mutilation (FGM)\(^1\) is a harmful practice that remains widespread. The most recent statistical overview of 27 countries in Africa\(^2\) and the Middle East\(^3\) shows that more than 125 million girls and women live with FGM and 30 million girls are at risk of being cut in the next decade. Due to migration, FGM has also been spread to other continents including Europe, the Americas, Australia and Asia (UNICEF, 2013b; Eneng Darol Afiah, 2013). In Europe, no comparable data for each Member State are available, making a total estimate for the European Union impossible (Leye et al., 2013). The European Parliament estimates that at least 500,000 women and girls in Europe have been subjected to FGM and that 180,000 girls and women are at risk of undergoing FGM every year (European Parliament, 2009). However, the methods used for this estimate are not clear (European Institute for Gender Equality [EIGE], 2013).

For a couple of decades, FGM has been framed within a human rights framework, viewing the practice as a form of Violence Against Women (VAW) and violating the rights of both the girl child and the adult woman. However, despite the wide range of human rights documents that make reference to FGM, there is a slow pace in the decline of the prevalence of FGM. Indeed, the Report “Violating Children’s Rights: Harmful Practices Based on Tradition, Culture, Religion or Superstition”, observes a “devastating failure of international and regional human rights mechanisms to provoke the necessary challenge to these practices and their

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\(^1\) The practice was initially referred to as “female circumcision”, which drew a direct parallel with male circumcision. The term “female genital mutilation” was used to highlight the fact that there are important differences between male circumcision and the procedure that is practiced on women. The word “mutilation” emphasizes the gravity of the act and underscores the fact that the practice is a violation of the rights of girls and women. As FGM has been a successful advocacy tool to underline the gravity of the action, we prefer to use the term FGM.


\(^3\) Yemen and Iraq.
effective prohibition and elimination in all regions” (International Council on Violence against Children, 2012).

This chapter first provides an overview of the basic facts about FGM, before sharing some insights about the human rights at stake. The case study described in this chapter focuses on how FGM is dealt with in the EU from a child rights’ perspective with a particular focus on protection, provision of services and participation. It provides a critical reflection on how the rights of the girls are (not) fulfilled. In line with the introductory chapter of this Handbook – where it is argued that the reality of children’s rights is much richer than the legal instruments and its implementation – this chapter argues that the limited impact might be due to an inadequate transformation of the children’s rights framework at national level and into the daily practice of those confronted with FGM. We will argue that there is a lack of a comprehensive approach that can join all stakeholders, tools and instruments as well as policies put in place for the prevention of FGM, protection against it, and the provision of services, in a coordinated strategy to put the human rights framework into practice. We will equally provide suggestions to tackle FGM more adequately.

2. Key facts about FGM

FGM is defined as a procedure that involves the “partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons” and includes four categories (WHO, 2008):

- Type I or clitoridectomy involves the partial or total removal of the clitoris and/or the prepuce.
- Type II or excision involves the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
- Type III or infibulation is the narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.
- Type IV includes all other forms of harmful procedures to the female genital genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization.

FGM can be considered as a social norm in a particular context, when individuals are aware of the rule of behaviour regarding the cutting of girls and know that it applies to them, and if individuals prefer to conform to this (UNICEF, 2013b). The reasons why FGM persists vary among communities. It may be considered to be necessary to raise a girl properly and to prepare her for adulthood and marriage. In communities where the practice is viewed as a prerequisite for marriage, economic necessity can be a determinant. FGM is often believed to be necessary to control women’s sexuality, to preserve a girls’ virginity, to ensure marital fidelity, to make girls clean and beautiful or as a necessity to eliminate “masculine” parts (such as the clitoris) of the genitalia. In many communities, religious arguments are put forward, although none of the monotheistic religions prescribes FGM (WHO, 2008).

The age at which FGM is performed varies between communities or regions, depending on local traditions and circumstances (WHO, 2008). The largest proportion of girls and women are cut between infancy and the age of fifteen (UNICEF, 2013a). A trend of decreasing the age of cutting was noted in some countries, while in other countries the age remained fairly stable (UNICEF, 2013a). This tendency to reduce the age is believed to be associated with parents wanting to reduce the trauma for their girls and to avoid older children reporting an excision
or denouncing their parents or excisors to the authorities, and to avoid interference from judicial authorities (UNICEF, 2005). Traditional practitioners perform most of the cases of FGM, although the so-called medicalization of FGM – the performance of FGM by medically skilled personnel – is on the rise in a number of countries (UNICEF, 2013b).

The health consequences vary according to the type of FGM (the extent of the cutting), the circumstances in which it was performed (in a health setting by medical skilled personnel versus a traditional excisor with non-sterile material at particular traditional FGM-sites), and the general condition of the girl. Immediate consequences include severe pain (the procedure is often performed without anaesthesia), bleeding (haemorrhage), shock (caused by pain and haemorrhage), tetanus or sepsis (bacterial infection), urine retention (due to the pain, swelling or oedema and to avoid urine having to pass the edges of the fresh wound), open sores in the genital region and injury to nearby genital tissue. The act can even lead to death due to haemorrhage, infections or shock (WHO, 2008). Long-term consequences include formation of scar tissue, cysts and abscesses, difficulties with menstruation and sexual intercourse, fertility problems, chronic infections of urinary tract, infections of the reproductive tract, and obstetric consequences (WHO, 2008; Banks et al., 2006).

Although evidence on the psychological and social consequences of FGM is weak (Berg, Denison and Fretheim, 2010), some of the documented psychological consequences include fear of sexual intercourse; post-traumatic stress disorder, anxiety, depression and memory loss (WHO, 2008; Vloeberghs et al., 2012). The impact on sexuality includes pain during intercourse, reduced sexual desire and reduced sexual satisfaction (Berg et al., 2010). The true extent of morbidity and mortality related to FGM remains blurred, due to a lack of population-based surveys to document the adverse outcomes of FGM, ethical issues, the unavailability or inaccessibility of health care, ignorance (problems considered normal in communities where FGM is common practice) or fear of legal retribution (Leye, 2008; Jackson et al., 2003; Obermeyer, 1999, 2003).

