FGC IN THE EUROPEAN UNION

A COMPARATIVE STUDY ON THE NATIONAL RESPONSE FROM THE UNITED KINGDOM, SWEDEN AND THE NETHERLANDS REGARDING FEMALE GENITAL CUTTING

ANNIKA VOOIS
12050814
ES4E-4D

COMMISSIONERS:
P. NIXON
M. ANGHEL

4 January 2016

European Studies
Faculty of Management & Organisation

THE HAGUE
UNIVERSITY OF
APPLIED SCIENCES

Executive Summary

The urgency of analysing the case of female genital cutting (FGC) increases due to the globalisation of today's world, enhancing multicultural societies dealing with benefits and challenges with respect to cultural differences. Generally, FGC originates from and is promoted as a highly valued cultural practice and social norm in Africa, some countries in Asia and the Middle East. However, due to migration, the prevalence of the practice is also increasingly growing within the European borders, where institutionalised individual rights are maintained but such practices are perceived as unacceptable.

The aim of this research was to investigating the line of acceptation and the governmental and non-governmental approach towards FGC within the liberal European Member States (MS) in terms of hard and soft power. The research was realised by the use of case studies on the United Kingdom, Sweden and the Netherlands and was focused on the nowadays large migration flow, which is likely to become an important point of focus for the future of FGC. Consequently, the main question to be answered within this dissertation is: What is the national response from the UK, Sweden and the Netherlands regarding female genital cutting and how could they improve their policy with respect to the nowadays large migration flow?

Analysis of primary and secondary literature showed that within Europe, FGC is perceived to be a violation of human rights and is considered to be a prosecutable crime. The opposing European opinion of FGC could be legitimised because of the threats on health and well-being of citizens due to the practice. However, throughout Europe, MS face a lot of difficulty in tracking cases of FGC and prosecuting offenders, despite of the assistance and multi-level hard and soft power efforts of European institutions and various national governmental and non-governmental organisations (NGOs).

Regarding the magnitude of the current migration flow, new measures need to be taken with respect to the national governmental and non-governmental approach to engage more efficiently in the matter of FGC. Recommendations were mostly made to increase the number of prosecutions and to disassociate the practice of FGC. These recommendations were mainly focused on the creation of community-based solutions, which should be enforced by the establishment of a network containing various (non)governmental bodies. Finally, to research if new measures turn out to be effective, it is important that all European MS investigate their prevalence rates each year to evaluate the situation within the country.

Table of Contents

1.0 Introduction P.1

§1.1 Context P.1

§1.2 The Research Focus P.2

§1.3 Report Structure P.3

2.0 Methodology P.4

§2.1 The Method of Approach P.4

§2.2 Data Specification P.5

3.0 Results P.7

3.1 The Historical, Anthropological, Medical and Legal Perspective on FGC P.7

§3.1.1 The History of FGC P.7

§3.1.2 The Anthropological Perspectives on FGC P.8

§3.1.3 The Medical Perspective on FGC P.9

§3.1.4 The Legal Views Towards FGC P.10

§3.1.5 The Outline P.13

3.2 The European Context and FGC P.14

§3.2.1 The Revival of FGC in Europe P.14

§3.2.2 The European Governmental Response to FGC P.15

§3.2.3 The European Non-Governmental Response to FGC P.17

§3.2.4 FGC and the Nowadays Large Migration Flow P.17

§3.2.5 The Outline P.18

3.3 Case Studies P.19

3.3.1 The United Kingdom P.19

§3.3.1.1 The Scale of FGC P.19

§3.3.1.2 The Governmental Response to FGC P.20

§3.3.1.3 The Non-Governmental Response to FGC P.22

3.3.2 Sweden P.24

§3.3.2.1 The Scale of FGC P.24

§3.3.2.2 The Governmental Response to FGC P.25

§3.3.2.3 The Non-Governmental Response to FGC P.27

3.3.3 The Netherlands P28

§3.3.3.1 The Scale of FGC P.28

§3.3.3.2 The Governmental Response to FGC P.29

§3.3.3.3 The Non-Governmental Response to FGC P.31

§3.3.3.4 The Outline P.32

4.0 Discussion/ Analysis P.33

§4.1 The Research Approach P.33

§4.2 The Results Obtained P.34

§4.3 The Outline P.40

5.0 Conclusion & Recommendations P.41

§5.1 Sub-Questions P.41

§5.2 Main-Research Question P.42

6.0 References P.45

7.0 Appendices P.53

§7.1 Figures & Tables P.53

§7.2 Full Legislation Related to FGC P.57

§7.3 Transcripts P.61

§7.4 Informed Consent Forms P.73

§7.5 Student Ethics Form P.77

1.0 Introduction

1.1 Context

In the modern times of globalisation, people from all over the world have the possibility and the opportunity to travel and live in other countries. Also within the European Union (EU), a great variety of ethnic groups are cooperating and living amongst each other, creating a high level of cultural diversity. This phenomenon of a heterogeneous society is seen in the Western society as highly beneficial for broadening the perspective of communities, increasing adaptability and understanding. However, cultural diversity can also create clashes between communities with a different ethnic background, resulting in several challenges within society. For example, the EU can be seen as a big liberal society with its own core values and fundamental rights. It considers cultural diversity, flourishing within a framework of democracy, tolerance, social justice and mutual respect between people and cultures, as essential for peace and security at all levels. Yet, when migrants with a different perspective on certain topics enter the European borders and have their own illiberal practices and traditions, conflict and misunderstanding can occur. To further illustrate this idea it is practical to look at the case of human rights vs. the right of cultural expression. The European countries mostly tend to follow UN's vision on such matters by "recognising the need to take measures to protect the diversity of cultural expressions, especially in situations where cultural expressions may be threatened by the possibility of extinction" ("Convention on the Protection", 2005, par.6). On the other hand, when cultural traditions form a serious threat to human rights, how should governments and its population approach these issues and where should they draw the line of acceptance and draw its limits?

FGC and its Emergence in Europe

One of the matters corresponding with the difficulty of encountering such challenges within liberal Europe is the case of Female Genital Cutting (FGC). As stated by the World Health Organisation, "Female Genital Cutting (FGC) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" ("Female genital mutilation", 2014, par. 2). According to the United Nations Refugee Agency (UNHCR), this practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East and among migrant and refugee communities from these areas in Australia, New Zealand, Canada and the United States ("Female Genital Mutilation, 2013, p.3). Yet, the puzzling nature of this practice is also gaining popularity within the EU, which has institutionalised individual rights

but consider such practices unacceptable. The European Parliament estimates that 500,000 girls and women in the EU have been subjected to FGC, and every year another 180,000 girls in Europe are at risk of being circumcised (Kern, 2014, par.11), which are rather unimaginable numbers to most of the European population. Consequently, the question on how the European Member States (MS) address and should approach this issue can be seen as rather interesting to investigate.

1.2 The Research Focus

This dissertation will carefully research the topic of FGC, how it was established and people's reason behind action within the advanced, but also less progressive global societies of the 21st century, to understand how this practice emerged in Europe. In addition, the different global views towards the practice in terms of human rights, cultural tradition and minority rights will be laid out and researched to understand the movements behind the views. Afterwards, the practice will be put in the European perspective by investigating the intensity of the matter and the approach towards the practice by developing case studies about the United Kingdom (UK), Sweden and the Netherlands. The aim of this research is to see where the countries mentioned have drawn their line of acceptation and what their governmental and non-governmental (NGO) approach is towards FGC in terms of hard or soft power, while residing within a Western country where such practices are rather incomprehensible. All these elements will be explored with the help of a main research question and several sub-questions to touch every metaphorical corner of the subject.

<u>The Main Research Question</u>

The European countries that will be investigated in this research share a common legal view towards the case of FGC. However, the way that the matter is being approached by each government varies intensely owing to legislation, campaigns and projects. Furthermore, non-governmental action taken by certain organisations that focus on the issue also differs per country. By thoroughly analysing and comparing the approach and action taken by both stakeholders will show the effective and the less effective approaches. Finally, the improvements that could be made to engage more efficiently in the matter of FGC will be displayed. These improvements will be made with respect to the nowadays large migration flow, since it might have an effect on the situation in terms of FGC and should be taken into account while giving recommendations on future action. The main research question that was deduced from this idea is: *What is the national response from the UK, Sweden and the Netherlands regarding female genital cutting and how could they improve their policy with respect to the nowadays large migration flow?*

Sub-question Specification

The first sub-question that corresponds with the main research question is: *How should FGC be perceived in the 21st century, as a matter of human rights or group rights?* This question will lay out the different global views towards the matter of FGG. Furthermore, it will pinpoint whether the practice should receive group rights and be tolerated in the name of freedom of cultural expression or should be fought by governments since it violates human rights.

Secondly, *what is the response of the European Union regarding Female Genital Cutting?* This question forces to change the focus from the global scale and zooms in on the European level with regards to the practice. The answer to this question will give an introduction of the situation within the EU. It will also lay out the European legislation and their action taken on the international level.

Afterwards, the focus will change again towards the national level and the countries that will be investigated in this dissertation with: *What is the governmental approach towards FGC in the countries mentioned?* The question will give insight on the national legislation, governmental campaigns and projects and will show the approach per government.

Fourthly, *what NGOs are combating FGC, in the UK, Sweden and the Netherlands, and how they are participating* is yet another question that will be used in this dissertation to go deeper into the participation of the other stakeholder in the fight against the practice. It will research their particular methods in their action per NGO.

1.3 Report Structure

This report will be divided into five sections, of which this section explains the broader scope of the subject of FGC within the European Union, as well as the arising research questions and the report structure. The second section gives an overview of the methods used for doing this research. Moreover, the results section gives a clear overview of the literature available on the topic and the primary data obtained. In addition, the following section, the discussion/analysis, discusses the information in the context of the existing literature found on FGC, linking, question, literature and case study data. This section will be followed by the conclusion and recommendations, giving an in-depth answer to the main research question on how to engage more efficiently in approaching this subject on the governmental level together with community focused organisations.

2.0 Methodology

This chapter intends to give an overview of the methods chosen to approach the topic of this dissertation, the specific primary and secondary data used, as well as the specific data consulted per sub-question.

2.1 The Method of Approach

The Abbreviation FGC

The abbreviation FGC (Female Genital Cutting) has been used throughout this dissertation instead of the term FGM (Female Genital Mutilation), which is the UN's preferred designation, because of the neutral nature of the term. As a Western individual, there is already a set attitude towards the practice. However, this subject needs to be approached in the most neutral way possible to be able to understand various opinions towards the practice and to formulate an unprejudiced dissertation.

The Case Studies

This research has been based mainly upon the usage of case studies about FGC within the UK, Sweden and the Netherlands. These countries have carefully been selected upon the representability for the rest of the European MS. Three countries have been selected with a dissimilar approach and situation towards the practice to be able to give recommendations which could be imposed by several MS.

According to the Gatestone Institute, the UK is dealing with the highest rates of FGC within Europe. Although the large efforts of the government and the specific legislation they maintain on FGC since 1985, here has yet to be a successful prosecution in British courts (Kern, 2014, par.4, 12). These facts show the importance of investigating this country to make improvements with respect to their national policy. Moreover, Sweden passed the first act prohibiting female circumcision in 1982, thereby becoming the first Western country to legislate against the practice, according to a UN report by E. Leye and A. Sabbe (Leye & Sabbe, 2009, p.3). In addition, as stated by the country's National Board of Health and Welfare, there is no evidence that FGC is being carried out in Sweden ("Claims 'no evidence' FGM", 2015, par.1,3,4), which makes investigation on the national approach rather interesting. In addition, the Netherlands will be the only country within the research with unspecific legislation on the practice, which means that the government prosecutes all types of FGC under assault and child abuse legislation (Boer & Desta, 2007, p. 16, 17). It is essential to compare the different forms of legislation to detect the most effective legal approach.

2.2 Data Specification

Primary and Secondary Data

The literature collected consisted of consulting secondary data within this dissertation, since it gives readily available second-hand information. This information was mostly obtained from reports and online literature, found on Google Scholar, and literature acquired from the library of The Hague University of Applied Sciences. All sources have carefully been selected on reliability. Furthermore, the official websites of the EU, the UK, Sweden and the Netherlands were also consulted in this research, to obtain reliable information on the national legislation, projects and campaigns on FGC.

Primary data was used because it provided a more in-depth look on the secondary data obtained. This information was gathered by using qualitative methods, including interviews, and not quantitative methods, such as surveys, because obtaining the public view on FGC legislation would have been irrelevant for this research. Interviews were held with several stakeholders participating in the matter of FGC to obtain expert views on various matters regarding the subject. These stakeholders included interviews with a representative, N. Kontoulis, of END FGM, which is a European NGO fighting the case of FGC within the European borders. Secondly, social-cultural anthropologist J. Abbink, specialized in African Studies, was consulted, along with M. Mos, senior public prosecutor at the Dutch Public Prosecution Service The Hague. Lastly, H. Othman, representative of FSAN, a Dutch NGO fighting the practice on the national level, was interviewed. The interviewees are specialists on the topic and are not directly involved in the practice of FGC, meaning that victims or executors of the practice were not approached, because of the sensitivity of the subject. In addition to the qualitative research, authorization forms were signed to protect the stakeholder's words and this research. These forms have been included in the appendix.

Data per Sub-question

The specific data used to research the first sub-question (*How should FGC be perceived in the 21st century, as a matter of human rights or group rights?*) varied from using primary, as well as secondary data. Most of the information came from online literature found on Google Scholar. Furthermore, the interview with social-cultural anthropologist J. Abbink added an expert view on this secondary information and helped adding to the literature that was already available on this specific corner of the topic, adding more reliability to this research.

The data used to collect information on the second sub-question (*What is the response of the European Union regarding Female Genital Cutting?*) also came primarily from online literature available on Google Scholar. Yet, just as with the first sub-question, an interview with END FGM was included in this research and added more value to answering this

question. This primary source could also provide a clear overview on Europe's view and actions towards the practice.

For the third sub-question (*What is the governmental approach towards FGC in the countries mentioned?*), information on legislation and governmental projects and campaigns was once more collected via reliable sources available on Google Scholar and on the national websites of the UK, the Netherlands and Sweden. In addition, the interview with senior public prosecutor M. Mos added specific information on the governmental view regarding the subject in the Netherlands, which was useful to confirm certain assumptions on the researched governmental approach.

Lastly, a variety of primary and secondary data was used to investigate the final sub-question (*What NGOs are combating FGC, in the UK, Sweden and the Netherlands, and how they are participating?*). Websites of influential NGOs within the countries investigated were explored to include knowledge on the general non-governmental approach on FGC. Primary data was covered by the interview with H. Othman from FSAN.

3.0 The Results and Literature Review

3.1 The Historical, Anthropological, Medical and Legal Perspective on Female Circumcision

This chapter will analyse the evolution of FGC throughout history and will give the anthropological and medical perspective on the practice. It is important to research where, when, how and why the practice started and is still executed to get a better understanding of people's reasoning to carry out female circumcision today. In addition, the chapter will give an in-depth look into the legal debate around female circumcision in terms of human rights and group rights.

3.1.1 The History of FGC

There is no exact place or date connected to the foundation of female circumcision. However, old scriptures have been found that mention the practice in certain regions, giving assumptions on where it was popular throughout history. For example, as mentioned in a report by E. Heger Boyle, a sociology professor at the University of Minnesota, Agatharchides of Cnidus, a Greek geographer, wrote about FGC in the second century B.C.. He mentioned the practice being executed among tribes residing on the Western coast of the Red Sea, modern-day Egypt. In addition, professor O. Meinardus, a coptologist devoted to the church of Egypt, assumed that FGC is rooted in the Pharaonic belief in which mortals reflected the bisexual traits of gods and every person possessed both the male and the female soul. It was believed that the female soul of the man was located in the penis and the male soul of the female in the clitoris, thus for a healthy gender development, the female soul had to be removed from the man and vice versa (Boyle, 2005, p.27). Furthermore, other theories suggest that that there is a clear connection between FGC and slavery. Reports from the fifteenth and sixteenth centuries suggest that Egyptians travelled to southern territories in the search for slaves, exporting Sudanic slaves to Egypt and Arabia. It was believed that females that were circumcised and sewn up in those times were sold for a higher price, because they were unable to conceive. The slave trade may have contributed to a widespread adoption of the practice towards the African continent, according to E. Heger Boyle (Boyle, 2005, p.27).

The explanation of Boyle for the continuation of the practice hundreds of years after the slave trade lies in the tradition of the practice. Few people know that FGC can be related to the mythodology of bisexuality or the slave trade, however, most people do stereotype uncircumcised girls as more masculine and unclean in the practicing regions (Boyle, 2005, p. 28).

Most of the early history of FGC comes from the non-Western countries. Yet, late history also suggests that the practice was being executed in the Western world. For example, “in the United Kingdom and the United States, there is evidence that in the nineteenth century the practice of female circumcision was performed by gynaecologists to cure so-called female weaknesses, such as nymphomania, insanity, masturbation and other ‘female disorders’,” according to a book by C. Momoh, a midwife specialised in FGC (Momoh, 2005 ,p.5).

3.1.2 The Anthropological Perspectives on FGC

The Socio-Cultural Aspect of FGC

Female circumcision is done regularly on girls, usually minors, and is promoted as a highly valued cultural practice and social norm in Africa and some countries in Asia and the Middle East. Various families, communities and cultures in which FGC is performed have different reasons for carrying out the practice in the 21st century. For instance, according to the WHO, it is believed that the practice is necessary to ensure that the girl conforms to key social norms, such as those related to sexual restraint, femininity, respectability and maturity (“Female genital mutilation”, 2012, p.1). In addition, some believe that the practice encourages hygiene, controls promiscuity, increases the sexual pleasure of the male and protects against unwanted pregnancies, as mentioned by T. Embaye of the International Organisation for Migration in Kenya. "There is often an expectation that men will marry only circumcised women," as stated by Margaret Chan, WHO's director-general (Oscarsson, 2010, par 8, 19). According to socio-cultural anthropologist J. Abbink, the cultural set of values of the community linked to the separate roles of men and females displays that FGC is essential for a women to be a full member of the community (Abbink, 2015,q.4). Consequently, the practice is performed in response to social pressure and supported by fundamental social norms, thus, ignoring the social norms frequently results in harassment and exclusion from important communal events and stimulates discrimination by people within their community, as stated by WHO (“Female genital mutilation”, 2012, p. 3). Unless there is a joint agreement within the community, individuals and families are likely to consider the social risks as more important than the physical and mental health risks to girls being circumcised. Even national legal restrictions against FGC can be seen as less important than the restrictions that can be imposed by the community for non-compliance with the practice. J. Abbink argues that it takes a lot of courage to reject FGC (Abbink, 2015, q.4). Furthermore, with respect to female circumcision, women are not only subject to, but are also involved in the execution. A girl’s female relatives are usually responsible for arranging female circumcision, which is generally performed by traditional female executers (“Female genital mutilation”, 2012, p. 1,3). "Although women are often responsible for the practical

arrangements, members of the extended family are usually involved in the decision-making," as stated by M. Chan (Oscarsson, 2010, par.17). However, J. Abbink mentions that the men within the community are left out of the preparation and the ritual itself, because that is believed to be a female matter (Abbink, 2015, q.4).

The Connection between FGC and Religion

Religiously speaking, according to socio-cultural anthropologist J. Abbink, FGC is practiced within many different cultures and among several adherents of the Islam, Christianity and local tribal religions. Female circumcision is mistakenly linked to religion, is not particular to any religious faith and predates Christianity and Islam, as stated by Abbink (Abbink, 2015, q.2). This could be acknowledged by the historical scriptures pointed out in the paragraph about the history of FGC. However, as mentioned by Human Rights Watch, some supporters of these religions still believe that the practice is stated as compulsory in their holy scriptures. As a result of this invalid link to various religions, and specifically to Islam, religious leaders have an important role to play in dissociating FGC from religion in general. The association of female circumcision with the Islam has been disproved by many Muslim scholars and theologians who say that FGC is not recommended in the Quran and is contradictory to the teachings of the Islam ("Q&A on Female Genital Mutilation", 2010, par. 9). Yet, religious leaders take varying positions with regard to FGC, some promote it, some consider it irrelevant to religion, and others contribute to its elimination, according to WHO ("Female genital mutilation", 2014, par. 5).

3.1.3 The Medical Perspective on FGC

Female circumcision can be seen as a public health issue, according to a report by N. Toubia, a Sudanese surgeon and women's health rights activist. He explains the health damages related to the different classifications or forms of FGC and subdivides them into two broad categories, including clitoridectomies (type one and two procedures) and infibulations (type three and four procedures). Each of these procedures involves the removal of certain genital parts; type one involves the removal of a part of the clitoris or the whole organ, which is also referred to as "Sunna circumcision", and type two involves the excision of the clitoris and the labia minora. Moreover, type four includes the removal of the clitoris and the labia minora. The labia majora are stitched together, leaving a small opening for the passage of urine and menstrual blood. Type three is seen as an intermediate form of type four and involve the cutting of the clitoris, the labia minora and includes the stitching of the labia majora, but leaves a larger opening. Figure one in the appendix illustrates the four types of FGC. The clarification of these different forms of female circumcision make it easier to standardise the

topic. However, the uncertified people who executed the circumcision have very different ways of carrying out the cutting, making it hard to classify the form in reality, as stated by N. Toubia (Toubia, 1994, p.1).

The physical complications of removing genital tissue, as stated by Toubia, should clarify the severe health damages that are related to female circumcision. The short-term complications include severe bleeding, pain and wound infections, which can lead to shock and death of the female. The long-term consequences vary per category, because of the interference with the passage of urine and menstrual blood. Consequently, type three and four are more likely to create internal infections and infertility. Yet, with each type, the possibility of the formation of cysts and pain during sexual intercourse is present. Also childbirth gives major problems and creates a big risk for circumcised women when health services are limited. If the woman is not de-infibulated, meaning that the vagina is reopened by removing stitches and skin, both the child and the mother is at risk of dying (Toubia, 1994, p. 1,2).

