

***Multisectoral  
Academic Training Guide  
on Female  
Genital Mutilation/Cutting***

*Directoras*

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*Coordinadoras*

**MAGALY THILL Y NORA SALAS SEOANE**



MULTISECTORAL ACADEMIC  
PROGRAMME TO PREVENT  
& COMBAT FEMALE GENITAL  
MUTILATION / CUTTING



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## List of abbreviations

FGM/C	Female Genital Mutilation / Cutting
MAP-FGM	Multisectoral Academic Programme to prevent and combat Female Genital Mutilation (FGM/C)
UN	United Nations
VAW	Violence Against Women
URJC	Universidad Rey Juan Carlos
ISCTE-IUL VUB	Vrij Universiteit Brussel
UAB	Universidad Autónoma de Barcelona
WHO	World Health Organization
IAC	Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC)
HTP	Harmful Traditional Practices
NGO	Non-Governmental Organization
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
OHCHR	Office of the High Commissioner for Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNIFEM	Former UN Agency, at present UNWOMEN
UNESCO	United Nations Organization for Education, Science and Culture
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
IUD	Intrauterine device
DHS	Demographic and Health Survey
MICS	Multiple Indicator Cluster Survey
EIGE	European Institute for Gender Equality
ICD	International Classification of Disease
EU	European Union
UNGA	United Nations General Assembly
EC	European Commission
PTSD	Post-Traumatic Stress Disorder
GCS	Genital Cosmetic Surgery
FGMo	Female Genital Modification
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights



## **Notes on institutions and authors**

### **IMPLEMENTING INSTITUTIONS**

#### **GENDER EQUALITY OBSERVATORY - UNIVERSIDAD REY JUAN CARLOS (URJC)**

The URJC is a public university located in the Madrid region, with 38,000 students and five campuses. It puts emphasis on providing interdisciplinary solutions to the problems of today. The Gender Equality Observatory was set up in 2015 to mainstream gender equality in the university and society, and to promote research and teaching in gender studies, as well as innovative projects and networking. It also works for the visibility of women in the fields of academia, science and research. It is the leading partner of the MAP-FGM project.

#### **ISCTE-IUL**

CEI-IUL (the Centre for International Studies) is a university-based multidisciplinary research centre within the University Institute of Lisbon (ISCTE-IUL). CEI-IUL aims to promote interdisciplinary research in social sciences, international relations and economics, focusing on areas of geographic specialisation: Africa, Asia, Europe and transatlantic relations.

#### **FONDAZIONE ANGELO CELLI**

Fondazione Angelo Celli per una Cultura della Salute (Angelo Celli Foundation for Health Culture) was founded in Perugia in 1987. Its main aim is the study of knowledge, values, behavioural patterns and lifestyles regarding individual and public health. Its theoretical and methodology framework is medical anthropology. Since 2014, it has also been recognised by the Ministry of Equal Opportunities as the Umbrian Centre for the Study and Prevention of FGM/C.

#### **RHEA-VUB**

The overall aim of the RHEA Centre of Expertise Gender, Diversity and Intersectionality is to contribute to knowledge generation on gender, diversity and intersectionality through scientific and interdisciplinary research and education. RHEA is an interfaculty research group headed by Gily Coene (director) and Karen Celis (co-director). It offers a platform for researchers from various VUB departments and faculties, and also offers advice on policies regarding equal opportunities and diversity.

#### **ROMA3 UNIVERSITY**

Established in 1992, Roma3 University is based in Rome, Italy. The university has an enrolment of over 40,000 degree candidates, including undergraduate, graduate and profes-

sional students. With its 12 departments, seven research centres, seven libraries and 12 PhD schools, the university is devoted to excellence in many disciplines, in national and international teaching and research.

### **WASSU-UAB FOUNDATION**

The Wassu-UAB Foundation is a scientific organisation of international scope that works for the management and prevention of FGM/C through anthropological and medical research applied to knowledge transfer. It hosts the Transnational Observatory of Applied Research to New Strategies for the Prevention of FGM/C, which integrates two research and training centres: in Spain, the Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices (IRGPS/HTP), and in the Gambia, the NGO Wassu Gambia Kafo. Born from the will to build a more equal world, it proposes a pioneering, innovative and sustainable methodology.

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# Chapter I.

## Introduction to the Multisectoral Academic Training Guide on FGM/C

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### **Summary:**

1. The Multisectoral Academic Program to Prevent and Combat FGM/C
2. The Multisectoral Academic Training Guide on FGM/C
3. Why and how to use the Multisectoral Guide for Academic Training on FGM/C

Female Genital Mutilation, also referred as excision, female genital cutting or female circumcision, is a harmful traditional practice with strong ancestral and socio-cultural roots. According to UNICEF data, it violates, at present, the rights of more than 200 million women and girls around the world. Usually practiced in 29 countries in the central strip of Africa and some Middle Eastern and Asian countries, Female Genital Mutilation / Cutting (FGM/C) has spread within hosting countries where migrants or refugees travel with their cultural background. Its increasing prevalence in Europe during the last two decades has been perceived with concern by professionals and public administrations, due to the lack of knowledge they generally show about the practice, its cultural meanings, its consequences, and the most efficient ways to prevent or protect as well as to support women and girls who have undergone FGM/C.

Little or no attention paid to FGM/C in national policies on eliminating gender-based violence, due to the lack of an intersectional approach to its

development, has sparked an alarmism which is not exempt of subtexts that stigmatize the practicing communities as a whole. Therefore it is essential to promote a comprehensive approach, culturally contextualized and with the necessary gender perspective, that puts emphasis on the prevention and adequate care. Only then can the re-victimization and/or discrimination of the survivors be avoided.

## 1. THE MULTISECTORAL ACADEMIC PROGRAM TO PREVENT AND COMBAT FGM/C

The Multisectoral Academic Program to prevent and combat Female Genital Mutilation (MAP-FGM) is aimed to contribute to the defence of women's human rights, including their sexual and reproductive rights, by the preventive multidisciplinary intervention of the practice and the effective protection of the girls at risk. The MAP-FGM Project, co-financed by the European Commission, constitutes an innovative biannual program that aims to raise awareness and to prepare future professionals of different fields and specialities that may, in the future, be in contact with populations coming from countries that practice FGM/C.

The investigation and ample experience since 1989 of the Transnational Observatory of Applied Research to New Strategies for the Prevention of FGM/C demonstrates that the professionals that work in direct contact with the families play a crucial role in the prevention of the practice. Legitimate professionals that have built relationships of trust with the families and who contribute to strengthening their bio-psychosocial development are the ones most prepared to prevent the practice through the use of social and human services. That is why it is patent and necessary the introduction of FGM/C in academic curricula at universities, where the future professionals who will have to attend to this complex matter with sensibility, respect and knowledge are trained.

To do so, a multidisciplinary team has developed this Multisectoral Guide, available in six languages, aimed at incorporating the training in the teaching contents of the different degrees offered at the five European universities involved in this pilot experience. Specifically, in the health, legal, social, political, educational and communication sciences, so that at least 500 students receive a comprehensive training that prepares them to prevent and protect effectively girls and women from FGM/C.

The Project seeks to stimulate the sensitivity and favour the interchange of knowledge and experiences among university professors, research staff, experts, public administrations and NGOs from different European, African and Asian countries. With that goal in mind, partners will organize four international conferences and seminars in Madrid, Brussels, Lisbon and Rome, and the outputs will be published on the Project website (<http://mapfgm.eu/>). Aspiring to involve

a wider audience, MAP-FGM will spread and disseminate, periodically, its results through electronic newsletters, publications and audio-visual material.

## 2. THE MULTISECTORAL ACADEMIC TRAINING GUIDE ON FGM/C

The Academic Training Guide is destined to promote and facilitate the incorporation of academic content about FGM/C in different university degrees such as medicine, nursing, education, psychology, social work, law, criminology, anthropology, international cooperation for development, gender and feminist studies, communication and journalism. The Guide has been drafted by teaching and research staff from different disciplines connected to the Rey Juan Carlos University, the Autonomous University of Barcelona, the Rome Tre University, the University Institute of Lisbon and the Vrij Universiteit Brussel, and experts from two specialized foundations with an ample trajectory in the intervention field (Wassu-UAB Foundation and Angello Celli Foundation).

The aim of the Guide is to offer, in a structured and accessible way, teaching contents for the training of future professionals that can play a key role in the prevention and abandonment of the practice and the assistance to women and girls. In that sense, it can be useful to the university teaching staff, to the academic authorities or to the students interested in acquiring academic and professional knowledge specialized on the subject. Its multisector character derives from the participation of authors coming from different disciplines, with various conceptual and epistemological focuses. The plurality of perspectives gathered in this guide reflect the intensity of academic debates and the complexity of the theoretical and practical dilemmas that the abandonment of the FGM/C poses, both in the countries of origin and in hosting countries.

## 3. WHY AND HOW TO USE THE MULTISECTORAL ACADEMIC TRAINING GUIDE ON FGM/C

The Multisectoral Academic Training Guide on FGM/C is organized into two parts. The first one, which is common to all disciplines, offers basic information about FGM/C (Chapter II, An introduction to FGM/C), as well as in-depth data useful to get an in-depth understanding of it (Chapter III, A in-depth understanding of FGM/C). The content of these two chapters will be of interest and useful to all the teaching staff and student body, regardless of their specialty, and it constitutes an initial approach to FGM/C knowledge-base.

The second part, formed of six sectoral chapters, has a methodological design adapted to the teaching activity of the university degrees and post-graduate degrees in medicine, nursing and midwifery (Chapter IV), law and criminology

(Chapter V), social work, education and psychology (Chapter VI), anthropology and cultural studies (Chapter VII), gender and feminist studies (Chapter VIII) and communication and journalism (Chapter IX).

In order to reach the goals and didactic competences of every discipline, each sectorial chapter has been developed by an inter-university group of experts. The composition of this group is reflected in the index of the Guide. Those chapters provide conceptual and theoretical content, practical information and recommendations, extracts of ethnographic interviews, bibliographical and audio-visual resources, dilemmas and questions to be solved, different proposals of debates and activities to use in the classroom, and evaluation exercises. All, with the purpose of facilitating the incorporation of the thematic in the formative curricula.

As well, we hope that MAP-FGM project will be a useful instrument for the integration of the gender perspective in university teaching, with a goal to promote and defend the rights of women and girls, regardless of their social class, religious confession, sexual identity or orientation, functional diversity, nationality, place of origin or cultural identity.

## Chapter II.

### An introduction to FGM/C

#### Summary:

1. Definitions, terminology and types of FGM/C (Adriana Kaplan and Nora Salas Seoane, Wassu-UAB Foundation)
2. Historicity of FGM/C and anti-FGM/C agendas (Ricardo Falcão, ISCTE-IUL)
3. Anthropological perspectives (Francesco Pompeo, University of Roma3)
4. The consequences of FGM/C (Els Leye, VUB)
5. Violence against women and the international human-rights framework (Laura Nuño Gómez and Magaly Thill, URJC)

#### Boxes:

Table 1. Types of FGM/C based on WHO classification

Table 2. Risks associated with FGM/C

Table 3. Principal regional and international documents to end FGM/C

Table 4. Human rights protected by international conventions and violated by FGM/C

#### Bibliographic references

### 1. DEFINITIONS, TERMINOLOGY AND TYPES OF FGM/C

Adriana Kaplan and Nora Salas Seoane (*Wassu-UAB Foundation*)

Female genital mutilation/cutting (FGM/C) is an ancient practice that remains a deeply rooted tradition supported by a complexity of symbolic and cultural meanings. It is mainly practised in 30 sub-Saharan African countries, the Middle East (Iraqi Kurdistan and Yemen) and Asia (Indonesia) (UNICEF 2016). Today, the local becomes global: migrants travel with their cultures, and the practice is widespread amongst the worldwide diaspora (Europe, the United States of America, Canada and Australia, amongst others).

FGM/C is defined by the World Health Organization (WHO 2016) as 'all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons'. UNICEF

estimates that around 200 million women have undergone the practice and more than 63 million girls could have it performed by 2050 (UNICEF 2016). The practice is internationally recognised as a violation of the human rights of girls and women, constituting an extreme form of discrimination against women, however, it is out of mothers' love and care for the future of their daughters that the practice is perpetuated, bringing ethnic and gender identity to the girls (Kaplan, Hechavarria and Puppo 2015).

FGM/C is an extremely complex, sensitive and politicised topic that is difficult to understand through normative definitions, classifications and geographical boundaries (which we will try to explore throughout this guide). The mass media usually broadcasts sensationalist news about FGM/C, which has contributed to a mainstream view of it as a horrible practice done by 'primitive' people. There has been, and still is, a wide debate on how to name the practice – at international level, and within academia and practising communities. As Sara Johnsdotter puts it, there is a division of labour between researchers and activists (Johnsdotter 2012).

The practice has been called female circumcision, or simply circumcision. The term refers to a cultural practice done to both sexes, a rite of passage to adulthood, not entailing violence or aggression in its meaning. This term is defended by relativist positions and used by practising communities. Muslim communities, like those in Sudan and Ethiopia, also call it *Sunna* (a tradition or recommendation) or they use the name in local languages. The Mandinka, an ethnic group living in the Gambia and Senegal, use *ñyaka*, or, in Somali, *gudniin gadbahaada* – names that have a symbolic and less emotional meaning. Local names are less stigmatising when doing any kind of preventive intervention with communities to avoid the practice, showing respect to their culture. Using 'cutting', 'cut' or 'cut woman' when establishing dialogue with practising groups is encouraged, as it is usually perceived as respectful (Kaplan 2003). The term 'circumcision' has been criticised because female circumcision is then being compared to male circumcision, but the female version deprives the woman of an organ and is much more invasive than the man's procedure, and with greater health consequences.

In the seventies, the term 'female genital mutilation' (FGM) was introduced in order to emphasise the violation of women's and girls' rights, mainly by feminist activists.<sup>1</sup> At the beginning of the nineties, the Inter-African Committee on Traditional Practices (IAC) and the World Health Organization (WHO) started using this term, which heralded the entrance of FGM/C in human-rights and gender-based violence agendas. Since the last United Nations Interagency Statement (WHO 2008), FGM is considered the best term to defend the abandonment of the practice at international level.

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<sup>1</sup> For further information about the historicity of the term, see Chapter II.2: Historicity of FGM/C and anti-FGM/C agendas.

The practice has also been referred to as being part of harmful traditional practices (HTP) affecting women's and girls' health. This implies a reference to other traditions, such as early marriages, breast-ironing, foot-binding, or honour killings.

The term 'female genital modifications' (FGMo) has been presented as a critique of the 'ambiguous use of the term "mutilation", which can be perceived as stigmatizing and [whose] use may be counterproductive to the establishment of effective caring relationships' (Fusaschi 2014, 95).

In the English version of the present guide, the practice will be referred to as 'female genital mutilation/cutting' (FGM/C). This term aims to give a wider scope to the practice and encompass the need to promote its abandonment as a harmful traditional practice through a respectful approach to behavioural change. The terminologies of the practice vary across countries and languages and for each translation of the guide, partners have agreed to use what they considered the most appropriate term.

FGM/C is mostly performed on baby girls and girls between the ages of zero and fifteen years, prior to the onset of menstruation. It can be occasionally performed on adult and married women.

WHO established four types of FGM/C in 1995, updated in 2007, with the latest classification reviewed in 2016, as follows. However, it is important to emphasise that it is often difficult to classify a procedure done by elderly women using blades or razors, who could be poorly sighted, so the practice is not accurate, as it is not mainly performed in medical settings (even if medicalisation is a growing trend). Current estimates indicate that around 90% of FGM/C cases include types I or II, and cases in which girls' genitals are nicked, but no flesh is removed (type IV). Some 10% are type III. The classification is exclusively biomedical, not taking into account a global-health approach to the topic.

Table 1. Types of FGM/C based on WHO classification (WHO 2016)

<p><b>Type I:</b> Partial or total removal of the clitoris and/or the prepuce (the fold of skin surrounding the clitoris). In Islamic culture, this type is known as <i>Sunna</i> ('tradition'), and it is compared to male circumcision.</p> <ul style="list-style-type: none"> <li>- Type Ia: Removal of the prepuce/clitoridal hood (circumcision).</li> <li>- Type Ib: Removal of the clitoris with the prepuce (clitoridectomy).</li> </ul>
<p><b>Type II:</b> Partial or total removal of the clitoris and labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva). It is also referred to as 'excision'.</p> <ul style="list-style-type: none"> <li>- Type IIa: Removal of the labia minora only.</li> <li>- Type IIb: Partial or total removal of the clitoris and the labia minora.</li> <li>- Type IIc: Partial or total removal of the clitoris, the labia minora, and the labia majora.</li> </ul>
<p><b>Type III:</b> Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together, which is referred to as 'infibulation'. This type is sometimes referred to as 'pharaonic', and its name comes from the Latin word <i>infibulare</i> ('to fasten with a clasp').</p> <ul style="list-style-type: none"> <li>- Type IIIa: Removal and apposition of the labia minora with or without excision of the clitoris.</li> <li>- Type IIIb: Removal and apposition of the labia majora with or without excision of the clitoris.</li> </ul>
<p><b>Type IV:</b> All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterisation. Detailed examples include:</p> <ul style="list-style-type: none"> <li>- pricking, piercing or incision of the clitoris and/or labia;</li> <li>- stretching of the clitoris and/or labia;</li> <li>- cauterisation (burning) of the clitoris and surrounding tissue;</li> <li>- scraping (<i>angurya</i> cuts) of the vaginal orifice or cutting (<i>gishiri</i> cuts) of the vagina;</li> <li>- introduction of corrosive substances into the vagina to cause bleeding, or of herbs into the vagina, with the aim of tightening or narrowing it;</li> <li>- and any other procedures that fall under the definition of FGM/C, as aforementioned.</li> </ul>

'Deinfibulation' refers to the practice of opening the sealed vaginal orifice in a woman who has been infibulated (Type III). It is often necessary for intercourse, to facilitate childbirth, or to improve the woman's health and well-being. 'Reinfibulation' refers to the procedure of narrowing the vaginal opening in a woman after she has been deinfibulated (e.g. after childbirth). It is also known as re-suturing.

Genital cosmetic surgery (GCS) has not been included in the typology presented herein. The practice has, worryingly, increased in the last few years, mainly in Europe and the United States. The American Society for Aesthetic Plastic Surgery reported that 400 girls aged 18 and under had labiaplasty in

2015 – an 80% increase on the 222 girls in 2014. A 2013 British report found that the number of labiaplasty procedures done by the National Health Service had increased fivefold over ten years<sup>2</sup>. The procedures were not medically indicated, and undertaken mostly for aesthetic reasons.

Other classifications and typologies of FGM/C have also been developed (Fusaschi 2003, 2011, 157; 2013)<sup>3</sup>.

## 2. HISTORICITY OF FGM/C AND ANTI-FGM/C AGENDAS

Ricardo Falcão (*ISCTE-IUL*)

The first explicit reference to female circumcision was made by the Greek geographer and historian Strabo, around the first century BC, recounting how zealously the practice was observed in Egypt. There is evidence, though, that female circumcision might have been a common practice in this region even before that period. More detailed descriptions started appearing, according to Sara Johnsdotter, during the fifteenth and sixteenth centuries, with European travellers to Africa. It was in later centuries (the eighteenth and nineteenth, primarily) that different interpretations brought considerations about the purposes of the practice – debates held on moral grounds, alongside hygienic and aesthetic considerations – although the origins of FGM/C remain a mystery (Johnsdotter 2012).

Clitoridectomy and infibulation have also been practised throughout history, and there are references in medical settings from the second century until the eighteenth century, when descriptions were accompanied by more information, namely of how this procedure was considered therapeutic in controlling sexuality and in a wide array of illnesses in Europe and North America. Therein it is reported to have been practised as a cure for masturbation, adultery or lesbianism, underlying the highly moralised views of the body in the eighteenth and nineteenth centuries (Johnsdotter 2012).

Roughly around the first quarter of the twentieth century, female circumcision became strongly contested, both on health and political grounds. Reports of bans on the practice date back to that time, in countries such as Kenya, Egypt and Sudan, promoted by colonial powers and actors, and local actors, even if animated by different rationalities.

For example, during the 1920s in Kenya, medical arguments were used by Protestant missionaries to denounce the practice within the remotest regions,

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<sup>2</sup> Rabin, Roni Caryn. 2016. 'More Teenage Girls Seeking Genital Cosmetic Surgery.' *New York Times*, April 25. Accessed October 21, 2016. [http://well.blogs.nytimes.com/2016/04/25/increase-in-teenage-genital-surgery-prompts-guidelines-for-doctors/?\\_r=0](http://well.blogs.nytimes.com/2016/04/25/increase-in-teenage-genital-surgery-prompts-guidelines-for-doctors/?_r=0).

<sup>3</sup> For further information, see Chapter III.2: The genitals and construction of a woman's body.

where there were concerns about a perceived association with abortion customs, low fertility rates, and the initiation rite through which girls would become women by going through excision. 'Protestant missionaries were partially successful in engaging London-based humanitarian and feminist groups in their campaign. Female parliamentarians and women's rights organisations argued before the House of Commons that clitoridectomy should be banned because of the dangers it posed to infants and mothers during childbirth (Thomas 1998, 130).'

If the medical arguments seemed to resonate widely, the colonial power, according to Lynn Thomas, seemed to be more concerned with the fact that abortion practised by communities on girls who got pregnant before being excised posed a problem to population size, which, in turn, posed 'a threat to labour-intensive economic schemes' (Thomas 1998, 129). Female parliamentarians' and missionaries' claims for a colony-wide prohibition of female circumcision met with the administrators' reluctance to formalise the prohibition in the penal code because of it being perceived as a form of interference in female initiations, instead opting for an 'education' and propaganda approach.

The example described is just an illustration of how far back the bans on FGM have been caught in debates around power and administration issues versus matters of cultural legitimacy. Other examples also point us to local efforts to eradicate the practice in Egypt in the 1920s, when the Egyptian Doctors' Society also called for a ban (Boddy 2007), or in Sudan, in 1946, when the practice was outlawed, even though it exists today. The historicity of the FGM/C agendas is marked throughout by many tensions between those advocating against the practice and those practising it.

The result of these agendas has been the product of decades of policymaking and awareness-raising from a myriad of different actors, both individual and institutional. Throughout the twentieth century, the debate changed from a health question into a question of individual (human) rights. The history of the agendas against FGM/C is accompanied by the change in the perception of the practice and its meanings, in time, on the part of both individuals and communities, of value, but also, and more importantly, by the evolving frameworks through which it is perceived and interpreted, and the legal instruments available to combat it.

The issue of FGM was first raised in the United Nations in 1952, by the Commission on Human Rights, and in 1958, the Economic and Social Council of the United Nations urged the World Health Organization to study 'operations based on [FGM/C] customs', but 'the World Health Organization took the position that the operations in question were based on "social and cultural backgrounds", and therefore outside its competence': (Hosken 1976). According to Hosken, this failure of recognition was also responsible for the lack of information on the practice, which was still a reality throughout the 1970s. Institutions like WHO and UNICEF believed that the problem should be resolved by the political leadership of African countries (Hosken 1978), stressing the question of cultural legitimacy, but also reminding us of

how, at its inception, the human-rights international-law framework was based on an androcentric view of the world that would be questioned from the 1970s onward.

The work of feminists in the 1970s helped to bring about the first international legislation specifically concerned with gender issues, considered 'a critical step toward international recognition of human rights abuses taking place within the private realm (Baer 2007, 98)'. Despite the evolution and the legal instruments providing a sort of 'bill of rights' for women, the first main policy documents failed to address the problematic nature of FGM/C straightforwardly (Berkovitch 1999). One such document only included a specific reference from 1990 onward, adopted in the ninth session of the Committee on the Elimination of Discrimination against Women, published under the name *CEDAW General Recommendation No. 14: Female Circumcision*.

Around the same time, during the 1970s, the first signs that a global agenda on the rights of women was becoming a reality began to appear. FGM/C was denounced by indigenous doctors and women's rights defenders, as well as Western feminists, who internationalised the debate. Within the first group was Egyptian doctor Youssef El Masry and his ground-breaking study, *The Sexual Tragedy of Arab Women in the Orient* (1962); the well-documented denouncement of the health, sexual and social consequences of FGM/C on women, made by the Egyptian feminist doctor Nawal El Saadawi (1969), who also opposed male circumcision and was fired from the Egyptian Health Ministry for her writings on women's sexuality; the systematic study of the FGM/C practice in Sudan by doctor Asma El Dareer (*Woman, Why Do You Weep?*, 1982); the plight against polygamy, clitoridectomy and infibulation by Senegalese Awa Thiam (*Speak Out, Black Sisters*, 1978); or the sustained research of Nahid Toubia and other authors testifying to experiences with FGM/C, like Evelyne Accad (1975) or Sierra Leone-based Olayinka Koso-Thomas.

The first Western feminists to denounce FGM/C in their writings were the French author Benoite Groult (*Ainsi soit-elle*, 1975) and the American feminist professor Mary Daly (*Gyn/ecology: The Metaethics of Radical Feminism*, 1978), but the publication that had the deepest repercussions was the famous *Hosken Report*, published in 1979 by American journalist Fran P. Hosken, who first gave global figures on the practice of FGM/C, using the language of human rights and medicine, but also insisting on the use of the expression 'mutilation'. Later on, FGM/C was also denounced by afro-descendent American writers Alice Walker and Pratibha Parmar (*Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women*, 1993).