3. FGM as a human rights violation

Initially, FGM was placed beyond the scope of international human rights law, because VAW in general and FGM more specifically was seen by the international community as a private matter carried out by individuals – rather than state officials. This changed in the 1990s with the global movement against VAW. Landmark events were the adoption of General Recommendation No. 14 on Female Circumcision4 (1990) where the Committee on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) strongly condemned FGM and recommended States parties to take appropriate and effective measures with a view to eradicating the practice of FGM. The adoption of General Recommendation No. 19 on Violence Against Women (1992)5 was equally important, because the CEDAW Committee explicitly included VAW more generally within the scope of CEDAW and thus international human rights law. The Vienna Declaration and Programme of Action (1993) expanded the international human rights agenda to include gender-based violence. It advocated the importance of “working towards the elimination of violence against

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women in public and private life, [...] and the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices [...]” (Vienna Declaration on Human Rights 1993, point 38). With the adoption of the Declaration on the Elimination of Violence against Women, for the first time FGM was recognized as a form of VAW. Article 2 of the Declaration explains that “[v]iolence against women shall be understood to encompass, but not be limited to, the following: […] female genital mutilation and other traditional practices harmful to women.” Although not legally binding, this declaration strengthened the growing international consensus that FGM of any type is a human rights violation. In 1994, the human rights implications of FGM were again addressed at the International Conference on Population and Development in Cairo: “In a number of countries, harmful practices meant to control women’s sexuality have led to great suffering. Among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women’s health.” UN agencies reinforced the classification of FGM as a human rights violation as well (WHO, 1997, 2008).

As explained in the introductory chapter of this Handbook, children’s rights are understood as fundamental claims for the realization of social justice and human dignity for children – just like human rights more generally. As FGM is commonly performed upon girls between 0 and 15 years, any violation of women’s rights may in principle be said to amount to a children’s rights violation too. However, the legal qualification of FGM as a children’s rights violation under the CRC is less straightforward than it may seem at first sight.

In the CRC, FGM is addressed most explicitly in the right to health. Article 24(3) CRC includes the obligation for States Parties “to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.” The CRC Committee adopted a general comment on the right to health in 2013, but deliberately excluded any discussion of harmful practices. The latter will be the subject of a separate general comment that is under preparation. It is therefore too early to say how the CRC Committee will interpret “traditional practices prejudicial to the health of children”. The article-wise scholarly commentary on the CRC does not offer much interpretative guidance either on this point (pp. 46–48). The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has argued that “Rape and other forms of sexual violence, including […] female genital mutilation, and forced marriage all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health.” FGM may bring the right to life (Art. 6 CRC) into bearing when a girl dies when undergoing FGM due to excessive bleeding, or when a woman dies during childbirth as a consequence of a tight infibulation or other related FGM problem. FGM may also contribute to neonatal death. Article 21 of the African Charter

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9 CRC Committee (2013), General comment No. 15, The right of the child to the enjoyment of the highest attainable standard of health (Article 24), UN Doc. CRC/C/GC/15.
on the Rights and Welfare of the Child (ACRWC) explicitly links harmful social and cultural practices with not only the health but also the life of the child, as well as with the child’s welfare, dignity, normal growth and development.

Another way of qualifying FGM under children’s rights law is to consider it as a form of violence against children, or as torture, cruel, inhuman and degrading treatment. Article 19 CRC obliges States Parties to take all appropriate measures to protect the child from all forms of physical or mental violence (for an elaborate discussion on Art. 19 CRC, see Lenzer, Chapter 16 in this Handbook). Article 37 CRC prohibits torture or any other cruel, inhuman or degrading treatment. In its general comment on violence, the CRC Committee mentions female genital mutilation as a harmful practice that comes under the notion of violence. FGM may be construed as a form of torture, cruel, inhuman and degrading treatment (Art. 37 CRC). The Committee Against Torture stated in its General Comment No. 2 that FGM falls within the mandate of the Committee. Likewise, the UN Special Rapporteur on VAW and the UN Special Rapporteur on torture have both recognized that FGM can amount to torture under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) if states fail to act with due diligence to protect, prevent, investigate and, in accordance with national legislation, punish FGM. However, the classification of FGM as torture is complex. Support for a children’s rights argument against FGM could also be sought in the CRC general principles. Article 3 CRC stipulates that “the best interests of the child” must be a primary consideration. However, different cultures have different understandings of what is in a child’s best interest. Parents may perceive of FGM as an act in their child’s best interest. Whereas support can be found in order not to interpret best interests in an overly culturally relativist way and deny (other) rights guaranteed to children by the CRC, a convincing cross-cultural best interests argument remains to be made.

11 CRC Committee (2011), General comment No. 13, Article 19: The right of the child to freedom from all forms of violence, UN Doc. CRC/C/GC/13, para. 27.
12 UN Committee against Torture, General Comment No 2, UN Doc CAT/SR/13/2 (2008), para. 18.
13 The previous UN Special Rapporteur on Violence against Women has clearly stated that FGM amounts to torture. See “15 Years of the Special Rapporteur on Violence Against Women, Its Causes and Consequences” (2009): the Special Rapporteur “views cultural practices that involve pain and suffering and violation of physical integrity as amounting to torture under customary international law, attaching to such practices strict penal sanctions and maximum international scrutiny regardless of ratification of CEDAW or reservations made thereto”. See also the Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, Commission on Human Rights, Fifty-eighth session, 31 January 2002, E/198/2002/83, para. 6.
14 Report by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Mr. P. Kooijmans, E/1986/15, para. 38; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, 15 January 2008 (UN Doc. A/HRC/7/3), paras 50–54.
15 UN General Assembly, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85.
16 Starting points may be found in the CRC Committee’s (2013) General Comment No. 14 on the right of the child to have his or her best interests taken as a primary consideration (Art. 3, para. 1).
Another entry point could be found in Article 12 CRC, which ensures the right of the child to express his or her views freely in all matters affecting him or her, and to have these views being given due weight. Whereas a right to express one’s views cannot be understood as a right to consent, the CRC Committee has in its general comment on Article 12 CRC explicitly welcomed the right to consent at a fixed age in health care. The social pressure to undergo FGM is usually very high, and in the rare case of a girl refusing to be excised, she will most likely be ostracized from her family and community, with very little possibilities to seek refuge. The question could therefore be raised whether it is possible to reasonably talk about real consent or autonomy when the social pressure in the community to undergo FGM is so high. Interestingly, the international children’s rights framework acknowledges the role of the parents and the family in making decisions for children (see inter alia Art. 5 CRC), although it places ultimate responsibility for protecting the rights of the child with the State.