For many girls and women, undergoing FGC is also a traumatic experience that could have lasting psychological complications, besides the physical damage. Yet, documentation on the emotional effects linked to FGC is limited. As stated in an article by P. Mulongo, Sue McAndrew and Caroline Hollins Martin, from the University of Salford, WHO came to the discovery that only 15 percent of the studies focusing on the health effects of female circumcision mentioned the mental damage. The studies on psychological consequences of FGC specified the consequences, such as depression, post-traumatic stress, sleeplessness, loss of appetite, weight loss or excessive weight gain, panic attacks and low self-esteem (Mulongo et all, 2014, p. 3).

The people living within the practicing communities are not always aware of the medical consequences related to female circumcision.It is often linked to their level of education, as stated by J. Abbink. However, he also argues that they must be aware of the fact that some girls get infections or do not survive the practice, especially with the awareness campaigns of NGOs. Consequently, these people seem to weigh these medical issues with their cultural requirements (Abbink, 2015, q.5). He states that some communities, as the Masai in Kenya, are even debating about how female circumcision could be replaced by an alternative ritual, such as a symbolic act to initiate women into adulthood (Abbink, 2015, q.3).

3.1.4 The Legal Views towards FGC

The practice of female circumcision was rarely spoken of in Africa and little known in the West until the second half of the 20th century. When the practice of female circumcision

became widely publicised in the Western countries, people were shocked that girls and women had their genitals excised within traditional societies, as mentioned in a book by Katherine Brennan, professor in the history department at Loyola University Maryland. Human rights organisations presented a detailed report in 1981 about the painful consequences. This raised the question whether longstanding cultural practices that conflict with human rights norms should be criticised and addressed by governmental institutions or not (Brennan, 1988, p.1). Ever since, many scholars and professionals have been trying to answer this question and gave their perspective on the topic.

A Matter of Human Rights

Opponents of the debate on female circumcision emphasise that the practice is harmful to a women's health and being and rather define the practice as female genital mutilation. They believe that the practice is a ritualised form of women and child abuse, which should be addressed by governmental institutions and organisations. These people generally support assimilation policies.

An example of the opponent view towards the practice in relation to violence against women is the statement made by R. Haji Dualeh, a Somali sociologist and politician. She said; "Female circumcision may be considered as another form of female sexual oppression, which is the manipulation of women's sexuality in order to ensure their control, domination, and exploitation. In specific terms it serves to harness women into a secondary, submissive role by giving them a negative concept of themselves". R. Haji Dualeh shared her opinion on this topic during the international meeting in Khartoum, Egypt, in February 1979, which was the very first time that female circumcision was discussed in an international manner, as mentioned in a report by Fran P. Hosken (Hosken, 1981, p.1). J. Abbink follows this attitude by stating that the issue of FGC is an inequality issue (Abbink, 2015, q.6) and H. Othman, representative of FSAN, states FGC is a humans right issue, but is mistakenly used in the name of culture and religion (Othman, 2015, q.11). In addition, A. Thiam, a politician and feminist in Senegal, condemns "the universal exploitation and degradation of women, who are mutilated for no other reason than they are female", as stated in a book by Mae G. Henderson, English professor and author of articles on diasporic writing, cultural studies etc. (Henderson, 2014, p.246). Moreover, during the United Nations (UN) Fourth World Conference on Women in Beijing in 1995, FGC was classified as a form of violence against women and was compared with battering, rape, sexual abuse and forced prostitution, as mentioned in a book by Bettina Shell-Duncan, a bio cultural anthropologist, and Y. Hernlund. Consequently, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was set up by the UN in 1981. This convention called and still calls for an

end to all gender discrimination, including FGC, and requires state governments to "modify the social and cultural patterns of conduct of men and women, with a view on achieving the elimination of prejudices and customary and all other practices which are based on the idea of gender inequality" (Duncan & Hernlund, 2000, p. 27,28).

Furthermore, many activists have urged that female circumcision should also be considered as a form of child abuse, a stance that links to the UN Declaration of the Rights of the Child, as reported by B. Shell-Duncan and Y. Hernlund. This declaration supports the idea that every child should be given the opportunity "to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity and should be protected against all forms of neglect, cruelty and exploitation". From this perspective, legal scholar Kellner argues that although labelling female circumcision as child abuse may "appear degrading to the traditions of the practicing communities; the physical and psychological well-being of the children should be regarded as a higher concern" (Duncan & Hernlund, 2000, p. 27).

Many Western countries have a clear legal vision towards the practice and have legislation to illegalise FGC. However, there has also been a development in the widely practicing countries with regards to changing their legal behaviour towards FGC. For example, according to the NOS, the Dutch public broadcasting body, Gambia prohibited female circumcision on 25 November 2015 and Nigeria had put a ban on the practice earlier in 2015 ("Gambia verbiedt vrouwenbesnijdenis", 2015, par. 5).

A Matter of Cultural Expression

This perspective is rather positive towards FGC and claims that cultural relativism should be used rather than universalism as the primary basis for establishing moral norms and legislation. The supporters of this perspective believe in the policy of multiculturalism. This occurs when many subcultures exist within the same jurisdictional framework with a comprehensive policy for all, but allows room for a variety of cultural norms. Policies of multiculturalism have been enacted in various ways and have focused upon such factors as the protection and preservation of minority cultures, or on the establishment of special group rights for a cultural minority, according to a report by H. Dahan Kalev, a lecturer and the director of the gender studies program at the Ben Gurion University of the Negev (Kalev, 2004, p. 340).

An example of this positive perspective towards FGC is Dr. Ahmadu, a post-doctoral fellow at the University of Chicago, who was raised in America and went back to her home country Sierra Leone. As stated in an article by Debra J. Dickerson, a well-known senior editor on race relations and racial identity, Ahmadu argued that the critics of FGC exaggerate

the medical dangers, misunderstand the effect on sexual pleasure and mistakenly view the removal of parts of the clitoris as a practice that oppresses women. She has lamented that her westernised "feminist sisters insist on denying us this critical aspect of becoming a woman in accordance with our unique and powerful cultural heritage" (Dickerson, 2007, par. 6). Moreover, according to a book by R. Mustafa Abusharaf, an Associate Professor of Anthropology, both practitioners and scholars defending accommodation of cultural difference and the "free exercise of culture" indicate that marking the ritual as a crime, reflects the inability to "read and to see and to hear female genital mutilation as a series of complex social practices" (Abusharaf, 2013, p. 6). Another example of a statement made about this positive legal perspective by a scholar is N. Omoigui, a Nigerian military historian and cardiologist. He stated; "our Constitution recognises religious secularity as a principle of state policy but accepts Common law, Islamic law and customary law as a reality. It must be tolerant and also respect cultural secularity in a multicultural nation. There are ethnic clans in Nigeria, like Ijebus and Itsekiris, which do not routinely circumcise their women. I respect their right to exercise that prerogative and expect them to respect mine too", to which he refers to his tradition to practice female circumcision (Omoigui, 2001, par. 5).

3.1.5 The Outline

This chapter gave a more in-depth look into the general case of female circumcision by stating facts and different views regarding the practice to create more understanding of the different perspectives. The practice of FGC will be put into the European context in the next chapter and will outline how the issue is approached by the European governmental and non-governmental bodies.

3.2 FGC in the European Context

Besides the fact that FGC occurs nowadays in Africa, the Middle East and in some Asian countries, the practice is increasingly executed within the EU, as mentioned in the introduction. The growing number of women subjected to FGC in the European MS has raised concern at the European policy making level. Since the European general legal view towards the practice fits with the idea that FGC is a violation of human rights, FGC is an unwanted practice and is considered to be a crime throughout the EU. This chapter focuses on female circumcision in the European context and zooms in on the overall situation within Europe, regarding scale, European legislation, institutional campaigns and the NGO approach in fighting the practice.

3.2.1 The Revival of FGC in Europe

As stated in the previous chapter, female circumcision was being executed within Europe until the 19th century to treat several diseases. However, according to a book by C. Momoh, the practice started to fade and later resurfaced during the 1980s with the arrival of immigrants, students, refugees and asylum-seekers from for example Eritrea, Somalia, Ethiopia, Sudan and Djibouti (Momoh, 2005, p.21). During the years after this first migrant wave, more immigrants came to Europe from practicing countries and started to settle and create their own families here, in which FGC is often still executed.

A report by the UN gives an overview of the current situation regarding FGC in some of the European MS. It states that in France, estimations vary from 4,500 to 7,000 girls at risk, and from 13,000 to 30,000 women being circumcised. Approximately 21,000 women with FGC live in Germany and an estimated 5,500 girls might be at risk. Moreover, an estimated 28,000 women with FGC live in Italy, while there are at least 4,000 to 5,000 girls with FGC in the country. In addition, approximately 6,700 girls and women at risk or who have undergone the procedure reside in Switzerland. Furthermore, a published statistical study by a non-profit organisation suggested that in 2001, 66.000 women with FGC and 20.000 girls at risk (under the age of 15), live in England and Wales (Leye & Sabbe, 2009, p.2). These numbers give a slight overview of the situation within the European MS, however, according to END FGM, “there is still a very significant lack of data and research preventing organisations to accurately determine the prevalence and evaluate the medical and psychological support needed by survivors in Europe” (Kontoulis, 2015, q. 1).

3.2.2 The European Governmental Response to FGC

The European Legal Dimension Regarding FGC

There are a number of texts and resolutions, which are binding and non-binding, set up by the EU and the UN in which FGC is directly condemned or which can be used by the European MS as a basis to reject FGC, as stated in a report by E. Leye, professor in global health/gender related practices at Ghent University. Examples of UN resolutions condemning FGC are the Universal Declaration on Human Rights (adopted in 1948), the International Covenant on Civil and Political Rights (adopted 1966), the International Covenant on the Elimination of all Forms of Discrimination Against Women (adopted 1979) and the Convention of the Rights of the Child (adopted 1989). An example of a European text is the European Convention for the Protection of Human Rights and Fundamental Freedoms, which was adopted in 1955 (Leye, nd., p.75,76). Furthermore, as mentioned by END FGM, the largest non-profit umbrella organisation in Europe fighting FGC, the EU also adopted a number of key directives on the topic. For example, the Victim's Rights Directive, adopted in October 2012, requires provision of support services to victims of FGC. The Asylum Reception Conditions Directive, endorsed by the European Council in October 2012, specifically mentions victims of FGC amongst vulnerable persons who should receive appropriate health care during their asylum procedure and the Asylum Qualification Directive, adopted in late 2011, in which FGC was included as grounds to be taken into account for international protection ("European Union", 2015, par.4). According to the European Parliamentary Research Service, the European Parliament would like to see more concrete deadlines for the EU actions and continues to pursue the EU to adopt more binding instruments to combat gender-based violence, such as FGC (Jurviste & Hennigan, 2015, par.1).

Nowadays, all responsibility to prosecute FGC still lies with the European MS. The national legal provisions that apply to the practice can be found in criminal laws and child protection laws in the European MS, as stated in the UN report by E. Leye and A. Sabbe. In the majority of European MS, FGC is prosecutable under general national criminal legislation (Leye & Sabbe, 2009, p. 2). For example, FGC is being prosecuted under provisions and articles in the penal code dealing with bodily injury, serious bodily injury, voluntary corporal lesions and sometimes also mutilation. Only 10 European countries adopted specific criminal provisions, which are displayed in Figure two in the appendix and include the year of adoption. The other European MS were urged by the European Parliament and Council of Europe to adopt specific legal provisions to prosecute and punish FGC. Furthermore, several national governments as well as the European Parliament, are currently debating how current criminal laws can be better implemented, because criminal court cases with regards to FGC are very limited and prosecution rarely occurs (Leye & Sabbe, 2009, p. 3,6).

Every country has its own particular approach towards fighting the practice in terms of policies, because of the different approaches towards the resolutions and directives. Yet, as noted by END FGM, "having an internal common approach to the implementation of existing policies on international protection within the EU will help achieve the eradication of the practice" (Kontoulis, 2015, q.1).

European Projects & Campaigns

The European institutions have been fighting the practice throughout the years by employing different action methods in terms of projects and campaigns. The latest measures taken by the different European institutions are as specified below.

The European Parliament

As stated by END FGM, the Parliament made a resolution in June 2012, which called for action to end female circumcision within Europe and abroad through more prevention, protection measures and non-binding legislation. In addition, they reminded and urged the European Commission of its commitment to develop a strategy to combat violence against women, which included FGC. Moreover, within the Parliament, almost 400 MEP (member of the European Parliament) candidates signed a pledge and committed to prioritise the fight against the practice if they were elected in 2014. Subsequently, 93 of these candidates were elected as MEPs. Furthermore, the European Parliament highlights female circumcision in the Parliament's Human Rights in the World report since 2009, which shows their high interest in ending the practice ("European Union", 2015, par. 2).

The European Commission

As a result of the reminder from the Parliament, the European Commission released its first-ever action plan 'Towards the elimination of female genital mutilation' on the International day of elimination of violence against women on 25 November 2013 ("European Union", 2015, par.3). This action plan includes projects towards a better understanding of FGC in Europe, promotes sustainable social change to prevent the practice and includes a plan to support MS in prosecuting female circumcision more effectively ("Towards the elimination", 2013, p.3). Moreover, according to END FGM, a high level round table discussion was organised on 6 March by the Commission where END FGM demands for European action against FGC. As a result, the Commission launched a consultation with civil society organisations on combating the practice in the EU. In addition, the lack of reliable statistics on FGC in Europe called for a "Study to map the current situation and trends of female genital mutilation in 27 EU MS and Croatia". This study was set up and developed on the request of

Commissioner V. Reding, a Luxembourg politician. Lastly, on the occasion of International Women's Day 2010, every Commissioner pledged their support to the Women's Charter and promised to strengthen National action against FGC ("European Union", 2015, par.3).

The European Council

In June 2014 the Justice and Home Affairs (JHA) Council adopted conclusions on Preventing and Combating All forms of violence against women and girls, including FGC. Secondly, in March 2010, the Employment and Social Committee Council (EPSCO) requested for the creation of tools and exchange of knowledge and practices to end the practice by establishing a European observatory body ("European Union", 2015, par.4).

3.2.3 The European Non-Governmental Response to FGC

END FGM

As mentioned earlier, END FGM is one of the most influential European non-governmental umbrella organisations set up by 11 national NGOs with nine objectives, linked to raising awareness, prevention, empowerment, protection, coordination and support. As stated by N. Kontoulis, communications and network officer at the organisation, "the network creates an empowering environment by establishing contacts with relevant stakeholders, providing understanding on FGC and by shaping EU internal and external policy" (Kontoulis, 2015, q.2). These relevant stakeholders that END FGM is gathering support from are the European Parliament, the European Commission and the Council of the EU. END FGM participates in public consultation held by the European Commission, the UN and the Council of Europe and established consortia with other networks to engage and shape European developments, such as an informal CSO (Civil Society Organisation) group to monitor the implementation of the Council of Europe Istanbul Convention, the most innovative and complementary tools in the fight against violence against women and girls. Furthermore, the network supports national NGOs in giving guidance, dissemination and training in fighting against FGC at national, regional or local level (Kontoulis, 2015, q.2,3,5).

3.2.4 FGC and the Nowadays Large Migration Flow

According to the UNHCR, around 20,000 females have been seeking asylum from FGC-practising countries in the EU every year and mainly come from Nigeria, Somalia, Eritrea, Guinea and Cote d'Ivoire. The number of asylum-seekers has remained relatively constant between 2008 with 18,110 people and in 2011 with 19,565 ("FGM & Asylum", 2013, p.5,9). However, this number is rising fast with the nowadays large migration flow. For instance, in 2013, over 25,000 women and girls came from practising countries and mostly applied for

asylum in Germany, Sweden, the Netherlands, Italy, France, the UK and Belgium. Estimations from the UNHCR show that around 16,000 women and girls could potentially have already been subjected to female circumcision at the time of their arrival in the MS in 2013 ("FGM & Asylum", 2014, p.2,3). Table one in the appendix shows a more detailed table on the estimated number of female applicants potentially affected by FGC in 2013. The numbers of asylum-seekers will likely increase in the upcoming years, meaning that the EU should be medically, legally and socially prepared for these cases.

3.2.5 The Outline

Within this chapter, the scene slowly moved from the global and more general picture of FGC towards the situation regarding FGC within the EU. As stated, the EU is against the practice and responds in terms of resolutions, directives and action plans on the topic to give legal guidance and support to the MS to combat FGC on the national level. This chapter also introduced the following chapter, which will concentrate and lay out the dissimilar extend of FGC and legal approach within the European MS by governmental and NGO bodies.

3.3 Case Studies

This chapter means to zoom in on the European countries that are being examined for this dissertation, the UK, Sweden and the Netherlands. The statistics on the number of people that had to undergo FGC and the people at risk of undergoing female circumcision are collected besides the national campaigns and legislation regarding the practice. Additionally, the role of the government and the NGOs in the fight against FGC are separately put in perspective. It is important to research these factors to understand the intensity of the situation and what could be improved in terms of legislation or governmental aid to give more effective recommendations in the fight against FGC on the European and the national level.

3.3.1 Case Study United Kingdom

3.3.1.1 The Scale of FGC

A prevalence study has been executed in July 2015 by the City University London, displaying the percentage of the population that is affected by FGC in England and Wales and gives national and local estimates on the subject. This research does not only contain estimates on the number of women with FGC living in England and Wales, but also the number of women with FGC giving birth and the numbers of girls born to women with FGC in the UK (Macfarlane & Dorkenoo, 2015, p.5). The number of girls born to women with FGC in the UK has been included because it gives estimates on the number of girls that might be circumcised in the future.

<u>The Number of Circumcised Women</u>

According to A. Macfarlane, a perinatal epidemiologist and statistician, and E. Dorkenoo, a Ghanaian-British campaigner against FGC, approximately 103,000 women born in practicing countries between the age of 15 and 49 with FGC were living in England and Wales in 2011, compared with the estimated 66,000 in 2001. Estimates showed that within England and Wales there are approximately 24,000 women aged over 50 years old with FGC and born in practicing countries and there must be nearly 10,000 girls aged 0-14 born in FGC practicing countries who have undergone or are likely to undergo female circumcision in the UK. By combining the figures for the three age groups, an estimated 137,000 women and girls with FGC, born in countries where the practice is executed, were permanently resident in England and Wales in 2011. This represented a prevalence rate of 4.8 per 1,000 population (Macfarlane & Dorkenoo, 2015, p.5). These women that immigrated from practicing countries towards the UK in 2011 mostly came from Somalia, Nigeria, Kenya, Ghana and Uganda. Figure three on this information can be found in the appendix.

The study also shows a timeline of migration in relation to female circumcision. The overall number of women between the age of 15 and 49, who were permanently resident in the UK but born in practicing countries, increased from 182,000 in 2001 to 283,000 in 2011, giving reason to expect that FGC is a fast growing subject.

Prevalence rates varied considerably per region, with London having by far the highest prevalence with 21.0 per 1,000 people. Rates for individual local authorities varied even more widely. The highest rates were in the London district, with 47.4 per 1,000 in Southwark and 38.9 per 1,000 in Brent. Outside London, Manchester, Slough, Bristol, Leicester and Birmingham had high prevalence rates, ranging from 12 to 16 per 1,000. In contrast, many mainly rural areas had outcomes below one per 1,000, but above zero. This shows that, for the most part, people born in countries where FGC is practiced tended to be concentrated in UK's urban areas (Macfarlane & Dorkenoo, 2015, p.6).

Future Subject to FGC

From 1996 to 2010,144,000 girls were born in the UK to mothers from practicing countries. It was estimated that 60,000 of these girls aged 0-14 in 2011 were born to mothers with FGC, according to A. Macfarlane and E. Dorkenoo (Macfarlane & Dorkenoo, 2015, p.6).

3.3.1.2 The Governmental Response to FGC

National Legislation on the Matter

Within the UK, the government has had specific legal acts on female circumcision since 1985. As stated by the Crown Prosecution Service, the national law counts female circumcision as illegal when the procedure include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons, meaning that every type is prosecutable ("Legal Guidance", nd., par.1). According to a report on FGC by the House of Commons and the Home Affairs Committee, the practice has been considered as a criminal offence since the Prohibition of Female Circumcision Act on 16 September 1985. Afterwards, this act has been replaced by the Female genital Mutilation act in 2003 and re-enacted the provisions of the 1985 Act. This changed the maximum penalty for FGC to 14 years imprisonment and made it a criminal offence for UK nationals or permanent UK residents to perform FGC overseas and to take a UK national or permanent UK resident overseas to undergo the practice ("Female genital mutilation", 2014, p.37). As stated by the Crown Prosecution Service, the Female Genital Mutilation Act finally came into force on 3 March 2004 and was again modified by sections 70 to 75 with the Serious Crime Act in 2015. This latest act on FGC applies to "girls", though there is no legal difference when it comes to women, and applies to all UK nationals, which is an individual who is a British citizen or a British overseas territories citizen. This

British citizen is a person who under the British Nationality Act 1981 is a British subject; or a British protected person within the meaning of that Act ("Legal Guidance", nd., par.2,3,5). A detailed description per section is displayed in the appendix where the entire legislation on FGC can be found.