Although used by authors like Awa Thiam and Nahid Toubia, and adopted in 1990 by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), the use of the term 'mutilation' sparked outrage among African women, who saw it as an 'imposition of different cultural rules celebrating the rights of the individual, removed from the ethnic or familial unit (Berkovitch 1999, 490)' and created an important and meaningful debate amongst feminist theorists of different epistemological and ontological orders. African women also mobilised towards the eradication of 'harmful traditional

practices' (also comprising FGM/C), creating the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in 1984.

Between the 1980s and the 1990s, FGM/C ceased to be an issue from only a health point of view and became a human-rights issue, and then, from the 1990s onward, a form of violence against women (VAW). The gender-specific frame for VAW and the recognition of FGM/C as a harmful action in the private realm is an important step in the mainstreaming of agendas. The creation of several international human-rights instruments has, on the other hand, allowed international institutions' frameworks to ascribe more funds to action against FGM/C, to knowledge production, and also to campaigning. The last twenty years have seen the multiplication and consolidation of the international instruments available to tackle FGM/C.

Despite the proliferation of legally binding instruments, and the advancement of countries' legislations and international organisations' capacities, concerns about the meaning of a global humanitarian governance (Fassin 2009), and considerations about the human-rights approach to FGM/C being too narrow and putting the stress on a victim-saviour nexus and on a much too essentialist notion of culture, serve as warnings against condemnations of FGM/C through the logics of cultural otherness. As FGM/C gains ground in Europe, new challenges to the human-rights agendas of migrant communities become more visible, as do conflicting agendas and rights that are not without their contradictions. These are also a consequence of the specific historicity of the institutionalisation of the fight against FGM, its frameworks and promoters, and its larger and narrower scopes.

### 3. ANTHROPOLOGICAL PERSPECTIVES

Francesco Pompeo (*University of Roma3*)

Anthropology, since its institutionalisation in the late nineteenth century, promotes scientific knowledge about otherness, assuming the epistemological centrality of sociocultural diversity in human experience. The discipline's history, with an almost century-old investigation, provides a large range of fieldwork evidence about FGM/C: ethnographic research, done in multiple social, geographical and historical contexts, has highlighted the complexity of these practices. The outcome is a great variety of situations, in terms of age, the impact on genitals, the actors involved and social rituals, depending on different local cultural contexts: a broad overview of modalities and meanings that assumes significance in relation to each specific sex/gender society regime. Only the full assumption of the anthropological perspective, developing the knowledge of these universes from the inside and from below, analysing symbolic power constructs – thought of orders – and gender relationships, can help to address a real non-ethnocentric discourse about FGM/C, finally sharing the debate with the actors involved. In a properly anthropological view, each practice

–ritualistic or not– is understandable only in relation to its own cultural and social context. Literally, its meaning is *relative* to a specific set of ‘values’.

This approach, in a deeper experience of cultural diversity, with the rejection of the evolutionary vision that characterised dominant Western thought, was defined in the post-war period of the 1950s as ‘cultural relativism’, or, rather, as a posture based on the general assumption that there aren’t better or worse cultures, *per se*. At the same time, the danger of an extremist, absolute amoral relativism, in which cultural diversity exists as a sort of unquestionable sphere of respect or legitimacy, was pointed out. Today, in many anthropological manuals, the subject of FGM/C is invoked to highlight the limits of extreme relativism. Moreover, cultural relativism was defined as a methodological approach, first as a critical attitude toward one’s own cultural values, then as a research pattern based on ‘a temporary suspension of judgment’ in order to separate observation and understanding from any moral judgment coming from a particular vision. In the ethnographic process, this retention of judgment is the indispensable premise for discovering the meaning of others while taking into account the researcher’s point of view. In general, only a methodological cultural relativism allows us to recover data and permits the awareness of the fact that corporeality is culturally and socially determined and corresponds to the models, or anti-models, that societies, and over individuals in an advanced capitalist society, incorporate and act upon.

The anthropological debate that has taken place over the past few decades has developed a strong critical and reflexive approach (Pompeo 2013), crossing postmodernism and feminist anthropology in order to deconstruct the Western universalistic point of view and decolonise some elements of its own knowledge device, starting with male ethnographic authority, and therefore proposing a vision of culture as a process and overcoming any stereotypical idea of tradition (Tamale 2008).

This perspective reveals different forms of dominance, such as ideological universalistic presumptions, engaging with overcoming the classic ‘we/they’ opposition (colonisers and the colonised), denouncing gender neutrality as the denial of women’s roles, and the complexity of power dynamics in relationships, abandoning any positivistic model of false objectivity and affirming the need to recognise differences and subjectivities in a non-sexist way. So, a critical approach that also assumes a dynamistic perspective promotes a new historical awareness through a diachronic approach to representations of otherness and a genealogical revision of the main categories. For example, the term ‘female genital mutilation’ was only accredited by WHO in 1995, instead of ‘female circumcision’, as a result of the policy undertaken and coordinated by the United Nations since the 1950s. In the mid-1990s, many organisations decided to shift to the use of more ‘neutral’ terms, such as ‘female genital cutting’, because they considered FGM to be judgmental and pejorative. However, the language used to name these practices remains controversial and requires careful ethical consideration in respect of women’s subjectivity.

In this sense, in the anthropological perspective, it is absolutely necessary to maintain strong critical attention to the language and categories used to describe FGM/C, in order to avoid unjustified attributions and easy generalisations. In a more general sense, in discussing this topic, we must counter any attitude-producing stereotypes as a consequence of simplistic Eurocentric judgments, especially about a supposed moral superiority. Some public rhetoric about FGM/C, focused only on complaints and moral indignation, risks reproducing the colonial pattern of civilising the 'barbarians' and the old idea of eradicating the 'primitive' by fighting against obscurantist traditions and dangerous superstitions. Many ethnographic studies have shown that use of the term 'mutilation' with women with FGM/C creates many problems because it is perceived as humiliating and derogatory. The irreversible change is very often not perceived by the social actors as a mutilation (Fusaschi; see Chapter III.2). This is a crucial matter. The question that follows is: how are we able to contribute to overcoming the practice(s) – with the actors involved or against them? We need to change the perspective in an anthropological way, to establish the conditions for a dialogue with concerned women able to recognise their subjectivities. Rather than using the term 'mutilation', it would be better to use *modification*, to build with social actresses a 'neutral' space, relatively free from bias, in which a cross-cultural dialogue and mediation develop. Shifting the emphasis doesn't justify the practices in any way. Rather, extending the gaze from below and from afar (we speak of people, and with people) allows us to understand how the body is socially constructed in local contexts, and how, through it, meanings linked to the relationships between the genders are given and negotiated.

In recent years, anthropology has developed a critical reflection upon humanitarian actions and reasons, with the aim of analysing the local and the global. Starting from the representation of the 'other' as a 'victim on the screen', it is possible to show how organisations build a representation of a drifted 'African humanity', made of women and children (Fusaschi 2010). From the point of view of these NGOs or international organisations, the survival of women and children depends on their development actions, inspired by a moral, pedagogical ideology. The debates on Africa proposed in the European media are directly connected with internal politics before alterity –namely migration– and some politically 'burning' subjects, like family, the role of women, adoption and sexual preference, civil rights, forced marriage, et cetera (Fassin 2010). In this sense, the state often presents migration as a problem, and the immigrant becomes morally suspect, requiring his/her 'social hyper-correctness' (Sayad 1999). The woman's migrant body bears suspicious 'origins', and, throughout her lifetime, she will be forced to confront her status as victim. A body of migrants can find a position of legitimacy in the host society, but only through the implementation of a bio-political device that is the 'new body': a body obliged to having been readjusted, re-regulated, and made appropriate for 'our' common living.

#### 4. THE CONSEQUENCES OF FGM/C

Els Leye (*VUB*)

FGM/C can have a serious impact on the health and well-being of women and girls. In the literature available, health consequences are described and most commonly classified based on the time at which they appear (short term –at the moment of, or immediately after, the cut– or long term), on the nature of the consequences (e.g. obstetric, psychological, sexual, social), or both. Although FGM/C is widely recognised as a procedure causing physical and psychological suffering, collecting and providing accurate data of FGM/C-related consequences and deaths- is challenging (WHO 2016, 1-7).

The consequences that occur with FGM/C will vary according to the type, the general condition of the girl/woman at the time of cutting, the circumstances in which it was performed (e.g. a venue in a remote rural area, far away from a health centre), the instruments used (e.g. a traditional knife), and the person performing the procedure (e.g. a traditional excisor, generally not surgically skilled, or with no medical background).

Despite the many challenges in documenting the exact extent and nature of the impact on the health and well-being of women and girls, recent WHO guidelines for the clinical management of female genital mutilation have been issued, based on a thorough review of available evidence. The table below (table 2) provides an overview of the health risks (both immediate and long term) and the obstetric risks, as well as the consequences on the psychosexual health of women and girls, and it is adapted from the overview provided in the WHO guidelines. All medical terms are explained in the column on the right<sup>4</sup>.

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<sup>4</sup> MedicineNet, Inc. 2016. Accessed October 22, 2016. <http://www.medicinenet.com>.

Table 2. Risks associated with FGM/C

<b>Immediate Complications (Berg et al. 2014a; Iavazzo et al. 2013, 1137-49)</b>	
Haemorrhage.	<i>Haemorrhage: (serious) bleeding.</i>
Pain.	
Shock.	<i>A critical condition that is brought on by a sudden drop in blood flow through the body. Shock may occur because of sudden blood loss due to the cutting of the clitoris and/or genital tissue (haemorrhagic shock), because of injury to the organs due to infection (septic shock), or because of damage to the nervous system (neurogenic shock).</i>
Genital-tissue swelling can occur due to local infection or inflammatory response.	
Infections may occur in the urinary tract, the genital tract, and/or reproductive tract. They can be acute or local, cause sepsis or septicaemia, and lead to the formation of abscesses.	<i>A urinary tract infection affects (part of) the urinary tract, consisting of the organs that produce, store and discharge urine. These organs include the bladder, the kidneys, the urethra and the ureters. The female genital tract consists of the internal and external female genitalia. The external genitalia are comprised of the pudendum, the clitoris and the female urethra. The reproductive tract (or internal genitalia) of a woman consists of the ovaries, the uterus, the Fallopian tubes, the vagina, the cervix and the vulva.</i>
Urination problems can occur, such as pain passing urine along the edges of the wound, leading to acute urine retention. Due to the damage to the urinary tract following the cut, problems may also occur.	
Wound-healing problems.	
Death can occur due to severe bleeding or septicaemia.	<i>Sepsis, blood poisoning or septicaemia: the presence of bacteria, other infectious organisms, or toxins created by infectious organisms in the bloodstream that spread throughout the body. It can be a life-threatening condition that requires urgent and comprehensive care.</i>

<b>Long-term risks (Berg et al. 2014a; Iavazzo et al. 2013, 1137-49)</b>	
Genital-tissue damage, with consequent chronic vulvar and clitoral pain.	
Vaginal discharge due to chronic genital-tract infections.	
Vaginal itching.	
Menstrual problems, such as dysmenorrhoea, irregular menses and difficulty in passing menstrual blood.	<i>Dysmenorrhoea: painful menses.</i>
Reproductive-tract infections, which can cause chronic pelvic pain.	
Chronic genital infections, including increased risk of bacterial vaginosis.	<i>Bacterial vaginosis: a condition characterised by abnormal vaginal discharge due to an overgrowth of normal bacteria in the vagina.</i>
Urinary-tract infections, which are often recurrent.	
Painful urination due to obstruction and recurrent urinary-tract infections.	

<b>Obstetric risks (WHO Study Group 2006, 1835-41; Berg et al. 2014b)</b>	<b>Risks related to pregnancy, childbirth and the post-partum period (after childbirth)</b>
Caesarean section.	<i>Use of surgery to deliver a baby. C-sections are major surgery and carry risks.</i>
Post-partum haemorrhage (loss of blood of 500ml or more).	<i>Post-partum is the period immediately after delivery.</i>
Episiotomy.	<i>A surgical procedure for widening the outlet of the birth canal to facilitate delivery of the baby and to avoid a jagged rip of the area between the anus and the vulva.</i>
Prolonged labour.	
Obstetric tears/lacerations.	<i>Perineal tears: laceration of the perineum, the area between anus and the vulva (labial opening to the vagina). Perineal tears mainly occur in women as a result of vaginal childbirth, which strains the perineum.</i>
Instrumental delivery.	
Difficult labour/dystocia	<i>Labour dystocia: difficult or abnormal labour or delivery.</i>
Extended maternity-hospital stay.	
Stillbirth and early neonatal death.	<i>Neonatal: pertaining to the newborn period, specifically the first four weeks after birth.</i>
Infant resuscitation at delivery.	

<b>Sexual-functioning risks (Berg et al. 2014a; Berg et al. 2010, 1-79)</b>	
Dyspareunia, which is higher with type III FGM/C.	<i>Dyspareunia: pain during sexual intercourse.</i>
Decreased sexual satisfaction.	
Reduced sexual desire and arousal.	
Decreased lubrication during sexual intercourse.	
Reduced frequency of orgasm or anorgasmia.	<i>Anorgasmia: failure to achieve orgasm (climax) during sexual intercourse.</i>

<b>Psychological risks (Vloeberghs et al. 2012, 677-95)</b>	
Post-traumatic stress disorder (PTSD).	
Anxiety disorders.	
Depression.	

While there might be a greater risk of immediate harms with type III FGM/C, relative to types I and II, these events tend to be considerably under-reported (Berg et al. 2014a).

In addition to the health risks summarised by WHO in the previous table, a number of procedures and day-to-day activities may be hindered due to anatomical distortions, including gynaecological examinations, cytology testing, post-abortion evacuation of the uterus, intrauterine-device (IUD) placement, and tampon usage, especially in cases of type III FGM/C (WHO 2016).

## 5. VIOLENCE AGAINST WOMEN AND INTERNATIONAL HUMAN-RIGHTS FRAMEWORK

Laura Nuño Gómez and Magaly Thill (*URJC*)

FGM/C has not always been considered a form of gender-based violence and a violation of human rights within the international community. For this traditional practice, which was initially addressed by the World Health Organization (WHO) and the Inter-African Committee on Traditional Practices (IAC) as a problem of women's and children's health, it took until the nineties to appear on the human-rights agenda, as part of the slow process of gender-mainstreaming the international law of human rights and defining violence against women as a violation of those rights (Rahman and Toubia 2001). While the critical review of

epistemological, cultural and juridical frameworks launched by feminist theory strongly challenged the androcentric nature of patriarchal laws (Bunch 1990, Walby 2011), the inclusion of women's rights in the interpretative framework of human rights was globally triggered by the international feminist movement and channelled into the United Nations' governance.<sup>5</sup> As a result of these interrelated developments, the formal declaration that 'women's rights are human rights' was finally obtained at the Vienna Conference on Human Rights, in 1993 (Peters et al. 1995).

In parallel, violence against women became part of the global agenda after the CEDAW committee acknowledged, in *General Recommendation No. 19, on Violence against Women*, that violence against women is a discrimination based on gender, thus establishing states' obligation to prevent, prosecute and protect (Nuño Gómez 2013). Through this recommendation, the UN repaired after more than twenty years the omission in the *Convention on the Elimination of All Forms of Discrimination against Women* (1979) of such widespread and serious phenomena like domestic violence, rape, sexual abuse, forced marriage, FGM/C or 'honour' killing. Right afterwards, the General Assembly adopted the ground-breaking *Declaration on the Elimination of Violence against Women* (1993), which provided the standardised definition of 'gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life' (Article 1). It also called upon states to 'condemn violence against women and [...] not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination' (Article 4).

With regard to international recognition of FGM/C as a form of gender-based violence, three major milestones are worth highlighting. The first is *General Recommendation No. 14, on Female Circumcision* (1990), which constituted the initial attempt by the CEDAW committee to call for 'appropriate and effective measures with a view to eradicating the practice of female circumcision'. In 1992, the same committee put FGM/C on par with violence against women by including the practice in its *General Recommendation No. 19*, although it was oddly described as 'a violation of the right to health services'. Finally, FGM/C and other traditional harmful practices against women were defined by the UN General Assembly as forms of violence against women occurring in the family, in its *Declaration on the Elimination of Violence against Women* (Article 2).

On the grounds of FGM/C being considered a form of violence against women, the international community has intensified its eradication efforts through education and prevention programmes, combined with a series of declarative and programmatic texts (see Table 3). At a regional level, the *Protocol to the African Charter on Human and People's Rights on the Rights of Women in*

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<sup>5</sup> In this process, UN conferences on women – held in Mexico (1975), Copenhagen (1980), Nairobi (1985) and Beijing (1995) – have played a key role.

Africa, also called the Maputo Protocol (2003), and the *Convention of the Council of Europe on Preventing and Combating Violence against Women and Domestic Violence*, or Istanbul Convention (2011) represent two binding reference documents for the harmonisation of national legal frameworks on FGM/C.

**Table 3: Principal regional and international documents to end FGM/C**

Institution	Document	Year	Art.
International Conference on Population and Development	<i>Programme of Action and Key Actions for the Further Implementation of the programme for action of the ICPD</i>	1994	4.22, 7.5, 7.6, 7.35, 7.40, key action 52
IV International Women's Conference	<i>Final Declaration and Platform for Action</i>	1995	N/A
UNICEF, WHO and UNFPA	<i>Female Genital Mutilation: A Joint Statement</i>	1997	All
Commission on the Status of Women	<i>Resolution on Ending Female Genital Mutilation (E/CN.6/2007/L.3/Rev.1)</i>	2007	All
OHCHR, WHO, UNAIDS, UNDP, UNIFEM, UNEC, UNESCO, UNFPA, UNHCR, UNICEF	<i>Eliminating Female Genital Mutilation: An Interagency Statement.</i>	2008	All
General Assembly of the United Nations	<i>Resolution on traditional and customary practices affecting the health of women</i>	2001	All
	<i>Resolution A/RES/67/146: Intensifying global efforts for the elimination of female genital mutilations</i>	2012	All
	<i>Resolution A/RES/70/1: Transforming our world: the 2030 Agenda for Sustainable Development</i>	2015	Goal 5.3
Organisation of African Unity (now African Union)	<i>Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Banjul Charter)</i>	2003	Art. 5
Council of Europe	<i>Resolution 1247 (2001) on Female Genital Mutilation</i>	2001	All
	<i>Resolution 1662 (2009) on Action to combat gender-based human rights violations, including the abduction of women and girls</i>	2009	Art. 1, 4, 5, 7.2, 7.4
	<i>Convention on preventing and combating violence against women and domestic violence (Istanbul Convention)</i>	2011	Art. 38

European Parliament	<i>Resolution of 20 September 2001 on Female Genital Mutilation (2001/2035(INI))</i>	2001	All
	<i>Resolution on Combating FGM/C in the EU (2008/2071(INI))</i>	2008	All
	<i>Resolution of 14 June 2012 on Ending Female Genital Mutilation (2012/2684(RSP))</i>	2012	All
European Union (European Commission and/or European Council)	<i>EU Guidelines for the Promotion and Protection of the Rights of the Child</i>	2007	Only mentioned
	<i>EU guidelines on violence against women and girls and combating all forms of discrimination against them</i>	2008	Only mentioned
	<i>Strategy for Equality between Women and Men 2010-2015</i>	2010	Key action 4.1
	<i>Communication: An EU Agenda for the Rights of the Child (COM(2011) 60 final)</i>	2011	No specific mention
	<i>Joint Statement of the Vice-President of the European Commission and the High Representative on the International Day against Female Genital Mutilation (MEMO/11/73)</i>	2011	All
	<i>Victims' Rights Directive (2012/29/EU), which establishes minimum standards on the rights, support and protection of victims of crime</i>	2012	Art. 17
	<i>Communication: Towards the elimination of Female Genital Mutilation (COM(2013)833 final)</i>	2013	All
	<i>Strategic Engagement for Gender Equality 2016-2019</i>	2015	3.4
	<i>Reflection paper of 9th European Forum on the rights of the child: Coordination and cooperation in integrated child protection systems</i>	2015	Ten principles applicable to FGM/C

As it commonly leads to severe consequences for women's physical, mental and sexual health, FGM/C is generally defined as a violation of the right to health and the right to the highest attainable standard of physical and mental health, including the right to sexual and reproductive health. FGM/C also impairs or nullifies core human rights, like the right to physical integrity and the right to life (when death results from the procedure), the right to security of the person and to be free from violence, the right to non-discrimination, to equality between men and women, and to equal protection

under the law (when FGM/C is legal, tolerated or constitutes a mitigating circumstance). Although some experts consider that excisors' and parents' lack of intentionality to inflict pain or suffering make it unclear that FGM/C impairs the right to be free from torture (Rahman and Toubia 2001), the Office of the UN High Commissioner for Human Rights (OHCHR) has acknowledged that FGM/C can amount to torture, or cruel, inhuman and degrading treatment or punishment (WHO 2008).

**Table 4. Human rights anchored in international law breached by FGM/C**

<p><b>The right to health</b> Article 3 of the <i>Universal Declaration of Human Rights</i>; Article 6 of the <i>International Covenant on Civil and Political Rights</i>.</p>
<p><b>Human dignity</b> Article 22 of the <i>Universal Declaration of Human Rights</i>.</p>
<p><b>The right to be free from discrimination (on the basis of sex)</b> Article 2 of the <i>Universal Declaration of Human Rights</i>; Article 2 of the <i>International Covenant on Economic, Social and Cultural Rights</i>; Articles 2 and 26 of the <i>International Covenant on Civil and Political Rights</i>; all articles of the <i>Convention on the Elimination of All Forms of Discrimination against Women</i>.</p>
<p><b>Equality between men and women</b> Article 3 of the <i>International Covenant on Economic, Social and Cultural Rights</i>; Article 3 of the <i>International Covenant on Civil and Political Rights</i>; all articles of the <i>Convention on the Elimination of All Forms of Discrimination against Women</i>.</p>
<p><b>The right to the highest attainable standard of health</b> Article 25 of the <i>Universal Declaration of Human Rights</i>; Article 12 of the <i>International Covenant on Economic, Social and Cultural Rights</i>; Article 12 of the <i>Convention on the Elimination of All Forms of Discrimination against Women</i>.</p>
<p><b>The rights of the child</b> Articles 2, 3, 6, 19, 24 and 37 of the <i>Convention on the Rights of the Child</i>.</p>
<p><b>The right to be free from torture, cruel, inhuman and degrading treatment or punishment</b> Article 5 of the <i>Universal Declaration of Human Rights</i>; Article 7 of the <i>International Covenant on Civil and Political Rights</i>; all articles of the <i>Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</i>.</p>

**Source:** European Institute for Gender Equality. 2013. *Female genital mutilation in the European Union and Croatia*. Luxembourg: Publications Office of the European Union.

Since FGM/C is, in the vast majority of cases, inflicted upon young girls, it also violates the rights of children to development, protection and participation (Miller et al. 2005), and triggers various articles of the *Convention on the Rights of the Child* (1989), including states' obligation to 'take all appropriate [...] measures to protect the child from all forms of physical or mental violence, injury or abuse [...] while in the care of parent(s), legal guardian(s) or any other person who has the care of the child' (Article 19). To submit a girl to FGM/C contradicts the principle of the best interests of the child, which must prevail in all actions concerning children (Article 3).

Although parents may believe that the social benefits of FGM/C (marriageability, family honour, etc.) outweigh the risk of physical and psychological consequences, this perception cannot justify a permanent and potentially life-threatening practice that constitutes a violation of girls' fundamental rights (WHO 2008). FGM/C is usually practised through coercion or the abuse of superiority or authority. Even when a girl agrees to undergo FGM/C, the aspiration to abide by her family's decision and be accepted in her community must not be mixed up with her free and informed will. It must instead be understood as the result of family pressures and social expectations put on girls and women (WHO 2008).

FGM/C may permanently compromise women's enjoyment of their sexuality. It is often justified on the grounds of protecting girls from excessive sexual emotion and helping to preserve their chastity (Miller et al. 2005). Its meaning, as a traditional practice that ensures women's virginity until marriage and fidelity thereafter, reinforces patriarchal control over women's sexuality and perpetuates unbalanced gender roles, norms and stereotypes. Due to its negative effect on women's sexual pleasure, FGM/C has been put in relation to marital rape and polygamy (Rahman and Toubia 2001). Another underlying idea behind FGM/C is that women's genitals are impure, dirty or ugly if uncut. As a result of this perception of the female body as flawed, women's physical appearances must be modified to fit standards far removed from health, well-being and gender-equality objectives. In this aspect, FGM/C can be equated with patriarchal norms anchored in other cultures (e.g. the abandoned foot-binding practice in China, or the promotion of anorexia through fashion and advertisement in the West). The prevention of FGM/C can, therefore, contribute to empowering women and girls in overcoming gender inequality.

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## Chapter III.

### An in-depth understanding of FGM/C

#### **Summary:**

1. Sociocultural meanings of the practice (Adriana Kaplan and Neus Aliaga, Wassu-UAB Foundation)
2. The genitals and construction of a woman's body (Michela Fusaschi, University of Roma3)
3. Migration, migratory movements and ethnicity (Ricardo Falcão, ISCTE-IUL)
4. The prevalence of FGM/C (Els Leye, VUB)
5. Geographies of FGM/C (Adriana Kaplan and Nora Salas Seoane, Wassu-UAB Foundation)
6. Critical aspects of the criminal prohibition of FGM/C (Julia Roper Carrasco, URJC)
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#### **Bibliographic references**

### 1. SOCIOCULTURAL MEANINGS OF THE PRACTICE

Adriana Kaplan and Neus Aliaga (*Wassu-UAB Foundation*)

FGM/C has achieved a great symbolic significance within practising communities. It is considered a crucial component of the socialisation process, and the practice exerts great social pressure on family members and the community as a whole. It is linked to two fundamental African values: the feeling of community membership, and the complementarity of the sexes.

