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

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

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

Introduction

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

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

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

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

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

L. Weil-Curiel
Commision pour l'Abolition des Mutilations Sexuelles (CAMS), Paris, France

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

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

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

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

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

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

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

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

Research methodology

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

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

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

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

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

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

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

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

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

Results

Legal provisions applicable to FGM

General criminal law in cases of performed FGM

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

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

Specific criminal law provisions in case of performed FGM

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

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

[1]For example in France, parents or persons having custody can be and have been prosecuted as accomplices.

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

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

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

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

Clitoridectomy (Type I), excision (Type II) and infibulation (Type III) are forbidden in all seven countries that have specific law provisions. Type IV of FGM (all other forms of FGM performed for cultural or non-therapeutic reasons), is also forbidden by law in all countries, except for Denmark that only mentions the first three types. In Belgium, piercing and tattooing are explicitly mentioned in the preparatory works of the law as being excluded from the law. In the UK, these two forms are implicitly excluded as they are not included in the definition of offences constituting FGM, as per the UK FGM Act 2003 [20]. The new Italian law excludes “any other practice that causes effects of the same kind” as Type I, II and III [1].

Specific laws applicable to FGM fail to deal with the issue of re-infibulation, which is the frequently requested process of ‘re-closing’ the vagina following childbirth.[2] They also

[2]This procedure is common after every childbirth (and between childbirths, after divorce, a.o.) among Sudanese women [12, 34] as cited in [4], but is rarely requested by Somali women [4]. The commonly requested re-tightening after delivery by most Somali women is closing until a narrowed vaginal opening, but not to the primary infibulated state that needs a de-fibulation [4].

Table 1 General criminal law provisions applicable to FGM in EU member states

Country	Criminal law provision	Criminal offence	Aggravating circumstances increasing penalty	Extraterritoriality	Criminal prosecutions for FGM	Penalty
Finland	Chapter 21, sections 5 & 6 of the Penal Code: assault or serious assault	Bodily injury; serious bodily injury; illness, unconsciousness	Loss of essential parts of the body; offence endangers life of the victim; offence causes death	No	No	Assault: fine or imprisonment of max 2 years; serious assault: imprisonment from 1 to 10 years
France	Article 222-9/10	Mutilation	Offence against minor; offence performed by parent/person having custody (prosecuted as accomplices)	Yes	Yes	Up to 20 years of imprisonment
Germany	Sections 224 and 226 of the Penal Code: serious and grave bodily harm	Bodily injury; serious bodily injury; voluntary corporal lesions; mutilation	Loss of essential parts of the body; permanent and incurable corporal lesions	Yes, if victim is German national and exigency of double incrimination or; if offender is German and (s)he has not been extradited to country where crime was committed	No	Serious bodily harm: imprisonment from 6 months to 10 years, and in less severe cases, from 6 months to 5 years
Greece	Articles 308–315 of the Penal Code: bodily injury	Bodily injury; serious bodily injury	Offence against minor; Offence performed by parent/person having custody; loss of essential parts of the body; permanent and incurable corporal lesions; offence endangers life; offence causes death	No	No	The penalty varies from 10 years imprisonment to pecuniary, depending on the type, seriousness and special conditions of the offence
Ireland	Criminal Justice Act 2000: bodily injury	Bodily injury; serious bodily injury; mutilation	Offence against minor; loss of essential parts of the body; permanent loss of working capacity; offence endangers life;	No	No	No details received