Thus, there has been legislation on this topic for 30 years, however, according to a report on FGC by the House of Commons and the Home Affairs Committee, until 2014 there had not been a single FGC-related prosecution in the UK. As stated in the report, the Crown Prosecution Service of the UK has been struggling to achieve a prosecution because of the lack of investigations by the police. For example, between 2010 and 2013, the UK's Metropolitan Police recorded that only 20 referrals made to the Prosecution Service as an FGC crime. According to the police two factors contributed to the small number of investigations. Firstly, the investigations rely on victims or witnesses to report to the police, which rarely happens. Victims are usually very young when they are being exposed to the practice, meaning that they are unlikely to realise that what has happened is considered to be a crime. Moreover, older victims might have been taught to think of the procedure as a positive thing, which represents their rite of passage into adulthood, and may not view FGC as a crime. In addition, it occurs that when the victim becomes aware that a crime has been committed against her, she may be reluctant to give evidence against her parents and relatives for fear of losing them, which is similar with witnesses. Furthermore, another reason for victims to not go to the police is that they often face huge social pressure from their families and communities to remain silent, fearing negative marriage prospects, rejection and violence if they try to speak out. Finally, the prospect of giving evidence at trial has the potential to be hugely traumatic for the individual concerned. The second factor connected to the low number of investigations has to do with the failure of health, education and social care professionals to refer cases to the police where they suspect FGC to have taken place ("Female genital mutilation", 2014, p.13). Consequently, from 31 October 2015 onwards, England obligates reporting by any professionals who are in contact with survivors or girls at risk, according to END FGM (Kontoulis, 2015, q.4).

Governmental Campaigns and Projects

FGC is a deeply embedded social norm within practicing communities, as stated in the first chapter. Families and individuals uphold the practice because they believe that their wider communities expect them to do so, and that they will face social punishment if they do not conform. According to the House of Commons and the Home Affairs Committee, the UK needs more than just legislation on the matter. They believe that rather improving understanding of these social norms and working with communities to critically review the practice is

essential to ending the generational cycle of FGC. The Association of Chief Police Officers (ACPO) mentioned that "community-driven solutions are fundamental to engender and drive sustained change", as stated in a report by the House of Commons and the Home Affairs Committee ("Female genital mutilation", 2014, p.43). Thus, communities Minister Stephen Williams announced on 5 December 2014 the names of 12 frontline community projects, such as FORWARD and the African Advocacy Foundation that will receive a share of £175,000 from the government to help end FGC within the UK. This government funding demonstrates the government's continued resolve to tackle these behaviours and practices and follows the pledge made at the International Day for the Elimination of Violence Against Women 2014 of a further £10 million to support women's refuges in 100 areas across the country. The money has been awarded to projects in those areas with greatest need and is in line with recently published data from NHS hospitals showing there to be 3 times the number of reported cases of FGC in London, compared to the rest of the country. More than 70 groups applied for funding and in addition to successful bids received from London, projects in Birmingham, Bolton, Bradford, Bristol, Essex, Leeds, Manchester, Nottingham and Rotherham will also be funded ("Funding frontline projects", 2014, par.1,2).

3.3.1.3 The Non-Governmental Response to FGC

Many NGOs play a big role nowadays in society and focus their work on matters, such as female circumcision, that are not always taken into account by public or private stakeholders. The NGOs mentioned in this paragraph are the most influential within the UK regarding the practice and all have their own methods to work on the issue.

<u>An alliance with Trust for London, the Esmée Fairbairn Foundation and Rosa</u>

The Female Genital Mutilation Initiative is an UK-wide initiative established by a formed alliance between Trust for London, the Esmée Fairbairn Foundation and Rosa (the UK Fund for Women and Girls), which are three independent charitable organisations. The alliance aims to safeguard young girls from female genital mutilation through community-based, preventive work, as stated in an interim report on account of the three founding organisations (Hemmings, 2011, p.3). It started in 2010 with an £1 million investment and a further investment of £1.6 million has now begun. The initiative is supporting fourteen smaller organisations across the UK, seven of these working in London ("Female Genital Mutilation", 2015, par.2), that are fighting FGC on the regional or local level. The objectives of the alliance are to raise awareness among affected communities about the national law and the health and psychological damages of FGC and to increase the confidence of women and men within affected communities to reject this practice as part of their cultural identity.

Furthermore, the Female Genital Mutilation Initiative wants to increase the skills and capacity within affected communities to influence individuals, groups, and statutory agencies, to strengthen the voice of women and communities speaking out against FGC and to improve co-ordination of activities amongst voluntary and community groups and statutory agencies working on this issue (Hemmings, 2011, p.3). In addition, the Initiative has commissioned an independent evaluation of its work, has supported conferences, an Open Space event, communications work to highlight the issue and the three founders regularly engage in discussions with the government, faith leaders and other interested bodies ("Female Genital Mutilation", 2015, par.2). This initiative has already achieved a lot in the case of FGC in the UK. For example, the arguments used by funded groups against FGC have become more sophisticated and have generated insights into what works in changing attitudes within affected communities in the UK. A stronger network of community-based organisations has also evolved, building the confidence of activists to speak out against the practice contributing to increasing the profile of FGC, in affected communities and in public debate ("Female Genital Mutilation", 2015, par.4).

Daughters of Eve

As stated on their website, Daughters of Eve is a non-profit organisation in the UK that works to advance and protect the physical, mental, sexual and reproductive health rights of young people from female genital mutilation practicing communities. They offer survival support, signposting services and works to protect girls and young women who are at risk from FGC. The organisation seeks to help young women who are at risk of FGC or gender-based violence to access the appropriate services to protect them. They give support and counselling for FGC sufferers and offer expert advice on issues affecting FGC victims such as childbirth, reversal procedures and reproductive health. Daughters of Eve takes a holistic approach and recognises that FGC occurs in a wider context of gender based violence and issues relating to gender inequality. Their aim is to support, advise, advocate and empower young people from FGC practicing and be their unedited voice. While working to end all gender-based violence practically FGC in one generation and gain equality for Young people by influencing policy change and key decision makers, through raising awareness and education, provide the services and support needed to help survivors of FGC and other gender based violence and by sharing good practice within the UK and international young on how we protect our girls from gender-based violence ("About us", nd., par.1,4-7).

3.3.2 Case Study Sweden

3.3.2.1 The Scale of FGC

The Migrant Population in Sweden

According to a report written by S. Johnsdotter, there is a large group of immigrants associated with female circumcision in Sweden from Somalia. Approximately 19,000 Somalis live in Sweden of which the largest groups live in Stockholm and Göteborg, while a few more than one thousand live in Malmö, the third largest city in Sweden. The second largest immigrant group in Sweden, also originating from a country where female circumcision is performed, is composed of Ethiopians. However, some of these categorise themselves as ethnic Somalis and many of them are Eritreans who were born while Eritrea was a region of Ethiopia. Another large group is composed of immigrants from Eritrea (Johnsdotter, 2003, p.6).

A Controversial Subject

Estimates from 2012 suggest there are around 42, 00 women and girls in Sweden who have undergone the procedure. Approximately 7,000 of them are under the age of ten. The numbers were drawn from calculations in 2012 based on how many women have origins in countries where at least half of the female population have been mutilated. However, Sweden did not have recent and specific prevalence studies on FGC. Yet, V. Berggren, associate professor of public health science, still argues in 2014, "The phenomenon is increasing in Sweden, due to increased immigration." In June 2014, an investigation in Norrköping, eastern Sweden, revealed that an entire class of school girls had been subject to the operation. The report ignited a media storm, and the county administrative board has decided to take measures to the health board, producing an online training program for school and health personnel on how to identify and prevent FGC ("Online course FGM", 2014, par.3,12,14).

Yet, according to the first report on FGC by the country's National Board of Health and Welfare, there is no evidence that Female Genital Mutilation is being carried out in Sweden. Sweden's report on FGC, which was commissioned in late 2013, will contain the National Board of Health and Welfare's first attempt to quantify roughly how many women in Sweden are affected. "We needed to know the magnitude of the problem, if it's really an issue for the healthcare system," Ahrne said. "Do we need training? Do we need to develop a new curriculum?" The conclusion of the report was clear; "We do not have any indications that it's taking place in Sweden," M. Ahrne, one of the report's authors, told The Local. "A lot of the immigrants from these countries are actually opposed to continuing this tradition" ("Claims 'no evidence' FGM", 2015, par.1,3,4).

On the first page of this paragraph it was already indicated by a study of the European Institute for Gender Equality that there were no prevalence studies of FGC in Sweden. Yet, the information above shows that research has been done on the subject, but still opposes media findings in the search of female circumcision in Sweden. According to Anissa Mohammed Hassan, the Somali woman who co-led a pilot FGC session with the young women in the heavily immigrant district of Norrköping, called for the introduction of genital examinations for all girls in Sweden aged six, just as all boys have their testicles checked. "The problem we have in Sweden is that there are no checks," she said. She has called for compulsory gynaecological checks for all children in the country to display the real scale of FGC in Sweden (Orange & Topping, 2014, par.2,3).

3.3.2.2 The Governmental Response towards FGC

Legislation on the Matter

As mentioned in Johnsdotter's report, Sweden passed the first act prohibiting female circumcision in 1982 and became the first Western country to create specific legislation against the practice (Johnsdotter, 2009, p.8). Sweden has also been noted for its proactive stance in reaction to the practice at a time when a relatively small numbers of immigrants were in the country, as stated in a report by the Irish Women's Health Council ("Female Genital Mutilation/Cutting", 2014, p.20). According to the law, all types of female circumcision are illegal, ranging from the most extensive, where large parts of the genitals are cut away and the vaginal opening is stitched together, to pricking of the clitoris with a sharp or pointed object, regardless of whether or not consent has been given for it. Those people attempting to perform, prepare or conspire to commit the offence of female circumcision are punishable by the Swedish law, as is a party who fails to report the practice. The principle of extraterritoriality, which exists in the UK law, is also applicable in Sweden, making FGC punishable even if it is committed outside of the country. In 1998 the law was revised with a change in terminology, from "female circumcision" to "female genital mutilation", creating a clearer view of the government's' opinion regarding the practice. Furthermore, more severe penalties for breaking the law were imposed. The law was further reformulated in 1999, to allow for prosecution in a Swedish court for someone who performed female circumcision, even if the act has been performed in a country where it is not considered as a criminal offence. In addition, the sections 2 and 3 of Chapter 2 of the Penal Code concern nationality and residency. These sections suggest that the nationality of the offender or the victim does not stand in the way of prosecution. If the crime has been committed in Sweden, any person, varying from asylum-seeker to an illegal immigrant, may be prosecuted in a Swedish court. If the crime has been committed abroad, the victim does

not have to be a Swedish citizen for prosecution to take place, and neither does the offender. However, they should be or have been Swedish residents (Johnsdotter, 2009, p.55,56).

Swedish legislation on FGC has been criticised for being too broad and has raised questions in previous years. For example, Johnsdotter says that the law states that the pricking of the clitoris with a sharp or pointed object is illegal. However, it remains unclear whether it would be possible to take a case including a symbolic pricking to court, based on the wording of the FGC law. Furthermore, the law on FGC does not mention cosmetic genital surgery and creates confusion on the subject as Swedish law does not mention age or ethnic background and considers consent irrelevant. There has not been a legal case against plastic surgeons or gynaecologists for violating the Act on FGC when performing cosmetic genital surgery on women in Sweden. However, in 2007, a woman stated that too much tissue had been removed from her labia and clitoris during a cosmetic operation of her genitals and that she felt mutilated. The case was not reported to the police. However, she filed a report to the Medical Responsibility Board and the surgeon received a formal warning. This example lies out the gaps in Swedish FGC legislation (Johnsdotter, 2009, p.2,3).

Nonetheless, S. Johnsdotter's reports state that since 1982, when the Swedish Act on FGC was passed, twenty suspected cases have been reported to the police and two cases were brought to court in 2006 (Johnsdotter, 2009, p.4). In one of the court cases, a mother was charged, while the other case involved formal allegations against a father. Both cases led to convictions and prison sentences of respectively three and two years (Johnsdotter, 2009, p.6).

Governmental Campaigns and Projects

Despite the fact that there is no professional information on the number of women who are in contact with female genital mutilation, in June 2003, the Swedish Ministry of Health and Social Affairs presented a governmental action plan against FGC and allocated 3 million crowns, approximately 328 000 euros, for the realisation of the project. The aims of the action plan are to work for a total abolition of FGC among girls who live in Sweden and to give adequate support to girls and women in Sweden who are already circumcised. The action plan is expected to be implemented by a variety of authorities including the government, various kinds of authorities, regional and local governments and NGOs. Besides the concerned immigrant groups, officials and professionals in for example the healthcare sector, the school and pre-school sector, the social sector, the police and the prosecution departments are being targeted too with this action plan, according to a report by Sara Johnsdotter (Johnsdotter, 2003, p.4).

Furthermore, the Swedish government has launched a national campaign trying to stop female circumcision in Sweden in 2009, including immigrants without citizenship. It has also moved to support girls and women in Sweden who are supposedly victims of circumcision. The act directs Swedish schools, preschools, hospitals, local health centres, social services, police authorities and prosecutors to understand, prevent and deal with circumcision (Oscarsson, 2009, par.18).

3.3.2.3 The Non-Governmental Response to FGC

The NGOs mentioned in this paragraph are the most influential within Sweden regarding the practice and all have their own methods to work on the issue, which is explained per section.

RISK

RISK is the Swedish acronym for the national association for ending FGC, with a board consisting of 10 members from different parts in Africa and Sweden. It is the biggest non-governmental and non-profit organisation in Sweden that works with grassroots and partner organisations, such as Save the Children and END FGM, to end FGC in Sweden and beyond. Risk was established in 1994 as an answer to the rising number of immigrants from Africa in 1970. RISK believes that the essential problem related to FGC is the low status within society of girls and women. Thus, the organisation is trying to enlighten people by sharing information on the practice and the dangerous health problems that may occur. RISK educates Swedish ambassadors, with another ethnic background, who will work in in areas with a high level of immigration from practicing countries. These ambassadors know their language, making it easier to inform and discuss about the practice. RISK is part of a nationwide FGC network and take part in meetings, conferences and discussions across the country to spread their information and vision ("RISKs arbete", nd., par.1,4).

Female Integrity

KVINNOINTEGRITET ("Female Integrity") is one of the smaller, more well-known grassroots associations set up by RISK and was officially established and registered in 1995 in Uppsala to campaign against FGC in the Uppsala region. The association campaigns for ending the practice by raising consciousness of the injurious effects of the practice through information and education, as RISK does. They operate together with the Ethiopian Women's Association in Uppsala and participate in national and international seminars where the progress of the campaign against FGC is discussed. Female Integrity works in close coordination and cooperation with the other branch associations of RISK in other regions ("About us", nd., par.1-3).

3.3.3 Case Study the Netherlands

3.3.3.1 The Scale of FGC

Female Genital Cutting in the Netherlands, a report by Pharos

Pharos, the Dutch Centre of Expertise on Health Disparities, a Dutch organisation focusing on the quality and affectivity of healthcare for migrants in the Netherlands has launched a research report on female genital mutilation in 2013 in association with the Social Healthcare department of the Erasmus Medical Centre. This prevalence study gives a clear view on the number of women living in the Netherlands with FGC and the number of girls at risk of the practice. On the first of January 2012, the organisation counted 71.800 women from countries where FGC is practiced and who are living in the Netherlands. Almost 63.400 women are coming from one of the 28 countries where FGC is practiced of a list of WHO. They make up 1% of the total female population in the Netherlands. Of the almost 70.000 registered females in the Netherlands, coming from countries where FGC is practiced, approximately 3/4 come from just six countries: Somalia, Ghana, Egypt, the Kurdish region in North Iraq, Ethiopia and Nigeria. The prevalence of FGC is quite high in some of these countries, including Somalia, Egypt, the Kurdish region in North Iraq and Ethiopia, but the prevalence in Nigeria is considerably lower or in Ghana even very low (Exterkate, 2013, p.11).

Half of the number of women coming from countries where FGC is practiced is living in Amsterdam, Rijnmond, The Hague and Utrecht and their surroundings. The Somali population is scattered over a number of regions in Arnhem/Nijmegen, the Veluwe, Flevoland and the four biggest cities of the Netherlands. Ghanaians live mostly in Amsterdam, Ethiopians/Eritreans and Egyptians live close to the four biggest cities and Nigerians in Flevoland and the Randstad (Exterkate, 2013, p.12).

The Number of Circumcised Women

The report indicates that of the almost 70.000 women coming from FGC countries and living in the Netherlands, approximately 40% circumcised, which is almost 28.000 women. Among these women, 87% is first generation migrant and 13% second generation. Research showed that 15% is younger than 19 years old, 75% of the women is between the age of 20 and 49 years old and 10% is older than 50. The figure 4 in the appendix gives more detailed information on the number of circumcised women in the Netherlands according to their nationality (Exterkate, 2013, p.13).

It seems that Ghana is not the most important country when it comes to the number of circumcised women in the Netherlands. Although the Netherlands houses many Ghanaian

women, FGC is not as big of a problem as among the Somali female population. The reason for this phenomenon is that within Ghana there are big differences between the regions concerning female genital mutilation. The women from Ghana living in the Netherlands seem to come from those regions where FGC is rarely practiced (Exterkate, 2013, p.13).

Future Subject to FGC

The total number of girls living in the Netherlands that is at risk of being circumcised varies between the 557 and the 3.477 girls per year coming from Somalia, Ghana, Egypt, Ethiopia and Nigeria. Furthermore, between the 9 and 297 girls with the Kurdish nationality from North Iraq are at risk of FGC each year. These numbers are estimates according to the number of girls being circumcised each year living in the Netherlands.

In addition, according to the research of Pharos, 1.705 girls were born in 2011 to a mother coming from one of the countries where FGC is practiced. Between the 0 and 939 of those girls will be circumcised by the age of 15 years old (Exterkate, 2013, p.16).

3.3.3.2 The Governmental Response Towards FGC

Legislation on the Matter

As explained in a report by M. de Boer and A. Desta, two representatives of VON, a Dutch NGO focusing on FGC, Dutch politics has been concentrating on female circumcision since the beginning of 1990 and has set their official legal vision towards the practice in 1991 with prosecuting all types of FGC under assault and child abuse legislation, meaning that the practice does not have specific legislation (Boer & Desta, 2007, p.16,17). However, deputies urged for a specific legislation in 2001 to show that the practice is a fundamental violation of human rights, which was answered negatively by the Dutch government in 2004. The government believes that specific legislation is not needed to effectively prosecute offenders (Boer & Desta, 2007, p.44). Also M. Mos, public prosecutor, thinks that the existing legislation is sufficient enough (Mos, 2015, q.11).

The general criminal law, applicable to FGC, are the Articles 300–304 of the Penal Code, consisting of the crimes of (grievous) bodily injury and Article 436, referring to the prohibition of unauthorised medical interventions. Furthermore, according to Articles 47–48 of the Dutch Penal Code, in addition to the person who actually performs the mutilation, people who assist, aid, procure or pay a third party to perform FGC are also inclined to be prosecutable. The statute of expiration for prosecuting serious cases of FGC has been extended to 20 years from the moment a girl reaches the age of 18, as mentioned in a report by the European Institute for Gender Equality (“The Netherlands”, nd.,p.1). In addition, the principle of extraterritoriality is also applicable since 1 February 2006, making FGC

punishable even if it is committed outside the country. Moreover, when it comes to the punishment for offenders, there has been made a distinction in years of imprisonment per case. For example, for abuse that results in serious bodily injury, the penalty is a maximum of four years imprisonment while if the circumcision has been executed by one of the parents of the child, the years of imprisonment can be raised with one and a half year, as explained by M. de Boer and A. Desta (Boer & Desta, 2007, p.44).

Yet, the Netherlands does not have many cases on FGC, as mentioned by the UN. Their first case has been in 2009 and not many have followed (Leye & Sabbe, 2009, p.7), which could be acknowledged by public prosecutor M. Mos (Mos, 2015, q.4). She argues that the low number of cases has to do with the fact that not many people report to the police about this issue because of social pressure from their community, or the idea that people might not be integrated and familiar within the Netherlands and do not know how to reach the police (Mos, 2015, q.6,7). Furthermore, M. Mos believes that the number of prosecutions could increase by expanding the legislation with the requirement to report if medical professionals are in contact with a case of FGC. Yet, she does not belief that the police or the public prosecution service should deal with the issue at the community level, but should be addressed by assistance agencies. It is not the government's task to fight the issue at the community level (Mos, 2015, q.12,14).

Governmental Campaigns and Projects

There has not been any national governmental program against FGC in the Netherlands before 2005. Only Dutch NGOs were campaigning to stop the practice and created a network to fight FGC together. Yet, in 2005, the Dutch Board of Public Health Care initiated a new, effective way to prevent the practice from happening. The policy is in line with the vision and recommendations of the WHO and Unicef and focused on the prevention of FGC while maintaining the legal prohibition. This policy was executed on different levels, making it more successful ("Beleidshistorie", 2015, par.4).

Furthermore, in 2006 the Ministry of Health, Welfare and Sports came up with a FGC prevention project, which had to be carried out in six big cities with relatively many people from the at risk communities. The Ministry worked intensively together with the Dutch Public Health Service (GGD), operating in these regions, Pharos, The Dutch Centre of Expertise on Health Disparities, and the Federation of Somali Associations (FSAN). The goal of this project was to create cohesive prevention activities. In addition, the project was meant to make people from the risk communities aware of the damage of female genital mutilation and to increase the feeling of importance of fighting FGC with partner organisations. This project has been improved in 2010 and advanced the task division with the partner

organisations, the GGD, FSAN and the Refugee Organisation the Netherlands (VON). There has also been more attention for medical and psychological care for the victims of female circumcision ("Beleidshistorie", 2015, par.5, 6).

3.3.3.3 The Non-Governmental Response to FGC

As in the UK and Sweden, the Netherlands also has several influential NGOs fighting FGC on the national level all have their own methods to work on the issue, which is explained per organisation.