The ancient history of the Dogon culture in Mali relates an incident of significance to the origin of FGM/C. According to the myth, 'Amma, God of the Sky, was alone and wanted to have intercourse with the Earth, whose form was like that of the female body. The Earth's sexual organs were like an ants' nest, and her clitoris was raised like a termite mound. Amma drew close, but the termite mound rose up, blocking penetration. It so happened that the Earth had the same sex as Amma, causing discord in the universe. Amma consorted many times with his wife, and harmony was restored to the universe once the termite mound had been removed (Castañeda Reyes 2003)'.

In some societies, the practice belongs to initiation ceremonies, bringing ethnic and gender identity (giving a feeling of belonging, a coming of age, and a sense of pride). FGM/C has also become the physical evidence of a girl's entry into womanhood, ensuring her femininity and the knowledge required to belong to the community and the secret world of women (Kaplan et al. 2013). Other reasons are given to justify the continuation of the practice, such as the need to follow tradition ('it has always been done', 'it is normal', 'it is natural') and religion ('it is Sunna', 'it is a religious obligation'); for hygienic reasons ('it is cleaner') and aesthetic purposes ('the clitoris may grow too much, like a penis'); to protect virginity and avoid promiscuity ('an uncut girl has an uncontrollable sex drive and will lose her virginity prematurely'); to guarantee family honour; to ensure a 'proper' marriage ('it is necessary to become a proper wife'); and/or to promote fertility ('it prevents stillbirths', 'women will be able to have more babies') and fecundity ('the external genitalia have the power to cause death, physical deformity or madness in the newborn') (Kaplan, Hechavarría and Puppo 2015, 29-32).

FGM/C is a practice highly valued in societies in which it exists. It is not considered isolated and exclusive from the private sphere and the world of women, but a piece that fits into a set of ritualistic, daily practices that influence the roles and statuses of women and men (gender-identity assignments). The preservation of ethnic identity is also an important factor distinguishing these societies from non-practising groups.

To ensure that girls are prepared for adulthood and marriage without being excluded from the community, families continue exercising the practice as a tradition that (accordingly, with what is mentioned) is seen as natural or normal. Sometimes the practice is viewed as a rite of passage that mothers and grandmothers organise and present to their daughters and granddaughters, considering it the best thing that they can do to raise and educate them properly. There are variations on the practising moment – from seven days after birth until prepuberty – although it is mainly performed before the first menstrual period, and it varies according to ethnic group. Today, the age when FGM/C is performed is decreasing, and the most important thing is to be cut, whether the rites surrounding the practice are respected or not (Kaplan, Hechavarría and Puppo 2015).

FGM/C is carried out in many societies, within Muslim, Coptic Christian and Jewish Falasha communities (e.g. Egypt and Ethiopia). Uncertainty about the origins of the practice lead some communities to link it with religion. It is interesting to note that, although neither the Bible nor the Koran subscribe to the practice, it is often justified as a religious mandate. In Muslim societies, it is considered Sunna, a religious tradition ('all that is good for God'), however, many Islamic academies and authorities demonstrate a positive position on the issue and condemn the practice when they are given the opportunity to articulate their views (Gomaa 2013).

A woman's external genitalia are seen as ugly and dirty by practising communities. For this reason, removing these structures makes a girl 'clean' and 'beautiful' (for hygienic and aesthetic purposes). Removal of the genital parts is considered the elimination of 'masculine elements', such as the clitoris. Infibulation is performed in order to make the genitalia 'smooth', thereby making a woman/girl beautiful. A belief sometimes expressed by women is that FGM/C enhances men's sexual pleasure. Moreover, in many societies, it is believed that eating food prepared by an unexcised girl is taboo (Johnsdotter and Essén 2010).

In many traditional societies, virginity is a prerequisite for marriage, and necessary for maintaining a family's honour. FGM/C is believed to ensure and preserve a girl's virginity, and only excised women are considered suitable for marriage and 'proper' wives, giving them access to land and security. Uncut girls are believed to have overactive and uncontrollable sex drives, and are thus likely to lose their virginities prematurely, becoming disgraces to their families if they have lost them before marriage. The desire for a 'proper' marriage may play an important role in the persistence of the practice. It is also believed that the tight vaginal orifice of an infibulated woman who has had chemicals placed into it to narrow it will enhance male sexual pleasure, thus preventing divorce or unfaithfulness. Nevertheless, some studies indicate that both genders blame each other for the continuation of FGM/C, and the reasons for infibulation and reinfibulation remain social concepts of 'normality', identity, tradition, religion and a silent culture between men and women (Berggren et al. 2006).

Certain communities believe in the power of the external genitalia to cause the death of an infant –stillbirth in primigravidae– or bring about physical deformity or madness in the newborn. Others believe that a woman's external genitalia have the power to blind anyone attending her during delivery, and being uncircumcised can also cause the death of one's husband or harm his penis. In addition, it is believed that excising a woman who fails to conceive will solve the problem of infertility.

## 2. THE GENITALS AND CONSTRUCTION OF WOMEN'S BODY

Michela Fusaschi (*University of Roma3*)

In anthropology and sociocultural sociology, the expression 'techniques of the body' includes the ways in which men and women learn and know how to use their bodies in society. This concept, proposed by Marcel Mauss, is based on the assumption that 'man's first and most natural technical object, and at the same time technical means, is his body' (Mauss 1936).

The techniques of the body are physio-psychosocial assemblages and cultural practices socially apprehended and constructed. Everyone in his/her lifetime becomes the object and subject of multiple and different bodily techniques, which are primarily divided by gender and age. Each individual technique can't be considered separate to the others: a technique is precisely developed in a differentiating process from the other ways of acting through the body and by letting the body act. Each society has its own special habits, and we understand how society works by understanding how the body works.

The relationship between body and society is fundamental and complex, and goes beyond the Cartesian opposition nature/culture. Mary Douglas (Douglas 1970), in her 'two bodies' theory, showed that the conception and experience of the physical body were shaped by the social body. The human body's symbols are used to express social experience, and, vice versa, the human body is 'educated' by society. The body is both a physical and cultural artefact, and everyone undergoes the dynamics of embodiment (Bourdieu 1977; 1980) and sociocultural values and norms.

The anthropologists Nancy Scheper-Hughes and Margaret Lock (Scheper-Hughes and Lock 1987) thus proposed the mindful-body concept, in order to rethink the articulation of mind and body, the individual and society, noting that their opposition is issued from Western-situated theoretical viewpoints and research paradigms. The three bodies are: the individual body, understood, in the phenomenological sense, as the lived experience of the body-self; the social body, referring to the representational use of the body as a natural symbol, as Douglas suggested, and to all the various practices through which men and women deconstruct their bodies in order to build symbolic ones; and the body politic, which refers to the regulation, control and surveillance of bodies (both individual and collective). In each society, the articulation of these three different dimensions produces multiform representations, meanings and concepts about anatomy, physiology, sex/gender, sexuality, sickness, health, hygiene, normality and deviance. Such an approach to the body –one that acknowledges corporeality as an object and a subject of every social practice– isn't a peculiarity of socio-anthropological disciplines.

Michel Foucault and Judith Butler stress this dimension quite powerfully, ascertaining that the body is the object of symbolic representations, discourse

orders and disciplinary practices. When Butler reminds us of Simone de Beauvoir's 'one is not born, but rather becomes, a woman' in order to introduce her performativity theory for sex/gender, she precisely deepens this approach. The body undergoes a process of gendered 'materialisation' (Butler 1993) that constitutes gender identity through the repetition of corporeal acts.

If, then, we consider that, in all societies, practices that interfere with bodies are aimed at (dis)adapting them to gendered cultural norms and making them more socially '(un)appropriate', we can better understand body modifications, on genitals as well. Body modifications on female genitals are trans-culturally universal: along with other kinds of signs on the body, they are aimed at instituting gender identity, additionally attributing to the bearers specific social privileges regarding life, marriage and family as a whole.

To objectively examine the physical 'deconstruction' of the female body is not enough to understand the society in which it is implemented. Rather, we need to understand that this 'physical-body deconstruction', paradoxically, builds the symbolic body and gender. In this sense, to understand the social construction of female genital modification, we need to understand the ideas and representations that go along with this process as integral parts of the considered culture.

Body modifications can be permanent/irreversible (e.g. FGM/C, but also tattoos or scarification) or temporary/reversible (e.g. hairstyles, body-painting, temporary tattoos or tanning) (Remotti 2000). Since 2003, ethnographic research in sub-Saharan African and European contexts has divided irreversible genital and extra-genital modifications into three categories, as follows: (a) reductive practices, (b) expansive practices, and (c) other modifications (Fusaschi 2003; 2011; 2013).

### *Reductive body modifications*

Reductive genital modifications decrease parts of the genitalia. This is the case for excision and infibulation, but also for castration and sterilisation. In this category, we also find forms of intimate cosmetic surgery, such as clitoral-hood reduction or labiaplasty, in the neoliberal era (Fusaschi 2011). Extra-genital modifications can also be deformations, such as the ones made in Chinese foot-binding.

In this category, we also find breast ablations for ritualistic purposes and reductive modification through cauterisation, as in the case of the young Aboriginal women in Northern Australia, who had both breasts cut to prevent breastfeeding, or the case of the women living around Lake Tanganyika, who underwent breast amputation as a form of punishment (Erlich 1991, 31).

<p><b>Reductive genital modifications</b> Clito-labial: clitoral excision and clitoral repositioning Vulva-perineal: vaginal narrowing, infibulation Uterine: castration, sterilisation</p>	<p><b>Reductive non-genital modifications</b> Deformations: feet Ablations: breast</p>
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### *Expansive body modifications*

This category includes operations aimed at stretching the female genitals, such as vaginal massage, practised in the area of the African Great Lakes, in Dahomey, Tanzania and Benin. These massages are intended to increase the organ's size –the symbol of sexual activity– and enhance sexual pleasure for procreative purposes.

Among extra-genital deformations, we find the so-called 'saucer lips' of the Amazonian people or the stretching of ear lobes. Another type of extra-genital deformation is breast augmentation, which assumes very different meanings, depending on the context in which it is performed (e.g. cosmetic surgery or rituals). Another practice is gavage, the fattening of the body through the forced administration of certain foods, as in the case of girls in Mauritania.

<p><b>Expansive genital modification</b> Clito-labial: elongation Vulva-perineal: vaginal dilatation</p>	<p><b>Expansive non-genital modifications</b> Deformations: lip- or ear-stretching, breast augmentation Artificial fattening Subcutaneous implants</p>
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### *Other body modifications*

This category includes all other operations that permanently alter the genitals (introcision, sub-incision, etc.). Extra-genital modifications herein can concern the neck (e.g. the Padeung 'giraffe' women of Myanmar/Burma), the skull (e.g. African pygmy society), and the trunk/chest (e.g. corsets and other bandages). In such practices, we include scarification, tattoos, teeth-filing, and the resurgence of traditions such as cutting, branding or burning.

<p><b>Other genital modifications</b> Ritual deflowering, introcision, abortion practices</p>	<p><b>Other non-genital modifications</b> Deformations (e.g. trunk/chest, neck, teeth, skull) Scarification, tattoos, cutting, branding, burning</p>
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In analysing all of these kinds of body modifications, other crucial dimensions have to be taken into account: namely the gender, the age, the consent, the will and/or the degree of awareness of the subjects. More broadly, local gender relationships and gendered symbolic orders should be considered.

If we refer to clitoridectomy –in all its various types, including aesthetic/surgical procedures– and infibulation, we often realise that, whether or not these procedures are performed under patriarchal or neoliberal regimes (indeed both), they are usually always part of larger programmes of socially hierarchised control over women’s sexualities and auto-determination, resulting in gender regimes conveying the exclusive legitimacy of binary, complementary and asymmetric gender identities.

### 3. MIGRATION, MIGRATORY MOVEMENTS AND ETHNICITY

Ricardo Falcão (*ISCTE-IUL*)

Due to international migration, FGM/C is now being recognised as a problem in Europe. Until the turn of this century, its prevalence on the Continent was still considered a fairly unknown issue and thought to be practised mainly in Africa, even if, in the past, there had been medical procedures considered forms of mutilation, according to today’s accepted definitions.

By becoming a European problem, or a problem taking place in European territory, the practice of FGM/C has posed new challenges for both anti-VAW (violence against women) and anti-FGM/C agendas. Not only are we dealing with practices that are considered specific to certain identities (gendered and ethnic), but we are also observing change in the way that FGM/C becomes an identity-marker for certain communities. Being a ‘European problem’ does not mean that it has ceased to be a problem attributed to a ‘cultural other’. There is a tendency for institutions to harbour culturalist perspectives, with FGM/C being perceived as a problem stemming from migratory movements and ethnicities.

The relationship between migrants and the communities that they form with the law in host countries is often marked by formal procedures that somehow contribute to defining a cultural otherness, often producing forms of discrimination and stigmatisation. Stigmatisation targets communities that practise FGM/C, for example, when (in some cases) they are subjected to compulsory genital examinations (Johnsdotter 2009) or become the object of gender discrimination in the face of legal action (Fusaschi 2015).

People in these communities also react, looking for alternative ways to ensure the continuity of the practice of FGM/C and keeping a low profile to avoid the hostility of institutions. Examples of this struggle with legal boundaries include lowering the age for FGM/C or trips to countries of

origin to undergo the cuts, to which legislative efforts have responded with externalisation articles. It is important to stress permanent negotiation between institutions and legal frameworks and individuals belonging to practising communities, and that negotiation is conducive to the permanent reconfiguration of balances.

When we consider FGM/C as an issue stemming from migration, we see it unfolding in at least four different directions: 1) an axis of governance and management of cultural difference intersected by questions that are specific to European policy in migration, rights to mobility and entry into territories, as shown by the growing focus on asylum demands on the basis of the risk of FGM/C, but also on the specific legislative turn to criminalisation in the large majority of European countries; 2) a bio-political axis, in which different institutions, like health centres, schools, police, social services, and immigration offices, manage people affected by the practice and apply guidelines that define it in an institutional setting, but often struggle with a lack of formation and information; 3) an axis linking migrant communities to their places of origin through many outlets, both material and symbolic (social, cultural, economic), and the influence that these have on the prevalence of the practice in countries of origin and host countries; and 4) the last axis, which points us in the direction of different conceptualisations of life cycles, gender or personhood, and different definitions of interpersonal violence, victimhood or trauma, on the part of institutions and those working in them, whose references are legal terms, and people, whose references are their sociocultural identities.

The changes that have occurred in the legislation against FGM/C are an important tool for allowing a better definition of those four axes, thus avoiding simple judgments on the part of those dealing with migrants and communities. There still are, however, well-founded fears of stigmatisation and discrimination (Johnsdotter 2009) against people in terms of their cultural (and national) identities and socialities.

The rhetoric against FGM/C can easily be appropriated and used against people in demeaning their legitimacy for self-assertion, through an uncritical defence of the legal framework that criminalises the practice, thus stressing the legal over the cultural, and failing to provide the proper instances in which people affected can voice their own concerns and sociocultural expectations in terms that take into account their own subjectivities.

Certain notions codified in international law and conventions should be taken very carefully, as they pertain to a specific framework and representation of individual rights that is often in contrast to different social constructions of gender, for example, but also of sexuality, kinship, and other important social factors that contribute to the understanding of FGM/C in context, and not as an abstraction.

Discrimination can also be a by-product of a lack of proper information. European countries and institutions have identified this problem, but only recently have they started to create reports on prevalence data. For example, the first study on prevalence in Portugal was delivered in 2015 (Lisboa et al. 2015). Trying to create a clear picture of how FGM/C is prevalent in Europe has become an urgent matter, both in terms of campaigning and in terms of action against the practice. Working directly with communities is also a strategy that has been gaining ground, and approaches like REPLACE put the community and its social norms at the centre of any behavioural-change strategy (Brown, Beecham and Barrett 2013).

The perception of FGM/C as a migration-induced problem has other consequences, and right at a time when anti-immigration rhetoric is on the rise all over Europe, with new forms of populism. Africa-to-Europe migration is particularly in focus, as the bulk of migrants who have undergone FGM/C, or who are at risk of being its victims, originate in this region of the globe, despite the fact that the practice does not exist in Africa alone.

The last two decades of migratory movements originating in Africa in the direction of Europe have seen quite a few important changes that cannot be overlooked, particularly in the last decade, as a consequence of the growing pressure of entry into European territories and an increase in the policing and management of borders. This period has marked the adoption of a new, more restrictive stance towards undocumented migration, and the rise of a more visible (and at times controversial) border control, led by Frontex (an agency created in 2004 by the European Council). This increasingly restrictive stance is seen by many scholars as favouring the logics of legality and formality over humanity.

The management of migratory flows should be in focus when we think of the practice of FGM/C, as many migrants often battle with an unclear legal status in the process of becoming documented or otherwise 'rejected'. Migrants from communities in which FGM/C is practised very often occupy the margins, or what might be called the 'grey areas' in terms of legality. This unclear or ambiguous status is often a deterrent in accessing health care, sparking fears of deportation. 'In the European Union, policies that limit undocumented immigrants' access to health care are widespread and vary substantially. These policies range from denying all access to providing limited access to emergency and preventive care' (Hacker et al. 2015).

On the other hand, FGM/C has also become grounds for the demand of asylum in the last few years, and an important number of 'professionals working with asylum-seekers and refugees [and other migrants] face multiple challenges, including: linguistic differences; pressures of finite time; inadequate cultural awareness; and deficient expertise. Co-ordinated inter-agency training is key for all professionals working with affected communities, enabling them to provide effective and culturally sensitive support to those affected and to protect children by being sensitised to warning signs' (UNHCR 2013, 8). Despite FGM/C becoming grounds for the demand of asylum and refugee status, the numbers of actual beneficiaries don't fall into the categories of 'countries of risk' or 'FGM-based decision[s]' (UNHCR 2013, 31).

When we think about FGM/C as an issue pertaining to migration, meaning something that ‘comes from elsewhere’ to become a European problem, too, we need to have a wide-ranging view of the many contradictions with which we are faced in the management of cultural difference. First of all, we should keep in mind that anti-FGM agendas are gendered in themselves. Secondly, we should also consider the grounds on which aspiring migrants enter European territories because their ambiguous legal status is a determining factor in their access to health care. Thirdly, the representation of migration is gendered and accompanied by culturalist-ethnicising views of identity. Finally, it is not enough to consider the insertion of individuals in social groups, but their integration into the whole of society, and their continuous relationship with their host countries and those of their origins. Migratory policies and access to citizenship, as well as an individual human-rights approach, intersect with cultural identities through FGM/C, thus defining the relationship between certain migrants and communities and institutions.

#### 4. THE PREVALENCE OF FGM/C

Els Leye (*VUB*)

Having reliable and representative data on the magnitude of FGM/C, both in countries of origin and among the diaspora, is important, for a number of reasons. It can provide information on where the problem is most widespread, and thus assist in allocation of resources. When assessed at regular intervals, it can assist in monitoring trends over time.

FGM/C is still widespread over the globe. UNICEF estimates that 200 million girls and women have undergone FGM/C worldwide (UNICEF 2016)<sup>6</sup>.

In order to have representative data, standardised surveys are used: the Demographic and Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS).<sup>7</sup> These surveys collect data from nationally representative samples of households in over 90 countries. In 27 African countries, plus Yemen and Iraq, nationally representative data on FGM/C has been collected. For Indonesia, another data source is used, one that collects data on FGM/C prevalence for girls under 12 years only.<sup>8</sup>

The DHS and MICS are often conducted at five-year intervals. They ask women of reproductive age (15 to 49 years old) about their FGM/C status and the circumstances surrounding the cutting (age at cutting, type of cutting, person

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<sup>6</sup> UNICEF defines the prevalence of FGM/C as the percentage of women aged 15 to 49 who have undergone some form of FGM/C (UNICEF Innocenti Research Centre 2005).

<sup>7</sup> The DHS was developed by icf International, and the MICS is directed by UNICEF.

<sup>8</sup> Riskesdas Basic Health Research Survey, Indonesian Ministry of Health, as mentioned in Shell-Duncan et al. 2016.

who performed the cut), as well as attitudes regarding the continuation of FGM/C and the FGM/C status of their daughters (Shell-Duncan et al. 2016, 1-30).

In the following table, an overview of the prevalence of FGM/C is provided.

**Table 1: Percentage of girls and women aged 15-49 who have undergone FGM in Africa, Indonesia, Iraq and Yemen, and girls aged 0-14 years with FGM (UNICEF 2016)**

Country	Percentage of girls and women aged 15 to 49 years with FGM	Percentage of girls aged 0 to 14 years with FGM
Benin	9%	0.2%
Burkina Faso	76%	13%
Cameroon	1%	No data provided
Central African Republic	24%	1%
Chad	44%	No data provided
Djibouti	93%	No data provided
Egypt	87%	14%
Eritrea	83%	33%
Ethiopia	74%	24%
Gambia	75%	56%
Ghana	4%	1%
Guinea	97%	46%
Guinea-Bissau	45%	30%
Indonesia	49%	49%
Iraq	8%	No data provided
Ivory Coast	38%	10%
Kenya	21%	3%
Liberia	50%	No data provided
Mali	89%	No data provided
Mauritania	69%	54%
Niger	2%	No data provided
Nigeria	25%	17%
Senegal	25%	13%
Sierra Leone	90%	13%
Somalia	98%	No data provided
Sudan	87%	32%
Tanzania	15%	No data provided
Togo	5%	0.3%
Uganda	1%	1%
Yemen	19%	15%

This 'global' estimation does, however, not include Europe, Japan, Australia or the USA, or any practising countries for which no data is available, such as Colombia, India, Oman, Saudi Arabia and Malaysia (Van Baelen, Ortensi and Leye 2016). In Europe, there are no ongoing, systematic, representative surveys that use a harmonised approach to gather data on FGM/C prevalence (EIGE 2013; Leye et al. 2014). However, the European Institute for Gender Equality has produced a methodology and data on the prevalence of girls at risk (EIGE 2015).

Such different methods for estimating prevalence in the context of migration are necessary, as the specific context does have an influence thereon.

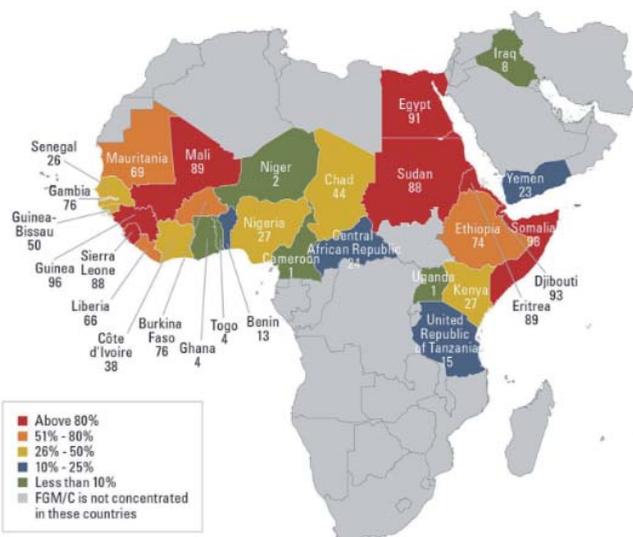
## 5. GEOGRAPHIES OF FGM/C

Adriana Kaplan and Nora Salas Seoane (*Wassu-UAB Foundation*)

FGM/C is mainly practised in 30 countries of sub-Saharan Africa, the Middle East (Iraqi Kurdistan and Yemen) and Asia (Indonesia). In African countries, the practice has been historically documented, with its prevalence measured by international agencies, namely the UN.

Map 1 shows the countries in which FGM/C is practiced and its prevalence therein.

**Map 1: Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country, in Africa and the Middle East**



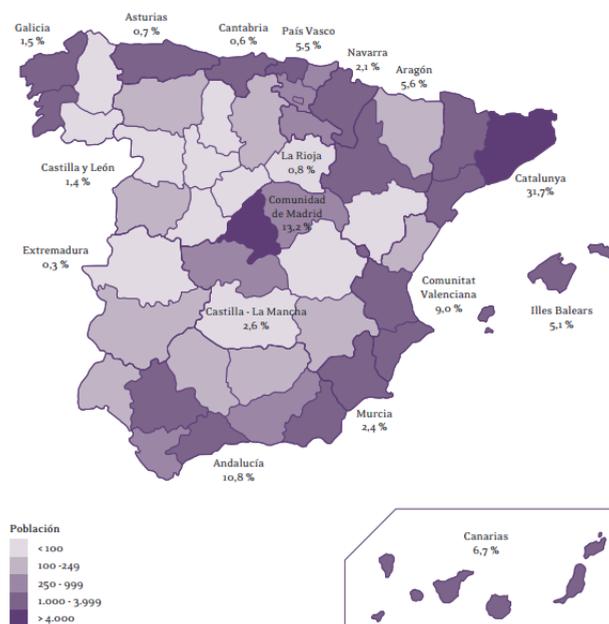
**Sources:** UNICEF 2013; UNICEF global databases 2014, based on DHS, MICS and other national representative surveys, 2004-2013.



With migratory movements, FGM/C can also be found among the diaspora. In Europe, there is no common criterion for measuring the prevalence of the practice, due to the lack of consensus on methodologies and sources of information. However, some studies have estimated the number of women who have undergone FGM/C living in destination countries, such as Belgium (Dubourg et al. 2011), France (Andro and Lesclingand 2007) and Italy (Istituto Piepoli 2009).