			offence causes death			
Luxemburg	Article 392 of the Penal Code: voluntary corporal lesions	Voluntary corporal lesions	Offence against minor; offence performed by parent/person having custody; loss of essential parts of the body; permanent and incurable corporal lesions; permanent loss of working capacity; offence causes death; offence causes disease; offence causes serious mutilation; offence carried out with premeditation	No	No	Voluntary corporal lesions: 8 days to 6 months imprisonment and fine to 251 to 1,000 euros; with premeditation: 1 month to 1 year, fine of 500 to 2,000 euros
Portugal	Articles 143–149 of the Penal Code: bodily injury or serious bodily injury	Bodily injury; serious bodily injury	Offence against minor; offence performed by parent/person having custody; loss of essential parts of the body; permanent and incurable corporal lesions; permanent loss of working capacity; offence endangers life; offence causes death	No	No	Bodily injury: up to 3 years; serious bodily injury: 2 to 10 years
Netherlands	Articles 300–304 penal Code: bodily injury or serious bodily injury	Bodily injury; serious bodily injury	Offence performed by parent/person having custody; serious corporal lesions; offence causes death	Yes, on the condition that the offender is a national or liability for preparatory acts in the Netherlands concerning a FGM operation abroad	No	Bodily injury: 2 years imprisonment or fine Serious bodily injury with premeditation: imprisonment of 12 years max or fine

do not take into consideration cosmetic genital surgery, such as vaginal tightening or lifting/reduction of labia that are performed for non-therapeutic reasons. For example, Swedish law does not mention age or ethnic background in its content, and considers consent irrelevant [18]. Consequently, the Swedish Act on FGM technically outlaws genital changes also in non-African women, and all gynaecologists or plastic surgeons performing such alterations to the genitalia for non-medical reasons could be prosecuted.

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

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

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

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

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

As is the case in all EU countries, child protection laws pertaining to child abuse exist in Belgium (Child Protection Law of 1965), France (Article 375 of the Civil Code), Sweden (Social Services Act; Care of Young Persons Act (1990) and the Act regarding Special Representative for a child of 1999) and the UK (Children Act of 1989). In Spain, the following child protection provisions are applicable: Civil Code Articles 9.6, 92, 93, 156, 158, 216.2, 217; the Parliamentary Law of Judiciary Power Articles 22.3 and 5; and the following national child protection laws: Parliamentary Law (Ley Organica 21/1987 de 11/11) and the Parliamentary Law for the Legal Protection of Minors, enacted 15th January 1996 (Ley Organica 1/1996 de 15/01, de Protección Juridica del Menor). Furthermore, autonomous communities in Spain have their own child protection laws that are applicable in case of child abuse. In none of the above-mentioned countries does separate child protection legislation with regard to FGM exist.

In the case of girls at risk of FGM, either voluntary child protection measures are undertaken, such as hearings with the family, providing information, counselling and warnings to the family; or compulsory child protection measures, such as removing a child from the family or suspending parental authority. Certain compulsory child protection measures are subject to court permission, e.g. suspension of parental authority, removal from the home and withdrawal of travel permission.

Table 2 Specific criminal law provisions applicable to FGM in EU member states

	Austria	Belgium	Denmark	Italy	Spain	Sweden	UK
Specific criminal law provision	Section 90 of the Penal Code	Article 409 of the Penal Code	Articles 245–246 Penal Code	Article 583b is of Penal Code	Article 149 of Penal Code	Act prohibiting FGM, 1982:316, changed in '98 & '99	PFC Act 1985 and changed in FGM Act 2003
Date of entering into force	01/01/2002	27/03/2001	1/06/2003	23/12/2005	1/10/2003	1/7/1982	3/3/2004 (FGM Act)
Applicable on genital mutilation of boys	Yes	No	No	No	Yes	No	No
Which forms of FGM are forbidden	Clitoridectomy Excision Infibulation All other forms Reinfibulation not specifically stipulated as illegal	Clitoridectomy Excision Infibulation All other forms, except piercings and tattoos Reinfibulation not specifically stipulated as illegal	Clitoridectomy Excision Infibulation Reinfibulation not specifically stipulated as illegal	Clitoridectomy Excision Infibulation All other forms, except any other practice that causes effects of the same kind Reinfibulation not specifically mentioned	Clitoridectomy Excision Infibulation All other forms Reinfibulation not specifically stipulated as illegal	Clitoridectomy Excision Infibulation All other forms Reinfibulation not specifically stipulated as illegal	Clitoridectomy Excision Infibulation All other forms, except piercings, tattoos and stretching of labia Reinfibulation not specifically stipulated as illegal
Criminal offence consists of	Performance Participation Attempt to	Performance Participation Facilitation Attempt to	Performance Participation Attempt to	Performance Participation Facilitation Attempt to	Performance Participation Facilitation (only if there's co-authorship) Attempt to	Performance Participation Facilitation Attempt to Procure for Failure to report knowledge of crime	Performance Participation Facilitation Procure for Counsel to procure
Aggravating circumstances	Loss of essential parts of the body; permanent and incurable corporal lesions; permanent loss of working capacity; offence	Offence committed against minor; offence performed by parent/person having custody; permanent and incurable corporal lesions; permanent	Loss of essential parts of the body; permanent and incurable corporal lesions; offence	No details received	Offence is committed against a minor; offence is performed by a parent/person having custody	Offence endangers life of the victim; crime involved particularly reckless behaviour	Not mentioned in 1985 Act or in 2003 FGM Act