Refugee Organisations the Netherlands (VON)

VON is the Dutch organisation for refugees living within the Netherlands and can be seen as an umbrella organisation and rules over approximately 400 local refugee organisations. They represent the interests of those who, because of justified fear of persecution had to leave their country and fled to the Netherlands to find safety and advise other agencies and governmental institutions on the matter. The organisation works towards a society in which human rights are respected, in which refugees are given shelter and the opportunity to participate within the community ("Volwaardige participatie voor vluchtelingen", nd., par.1,2). VON is against FGC and believes that the practice is an act of oppression of women. They have been fighting the practice from 1980 onwards and created the change-makers program to talk within practicing refugee communities about FGC, encourage change in mentality towards the practice and support the battle for emancipation of women ("Changemakers tegen FGM", par.1,2).

Federation of Somali Organizations the Netherlands (FSAN)

FSAN, the Netherlands, is a platform for and created by Somalis. The organisation was established in 1994 and acts as a national advocate and spokesperson for the Somali community in the Netherlands. The main goal of the federation is to create optimal participation and integration of Somalis in Dutch society and strengthen the position of the Somali community in general. The federation solves local problems within the Somali community and talks with people about local and national issues, including the issue on FGC ("Home", 2015, par.1,2). FSAN has been fighting against the practice from 1990 onwards and mainly focusses on the prevention of FGC and giving education on the topic ("VGV", 2015, par.1).

No Game

No Game is a motivated group of young adults with different cultural backgrounds fighting FGC on the grassroots level, as explained on their website. They give free education to teenagers about female genital mutilation at high schools and other community areas within the Netherlands. It's important for the organisation to work with young adults to spread the information, because from experience it is acknowledged that teenagers rather talk to peers about complex issues like female genital mutilation. They talk about prevention with teenagers with a cultural background in which FGC is common. Furthermore, No Game wants to make sure that people can talk freely about female genital mutilation and tries to help teenagers with what they can do when they get in contact with someone dealing with FGC. Education is essential to make people aware of the dangers of FGC to make sure that they will not circumcise their children at a later age. The organisation is part of the Pharos foundation, which is an information and advice centre regarding the health of refugees and migrants. Pharos has been fighting the practice since 1990 ("No Game", nd., par.1,2).

3.3.3.4 The Outline

The necessary information with respect to all investigated case studies has been collected and laid out in the previous chapter. This information will largely contribute to answering the main research question of this dissertation. Within the next chapter, the same material will be analysed and discussed.

4.0 Discussion/Analysis

In this chapter, the results section is analysed and discussed. Firstly, remarks were made on the research approach, which helped to obtain the information within the dissertation, and were critically revised and discussed. Afterwards, the gathered results were analysed and arguments have been chronologically listed and further elaborated within this chapter to come closer to answering the research questions of this dissertation.

4.1 The Research Approach

Scope of the Research

This dissertation is focussed on the European approach towards the case of FGC and on what policies are created within the MS to fight the issue. Yet, many other Western and non-Western continents and countries oppose the practice and fighting FGC by using various methods. For example, according to PATH, an international non-profit organisation focused on health, countries with laws or regulations against FGC include Burkina Faso, Central African Republic, Djibouti, Ghana, Guinea, Sudan, Sweden, and the United States (Reymond et all, nd., par.16). All these countries most likely use very diverse and distinct national policies and regulations to fight the practice. If the research scope of this dissertation would have been larger, it would be more likely to come up with more diverse recommendations and a more reliable answer to the main research question. However, this demarcation was chosen because of the time available for this particular research.

Primary Data Obtained

As mentioned in the methodology, this dissertation was established with the help of collecting primary and secondary data. Although four interviews were gathered of almost all stakeholders included in this research, for instance NGOs and governmental bodies, it would have been favourable to contact practicing communities as well. Consulting individuals at the FGC-community level might have given more information on the supporting view regarding the issue of balancing this research, because different research projects provided a non-positive output on the same topic. Yet, considering the sensitivity of the subject, it might have been inappropriate and unrealisable to request an interview from FGC communities.

Furthermore, only one interviewee was taken into account for most expertise fields included within this research, which might have led to generalisations on the subject, as stated by C. Boyce, MA Evaluation Associate, and P. Neale, PhD Senior Evaluation Associate (Boyce & Neale, 2006, p.4). If more individuals would have been consulted per field, different answers might have been collected, thus, creating a more reliable answer to the research

question. This was not achieved due to lack of time and due to the experience that interviews are quite time consuming. However, the interviews were carefully generated to discover clear and reliable arguments behind statements to maximise reliability of the four obtained interviews.

4.2 The Results Obtained

This paragraph is divided into three chapters, corresponding with the chapters in the results section (chapter 3.1, 3.2 and 3.3) and will analyse the legal debate around FGC, FGC in the European context and in the context of the researched case studies respectively.

FGC in the 21st Century - Human Rights Versus Group Rights

The existence of FGC within this century was globally debated by scholars and professionals with respect to human rights and group rights in the past. Opponents of the practice view the practice as a violation of human rights, a form of female sexual oppression, child abuse and universal exploitation and degradation of women, which should be fought by governmental institutions and organisations. Yet, as stated in the first chapter, supporters believe that critics exaggerate the medical consequences and misunderstand the meaning and effects of the practice. These scholars are rather supportive towards the practice and argue that governments should uphold the freedom of cultural expression and adopt minority rights. Other results from the first chapter and supporting literature can be used to analyse and discuss this legal debate around FGC.

The rights of persons belonging to minorities are among the values upon which the Union is founded and which it is explicitly committed to promote inside the Union, according to the Treaty on European Union (TEU) ("The European Union", nd., p.13). Yet, this important value does not seem to be applied in the case of female circumcision, because of the absence of minority or group rights on this subject throughout the Union. When looking at the opponent view with respect to FGC, various arguments could support the judgement when looking at the UN Universal Declaration of Human Rights, adopted in 1948. Article one and two of the declaration consider the right for equality and the freedom from discrimination, which is violated with FGC ("The Universal Declaration", nd., par.2,3). According to the WHO, "FGC reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women" ("Female Genital Mutilation", nd., par.1). Socio-cultural anthropologist J. Abbink argues that FGC is an inequality issue, because of the idea that a woman within the community who has not yet been subjected to FGC is "unclean" and needs to be "changed" to become marriageable and respectable for the rest of the community (Abbink, 2015, q.6). Furthermore, article five on the right to be free from torture and

degradation treatment is also being violated, because of the harmfulness of the practice, which is often done without permission from the victim ("The Universal Declaration", nd., par.6). Medically speaking, as stated by N. Toubia, a Sudanese surgeon and women's health rights activist, FGC involves many physical complications, such as wound infections which could lead to shock and death of the female, infertility, major problems during sexual intercourse and childbirth, as well as lasting psychological complications (Toubia, 1994, p.1,2). This medical statement made by N. Toubia shows that FGC is also in nonconformity with the UN Declaration of the Rights of the Child, adopted in 1959. According to this declaration children should be given the opportunity "to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner" (Duncan & Hernlund, 2003,par.1,2) and is offended with the execution of FGC. Moreover, the physical health damages of women subjected to the practice brings the life of her and her unborn child in danger.

The medical statement made by N. Toubia carefully initiates the truth about the damaging effects of the different forms of circumcision on the female body. J. Abbink argues that supporters of FGC living within the practicing communities must be aware of these medical consequences and should realise that some girls get infections or do not survive the practice. However, these people seem to outweigh cultural requirements above medical issues deliberately (Abbink, 2015, q.3). Thus, the large number of cases of FGC shows that supporters of the practice rather avoid the social risks of the community by accepting the medical health risks and the legal risks of the country they live in. This means that governments might need to step in and take care of these individuals that are at risk of being circumcised, since their own community is more concerned about social pressure rather than taking care of their children.

In addition, article 27 of the Universal Declaration of Human Rights regards the protection of the right to participate in the cultural life of the community. This article would suggest support for the cultural practice. However, as stated before, the practice often happens without the consent of the person subjected to female circumcision, meaning that the practice is forced upon the individual and leaves no choice for the victim to participate in the cultural life of the community or not. Consequently, this article is not in favour of the supporter side and rather shows that FGC is more of a violation of the person's identity and integrity. According to D. Eldin M. Elsayed, associate medicine professor at the Alzaiem Alazhari University, Sudan, "FGC obviously violates the fundamental ethical principles of bodily integrity, autonomy and self-determination without the full informed consent of the victim" (Elsayed et all, 2011, p.67).

The Existence of FGC in the European Union

As stated in the introduction, cultural diversity and multicultural societies become more common within today's globalised world, which involves certain benefits and challenges. According to C. Momoh, FGC started to become an issue in the EU during the 1980s with the arrival of immigrants, refugees, students and asylum-seekers from practicing communities from for e.g. Eritrea, Somalia, Ethiopia, Sudan and Djibouti (Momoh, 2005, p.21). Moreover, the urgency of the issue has grown during the last couple of years, as the number of asylum-seekers from FGC countries increased with over 25,000 females in 2013, as mentioned by UNHCR ("FGM & Asylum", 2013, p.2,3). The European Commission states that "female circumcision is considered a crime in the EU and the issue is an unacceptable violation of human rights and of the rights of women and girls" ("Eliminating FGM", 2015, par.1,3).

The EU is quite efficient in taking measures against the practice to support their MS on the national level. For example, the Union adopted a number of hard power measures by setting key Directives on the topic, including the Victim's Rights Directive, requiring provision of support services to victims of FGC, as mentioned by END FGM. Furthermore, the Union adopted the Asylum Reception Conditions Directive, which specifically mentions victims of FGC amongst vulnerable persons who should receive appropriate health care during their asylum procedure, and the Asylum Qualification Directive, which includes FGC as grounds to be taken into account for international protection ("European Union", 2015, par.4). Also the European Convention for the Protection of Human Rights and Fundamental Freedoms, adopted in 1955, helps to direct their MS to reject FGC, according to E. Leye (Leye, nd., p.75,76). In addition, the Union adopted soft power methods, such as projects and campaigns initiated by the different European institutions, to not only set goals but support the MS on a deeper level. For instance, with the first action plan 'Towards the elimination of female genital mutilation', 2013, the EU works towards a better understanding of FGC in Europe and promotes sustainable social change to prevent FGC and includes a plan to support MS in prosecuting FGC more effectively, as stated by the European Commission ("Towards the elimination", 2013, p.3).

However, according to END FGM, "there is still a very significant lack of data and research preventing organisations to accurately determine the prevalence and evaluate the medical and psychological support needed by survivors in Europe, making the eradication of FGM difficult" (Kontoulis, 2015, q.1,3). This issue could still be addressed by the EU by setting directives that every MS should execute prevalence studies each year and research the support needed by victims. These prevalence studies need to be funded, because according to N. Kontoulis of END FGM, "without funding it is impossible to develop research in the area but also to develop cross-border programs" (Kontoulis, 2015, q.3).

Furthermore, the European Parliamentary Research Service mentioned that they would like to see more concrete deadlines and more binding instruments for the MS to combat FGC. If such a binding instrument would be generalised and well-created by the EU for all the European MS, the issue might be combatted more efficiently, because each MS has its own legislation and policies now and might not be as well-formulated everywhere. This could be acknowledged by N. Kontoulis, representative of END FGM, who believes that "having an internal common approach to the implementation of existing policies on international protection within the EU will help achieve the eradication of the practice" (Kontoulis, 2015, q.1).

FGC at the National Level

The Governmental Approach

Table 2 The Governmental Response per Case Study

Case Study & Approach	United Kingdom	Sweden	Netherlands
Governmental Response	- Recent prevalence studies - Specific & detailed legislation on FGC - Funding 12 community projects in areas with greatest needs	- No recent prevalence studies - Specific legislation on FGC - Governmental action plan & national campaign	- Recent prevalence studies - Unspecific & detailed legislation on FGC - Governmental policy, prevention project
Obstacles	- Low number of prosecutions	- Broad legislation - Low number of prosecutions	- Low number of prosecutions

Table two gives an overview of the case studies from the results and is specifically directed at the governmental approach towards FGC on several points.

As mentioned in the previous section, prevalence studies are important to be able to fight the practice efficiently and as stated by N. Kontoulis, "without data, determination of prevalence is impossible or just not accurate" (Kontoulis, 2015, q.3). The table shows that the

UK and the Netherlands did make effort to investigate the prevalence, which displays the percentage of the population that is affected by the practice of FGC, within their borders. The UK has performed such prevalence studies in July 2015 and the Netherlands in 2013. However, Sweden did not perform prevalence studies recently, but only estimates were drawn from calculations in 2012 on how many women have origins in countries where at least half of the female population have been mutilated ("Online course FGM", 2014, par.14).

In addition, the legislation within the researched case studies varies per MS. As can be seen from Table 2, Sweden and the UK have specific legislation on FGC, while the Netherlands prosecute offenders of all types of the practice under assault and child abuse legislation, as explained by M. de Boer and A. Desta, two representatives of VON, a Dutch NGO focusing on FGC (Boer & Desta, 2007, p.44). European MS with unspecific legislation were urged by the European Parliament and Council of Europe to adopt specific legal provisions to prosecute and punish FGC (Leye & Sabbe, 2009, p.3). Yet, M. Mos, Dutch senior public prosecutor, argues that that the existing unspecific legislation is sufficient enough (Mos, 2015, q.11). Moreover, if there was a difference in efficiency to prosecute offenders with specific or unspecific legislation, there would have been a difference in the number of prosecutions. However, according to a UN report by E. Leye and A. Sabbe, criminal court cases regarding FGC are very limited and prosecution rarely occurs throughout all European MS (Leye & Sabbe, 2009, p.6). For example, as stated by the UK's House of Commons and the Home Affairs Committee, which has specific legislation for 30 years on FGC, there has not been a single prosecution until 2014 ("Female genital mutilation", 2014, p.13). Consequently, the low number of prosecutions cannot be caused by having unspecific legislation. According to the UK Metropolitan Police, two factors have influence over the number of prosecutions; the victims or witnesses, as well as health, education and social care professionals rarely report the case of FGC to the police ("Female genital mutilation", 2014, p.13). Thus, MS should rather focus on the number of reports to the police than on (un)specific legislation. The UK already took measures by focusing on the influence of health, education and social care professionals. N. Kontoulis states that from 31 October 2015 on, England obligates reporting by any professional who is in contact with victims or girls at risk (Kontoulis, 2015, q.4), which might increase the number of prosecutions. Nonetheless, the legislation, whether it is specific or unspecific, needs to be clear and should include all offenders. As mentioned by Sara Johnsdotter, Swedish legislation on FGC has been criticised for being too broad and has raised questions in previous years about what is and what is not prosecutable (Johnsdotter, 2009, p.2,3). Thus, European MS should make sure to be clear in their legislation and include all forms of offend with respect to FGC.

To compare the governmental action in terms of projects and campaigns, all investigated MS invested time and money in national and community projects to fight the practice on all levels. The UK is doing especially well by funding 12 frontline community projects and indicate the importance of governmental action besides legislation ("Funding frontline projects", 2014, par.1,2). According to the House of Commons and the Home Affairs Committee, improving understanding of social norms and working with communities to critically review the practice is essential to end the generational cycle of FGC. Furthermore, the Association of Chief Police Officers mentions that "community-driven solutions are fundamental to engender and drive sustained change" ("Female genital mutilation", 2014, p.43), which should be applied by every MS.

The Non-Governmental Approach

Regarding the NGO approach towards FGC within all investigated MS, each organisation has its own specific way of dealing with each aspects of the practice in terms of soft power methods. For example, VON, the Dutch organisation for refugees, focusses on talking about FGC with refugees and changing mentality towards the practice ("Changemakers tegen FGM", par.1,2), while FSAN, the Dutch platform for Somalis, works on the prevention and education of FGC ("VGV", 2015, par.1). Most of these organisations target the problem at many different levels and some work together with other non-governmental and governmental organisations to end the practice more effectively by creating a network. According to the alliance with UK's NGO Trust for London, the Esmée Fairbairn Foundation and Rosa, their strong network of community-based organisations has built the confidence of activists to speak out against the practice and contributed to start public debate within communities ("Female Genital Mutilation", 2015, par.4). Thus, creating powerful networks could start the debate on ending the practice at the level where the practice once started, the community level. Furthermore, RISK, the Swedish national association for ending FGC, and FSAN educate ambassadors, with another ethnic background, to talk with communities in their own language ("RISKs arbete", nd., par.1,4) (Othman, 2015, q.4). As stated by H. Othman, representative of FSAN, FGC is a sensitive subject to talk about, but progress has been made due to the deployment of ambassadors. It becomes easier to reach larger communities and to talk about FGC and the consequences of it with the help of the ambassadors (Othman, 2015, q.5,6). Consequently, this idea of creating community ambassadors might increase trust from communities to talk about the practice and could be used by each community-based organisation. However, as stated by H. Othman, the government should acknowledge the benefits of ambassadors and provide support to become more successful (Othman, 2015, q.10).

4.3 The Outline

In this chapter, a clear analysis on the research approach and the obtained results is given. The arguments made and the elaboration of it gave an answer to the sub-questions, which are mentioned in the introduction, and will help responding the main research question in the next chapter, the conclusion & recommendations.

5.0 Conclusion & Recommendations

In this section, answers are provided to the research questions stated in the introduction that follow from the insights obtained during this research. Ultimately, some recommendations could be given with respect to the governmental and non-governmental policy to fight the issue of FGC. These recommendations can be found in this chapter to answer the main research question and are further explained with respect to the large number of individuals crossing the borders from practicing countries. The measures laid out in this chapter will also be adoptable for other European MS.

5.1 Sub-Questions

How Should FGC be Perceived in the 21st Century, as a Matter of Human Rights or Group Rights?

The issue of FGC is rather a case of human rights than a cultural practice that deserves to get minority or group rights from national governments. The health and well-being of citizens should come first and since FGC violates several articles in the Universal Declaration of Human Rights and the UN Declaration of the Rights of the Child, as well as bringing the lives of citizens in danger, the practice needs to be abolished globally. Thus, governments and national institutions should be able to protect their people and take measures to terminate the practice.

What is the Response of the European Union Regarding Female Genital Cutting?

Regarding the EU, the Union does not tolerate FGC in the name of liberalism or multiculturalism and guards its limits of acceptation. The practice is already perceived to be a violation of human rights and is considered to be a prosecutable crime throughout the European MS. In terms of hard and soft power measures, the EU shows to be quite decisive to fight FGC and to support their MS on the national level by setting binding directives and with the creation of an action plan 'Towards the elimination of female genital mutilation'. However, it could be concluded that all investigated MS still face difficulty in tracking cases of FGC and prosecuting offenders despite the assistance of the EU.

What is the Governmental and Non-Governmental Approach Towards FGC in the UK, Sweden and the Netherlands?

The above mentioned problem keeps occurring within the borders of the UK, Sweden and the Netherlands, regardless of the different multi-level hard and soft power efforts of the governmental bodies, such as maintaining specific or unspecific legislation and funding

prevention campaigns. Even the various measures taken by several NGOs that fight the matter throughout the investigated MS, such as discussing the practice openly with FGC-communities, has not solved the problem yet. Nevertheless, several NGOs have built the confidence of activists to speak out against the practice and contributed to start a public debate within communities on FGC due to the creation of a strong network of community-based organisations and with the deployment of ambassadors. Yet, regarding the magnitude of the current migration flow, in which 25,000 females have been seeking asylum from FGC-practising countries in 2013, new measures still need to be taken with respect to the governmental and non-governmental approach to engage more efficiently in the matter of FGC.

5.2 Main Research Question

The main research question has already been partly answered with the conclusion made on the two sub-questions with respect to the governmental and non-governmental approach towards FGC in the researched countries. This section will further elaborate on the improvements that could be made in the future.

What is the National Response from the UK, Sweden and the Netherlands Regarding Female Genital Cutting and how could they Improve their Policy with Respect to the Nowadays Large Migration Flow?

The problem of FGC originates at the community level. Thus, it is necessary for the government to address this level. The Association of Chief Police Officers also acknowledge that "community-driven solutions are fundamental to engender and drive sustained change" ("Female genital mutilation", 2014, p. 43). Consequently, governments should create a network together with NGOs and medical, education and social institutions within their borders to have one national system in which information on the issue can be passed on between them and new ideas can be created to become more effective on the fight on the community level.

Secondly, the scale of the issue in all researched countries shows that the problem is grand and will only increase with the arrival of new migrants. The number of prosecutions needs to be increased to show a signal to all practicing communities that there will be consequences for those who execute FGC. This could partly be realised by setting legislation that is broad enough to be able to include all offenders and specific enough to avoid confusion of what is and what is not prosecutable. This improvement mostly counts for the Swedish legislation. Furthermore, as mentioned by the UK police and Dutch senior public prosecutor M. Mos, the low number of investigations and prosecutions has to do with the

failure of health, education and social care professionals to refer cases to the police where they suspect FGC to have taken place ("Female genital mutilation", 2014, p.13) (Mos, 2015, q.12). To avoid this, a reporting obligation for health, education and social institutions should be added to the national legislation along with a punishment if this obligation is not followed, which is already added within UK legislation. In addition, M. Mos mentioned that the low number of investigations might also have to do with the lack of both integration and knowledge of individuals to reach the police (Mos, 2015, q.6,7). This problem should be addressed more thoroughly by the national NGOs who work at the community level along with the lack of reports connected to shame and the fear of harassment and exclusion for an individual within the community. NGOs will have to educate individuals about how to reach the police and the importance of it. Moreover, it is important to support and protect individuals that have reported FGC. Another approach to increase the number of prosecutions and to disassociate FGC from the cultural tradition, it is important to take religious leaders into account. As mentioned by Human Rights Watch, religious leaders have an important role to play in dissociating FGC from religion in general ("Q&A on Female Genital Mutilation", 2010, par. 9). Consequently, the network should cooperate with religious leaders to ban the practice.