In Spain, a map on FGM/C is regularly updated every four years, locating women coming from countries in which FGM/C is practised, geographically and demographically (Kaplan, Merino and Franch 2002; Kaplan and López 2010, 2013; GIPE/PTP 2006). This tool allows for comparisons on migratory movements over time. It is also helpful, by informing policymakers in the design and implementation of programmes to prevent the practice and support the management of its consequences in women and girls at a local level. To give a more informed insight on health policies and to raise awareness on the geographical placement of potential cases of FGM/C, Portugal and Belgium have their own maps on the prevalence of the practice. These maps give the estimation of women aged under 15 years who could have undergone FGM/C, or are at risk thereof, living in Portugal and Belgium (Maps 4 and 5).

Map 3: FGM/C in Spain



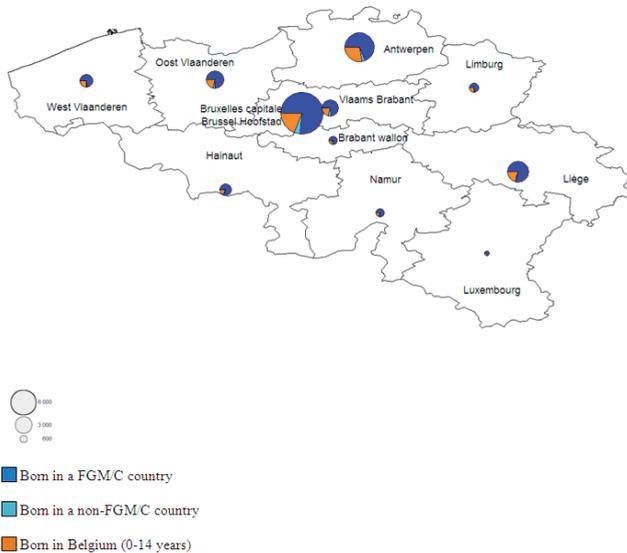
**Source:** Kaplan, Adriana, and Antonio López. 2013. *Mapa de la Mutilación Genital Femenina en España 2012*. Spain: UAB, Bellaterra. Antropología Aplicada 2. Servei de Publicacions.

Map 4: FGM/C in Portugal



Source: Teixeira, Ana Lucía. 2016. 'Estimating the prevalence of female genital mutilation in Portugal'. *Public Health* 139:53-60.

Map 5: FGM/C in Belgium



Source: Dubourg, Dominique, Fabienne Richard, Els Leye, Samuel Ndamé, Tien Rommens, and Sophie Maes. 2011. 'Estimating the number of women with female genital mutilation in Belgium.' *The European Journal of Contraception & Reproductive Health Care*, 248-57.

## 6. CRITICAL ASPECTS OF THE CRIMINAL PROHIBITION OF FGM/C

Julia Roper Carrasco (*URJC*)

### **Previous differentiation: Countries of origin and host countries of communities who practice FGM/C**

The intervention of criminal law as a response to FGM/C and prevention mechanism raises various issues that have not yet been satisfactorily resolved and which must be taken into account. To understand them, a distinction should be established between the very different kinds of political, legal and social contexts of countries of residence. On one hand, in the regions of the world in which FGM/C is widely extended –mostly (but not only) African countries– the most important difficulty is the ineffectiveness of criminal law.

Despite the fact that, in many of these countries, FGM/C has been outlawed under international pressure, in practice, it is not prosecuted, for various reasons. In some cases, it is due to a lack of resources for implementing prevention policies, which are necessary to enact prohibition. In other countries, state weakness and corruption curb interest for an issue that is not considered a priority. To these constraints is often added the sociocultural challenge of modifying long-standing traditions that are deeply rooted in tribal structures, ones in which the individual's persona has a relatively low value, compared to the power of the community (Kaplan 2003, 21). The ineffectiveness of criminal law in countries of origin contributes to the consolidation of the practice, since it reinforces the belief that, aside from what is laid down in the law, moral, social and cultural norms are valid and can prevail (Roper Carrasco 2001, 1395-96).

In destination countries, this conviction endows migrants with the pretension of having the right to cultural identity through the preservation of their own traditions. Migrants' feelings of being uprooted and their subsequent vulnerability explain the need to reaffirm this identity through traditional or religious practices (just like fasting during Ramadan or wearing traditional clothes) to protect their dignity as human beings. The clash between this aspiration and the reality of the destination countries is even more dramatic in the case of FGM/C. While wearing a veil in Western countries is more or less accepted, FGM/C is a practice that evokes revulsion within the host society. As a result, a feeling of disapproval, emphasised by the fact that FGM/C is a criminal practice, extends not only to the victims of the practice and girls at risk, but also to their parents and relatives (Sanz Mulas 2014, 11-38).

### **Penal law and FGM/C in the Western world. Starting point: essential penal prohibition**

The intervention of criminal law in the fight against FGM/C is essential. FGM/C is a serious offence against fundamental legal assets, like physical integrity and, more broadly, personal health (including psychological health, physical well-being, and the full enjoyment of sexuality and motherhood). The threat of a penalty is a necessary measure to spread the idea, especially within practising communities, that FGM/C is a serious injury that cannot be justified by the cultural component attributed to the practice (Ropero Carrasco 2003, 372-74).

The primacy of the protection of fundamental rights over any customary practice (even if it is considered a cultural manifestation) is embedded in international law. For instance, the *UN Declaration on the Elimination of Violence against Women*, of 1993, establishes in its Article 4 that the state should not invoke any custom, tradition or religious consideration to avoid its obligation to eliminate violence against women. Other international instruments, at a global or regional level (especially the European Union and the Council of Europe), have further consolidated this principle. Since FGM/C is a violent practice that injures girls' and women's physical integrity and health, international law has acknowledged that it is a form of gender-based violence (Sanz Mulas 2014, 11-42; Mestre i Mestre and García Añón 2008).

### **The consequences of penal intervention**

It is to be expected that penal intervention will achieve its essential goal, that of prevention, so that the criminalisation of FGM/C will have a dissuasive effect and contribute to eradicating the practice. Alongside this positive effect, it is an ethical and necessary task to acknowledge the negative consequences that can arise from the application of criminal law (Leye and Deblonde 2004, 44). Resorting to penal law has, indeed, a cost, since the instrument used –the imposition of a punishment– represents a limitation of fundamental rights, accompanied by social marginalisation (Fusaschi 2014, 101), described as follows.

If a migrant or a couple of migrants whose daughter has undergone FGM/C realise that they (or other relatives) can be prosecuted for the crime, he/she/they might not bring the victim or the concerned relatives to his/her/their destination country of residence, and family reunification might therefore be hindered (Llabrés Fuster 2006, 70). Once in the destination country, these migrants may try to avoid situations in which FGM/C is likely to be detected, like medical examinations.

Secondly, the incrimination of the parents as promoters of the mutilation might create a situation that puts the child at higher risk of lack of protection, considering the precarious socioeconomic circumstances of these groups in general (Sanz Mulas 2014, 31).

Moreover, there is a risk that the incrimination may favour, at least initially, a consolidation of these practices by communities in order to reaffirm their ethnic identities (Foblets 2006, 310).

Finally, the social stigmatisation that any penal punishment usually entails may end up aggravating the marginalisation of migrant groups associated with FGM/C, based on the erroneous idea of cultural superiority (Herrera Moreno 2002, 51).

### **The intervention of criminal law at the lowest-possible cost**

The criminal prosecution of FGM/C must not be the only way to combat the practice. Programmes of education, prevention and protection for women and girls –all aimed at creating a change in beliefs and behaviours, as well as assistance to migrants– are likely to provide more comprehensive protection of all concerned interests. This is why the criminalisation of FGM/C must be inserted in wider programmes that guarantee the preservation of the various legal assets involved (Torres Fernández 2005, 960).

Otherwise, a double risk may arise: on one hand, FGM/C may be prosecuted without mitigating the possible negative repercussions of the prosecution (Kaplan 2003, 30), or on the contrary, in an attempt to avoid these consequences, the reporting of these practices, or the imposition of condemnatory sentences, will be foregone.

## **7. A COMPREHENSIVE APPROACH TOWARDS THE ABANDONMENT OF FGM/C**

Els Leye (*VUB*)

Given the complexity of the phenomenon of FGM/C, it is important to approach it at different levels. A comprehensive approach, focusing on prevalence, prevention, protection, prosecution and the provision of services (the five Ps), is commonly used when discussing gender-based violence, including FGM/C (EIGE 2013).

As the prevalence of FGM/C has been discussed elsewhere in this manual, this chapter will focus on the remaining Ps: prevention, protection, prosecution, and the provision of services.

### **Prevention**

FGM/C prevention work needs to target deeply inherent sociocultural patterns of behaviour, which are its root causes and should be tackled within the EU, as well as in the countries in which acts of FGM/C occur (EIGE 2013). The Council of Europe's 2010 *Convention on Preventing and Combating*

*Violence against Women and Domestic Violence*, or Istanbul Convention, defines prevention as ‘the development of measures to promote changes in the social and cultural patterns of behaviour of women and men with a view to eradicating stereotypes and prejudices, customs, traditions and all other practices which are based on the idea of the inferiority of women or on stereotyped roles for women and men. It implies supporting the creation of an enabling environment for women and girls and encouraging their empowerment. It also means the reinforcement of institutions in a position to provide a response to the issue of violence against women’ (Council of Europe – Amnesty International 2014).

A wide range of activities can be used to prevent FGM/C. Some of the most popular ones are: awareness-raising and sensitisation among the various target groups (including men and boys), training (health) professionals, setting up community-led interventions, issuing public statements against FGM/C, using the media to convey messages, empowering women and girls, addressing gender stereotypes, and ensuring that culture, customs, religion, tradition or so-called ‘honour’ shall not be invoked to justify any act of violence (Johansen et al. 2013). Prevention activities are targeted at changing behaviour, towards the abandonment of all forms of FGM/C. However, in reality, resources for community organisations that work on the prevention of FGM/C are limited, leading to few activities focusing on long-term behavioural change (EIGE 2013).

### **Protection**

Protection from FGM/C has been identified with regard to protecting girls from being subjected to the practice, protecting from further harm those who have already been subjected to FGM/C, and providing international protection.

Child protection: Girls who are at risk of FGM/C should be adequately protected. Professionals who may encounter girls at risk include teachers, health professionals, the police, social workers and child-protection officers. Most countries have child-protection policies in place, which can be used to protect a girl from FGM/C. However, it is essential for professionals who are confronted with FGM/C to know the risk factors and the legislative and protective mechanisms that are in place at national or regional levels (EIGE 2013). In this respect, professional-secrecy provisions that regulate the duty of reporting cases of child abuse are important to take into consideration.

Victims of FGM/C should be provided with a range of specialised services, including legal, psychological, social-assistance and health services, to ensure their recovery from trauma and the prevention of serious health conditions, according to the UN Commission on the Status of Women (2011). For more, see ‘The provision of services’.

International protection: Victims or potential victims of FGM/C can be considered members of a particular social group under the Geneva Convention of 1951. FGM/C is recognised as a form of violence against women, amounting to gender-based persecution and child-specific persecution, and can thus be considered grounds for claiming asylum. This means that girls or women seeking asylum because they have been subjected to FGM/C, or are likely to be subjected to it, can qualify for refugee status under the Geneva Convention (UNHCR 2009; Council of Europe and Amnesty International 2014).

### **Prosecution**

In many countries, FGM/C has been outlawed. However, the number of court cases remains limited (Leye et al. 2007; Johnsdotter and Mestre i Mestre 2015), due to difficulties in finding sufficient evidence to bring a case to court and the obstacles in detecting cases of FGM/C (Leye et al. 2007). It is commonly accepted that laws alone cannot curb the practice of FGM/C, but that efforts to criminalise it should go hand in hand with prevention, protection and the provision of services.

Prosecuting FGM/C is an integral part of any human-rights-based approach to combating violence against women (EIGE 2013). As per the Istanbul Convention, for example, states are required to take the necessary legislative and other measures to ensure that investigations and judicial proceedings in relation to violence against women (including FGM/C) are carried out without delay.

Having criminal laws in place helps to create an enabling environment for actions against FGM/C. It provides a legal platform for action and offers legal protection for women, and it can discourage excisors and families, for fear of prosecution (Johansen et al. 2013). However, research on the implementation of criminal laws regarding FGM/C among the diaspora has revealed a number of obstacles regarding the criminalisation thereof (Leye et al. 2007; Johnsdotter and Mestre i Mestre 2015), and its impact on working towards the desired social abandonment of all forms of FGM/C remains unclear.

### **The provision of services**

A wide variety of services are involved in the provision of support for women with FGM/C, or those at risk thereof. Given the wide array of sectors involved, their effective cooperation is of paramount importance. These sectors include child-protection agencies, the police, health-care services, schools, NGOs and prosecution services. These services range from counselling (legal, psychological and sexual) to financial assistance,

appropriate health care, and social services. The services can be either general (e.g. services that are available for the general public, such as legal counselling) or specialist (e.g. specialist FGM/C clinics in Belgium).

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## **Chapter IV.**

### **Medicine, nursing and midwifery**

#### **Didactic objectives:**

1. To raise awareness in future health workers about the importance of a culturally sensitive and holistic approach in dealing with women and girls affected by, or at risk of, FGM/C;
2. To familiarise future health workers with real FGM/C cases in order to better understand their complexity when caring for women and girls with, or who are at risk of, FGM/C; and
3. To provide insights into the technical and clinical management of complications related to FGM/C.

#### **Summary:**

1. Caring for women and girls with, or who are at risk of, FGM/C (Maya Pellicciari and Sabrina Flamini, Fondazione Angelo Celli)
  - 1.1. Health workers and FGM/C cases
  - 1.2. How to respond to women and girls with FGM/C
  - 1.3. How to recognise/identify genital modifications
  - 1.4. Case management and ethical/professional implications
  - 1.5. Commitment to reporting cases of FGM/C
2. Preventive intervention regarding FGM/C (Nora Salas Seoane, Wassu-UAB Foundation)
  - 2.1. The crucial role of preventive intervention
  - 2.2. Preventive intervention: by whom and how
  - 2.3. Tools for the prevention of FGM/C
3. Clinical management of FGM/C and its complications (Els Leye, VUB)
  - 3.1. Management of long-term complications, including keloid, fistula and incontinence, abscesses, clitoral neuroma and cysts (FOD Volksgezondheid 2011)
  - 3.2. Deinfibulation (FOD Volksgezondheid 2011; World Health Organization 2016)
  - 3.3. Psychosexual counselling and therapy
  - 3.4. Reconstructive surgery of the clitoris after FGM/C
  - 3.5. Examples of available health-care services and guidelines in Europe

**Boxes:**

Dilemma: What is normal? What is pathological? What is the role of the health worker in similar cases?

Exercise: Try to figure out all possible situations through role-play or team discussions.

The Case of Liza

Interview excerpt (Bagaglia et al. 2014, 60)

Interview excerpt (Bagaglia et al. 2014, 59)

Exercise: Role-play the relationship between the health worker and the patient with FGM/C.

The Case of Sarah

Legal Process of Asylum-Seeker Claims Based on FGM/C: Italy, Spain, Belgium and Portugal

Commitment to reporting cases of FGM/C: Italy, Spain, Belgium and Portugal

An example of preventive intervention within paediatrics

Exercise: Identify possible ways of continuing preventive intervention with this family.

The Case of Giulia/Interview excerpt (Bagaglia et al. 2014, 87-89)

Dilemma: Long-lasting debates (ethical, legal, anthropological and medical)

**Bibliographic references**

There are different ways to approach the body, health, sickness and disease. This chapter focuses on care for those who have had FGM/C and the prevention of FGM/C amongst those at risk, from a comprehensive, socially and culturally acceptable, primary health-care perspective. Given the complexity of FGM/C, such a perspective is deemed more appropriate than biomedical, hospital-based or illness-related perspectives.

## 1. CARING FOR WOMEN AND GIRLS WITH, OR WHO ARE AT RISK OF, FGM/C

Maya Pellicciari and Sabrina Flamini (*Fondazione Angelo Celli*)

### 1.1. Health workers and FGM/C cases

Symptoms and diseases, although they have an organic base, are perceived subjectively by patients in many different ways: illness (feelings like pain, fatigue, weakness, discomfort, distress, confusion, fears, recovery expectations) is a very personal experience, and it can be shaped by many non-disease-related factors, such as cultural beliefs. Reported symptoms might not be confirmed through medical diagnosis, or a diagnosis might not match the patient's feelings

and perceptions. This gap can deeply affect the ‘success’ of the consultation, examination and recovery. People might perceive and sense their symptoms and/or diseases in totally different ways to health workers. The biomedical perspective tends to be reductionist, omitting the sociocultural framework in which symptoms and/or diseases are produced and performed<sup>9</sup>.

FGM/C is a cultural practice, but a health worker might be tempted to treat it merely as a symptom or disease, and/or be surprised to find that some women consider themselves perfectly ‘normal’ and healthy, and do not wish to be treated for what a doctor considers a symptom. Normality is not to be considered universal, but as a perspective based on values, norms and representations (cultures), even when it concerns seemingly neutral (natural/organic/medical) issues.

**Dilemma:**

**What is normal? What is pathological? What is the role of the health worker in similar cases?**

Biomedicine views urinating difficulties as symptoms requiring care. In some cases, however, getting a slow, dripping urinary flow is one of the reasons why infibulation is performed. It confirms the success of constructing a feminine body, differentiating it from the male body, which is characterised by a fast and large urinary flow. In this case, to ask the patient if she urinates ‘normally’ is not an appropriate question. The answer will be driven by what she considers ‘normal’ and may not be of help to health workers in producing a proper diagnosis. Asking, ‘How long does it take to urinate?’ is instead a more useful question and avoids cultural biases.

FGM/C is not in itself a disease, nor is it necessarily connected to symptoms. FGM/C refers to a set of different practices of genital modifications that may or may not have medical consequences, i.e. resulting in symptoms and disease. The more invasive the practice (e.g. infibulation), the more severe the health consequences can be. In most cases, people do not contact health services asking explicitly for the treatment of FGM/C. Often, they don’t know that FGM/C can even have health consequences.

Generally, a health worker can be faced with FGM/C in the following situations:

The patient refers to services for reasons not related to FGM/C, and the health professional has assessed FGM/C during other examinations, e.g. a paediatrician exploring genitals during a routine visit; a dermatologist during a preventative skin-mole check-up; a gynaecologist/nurse/midwife during general check-ups, prenatal visits, treatment or preventative care; or during the collection of a patient’s medical/psychological history.

<sup>9</sup> For further reading on the distinction between illness, sickness and disease, see: Eisenberg 1977; Russell 2009. Also see: University of Hyderabad (India). 2016. ‘E-learning postgraduate course on the sociology of health and disease.’ Accessed October 25, 2016. <https://www.youtube.com/watch?v=Wb39aXpqOmQ>.

The patient refers to services for symptoms related to FGM/C, even though she is not aware that they are connected (e.g. problems urinating, colic, menstrual pain or sexual difficulties).

The patient refers to services explicitly for an FGM/C-related issue. This could include: (a) inappropriate requests (e.g. parents asking for their children to undergo FGM/C; a pregnant woman requesting reinfibulation after giving birth); (b) requests for the treatment of symptoms attributed to FGM/C; (c) requests for intervention with deinfibulation and/or clitoris reconstruction; (d) requests for gynaecological certification for asylum seekers (in applicable countries).

Each situation relates to the different levels of patients' adherence to, and participation in, health services, and each requires health workers to adopt different attitudes, behaviours and interventions therein.

### **Exercise**

For each of the aforementioned cases, try to figure out all possible situations through role-play or team discussions.

### **The Case of Liza**

Liza is a 31-year-old asylum seeker from Nigeria who came to Italy with her husband and three-year-old daughter. Medical certification reported a type II FGM, but she has no memory of this experience. She talks about excision as something 'natural' and obvious, even if she discusses sexual problems that she connects to the intervention. During the first paediatric visit for her daughter, Liza naively asks the doctor where and by whom she could have an excision done for the baby. During another interview, this time with an anthropologist, she discloses details that further clarify the reasons of her request: she wants to find a remedy for the excessive sensitivity of the baby when she touches the genitals while washing her – something that she considers a disorder linked to the 'oversized' external genitals.

From the record cases of the Umbrian Centre for the Study and Prevention of FGM (Italy), 2016.

## **1.2. How to respond to women and girls with FGM/C**

Due to the presence of migrant/refugee populations in Europe, it is likely that health workers will meet a woman/girl with modified genitals. In these cases, the kind of reaction that they have plays an important role in setting up a good relationship with the patient and may improve compliance levels. Health workers should be aware that every verbal and non-verbal sign (facial expressions, gestures, silences, comments, tones and terminology) can be misinterpreted by patients and trigger reactions that can negatively affect care relationships. They are, in fact, constantly under patient observation, and their attitudes and behaviour can induce worry, anxiety, shame or offence. Health

workers should be sensitive and careful, paying attention to reactions that they may consider harmless, but instead convey racist attitudes and/or cause stigmatisation and abuse.

Scandalised and shocking reactions could come from untrained professionals, unprepared to deal with, or discuss, genital modifications.

Blame and/or victimisation are also very common reactions. Both come from the Eurocentric, paternalistic approach to what is different, unexpected or unknown – that which seems to be considered inferior, ‘strange’, or in need of conversion or salvation.

Amazed reactions, sarcasm and excessive curiosity can be considered quite harmless by health professionals, but they often hide an exoticised and spectacularised vision of diversity that makes the patient feel bizarre and ridiculous.

#### Interview excerpt (Bagaglia et al. 2014, 60)

*“The first time I went for a visit, immediately as I lay down, the gynaecologist got shocked and exclaimed, “Oh, madam! What happened to you?! Have you been burnt?!” And I said, “No! It’s been sewn! Isn’t that written in your books?! You are a doctor – they talk about this in the manuals,” because my husband was a doctor, and he told me about it. I said, “Isn’t there any manual regarding this African issue?!” And he replied, “No, I never heard about this!” “OK, it’s time to do it because we are many now here in Europe!”” (A Somali woman, 70 years old)*

#### Interview excerpt (Bagaglia et al. 2014, 59)

*“A lady doctor came and visited me, then called the nurse and other doctors – many of them came! I have taken it so badly because she exactly said, “Come, see what a spectacle!” She was talking about excision and epilation of pubic hair. Also, in another clinic, there was a doctor who was not able to understand what it was, but there was his friend, a black nurse, who was saying, “Look, for you, it’s news, but in our country, it exists!”” (An Ethiopian woman, 38 years old)*

In the face of these attitudes and behaviours, the patient can feel rejected or judged, as if she embodies incorrect or inferior traditions and values. As a reaction, she can refuse any contact with health services, or adhere to or defend FGM/C, even if she previously criticised the practice or was open to change. Special attention should be given to the use of terminology and words, as sometimes patients do not know technical or official terms used to refer to genital modifications. They can also be upset about words like ‘mutilation’, often understood as ethnocentric, discrediting and discriminating. A general reference to ‘(female) circumcision’ or the use of the term in the woman’s own language would be more helpful to introducing the topic, if used<sup>10</sup>.

<sup>10</sup> For further reading on the ethics of terminology and care, see Vissandjée et al. 2014.

### Exercise

Role-play the relationship between the health worker and the patient with FGM/C.

### 1.3. How to recognise/identify genital modifications

The WHO types (see Chapter II of this guide) are a useful tool for the identification of genital modifications and their severity. However, given that FGM/C consists of non-standardised interventions, often performed on a patient at a very early age, they can ultimately shape genitals in several different ways, which cannot be captured by the four WHO typologies. For this reason, health workers often encounter difficulties in identifying genital modifications according to the WHO types. Attentive observation, supported by an accurate and culturally sensitive medical history, can help the health worker to identify even the less invasive forms of FGM/C.

FGM/C identification skills are very important for health workers. They should develop a professional capacity to properly recognise and correctly describe the observed alterations, for several reasons:

It is necessary for the proper assessment of every case, in order to make the most appropriate decisions in the best interest of the patient.

It helps to *not* overestimate situations in which FGM/C is not a priority.

#### The Case of Sarah

Sarah is 23 years old, but she looks younger. She left Nigeria four years ago, and after two days on a small boat, she reached Italy in a clandestine landing, in Lampedusa. She is reluctant to speak about this landing, suggesting that it has been a hard and painful experience that she does not want to recall.

Sarah lives in a small flat with many other people. Someone told her that she should report the person pushing her into prostitution in order to obtain a residence permit, but she says that there is nobody to denounce. She feels entrapped in a no-way-out situation that she would like to escape, but she does not know how to do so.

Sarah is constantly looking for a job – a regular one – allowing her to escape the sex trade and regularise her presence in Italy. When we ask what kind of job she would like to do, she replies, 'Whatever – any kind of job!' We can easily imagine that she is waiting to understand whether our meeting will have something in store for her – a job? A place to stay? A residence permit? Useful information? What a disappointment when we start talking about female circumcision! 'Oh!' she says, so that is what we are interested in talking about, then? Is this why we are interested in her? Is this what we think she really needs? The tension drops, expectations crash. The tone becomes easier, Sarah smiles, amazed when she realises that we are not circumcised, that our genitals have not been treated or embellished, as have her own (Bagaglia et al. 2014, 33-34).

It helps to avoid underestimating the patient and not miss the opportunity to offer prevention insights to the family, also in apparently less invasive cases (e.g. a lack of prick marks may indirectly support the idea that they are not so harmful, and, therefore, families could easily perform these prickings on their daughters).

It is necessary to provide certification in the legal process of asylum-seeker claims based on the fear of FGM/C.<sup>11</sup> In this respect, it is required that health workers use the WHO terminology, to avoid any misunderstanding.

**Italy:** To have undergone FGM/C (or merely being at risk thereof) in Italy is considered a prerequisite for the recognition of refugee status for gender persecution (*Geneva Convention; Legislative Act No. 251/2007, Articles 2 and 7*). Asylum seekers identified as FGM/C victims are considered 'people with specific care needs' that should be recognised and granted by governmental health structures (*Legislative Act No. 142/2015, Article 17*). One form of proof for such identification is a medical certificate.