Table 2 (continued)

	Austria	Belgium	Denmark	Italy	Spain	Sweden	UK
	causes death of the victim	loss of working capacity; offence causes death of the victim	endangers life of the victim; offence causes death of the victim				
Does the consent of the victim affect the legal qualification of the act?	No	No	No	No	No	No	No
Applicability of extraterritoriality	Yes	Yes	Yes	Yes	Yes	Yes	Not in 1985, but in 2003 Act
Conditions for applicability of extraterritoriality	Double incrimination, unless both the victim and offencer are Austrians; offender must be found on the territory if he/ she is a foreigner	Victim is a minor; offender must be found on the territory	Double incrimination; victim is a resident	Victim is a resident	Double incrimination; complaint of the victim; offender has not been judged, absolved, condemned or indulted in a foreign country for the same charges	Offender is in some way connected to Sweden	Victim is a national or permanent resident or offender is a national or permanent resident
Criminal prosecutions for FGM?	No	No	No		Yes, in these court casesFGM was still treated under general criminal law	No	No
Penalty	Depends on the seriousness of the injury (up to 15 years of imprisonment if victim dies)	Performance: imprisonment from 3 to 5 years; attempted performance: imprisonment from 8 days to 1 year	Up to 6 years if the act does not have severe consequences. If the practice implies "severe consequences" the penalty can be up to 10 years		6–12 years imprisonment	Imprisonment for max 4 years; imprisonment for min 2 years and max 10 years	From conviction or indictment, to imprisonment for a term not exceeding 14 years, or a fine or both (FGM Act 2003); from summary conviction to imprisonment for a term not exceeding 6 months, or a fine not exceeding the statutory minimum or both (PCFA 1985)

However, all five countries – with the exception of Belgium – have developed specific child protection guidelines or protocols on the protection of a girl at risk of FGM. In the UK for example, the policy document "Working together to safeguard children," issued by the Department of Health, contains guidelines on how professionals should work together to promote children's welfare. In this document, a specific reference is made to the practice of FGM. The new London Child Protection Procedures (introduced in November 2003 and replacing the local Area Child Protection Procedures) provide the statutory sector[3] with a specific framework within which to work effectively to protect children from FGM.

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

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

Legal provisions regarding professionals' confidentiality

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

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

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

[4]Guideline regarding excision of girls.

[5]Mother and Child Health Care service, a public service provided in each of the French departments.

[6]Protocol for the Prevention of Female Genital Mutilation in the area of Gerona.

[7]Protocol of Proceedings to prevent female genital mutilation.

[8]Female genital mutilation: An educational material for schools, social authorities and the health sector.