In the case of the large migration flow from FGC-countries, NGOs should immediately approach the immigrants from practicing communities that received asylum. These immigrants should receive education on the issue and FGC needs to be discussed more openly in their own language by developing a network of community agents with the same ethnic background. As stated by H. Othman, representative of FSAN, the government should acknowledge the benefits of ambassadors and provide support to become more successful (Othman, 2015, q.10). In addition, the network created between the government, NGOs and medical, education and social institutions should work together on a strict and effective integration policy to notify immigrants on the Western view regarding the practice and on the national legal prohibition of FGC and its consequences. However, as stated by socio-cultural anthropologist J. Abbink, some communities face more difficulty with integrating into the society they reside in than others, which has to do with the cultural traits and the willingness of the community to get education and work (Abbink, 2015, q.8). Thus, the network created should get better insight in which practicing communities have more difficulty integrating and should establish different methods of addressing integration per community to create the best outcome.

Furthermore, J. Abbink also mentioned a development in Kenya in which the tradition of female circumcision is being replaced by a harmless ritual to initiate the marriageability of females in the community (Abbink, 2015, q.3). Consequently, NGOs might have to investigate

if there is willingness from communities to replace FGC with a harmless ritual executed for the same reasons.

Finally, it is important that all European MS investigate their prevalence rates each year to identify the situation within the country and to see if new measures turn out to be effective or need to be changed.

6.0 References

Abusharaf, M. (2013). *Female circumcision*. Philadelphia: University of Pennsylvania Press. Retrieved from https://books.google.nl/books?hl=nl&lr=&id=JO_SBQAAQBAJ&oi=fnd&pg=PP2&dq=Abusharaf,+R.+M.+(Ed.).+(2013).+Female+circumcision:+multicultural+perspectives.+University+of+Pennsylvania+Press.&ots=x7iBwc72Ht&sig=OkfhpUnGau7dLHmadFoxiY_AfVI#v=onepage&q&f=false

Boyce, C., & Neale, P. (2006). *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input*. Retrieved from http://www2.pathfinder.org/site/DocServer/m_e_tool_series_indepth_interviews.pdf

Boyle, E. H. (2005). *Female genital cutting: Cultural conflict in the global community*. Maryland: The Johns Hopkins University Press. Retrieved from https://books.google.nl/books?hl=nl&lr=&id=fLbe1rWQwVwC&oi=fnd&pg=PR7&dq=Boyle,+E.+H.+(2005).+Female+genital+cutting:+Cultural+conflict+in+the+global+community.+JHU+Press.&ots=meiMqwEW5_&sig=cx_7B7yNl3c5OcCC9P20PS1rr-0#v=onepage&q&f=false

Brennan, K. (1988). *The influence of cultural relativism on international human rights law: Female circumcision as a case study*. Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/lieq7&div=24&id=&page

De Boer, M., & Desta, A. (2007). *Meisjesbesnijdenis in Nederland*. Utrecht. Retrieved from http://www.vluchtelingenorganisaties.nl/attachment/794

Dickerson, J. D. (2009, December 2). Crazy as they need to be: Circumcised women who support the practice. *Mother Jones*. Retrieved from http://www.motherjones.com/mojo/2007/12/crazy-they-need-be-circumcised-women-who-support-practice

Elsayed, M., Elamin, M., & Sulaiman, M. (2011). *Female genital mutilation and ethical issues*. Retrieved from http://www.sjph.net.sd/files/Vol6N2/Brief Communications1.pdf

Exterkate, M. (2013). *Vrouwelijke genitale verminking in Nederland: Omvang, risico en determinanten*. Utrecht. Retrieved from http://www.pharos.nl/documents/doc/webshop/vrouwelijkegenitaleverminkinginnederland.pdf

Hemmings, J. (2011). *The FGM initiative*. Retrieved from http://www.rosauk.org/wp-content/uploads/2015/10/FGM-Interim-Report-Nov-2011.pdf

Henderson, G. M. (2014). *Speaking in tongues and dancing diaspora: Black women writing and performing* (1st ed.). New York: Oxford University Press. Retrieved from https://books.google.nl/books?id=ylNxAwAAQBAJ&pg=PA246&lpg=PA246&dq=Female+circumcision+may+be+considered+as+another+form+of+female+sexual+oppression&source=bl&ots=QEXLudrIYl&sig=blUuPS8g6haGSR-te-ghTFXItuU&hl=nl&sa=X&ved=0CCAQ6AEwAGoVChMI4ZLp9YKLyQIVhpQP

Hosken, F. P. (1981). *Female genital mutilation and human rights*. Retrieved from http://link.springer.com/article/10.1007%2FBF02685563?LI=true#page-1

Johnsdotter, S. (2004). FGM in Sweden. Ghent. Retrieved from http://www.intact-network.net/intact/cp/files/1385899333_FGM in Sweden.pdf

Johnsdotter, S. (2009). *The FGM legislation implemented: Experiences from Sweden*. Retrieved from http://www.uv.es/cefd/17/Johnsdotter.pdf

Jurviste, U., & Hennigan, I. (2013). Female genital mutilation (FGM) in EU. Retrieved November 20, 2015, from http://epthinktank.eu/2013/11/21/female-genital-mutilation-fgm-in-eu/

Kalev, H. D. (2004). *Cultural rights or human rights: The case of female genital mutilation*. University of Ben Gurion. Retrieved from

https://books.google.nl/books?hl=nl&lr=&id=JO_SBQAAQBAJ&oi=fnd&pg=PP2&dq=Abusharaf,+R.+M.+(Ed.).+(2013).+Female+circumcision:+multicultural+perspectives.+University+of+Pennsylvania+Press.&ots=x7iBwc72Ht&sig=OkfhpUnGau7dLHmadFoxiY_AfVI#v=onepage&q&f=false

Kern, S. (2013). UK: The crisis of female genital mutilation. Retrieved October 25, 2015, from http://www.gatestoneinstitute.org/3705/uk-female-genital-mutilation

Leye, E., & Sabbe, A. (2009). *Overview of legislation in the European Union to address female genital mutilation: Challenges and recommendations for the implementation of laws*. Ghent. Retrieved from http://www.un.org/womenwatch/daw/egm/vaw_legislation_2009/Expert Paper EGMGPLHP _Els Leye_.pdf

Macfarlane, A., & Dorkenoo, E. (2015). *Prevalence of female genital mutilation in England and Wales: National and local estimates*. London: City University London, Equality Now. Retrieved from http://www.trustforlondon.org.uk/wp-content/uploads/2015/07/FGM-statistics-final-report-21-07-15-released-text.pdf

Momoh, C. (2005). *Female genital mutilation*. Abingdon: Radcliffe Publishing Ltd. Retrieved from https://books.google.nl/books?hl=nl&lr=&id=dVjIP0RfVAMC&oi=fnd&pg=PR5&dq=Momoh,+C.+(2005).+Female+genital+mutilation.+Radcliffe+publishing.&ots=TFiZc1M6VI&sig=3Htwp70itQwTxPnVI8gBufKTGQo#v=onepage&q=Momoh%2C C. (2005). Female genital mutilation. Radcliffe publishing.&f=false

Mulongo, P., McAndrew, S., & Martin, C. H. (2014). *Crossing borders: Discussing the evidence relating to the mental health needs of women exposed to female genital mutilation*. Wiley Publishing Asia. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/inm.12060/full

Nd. (n.d.). About us. Retrieved November 15, 2015, from http://www.dofeve.org/about-us.html

Nd. (n.d.). About us. Retrieved November 16, 2015, from http://www.femaleintegrity.se/about.htm

Nd. (n.d.). Changemakers tegen FGM. Retrieved November 7, 2015, from http://www.vluchtelingenorganisaties.nl/page/86/nl

Nd. (2015). Classification of female genital mutilation. Retrieved December 9, 2015, from http://www.who.int/reproductivehealth/topics/fgm/overview/en/

Nd. (n.d.). Female genital mutilation (FGM). Retrieved December 28, 2015, from http://www.equalitynow.org/fgm

Nd. (n.d.). Female genital mutilation legal guidance. Retrieved October 8, 2015, from http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/

Nd. (n.d.). *Female genital mutilation/cutting*. Retrieved from http://health.gov.ie/wp-content/uploads/2014/03/fgm.pdf

Nd. (n.d.). Home. Retrieved October 26, 2015, from http://www.fsan.nl/index.php

Nd. (n.d.). Nationellt arbete. Retrieved December 20, 2015, from http://www.f-risk.org/risks-arbete/

Nd. (n.d.). No Game. Retrieved November 1, 2015, from http://www.no-game.nl/no-game/onze-voorlichting

Nd. (n.d.). *The European Union and the protection of the rights of persons belonging to minorities*. Retrieved from http://www.eidhr.eu/files/dmfile/minorities-guide_en.pdf

Nd. (n.d.). *The Netherlands*. Retrieved from http://eige.europa.eu/sites/default/files/documents/current_situation_and_trends_of_female_genital_mutilation_in_netherlands_en.pdf

Nd. (n.d.). Universal Declaration of Human Rights. United Nations OHCHR. Retrieved from http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

Nd. (n.d.). VGV. Retrieved October 29, 2015, from http://www.fsan.nl/tegen_vrouwenbesnijdenis.php

Nd. (n.d.). Volwaardige participatie voor vluchtelingen. Retrieved November 5, 2015, from http://www.vluchtelingenorganisaties.nl/

Nd. Female genital mutilation act 2003 (2003). legislation.gov.uk. Retrieved from http://www.legislation.gov.uk/ukpga/2003/31/introduction

Nd. (2005). *Convention on the protection and promotion of the diversity of cultural expressions*. Paris. Retrieved from http://unesdoc.unesco.org/images/0014/001429/142919e.pdf

Nd.(2009). European Union. Retrieved December 5, 2015, from http://www.endfgm.eu/en/tracking-europes-response/european-union/

Nd. (2010). Q&A on female genital mutilation. Retrieved November 5, 2015, from https://www.hrw.org/news/2010/06/16/qa-female-genital-mutilation

Nd. Criminal Code (2012). Wetboek van Strafrecht. Retrieved from http://www.ejtn.eu/PageFiles/6533/2014 seminars/Omsenie/WetboekvanStrafrecht_ENG_PV.pdf

Nd. (2012). *Understanding and addressing violence against women*. Retrieved from http://apps.who.int/iris/bitstream/10665/77428/1/WHO_RHR_12.41_eng.pdf

Nd. (2013). *Too much pain: Female genital mutilation & asylum in the European Union*. Retrieved from http://www.unhcr.org/531880249.html

Nd. (2013). *Towards the elimination of female genital mutilation*. Brussels. Retrieved from http://ec.europa.eu/justice/gender-equality/files/gender_based_violence/com_2013_833_en.pdf

Nd. (2014). Female genital mutilation. Retrieved December 10, 2015, from http://www.who.int/mediacentre/factsheets/fs241/en/

Nd. (2014). *Female genital mutilation: the case for a national action plan*. London. Retrieved from http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/201.pdf

Nd. (2014). Online course to stop female genital mutilation. *The Local Se*. Retrieved from http://www.thelocal.se/20140623/online-course-stop-female-genital-mutilation-sweden

Nd. (2014). *Too much pain: Female genital mutilation & asylum in the European Union*. Retrieved from http://www.refworld.org/pdfid/5316e6db4.pdf

Nd. (2014, December 5). Funding for frontline projects in fight to end female genital mutilation. Retrieved November 2, 2015, from https://www.gov.uk/government/news/funding-for-frontline-projects-in-fight-to-end-female-genital-mutilation

Nd.(2015). Beleidshistorie. Retrieved December 19, 2015, from http://www.pharos.nl/nl/kenniscentrum/meisjesbesnijdenis/feiten-en-cijfers/in-nederland/beleidshistorie

Nd. (2015). Claims “no evidence” of FGM in Sweden. *The Local Se*. Retrieved from http://www.thelocal.se/20150103/no-evidence-fgm-taking-place-in-sweden-report

Nd. (2015). Claims “no evidence” of FGM in Sweden. *The Local Se*. Retrieved from http://www.thelocal.se/20150103/no-evidence-fgm-taking-place-in-sweden-report

Nd. (2015). Eliminating female genital mutilation. Retrieved January 1, 2016, from http://ec.europa.eu/justice/gender-equality/gender-violence/eliminating-female-genital-mutilation/index_en.htm

Nd. (2015). Female genital mutilation. Retrieved November 23, 2015, from http://www.trustforlondon.org.uk/policy-change/strategic-work/female-genital-mutilation-2/

Nd. (2015, November 25). Gambia verbiedt vrouwenbesnijdenis. *NOS*. Retrieved from http://nos.nl/artikel/2071275-gambia-verbiedt-vrouwenbesnijdenis.html

Omoigui, N. (2001). HB 22 bill and genital mutilation. Retrieved October 4, 2015, from http://www.circumstitions.com/FGM-defended.html

Orange, R., & Topping, A. (2014). FGM specialist call for gynaecological checks for all girls in Sweden. *The Guardian*. Retrieved from http://www.theguardian.com/society/2014/jun/27/female-genital-mutilation-fgm-specialist-sweden-gynaecological-checks-children

Oscarsson, M. (2009, September 21). Sweden, Denmark and Norway try to stop genital mutilation among immigrants at home and abroad. *Minnpost*. Retrieved from https://www.minnpost.com/global-post/2009/09/sweden-denmark-and-norway-try-stop-genital-mutilation-among-immigrants-home-and-

Oscarsson, M. (2010, May 30). Scandinavia fights female circumcision. *Globalpost*. Retrieved from http://www.globalpost.com/dispatch/europe/090916/scandinavia-female-genital-mutilation

Reymond, L., Mohamud, A., & Ali, N. (n.d.). Female genital mutilation - The facts. Retrieved December 26, 2015, from http://www.path.org/files/FGM-The-Facts.htm

Shell-Duncan, B., & Hernlund, Y. (2000). *Female "circumcision" in Africa*. London: Lynne Rienner Publishers, Inc. Retrieved from https://books.google.nl/books?hl=nl&lr=&id=rhhRXiJIGEcC&oi=fnd&pg=PR7&dq=+Shell-Duncan,+B.,+%26+Hernlund,+Y.+(2000).+Female%22+circumcision%22+in+Afr

ica:+culture,+controversy,+and+change.+Lynne+Rienner+Publishers.%5C&ots=IF4jjc1j6S&sig=L2rCx9Lv5kGZQ8hYDh-L1m6dJ6A#v=onepage&q&f=false

Steven, T. Declaration of the rights of the child (2003). Unicef. Retrieved from http://www.unicef.org/malaysia/1959-Declaration-of-the-Rights-of-the-Child.pdf

Toubia, N. (1994). Female circumcision as a public health issue. *The New England Journal of Medecine*. Retrieved from http://www.nejm.org/doi/pdf/10.1056/NEJM199409153311106

Verhoeven, N. (2010). *Wat is onderzoek?* (3rd ed.). The Hague: Boom Lemma.

7.0 Appendices

7.1 Figures & Tables

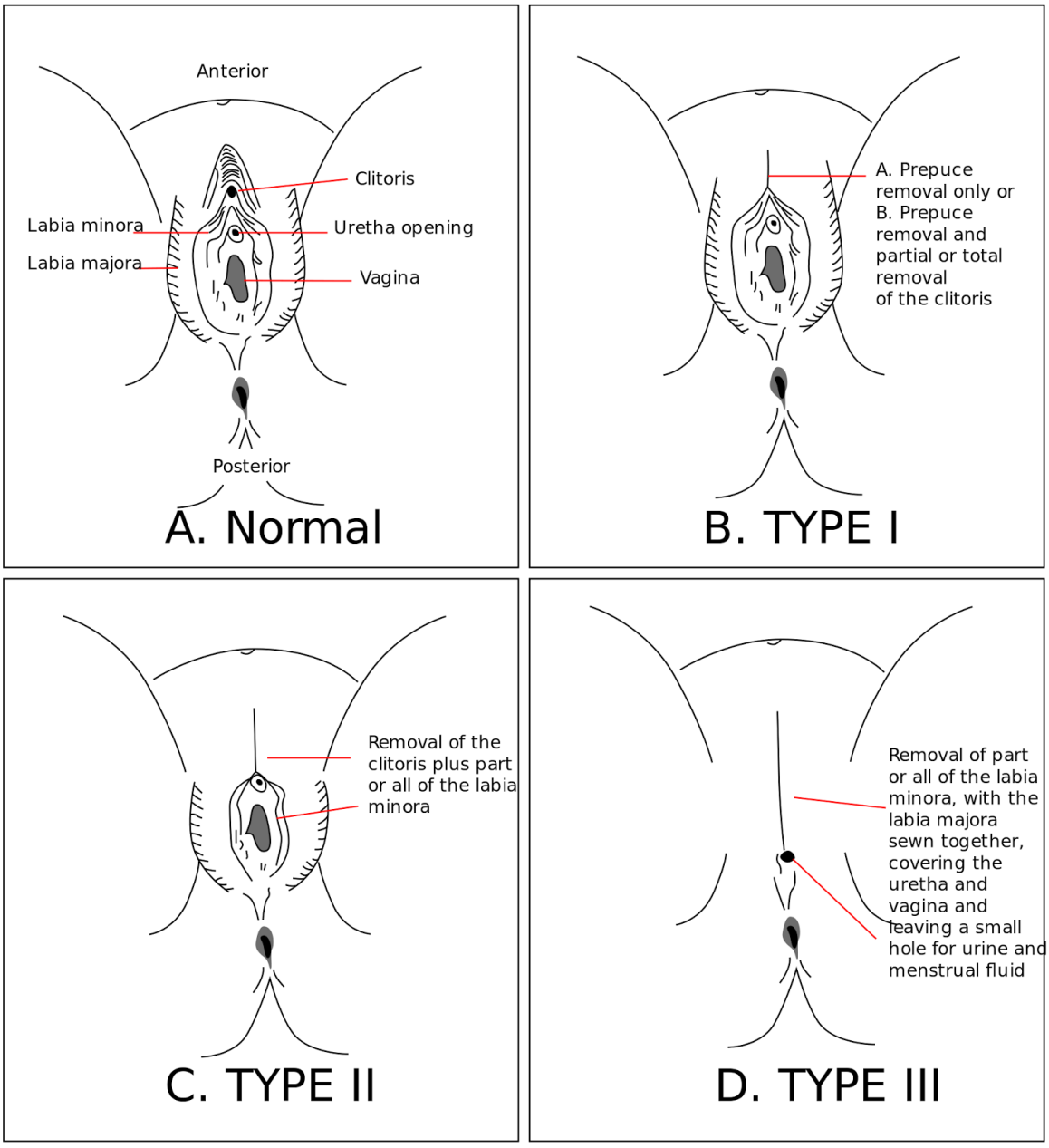

Figure 1: The different types of FGC ("Classification of female genital mutilation", 2015, par.2)

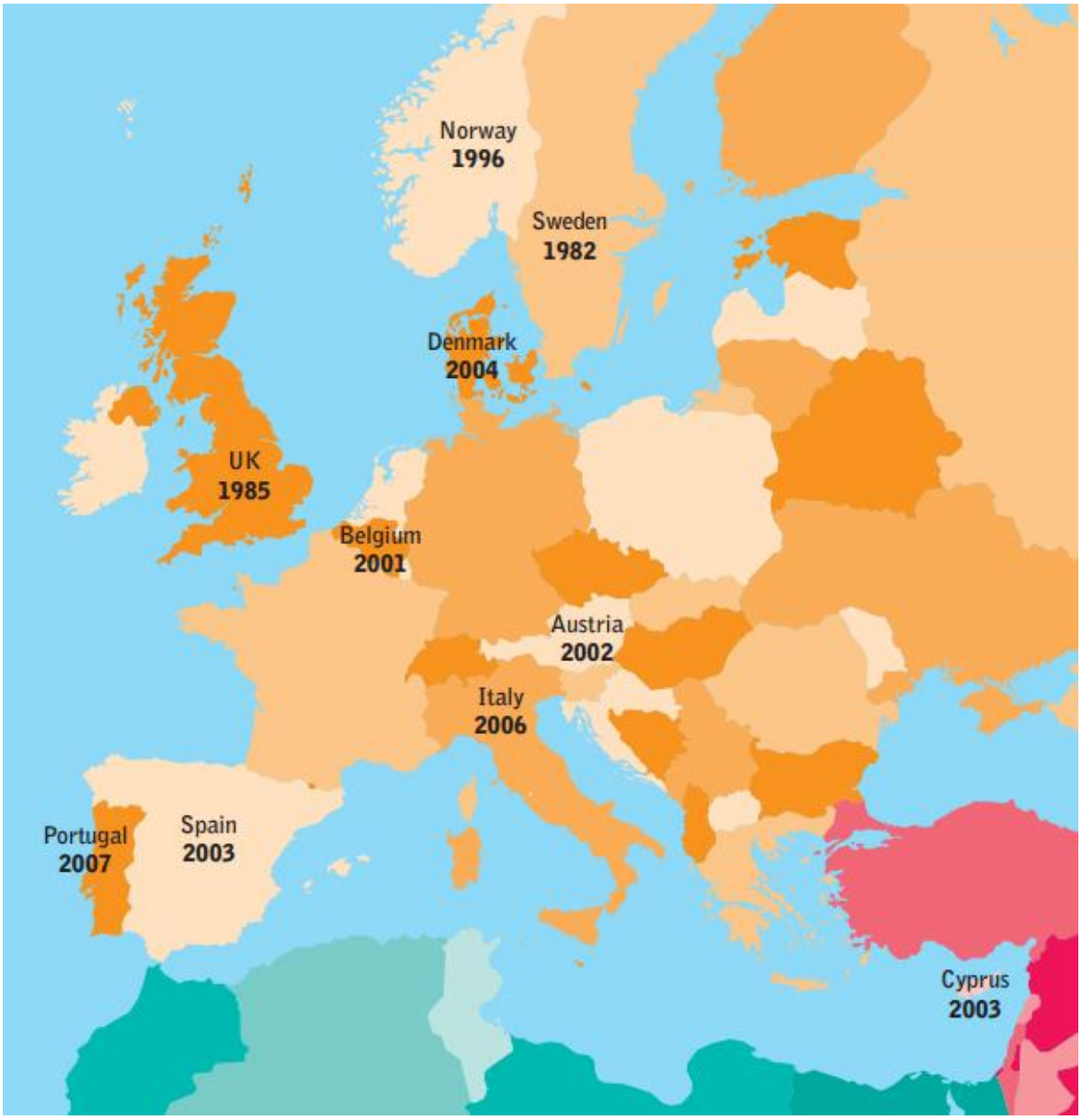

Figure 2: Countries with specific criminal laws in Europe and the year the laws were adopted (Leye & Sabbe, 2009, p.13)