**Spain:** According to Law 12/2009 of 30 October 2009, which regulates the right to asylum and subsidiary protection, asylum seekers can obtain refugee status when persecuted for gender-based violence and 'sexual acts when performed to children or adults alike'. There is no specific mention of FGM/C, but it is understood to be included within the aforementioned section. Acceptance depends on the case and the documentation presented.

**Belgium:** The fear of FGM/C is recognised as a basis for seeking asylum and granting refugee status. Women can ask for asylum if they fear FGM/C (in cases where they are not already excised), they fear a more severe form of FGM/C than they already have, or they fear FGM/C for their daughters. A medical certificate is necessary.

**Portugal:** Asylum seekers identified as FGM/C victims are considered 'applicants with special reception needs', according to Law No. 26/2014, Article 2, No. 1, Paragraph ag). This law also sustains Article 5, which states that acts of sexual violence and 'acts committed specifically based on gender or against minors' are acts of persecution, which represent a basis for seeking asylum and refugee status. Proof and witnesses are required for granting international protection.<sup>1</sup>

#### 1.4. Case management and ethical/professional implications

Faced with a well-identified FGM/C case, a health worker could enable a range of different paths, from pure prevention to final, reparative surgery, depending on the severity of the situation and the demand/compliance of patients.

Given the complexity of FGM/C and its possible negative impact on physical and psychological health, the approach should be multidisciplinary. It is advisable for the

<sup>11</sup> For further reading on the link between FGM and asylum, see: UNHCR. 2009. 'Guidance Note on Refugee Claims Relating to Female Genital Mutilation.' Accessed October 27, 2016. <http://www.refworld.org/docid/4a0c28492.html>.

operator/service to be part of a wider referral network of professionals or identify/consult a local multidisciplinary centre specialising in FGM/C to refer patients.

Prevention can be the main focus in all situations, taking into consideration that the whole family (including those remaining in the country of origin) is to be involved, to assure a real abandonment of the practice (see section two in this chapter). Paediatricians, in particular, play a key role, as they have the chance to monitor cases at risk through periodical genital examinations and regular in-depth conversations with families. The management of specific symptoms that patients directly or indirectly relate to FGM/C also gives the health worker a chance to discuss the prevention of their daughters being cut, or offer patients reparative surgery. In the case of severe symptoms (see section 3.2. in this chapter), surgical intervention may be required.

The most complex situation comes when deinfibulation and/or clitoral reconstruction are chosen (suggested by health workers or demanded by patients). These steps require total compliance by the patients, together with the eventual involvement of relatives, a multidisciplinary approach, and constant counselling support throughout the entire journey (during decision-making, as well as after the intervention; see sections 3.3. and 3.4. in this chapter).

The presence of linguistic mediators, anthropologists and other community facilitators is always highly recommended. This can play a crucial role in defining the care path and its continuity and efficacy.

## **1.5. Commitment to reporting cases of FGM/C**

In all European countries, health workers are committed to reporting bodily injuries, in case these are criminal offences. FGM/C is considered a criminal offence, but given the fact that it includes very different practices with varying consequences (in some cases, such consequences are totally absent), there is a huge and contentious debate about this professional commitment. Many professionals choose to use conscientious objection, especially when they are convinced that the FGM/C was performed a long time ago, and in the country of origin. Health workers have a responsibility to inform patients about local laws on FGM/C and the penal implications for teachers and practitioners, as well as the health consequences of genital interventions. Dialogue and the establishment of trusting relationships are often considered preferable to the intervention of reporting, which can ultimately lead to dramatic consequences for minors, like house arrest for parents and/or depriving them of authority over their children by entrusting the latter to social services. Simply mentioning this possibility can be perceived as a threat, and it can easily push families into interrupting care relationships (with subsequent health consequences) and finally fleeing the country, thus disabling any real reduction in FGM/C rates.

**Italy:** The law (Legislative Act No. 7/2006) clearly identifies judicial authority as the only one entitled to pronounce the admissibility of cases, calling officials (health workers included) to report any suspected or declared cases of FGM/C, even those at risk thereof, and even when concerning women of age (the minor age is considered an aggravating circumstance).

**Spain:** FGM/C is considered a serious offence in the penal code (Article 149.2). Parents can go to prison for six to twelve years, losing custody of their daughter(s) in the process. The code also makes it punishable for those who permit, collaborate in, or perform FGM/C. If the practice is performed outside Spanish territory, the person can only be condemned if s/he has Spanish nationality or lives permanently in Spain (Organic Law 1/2014). Health professionals have a duty to report any criminal offence identified. Following these laws, professionals have a duty to report cases in which a girl who has FGM/C performed and her parents are Spanish residents or have been living in Spain for a long time. They do not have a duty to report girls who arrive in Spain with FGM/C already performed.

**Belgium:** In Belgium, there is no duty for professionals to report suspected or declared cases of FGM/C. A specific criminal code (Article 409 of the penal code) makes it punishable to perform, attempt or facilitate FGM/C.

**Portugal:** The practice of FGM/C is a crime punishable under the Portuguese penal code (Law n. 83/2015, Article 144<sup>o</sup>-A), with two to ten years in prison. If FGM/C is considered a 'qualified offense to one's physical integrity', the sentence can rise to twelve years in prison (Article 145<sup>o</sup>), and all these penalties can be aggravated if the offences cause the death of the victim (Article 147<sup>o</sup>). Even if committed outside Portuguese territory, the law may be applicable, due to an extraterritoriality clause. FGM/C is a public crime, therefore, health professionals, like all citizens, have a duty to report it to the authorities, and the victim's complaint is not required to start a criminal investigation.<sup>2</sup>

## 2. PREVENTIVE INTERVENTION REGARDING FGM/C

Nora Salas Seoane (*Wassu-UAB Foundation*)

### 2.1. The crucial role of preventive intervention

Preventive intervention refers to any health-education action undertaken by health professionals to promote positive attitudes towards the abandonment of FGM/C. The intervention's aim is to prevent the performance of FGM/C on babies and girls, and to improve the health of women and girls who have undergone the procedure and who might be suffering its consequences. Preventive interventions are performed in medical consultations within a broad health-education approach, mainly with women (mothers, or the potential mothers of girls), men (whom it is important to include in the intervention, when feasible), and families and communities from countries where FGM/C is practised (Kaplan, Toran and Bedoya 2006a; Kaplan, Moreno and Pérez Jarauta 2010a).

Health-care users are understood to be active within their agencies, and the aim of the intervention is to empower women and girls with knowledge to

make informed decisions about their bodies and their lives, and those of their daughters. The health professional's role is to transfer scientific and clinical knowledge about the health consequences of FGM/C (short and long term) for girls and women. They have a legitimacy, on one hand, as health professionals, and, on the other, of being the health caretakers of families, having a crucial role to play in the prevention of the practice (Kaplan, Salas and Mangas 2015).

Professionals should have received training on FGM/C to tackle such a complex and sensitive issue, with powerful social meaning for the communities that practise it. Knowledge about its anthropological background and the social reasons for carrying out FGM/C is crucial to deconstructing it with families and having a greater chance of success in the preventive intervention. If the professional is not trained, s/he will not be able to identify FGM/C or undertake appropriate prevention of the practice. The professional must bear in mind the cultural and social background of the user, as well as her personal history of migration. The transfer of knowledge should always be accompanied by respect and emotional support, as the professional might be entering a highly intimate and painful sphere. Empathy, dialogue, confidence-building and sufficient time are all needed in order to share experiences and views on the topic. Women are usually open to speaking if the intervention is done this way.

Health professionals also have a duty to inform patients about the legal framework of FGM/C in the country in which they now live. Above all, professionals must offer support to families in order to help them to avoid the practice and protect their daughters, given the high social pressure from their countries of origin, and mainly from African countries. Preventive interventions also have a transnational effect in the countries of origin, informing members of patients' families and communities about the harmful nature of the practice.

The most common risks for a baby or a girl to have FGM/C performed are as follows:

- Her family comes from a country, and/or is affiliated with an ethnic group, that practises FGM/C.
- Her mother and/or sisters have been subjected to FGM/C.
- Her family plans to return to live in its country of origin, seeking integration into the community.
- Her family is planning to travel to its country of origin for holidays, to visit family, and/or to present the new daughter.
- Her family expresses its intention to perform FGM/C on her.

It is very important to make a deep assessment of the situation before considering the girl at risk.

## 2.2. Preventive intervention: by whom and how

Preventive interventions are mainly performed in the following health areas:

- Paediatricians and paediatric nurses;
- General practitioners and general-practice nurses;
- Community medicine; and
- Health and reproductive-health services (obstetricians, gynaecologists, midwives).

Paediatricians and paediatric nurses have a crucial role within the health sector, as they can work with the family once a baby girl is born, during her life cycle, to prevent the practice. Health and reproductive-health services can play a role in detecting women with FGM/C and assess if they are in need of help, as well as developing preventive interventions in case there are girls, or future baby girls, within the family. General practitioners and community-medicine doctors can play a role by doing preventive interventions in their general practices, as families usually have confidence in these professionals.

Interventions can be classified as follows:

- *Long-term preventive intervention*: It is more often developed by paediatric controls once the baby girl is born or during her life cycle. It can be initiated in sexual- and reproductive-health services through pregnancy controls, informing paediatrics about a potential risk within a family.
- *Specific preventive intervention*: It is more often performed by general practitioners and general-practice nurses, but it can be developed in other services. When the professional finds a health complication that can be derived from FGM/C, s/he takes the opportunity to speak about it, starting an intervention. It is preferable to have built a rapport before speaking about FGM/C, otherwise, be careful, respectful and sensitive.
- *Community prevention*: Health professionals can speak about the health consequences of FGM/C in conferences or activities organised with communities. Group activities can be very beneficial if done with the appropriate knowledge and respect for the tradition – the debate arising can facilitate further debate about the appropriateness of the practice in the community.
- *Management of the health consequences of FGM/C*: The first step is to assess to what extent there is physical, psychological and sexual damage, and assess potential and adequate treatments. If the woman is pregnant or intends to get pregnant, it is important to assess the degree of potential complications during delivery. If the future baby is a girl, preventive interventions can start taking place. Professionals can offer psychological support, referring the woman to a mental-health

service. She may be a woman with physical and sexual complications, or a mother with a sense of guilt, adopting an attitude against the practice, not performing it on one daughter while the other has been cut, etc. Adolescent girls – in need of information and support about their sexuality – can feel uncomfortable in a culture in which FGM/C is blamed (Kaplan, Salas and Mangas 2015).

### 2.3. Tools for the prevention of FGM/C

The major elements needed for adequate preventive interventions are: knowledge about FGM/C, respect, sensitivity and common sense. There are also other tools that can help to develop interventions, as follows:

- *Preventive agreement*<sup>12</sup>: The preventive agreement is a document/letter designed for families to garner support against the practice when they travel to their countries of origin. In this letter, families agree to take care of their daughters during the travelling period, following the instructions of international vaccination centres and avoiding the performance of FGM/C. The document has proven successful in the Gambia, Senegal and Guinea-Bissau. Families show the ‘official’ document with stamps from the health facility to their elders, letting them know about the health consequences of the practice and the prohibition of performing it by the countries of destinations’ laws and the fatal consequences if performed.
- *Fold-out posters/guides/manuals*: There is a wide range of manuals and guides on the prevention and management of FGM/C by health practitioners in different European countries. Fold-out posters are also available to use in medical-consultation settings.<sup>13</sup>
- *The importance of registering*: It is important to register preventive interventions or the detection of FGM/C in the clinical history, through the International Classification of Disease (ICD), in which codification for FGM/C is included. If the woman/girl has undergone the practice, it should be registered, and if there is a risk for the girl, it has to be registered, too. This can facilitate coordinated interventions with other professionals in case it is needed, even if, sometimes, when professionals have not been trained, it could lead to confusion (Kaplan, Salas and Mangas 2015).

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<sup>12</sup> For more information about the preventive agreement, see: Fundación Wassu-UAB. 2015. ‘Sharing tools, for prevention.’ Accessed October 27, 2016. [http://www.mgf.uab.es/eng/resources\\_for\\_professionals.html](http://www.mgf.uab.es/eng/resources_for_professionals.html).

<sup>13</sup> For an example, see: Fundación Wassu-UAB. 2015. ‘Sharing tools, for prevention.’ Accessed October 27, 2016. [http://www.mgf.uab.es/eng/resources\\_for\\_professionals.html](http://www.mgf.uab.es/eng/resources_for_professionals.html).

### **An example of preventive intervention within paediatrics**

This concerns a family from Egypt, living in a city nearby – Barcelona, Spain – with five children: four girls (22, 19, 16 and 14 years old) and a baby boy (nine months).

The paediatrician has been assisting the family for five years, but she never thought about FGM/C until she received training and knew that, in Egypt, there is a high prevalence of the practice. She decides to speak with the family about the issue and start an intervention.

The mother and all children come for a check-up of the baby boy. The doctor asks openly if the mother and her girls have been cut. She has enough confidence with the family to do so, with respect and sensitivity, after getting training about FGM/C. The mother answers that, of course, they have been cut, at the hospital – she and the first three girls, as it is a normal practice, a tradition, in their home country. The youngest girl was not cut, as it had been prohibited by law in Egypt recently, she says.

In this case, it is beneficial to do a long-term preventive intervention with the family. They think FGM/C is a good practice by tradition, and the doctor can deconstruct these beliefs step by step, with scientific knowledge about the health consequences that it can entail.

The youngest girl has not been cut because it has been prohibited. We could ask the family why a country prohibits a practice that is 'good' for girls and women. This girl could undergo FGM/C on a trip to Egypt. By doing preventive intervention, we can prevent other girls in this family from undergoing the practice. For example, the eldest daughter is about to get married in Egypt, and if she has a baby girl, she would probably have the practice performed on her.

From an FGM/C consulting programme at a primary-care health centre in Catalonia, Spain, by the Wassu-UAB Foundation.

### **Exercise: Identify possible ways of continuing preventive intervention with this family**

Case: This concerns a family from Senegal. They have two boys (nine, born in Senegal, and six, born in Catalonia) and a girl (four, born in Catalonia). The paediatrician has been attending the family for six years, gaining its confidence, and after training in FGM/C, she decides to start an intervention. She asks the mother if FGM/C is practised in her country of origin, and the mother says yes, she underwent the procedure, but she does not want to do it to her daughter. When the paediatrician explains the health consequences that the practice could entail, the mother states again that she does not want to practise it on her daughter. However, when she is leaving the health setting, she asks, 'Would it not be good to perform FGM/C to solve this itching my daughter is experiencing?'

It is clear that this woman is not convinced that FGM/C has more inconvenience than advantages for her daughter. Think about what you can do as a health practitioner to continue performing preventive intervention.

From an FGM/C consulting programme at a primary-care health centre in Catalonia, Spain, by the Wassu-UAB Foundation.

### 3. CLINICAL MANAGEMENT OF FGM/C AND ITS COMPLICATIONS

Els Leye (VUB)

#### 3.1. Management of long-term complications, including keloid, fistula and incontinence, abscesses, clitoral neuroma and cysts (FOD Volksgezondheid 2011)

*Neuroma of the nervus dorsalis of the clitoris:* This can occur in all forms of FGM/C. The cutting of this nerve and the pressure put upon it by scar tissue can lead to the proliferation of neural tissue and, in the worst case, to the growth of a painful tumour. A neuroma can have a diameter of many centimetres. The treatment consists of its removal.

*Keloid:* This can occur in all forms of FGM/C. Keloid is difficult to treat, as the removed scar tissue often comes back after surgical removal. It is therefore essential to reduce this risk as much as possible. After the operation, scar-tissue formation can be avoided by applying corticosteroids locally.

*Fistula:* This is a complication that occurs mostly in type III FGM/C. The treatment of fistula needs specific expertise and a skilled surgeon. In non-complex cases, the treatment is 90% successful, and 60% successful in more complex cases. Post-operative care should be done for at least two weeks, to avoid infection and guarantee a sustainable result. Psychological counselling is equally recommended. Caesarean sections are recommended for future pregnancies/deliveries.

*Epidermal inclusion cysts:* This can occur in all forms of FGM/C. The location of the cyst and the iatrogenic consequences of a surgical intervention on already damaged tissue should be taken into consideration when deciding to remove it. In cases of large or infected cysts, a marsupialisation should be done (a permanent surgical opening and stitching of the cyst to allow a permanent flow of the content of the cyst).

*Pseudo-infibulation:* This can occur after excision (type II). Pseudo-infibulation is the adhesion of the edges of the excised labia minora during wound-healing. No oestrogenic ointment should be applied. The adhesion will be incised over the total length, and the labia are spread using vaseline gauze, for example, until the wound is totally healed.

#### 3.2. Deinfibulation (FOD Volksgezondheid 2011; World Health Organization 2016)

The World Health Organization recommends deinfibulation for preventing and treating obstetric, as well as urologic, complications in women and girls living with type III FGM/C.

At the first consultation, each woman or girl with FGM/C should be examined to assess the type thereof and the width of the vulva. The findings should be carefully noted in the file of the patient, to avoid recurrent examinations. Health

professionals should provide detailed, balanced and unbiased information on the procedure of deinfibulation and explain why it is needed, and the expected benefits and potential risks thereof, including information on the anatomical and physiological changes that can be expected post-operation (e.g. faster micturition, increased vaginal discharge). This should be done during a preoperative briefing.

Deinfibulation can be done antepartum or intrapartum, in order facilitate childbirth in women living with type III FGM/C, depending on the context. Women should be allowed to express their preference on the timing, but the timing will also depend on accessibility to health-care facilities (antepartum, in case the woman lives far from a health facility), the place of delivery (antepartum, in a case of home delivery), and the health-care provider's skill level (antepartum, if a less experienced health worker is involved).

#### **The Case of Giulia/Interview excerpt (Bagaglia et al. 2014, 87-89)**

Giulia is an Italian midwife working in a public hospital. She had the chance to treat a young Somali woman who chose to be deinfibulated in order to have a natural delivery.

*I didn't see her as a subjugated person, or as someone who didn't accept criticism – not at all! I've seen a determined person, who consciously made her choices. [...] We met as two adult women who lived different lives and experiences, who met one another and shared a lot. [...] When we read or listen to the news on TV, we think that FGM is something far from us – that this is not the reality. They talk about infibulations, and you always think, "Yes, but this is not my reality. I don't want to encounter this. It's not my problem!"*

*Even when our hospital called us for training or refresher courses, telling us that this was a big problem, I never thought it was something actually interesting to me, something concerning me, but, for the first time, this was a reality I had to take into consideration. I was there. It was not so far away, and when I watched with my eyes, it did not terrify me. I didn't feel disgust or rage – I have to be honest. I was so pleased to see how brave she was, to see her deep knowledge, which was not subjugation, nor constraint or fear. It was like if she were just saying, "Well, back then they were doing this, but now we know that what we were doing was a mistake!" Like, for us, someone could say, "They removed your tonsils," because, in the seventies, if you were sick, they removed your tonsils – no need to be upset, they were used to it, it was a custom.*

*This person had a very low education level – only primary school – but I got the impression of a very self-aware person. [...] The reopening through deinfibulation involved a surgical wound that had to heal on its own – as doctors say, "healing by second intention" – when you leave the skin, the underskin, to have a spontaneous recovery, just cleaning it with water, just with detergent products, without reconstructing the tissue.*

*Of course, as a woman, putting the medication on these genitals, on this very sensitive area, I was identifying with her, and the impact for me was personally very hard. [...] I think she was very good, very much so, because that area always comes into contact with biological fluids, because during pregnancy one has to pee more frequently, and the urine burns! Pee was burning this cicatrising wound, a very well-done and regular cicatrix, but very slow to recover. She was also sitting on it, with a very imminent pregnancy, being in the second trimester, so the abdomen and the uterus were very big, and I was asking her, "How can you resist?! I see that you are very, very good," and she was replying, "Yes, at the beginning, it was hurting, but now I'm getting used to it!"*

### 3.3. Psychosexual counselling and therapy

Psychological support should be available for girls and women who are going to receive, or have received, any surgical intervention to correct the health complications of FGM/C. This support can range from special programmes to quite simple, inexpensive modifications of, or additions to, the required medical procedures, including the provision of procedural information or emotional support.

WHO suggests that cognitive behavioural therapy be considered for girls and women with FGM/C who are experiencing symptoms consistent with anxiety disorders, depression or post-traumatic stress disorder (PTSD). Sexual counselling is recommended for preventing or treating female sexual dysfunction amongst women living with FGM/C (WHO Guidelines 2016). However, other therapies can also be considered, depending on the personal situation of the woman/girl.

### 3.4. Reconstructive surgery of the clitoris after FGM/C

This type of surgery is currently offered in a number of countries, mainly in Europe. The technique consists of the removal of the skin covering the distal end of the clitoral stump. The clitoris is then liberated from the surrounding scar tissue, and the *ligamentum suspensorium* of the clitoris is cut, to lower the clitoris to where the *glans clitoridis* is normally situated. A stitch through the periosteum and the interpositioning of the two *musculus bulbocavernosus* above the distal part of the clitoral stump prevents the stump from pulling upwards. The upper part of the incision is then stitched in two parts (WHO Guidelines 2016).<sup>14</sup> Reconstructive surgery of the clitoris should be guided by a multidisciplinary team that offers psychological and sexual counselling.<sup>15</sup> It is important to note that WHO did not issue a recommendation on this type of surgery, due to inconclusive evidence of its benefits.

#### Dilemma

Long-lasting debates (ethical, legal, anthropological and medical) are still open about parallels that can be drawn between FGM/C (condemned and forbidden) and biomedical cosmetic genital surgery (allowed and promoted), as well as about the ethics around justifications for FGM/C.<sup>3</sup>

<sup>14</sup> For more information on the technical procedure, see: Abdulkadir, Rodriguez and Say 2015.

<sup>15</sup> For more information on such care, see: De Schrijver, Leye and Merckx 2016.

### 3.5. Examples of available health-care services and guidelines in Europe

There are a number of services available for health professionals that can assist in providing adequate care and support for women and girls living with FGM/C. These range from technical guidelines, e.g. how to perform a deinfibulation, to codes of conduct for professional bodies that assist in making informed decisions and specialised multidisciplinary centres that provide not only clinical management for FGM/C-related problems, but also psychological and sexual counselling and support for women and their families.

The following are some links to these resources:

**African Well Woman Clinics in the UK**

<http://about-fgm.co.uk/resources/specialist-health-services>

**FGM/C referral centres in Belgium**

[www.stpierre-bru.be/nl/service/gyneco/cemavie.html](http://www.stpierre-bru.be/nl/service/gyneco/cemavie.html)

**Guidelines from the Royal College of Obstetricians and Gynaecologists, UK**

[www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf](http://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf)

**Online course for health professionals**

[www.e-lfh.org.uk/programmes/female-genital-mutilation](http://www.e-lfh.org.uk/programmes/female-genital-mutilation)

**Regional Centre for FGM/C prevention and care, Careggi University Hospital (Florence, Italy)**

[http://www.aou-careggi.toscana.it/internet/index.php?option=com\\_content&view=article&id=53:ostetricia-e-ginecologia&catid=122&Itemid=909&lang=it](http://www.aou-careggi.toscana.it/internet/index.php?option=com_content&view=article&id=53:ostetricia-e-ginecologia&catid=122&Itemid=909&lang=it)

**Umbrian Centre for the study and prevention of FGM/C (Perugia, Italy)**

[www.mgf-umbria.it](http://www.mgf-umbria.it)

**Department of Obstetrics and Gynecology, Geneva University Hospital (Switzerland)**

[www.ncbi.nlm.nih.gov/pubmed/27350225](http://www.ncbi.nlm.nih.gov/pubmed/27350225)

**FGM/C video resources for health-care professionals (UK)**

[www.gov.uk/government/publications/fgm-video-resources-for-healthcare-professionals](http://www.gov.uk/government/publications/fgm-video-resources-for-healthcare-professionals)

**Dexeus Clinic, Barcelona (Spain)**

<http://campus.dexeus.com/quienes-somos/fundacion-dexeus/accion-social>

**Department of Gynaecology, University Hospital Clinic of Barcelona (Spain)**

[www.hospitalclinic.org](http://www.hospitalclinic.org)

**National Health Joint Protocol on FGM, published by Ministry of Health, Social Insurance and Equality (Spain)**

[http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/Protocolo\\_MGF\\_vers5feb2015.pdf](http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/Protocolo_MGF_vers5feb2015.pdf)

**Orientations for health professionals, published by The Ministry of Health, especially 'Fluxogram: approach and protection of the newborn, child and youth in the framework of Female Genital Mutilation' (p. 11) (Portugal)**

[https://www.cig.gov.pt/wp-content/uploads/2013/12/orientacao\\_DGS.pdf](https://www.cig.gov.pt/wp-content/uploads/2013/12/orientacao_DGS.pdf)

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## Chapter V.

# Human-rights, penal law and immigration and asylum laws

### **Didactic objectives:**

1. To familiarise law students with the main concepts and problems in relation to FGM/C;
2. To show and discuss relevant aspects of human rights, criminal, migratory and asylum law in relation to FGM/C;
3. To review essential international legislation on FGM/C;
4. To review national legislation, penal law and asylum sentences on FGM/C; and
5. To carry out practical exercises and debate theoretical issues on FGM/C.