Table 3 Child protection measures in the EU

	Belgium	France	Spain	Sweden	United Kingdom
Child protection provision(s)	Child protection law (1965)	Article 375 of the Civil Code	Civil Code, articles 9.6, 92, 93, 156, 158, 216.2, 217 ; Parliamentary Law of Judiciary Power: articles 22.3 and 5; National child protection laws: organic law 21/1987, 1st November and organic law 1/1996, 15th January; Autonomous communities have their own child protection laws	Social Services Act; Care of Young Persons Act (1990); Act regarding Special Representative for a Child (1999)	Children Act 1989
FGM is specifically mentioned	No	No	No	No	No
A specific FGM child protection guideline is provided	No	Yes; regional guideline applicable in Paris; information brochures disseminated nationally	Yes; Girona Protocol (only applicable in Catalonia); Interdisciplinary Commission on FGM was constituted on 14/11/2003 to discuss and approve the “Aragon Protocol”	Yes, elaborated by the Swedish Board of Health (2002)	Yes, in the sense that FGM is mentioned in the chapter entitled “Child protection in specific circumstances” by Department of Health (1999)
Voluntary child protection measures	Hearing with the family; informing, counselling and warning	Hearing with the family; informing, counselling, warning	Hearing with family; informing, counselling, warning	Hearing with the family; informing, counselling, warning	Hearing with the family; informing, counselling, warning
Compulsory child protection measures	Certain acts are subject to court permission, e.g. travel permission; removing the child from the family; suspending parental authority	Certain acts are subject to court permission, e.g. travel permission; removing the child from the family; suspending parental authority	Certain acts are subject to court permission, e.g. travel permission; periodic medical (genital) examination of a child; removing the child from the family; suspending parental authority	Medical (genital) examination of a child; removing the child from the family; suspending parental authority	Certain acts are subject to court permission, e.g. travel permission; removing the child from the family; suspending parental authority
Child protection interventions	No	Yes	Yes	Yes	Yes

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Act. The UK has the Human Rights Act and the Data Protection Act, but has also developed several policy documents relating to confidentiality and child protection. For example, the document "Working Together to Safeguard Children," states that personal information about children and families held by professionals should not generally be disclosed without the consent of the subject except where there is a need to protect the child's welfare [20].

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

Implementation of laws

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

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

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

Table 4 Professional secrecy provisions in the EU

	Belgium	France	Spain	Sweden	UK
Professional secrecy provisions	Article 458 and 458bis of the Penal Code	Article 226-13 and 226-14 of the Penal Code; Article 434-3 of the Penal Code	Article 263 of the Criminal Procedure Law	Secrecy Act (1980)	Working Together to Safeguard Children document; professional guidelines
FGM is specifically mentioned	Yes	No	No	No, specific guidelines elaborated by the Swedish Board of Health and Welfare (2002)	Yes
Which professionals are envisaged?	Health professionals; "other professionals bound to secrecy" such as education staff and social workers	Health professionals	Lawyers; priests	Health professionals, social authorities	Health professionals, social workers, police, education staff
Conditions for disclosing information	Art. 458bis: crime of FGM is committed against a minor AND the victim is in danger AND he/she cannot ensure the integrity of the minor	When the law imposes or authorises disclosure, e.g. in case of deprivation or abuse, incl. Sexual harm or assault committed against a minor or any person unable to protect herself	Not specified	In case of any crime which may lead to a minimum of 2 years imprisonment if the purpose is to prevent a crime	When there is a need to protect the child's welfare and safety
Duty or right to report	Right to report to prosecution authorities	Duty to report to administrative or judicial authorities	Health professionals and teachers have a duty to report to police or judicial authorities; citizens have an obligation to denounce to prosecutor, competent court instruction judge or police	Duty to report any suspicion of child abuse to the social authorities; social authorities may report a crime involving a child to the police	Duty to report to social services

Belgium

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

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

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

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

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

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

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

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

One key informant stated that evidence gathering is even more complex in extraterritorial cases. Two key informants stressed the lack of coordinated action at

European judiciary level and arbitrary cooperation between African and European fieldworkers to protect girls that travel abroad, which further exacerbates an inadequate follow up of excisors travelling around Europe and girls that travel to Africa.