Table 1: Estimated number of female asylum-seekers potentially affected by FGC in 2013 ("FGM & Asylum", 2014, p.3)

Country of Origin	Female applicants 2013*	Prevalence rate**	Estimated number of female applicants potentially affected by FGM 2013
Benin	45	12.9%	6
Burkina Faso	75	75.8%	57
Cameroon	490	1.4%	7
Central African Rep.	130	24.2%	31
Chad	105	44.2%	46
Côte d'Ivoire	605	38.2%	231
Djibouti	95	93.1%	88
Egypt	1,210	91.1%	1,102
Eritrea	4,120	88.7%	3,654
Ethiopia	795	73.3%	583
Gambia	315	76.3%	240
Ghana	355	3.8%	13
Guinea	1,570	96.9%	1,521
Guinea-Bissau	45	49.8%	22
Iraq***	3,480	8.1%	282
Kenya	220	27.1%	60
Liberia	35	65.7%	23
Mali	610	85.2%	520
Mauritania	195	72.2%	141
Niger	10	2%	0
Nigeria	3,655	27%	987
Senegal	305	25.7%	78
Sierra Leone	245	88.3%	216
Somalia	5,635	97.9%	5,517
Sudan	455	69.4%	316
Tanzania	70	14.6%	10
Togo	165	3.9%	6
Uganda	350	1.4%	5
Yemen	160	38.2%****	61
Total	25,545		15,826

* Calculated using monthly data

** Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change, produced by UNICEF in July 2013

*** Not included in the statistics presented in *"Too Much Pain"*

**** PAPFAM report 2003

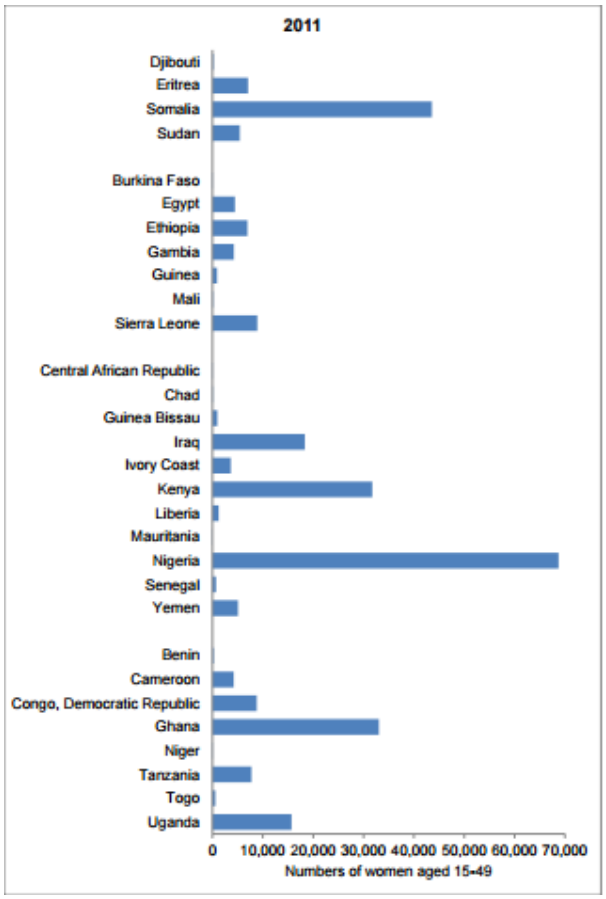

Figure 3 : The number and ethnicity of female immigrants UK aged 15-49 (Macfarlane & Dorkenoo, 2015, p.15)

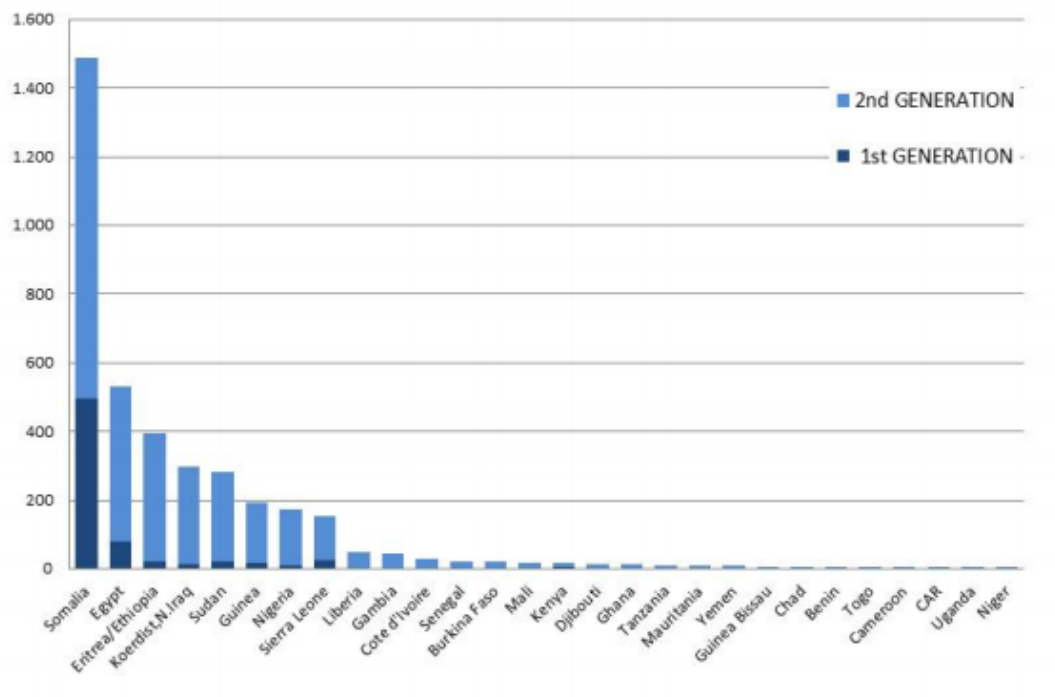

Figure 4 : Estimated number of girls living in the Netherlands by country of origin and generation, who are at risk of FGC (Exterkate, 2013, p.28)

7.2 Full Legislation Related to FGC

Legislation FGC United Kingdom

Female Genital Mutilation Act 2003 - 2003 CHAPTER 31

An Act to restate and amend the law relating to female genital mutilation; and for connected purposes. [30th October 2003]
Be it enacted by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

1 Offence of female genital mutilation

(1)A person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.

(2)But no offence is committed by an approved person who performs—

(a)a surgical operation on a girl which is necessary for her physical or mental health, or

(b)a surgical operation on a girl who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.

(3)The following are approved persons—

(a)in relation to an operation falling within subsection (2)(a), a registered medical practitioner,

(b)in relation to an operation falling within subsection (2)(b), a registered medical practitioner, a registered midwife or a person undergoing a course of training with a view to becoming such a practitioner or midwife.

(4)There is also no offence committed by a person who—

(a)performs a surgical operation falling within subsection (2)(a) or (b) outside the United Kingdom, and

(b)in relation to such an operation exercises functions corresponding to those of an approved person.

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

2 Offence of assisting a girl to mutilate her own genitalia

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

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

(1)A person is guilty of an offence if he aids, abets, counsels or procures a person who is not a United Kingdom national or permanent United Kingdom resident to do a relevant act of female genital mutilation outside the United Kingdom.

(2)An act is a relevant act of female genital mutilation if—

(a)it is done in relation to a United Kingdom national or permanent United Kingdom resident, and

(b)it would, if done by such a person, constitute an offence under section 1.

(3)But no offence is committed if the relevant act of female genital mutilation—

(a)is a surgical operation falling within section 1(2)(a) or (b), and

(b)is performed by a person who, in relation to such an operation, is an approved person or exercises functions corresponding to those of an approved person.

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

(1)Sections 1 to 3 extend to any act done outside the United Kingdom by a United Kingdom national or permanent United Kingdom resident.

(2)If an offence under this Act is committed outside the United Kingdom—

(a)proceedings may be taken, and

(b)the offence may for incidental purposes be treated as having been committed,

in any place in England and Wales or Northern Ireland.

5 Penalties for offences

A person guilty of an offence under this Act is liable—

(a)on conviction on indictment, to imprisonment for a term not exceeding 14 years or a fine (or both),

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

6 Definitions

(1)Girl includes woman.

(2)A United Kingdom national is an individual who is—

(a)a British citizen, a British overseas territories citizen, a British National (Overseas) or a British Overseas citizen,

(b)a person who under the British Nationality Act 1981 (c. 61) is a British subject, or

(c)a British protected person within the meaning of that Act.

(3)A permanent United Kingdom resident is an individual who is settled in the United Kingdom (within the meaning of the Immigration Act 1971 (c. 77)).

(4)This section has effect for the purposes of this Act.

7 Consequential provision

(1)The Prohibition of Female Circumcision Act 1985 (c. 38) ceases to have effect.

(2)In paragraph 1(b) of the Schedule to the Visiting Forces Act 1952 (c. 67) (offences against the person in respect of which a member of a visiting force may in certain circumstances not be tried by a United Kingdom court), for paragraph (xi) there is substituted—

8 Short title, commencement, extent and general saving

(1)This Act may be cited as the Female Genital Mutilation Act 2003.

(2)This Act comes into force on such day as the Secretary of State may by order made by statutory instrument appoint.

(3)An order under subsection (2) may include transitional or saving provisions.

(4)This Act does not extend to Scotland.

(5)Nothing in this Act affects any criminal liability arising apart from this Act.

("FGM Act 2003", 2003, par. 1-9)

Legislation FGC Sweden

Act Prohibiting Female Genital Mutilation [Lag (1982:316) med förbud mot könsstympning av kvinnor]

Section 1: Operations on the external female genital organs which are designed to mutilate them or produce other permanent changes in them (genital mutilation) must not take place, regardless of whether consent to this operation has or has not been given.

Section 2: Anyone contravening Section 1 will be sent to prison for a maximum of four years. If the crime has resulted in danger to life or serious illness or has in some other way involved particularly reckless behavior, it is to be regarded as serious. The punishment for a serious crime is prison for a minimum of two and a maximum of ten years. Attempts, preparations, conspiracy and failure to report crimes are treated as criminal liability in accordance with section 23 of the Penal Code. [Quoted from Rahman & Toubia (2000:219).]

Section 3: A person who violates this law is liable to prosecution in a Swedish court, even if Section 2 or 3 of Chapter 2 of the Penal Code is not applicable.

(Johnsdotter, 2009, p.2)

Legislation FGC the Netherlands

Criminal Code Section 300 - 304, 436, 47- 48

Part XX. Assault
Section 300 1. Assault shall be liable to a term of imprisonment not exceeding three years or a fine of the fourth category. 2. If the offence results in grievous bodily harm, the offender shall be liable to a term of imprisonment not exceeding four years or a fine of the fourth category. 3. If the offence results in death, the offender shall be liable to a term of imprisonment not exceeding six years or a fine of the fourth category. 4. The intentional harming of health shall be considered as equivalent to assault. 5. An attempt to commit this serious offence shall not be punishable.

Section 301 1. Assault committed with premeditation shall be liable to a term of imprisonment not exceeding four years or a fine of the fourth category. 2. If the offence results in grievous bodily harm, the offender shall be liable to a term of imprisonment not exceeding six years or a fine of the fourth category. 3. If the offence results in death, the offender shall be liable to a term of imprisonment not exceeding nine years or a fine of the fifth category.

Section 302 1. Any person who intentionally inflicts grievous bodily harm on another person shall be guilty of aggravated assault and shall be liable to a term of imprisonment not exceeding eight years or a fine of the fifth category. 2. If the offence results in death, the

offender shall be liable to a term of imprisonment not exceeding ten years or a fine of the fifth category.

Section 303 1. Aggravated assault committed with premeditation shall be liable to a term of imprisonment not exceeding twelve years or a fine of the fifth category. 2. If the offence results in death, the offender shall be liable to a term of imprisonment not exceeding fifteen years or a fine of the fifth category.

Section 304 The terms of imprisonment prescribed in sections 300-303 may be increased by one third: 1°. if the offender commits the serious offence against his mother, his legal father, his spouse, his 129 partner, his child, a child over whom he exercises parental authority or a child whom he cares for or raises as part of his family; 2°. if the serious offence is committed against a civil servant during or in connection with the lawful performance of his office; 3°.if the serious offence is committed by administering substances harmful to life or health.

Section 304a If a serious offence, punishable under section 302 or 303, is committed with terrorist intent, the determinate term of imprisonment prescribed in that section shall be increased by one half and, if a determinate term of imprisonment not exceeding fifteen years is prescribed for the serious offence, life imprisonment or a determinate term of imprisonment not exceeding thirty years shall be imposed.

Section 304b 1. Conspiracy to commit with terrorist intent the serious offence defined in section 303 shall be liable to a term of imprisonment not exceeding ten years or a fine of the fifth category. 2. Section 96(2) shall apply mutatis mutandis.

Part I. Minor Offences related to the General Safety of Persons and Property

Section 436 1. Any person who, without being licensed to practise a profession for which a licence is required by law, practises that profession without necessity, shall be liable to a fine of the second category. 2. Any person who is licensed to practise a profession for which a licence is required by law and who, without necessity, exceeds the limits of his licence, shall be liable to a fine of the second category. 3. If during the commission of the minor offence, one year has not yet expired since a previous conviction of the offender for a similar offence became final, a term of detention not exceeding two months or a fine of the third category may be imposed in the case set out in subsection (1), and a term of detention not exceeding one month or a fine of the third category may be imposed in the case set out in subsection (2).

Part V. Participation in Criminal Offences

Section 47 1. The following persons shall be criminally liable as offenders of a criminal offence: 1°. any persons who commit the offence, either personally or jointly, or who cause an innocent person to commit the offence; 2°. any persons who, by means of gifts, promises, abuse of authority, use of force, threat or deception or by providing opportunity, means or information, intentionally solicit the commission of the offence. 2. With regard to the last category, only those acts they intentionally solicited, and their consequences, shall be taken into account.

Section 48 1. The following persons shall be criminally liable as accomplices to a criminal offence: 1°. any persons who intentionally aid and abet the commission of the serious offence; 2°. any persons who intentionally provide opportunity, means or information for the commission of 43 the serious offence.

("Criminal Code", 2012, p. 42, 128, 129, 158)

7.3 Transcripts

Transcript Interview with Representative END FGM N. Kontoulis
9 November 2015

Biography
N. Kontoulis works as a communications and network officer at END FGM. She monitors the developments at the European institutions and leads advocacy and communications activities of the END FGM Network, as well supporting the organisational development of the organisation.

1) Why does your organisation focus on the European level regarding FGC? Because most organisations only see necessity for action abroad.
a. Because it happens in Europe
Actions are needed both outside Europe and inside Europe through internal policy; and European community based programmes. According to the EIGE studies and UNHCR studies in 2013, each year, 180 000 girls and women in Europe are estimated to be at risk of FGM and that there are 500 000 women and girls living with lifelong consequences of FGM in Europe. Those numbers include the survivors now living in Europe. The practice is recognised as a form of violence against women and girls as well as a violation of human and children's rights in the EU internal policy making.
b. Because a coordinated European approach to combat FGM in Europe is lacking.
Many challenges still exist making it difficult to develop adequate national and EU policies strategy (European commission (2013 Communication), EP resolution (2014), Council of the EU conclusion (2014)) on the elimination of FGM. There is still a very significant lack of data and research preventing us to accurately determine the prevalence and evaluate the medical and psychological support needed by the survivors in Europe. Much is still to be done to develop awareness among all three generations (young, adult and elderly).
Having an internal common approach to the implementation of existing policies on international protection within the EU will help achieve the eradication of the practice. It is essential that the messages and application of international protection (Istanbul Convention) and European protections (EU Asylum directives and EU Victims directive) are applied in the same way across the EU.
The development by the DG Justice of 10 principles which guide European national Authorities, NGOs in achieving the Best interests of the child especially regarding criminal proceedings is a step in which the Network is fully engaged in.
FGM is also linked to a number of different issues (Gender Equality, Discrimination, Asylum, early child marriage, trafficking) addressed by EU policies and programmes affecting girls and women in Europe. It is therefore important to have a coherent approach among them. EU MS have obligations to offer better protection to refugees and asylum seekers at risk of, or living with FGM.

2) I saw that the network creates an enabling environment for coordinated and comprehensive action by European decision-makers to end FGC. How is this exactly executed and what changed already on the European level by the action of the network?
The Network creates an empowering environment by establishing contacts with relevant stakeholders, providing understanding on FGM and by shaping EU internal and external policy.
a. Establish contact
The network is establishing contact by first determining the relevant stakeholders (European Parliament, Commission, Council of Europe, Council of the European Union) then gathering support from those stakeholders.

b. Provide understanding of FGM
By providing understanding of FGM and support to those stakeholders to allow them to advocate for the use of an holistic approach in the development of tools, programmes, legislations to fight against FGM, but also in the type of communication they are using (words are very powerful) to send the message.
c. Shape EU internal and external policy
The network participates in public consultation held by the European Commission, the UN, the Council of Europe. We have also established consortia with other networks to engage and shape
European developments, such as an informal CSO group to monitor the implementation of the Council of Europe Istanbul Convention and another organised by Victim Support Europe on monitoring the transposition into national Law of the Victim's Rights Directive(ex: Grevio, Victim support Europe). The Network is also often invited to participate and contribute to conferences (Istanbul convention, Replace 2, Intact conference), this give us an opportunity to share our message with a broader audience, meet with key stakeholders and follow up on actions.

3) Do you think that the European Union is doing a good job already in fighting FGC? Or do you think that still a lot has to be changed?
The following instruments are tools that have been put in place by the European Union in fighting FGM:
The European Commission released its first-ever action plan 'Towards the elimination of female genital mutilation' on the International day of elimination of violence against women (25 November 2013).
Asylum directives: Recognize FGM as a persecution based on membership of a particular social group, making it a ground in which refugee status can be claimed, and also it constitute 'serious harm' in the context of a claim to a subsidiary protection. However, in the asylum procedural process, many challenges are faced by FGM survivors or those at risk, making it difficult for them to secure protection. In this context, the recognition of FGM as a ground for asylum claim was a very important step made by the Union. As previously mentioned, many have a hard time securing protection. Asylum professionals working in asylum centre often lack specialised training and knowledge on gender issues and FGM, which creates a barrier between them and the asylum seekers, making it difficult to establish the facts, access the credibility and needs of the vulnerable person.
Victims' Directive: Provide victims with rights without distinction of nationality or residential status and members states with obligations. The deadline for this directive to become part of national law in all European MS is 16th November 2015. Having now minimum rights for victims and obligation to MS to aid victims fully enjoy those rights are a step in the right protection. One of the important aspects of this directive is the obligation to do an individual assessment to determine the level of vulnerability of the person and the risk of victimisation that they may face. It is regrettable that the contents of the assessment are left to MS to determine, this could develop divergence in the determination of vulnerability and risk of victimization. More harmonisation is needed.
Istanbul Convention is the most innovative and complementary tools in the fight against Violence against women and girl in general and towards the eradication of FGM more specifically. Since the convention entered into force in August 2014, the Network has been pushing for ALL Member States to sign and ratify the convention, but also for the Union itself to sign and ratify the Convention. In October 2015, the Commission published a roadmap on a possible EU accession to the Istanbul Convention. This document concluded that this accession would complement the work of the Commission in its fight against violence against women and girls. This would also complement the Victim's Directive.
On the 25th of September 2015 the UN Security Council adopted the Sustainable Development Goals, which is a global commitment in which the European Union via the

Commission was one of the driven actors to the establishment of this text. The elimination of FGM is one of the goals of the SDGs, under section 5.3. The Commission has been advocating and promoting a convergence between its external policy and internal policy.
The lack of data; the cuts on funding makes the eradication of FGM difficult. Without data, determination of prevalence is impossible or just not accurate. Without funding it is impossible to develop research in the area to develop tools such as REPLACE 2 but also to develop cross-border programs like Men speak out.
The European Union has now put many instruments in place and put FGM on the European agenda. But to keep it there, sustained political will is needed. These instruments need to be monitored, to ensure that they are properly implemented.

4) How do you think the European Member States are performing in fighting FGC and is there a big difference between the MS according to the network?
Thank to NGOs working on the ground and thanks to the previous work of the Amnesty international Campaign, FGM has taken centre stage to the legislative and political platform in certain MS. Some Members States have specific legislation criminalising and prohibiting FGM (UK, Spain); others have added it into their criminal code (France). Starting the 31st of October 2015, mandatory reporting by any professionals who will potentially have contact with survivors or girls at risk (nurses, teachers, doctors) will be put in place in England. To learn more about this, please contact our national member Forward UK. In terms of national data collection, it is difficult to compare between MS, because they do not use the same indicators/framework methods. For more information on national performance, please contact our national members representative. The Network has seen an increase in the development of prosecution of FGM perpetrators. However because the practice is enshrined in culture and tradition, but also for the best interest of those at risk, more emphasis must be put on prevention through the training of professionals, women and community education and empowerment.