### **Summary:**

1. Human rights and FGM/C
  - 1.1. FGM/C as a harmful practice and violation of human rights (Julia Roper Carrasco, URJC; Rut Bermejo Casado, URJC)
  - 1.2. Multiculturalism and human rights (Cristina Santinho, ISCTE-IUL)
  - 1.3. Androcentrism of human rights (Magaly Thill, URJC)
  - 1.4. FGM/C in international law (Julia Roper Carrasco, URJC)
  - 1.5. FGM/C in European law (Rut Bermejo Casado, URJC)
2. Penal law and FGM/C
  - 2.1. Penal laws in Africa, the Middle East and Asia (Magaly Thill, URJC)
  - 2.2. Penal laws in the European Union (Els Leye, VUB)
  - 2.3. Perpetrators and cultural motivations (Magaly Thill, URJC)
  - 2.4. Legitimacy and the effectiveness of penal law: The proportionality principle (Julia Roper Carrasco, URJC)
  - 2.5. Problems arising from the enactment of penal law (Julia Roper Carrasco, URJC)
3. Migratory law and asylum
  - 3.1. Asylum and FGM/C (Rut Bermejo Casado, URJC)
  - 3.2. Family reunification and FGM/C (Julia Roper Carrasco, URJC)
  - 3.3. Stigmatisation versus integration (Cristina Santinho, ISCTE-IUL)
  - 3.4. International cooperation and prevention of FGM/C (Cristina Santinho, ISCTE-IUL)

**Boxes:**

Table 1. Countries with laws against FGM/C and dates of adoption

Box 1. Practical exercises to be used in the classroom

Box 2. Evaluation

**Bibliographic references**

## 1. HUMAN RIGHTS AND FGM/C

### 1.1. FGM/C as a harmful practice and violation of human rights

Julia Ropero Carrasco and Rut Bermejo Casado (*URJC*)

Female genital mutilation/cutting (FGM/C) is defined by the World Health Organization (WHO) as a set of harmful procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural, religious or other non-therapeutic reasons. FGM/C may produce short-term health complications –shock, bleeding, infection and injuries– that can cause death. It also results in serious long-term harm on reproductive and sexual health, including recurrent infections, infertility, cysts and complications during labour and childbirth.

For women who have undergone excision, FGM/C may nullify or impair sexual enjoyment, while, in its most aggressive form –infibulation– first sexual intercourse will be extremely painful for the woman, who will most probably have to be submitted to another procedure prior to penetration of the vagina by the penis, in order to provide access thereto. Moreover, FGM/C may entail psychological sequelae, like post-traumatic stress disorder, chronic anxiety, insecurity and lack of confidence (Ropero Carrasco 2003, 357-58).

Due to its life-threatening short-term effects and its serious long-term physical, sexual and psychological consequences, FGM/C was defined by the United Nations, across all its four types, as a harmful practice, a form of torture and ill-treatment, a form of violence against girls and women, and a violation of the rights of the child, who has no possibility of providing informed consent (*ibid.* 360-61).

## 1.2. Multiculturalism and human rights

Cristina Santinho (*ISCTE-IUL*)

'Female genital mutilation is not tradition. It's not culture. It's a crime.' This statement was part of a campaign against FGM/C that was launched in Lisbon in July 2016, bringing together, in partnership, the Portuguese government and the government of Guinea-Bissau.

It continues, 'Female genital mutilation is a form of physical and psychological violence and a violation of [the] human rights of girls and women. To say no is a right and a duty (P&D Factor 2016).'

It is tempting to approach FGM/C from the angle of human rights, to use them as dissuasive elements when people are confronted with the potential punitive application of penal law (Mutua 2002), but we must remember that FGM/C is a cultural practice – it would be risky not to – with political, economic and religious implications, as well as those related to gender and power (Boyle 2002).

To keep a balance between individual human rights and multiculturalism with regard to FGM/C in a global world, where merchandise, people, knowledge and practices circulate, it is necessary to take into consideration the following aspects:

1. Human rights are frequently depicted as Western moral values and associated with political impositions historically rooted in colonialism.
2. Human rights have also become a concern for non-Western countries, but it is important to understand if they are in fact implemented in local contexts and in what way(s).
3. Some institutional interventions develop a racist bias by labelling FGM/C a barbaric practice that belongs to 'backward' cultures, in which the role of women is constantly relegated to a subordinate position. We should note that analogous situations in Western contexts, resulting from social pressure concerning aesthetics, make women undergo surgical procedures like augmentation or reduction of the grand labia, clitoral reduction, vaginal tucks, or, on other levels, anorexia.
4. The application of human rights should strive to safeguard human dignity. This implies a detailed ethnographic work, looking for the social, symbolic and economic significance of FGM/C, instead of demonising those who practise it. This will be an opportunity to create an intercultural dialogue that is introspective and profound, and respects that dignity.
5. Considering the aspects related to globalisation, culture should be perceived as being in constant transformation and not essentialised.

In an attempt to overcome relativist positions that deny the mere possibility of universalism, Parekh claims that the fact that human beings grow up and live within a culturally structured world does not mean that they are determined by their culture, in the sense of being unable to critically evaluate its beliefs and practices (Parekh 2000, 336). According to this vision, some kind of moral universalism –relatively minimal and consistent in its fairly general abstract concepts, such as human rights– is perfectly compatible with multiculturalism (ibid. 133-34).

### 1.3. Androcentrism of human rights

Magaly Thill (URJC)

As phenomena that regulate individual behaviours and social relations in a specific context, laws reflect the socially regulated models of men and women embedded in each society and their relations with each other and with the group. Feminist legal theory has highlighted how the principle of universality of human rights, as endorsed by modern philosophers (initially applicable to white male landowners and later extended to every human being), was in fact flawed (MacKinnon 2006). The principle of non-discrimination on the basis of sex, anchored in the *Universal Declaration of Human Rights*, as a result of women's demands to be included in the international system of rights and freedoms, did not bring the revision of the allegedly neutral, but, in reality, masculine subject (Facio and Fries 1999).

Criticism arose among feminist scholars about how international conventions on human rights reaffirmed the dichotomy between private and public spaces, without recognising rights that are of special importance to women, namely: sexual and reproductive rights, the right to equality in the sphere of intimacy and family, the recognition of reproductive work, and the right to be free of gender-based violence (Charlesworth 1994).

After several decades of organised activism and advocacy, feminist demands finally came through, when, triggered by the United Nations General Assembly's ground-breaking *Convention on the Elimination of All Forms of Discrimination against Women* in 1979 and several international conferences on the situation of women, the governments of the world acknowledged that 'women's rights are human rights' in the Vienna World Conference on Human Rights (1992) and adopted the UN's *Declaration on the Elimination of Violence against Women* (1993) and its *Beijing Declaration and Platform for Action* (1995).

Feminist critical theory of law has pursued a redefinition of human rights that would make possible women's real participation and reflect their needs and wishes – a new pact of citizenship that considers women the subjects of rights,

instead of objects of legal regulation (Bodelón 2009, 113). The (albeit slow) incorporation of FGM/C into international law as a violation of human rights is an example of how women's activism can instigate change.

The definition of FGM/C as a form of discrimination and violence against women has led to the growing banishment of the practice. It also allows for the establishment of a legal distinction between the less intrusive form of type I (Type Ia, see Chapter II Table 1), often called *Sunna*, and the comparable surgical intervention of male circumcision, by referring to the patriarchal relations of subordination that the former underpins. Additionally, feminist approaches suggest critically analysing the concept of consent by taking into consideration the deep implications of the lack of women's social, economical and psychological autonomy in patriarchal cultures on their capacity to provide free consent (Rahman and Toubia 2000, 65-66).

#### 1.4. FGM/C in international law

Julia Roper Carrasco (*URJC*)

For centuries, the practice of FGM/C has not attracted the attention of public authorities in the international arena. This lack of interest can be explained by a series of reasons, including a reluctance to meddle in family life or with a possible cultural practice, and a lack of interest in a problem that only concerns marginalised social groups, namely women of the Third World. In the past three decades, UNICEF, WHO and other United Nations agencies have championed the condemnation of FGM/C, and human-rights and civil society organisations have promoted education programmes against the practice and called upon the states and supranational bodies to adopt different measures (Roper Carrasco 2001, 1393-96).

In international law, the starting point was the United Nations' *Convention on the Elimination of All Forms of Discrimination against Women*, in 1979, which, in its Article 5, demands that all states 'shall take all appropriate measures [...] to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women'. Also, the United Nations' *Declaration on the Elimination of Violence against Women*, in 1993, establishes in Article 4 that states should not invoke any custom, tradition or religious consideration to avoid their obligations regarding the elimination of violence against women. The *International Covenant on Economic, Social and Cultural Rights* recognises the right to the enjoyment of the highest attainable standard of physical and mental health (ibid. 1393-94).

It was not until the 1990s, however, that FGM/C was expressly mentioned in international texts. The 1994 International Conference on

Population and Development (Cairo) called out for governments to develop specific programmes to eradicate FGM/C, and the *Beijing Declaration and Platform for Action* (1995) condemned the practice, calling on the states to adopt necessary measures for its eradication. Finally, the *General Assembly Resolution 56/128 on Traditional or Customary Practices Affecting the Health of Women and Girls* (2001), of similar content to the International Conference on Population and Development, put a special emphasis on strengthening women's human rights and independence.

Finally, in 2012, the General Assembly of the United Nations endorsed its first specific resolution on FGM/C: *Resolution A/RES/67/146: Intensifying global efforts for the elimination of female genital mutilations*. International law on FGM/C has been further strengthened with regional initiatives like the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (Banjul Charter), of the African Union, and the *Convention on Preventing and Combating Violence against Women and Domestic Violence* (Istanbul Convention), of the Council of Europe.

## 1.5. FGM/C in European law

Rut Bermejo Casado (URJC)

The EU has expressed a strong commitment to eliminating FGM/C. The European Commission communication *COM (2013) 833 final: Towards the elimination of female genital mutilation* sets out a list of measures that the Commission will take in the coming years (European Commission 2013). Following the landmark resolution of the General Assembly of the United Nations of 2012, *Intensifying Global Efforts for the Elimination of Female Genital Mutilations* (UNGA 2012), the EU adopted this communication, which focuses on:

- supporting non-governmental work to combat FGM/C at a grassroots level;
- supporting projects in non-EU countries with a high prevalence of FGM/C; and
- promoting the European Institute for Gender Equality, which develops and provides resources on FGM/C.

Before this specific communication, the EU had included FGM/C among forms of gender-based violence and violence against children, as stated in its *Strategy for equality between women and men: 2010-2015* (European Commission 2010), in the *Directive 2012/29/EU*, on the rights of victims

(European Union 2012), and in the *EU Agenda for the Rights of the Child* (European Commission 2011).

The EU communication of 2013 was developed on the basis of a written opinion of the EU Advisory Committee on Equal Opportunities for Women and Men, and on the basis of the recommendations of a high-level round-table on FGM/C. It covers internal and external policies, and develops a holistic, integrated approach, with particular emphasis on prevention.

## 2. PENAL LAW AND FGM/C

### 2.1. Penal laws in Africa, the Middle East and Asia

Magaly Thill (*URJC*)

Article 5 of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (2003) stipulates, 'States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards, including [...] prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them.'

In accordance with this obligation, 24 African countries have already enacted laws against FGM/C (see Table 1), and in the other countries, the practice may be prosecuted through general provisions on injury.

**Table 1. Countries with laws against FGM/C and dates of adoption**

Country	Year of adoption of penal laws
Benin	2003
Burkina Faso	1996
Central African Republic	1966, 1996
Chad	2003
Côte d'Ivoire	1998
Djibouti	1995, 2009
Egypt	1996, 2008
Eritrea	2007
Ethiopia	2004
Gambia	2015
Ghana	1994, 2007
Guinea	1965, 2000, 2006
Guinea-Bissau	2011
Kenya	2001, 2011
Mauritania	2005
Niger	2003
Nigeria	2015
Senegal	1999
Somalia	2012
Sudan (two states):	
State of South Kordofan	2008
State of Gedaref	2009
Tanzania	1998
Togo	1998
Uganda	2010
Zambia	2005, 2011

**Sources:** Kaplan, Adriana, Suiberto Hechavarría, and Noria Liset Puppo. 2010. *Manual on Female Genital Mutilation/Cutting for health professionals: The Gambia* (2<sup>nd</sup> edition), 35-36. Barcelona: UAB, Bellaterra; and United Nations Population Fund (UNFPA). 2015. 'Female genital mutilation (FGM) frequently asked questions.' Accessed November 4, 2016. [http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#banned\\_by\\_law](http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#banned_by_law).

Although studies have shown that FGM/C is also found in the Middle East (United Arab Emirates, Iraq, Kuwait, Oman, Yemen, Iran, etc.), in Western Asia (Indonesia, India, Malaysia, Pakistan and Sri Lanka) and among some ethnic groups in Latin America (Colombia, Ecuador and Peru), few countries have enacted legal bans on FGM/C: Yemen (2001), Colombia (Resolution No. 001 of 2009, by indigenous authorities) and Iraqi Kurdistan (2011). The taboo that still

surrounds women's sexual rights and sexuality in general, the description of FGM/C as a backwards practice, and the emphasis put by international agencies on the 'Africanness' of FGM/C may have all hampered the acknowledgement of its prevalence and non-African countries' adoption of legal provisions against it.

Although the legal ban on FGM/C makes clear what is wrong and what is right under the law, therefore giving legitimacy to the work of prevention, it continues to be widely practised. The sporadic enforcement of laws and low punishment rates have undermined their deterring effect and allowed FGM/C to be increasingly medicalised (Muthumbi et al. 2015, 38). When prohibition does not bring with it community education programmes aimed at effective changes in practices, it has the potential side effect of inhibiting people from seeking help in case of complications, increasing girls' mortality rates (Kaplan et al. 2010, 35-36). Moreover, excisors – most of them women – are not always aware of the ban, especially in rural and isolated areas. Additionally, cultural norms along ethnic and religious lines are usually more deeply rooted in countries with weak state institutions.

It is also worth remembering that penal laws may require several steps before enactment and face a lot of resistance in the process. In Sudan, for instance, the 2008 Children's Act project was reviewed by the Council of Ministers, and its 13th article, which banned FGM/C, was dropped because of a fatwa of the Islamic Jurisprudence Council, which called for a distinction between the different types of FGM/C, and not to ban the practice known as Sunna (cutting of the clitoris) (Redress 2009). On the contrary, the Kenyan ban on FGM/C, of 2001, was expanded in 2011 to apply to adult women, and an extraterritoriality clause was added, extending prosecution to citizens who commit the crime abroad.

## 2.2. Penal laws in the European Union

Els Leye (*VUB*)

In the European Union, FGM/C is prohibited under FGM/C-specific criminal law or under general criminal law. In countries where FGM/C is prosecutable under general criminal legislation, provision and articles on bodily injury, serious injury and mutilation are applicable to FGM/C and can be used to prosecute a person in a court of law. In other countries, criminal laws that deal specifically with FGM/C have been introduced. This is the case for Austria, Belgium, Croatia, Cyprus, Denmark, Germany, Ireland, Italy, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the UK (EIGE 2015; Johnsdotter and Mestre i Mestre 2015; Leye and Sabbe 2009).

It is important to take into consideration the principle of extraterritoriality when prosecuting FGM/C. This principle makes it possible to pursue the practice, even when it is committed outside the borders of a European country (e.g. in

Africa). Conditions for the application of this principle differ from state to state (for an overview, see Leye and Sabbe 2009). The majority of EU countries include this principle in their general criminal law, and all EU member states with FGM/C-specific laws foresee the principle of extraterritoriality in their respective laws (EIGE 2013).

It is, however, important to carefully consider the implementation of criminal laws. A number of obstacles have been identified therein, most notably regarding the reporting of cases and in finding sufficient evidence to bring a case to court (Leye et al. 2007). Prosecuting parents should not be the primary focus of a country's intervention to work towards the abandonment of FGM/C. Once the act has been performed, prevention and protection have failed. In order to bring about sustainable social change towards the abandonment of all forms of FGM/C, efforts should be primarily focused on the prevention of the practice, rather than developing and implementing repressive measures.

### **2.3. Perpetrators and cultural motivations**

Magaly Thill (*URJC*)

Most often, excisors are women from the victim's community or family who earn their living from this activity. The practice of FGM/C also provides them with a social status, as initiator of this culturally valued rite of passage. According to social, cultural and religious beliefs, FGM/C is considered by both parents and excisors to be a practice that will benefit the victim, whose marriageability will be increased.

Although FGM/C might be practised in secret by excisors who come for visits, girls who live in European countries (where FGM/C is a criminal offence) are usually brought back to the country of origin to undergo the procedure, in order to avoid prosecution. This has led to increasing recognition of the principle of extraterritoriality in the prosecution of FGM/C –although, often, either the offender or the victim must be a citizen or a resident of the European country concerned– and the cancellation of the double-incrimination principle (EIGE 2013, 43).

Although parents may be sued as perpetrators for aiding or abetting the commission of FGM/C, the difficulty of bringing a girl to testify against her parents, as well as the negative consequences on her well-being of the implementation of a prison sentence on one or both of them, is a dilemma to be weighed, as the best interests of the child should prevail.

## **2.4. Legitimacy and the effectiveness of penal law: The proportionality principle**

Julia Ropero Carrasco (*URJC*)

Penal law is an institutionalised, coercive instrument that has the main effect of enacting perpetrators' imprisonment, depriving them of their right to liberty. Thus, in the international community's cultural and political tradition of human rights and democratic values, the use of penal law is limited by the principle of minimum intervention: to be legitimate, a penalty must be effective and avoid breaches of fundamental rights and interests.

In terms of FGM/C, the legitimacy of penal intervention is based on the protection of essential human rights: the right to life, to physical integrity, and to health, in a wide sense, including the right to full enjoyment of sexuality as an essential part of every person. In this sense, the question of consent hardly has any relevance. It definitely does not if/when we are dealing with minors, since, legally, a minor cannot give valid consent. Moreover, neither compared law nor international law recognises full validity of consent for adults when physical integrity and health are undermined. In these cases, consent is only used as an adjustment to a penalty, but it cannot allow exemption from a penalty.

The effectiveness of penal law poses several problems, too. In countries of origin, mainly in sub-Saharan Africa, the low investigation rate and limited punishment of the practice, despite its explicit criminalisation, have consolidated the belief that FGM/C is justified as a cultural right and, therefore, stands outside the scope of penal law. In the destination countries, the effectiveness of penal law is threatened by two factors: firstly, migrants are unaware that FGM/C is illegal, or they believe that the offence is not prosecutable; and, secondly, because the human drama of a penal intervention can dissuade judges from sentencing offenders (Sanz Mulas 2014, 42). Regarding the last point, there is a debate on whether the heavy penalties for genital mutilations in most Western countries are proportionate to the injuries caused, or whether it is necessary to make distinctions between different cases.

## **2.5. Problems arising from the enactment of penal law**

Julia Ropero Carrasco (*URJC*)

The application of penal law to punish FGM/C in Western countries has come up against a series of practical problems, but also against others, of a social and ethical nature.

From a technical point of view, providing evidence of FGM/C is not a difficult task – any doctor or health professional can ascertain it and offer a

valid testimony in the penal process. Nevertheless, obstacles appear in two areas, essentially: determining the place where FGM/C was practised (and this is important in establishing the competence of the court), and determining the person to be held responsible for the offence. To overcome the first obstacle, some countries recognise the competence of their courts regardless of the place where FGM/C took place, provided that the victim finds herself in an area under their jurisdiction (Torres Fernández 2005, 943-44).

Most countries recognise the responsibility of the parents, derived from the omission of looking after or protecting their daughter, regardless of whether or not they participated directly in the procedure. This responsibility by omission requires the existence of wilful default – that is, that the father or the mother knew about FGM/C being performed on their daughter. This is why error or ignorance is a circumstance that has to be taken into account. If the parents are unaware of the fact that FGM/C has been practised on their daughter, exemption or adjustment of the penalty should apply. The error may also be related to the prohibition of the practice, e.g. if the parents did not know that FGM/C was prohibited or, knowing that it was, they believed that there were grounds for justification based on the legitimate exercise of a right. This situation is not unreasonable to assume in the case of migrants who come from countries where the practice is widespread, despite prohibition. Once again, this circumstance could lead to an adjustment of the penalty (Ropero Carrasco 2003, 368-74).

Finally, if penal law and society in general want to strengthen their interest in protecting victims, they cannot avoid the ethical dilemma of penal intervention. Whereas the need to protect minors may lead to the imprisonment of parents and the enabling of official mechanisms of reception and care for the child, the application of such penalties leads to dismantlement of the family unit in a particularly disadvantaged social sector. Moreover, the labelling of migrants as criminals which is derived from the penal punishment represents an obstacle to the best protection of victims of FGM/C.

### 3. MIGRATORY LAW AND ASYLUM

#### 3.1. Asylum and FGM/C

Rut Bermejo Casado (*URJC*)

The UNHCR's *Guidance Note on Refugee Claims relating to Female Genital Mutilation* of May 2009 (UNHCR 2009) states that a 'girl or woman seeking asylum because she has been compelled to undergo, or is likely to be subjected to FGM/C can qualify her for refugee status under the 1951 *Convention relating*

to the Status of Refugees'. The UNHCR guidelines deem FGM/C a form of gender-based violence that inflicts severe mental and physical harm and amounts to persecution.

In this sense, the *European Parliament Resolution of 2 February 2006 on the current situation in combating violence against women and any future action*, assures us that, despite the fact that FGM/C is not literally stated in *Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted*, those practices are included in the concept of acts of sexual violence. Additionally, although no EU member state except Hungary mentions FGM/C in its provisions on asylum, national laws leave room to claim for asylum on the grounds of fear of being subjected to the practice, including reinfibulation, as a form of gender-based persecution or as a gender-/child-specific act of persecution.

For instance, the Spanish Supreme Court claimed, in its sentences of 15 February 2007, 11 May 2009 and 15 June 2011, that 'where there is enough evidence, according to the circumstances of each case, that a woman is persecuted on the basis of her gender, which has been the reason why practices that are contrary to human dignity, like forced marriage and mutilation of a genital organ, were imposed on her, and that the legal framework of the country of origin doesn't provide effective legal protection, asylum protection has to be given in light of the articles 3 and 8 of the *Law 5/1984, 26 March, on asylum and refuge condition*' (Pérez Vaquero 2010).

In the European Union, 14 other countries have already provided international protection to asylum seekers on the basis of FGM/C: Austria, Belgium, France, Germany, Hungary, Ireland, Italy, Lithuania, Latvia, the Netherlands, Romania, Slovakia, Sweden and the United Kingdom (EIGE 2013, 46-47).

### 3.2. Family reunification and FGM/C

Julia Roperó Carrasco (URJC)

The right to family reunification is a migrant's right to maintain the unity of his/her family. This right is justified by other fundamental rights, recognised in treaties and in international human-rights law, like the right to privacy and family life. *Council Directive 2003/86/EC of 22 September 2003 on the right to family reunification* aims to establish common norms that enable members of the family of nationals from outside the EU who legally reside within its territory to be reunited with their families in the country in which they now live. In compliance with this Directive, most European countries have embedded provisions to enforce this right in their national legislation on migration.

In practice, the right to family reunification can come up against the penal prohibition of FGM/C. This happens when a migrant wants to exercise his/her right to family reunification with regard to a daughter who has undergone FGM/C in the country of origin. The arrival of the minor could end in a penal process against the father or, what is more likely, against the mother, who is often the parent who is reunited and is commonly considered to have agreed to practising FGM/C on her daughter. Then, the penal prohibition of FGM/C is an obviously dissuasive element against this very legitimate aspiration of family reunification (Ropero Carrasco 2003, 384-85).

### **3.3. Stigmatisation versus integration**

Cristina Santinho (*ISCTE-IUL*)

The term ‘mutilation’, associated with criminalising policies, has generated heated debates, particularly in feminist anthropology (Walley 1997). Several authors have pointed out that the use of this term, allied with the criminalisation of FGM/C, risks stigmatising the families and women who practise it.

Some considerations need to be taken into account:

1. Western arguments for legal pursuit and condemnation are responsible for the concealment of the practice. This is due to the fact that, on a cultural level, people think that they are doing something positive for the future integration of girls into society, for example, guaranteeing a socially adequate marriage.
2. The term ‘mutilation’ may be rejected because FGM/C might be considered, for those who practise it, an embellishment of the sexual organ, providing future advantages for the married woman.

Several anthropologists and activists suggest use of the term ‘cut’ or ‘excision’ instead of ‘mutilation’, in order to avoid stigmatisation and concealment of the practice. The limitation of language echoes the complexity of this theme.

The integration of communities that undertake this practice in a Western context and the desired end of FGM/C should rely on the development of non-discriminatory and non-stigmatising actions and policies. Health and educational projects aimed at the eradication of this practice are more effective when working closely with communities. Intercultural dialogue aimed at a mutual agreement for the eradication of FGM/C should be a natural consequence of a more generalised promotion of the profession of intercultural mediator.

### 3.4. International cooperation and prevention of FGM/C

Cristina Santinho (ISCTE-IUL)

A literature review shows that the measures adopted in international cooperation for the eradication and prevention of FGM/C have not been highly effective. The United Nations has warned that, in spite of sustained rates of decline over the past three decades, population growth may result in up to 63 million more girls being cut by 2050 (UNICEF 2016). The alarming number of girls who are still submitted to FGM/C brings us to the conclusion that international cooperation on its legal aspects and increasing criminalisation of the practice in national laws may continue to have reduced effects, unless a different strategy is put in place and policies take into consideration the deep sociocultural roots of the practice, both in countries of origin and across the diaspora (Shell-Duncan 2008; Shweder 2002; Thiam 1983).