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

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

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

France

The case study in France focused on the Paris region, where a number of cases have been reported. Within the PMI services of the Paris region, health professionals received instructions to perform inspections of the external genitalia of all girls during medical follow-up and monitoring of the child until she is 6 years old, and to note and date the state of the (normal) genitalia in the so-called *Carnet de Santé*[9] [31]. In case the girl comes from a community that practices FGM, it is also advised to write down and date when the parents have been informed about the potential dangers related to FGM and the illegality of the practice. However, it is important to note that medical follow-up of newborns and children up to 6 years is not compulsory in France.

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

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

Box 1: Court case of Awa Greou, Assize Court of Paris, 1999

Following a reported case of FGM by a young woman, a criminal case was opened. The victim reported that she and her three younger sisters were excised in the eighties, and that she was afraid her younger sisters would be forced to marry. She also revealed the name of the excisor who performed FGM on her and her sister. After investigating the whereabouts of the excisor, the excisor was arrested in 1994 and put to trail in February 1999. During the investigation, the electronic address book of the excisor was seized, after which long investigations in all Ile-de-France regions were initiated. The police questioned some 70 families, and examined their daughters in hospital. Besides the mother of the victim, 25 other parents involving 48 child victims acknowledged the excisor as the perpetrator, and were equally put to trial. The excisor was sentenced to 8 years and the victim's mother to 2 years of stiff imprisonment. The other parents had suspended prison penalties: 5 years for twenty of them and 3 years for three of them. The court granted compensation to the 48 victims: 13.000 € each. Since a court decree in 1999, compensations in France for the child victim may be up to 25,000 € [36].

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

Box 2: Child protection intervention, Paris, 1994

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

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

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

All key informants mentioned that identifying cases was one of the main barriers to implementing the law, caused by a number of reasons: doctors and other service providers who do not want to betray the trust that families put in them; service providers who want to

avoid the nuisance of reporting FGM to the authorities; and certain population groups that are very hard to reach.

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

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

Identifying cases is further exacerbated by the fact that, according to some key informants, not all health professionals follow the instructions of the PMI regarding systematic screening [36].

Some key informants expressed concern about the occasional lack of follow-up by prosecutors and another mentioned the lack of guidelines for professionals who are confronted with a girl at risk of FGM that might have an impact on the implementation of the law [36].

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

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

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

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

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

Spain

The case study in Spain focused on two autonomous regions – Catalonia and Valencia, where a number of interviews have been done with judges, public prosecutors, lawyers,

police officers, medical doctors, social workers and immigrants. Five interviews have been translated from Spanish to English, of which excerpts are included below.

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

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

Neighbours informed the social services of the intention of the Senegalese parents of a girl to travel to their home country to have FGM performed on the child. The social services informed the prosecuting authorities, who solicited the initiation of the committal proceedings and the adoption of urgent preventive measures: prohibition for the child of leaving the country, and if advisable, withholding the passport, and taking the statements of the parents as well as informing them of the penal consequences of the act to the parents. After that, the parents assured that although they had planned to have FGM performed, they would no longer do it. The Court handed down a ruling in which it was formally agreed to request the parents to abstain from promoting any action that impaired the integrity of their children, warning them of the penal consequences, and they were requested to inform the authorities about their return to Spain for a medical examination of the girl. Upon their return from Africa, a gynaecological examination was performed, that found no sign of FGM. Afterwards, the case was dismissed without prejudice, since evidence of an offence was not found [11].

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

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

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

The lack of knowledge about the procedures to follow when a case is reported is also another obstacle, although an important difference was noted between professionals interviewed in Valencia and in the Catalan area. The existence of the protocol for the prevention of FGM in Catalonia, and the fact that it is known locally, are considered to be the main causes of the different levels of knowledge between Catalonia and Valencia –

where no protocols for professionals are provided [11]. There was also a difference noted between the professionals' own perception of their knowledge about FGM and the actual reality of that knowledge, as well as a lack of interest in the matter.

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

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

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

Box 4: Case Cervera (Lérida), 2002

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

Source: Vanguardia (Newspaper), 25-4-2003, in: [11].