FGM may also be construed as a violation of the right to be free from discrimination (Art. 2 CRC). A child has the right to be protected from all forms of discrimination irrespective of his or her sex or other status. Article 21 ACRWC explicitly mentions customs and practices “discriminatory to the child on the grounds of sex or other status”. From a women’s rights perspective, FGM fits within the definition of “discrimination against women” that follows from Article 1 of the CEDAW. The practice itself reflects deep-rooted inequality and power imbalances between the sexes. FGM is a practice applied to women and girls that has the effect of nullifying their enjoyment of fundamental rights. FGM aims, amongst others, at controlling women’s sexuality, which carries a fundamental discriminatory belief of the subordinate role of women and girls in society. Less attention has been paid to the particular ways in which children experience discrimination, notwithstanding the fact that the discrimination of girls has gradually become a separate issue from that of women and hence has been addressed through different standards (Besson, 2005). Notwithstanding the differences between FGM and male circumcision, there are important similarities in that both involve the removal of healthy parts of one’s most intimate sexual organs, without a medical necessity and without informed consent. The emphasis on consent with regard to male circumcision may provide support to the argument that in case of more intrusive acts, even more emphasis should be put on consent.

4. State duties in relation to FGM

The campaign against FGM has gained considerable momentum at policy-level. But what exactly are the duties for states that follow from the human rights framework with regard to FGM?

At the international level, traditional practices are specifically mentioned in CEDAW and the CRC. Article 5 of CEDAW requires States parties to “…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 the superiority of either of the sexes or on stereotyped roles

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17 CRC Committee’s (2009) General Comment No. 12, The right of the child to be heard, para. 102.
18 Besson points out the ambiguity of these girl-specific discrimination approaches: “Although this may have benefited girls, it also means that gender-oriented measures lack coherence overall…”
19 First of all, the reasons given for the practice are different. FGM violates the right to be free from discrimination, because FGM is linked to a reduction in women’s sexual desire and an irreversible loss of capability of sexual functioning (WHO and UNAIDS, 2008). This is not the case for male circumcision. There is also a major difference in the amount of harm done. It has often been argued that the equivalent of FGM types I, II and III equals gradual amputation of the penis.
for men and women.” Article 24(3) of the CRC provides that “States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.” Neither the CEDAW nor CRC elaborated what exactly would be “effective and appropriate measures.”

At the regional level, the Maputo Protocol addresses the elimination of harmful practices, including FGM. Article 5 says that “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.” These measures are: (a) awareness-raising through information campaigns, formal and informal education, and outreach; (b) prohibition, through legislative measures backed by sanctions, of all forms of FGM, including the medicalized procedure; (c) support for victims of FGM in the form of health care, legal counsel, psychological care and support, and education and training; and (d) protection of women who are potential victims of FGM or other forms of violence, abuse or intolerance.

The so-called “soft law” instruments elaborate further on what action is expected from States’ parties against FGM. Article 4 of the Declaration on the Elimination of Violence against Women submits that states should refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to FGM.²⁰ States are urged to prohibit all forms of FGM (including the medicalized procedure), through the enactment and effective enforcement of national laws.²¹ Legal obstacles to prosecution of FGM cases need to be removed and therefore laws need to be reviewed and revised, adjusted or amended as appropriate. This has been stated in several documents, including General Assembly resolutions,²²
general comments of treaty bodies, reports of special rapporteurs, UN Secretary-General reports and World Health Assembly resolutions. In addition, several human rights documents and reports of treaty monitoring bodies recommend that states put in place adequate and concrete national accountability mechanisms for implementation and monitoring of legislation and national policies. There is also a need to adopt effective and appropriate measures aimed at preventing and abolishing FGM. Various bodies have called upon states to develop national action plans and strategies to eradicate FGM. States have also

Resolution 60/141 on The Girl Child, para. 9; GA Resolution 61/143 on Intensification of efforts to eliminate all forms of violence against women, para. 8(c); GA Resolution 62/140 on The Girl Child, para. 13; GA Resolution 63/155 on Intensification of efforts to eliminate all forms of violence against women, para. 16(b); GA Resolution 67/146 on Intensifying global efforts for the elimination of female genital mutilations, para. 4.

23 ESCR General Comment No. 16 on the equal right of men and women to the enjoyment of all economic, social and cultural rights, para. 29; CEDAW General Recommendation no. 24 on Women and health, para. 15(d);


25 Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/53/354, of 10 September 1998), para. 10; Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/58/169, of 18 July 2003), para. 12; Report on Ending Female Genital Mutilation (E/CN.6/2010/6), para. 1; Report on Ending Female Genital Mutilation (E/CN.6/2012/8), para. 47.

26 Resolution on Female Genital Mutilation (WHA61.16), para. 1(2).

27 GA Resolution 53/117 on Traditional or customary practices affecting the health of women and girls, para. 3(c); GA Resolution 67/146 on Intensifying global efforts for the elimination of female genital mutilations, para. 12; Commission on the Status of Women: Ending female genital mutilation E/CN.6/2010/L.8, para. 15; Report on Ending Female Genital Mutilation (E/CN.6/2012/8), para. 48.