5) Your network consists of multiple national NGOs. How does the network support these NGOs in fighting on the national/regional/local level?
Through support, guidance, dissemination and training, the Network supports national NGOs in fighting against FGM at national, regional or local level. The Network provides its national members with support on developing their national advocacy strategy, which reflect on the national/regional/local specific needs of actions.
The Network tries to guide its members in understanding the differences and linkages that can be made between national/regional/local stakeholders and European stakeholders. The Network creates an environment for members to find partners in other MS and creates a cross-border element to the prevention and /or protection of FGM survivor or /girls at risk. Through its channels of communication and social media it disseminates information to and from its Members. By providing training to its members on EU legislation, the Network gives them the tools to follow the proper implementation of those legislations by MS and opportunity to contribute to the proper implementation and training of officers. The Network enables them to make MS accountable to their actions or inactions.

6) How do you think the situation regarding FGC will be in Europe in a few years with all the asylum-seekers from Africa and other "risk" countries? Do you already take measures for this?
I think European leaders, as all leaders across the world, need to act together. FGM is a global issue, which spans continents, ethnicities, religions and social classes. If leaders, governments, professionals, institutions and NGOs do not work together on this, it will be hard to end the practice. That is why we ask for a coordinated, cross-border approach in terms of training, data collection, sharing of information between professionals (police services, judicial authorities etc).

We also work on this concept of building bridges (see our strategic priority 2 and our objective 7 in our strategic plan) to encourage a coordinated approach.

Transcript Interview with Socio-Cultural Anthropologist J. Abbink

10 November 2015

Biography

J. Abbink is a socio-cultural anthropologist and carries out research on the history and cultures of the Horn of Africa, particularly Ethiopia. His projects include a historical-cultural study of the relationship between political change and ethnicity in Ethiopia, an ethno-history of South Ethiopia, and a study of violence and culture among southwestern Ethiopian ethnic groups. Abbink is also Professor of African Ethnic Studies at the VU University in Leiden.

1) Waar denkt u dat vrouwenbesnijdenis is begonnen en waarom?

Is niet te beantwoorden die vraag. Het is een oud gebruik in het Midden-Oosten, Noord-Afrika en Oost- Afrika en het heeft niets perse een religieuze achtergrond wat we ervan weten. We weten al natuurlijk dat het al bestond in Egypte, vandaar de naam faraonische besnijdenissen voor de ergste vorm. Terwijl dat niet overal in Egypte voorkwam. Maar we weten niet precies waar het vandaan komt nee, maar het heeft iets te maken met de gender verhoudingen, man-vrouw verhoudingen en de herdefinitie van de vrouwelijke rol in de samenleving. Maar exact is niet te zeggen van waar dat vandaan komt nee.

2) U denkt dus zelf ook dat het toen niet is begonnen in relatie met religie?

Nee, want het is een voorchristelijke, voor-islamitische gewoonte al ja die later is geïncorporeerd in religies al niet met toestemming of goedkeuring van de religie. Laten we zeggen dat het deel kan zijn geweest van lokale religies, lokale tribale religies. Dat zeker. En met name natuurlijk in Sudan, Egypte, delen van Ethiopië, delen van Kenia en Centraal Afrika is het zeer wijd verbreid. Dat is echt het kerngebied van de hele zaak.

3) En waarom denkt u dat vrouwenbesnijdenis nu heel erg wordt gelinkt aan religie?

Nou, omdat religieuze autoriteiten zich daarover uitspreken. Met name islamitische religieuze autoriteiten die daar, dat is een heel dubbelzinnige houding ten aanzien van vrouwenbesnijdenis in de islamitische religie. Sommige imams zijn, en andere religieuze leiders, het is een religieus voorschrift. En in de handboeken van de Islamitische wet staat er iets over maar het gaat met name erover hoe de Koran wordt geïnterpreteerd over de kuisheid, weet ik veel hoe ze het noemen, van de vrouw en man ten opzichte van elkaar. En die islamitische wet, die interpretatie en die autoritatieve interpretatie van de wet die in de Koran staat, die moet je dan nemen. De koran zelf heeft op sommige dingen een ambivalente formulering. Ten tweede, in het Christendom is het natuurlijk niet geaccepteerd, is het nauwelijks ook een issue maar dat gaat over het Westers Christendom, het missionaire Christendom. Je hebt in Afrika twee vormen van native Christendom, het koptisch Christendom en het Egyptisch en Ethiopische Orthodox Christendom, dat is eigenlijk dezelfde soort leer die samen zijn gekomen in de eerste en tweede eeuw in Ethiopië sinds het begin van de vierde eeuw. De kerk autoriteit in Ethiopië en Egypte zeggen niet dat het een religieuze plicht is, dat staat ook niet in de wetboeken, maar ze hebben het wel steeds gedoogd. Maar ze hebben daar geen dogmatische uitspraken over gedaan. Maar wat we nu zien is dat veel zogenaamde hervormers in zowel het Christendom maar met name Islam erop staan dat het een religieuze vereiste is. Dus hoogst omstreden binnen de Islam als ook daarbuiten. Dat is die discussie die nu aan de gang is. En je hebt van die fundamentalisten, die fanatici die zeggen dat het geen voorschrift is voor de vrouwen maar andere fundamentalisten die zich net zo Islamitisch noemen die zeggen van het is wel een voorschrift. Dus ze grijpen waarschijnlijk op verschillende wetsscholen in de Islam, een van

die vier wetsscholen waarvan sommige veel strenger zijn dan anderen. In landen als Eritrea, Kenia en Ethiopië zijn ze hard bezig om dat wettelijk te verbieden. En dit heeft effect. In Ethiopië en Eritrea gaat het langzaam maar wordt het steeds meer, het is een betoog over de gezondheid van de vrouw die geschaad wordt door een besnijdenis en praktisch gezien is dit ook zo. En ook steeds maar weer in het onderwijs wordt erop gewezen dat het niet de bedoeling is en toch gaan die vrouwen en die kinderen en meisjes erover nadenken en gaan erover met elkaar in debat, gaan met hun man en vrienden in debat en geleidelijk aan zie je een erosie, een ten kwestie stellen van die gewoonte. Met name in Eritrea en delen van Ethiopië is het absoluut aan het afnemen. En in Kenia zie je ook interessante dingen waarbij binnen gemeenschappen als de Masai en andere groepen die het doen een soort cultureel debat op gang komt over wat kunnen we dan doen als alternatief voor het zeg maar inwijden of klaarmaken voor de huwbaarheid, de huwelijkheid enzo daar gaat het vaak om. En dan zie je dat ze vervangende rituelen ontwikkelen zoals een symbolische besnijdenis, een symbolisch gesture die vrouwen moeten doen om zich als huwbare vrouw te doen afficheren. Dus daar zijn ook een hoop voorbeelden van bekend en die zijn ook beschreven. Dus daar is verandering aan de gang zonder meer.

4) Denkt u dat vrouwenbesnijdenis voor een groot gedeelte echt te maken heeft met de pressure van society in deze landen?

Ja zeker. Maar daar moet je dus bij in begrijpen de vrouwen zelf. Het cultureel waardepatroon en de veronderstellingen en representaties voorstellingen rond de man-vrouw verhoudingen, de man en vrouw rollen is zodanig dat vrouwen er ook van overtuigd zijn dat om een goed volwaardig lid van de samenleving te zijn en een huwbare en “clean” persoon te zijn, je besneden moet zijn. Dat is met name sterk in de Somalische samenleving en in de Affa samenleving in Ethiopië en in andere groepen in Ethiopië en daar zijn de vrouwen er vast van overtuigd dat je moet het hebben gedaan omdat anders val je er echt buiten. De meerderheid van de vrouwen denkt nog zo en als je het niet doet is er een hele moedige beslissing voor nodig die je ook dan moet volhouden en ten eerste krijg je dan de laag van de andere vrouwen over je heen, de volle laag krijg je dan van die vrouwen, maar ook van de mannen die eisen dat een vrouw zeg maar goed voorbereid, inclusief de besnijdenis, naar het huwelijk gaat. Dus die druk is groot. Maar toch is het zo dat ook mannen niet helemaal laten we zeggen dogmatisch zijn als het gaat om het denken over alternatieven. De druk is net zo groot van de vrouwen als van de mannen.

Uit het ritueel en de voorbereiding wordt de man helemaal buiten gelaten. Maar dan zie je wel dat er een vertekening optreedt want dan wordt er gedacht van ja die mannen zijn eigenlijk onverschillig daarover en die hebben er niet zo interesse in, maar dat is onjuist. Die mannen veronderstellen dat het gebeurt maar goed het is een vrouwenzaak, we laten het aan de vrouwen over. Als je zou zeggen van ja uw dochter gaat toch niet zich besnijden en gaat dan trouwen, dan zegt die man, die vader, van ja maar ja wacht even dat is niet helemaal de bedoeling. Dus ze bemoeien zich er niet mee en in principe ten opzichte van buitenstaanders en vooral blanke interviewers en buitenstaanders die hen erover komt ondervragen dan zeggen ze van ja eigenlijk is die gewoonte niet zo fijn, dat had anders gekund. Maar in de praktijk als die mensen weer weg zijn houden ze toch vast aan die conservatieve houding ten aanzien van de besnijdenis van hun dochters. Dus dat moet je op een goede manier onderzoeken en op een goede manier inschatten in die cultureel-sociale context waarin die mensen leven. Dus hoewel ze er dus niets mee te maken hebben met de feitelijke acties rond die besnijdenis, wordt er toch een beetje verondersteld dat het toch wel doorgaat. Maar er zijn dus ook gemeenschappen die er toch over praten en die geleidelijk aan open komen te staan voor alternatieven die ook een soort markering van de staat van meisje naar huwbare vrouw symboliseren en dan zijn ze wel bereid om daarover na te denken.

5) Denkt u dat de mannen ook verder weten wat voor medische problemen vrouwenbesnijdenis geeft? Of denkt u dat zij daar wat dat betreft echt geen zicht op hebben?

Nou hoe minder geletterd ze zijn hoe minder ze ervan weten maar ik denk dat ze het wel zien dat sommige meisjes dat niet overleven en doodbloeden of zoiets of infecties krijgen. Tegelijkertijd wegen ze dat af tegen cultureel vereiste ideaal wat ze dat hebben moeten ondergaan, maar ze zijn zich er wel van bewust, en zeker nu in de huidige mondiale tijd van voorlichtingscampagnes, van NGO actie overal kan ik me niet voorstellen dat mensen niet weten dat er health risks zijn. Dus dat offensief zeg maar van het gezondheidsperspectief dat heeft voldoende impact gemaakt dat ze hier toch wel vanaf weten ja, dat maakt ze meer ontvankelijk hiervoor. En dan heb je ook dat probleem dat in zeer zware vorm van besnijdenis met die infibulatie waarbij alles wordt dichtgenaaid, dat dat helemaal ellendig is vanwege het eerste seksuele contact die mensen dan hebben en dat is voor de man ook niet altijd supergoed denk ik. Maar dat weet ik niet, daar kan ik niet over oordelen. Maar dan zullen ze ook zien dat dat de risico's voor hun dochters of vrouwen groot zijn en dan kunnen ze misschien ook ietsje meer besef krijgen van dat het in deze tijd toch anders zou kunnen ook.

6) En u denkt ook in ieder geval dat het inderdaad de vrouwen in de samenleving echt een standplaats geeft omdat ze wordt besneden. Dus dat het echt een gender equality ook issue is daarnaast.

Nee, het is een inequality issue. Het is zwaar inequality, maar de mensen die daarover vragen, zowel vrouwen als mannen in zo een samenleving, want dat doen ze daar in Ethiopië of Eritrea die zeggen van hoe bedoel je inequality? Het gaat om complementariteit, de vrouw en de man verschillend maar complementair, evenveel waard maar gewoon anders. Dat is dus het vertoog he. En bij vrouw zijn hoort gewoon dit. Dus dat is het gewoon. Dus je moet een enorme inspanning plegen om hen ervan overtuigen dat er toch een vorm van assymmetrie aan de gang is in die man/vrouw relatie. Want in feite is het toch een oorspronkelijk vertoog van man/ vrouw verschil wat waarschijnlijk door de patriarchale samenleving is ingevoerd of opgelegd he. Dat de vrouw nu eenmaal "unclean" is in die staat en dan veranderd moet worden ten einde huwbaar en acceptabel te zijn. Dus in feite is het deel van de patriarchale cultuur als je dat echt tot op de grond zou uitzoeken volgens mij. Dus ja man/vrouw ongelijkheid in feite ja.

7) En weet u of er trouwens ook een traditie is bij de man om de man klaar te maken voor het huwelijk? Of dat niet?

Nee, niet via besnijdenis en ook niet via andere zaken. Ja het is wel een samenleving die inwijdingsceremonies of initiatierituelen heeft voor de man om adult status, volwassen status te bereiken maar dat is dan lang niet alleen om klaar te maken voor het huwelijk, dat gaat ook om sociale volwassenheid. Maar dat is enorm verschillend in allerlei samenlevingen, tribale , ethnische samenlevingen die je in dat gebied vind ja. Maar meestal gaat het over iets meer dan inwijden voor het huwelijk. Dat is voornamelijk gecentreerd om de vrouw. Maar mannen hebben natuurlijk een breder maatschappelijk, politieke functie in de samenleving dus je moet in dat opzicht dus worden voorbereid op volwassenheid.

8) Waarom denkt u dat tweede en derde generatie migranten hier in Europa nog steeds vrouwenbesnijdenis uitvoeren terwijl ze weten dat het hier illegaal is en geen traditie?

Ja goeie vraag, dat begrijp ik ook niet. Omdat mensen zich onvoldoende willen aanpassen, door het anders zijn wat bijna dag in en dag uit wordt bevestigd door de samenleving waarin ze wonen. Willen handhaven, willen bevestigen. En naarmate een gemeenschap groter wordt neemt ook de sociale druk om gewoonten uit het land van herkomst te behouden toe. Dat zie

je in elke gemeenschap. Kijk kleine en diffuus georganiseerde gemeenschappen, laten we zeggen onder de tienduizend, onder de vijftienduizend mensen is die sociale druk er niet want mensen wonen, bijna gelukkig voor velen, worden verspreid. De grotere groepjes worden compacter, worden meer territoriaal geconcentreerd, krijg je meer sociale controle en dan krijg je dat effect van wij zijn nou eenmaal Somalisch, dit is een gebruik die wij moeten vasthouden. Daar komt het een beetje op neer. Dit is ook een soort reflectie van het gebrek aan integratie, laat staan assimilatie van die groepen. Assimilatie zal zelden optreden in deze tijd, maar ook het gebrek aan integratie. Dus dat zijn van die overwegingen die meespelen en dat duidt ook aan dat er een zekere sociaal educatieve stagnatie plaatsvind in die gemeenschap omdat ze te weinig succes hebben in het sociaal doorstromen, sociaal, ook werk vinden he. Zoals je weet in de Somalische gemeenschap waar het het sterkste is in Nederland, die grootte van FGM, die is voor 70% niet werkend. Dat komt door te weinig opleiding, door onwil volgends mij, ook gebrek aan affiniteit met deze samenleving, noem maar op, om persoonlijke redenen, sociale desoriëntatie, familie fragmentatie, veel paren die scheiden. Vrouw die wil eruit omdat ze toch lekker een uitkering kan krijgen met kinderen en ze is niet afhankelijk van de man. Ook specifiek in deze gemeenschap zijn mannen individualistisch, kunnen niet tegen gezag dus is dat vaak moeilijk. Dus die valt terug op de gemeenschap, die gaan samen zitten chaad kauwen enzovoort en ja dan krijg je dat soort processen die in stand houding van eigen groepsgewoonten te bevorderen en dat geldt ook voor vrouwen die samentrekken in groepjes enzovoort. En dan krijg je die druk die weer ontstaat ja en dan spelen die valide, geachte normen en waarden over wat een goed Somali persoon is hier in Nederland of en natuurlijk in Somalië. Maar ja in de toekomst is dat niet meer houdbaar, ja sustainable. Die gewoonte zal en gaat verdwijnen natuurlijk op een gegeven moment. Je krijgt last met Justitie en Politie. Gezondheidsdiensten enzovoort gaan dit allemaal merken en die consultatiebureaus enzovoort. Dus die druk blijft bestaan en die moet ook worden aangehouden want dat is in dit land gewoon tegen de wet. Het kan gewoon niet. Ook al zijn we als cultureel divers land zeer tolerant ten aanzien van al die verschillende culturen enzovoort, dit is iets wat in deze samenleving gewoon niet kan en waarvan ook veel meisjes op latere leeftijd van uit die gemeenschappen, ik wou dat ik het niet gedaan had, ik werd onder druk gezet, ik heb het moeten doen, ik had het liever niet gedaan. Dan krijg je dat allemaal terug.

9) Heel veel mensen hier in Nederland, Sweden en Engeland doen het echt in het geheim, FGM. Hoe denkt u dat het het makkelijkst kan worden getraceerd. Echt de practice zelf, dat het wordt gedaan, want dat is natuurlijk moeilijk als mensen het in het geheim doen. En ook voordat het echt wordt gedaan.

Weet ik niet. Dat is erg moeilijk. Je moet het traject van die immigranten bijhouden, dus stel er zijn twee groepen, de mensen die er al zijn en mensen die aankomen. De mensen die aankomen zijn makkelijker, moet je zo gauw op de hoogte brengen van de wetgeving in het land en je moet ze in contact stellen met de medische diensten, moet je ze erop wijzen dat die medische diensten, die artsen en consultatiebureaus dat niet tolereren en dat gaan melden. Dat zal je moeten verplichten. Ze hebben in principe een medisch geheim maar geheim is hier niet van toepassing want het is een overtreding. Dus in alle instanties die te maken hebben met de gezondheid van de medische aspecten van die migranten moeten ze dit voortdurend naar voren brengen. En die diensten, huisartsen, consultatiebureaus enzovoort, ziekenhuizen, moeten een meldingsplicht hebben en die moeten gaan aanleggen en die moeten die mensen gaan volgen en uitleggen van doe het niet want je krijgt juridische consequenties en die moet je dan ook nemen he, die juridische stappen. En niet zeggen van het is nou gebeurd dus ga maar. Je moet ook wat gaan doen anders is het weer zo een slappe gedoogs toestand in Nederland. Het is echt heel slecht voor de seksuele en de medische gezondheid van de meisjes later. En mensen die al hier zijn daar is het vaak al te laat want sommige mensen komen hier met een besnijdenis natuurlijk en dan kan je er niets meer aan doen. Maar ook die mensen kun je als die in verwachting zijn en ze zijn bij een vroedvrouw of

bij een consultatiebureau die moet je ook inlichten over dat het in dit land de gewoonte is en juridisch ook verplicht is om dat te voorkomen en dat niet te doen. En dat als je wel doet dat je dan wordt gemeld en dat je dan wordt geregistreerd in een of ander register dat het je later in het leven moeilijk wordt gemaakt bij bepaalde zaken. En daarnaast, je moet ook echt die strafvervolging veranderen want het moet natuurlijk niet toenemen. En het kan want veel Ethiopiërs en Eritreërs die hier zitten die doen het veel sneller. Die gaan er veel sneller mee ophouden dan de Somalis, omdat Ethiopiërs en Eritrees meer affiniteit hebben met de moderniteit zeg maar en minder vasthouden aan traditie, en zich meer oriënteren op de samenleving. Ook omdat ze iets succesvoller zijn in het vinden van educatie, goede opleiding he, en werk dan de Somalis. Dat speelt ook mee volgens mij. Dus die zijn ontvankelijker voor die boodschap. Somalis zijn wat dat betreft meer geïsoleerd, meer gesloten zeg maar, meer onhandelbaar laten we zeggen.

10) We hebben nu die migranten stroom vanuit Afrika en het Midden-Oosten, en dat zijn ook wel de risico landen waar ze vandaan komen. Hoe kunnen wij die mensen er meteen al op voorbereiden om te weten hoe het hier gaat. U bent hier al op ingegaan maar heeft u nog andere opmerkingen hierover?
De meeste mensen vanuit de vluchtelingen stroom zijn vanuit het Midden-Oosten en Syrië enzovoort waar het minder voorkomt. Dus voor de meesten zal het geen extra inspanning vereisen, maar ik zou bijna zeggen van bij iedere intake, op wat voor manier dan ook, zou het belang van het in acht nemen van de huidige in Nederland geldende normen en waarden rond gezondheid, rond de wet enzo. Zo moet het worden benaderd, waaronder zoiets belangrijks als FGM. Maar ik zou dan met name die boodschap overbrengen bij Somalis, Eritrees en Ethiopiërs om dat extra te benadrukken ja. Verder kan je ze niet benaderen want ze spreken geen Nederlands, ze spreken waarschijnlijk weinig Engels. Dus je moet dan in het traject wat ze hebben, in de begeleiding en voor de geaccepteerde asielzoekers een taalcursus en inburgeringscursus aanbieden enzovoort en het gewoon erbij zeggen. Zoals bijvoorbeeld homoseksualiteit ook wordt besproken. Dus het hangt gewoon af met de contacten die ze hebben met de officiële instanties en begeleiding in dit land, want in sociale contacten met de rest van de bevolking zal het weinig aan de orde komen. In landen als in Ethiopië en Eritrea doen ze dat ook. Er is in die landen keiharde wetgeving hiertegen en het is absoluut verboden. Je krijgt een zware geldboete of gevangenisstraf. Maar ze proberen een breuk te creëren in die traditie. Je kan het ook geleidelijk aan doen zoals Kenia, die praten erover en zorgen voor een evolutie die op gang wordt gebracht waarbij mensen zelf binnen hun sociaal culturele waarde patroon denken van moet dit doorgaan. Dat duurt langer maar het is vaak wel effectiever.