Sweden

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

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

Only a few cases have led to reliable conclusions that FGM had actually been performed (unclear if performed before or after migration to Sweden). Many of these cases were about fear of future performance of FGM or turned out to be unfounded [18]. Although some cases have reached the prosecution authorities, Sweden has never had any court case on

FGM. This was due to the following facts: after investigations it turned out that no crime was committed; it was impossible to prove that FGM was performed or it was impossible to prove that the performance of FGM was illegal [18].

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

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

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

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

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

Status: Suspicion of performed illegal circumcision; suspicions unfounded.

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

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

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

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

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

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

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

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

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

UK

In the case study in the UK, five key informants were identified and interviewed: a FGM specialist midwife, a gender and youth advisor, a solicitor, a project[10] manager and the head of the child protection section in the social services department.

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

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

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

[10] The project manager is responsible for a project in Nigeria that works with women and girls who have suffered Vesico Vaginal Fistula and Recto Vaginal Fistula as a result of FGM (Type 4) and early pregnancy and obstructed labour [21].

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

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

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

> "Where laws are made without them necessarily understanding the laws of a country, it becomes very difficult for practising communities not to feel that they are being discriminated against...that is where implementation of the law without careful preparation of the community becomes problematic. As you are aware, it is easier to make a law than to implement it. Implementation of the law actually requires adequate

> preparation, it involves resources, and involves testing the ground and I think this is where it may become very, very difficult" (Gender and youth advisor) [20].

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

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

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

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

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

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

Discussion

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

With regard to FGM legislation and its enforcement, this research provides a number of insights in the implementation of laws regarding FGM in Europe. The research clearly showed that both criminal laws and child protection laws are being implemented in four of

the five countries (except Belgium): cases are reported and investigations have been initiated, although the number of cases brought to criminal court is limited to France only. No evidence was found to state that specific criminal law provisions are necessary to guarantee the punishment of FGM, or that they are more successful in their implementation than general criminal law provisions.

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

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

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

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

Knowledge and attitudes

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

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

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

Reporting cases

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

Several key informants suggested genital examinations of girls as a method to increase the number of cases reported or to find evidence of performance of FGM. The example of

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

Finding evidence

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

[11]Commission Fight Against Female Genital Mutilation (*'Commissie Bestrijding Vrouwelijke Genitale Verminking'*).

Protection of girls at risk of FGM

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

Conclusions and recommendations

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

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

[12]Such an order can prevent girls of being taken out of the country.

Taking into consideration the following suggestions could enhance the implementation of FGM laws.

1. Where specific law provisions exist, they should be very clear about the forms of FGM that are prohibited, especially with regard to the emerging practice of piercing of the genitals and cosmetic vaginal surgery vis-à-vis FGM.
2. In the event that specific legislation is developed, or that there are amendments made to existing legislation, the government must ensure that community NGOs working towards the prevention of FGM are brought on board to ensure that they are able to inform their community members. These NGOs have been highly proactive in seeking to protect girls and to prevent FGM from taking place in the first instance, and a legal framework has been very helpful. Consequently, these NGOs need to be adequately provided with resources to advocate for the implementation of the law.
3. To avoid confusion, there should be a clear description of what re-infibulation entails, and what is permissible under the law so that medical professionals are fully informed.
4. Professional organisations should develop clear operational guidelines regarding re-infibulation.
5. The limits of applicability of extraterritoriality, and more specifically the exigency of double incrimination in the context of FGM, should be carefully analysed.

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

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

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

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

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

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

8. At EU level, co-operation is necessary between judiciaries to facilitate the provision of evidence and at national level between various authorities in a country (child protection, police, health sector, schools, migration officials etc).
9. Co-ordination between fieldworkers (state agencies, NGOs, etc.) in Europe and Africa is necessary to protect girls who travel between Africa and Europe.
10. Countrywide and European wide agreed protection protocols need to be developed to ensure that no cases go unreported.

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