29 CCPR General Comment No. 28 on Equality of rights between men and women (Article 3), para. 3; ESCR General Comment No. 14 on The right to the highest attainable standard of health, para. 22; CRC General comment No. 13 on The Right of the Child to Freedom from all Forms of Violence (CRC/C/GC/13), para. 72(g); GA Resolution 56/128 on Traditional or Customary Practices Affecting the Health of Women and Girls, para. 3(h); GA Resolution 61/143 on Intensification of efforts to eliminate all forms of violence against women, para. 8(f); Report and Programme of Action of the International Conference on Population and Development, Cairo, 5–13 September 1994 A/CONF.171/13/Rev.1, para. 5.3; Report of the World Summit for Social Development, Copenhagen, 6–12 March 1995, para. 79(b); Commission on the Status of Women: Resolution 51/1 on Women, the girl child and HIV and AIDS, para. 13.

been urged to allocate sufficient financial resources for implementation of policies and legislative frameworks aimed at abandoning FGM. States should also introduce appropriate educational and training programmes and seminars, as well as awareness-raising campaigns, based on research findings about the problems arising from FGM to systematically reach the general public, relevant professionals, families and communities, including through the media and featuring television and radio discussion. The importance of education and the dissemination of information in raising awareness of FGM is emphasized in the Maputo Protocol and many UN human rights documents. States should facilitate the establishment of multidisciplinary information and advice centres regarding the harmful aspects of FGM, as noted by the Committee on the Rights of the Child. States should recognize the important role that


33 CEDAW General Recommendation no. 14 on Female Circumcision; GA Resolution 67/146 on Intensifying global efforts for the elimination of female genital mutilations, para. 9.

34 See Article 5(a) of the Maputo Protocol: “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.”

35 GA Resolution 52/99 on Traditional or customary practices affecting the health of women and girls, para. 2(d); GA Resolution 53/117 on Traditional or customary practices affecting the health of women and girls, para. 3(g); GA Resolution 54/133 on Traditional or customary practices affecting the health of women and girls, para. 3(g); Report and Programme of Action of the International Conference on Population and Development, Cairo, 5–13 September 1994 A/CONF.171/13/Rev.1, para.13.14(b); Beijing Declaration, Platform for Action and the Report of the Fourth World Conference on Women, paras. 107(a), 124(k) and 276(b); Commission on the Status of Women: Ending female genital mutilation E/CN.6/2010/L.8, paras. 3, 7, 10 and 23; Report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 114; Report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/1996/53), para. 112 and 114; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/66/254), para. 57; Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/53/354, of 10 September 1998), para. 2, 7, 17, 40 and 54; Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/56/316, of 22 August 2001), paras. 9 and 40; Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/58/169, of 18 July 2003), para. 24 and 49; Report of the Secretary-General on Ending Female Genital Mutilation (E/CN.6/2010/6), para. 21; Report of the Secretary-General on Ending Female Genital Mutilation (E/CN.6/2012/8), para. 50; Resolution on Female Genital Mutilation (WHA61.16), para. 1(1).

NGOs play in the eradication of FGM and give them all necessary support and encouragement.37 States are also recommended to establish or strengthen comprehensive and accessible sexual and reproductive health support services to respond to the needs of girls and women and to provide adequate training for health-care workers (nurses, midwives, doctors and other relevant personnel) at all levels on issues raised in the context of FGM.38 Finally, states are recommended to collect and disseminate basic data about the prevalence, trends, attitudes and behaviour regarding FGM, as well as on reported cases and enforcement of legislation.39 Universities, medical or nursing associations, national women’s organizations or other bodies, can do the data collection.40

Although the United Nations, the African Union, the Council of Europe and the European Union have played a significant role in recognizing FGM as a human rights violation, the challenge of ending FGM ultimately rests at the national level. The case study of Europe demonstrates some of the challenges faced when translating the human rights framework regarding FGM into daily practice, and is described in the following sections.

5. Translating human rights into practice: The case of FGM in Europe41

Below, we provide some reflections on how human rights are put into practice in the EU, based on research performed in 2012 in all 28 EU Member States. This research aimed at mapping the situation and trends of FGM in the EU and to provide the European Commission with recommendations on how to tackle FGM in several areas (prevention, prosecution, protection,

37 CEDAW General Recommendation no. 14 on Female Circumcision; GA Resolution 52/99 on Traditional or customary practices affecting the health of women and girls, para. 3(f); Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/53/354, of 10 September 1998), para. 25; Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/56/316, of 22 August 2001), para. 12; Report of the Secretary-General on Ending Female Genital Mutilation (E/CN.6/2012/8), para. 49; World Health Assembly Resolution on Female Genital Mutilation (WHA61.16), para. 1(4); Report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 132.


39 GA Resolution 54/133 on Traditional or customary practices affecting the health of women and girls, para. 3(c); GA Resolution 56/128 on Traditional or customary practices affecting the health of women and girls, para. 3(c); Commission on the Status of Women: Resolution 51/3 Forced marriage of the girl child, para. 3(e); Report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2002/83), para. 130; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment(A/HRC/7/3), para 76; Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/53/354, of 10 September 1998), paras 15 and 34; Report of the Secretary-General on Traditional or customary practices affecting the health of women and girls (A/58/169, of 18 July 2003), para. 49.

40 CEDAW General Recommendation no. 14 on Female Circumcision.

41 The authors wish to acknowledge the following researchers that assisted in the EIGE study, on which this section is based: Lut Mergaert, Catarina Arnaut, Jessika Deblonde, Anke Van Vossole and Sioban O’Brien Green.
provision of services and prevalence of FGM in the EU). The paragraphs below focus on child protection, the provision of services and participation, following the CRC Committee’s general principles framework, as explained in the introductory chapter of this Handbook.