Additionally, while laws determine sentences for the people responsible for the practice, the penal consequences are hardly felt. While very few cases are brought to the courts and, in the context of wide sociocultural support, the imprisonment of perpetrators and/or parents is unlikely, the adoption of criminal law against FGM/C will not deter parents from cutting their daughters. This shows us that a legal ban alone is not sufficient, and the need to emphasise/increase social dialogue between state institutions, NGOs and local power networks, in both Western contexts and countries of origin, will lead to the abandonment of the practice through effective prevention programmes.

International cooperation for the elimination of FGM/C will be as effective as its capacity to consolidate institutional networks and local associations, co-opting religious leaders, excisors and other actors responsible for the practice, and key professionals in schools and social- and health-care services. We can also predict that efficiency in the eradication of the practice will increase the more we focus on the protection of children, through instruments like the UN's *Convention on the Rights of the Child* (UNGA 1989) and the massive implementation of girls' access to schooling.

### **Box 1. Practical exercises to be used in the classroom**

#### **Practical exercise No. 1:**

Students should carefully read the provisions on FGM/C in national criminal law and the following case.

A Senegalese man has lived in your country for several years, and he has been granted administrative recognition of his rights to family reunification. His wife and daughters have recently come to your country. When the oldest girl, aged eight, goes to a health centre in your country for the first time, the doctor concludes that she has undergone FGM/C and files a complaint. While the father is acquitted, the mother is arrested on charges of injury caused by the practice when the girl was in her custody in Senegal.

Students will be then divided in two groups:

1. One group will try to demonstrate that the mother should be indicted, adopting the position of public prosecutor.
2. Another group will prepare the defence of the mother. Acting collectively as the defendant's lawyer, they will also take into consideration elements relating to the protection of the child.

In the debate, students should highlight the conflicting rights at stake (those of the mother, the daughter, and the youngest daughter, aged three months, who has not undergone FGM/C).

#### **Practical exercise No. 2:**

DB, a Nigerian woman, has applied to the Spanish Ministry of Domestic Affairs for asylum. In her application, she stated that she was born in Uselu, a city in the south of Nigeria, close to Benin City. She explained that, in her village, her father arranged her marriage to a much older Muslim man, who enjoyed positive socio-economic status and was already married to two young women. The applicant had also been submitted to FGM/C. In order to escape this marriage, she refused to consent, first fleeing to Togo and Ghana, and, afterwards, to Spain. Nowadays, she lives in Valencia, and she is in a personal relationship with someone else.

The Ministry of Domestic Affairs, in its 14 April 2004 Resolution, denied the applicant's request for asylum, arguing that her statement was implausible and incongruous, and that evidence of persecution was non-existent. The applicant appealed the resolution before the National High Court, which partially denied the right of asylum in its sentence of 24 March 2006. However, after evidence of FGM/C was admitted, the court approved the decision to allow the applicant to stay in Spain on humanitarian grounds, under Article 17.2 of Spanish Asylum Law.

This decision was also appealed by the applicant, on the basis of a violation of Article 3.1 of Spanish Asylum Law and Article 1.A.2 of the Geneva Convention. According to the applicant, she complied with the legal conditions for refugee status (physical and psychological injuries due to FGM/C and the risk of forced marriage). The Supreme Court, in its sentence of 11 May 2009, ruled in her favour, recalling previous judgements in which it concluded that a situation of vulnerability and social, political and legal marginalisation of a woman in her country of origin, which infringes on her human rights in an evident and serious way, is a reason for asylum. The court also determined that the persecution-for-gender reason, including harassment and threats to force a woman to get married, may be interpreted as part of social persecution. The court also affirmed that in Nigeria, FGM/C is commonly practised on adult women, and these women do not have effective legal protection against these practices in that country, therefore recognising the applicant's right to asylum.

In another case, the same court (in its sentence of 4 May 2008) had repealed the right of asylum from a Nigerian woman who had fled for reasons similar to those of DB. She was living in Warri, and when she was twelve, a suitor to whom she did not want to get married was accepted by her father, who tried to make her undergo FGM/C. She refused, and she was beaten several times until she managed to flee with the support of her mother and a friend. The court dismissed the application, judging that no sufficient information had been provided on the geopolitical situation of Nigeria to justify asylum.

**Questions:**

1. Taking into consideration national and international provisions on asylum, is the denial of asylum well founded?
2. Critically assess (with arguments favouring and against) the fact that the situation in Nigeria around the protection of women's rights is considered differently in both judgements.
3. If asylum is given to a Nigerian woman on the grounds of FGM/C, as judged in the sentence of 11 May 2009, how is this decision compatible with punitive measures taken against mothers with FGM/C who arrive to Spain with their daughters, who have also been subjected to FGM/C?

**Box 2. Evaluation**

1. Select and analyse two criminal judgements on FGM/C, one conviction and one acquittal, adopted by a national or regional court. You can refer to national and international legislation and jurisprudence. Give your own opinion, taking into consideration the dilemmas that the decisions pose.
2. Answer the following questions.
  - Do you consider penal law a useful instrument in combatting FGM/C?
  - What are the risks entailed by penal intervention?
  - What legal principles should prevail in the persecution of those who have committed FGM/C?

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## **Chapter VI.**

### **Social work, education and psychology**

#### **Didactic objectives:**

1. To improve the cultural competencies of students in social work, education and psychology in relation to FGM/C issues;
2. To promote intercultural dialogue on sensitive subjects like FGM/C;
3. To find strategies to deal with, and support girls and women with, FGM/C; and
4. To encourage debate and discussion through critical cases and dilemmatic examples.

#### **Summary:**

1. Social work (Cecilia Gallotti, Roma3)
  - 1.1. General aspects
  - 1.2. Practical aspects
  - 1.3. Critical aspects
  - 1.4. Dilemmas
  - 1.5. Orientations
2. Education (Valentina Vitale, Roma3)
  - 2.1. General aspects
  - 2.2. Critical aspects
  - 2.3. Orientations and suggestions
3. Psychology (Carla Moleiro, ISCTE-IUL)
  - 3.1. General introduction, theoretical references
  - 3.2. Practical aspects
  - 3.3. Orientations for evaluation

#### **Boxes:**

Interview excerpts (Gallotti 2009)

Discuss the different responses: To talk or not to talk about it?

Discuss the following dilemma: 'How could I discover their real thoughts?'

Suggestions for case analyses

A suggestion for a case analysis in class

Discuss the following dilemma.

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## 1. SOCIAL WORK

Cecilia Gallotti (*Roma3*)

### 1.1. General aspects

The engagement on FGM/C in migration contexts has highlighted the need for a greater connection between the social and health sectors, and for a shift from an exclusively clinical-care view towards an approach that addresses the phenomenon in its sociocultural complexity. Today the issue of FGM/C is incorporated into the social policies of EU countries, not only with goals related to contrast, but also those related to prevention, in terms of the 'social integration' of women and girls involved in FGM/C practices.

Beyond the specificities and significant differences among the strategies adopted, it is possible to identify some general social-work trends in FGM/C prevention: implementing integrated social and health networks as a basis for a model of coordinated action; organising reception procedures and dedicated support services; training social workers; and the realisation of educational activities for younger generations in schools and local associations.

### 1.2. Practical aspects

#### *Local and integrated social and health networks*

The main objectives of networking include:

- the coordination of efforts at the social- and health-care levels, e.g. gynaecology, obstetrics, paediatrics, general medicine, nurses, sexologists, psychologists, social workers, educators and mediators, but also professionals working in the fields of asylum and trafficking;
- integrating the actions of diverse stakeholders (other services and associations) at local and national levels; and
- effective outreach work, to inform and raise awareness about FGM/C prevention among women and their families in a coherent and widespread manner.

This last point is clearly a delicate one. On one hand, information on legal and health aspects offers women the ability to understand how their circumcision is interpreted in the migratory contexts in which they live. On the other hand, communication aimed at prevention can cause stigmatisation and, consequently, cultural resistance.

Often, 'top-down' unilateral messages of prevention do not consider the intercultural relations that underlie FGM/C. That is why some networks have introduced participatory and community projects using mediators and *femmes-relais*. It is understood that most of the women involved regard the topic of FGM/C as a private matter, and moving it into the public domain should not be taken for granted.

### *Dedicated reception procedures*

Some contexts are considered particularly significant in prevention work: health care, pregnancy and childbirth; counselling and youth centres dealing with sex education; and reception centres for asylum seekers.

Regarding health-care settings, certain hospitals and other services with a high number of women with FGM/C are equipped with specific systems for deinfibulation needs related to childbirth (and eventual/subsequent requests for reinfibulation) and, in some cases, even for psychological counselling. Regarding social services, dedicated hubs are not strictly necessary. Some national and international associations (GAMS Belgique and INTACT 2014) have pressed to designate and train 'reference persons', as a contact within the service itself, to accompany/advise colleagues dealing with FGM/C cases. Furthermore, setting up a pool of intercultural mediators and community leaders on the topic of FGM/C has been advocated.

### *Awareness and training of professionals*

Although dedicated training has already taken place in certain contexts, social and health professionals continue to feel little competency when it comes to this issue (Simonelli et al. 2013). They question their own roles, the duty or extent of professional secrecy, the appropriate approach to adopt, etc.

The general aims of social workers' training include:

- increasing their knowledge of the contextual variability of female genital modifications;
- improving their competencies in interacting with women with FGM/C; and
- providing them with interview techniques in interpersonal dialogue when relating to families.

Some specific objectives can also be highlighted.

Social workers' training should transmit knowledge about FGM/C and practical guidance, but also aspire to provide a more complex and critical comprehension of the phenomenon itself, in particular, by:

- putting FGM/C in a broader matrix of cultural representations of health, sexuality and body-modification practices, considering the historical and cultural changes of the 'traditions' in global landscapes;

- providing knowledge on territorial variability, the plurality of migratory stories, and the differences in life contexts of women with FGM/C;
- taking into account the specific system of power, of gender and generations, and the negotiations within families and groups to which women belong; and
- considering women's points of view on social and health services, modalities of access to and use of these services, their perceptions and needs regarding the medical treatment of FGM/C, and, more generally, in relation to their intercultural interactions.

### **1.3. Critical aspects**

Prevention work can no longer be viewed as a one-way process. Research exploring the points of view of migrant women with FGM/C shows that 'tradition' is now placed in a global and networked context of meanings, in which the functions of the practice change and the paradigm of negative judgment, at least in principle, is becoming hegemonic. This has the power to generate some contradictions and new vulnerabilities connected to stigma and intercultural relations.

In fact, in the context of social services, placing intercultural relationships in the 'humanitarian framework of aid' (Fusaschi 2015) and FGM/C in a conceptual frame of 'condemnation' is commonplace among professionals. It has been observed that this not only hinders participation by women in prevention programmes, but also contributes to creating specific vulnerabilities related to the stigma of 'being circumcised and therefore reprehensible'.

These women can no longer be considered targets for support strategies by 'other' women, supposed to be better and 'freer'. Prevention work must be placed in the wider framework of alliance and not aid, recognising the fact that these women seek greater participation, laboriously form their own associations, and report problems with a lack of public spaces. In short, they call us towards a new common strategy about the 'integrity' of the body and 'social integration'.

### **1.4. Dilemmas**

Many social workers 'discover' FGM/C only when they accompany the women with whom they are entrusted for routine gynaecological examinations. Even in health-care settings, except in cases of childbirth, professionals do not recognise FGM/C easily, particularly in cases of excision. One of the most commonly reported dilemmas is what we call 'the denial cycle'.

### Interview excerpts (Gallotti 2009)

A gynaecologist working in the public service:

*'When I'm carrying out the visit, I ask what happened, how and why, but they avoid [the question] and smile without going into details. I don't know if it's reluctance or if they don't even understand why I ask them, like I'm asking why they have an ear.'*

A Nigerian woman, a service user:

*'It's the first time that these workers see the women. They look at them strangely and don't know what to say, but I am a bit ... ashamed because – even now – even now, if I have to go for a medical visit, they think badly, yes – "What is this thing? What is this?" – just because you don't know about it! So they look at it like it is something strange – "God, this is disgusting!" – but if I see a doctor who is black like me, no!'*

The preconception of the 'cultural taboo' surrounding FGM/C can become a double bind with paradoxical effects: both parties seem caught in a mutual system where one thinks the other is unwilling to talk. However, according to the well-known axiom of communication theory, 'one cannot *not* communicate,' what is unsaid on excisions inevitably generates vague interpretations and reciprocal stereotypes and misunderstandings, all of which end up increasing distance and incomprehension.

### Discuss the different responses

#### To talk or not to talk about it?

1. Respecting the supposed cultural taboo and avoiding problems by naming FGM/C in an inappropriate manner and disrespecting the intimacy and privacy of women.
2. Talking about it because an awareness of the problem is a crucial element of prevention and discouragement to the perpetuation of FGM/C on girls.
3. *'Asking is necessary, and enquires, but there's no need to call many people! It's a personal thing – personal! – so you ask, then I'll explain what it is.'* (Extract from an interview with a Somali woman in ethnographic research; Gallotti 2009.)

### Discuss the following dilemma

*'How could I discover their real thoughts?'*

This was the question being asked by Christine Walley during her fieldwork in Kenya (Walley 1997). She interprets women's resistance to talking about FGM/C as being caused by the fact that they cannot publicly criticise circumcision.

In migratory contexts, the same question often arises in the minds of professionals who encounter women with FGM/C, but the cause of their resistance to talk seems to be reversed because it is derived from the fact that they cannot publicly criticise *them*. Discuss this apparent paradox.

### Suggestions for case analyses

A female mediator who works in an advice centre attended by women with FGM/C 'confesses' to a colleague whom she trusts to having been, in the past, an operator of male and female circumcisions in her country.

- *So, when you were little, you saw your dad doing it?*
- *Yes, yes, but here I do not. No, my father was not a doctor – it was something he learnt from his father. It is passed down from father to son. He explained to me that the women's was easier! Both of the labia minora are removed from the bottom ... remove all this and all that, then remove a little of the clitoris – you take away a bit, a piece, and that's enough. Instead, for the males, it's necessary to pull it all up, up to the top, because a person who knows how to do it understands when everything is already pulled up, and then cuts ... also loses blood, they tie it with a thread – black thread we use. Here, they do it at home, they don't know how to do it or don't have the right things, but all that I do here is just pierce ears – that's it. I don't do anything else (Gallotti 2009).*

#### Discuss the different reactions that might follow from this case:

1. Report the matter to the head of the centre or consider it a professional secret.
2. Keep an eye on the mediator to see if she lies or double-crosses the centre, or try to find a way to valorise her competencies.

List other, similar situations. Role-play in reverse (mediator/colleague) to explore the emotions and reflections on your own reactions to the coming-out of the mediator.

## 1.5. Orientations

Reflect on the meaning and use of silence by women. Silence can be subversive. The supposed reticence of women to talk about FGM/C with social workers may have to do not only with an understandable need to protect oneself, one's private sphere and social integrity, but also with intercultural stigma, and with the difficult management of pluricultural belonging in a world that judges FGM/C as 'barbarity'.

Note that the social-/health-care system itself, with its institutional categorisations, is part of an ongoing process of change. Therefore, a decisive factor in an adequate intervention is the critical reflection of the service itself, on its language and its ideologies.

Consider FGM/C not only as objective problem to be prevented, but also, especially in migratory contexts, as an element of a field of interactions in which we are all included. In this sense, for those who work in social services, it is primarily important to exercise cultural decentralisation and improve intercultural competence.

## 2. EDUCATION

Valentina Vitale (*Roma3*)

### 2.1. General Aspects

Another important area in the application of social-prevention projects regarding FGM/C is the educational and school environment. How to deal with young girls and women is a complex matter. The private and intimate sphere of family has to be considered. This is extremely delicate and controversial at the same time. Because of some experiments that have been made in some countries of origin, a strong debate has been raised.

In some African countries (e.g. Burkina Faso<sup>16</sup>), some schools have adopted procedures like the examinations of girls' genitals during school medical examinations – a practice that is considered discriminatory and traumatic for the child at risk. Perhaps, in these cases, a softer approach would be the right path to follow to open a dialogue with the children, and possibly the parents, during the medical examinations, but the education issue has become more evident in countries of migration flux, especially.

On one hand, confrontation with the social and cultural structures of the country of immigration can lead to a greater awareness of the damages of this kind of operation and open up to questioning the reasons why these practices are still perpetuated. On the other hand, the pressure to maintain the practice may even increase in the migrant community because the feeling of protecting a 'cultural identity' and traditions is strengthened. In migratory contexts, then, FGM/C can be, for parents of girls, a path for strengthening sociocultural traditions, and a way to keep families symbolically attached to their roots and have them accepted into society when they return to their countries of origin.

Since these girls attend school in European host countries, teachers and school operators should be actively involved in the initiatives and interventions of training and awareness on FGM/C.

The growing size of migration flows over the years has strengthened the debate about the inclusion of immigrant students in hosting countries. The school represents an institution that contributes to the dynamic inclusion of migrants, first of all, because it is usually one of the first institutions in which migrant families establish a stable relationship, and, secondly, because of the educational and relational connection between the parties involved.

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<sup>16</sup> Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH. 2011. 'Ending Female Genital Mutilation.' Accessed December 1, 2016. <https://www.giz.de/expertise/downloads/giz2011-en-fgm-bildung.pdf>.

The school environment is an important context for social inclusion, and other institutions look to it as a possible base for discussion, information and the prevention of FGM/C. It is believed, therefore, that schools should also provide the appropriate knowledge, skills and intervention instruments capable of identifying girls who are potentially at risk thereof and take action towards the parental choice of practising genital modifications on their daughters.

## **2.2. Critical aspects**

Surely, teachers and experts have the right knowledge and tools to handle every case of genital modification (according to statistics so far, they rarely do). From a critical point of view, in the school context, education, prevention and enforcement regarding FGM/C means essentialising the issue of violence, spreading social worries and contributing to increasingly negative stereotypes of the African continent, thus creating discrimination against migrant pupils coming from the areas where FGM/C is practised.

Teacher and school-staff training and awareness-raising initiatives for pupils and parents should not be centred on the issue of FGM/C. Schools should not talk about it exclusively, but about a much bigger issue, such as gender-based violence. The role of schools and teachers is to create inclusion and increase socialisation among students who have different experiences and backgrounds, minimising forms of discrimination and exclusion.

It is essential, therefore, that teachers and school staff are trained and prepared to:

- deal with cultural and linguistic differences, as well as disabilities and learning issues, to avoid the risk of creating a non-uniform method of analysis;
- implement alterity education models, helping pupils and parents to overcome assimilative and ethnocentric positions;
- reduce difficulties in pupils' school integration; and
- contribute to the reduction of early school-leaving.

Additionally, the school has the task of disseminating the correct information, promoting prevention, enforcing and raising awareness about gender-based violence, and developing projects or activities to prepare teachers and encourage young students to reflect on issues such as gender as a social construction, stereotypes and gender biases, patriarchal patterns, gender discrimination and sexual violence against women, domestic violence, bullying, etc.

In addition to its gender-based-violence discussions with students, the school should deal with other issues that affect the body, like sexuality and other

types of modifications (being transgender, for example), inserting FGM/C into a wider discourse about bodies and culture.

In this way, the school will spread the idea that gender-based violence is a widespread problem in Europe and cannot be solely attributed to non-European contexts, and therefore only identified in FGM/C practices.

### **2.3. Orientations and suggestions**

In the event that a minor subjected to FGM/C is encountered in the school, there are some important aspects to consider regarding the mode of action. Health services (e.g. a paediatrician, a gynaecologist, etc.) and social services (e.g. family counselling) should be contacted. They can play an important, supportive role, especially in family relationships. If the child or other family members have communication difficulties because of a language barrier, involving a language mediator who can act as an interpreter is recommended.

The school, then, in collaboration with the health and social services, is responsible for promoting a climate of mutual trust, avoiding attitudes of cultural superiority and refraining from any value judgment, to establish contact and open a dialogue with the child's family.

It is essential to avoid making stigmatising actions towards both the family and the minor, who may not perceive themselves as 'mutilated'. By making them perceive this, it creates a perception of the child being a 'victim'. The school intervention, along with that of the relevant services, must take into account the fact that parents may not be comfortable speaking publicly about FGM/C. This is because talking about anything having to do with sexuality is taboo for many migrant communities. An intervention within a protected system like the family is often perceived as an interference in confidential matters, which have nothing in common with the rest of society.

This attitude may be misunderstood by migrant families, who are coming from different social and cultural contexts to the Western one in which they now find themselves, and extraneous to the institutional systems of intervention. Finding appropriate communication channels also depends on a growing awareness on the part of communities that practise FGM/C that it is, in European countries, a violation of the law.

If a case of FGM/C performed on a minor is found in the school, it is necessary to avoid any kind of aggressive or exclusively repressive intervention that would lead the family to withdraw the child from school, causing further damage to her personal growth and social inclusion.

### 3. PSYCHOLOGY

Carla Moleiro (*ISCTE-IUL*)

#### 3.1. General introduction, theoretical references

##### *Intercultural counselling competencies*

As psychologists, we frame the work in this field within the domain of intercultural counselling and/or clinical competencies. Originally conceptualised as cultural sensitivity or responsiveness, definitions and perspectives on the meaning of intercultural competence vary.

The foundations of multicultural counselling were laid down by Sue, Arredondo and McDavis (1992), who presented a tri-dimensional model that posited the central role of (i) the counsellor's/clinician's awareness of his/her own values and biases, and the patient's world view; (ii) knowledge; and (iii) culturally sensitive intervention skills/strategies (Arredondo et al. 1996).

The first dimension, awareness, refers to the way that the helper's attitudes, beliefs, values, assumptions and self-awareness affect how s/he interacts with those patients who are culturally different to themselves. It involves the exploration of the self as a cultural being, and of one's own cultural preconceptions.

The second dimension, knowledge, relates to the informed understanding of cultures that are different to one's own, including histories, traditions, values, practices, and so forth. It also involves knowledge about such concepts and processes as cultural influences on psychosocial development, acculturation models and acculturation stress, ethnic and racial-identity development, cultural communication styles in the helping relationship, perceived discrimination as a risk factor in well-being, and culture-bound syndromes and culture-specific interventions.

Finally, an important third dimension is in the ability to engage in effective and meaningful interactions with diverse individuals, including the development of a relationship, by integrating one's awareness and knowledge into practical skills in the helping relationship, assessment and intervention (Arredondo et al. 1996; Pope-Davis et al. 2003).

Taken globally, all perspectives on intercultural competencies imply that practitioners (e.g. psychologists) in clinical settings are able to demonstrate their ability to provide adequate, quality care to culturally diverse patients. As such, it has been defined as a dynamic and complex process of being aware of, and recognising, individual and cultural differences, reflected in the practitioner's attitudes and beliefs, knowledge, and skills in working with individuals from a variety of cultural groups, including those categorised by race, ethnicity, religion,

gender, social class, sexual orientation, or disability (Constantine and Ladany 2001; Daniel et al. 2004).

### *A biopsychosocial approach (to health)*

A second, important theoretical foundation for psychologists who work with women and communities with FGM/C practices is the biopsychosocial approach to health. This approach defines health as an overall state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO 2000). As such, it frames health in a holistic (mental and physical well-being) and systemic (within a micro-, meso- and macro-systemic) context.

Health (and illness) processes are the result of biological (e.g. lesions and infections), psychological (e.g. individual behaviours and attitudes, stress, and coping mechanisms) and social factors (e.g. social support, community-health behaviours and social norms). Hence, developing interventions from a psychosocial approach to health (Straub 2013) means examining health-related topics such as FGM/C via psychosocial processes (e.g. gender, social identities and norms, intercultural processes, discrimination and oppression), and in a cultural context. It also means making use of the concept of 'social interaction' to integrate, in a coherent framework, the various levels of analysis in health issues: at the individual level, the interpersonal level, the group level, and the community level.

### **3.2. Practical aspects**

Psychological interventions in this context may take place at different levels, as follows.

**Individual:** Understand and examine the health, psychological, familial and social consequences of FGM/C for a particular child or woman, e.g. post-traumatic stress disorder and the relation of experiences of discrimination and prejudice to health and mental health.

**Interpersonal:** Promote cultural empathy in the professional relationship (including verbal and non-verbal communication), including the involvement of cultural mediators in the clinical context.

**Group level:** Understand and examine gender issues and group-membership identification, intervening, for instance, in support of victims of gender violence, in promotion of integration-migration processes (recognise ethnic-identity development models and acculturation processes).

**Community level:** Investigate community social norms, promote community empowerment, and involve community leaders, e.g. behavioural change with community engagement through the design of customised interventions based on a readiness to change and participatory action research (Barrett et al. 2015)

### A suggestion for a case analysis in class

A 25-year-old woman from Conakry, Guinea, presents at your clinic, referred by a primary caregiver. She presents with a set of somatic symptoms (e.g. strong headaches, chronic fatigue) and anxiety (e.g. she feels anxious outside the home and avoids social/community events). She is married and has two children, and she arrived in your country less than a year ago. She is currently expecting her third child, and her primary caregiver is providing prenatal care.

#### Discuss some of your concerns in this case:

1. Establishing the counsellor relationship.
2. Assessing her systemic context (marital, familial and social relations).
3. Co-constructing goals and tasks for your work with her as a counsellor.

### Discuss the following dilemma

You are working in a preschool in which three children from a refugee family were recently received. They come from Somalia. The children are aged two, four and five, and they are all girls. In the weekly school-team meeting, the teacher of the oldest child says that she (Muna) still has difficulty controlling her sphincter muscles and often wets herself. The school director informs you and the team that Muna's mother has said that she is circumcised, and she has maintained a problem with sphincter control since then. Some staff members express the opinion that you should notify Child Protection Services of this practice and family situation, and others do not.

### 3.3. Orientations for evaluation

1. Role-play the first consultation in a counselling situation.
2. Write a discussion of a case vignette.

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## Chapter VII.