Transcript Interview Senior Public Prosecutor M. Mos
28 December 2015

Biography
M. Mos is a senior public prosecutor and the Head of Department of Administrative and Legal Affairs at the Dutch Public Prosecution Service The Hague.

1)**Kunt u mij vertellen wat uw functie precies inhoudt?**
Nou, ik ben officier van Justitie.

2) Wat heeft u functie in relatie te maken met het onderwerp van vrouwenbesnijdenis?
Ja, het is een strafbaar feit. Dus dat is de relatie met officier van justitie.

3) Oke, en ik heb zelf ook al gezocht wat een officier van justitie precies doet en klopt het dat u dan ook bij rechtszaken zit en deze zaken dus eigenlijk behandeld.
Ja.

4) Heb u in de afgelopen tijd veel rechtszaken bijgewoond wat betreft vrouwenbesnijdenis?
Nou ik heb die collega van mij die zegt dat er niet zoveel zijn. Tenminste voor zover wij daar overzicht over hebben. Zij heeft de landelijke portefeuille en er is niet een groot aantal rechtszaken geweest in Nederland op dat gebied.

5) Weet u hoeveel het er ongeveer zijn?
Nee, dat weten we niet, want we registreren het niet op die manier.

6) Heeft u enig idee hoe het komt dat er niet zoveel rechtszaken zijn wat vrouwenbesnijdenis betreft?
Ja ik denk dat dat komt ook vaak omdat die mensen zelf niet naar de politie gaan en dat het dan daardoor bij ons niet bekend raakt. Dus dan is er ook geen strafzaak.
7) En waarom denkt u dat mensen niet zo snel naar de politie gaan? Want er zijn natuurlijk ook omstanders die het kunnen opmerken.
Dat weet ik niet goed, want ik ken het fenomeen niet volledig maar ik kan me zo voorstellen dat er allemaal sociale druk is waardoor in de groep waar die mensen in zitten. En bovendien zijn er misschien ook mensen die ook niet goed weg weten in Nederland om naar de politie te gaan en zijn denk ik vaak mensen die redelijk in hun eigen groep functioneren maar niet helemaal geïntegreerd zijn in de Nederlandse samenleving dus dan is het altijd spannend om naar de politie te gaan. Dat zijn denk ik wel de grootste redenen.

8) Maar als ik het dus goed begrijp hebt u dus in de afgelopen tijd ook niet echt een rechtszaak bijgewoond hierover?
Nee.

9) Zou er nog een andere reden zijn waarom er niet zoveel rechtszaken zijn naast dat het misschien weinig wordt aangegeven?
Nou, ik zou niet weten wat voor reden nog meer. Kijk op het moment dat iemand zich bij de politie meld met dit letsel en met dit strafbaar feit dan zal er zeker onmiddellijk opgetreden worden.

10) Maar u weet niet of het misschien heel moeilijk is om zo een zaak goed te onderzoeken om bewijs te vinden.
Nou ik kan me niet voorstellen dat dat moeilijk is want dat letsel dat is waarschijnlijk heel makkelijk zichtbaar en het is natuurlijk een verschrikkelijk vervelend onderzoek, want het is een lichamelijk onderzoek, maar dat zal het probleem ook niet zijn en het strafbaar feit is ook niet ingewikkeld. Het is gewoon mishandeling of zware mishandeling.

11) Hebt u enig idee hoe de wetgeving staat tegenover vrouwenbesnijdenis en hoe het in de wet is geïncorporeerd?
Nou er is niet een aparte bepaling voor, het valt gewoon onder mishandeling of zware mishandeling zoals het in het boek van strafrecht is neergelegd. En dat is ook voldoende hoor, dat volstaat.

12) Denkt u niet dat de regelgeving wat specifieker kan in Nederland?
Ik denk dat de wetgeving voldoende is. Ik zou me hooguit voor kunnen stellen dat, want het wordt natuurlijk niet altijd zichtbaar doordat iemand zichzelf bij de politie meld, maar dat het wordt opgemerkt als iemand bij de dokter komt en behandeld moet worden en de dokter

mag natuurlijk niet zomaar informatie delen als die ernstig letsel bij iemand ziet waarvan die denkt dat het door strafbaar handelen gekomen is en misschien dat je op dat gebied in Nederland wel specifieke regelgeving nodig hebt om de dokter de gelegenheid te geven om wel informatie te verstrekken daarover. In principe kan hij dat wel want hij kan zijn beroepsgeheim doorbreken als hij vind dat het belang van de patient daarmee gediend is. Artsen doen dat niet snel, maar dat is ten onrechte hoor. Dat is gewoon een ten onrechte aanname dat ze daardoor hun beroepsgeheim niet mogen schenden maar dat is natuurlijk onzin, want beroepsgeheim is er om de patient ten goede te komen en dokters doen af en toe net alsof het voor hunzelf bedoelt is.

13) Denkt u nog dat er andere dingen verbeterd kunnen worden wat betreft wetgeving, bestraffing en maatregelen vanuit de politie en de regering om berechting en opsporing te verbeteren?
Nou nee, ik zou niet weten wat. Ik denk alleen, kijk niet de wetgeving, maar ik denk wel dat het voor de politie goed is, maar dat hebben ze ook al he, dat je daar deskundige rechercheurs voor nodig hebt om te weten in wat voor soort cultuur dit soort dingen gebeuren en op welk moment en ook welke cultuur dat wel of niet gedaan wordt om ook betere verhoren te krijgen. Dan stel je sneller je bewijs bij elkaar.

14) En denkt u niet dat het ook nog handig zou zijn om bijvoorbeeld binnen de politie of vanuit de politie een soort community agenten op te stellen die eigenlijk in gesprek gaan met mensen over dit fenomeen?
Nou ik denk niet dat de politie dat moet doen. Dat zouden hulpverlening instanties moeten doen. Ik denk niet dat de politie daarvoor is.

15) Kunt u een voorbeeld geven van een hulpverlenende instantie die dat zou kunnen doen?
Nee want daar heb ik geen zicht op. Ik heb alleen maar zicht op politie en openbaar ministerie maar ik weet wel dat de politie niet voor dit soort dingen is.

16) Staan jullie wel in contact met NGOs dus bijvoorbeeld FSAN of andere instanties waar jullie samen mee werken op dit gebied?
In principe doet het openbaar ministerie niet dat tenzij ze iemand vertegenwoordigen zeg maar een slachtoffer, maar in principe hebben wij weinig contact met dat soort mensen. Hooguit als we met elkaar willen bespreken wat de beste aanpak is voor een bepaald fenomeen. Maar dat gebeurt zeker niet elke keer.

17) Denken jullie niet dat het dan misschien handig zou zijn om toch meer een soort van netwerk te creëren tussen de politie en instanties om het fenomeen beter te begrijpen en te bestrijden?
Dat zou kunnen maar nogmaals, ik denk niet perse dat dat de taak van het openbaar ministerie en de politie is. Maar om uiteindelijk het fenomeen beter te bestrijden zeker, maar daar zal de politie ook alles aan doen om die informatie boven tafel te krijgen en dus ook met dat soort organisaties te praten. Maar die zullen ook elders hun informatie vandaan halen.

18) Oke, u zei dus al dat er weinig rechtszaken zijn geweest wat dit betreft. Heeft u wel enig zicht gehad of mensen überhaupt zijn berecht?
Nee, weet ik niet.

19) Heeft u zelf nog vragen of opmerkingen?
Neehoor.

Transcript Interview Representative FSAN H. Othman
28 December 2015

Biography:
H. Othman is of Somali background and very involved in the Somali community and culture. She is project assistant at FSAN and currently working on a project on child rights. Within this interview she takes the role of representing the organisation.

1) Wat doen jullie precies?
De Federatie Somalische Associaties Nederland (FSAN) is opgericht in 1994. Het is een koepelorganisatie. Het biedt informatie en kennis aan diegenen die op zoek zijn naar expertise op het gebied van Somalië, Somaliërs in Nederland en diaspora, Somalische cultuur en geschiedenis. FSAN is zeer actief tegen vrouwenbesnijdenis ook wel Vrouwen Genitale Verminking genoemd. De afkorting hiervan is VGV. Tevens is FSAN ook de belangenbehartiger en spreekbuis van de Somalische gemeenschap in Nederland. FSAN is ook actief met initiatieven die vredesopbouw en ontwikkeling van Somalië als doel hebben. De organisatie bestaat ook voor een hele grote deel uit professionals die hun specialistische kennis en visie inzetten voor deze doelstellingen.

2) Komt vrouwenbesnijdenis veel voor binnen de Somalische gemeenschap in Nederland en hoe komt dit?
Doordat er veel immigranten naar Nederland zijn gekomen vanuit diverse landen waar Vrouwen Genitale Verminking wordt uitgevoerd. Somalië behoort tot één van die landen. In Nederland komt VGV ook voor. 40% tot 50% van de meisjes loopt de risico om besneden te worden. Daarnaast is er ook een hoge percentage van de vrouwen die al besneden zijn. Dit is ongeveer 40% van de immigranten vrouwen.

3) Ik had vernomen dat vrouwenbesnijdenis vaak wordt uitgevoerd om religieuze redenen. Hoe zien jullie de connectie tussen FGM en bijvoorbeeld de Koran? Wordt hier überhaupt een connectie gelegd?
Er wordt in de Koran geen connectie gelegd met FGM. Dit houdt direct in dat FGM niet uitgevoerd dient te worden. Er zijn een aantal islamitische geestelijken die een fatwa hebben uitgesproken waarin zij aangeven dat het uitvoeren van FGM schadelijk is voor je gezondheid. Islamitische mensen moeten hun lichaam juist beschermen tegen schadelijke dingen en daarom is het ook verboden.

4) Wat doen jullie aan vrouwenbesnijdenis binnen de Somalische gemeenschap?
VGV is vanaf het begin een heel belangrijk aandachtspunt voor FSAN. Wij richten ons ook op de preventie. Dit is gericht op voorlichting en preventie binnen de risicogroepen. Dit gebeurt via lokale en regionale zelforganisaties, training en begeleiding van sleutelpersonen uit de eigen gemeenschap. Tevens traint FSAN ook professionals. FSAN doet ook mee aan verschillende overlegorganen met betrekking tot de strijd tegen VGV. Dit gebeurt zowel op nationaal en internationaal niveau. FSAN is samenwerkingspartner van een groot aantal landelijke organisaties zoals: • Landelijke en regionale GGD afdelingen; • Pharos, landelijk kenniscentrum voor gezondheid van migranten en vluchtelingen; • VON, Vluchtelingen Organisaties Nederland; • Een groot aantal Afrikaanse zelforganisaties; • VGV sleutelpersonen.
Er wordt ook zorg besteed aan vrouwen die besneden zijn. VGV gaat vaak gepaard met lichamelijke, seksuele en psychosociale klachten. Het is belangrijk dat besneden vrouwen weten waar ze met hun klachten terecht kunnen, waar ze passende zorg kunnen vinden en dat er een juiste en snelle respons is op dit soort klachten.

Bovendien hebben wij zoals eerder benoemd ook sleutelpersonen. Deze sleutelpersonen voeren huiskamergesprekken, huisbezoeken en voorlichtingsbijeenkomsten ter preventie van VGV. De sleutelpersonen die dit uitvoeren zijn getraind door FSAN.
Wij hebben ook diverse informatie boekjes ontwikkeld waaronder;

- Focalpoint
- Sleutelpersonen in beeld; het belang van nazorg bij vrouwenbesnijdenis en de rol van sleutelpersonen in de strijd tegen VGV
- Verschillende dvd's

5) Merken jullie dat het moeilijk is voor de Somalische bevolking om in discussie te gaan over het onderwerp? Waarom is dit zo?
Het is een moeilijk onderwerp om over te hebben in het algemeen, maar door de komt van de sleutelpersonen is hier wel een vooruitgang in geboekt.

6) Heeft jullie werkwijze om FGM te bestrijden aanzienlijk effect volgens jullie? En hoe merken jullie dit?
Ja dit heeft zeker effect. Door middel van de sleutelpersonen bereiken wij een steeds grotere groep van de Afrikaanse gemeenschap. Dit houdt in dat FGM wordt besproken en de gevolgen daarvan ook worden behandeld.

7) Wat zouden jullie nog kunnen verbeteren denken jullie?
De betrokkenheid van sleutelpersonen is erg belangrijk. Wij willen graag nog meer sleutelpersonen trainen over FGM, zodat wij steeds een grotere groep kunnen bereiken.

8) Hoe vinden jullie de methode die door de Nederlandse regering wordt gebruikt om vrouwenbesnijdenis te voorkomen en te bestraffen?
Dit vinden wij heel goed. Wij maken tijdens onze voorlichtingen, huiskamergesprekken en huisbezoeken gebruik van de verklaring tegen vrouwenbesnijdenis. Deze hebben wij in diverse talen als: Somalisch, Arabisch, Engels, Frans, Nederlands en Tigriaans etc.

9) Geloven jullie dat dit beter kan en hoe?
De overheid kan een lichamelijk onderzoek niet verplichten vanwege de privacy schending. FSAN staat hier ook achter. De overheid zal wel duidelijk kunnen maken door middel van sociaal media (hier wordt veel gebruik van gemaakt) dat FGM streng verboden is in Nederland.

10) Wat zien jullie zelf graag veranderen binnen de politiek en wat zou jullie van buitenaf kunnen helpen in jullie strijd tegen FGM?
Het zou mooi zijn dat de overheid de nut en belangrijkheid van de sleutelpersonen en hier ook op enige manier ondersteuning in biedt.

11) Hoe kijken jullie als organisatie naar vrouwenbesnijdenis? Geloven jullie dat dit een human rights issue is of een vorm van culturele traditie dat zou moeten worden getolereerd door de politiek?
Het is uiteraard een humans right issue, maar het wordt gebruikt in de mom van cultuur en religie terwijl dit niet het geval is. Het gaat hier om vrouwen waarbij hun mensenrechten wordt geschonden, doordat hen opzettelijk lichamelijke pijn wordt aangedaan.

7.4 Informed Consent Forms

Informed Consent Form - Representative END FGM N. Kontoulis

Informed Consent Form

A comparative study of the national response towards female genital cutting within the United Kingdom, Sweden and the Netherlands

The dissertation gives insight on the problem of FGC, where & why it started and the governmental and non-governmental response towards FGC. The factual information found on these topics in addition to scholars' views about how Western society should deal with FGC will be analysed and will help to formulate a new action plan on how FGC should be addressed on the national and the European level.

If you agree to take part in this study please read the following statement and sign this form.

I am 16 years of age or older.

I can confirm that I have read and understood the description and aims of this research.

The researcher has answered all the questions that I had to my satisfaction.

I understand that the researcher offers me the following guarantees:

- All information will be treated in the strictest confidence by publishing the information only for university purposes and by signing to accept or deny the following:

  I accept / deny my name being used throughout the dissertation. (Please underline the word you wish to be applicable)

- The information given will stay of indifferent meaning.

I consent to take part in the research on the basis of the guarantees outlined above.

Natalie Kontoulis

Communications and Network Officer of the End FGM European Network

Signed: Natalie Kontoulis Date: 9 November 2015

Informed Consent Form – Socio-Cultural Anthopologist J. Abbink

Informed Consent Form

A comparative study of the national response towards female genital cutting within the United Kingdom, Sweden and the Netherlands

The dissertation gives insight on the problem of FGC, where & why it started and the governmental and non-governmental response towards FGC. The factual information found on these topics in addition to scholars' views about how Western society should deal with FGC will be analysed and will help to formulate a new action plan on how FGC should be addressed on the national and the European level.

If you agree to take part in this study please read the following statement and sign this form.

I am 16 years of age or older.

I can confirm that I have read and understood the description and aims of this research.

The researcher has answered all the questions that I had to my satisfaction.

I understand that the researcher offers me the following guarantees:

- All information will be treated in the strictest confidence by publishing the information only for university purposes and by signing to accept or deny the following:

  I accept / ~~deny~~ my name being used throughout the dissertation. (Please underline the word you wish to be applicable)

- The information given will stay of indifferent meaning.

I consent to take part in the research on the basis of the guarantees outlined above.

Prof. Dr. G.J. Abbink

Signed: **Date:**10 November 2015

Informed Consent Form – Senior Public Prosecutor M. Mos

Informed Consent Form

A comparative study of the national response towards female genital cutting within the United Kingdom, Sweden and the Netherlands

The dissertation gives insight on the problem of FGC, where & why it started and the governmental and non-governmental response towards FGC. The factual information found on these topics in addition to scholars' views about how Western society should deal with FGC will be analysed and will help to formulate a new action plan on how FGC should be addressed on the national and the European level.

If you agree to take part in this study please read the following statement and sign this form.

I am 16 years of age or older.

I can confirm that I have read and understood the description and aims of this research.

The researcher has answered all the questions that I had to my satisfaction.

I understand that the researcher offers me the following guarantees:

-All information will be treated in the strictest confidence by publishing the information only for university purposes and by signing to accept or deny the following:

I accept / deny my name being used throughout the dissertation. (Please underline the word you wish to be applicable)

- The information given will stay of indifferent meaning.

I consent to take part in the research on the basis of the guarantees outlined above.

Public Prosecutor M. Mos

Signed: Date: 28 December 2015

Informed Consent Form – Representative FSAN H. Othman

Informed Consent Form

A comparative study of the national response towards female genital cutting within the United Kingdom, Sweden and the Netherlands

The dissertation gives insight on the problem of FGC, where & why it started and the governmental and non-governmental response towards FGC. The factual information found on these topics in addition to scholars' views about how Western society should deal with FGC will be analysed and will help to formulate a new action plan on how FGC should be addressed on the national and the European level.

If you agree to take part in this study please read the following statement and sign this form.

I am 16 years of age or older.

I can confirm that I have read and understood the description and aims of this research.

The researcher has answered all the questions that I had to my satisfaction.

I understand that the researcher offers me the following guarantees:

-All information will be treated in the strictest confidence by publishing the information only for university purposes and by signing to accept or deny the following:

I accept / deny my name being used throughout the dissertation. (Please underline the word you wish to be applicable)

- The information given will stay of indifferent meaning.

I consent to take part in the research on the basis of the guarantees outlined above.

Signed: 

Date: 28-12-2015

7.5 Student Ethics Form

Student Ethics Form

European Studies
Student Ethics Form

Your name: Annika Voois

Supervisor: M. Anghel

Instructions/checklist
Before completing this form you should read the APA Ethics Code (http://www.apa.org/ethics/code/index.aspx). If you are planning research with human subjects you should also look at the sample consent form available in the Final Project and Dissertation Guide.

a. [x] Read section 3 that your supervisor will have to sign. Make sure that you cover all these issues in section 1.
b. [x] Complete sections 1 and, if you are using human subjects, section 2, of this form, and sign it.
c. [x] Ask your project supervisor to read these sections (and the draft consent form if you have one) and sign the form.
d. [x] Append this signed form as an appendix to your dissertation.

Section 1. Project Outline (to be completed by student)

(i) Title of Project: A Comparative Study on the National Response from the United Kingdom, Sweden and the Netherlands Regarding Female Genital Cutting

(ii) Aims of project: The aim of the project is to analyse the reason behind action of FGC, the European governmental and non-governmental approach towards a practice that goes against the beliefs, norms and values of a western society, and to come up with recommendations on how to engage more efficiently in the matter of female circumcision.

(iii) Will you involve other people in your project – e.g. via formal or informal interviews, group discussions, questionnaires, internet surveys etc. (Note: if you are using data that has already been collected by another researcher – e.g. recordings or transcripts of conversations given to you by your supervisor, you should answer 'NO' to this question.)

YES / N0

This project is designed to include research with human subjects. I understand that I have to obtain ethical clearance to interview people (formally or informally) about the topic of my research.

Section 2 Complete this section only if you answered YES to question (iii) above.

(i) What will the participants have to do? (v. brief outline of procedure): The participants will have to answer questions that will help doing research and collect expert views on the

topic of my dissertation. These questions will vary per participant and will be carefully selected upon the role of the participants regarding FGC.

(ii) What sort of people will the participants be and how will they be recruited? The people that will be selected include a representative of each stakeholder incorporated in this research. This means that a representative of an NGO will be selected, an expert on the socio-cultural aspect of FGC and a representative of the government will be selected. The interviewees are specialists on the topic and are not directly involved in the practice of FGC, meaning that they are not victims or executers of the practice. All participants will be contacted by email to ask permission to get an interview. Furthermore, consent forms will be obtain for each interview to give the interviewee the option to remain anonymous if they wish so.

(iii) What sort stimuli or materials will your participants be exposed to, tick the appropriate boxes and then state what they are in the space below?

Questionnaires[ ]; Pictures[ ]; Sounds [x]; Words[x]; Other[ ].

The participants will be exposed to questions included in my interview, and the use of a voice recorder to be able to write a full transcript per interview and to assure the exact wording of the interviewee.

(iv) Consent: As stated before, an informed consent form will be obtained from each interviewee before they take part in the interview. This consent form will explain the means of my research and state what the interviewee will be doing to support the dissertation. In addition, this form will also state that the participants can withdraw from the study at any time and will display a section in which they can accept or deny the usage of their names throughout the dissertation and the transcript.

(vi) What procedures will you follow in order to guarantee the confidentiality of participants' data? To guarantee the confidentiality of the interviewee, their words will only be published for university purposes and the participant has the option to accept or deny the usage of their names throughout the dissertation and the transcript.

Student's signature: ..... date: .....

Supervisor's signature (if satisfied with the proposed procedures):

date: Dec. 18th, 2015