5.1. Protecting the rights adequately

FGM is performed on non-consenting girls – in most cases before the age of fifteen – and has severe consequences on their health and wellbeing. These facts have urged many countries to classify FGM as a form of child abuse. In all EU Member States, general child protection laws exist and can be used in case of FGM (EIGE, 2013). When there is a suspicion of FGM, either voluntary (e.g. a hearing with the family) or compulsory measures (i.e. withholding the passports of parents to avoid them travelling; upheaval of parental authority) can be taken; the latter are subject to court order (Leye and Sabbe, 2009). The fact that interventions to protect girls from FGM have been taken in nine countries (EIGE, 2013), underscores that girls in the EU are at risk of the practice. However, few countries developed specific policies to protect girls from FGM (EIGE, 2013). These policies support the implementation of child protection laws for professionals, and include risk assessment protocols and referral procedures. Proper risk assessment is key to adequately protect girls, as it can assist those professionals confronted with risk situations (police officers, teachers, health professionals, etc.) to adequately assess the level of risk and provide guidance on adequately responding to risk situations. In the majority of the EU countries, policies for teachers as well as risk assessment instruments were notably lacking (EIGE, 2013). Registration of child protection cases of FGM is weak in all EU Member States, due to lack of adequate registering of FGM in child protection records. Registrations could however be very helpful in monitoring and evaluating child protection services, and provide conclusive data on the number of cases reported, subsequent investigations or outcomes of investigations and as such, better target and steer the development of child protection policies and services.

Criminal laws have been put in place that make FGM illegal. In Europe, thirteen countries developed specific criminal law provisions dealing with FGM. In all other EU Member States, legal provisions dealing with bodily injury, mutilation and removal of organs or body tissue may be used for criminal prosecution of FGM (EIGE, 2013). However, the

42 For a full overview of this research, please consult the Report “Female Genital Mutilation in the European Union and Croatia”, at the website of the European Institute for Gender Equality: www.eige.eu (EIGE, 2013).
43 “Guided by what has gradually come to be seen as the four underlying principles, i.e. of non-discrimination, best interests of the child, survival and development, and participation (Committee on the Rights of the Child, 2003, §12), the CRC grants children rights relating to protection, provision and participation.”
44 These included interventions in Denmark, France, Finland, Germany, Italy, the Netherlands, Spain, Sweden and the UK. In Denmark, Germany, Italy and Spain, the interventions were court cases regarding child protection measures for FGM.
45 The countries with such policies are Denmark, France, The Netherlands and the UK.
46 Only France, the Netherlands, Spain and the UK seem to have some recording procedures put in place within the child protection sector (EIGE, 2013).
48 These countries are: Austria, Belgium, Croatia, Cyprus, Denmark, Germany, Ireland, Italy, Malta, The Netherlands, Spain, Sweden and the UK.
implementation of the law – or the fulfilment of the protection rights by a State – remains problematic in European Member States as only six countries had criminal court cases (EIGE, 2013).

Even if a country succeeds in prosecuting cases of FGM, this points to the fact that overall the system is not adequate enough in detecting and preventing FGM and that professionals and civil society organizations (CSOs), in charge of child protection and prevention of FGM, were not successful in avoiding FGM from happening. Court cases are only one indicator of the law enforcement process; the implementation of laws constitutes a totality of actions that are undertaken de facto, to give effect to the legal provisions at distinct levels of interactions by a number of stakeholders, who make use of multiple strategies: health and child protection officials who report cases, police officers and prosecutors who investigate cases, and judges and lawyers in the court room. The reality of the implementation of a law is characterized by the involvement of all these stakeholders and strategies (Leye et al., 2007; Ford, 2005). Major challenges with regard to the implementation of the criminal laws in the EU involve difficulties in the reporting/denouncing of cases of girls at risk or performed FGM, and finding sufficient evidence to bring a case to court (EIGE, 2013).

5.1.1. Reporting of cases

Several barriers have been documented in reporting and denouncing cases of FGM earlier (Leye et al., 2007), that were confirmed by the European case study (EIGE, 2013). One of these barriers includes the lack of willingness of family and community members to report cases of girls at risk, due to loyalty issues towards the community and family. Girls might be reluctant to report parents, as they are dependent on their family and community. Communities also need to be aware of the law and its repercussions when breaching it. When performing FGM, they have committed a crime, which is contrary to their intention of acting in the best interest of the girl. If parents are aware of the law, the benefits of having a daughter excised, i.e. conforming to the social norm might outweigh the negative effects of acting against the law. Furthermore, FGM is also performed in communities that are sometimes hard to reach by health and social services, making the detection of cases difficult (Leye et al., 2007).

Indeed, several professionals (such as doctors, nurses, teachers or social workers) play a critical role in identifying girls at risk, in reporting to the relevant authorities and in initiating protective measures (EIGE, 2013). In order to be able to play this role, these professionals have to be knowledgeable about FGM, and about the subsequent actions to take, in the case of a girl at risk or the case of performed FGM. Research showed that such knowledge is lacking (EIGE, 2013; Leye et al., 2007), resulting in an underreporting of cases and girls not offered adequate protection. Attitudes of health and child protection professionals, police officers and prosecutors, as well as judges and lawyers, equally influence the adequate implementation of laws. In particular, the fear of being labelled a racist and the respect for other cultures have resulted in the inaction of these professionals (Leye et al., 2007). Such attitudes have been noticed elsewhere as well (see for example Moynihan and Webb, 2009; Raman and Hodes, 2012). France has countered the “respect for other cultures”-argument in its court cases. French law considers that every person living in France is subject to the law, making no difference between origin and nationality; hence, all children enjoy the same rights, including the right to protection from

49 These countries were: Denmark, France, Italy, the Netherlands, Spain and Sweden; the majority of the court cases took place in France.
abuse (Leye et al., 2007). According to Weil-Curiel, FGM should not be considered differently than any other form of child abuse, and that, should the court take into consideration this cultural argument, some children within French jurisdiction would be discriminated against as only children of African origin are subjected to FGM (Weil-Curiel, 2003, 2004b).

In cases where FGM has been performed, professionals need to consider protection of other female siblings from undergoing the same procedure. However, professionals who deal with girls at risk of FGM, struggle with finding the right balance between prosecution and prevention. The prevention of FGM entails seeking collaboration with the family to prevent FGM from taking place on a girl and her sisters, and this is sometimes conflicting with prosecution, where penalties such as imprisonment of parents, might jeopardize a family that is functioning well and is usually acting in the best interest of its children. Child protection officers act from a different angle than judicial authorities when assessing possible protective actions. The police might act according to the rule of law to protect a girl, for example, by taking compulsory measures such as withholding the passports of the parents or imprisoning them, while a child protection officer is reluctant to report a girl at risk as he or she might prefer to continue working with the family in a relation of trust, in order to protect other female siblings from FGM and not to destabilize. A report published in the UK underlines the importance of recognizing FGM as a form of child abuse and to integrate it into all UK child safeguarding procedures in a systematic way (Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Equality Now, and UNITE, 2013).

Professional’s secrecy provisions and related disclosure regulations, that deal with the right or duty to report cases of child abuse among others, need to be taken into consideration as well. These are important mechanisms to ensure the implementation of the law and the protection of girls at risk. Professionals should be aware of it, as well as of the sanctions for non-reporting, the risk indicators of FGM, the procedures to be followed in the case of a risk situation, relevant referrals to be made and their time frame (EIGE, 2013).

5.1.2. Finding evidence

Some of the difficulties in finding evidence are equal to those concerning the reporting of cases, in particular the lack of knowledge about FGM, the attitudes of professionals and the secrecy surrounding FGM (Leye et al., 2007). Finding sufficient proof of FGM is difficult, as generally speaking, there is no written proof of it. Medical examinations of the genital area are possible, and have been done or proposed in some EU countries to establish whether or not the genitals are intact and as a means to enforce the law. For example, in France, the “Protection Maternelle et Infantile”\(^{50}\) received instructions to perform inspections of the external genitalia of all girls during medical follow-up and monitoring of the child until she is six years old, and to note and date the state of the (normal) genitalia in the “Carnet de Santé”.\(^{51}\) In cases where

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50 The PMI is a governmental organization, set up by the Ministry of Health. It provides a national system to protect mother and child, and takes preventive measures (at medical, educational, psychological and social level), monitors and controls services for children from 0 to 6 years and provides family assistance (http://wikipedia.org/wiki/Protection_maternelle_et_infantile).

the girl comes from a community that practices FGM, it is also advised to write down and date when the parents have been informed about the potential dangers related to FGM and the illegality of the practice (Leye et al., 2007). This medical follow up of newborns and children up to six years is not compulsory, and not all health professionals follow these instructions (Weil-Curiel, 2004b). In the Netherlands, in 2005, a special commission “Fight Against Female Genital Mutilation” investigated the possibility of compulsory gynaecological screening of girls of African origin. After this inquiry, the Dutch Minister of Public Health, Welfare and Sports, concluded that the Dutch government does not have the legal power to oblige citizens to cooperate with gynaecological examinations of underaged girls of a specific population group. The main arguments are that it is against the individual’s right to freedom and only perpetrators, not victims, can be obliged to undergo such examinations. Moreover, this can only be done when the public health is in danger, which is clearly not the case in this instance. The Commission also states that imposing such a measure on a specific population group is against the principle of non-discrimination (Commissie Bestrijding Vrouwelijke Genitale Verminking, 2005). Leye et al. have already pointed out that such compulsory examinations of the genitals have not been suggested to detect systematically cases of child sexual abuse among the entire population (Leye et al., 2007). Hence, why such a measure for African girls is considered discriminatory and intrusive. Moreover, questions can be raised regarding the feasibility of it, as such screening would require skilled health professionals that can detect even the slightest alteration in the genitals and might need consent of the parents.

Finally, finding evidence when FGM is performed in Africa, will need cross-border investigations, which are highly complex. As the extended family is often involved in decision-making, finding the perpetrators and/or facilitators of the act is problematic, as well as gathering criminal evidence to prosecute when non-family members have performed FGM. The fact that the onus is put on girls who have undergone FGM to testify against their parents and/or families in court, attributes to this complexity.

The issues identified above regarding the implementation of legislation indicate that the provision of a legislative framework, i.e. a specific criminal law and a child protection policy on FGM, do not suffice to curb the practice of FGM. Criminalizing FGM might also have non-intended effects. It has been argued that the practice might go underground and hence deprive girls from adequate protection (Vandenhole, 2012). Another effect that was noted was the lowering of the age of cutting. Among the cited reasons for this earlier age, is being able to do the cutting more discretely, particularly when people have been sensitized to end FGM or where the practice has been criminalized (Hernlund, 2000; Shell Duncan et al., 2011; UNICEF, 2013b).

In conclusion, the national legal framework, based on international human rights, is necessary to set the standard and provide an enabling environment for CSOs to act. It also provides professionals an additional tool to prevent FGM from happening. However, given FGM is considered a social norm, enacted by groups, that interacts with legal norms (enacted by States) and moral norms (internalized values of right and wrong), “any analysis undertaken to inform policies and programmes aimed at abandoning FGM needs to explore the 3 types of norms and how they interact with one another” (UNICEF, 2013b). In order to adequately change attitudes and behaviour on FGM, i.e. changing the social norm, laws are considered to be one of a set of interventions by governments that should be accompanied by other measures that target behaviour change in communities, as well as measures that target stakeholders. Such behaviour-change measures should address FGM within its broader social context, and take into account the degree of social support for the practice (Raman and Toubia, 2000; UNICEF, 2010;
5.2. Providing appropriate services for girls at risk of FGM and those with FGM

When looking at services provided for girls at risk or for those who have already undergone FGM, it is important not only to consider the capacity building for professionals, to optimize service delivery, but equally, the available services. Most commonly, it is the health sector that will be confronted with women and girls who have undergone FGM, and the child protection sector with cases of girls at risk. Most of the services in Europe that cover protection, prevention, provision of training and support are delivered by CSOs and health professionals. Specialized health services, such as the African Well Women Clinics in the UK that provide a multidisciplinary approach, have been put in place. CSOs provide training to a wide range of professionals, offer protection to girls and women, provide prevention activities among communities and professionals, raise awareness on the issue, etc. This service provision is supported by a variety of manuals, guidelines and protocols that have been developed for professionals and organizations that provide services (EIGE, 2013).

However, the main focus of service provision in the EU lies on gynaecological services, and there is a lack of services providing psychological care and psychosexual counselling. Health services that are available are provided through the existing health system, and specialized services such as the African Well Women Clinics are rather exceptional. Other issues include the concentration of services in larger urban areas, the ad hoc nature of service provision (mainstreaming FGM in existing services and institutionalization of services for victims of FGM are lacking) and training, the non-inclusion of FGM in curricula of health professionals and a lack of assessment of quality and effectiveness of existing tools that support service provision. Moreover, CSOs, as the major actor for service provision, struggle with a lack of financial and human resources, which is a major impediment to effective service delivery (EIGE, 2013).

As FGM is considered a form of child abuse in European Member States, such states should provide adequate child protection services. Existing services should be able to assess the risk that a girl will be excised, but they should equally be able to respond adequately in case FGM has been done. Professionals involved should be knowledgeable about how to deal effectively with cases of FGM, who to contact, how to determine risk factors and the legislative and protective mechanisms that are in place at a country or regional level. Some guidelines that support professionals in protecting girls have been developed. One example is the “Multi-Agency guidelines: female genital mutilation”, developed by the Home Office in the UK. These include information on identifying when a girl (including an unborn girl) or young woman may be at risk of being subjected to FGM and responding appropriately to protect them; identifying when a girl or young woman has been subjected to FGM and responding appropriately to support them; and measures that can be implemented to prevent and ultimately eradicate the practice of FGM. However, training for child protection officials is rare in the EU and if such training exists, it does not seem to be conducted on a continual, structured and national basis, and very often CSOs are relied on to provide training on FGM (EIGE, 2013).

52 African Well Women Clinics are services in the UK that provide specialist services, including clinical management, counseling and prevention. For more information see http://eige.europa.eu FGMontent/african-well-woman-clinics
53 Such services are equally provided in Belgium, Italy, Sweden and France.
As argued above, in order to prevent all forms of FGM, sustainable changes in social and cultural norms and behaviour among women and men, and children, are required. This cannot be achieved by adopting laws and a repressive enforcement. Sustainable behaviour change strategies and interventions regarding FGM have been discussed elsewhere (Leye et al., 2005; Brown et al., 2013). The creation of an enabling environment for behaviour change should equally include training of professionals in close contact with women who have had FGM or girls at risk, as well as regular awareness-raising campaigns, and providing teaching materials that include gender equality.

In the EU, most of the instruments that are developed have focused on prevention, in particular on awareness raising and providing training to professionals and advocacy efforts. The main issues in the EU Member States with prevention are that engaging with women, girls and communities that are most at risk, appears less pronounced, and there are insufficient efforts done towards lasting behaviour change. Especially working with young girls at risk of FGM (and with men and religious leaders) seems to be lagging behind to working with women. As said before, most of the prevention work is done by CSOs, and their chronic lack of sufficient funds and resources hamper an adequate long-term strategy to change social and cultural norms related to FGM. Finally, most prevention activities are done in the absence of accurate FGM prevalence data and firm evaluations, which makes assessment of success factors and areas in need for more work, problematic (EIGE, 2013).

One of the proposals for a service that has raised considerable controversy was the proposition of the American Association of Paediatrics, to perform a ritual nicking of the clitoris, to meet cultural requirements but at the same time limit health consequences (Song, 2010). Ever since the early nineties, debate has been ongoing on providing such “light” forms of FGM to avoid health complications of more severe forms of FGM. Providing this service by medically skilled personnel is considered, by those advocating for it, to be a necessary step towards total eradication of all forms of FGM. In the Netherlands, in 1992, two researchers argued that there were mutilating and non-mutilating forms of FGM, and that the government should allow for the non-mutilating forms (incisions in clitoris). The same was proposed in 1999 in Germany, by a medical doctor, who saw incisions in the clitoral hood as the only solution as the ritual itself would never change, and in Italy, in 2003, a medical doctor argued such incisions would prevent illegal infibulations conducted during school holidays, when girls are taken to Africa (Leye et al., 2006). Those opposed to such “harm-reduction strategy” have repeatedly pointed to the fact that performing “light” versions of FGM by medical health professionals is against medical deontology, that such incisions are equally violating the right to bodily integrity and that in some communities, girls are “redone”, if they notice that only an incision has been done (Baumgarten and Gahn, 2002). The assumption that a ritual will never change has been countered by recent statistics, which show that in some countries, younger generations do not undergo infibulations (UNICEF, 2013a), or that the meaning of the ritual changed: in some communities where it was part of the coming of age ritual, the cutting has been taken out of this initiation ritual – which is maintained – while FGM is performed on younger girls (Johansen et al., 2013). In Europe, some communities have switched from infibulations to Type II or Type I. However, in most countries, the type of FGM has not changed much across generations, which suggests that promoting less severe forms of FGM “does not hold much promise” and that the “benefits of a marginal decrease in harm resulting from less severe forms of FGM need to be weighed against the opportunity cost of promoting the end of FGM as one of many harmful practices that jeopardise the well-being of girls and infringe upon their rights” (UNICEF, 2013a).

The recurrent suggestion of pricking or incising the genitals, as a harm reduction strategy, seems to stem predominantly from health professionals. It is a short-term solution, viewed from
a health perspective only, and ignores the human rights dimension. Addressing FGM as a health issue only is believed to be one of the reasons of the increasing medicalization of the practice. Health professionals are generally considered as respectful individuals that have authority when it comes to health issues. When professional health organizations such as the AAP are publicly advocating for performing FGM by health professionals (in this case paediatricians), the effect of such a statement and its impact on the global campaign for the abandonment of all forms of FGM should not be underestimated. Maintaining FGM by performing ritual nicking does not contribute to the debate and questioning of the practice by the communities, which is a result of decades of campaigning against FGM. On the contrary, it legitimizes and contributes to upholding the practice.

5.3. The poor participation of girls and women in the FGM dialogue

It is of vital importance that policies and interventions are developed in full partnership with the communities that practice FGM. Partnerships with community-based organizations and professionals likely to be confronted with FGM, are also a prerequisite to develop and implement sustainable policies to tackle FGM. In the EU, a few countries have made efforts to include the communities in policy development or in the design of interventions, most commonly by collaborating with community based organizations that work towards the abandonment of FGM. The EIGE study identified several practices with potential, notably where such partnerships were formed to develop national action plans on FGM, to exchange experiences, to lobby national or international organizations, to provide services or to raise funds. However, in most cases, FGM-affected communities are not actively involved in policy dialogues on FGM, in the design of support services or in the drafting of specific criminal laws. The EIGE study found no evidence of involvement of minor girls in such partnerships in any of the EU countries. Finally, and as mentioned before, it is particularly striking to note that efforts in preventing FGM are rarely targeted at the communities themselves, but rather at professionals (EIGE, 2013). This might be a direct consequence of the fact that communities do not participate fully in dialogues with regard to the most effective strategies to deal with FGM.

In the field of FGM, a top-down approach is not effective, as outreach to communities that practice FGM is crucial in prevention work (Leye and Mergaert, 2012). Hence, why a community-based, participatory approach is paramount when developing interventions, policies or research studies. A notable practice with potential in the EU in this area is the END FGM-European Campaign, led by Amnesty International Ireland. This campaign (2009–2014) aims to put FGM on the EU agenda and “to echo voices of women and girls living with FGM and those at risk of being subjected to it” (End FGM European Campaign, 2009). The campaign is based on and advocates for the recognition of the principles of the human rights-based approach. This approach frames FGM as a human rights violation, aims at empowering rights holders, who are defined as women and girls living with or at risk of FGM, and seeks active and meaningful participation of those directly affected by the practice of FGM. According to the Campaign, active participation of rights holders in the development of policies affecting them and their communities is crucial to the success of any measures proposed at EU level. To

54 Medicalization of FGM refers to situations in which FGM is practised by any category of health care provider, whether in public or private clinic, at home or elsewhere (WHO, 2010. Global strategy to stop health care providers from performing female genital mutilation).
achieve its objectives, the Campaign has worked in partnership with 14 (community-based) organizations in 13 EU countries.

6. The need for a comprehensive approach to tackle FGM

FGM constitutes a violation of the rights of young girls and women. The human rights framework provides guidance for setting standards at national level and in creating an enabling environment for governments and CSOs to develop actions to tackle FGM. However, the implementation of international human rights law at national level and community level is facing multiple challenges. The case study of Europe showed that even in a context where policies and laws regarding FGM have been put in place, with available resources and an enabling political environment, implementation is not an automatic and easy process. It demonstrated that despite robust child protection policies being in place in the EU, the existing systems for protecting girls from child abuse show shortcomings when it comes to protecting girls from being subjected to FGM. Service provision lacks resources, and is often not provided in a structural way, but rather on an ad hoc basis, focused on awareness raising and sensitization, and is not provided at all levels. Although important first steps when tackling FGM are taken, more needs to be done to achieve sustainable behaviour change. Furthermore, girls and women affected by FGM participate poorly in the FGM dialogue: they are seldom actively involved in policy dialogues, in designing interventions of services or in drafting legislation. However, states alone are not able to deal with FGM, the particularities of FGM require full partnership with community-based organizations in the planning and implementation of all actions. They can liaise with and speak for the affected communities, and are crucial to make the work for abandoning FGM more effective (Leye and Mergaert, 2012). It should also be noted that in the EU there is an absence of baseline data and insufficient monitoring and evaluating mechanisms that can assist in following up on progress made by governments and states with regard to FGM. Robust data help in better targeting resources, in monitoring and steering the implementation of policies and activities, and consequently in making any action that deals with FGM more efficient and effective. The difficulties demonstrated when looking at prosecuting FGM, showed that many actors and strategies are involved when enforcing a criminal law. The call for more prosecutions regarding FGM, as is noted for example in the UK, should be regarded with caution. Having no court cases on FGM does not necessarily mean that the law is not being implemented. It might also point out that prevention and protection strategies are actually working. Having parents stand in court means that – ultimately – governments, CSOs and other stakeholders have failed in protecting a girl from being subjected to FGM. The ultimate goal of any intervention is to reach sustainable behaviour change, i.e. the abandonment of all forms of FGM. In order to take the above-mentioned elements into consideration, a comprehensive, multidisciplinary approach is necessary to deal with FGM. Such an approach should be adapted to each local context – this means that prior to an intervention a baseline assessment should be done to gain in-depth knowledge of the meaning of FGM in that particular context – and should focus not only on protection, provision and partnership, but equally have reliable prevalence estimates, while also trying to find the right balance between prosecution and prevention.

A coherent and comprehensive policy framework should not be limited to awareness raising or to successfully prosecuting FGM. Such an approach requires attention for the protection of girls and women at risk, the investigation of cases and subsequent prosecution of persons found guilty of practising FGM, the provision of services (health care, psycho-sexual care, psychological, social and medical counseling, legal advice) to those affected by FGM, as well as
the building of and support for partnerships between actors involved in dealing with FGM (including statutory and non-statutory actors, public bodies and private actors, including CSOs and community based organizations) (Leye and Mergaert, 2012).

**Questions for debate and discussion**

- A view opposing the belief that FGM constitutes a human rights violation is that of cultural relativism. What are arguments in favour and against such a cultural relativist approach – compared to the universalist approach?
- To what extent may the consideration of “the best interests of the child” be subject to cultural interpretation?
- To what extent is it possible to reasonably talk about real consent or autonomy when the social pressure in the community is so high to conform to the social norm of practising FGM?
- Would you consider the “light” or “non-mutilating” forms of FGM (incisions in clitoris) a human rights violation? If so, why? Would it be a good strategy to introduce “non-harmful” FGM?
- How should a comprehensive framework dealing with FGM look like?
- Why is adaptation to the local context important, when designing an intervention that deals with FGM?

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