# Anthropology and international development

### Didactic objectives:

1. To familiarise students with the anthropological approaches to FGM/C;
2. To raise students' awareness of the sociocultural implications of development policies related to FGM/C;
3. To understand the importance of the ethnographic-based approach to FGM/C; and
4. To highlight the importance of self-reflexive and critical approaches to humanitarian intervention.

### Summary:

1. Ethnography: FGM/C and cultural differences (Ricardo Falcão and Clara Carvalho, ISCTE-IUL)
  - 1.1. FGM/C, violence, sexuality and marriageability
  - 1.2. FGM/C as seen by men and the social pressure put upon women
2. FGM/C as a tradition and FGM/C as a social norm (Adriana Kaplan and Neus Aliaga, Wassu-UAB Foundation)
  - 2.1. A rite of passage and a rite of institution
  - 2.2. What is a social norm?
3. Moral economies and international development (Giovanna Cavatorta and Francesco Pompeo, University Roma3)
  - 3.1. Sites of intervention: Social arenas, multi-positioned subjects and local fields of definition
  - 3.2. Human rights and moral economies: An overview
  - 3.3. Researching the humanitarian and moral object of 'FGM/C'

### Boxes:

Debate: Knowing cultural differences

Debate: The study of sexuality in Africa

Debate: How is 'violence' perceived in different cultures?

Debate: Marriageability, inter-ethnic marriages, social pressure and contingency in West Africa

Debate: The significance of FGM/C

Debate: Anticulture or antiprogress?

Exercise: Role-playing

Evaluation

### Bibliographic references

## 1. ETHNOGRAPHY: FGM/C AND CULTURAL DIFFERENCES

Ricardo Falcão and Clara Carvalho (*ISCTE-IUL*)

FGM/C is a complex issue that addresses the opposition between individual rights and social norms, between external actors and local individuals, international institutions and national autonomy. The anthropological approach is aimed at understanding the multiple points of view on FGM/C. It tackles both the activities and the ethical justifications of the humanitarian enterprise involved in anti-FGM/C campaigns and the local intervenients, including those responsible, practitioners and subjects.

Anthropology favours a holistic approach to understanding FGM/C as part of a broader social construction of the gender difference in different societies. Female identities are built up to be in opposition and yet complementary to male identities, and this is embedded in their bodies in numerous and different ways, including FGM/C.

Through an ethnographic approach, based on detailed descriptions of the FGM/C processes and actors, anthropologists are able to understand the different experiences of the practice, its evolution and adaptation. They highlight actors' interpretations of social reality and cultural representations (the *emic* perspective), as opposed to the social representation of the same reality (the *etic* perspective).

Stressing the emic approach, some anthropologists favour the expression 'female genital modifications (FGMo)', which does not stigmatise women subjected to the practice as being 'mutilated', as in FGM/C. The anthropological perspective of FGM/C is concerned with cultural difference, perceived and elaborated as a relationship between observers and the observed, those brought up with FGM/C as a cultural reference, and those brought up without it. The study of this relationship and the limits of such knowledge are commonly defined as epistemology.

Anthropological epistemology states that an absolute knowledge of cultural otherness is not possible, and advocates for a 'methodological relativism', or relativism as method. Ethnography is the knowledge acquired by experiencing the perceptions of cultural otherness, the symbolic significance of being in the world, both as a collective identity and an individual self and body. This knowledge emerges from the multiple interactions of individuals in social life – their interpretations, representations and manipulations of the rules and social norms. It is a translation of the complexity of a social space, and an education into what it means to inhabit different realities.

Kirsten Hastrup tells us, 'Because individuals are by their nature parts of a larger social space [...] but also represent discontinuities within it [...] the social space is in practice permanently contested and reshaped. Fieldwork reveals how in practice agreements are reached or broken. The social space is dynamic ... (Hastrup 2005, 139).'

Ethnography is like an education on what it means to interpret the world from a particular point of view, rather than a method that we can apply to reality to make it talk.

Understanding the importance of ethnography in better explaining how FGM/C becomes a socially relevant practice, wherever it may occur, is:

- 1) to consider the existence of different social processes and negotiations in a social space because
- 2) social actors have a position that is complex, dynamic and changeable; and
- 3) the relative positions of social actors concerning the practice of FGM/C depend on a myriad of variables and contingencies (Hernlund and Shell-Duncan 2007); and
- 4) finally, to reject single strategies for tackling FGM/C or single explanations of the phenomenon.

#### **Debate: Knowing cultural differences**

Consider, for example, a Gambian woman of the Mandinka ethnic group going to a health centre in Barcelona. Knowing that, in her culture, women are normally circumcised as a rite of passage, would you consider FGM/C synonymous with her 'becoming a woman' and a factor in how she should be approached about the possibility of her daughter being cut?

### **1.1. FGM/C, violence, sexuality and marriageability**

*'Social customs [...] are not pathologies (Shell-Duncan 2008, 229).'*

Even if ethnographic knowledge is sometimes thought to be interpretative, this does not eliminate the possibility of using a structured analysis aimed at answering specific questions, contributing to a better understanding of concrete tendencies. This knowledge often interrelates unexpected realities and seemingly disconnected subjects. This approach is exemplified in studies of sexuality, violence and/or marriageability in African contexts.

#### **Debate: The study of sexuality in Africa**

Signe Arnfred, a Norwegian scholar who has studied sexuality in Africa, points to an often forgotten dimension when she considers:

*'... the ways in which issues of sexuality in Africa are conceptualised in contemporary (often donor-driven) investigations and debates, centring on illness and violence (HIV/AIDS, female genital mutilation). [...] Sexuality – and female sexuality in particular – seems to be linked to violence and/or death. Not much is said about pleasure and enjoyment, or desire – certainly not female desire (Arnfred 2004, 59).'*

The aforementioned highlights the fundamental contrast between ‘illness and violence’ and ‘pleasure and enjoyment, or desire’. This stark contrast underlines how sexuality-related issues in Africa are negatively charged, but also how there seems to be an inherent dualism between visions pointing to a negative reality and those stressing a more positive and empowered view of the world of women, where gendered visions are not reified into an all-encompassing patriarchy without the understanding of its particular manifestations.

FGM/C’s significance as a form of gender-based violence is limited when violence against women is sometimes widespread and part of everyday life. Methodologically, one should be interested in knowing that the negativity surrounding gendered perspectives seems to exist prior to any analysis, making it an issue in the practice of FGM/C. The clear-cut categories normally employed in an analysis of FGM/C do not refer to local conceptualisations, thus presenting important limitations in the understanding of local customs and perceptions. Thus, negative perceptions of FGM/C need very careful confirmation amidst social actors so that activists and researchers can understand the social support, or lack thereof, for the practice. Positive and negative biases towards FGM/C need to be explored in their full complexity, and a methodological-relativism approach should be employed – there are no high moral standards from which to judge reality.

Detailed descriptions can provide alternative and more complex perceptions. Women in FGM/C-practising communities may not perceive themselves as victims of violence. The idea of ‘violence’ needs to be culturally contextualised when it comes to FGM/C. This thinking led a US-based anthropologist of Sierra Leonean origin, Fuambai Ahmadu, herself circumcised, to express her concern that ‘most studies on female initiation and the significance of genital cutting relate to the continued insistence that the latter is necessarily “harmful” [...] based on the alleged physical, psychological, and sexual effects of female genital cutting [...] [and that] according to this line of analysis, excision is necessary to patriarchy (Ahmadu 2000, 284)’.

Ahmadu’s stance in the FGM/C debate is controversial, especially for subscribers to the zero-tolerance movement, but it comes as necessary subjectivity, making us reconsider the different realities that are subsumed into the abbreviation FGM/C, which she considers overly focused on infibulation, and thus on its most extreme form.

#### **Debate: How is ‘violence’ perceived in different cultures?**

Imagine that you are part of a community that practises FGM/C, and you feel that keeping traditions is an important element of your identity. How would you feel if people who did not share your cultural background told you that you were the victim of gender-based violence? Can you relate? Can you relate to recent examples of such approaches to cultural difference? Discuss the anti-FGM/C arguments, both as a consequence of the rights of individuals, children and women, and as a form of gender-based violence. Contrast these anti-FGM/C arguments with those in favour of keeping traditions, even if they entail instances of body manipulation.

Ahmadu's radical position, refusing a 'pro' or 'against' position towards FGM/C, reminds us of the complexity of the practices that lead to the cutting of women coming of age. The criminalisation of these practices has faced considerable backlash, indicating the strength and resilience of cultural beliefs. According to Ahmadu, practising communities in the Gambia no longer perform FGM/C in large festivities after the winter harvest, but in more restricted settings, and at increasingly younger ages. Her fieldwork in the Gambia has led her to understand FGM/C as an important gendering practice, not easily taken into account by outsiders adopting a global discourse thereon (see the third section of this chapter).

Promoting a 'behavioural change towards FGM/C', when such behaviour is rooted in social norms and beliefs, implies a capacity to understand what the experience of being cut says about gender roles as cultural constructions. Western explanations, based on rational-utilitarian paradigms, may be perceived as external and imposed by people with a different cultural background and world view. This amounts to saying that the rights of people protected by human-rights instruments are being externalised, meaning that they are being imposed upon by agendas that do not take into consideration their locality or the spatiality of social relations. Most of the local resistance to anti-FGM/C actions springs from bad management of 'cultural differences', expressive of the cultural conceptualisations of gender, personhood, family, social structure and morality, but also violence or pleasure, and illness or enjoyment. In different times and places, people conceptualise the world according to different cultural, symbolic and linguistic terms, holding different backgrounds and making use of different cultural representations.

There are 'strategic' social approaches to considering how the practice of FGM/C takes place, but, being a general trend, it does not confirm or deny any preconceived theoretical arguments, like the one that alleges that 'FGM/C exists because of men', and not as a means of constitution in parallel gender hierarchies, for example, in communities where men's circumcision is practised alongside women's.

## **1.2. FGM/C as seen by men and the social pressure put upon women**

On one hand, patriarchy is a general characteristic commonly associated with FGM/C, particularly via the feminist approach. On the other hand, the complexity of social dynamics contributing to its continuity also requires that concrete indicators be used in order to understand the attitudes regarding this practice.

A study that explores the knowledge and attitudes of Gambian men towards FGM/C provides us with an insight into the general perceptions thereof:

*FGM/C has been practiced for centuries, having acquired a deep cultural meaning. Under a shared vision of the world where life is understood in cycles, FGM/C had been linked with the moment in which a girl becomes a woman in many societies. During the*

*rite of passage to adulthood, within a ceremony secretly kept from outsiders, especially men, initiates were taught about the cultural and social wealth of their community, as well as their roles and responsibilities as women, mothers and wives, establishing gender power relationships (Kaplan et al. 2013, 2).'*

The same study shows how men take little part in the decision-making process, and that, consequently, 'FGM/C appears mainly as a women's choice (75,8%) or a decision of other relatives and community members (10,0%) (ibid., 4).' It also maintains that, 'Seen through men's eyes, the secret world of women remains embedded in cloudy concepts shaped by culture in ethnic tradition, also influenced by religion ... (ibid., 8).'

Attitudes and knowledge on both individual and collective levels are important to better understanding how the sociology of FGM/C influences its prevalence.

### **Debate: Marriageability, inter-ethnic marriages, social pressure and contingency in West Africa**

If marriageability is a common argument for the prevalence of FGM/C, it has different values in different cultural settings. In West Africa (in countries like the Gambia or Senegal) and in East Africa (in countries like Kenya), this widely accepted 'factor of prevalence' for FGM/C seems to have different, relative weights. According to Hernlund and Shell-Duncan:

'The issue of marriageability is central to the convention model proposed by Mackie (2000), and this concern certainly seems to be driving the practice in many parts of Africa. As Hernlund concluded from previous research in primarily urban areas of the Gambia, however, the assumption that FGC is necessary in order for a woman to "find a husband" is not borne out in this region (Hernlund 2003; see also Ahmadu 2005). For one thing, it is extremely rare to encounter in the Gambia a woman who remains unmarried against her will. Second, with interethnic marriage being so common and accepted, it is not credible to claim that a Gambian woman – from a circumcising group but herself uncircumcised – would perceive herself as not being able to marry at all, as her potential marriage pool includes men from non-circumcising ethnic groups' (Hernlund and Shell-Duncan 2007, 51).

Instead, Hernlund and Shell-Duncan consider that a much stronger element in the prevalence of FGM/C in Senegambian societies is social pressure.

'The driving factor behind the persistence of FGC has been a powerful convention of female pressure, rather than a concern with marriageability (see also Ahmadu 2005). [...] Female social pressure manifests itself not only in the context of interethnic marriage, but also in mixed-ethnicity peer groups and young women. Sometimes Wolof girls, for example, "join" their friends when they are going to circumcision, even against the will of their own parents (Hernlund 2003). In the present date we are seeing evidence, however, that such cases are becoming slightly less common, at least in urban areas of the Gambia, where girls are increasingly circumcised alone or with one other girl, and with little accompanying ritual or training. In these cases, there is less [of] a group dynamic for uncircumcised girls in which to get swept up' (Hernlund and Shell-Duncan 2007, 53).

- Consider the possible implications of emphasising these different explanatory elements: marriageability and social pressure.
- Consider how these represent different social dynamics.

## 2. FGM/C AS A TRADITION AND FGM/C AS A SOCIAL NORM

Adriana Kaplan and Neus Aliaga (*Wassu-UAB Foundation*)

### Debate: The significance of FGM/C

'In present day Kenya, the significance of female circumcision has changed and the practice is regarded differently by different individuals as well as by different groups of women. As Njambi above states, it was while growing up that the idea of the need for circumcision was instilled in her and thus she went through the practice because of what it meant for her as an individual woman. This was regardless of how others – such as her parents – perceived it; for her it was about a personal journey. This is just one example of the situation in which the practice tends to have a personal rather than group significance: Njambi (2007) even presents the practice as a means of empowerment. FC provided access to social, political and economic power in an undeniably patriarchal society (Njambi, 2004). Hence, the perpetuation of FC served both the interests of the individual and those of the community. It reinforced the sense of female solidarity that was experienced during and after these ceremonies, consequently leading to the re-formation or re-invention of traditional practices.' (Esho, Van Wolputte and Enzlin 2011, 64).

The act of FGM/C is linked with religion, ethnicity, gender (promoting femininity), sexuality, health, cleanliness, age, marriage (premarital virginity, marital fidelity) and socialisation (rite of passage, honour). It does not only have significance within a community group, but also a meaning for the individual, conforming to a belief and value system that differs in each practising community, in every context, and that changes with time.

### 2.1. A rite of passage and a rite of institution

In some communities, and in cultural and social terms, circumcision (both male and female) is part of a rite of passage from childhood into adulthood, and the practising ages differ according to variables such as sex, ethnicity, place, and demographic density of the practising groups. The ritual is essential to boys' and girls' future access to the adult world, and, as in many cultures, the secret world of women is clearly defined and different to the secret world of men (Kaplan et al. 2013). Circumcision is a life mark that symbolises inclusion in a group, and it is a matter of social belonging and membership – the difference between being inside or outside (Kaplan, Hechavarría and Puppo 2015, 31-32).

Arnold Van Gennep (1960) described the rite of passage as a social phenomenon of great importance, comprised of three main stages and presented through the example of FGM/C:

1. Separation: Girls and boys are isolated from the community and circumcised. The rupture with the previous stage (childhood) is marked by the prepuce cut or the excision of the clitoris, the blood and the pain.

2. **Marginalisation:** It lasts for the time of healing. This is the moment when lessons about the adult world are transferred firmly and with severity, in order to obtain cultural and social richness and to understand all the rights and obligations of the society. It is a high-risk period, surrounded by care and strict norms, taboos and prohibitions regarding FGM/C, hygiene, food, clothes, etc., and behavioural norms about relationships with fathers, elderly people, other genders and other ethnic groups (learning the history of the interrelationships between them).
3. **Aggregation:** The initiated are presented publicly in a big celebration, as new members who have acquired new roles and social status. They are legitimised and accepted by the community, and now belong to the secret world of women or men.

The ritual actors are the supervisors of the initiation and are legitimised by the most elderly people of the village. The one leading the group organises the operation, and s/he is responsible for the regulation, development and fulfilment of the ritual (Kaplan, Moreno Navarro and Pérez Jarauta 2010).

The idea of ‘communitas’, a type of human interaction that emerges when there is no specific social structure, offers a more explicit description, indicated by the liminal period of the rituals, when individuals are subjected to a common authority and equal in their ambiguous condition, without being evaluated on that stage (Turner 1969).

When FGM/C is described as a ritual, we need to establish the ‘social function’ and the ‘social significance’ of the boundaries/limits that determine to whom the rite belongs and to whom it does not, defining the separation of ‘those who have undergone a rite, from those who have not yet undergone it and those who will not undergo it in any sense’ (Bourdieu 1991, 117). To draw the attention to the ‘line’ (dividing those subjected to the rite from those who are not) instead of focusing on the ‘passage’, implies that the ‘rites of passage’ are ‘rites of consecration’, ‘rites of legitimation’ or ‘rites of institution’ (Bourdieu 1991).

*‘The rite of institution tends to integrate specifically social oppositions, such as masculine/feminine, into series of cosmological oppositions, which represents a very effective way of naturalizing them. Thus sexually differentiated rites consecrate the difference between the sexes: they constitute a simple difference of fact as a legitimate distinction, as an institution’ (Bourdieu 1991, 118).*

A girl who has undergone FGM/C is recognised by her community as a ‘proper woman’, and treated differently and distinctively to those girls who are not circumcised. The body and the genitals of the child are socially and culturally linked to a gender, and, therefore, to a particular act of institution (‘becoming what you are’). A circumcised girl/woman will also have an obligation to behave as expected (differently to a boy/man) and ‘fulfil and live in conformity with her social essence’. In the words of Bourdieu, ‘To institute, to give a social definition,

an identity, is also to impose boundaries [...] not only accorded and recognized as rights and privileges, but assigned, imposed, like duties, through emphasis, encouragement and incessant calls to order' (Bourdieu 1991, 121).

### Debate: Anticulture or antiprogress?

'What direction individual women take should be left to them and their immediate family members. Just as much as diehard "traditionalists" must relinquish their insistence that uncircumcised women are not socially and culturally "women" and therefore must be denied legal rights and dignity within society, hard-line efforts by abolitionists to coerce women to reject the practice and to stigmatize those who uphold their ancestral traditions as "illiterate", "backward", and against "women's rights" and "progress" are unacceptable. In this "debate", the majority of "circumcised" African women are unfortunately caught between a rock and a hard place, as the adage goes: either break traditional customary laws and face the consequences of "not belonging" or ignore increasing efforts to ban the practice and face possible legal penalties instigated by eradicators at the national and international level. Today, it seems that the pressure on "circumcised" African women, educated or not, is to choose between these two extremist positions: to be either "anticulture" or "antiprogress"' (Ahmadu 2000, 309).

Nowadays, in some cultures and in urban areas, the age of girls on whom FGM/C is practised is decreasing, and it is performed individually and without celebration (Hernlund 2000). This very private, and even secret, performance is a consequence of existing penal sanctions in countries where FGM/C is performed, and of campaigns against the practice on an international level.

## 2.2. What is a social norm?

In 2008, Hobart Peyton Young summarised the concept of social norms as follows:

*'Social norms are customary rules of behaviour that coordinate our interactions with others. Once a particular way of doing things becomes established as a rule, it continues in force because we prefer to conform to the rule, given the expectation that others are going to conform (Mackie et al. 2015, 21).'*

Mackie et al. (2015) explain that a social norm:

- is an action that is thought normal, typical and/or appropriate to do inside a group (Paluck and Ball 2010);
- receives support from a reference group;
- depends on others' actions;
- is dependent on others' beliefs and social expectations;
- has a reference group maintaining it;

- receives approval or disapproval and is socially influenced;
- is a behavioural norm that coordinates and influences interaction with others; and
- is composed of three elements: 1) social expectations (a belief about what others do and what others think one should do); 2) a reference group; 3) social influence (approval or disapproval with positive or negative sanctions).

There are indicators (DHS and MICS) that help to identify (but not establish) when a social norm is present in a specific community.

The main indicators are (Mackie et al. 2015, 59-63):

- a very high prevalence of the practice/norm in a specific place or ethnic group and a very low prevalence in another place/group nearby;
- disagreement between attitudes and behaviours (i.e. to personally oppose the practice/norm, but to keep practising it nevertheless);
- persistence of the practice over time; and
- rapid changes in the practice.

Mackie (1996, 2000) proposes a game-theoretic model to explain why the practice needs a convention shift in order to encourage the abandonment of FGM/C (a mass of people abandoning the practice and allowing their children to marry uncircumcised women), as far as the practice is a social convention and it is followed without question (Shell-Duncan et al. 2011).

### **Exercise: Role-playing**

'When practising communities migrate to Europe, new complexities surrounding the continuation of traditions like FGM/C appear.

Imagine that you come from a community in which FGM/C is performed and you have recently migrated to Europe, where you have to face the context explained as follows. Try to figure out what your reaction, thoughts, decisions and influences would be, and what would imply a shift in the social norm.

An encounter with a non-practising culture that does not necessarily know about FGM/C, and when it does, condemns and prosecutes it with legal instruments that criminalise the tradition.

Uncertainty about juridical and administrative stability.

A conflict of loyalties with elders in countries of origin: They come from gerontocratic societies, where power is held by the elders, who represent and legitimise the recurrence of the tradition.

The perception that FGM/C is not a problem due to other basic needs and urgencies (work, school, residence, legal issues).

The symbolic violence about FGM/C that is widespread in the media, through pictures and words.

The need of the myth of return and its incidence in the socialisation process of children and in gender- and ethnic-identity building'(Kaplan, Moreno Navarro and Pérez Jarauta 2010, 26-27)

### 3. MORAL ECONOMIES AND INTERNATIONAL DEVELOPMENT

Giovanna Cavatorta and Francesco Pompeo (*University Roma3*)

#### 3.1. Sites of intervention: Social arenas, multi-positioned subjects and local fields of definition

On a general level, anthropology, with its combination of participation and observation, entails an emphatic involvement with its interlocutors and produces the insider's view, which is needed for an understanding of the social dynamics in everyday life. In this respect, it offers some key reflexive concepts, helping social researchers, developers and operators tackling the 'FGM/C matter' in handling the challenges that they have to face.

Firstly, as local subjective positions vis-à-vis practices are never homogenous or monolithic, a more accurate notion of the social actor is required. Considering people as multi-positioned subjects, Henrietta Moore suggests that social actors do not express a singular subjective gendered position, but that each one takes up multiple, even contradictory, positions 'within a range of discourses and practices' (Moore 1994, 55). This implies that each society has different attitudes and visions that cannot be reduced to a single gender or ethical system. It is thus essential to simultaneously understand and locate multi-positioning in order to prevent developers or social operators from adopting culturalist attitudes, such as believing 'that the shared conceptions peculiar to a given social milieu, or even more so to a given African village, are stable and ancient, exist at all levels, are homogenous and reflect a world view cemented by common values' (Olivier de Sardan 2005, 83).

Secondly, the historical, dynamist and critical approach that anthropology offers obliges us to reconsider the macro-frame in which FGM/C rises as an issue and how it is articulated in each local context. In the global human-rights agenda promoted by UN agencies and other transnational organisations, some irreversible modifications of women's genitals are, under the label of 'genital mutilation', cast as a decontextualised universal practice (see Fusaschi, III.2., 'The genitals and construction of a woman's body,' in the third common chapter of this guide). Moreover, a global moral and social intolerable is produced. Such discursive production structures policies and local interactions in the field, determining the asymmetries of power among the actors involved. Educational and development projects dealing with FGM/C and promoting its abandonment constitute arenas in which the very act of naming, defining and locating mutilation or harm is complex, and quite often conflicting.

*'Development enterprise is always an arena in which various logics and strategies come into confrontation: those of the initiators of the development enterprise confront those of the so-called target population (Olivier de Sardan 2005, 137).'*

In this sense, in projects promoting the abandonment of FGM/C, the relationships of power between the different implicated actors (NGOs' expatriate and local staff, governmental and other local authorities, target groups, etc.) should be seriously considered, as they also account for an economic dimension. This involves analysing the social hierarchies among members of communities and the 'experts', including local 'experts' receiving income and benefits from the project. The economic dimension is, in fact, a meaningful factor in these practices, not only with regard to excisors (Gosselin 2000a, 2000b). Economic privilege is also one of the issues on which some pro-FGM/C groups base their anti-Western/neocolonialist discourse (Cavatorta 2015).

In each local field of definition on irreversible practices on female genitalia, whether in Europe or elsewhere, we find several deep-rooted cultural meanings and different moral postures. Since *The Hosken Report* (1982), those local fields have been structured by the conflict between people promoting discourse overlapping with the hegemonic, Western 'anti-FGM' frame and those who are not, but among the latter we find people who are not favourable to such practices as well, and, even if they disagree in other ways, quite agree with the abandonment and struggle for achieving it. For example, a lot of fieldwork has highlighted the social significance of the anti-FGM position, proposing a strong confessional discourse on the untouchability of a woman's body (considered a 'divine' artefact), acknowledging the religious interpretation as a very authoritative one (Abusharaf 2006; Hadi 2006; Cavatorta 2015).

### **3.2. Human rights and moral economies: An overview**

Looking at the transnational humanitarian government, such practices progressively passed from being framed as a health matter to a human-rights one (Shell-Duncan 2008), and lastly as a mixture of the two (Baer and Brysk 2009). This is far from being a neutral process, and a rethinking of the human-rights regime is required.

The anthropologist Sally Engle Merry (2006), in her research on the transnational movement against violence towards women, showed how human rights-based discourse and laws, particularly the ones linked to gender-based violence, are developed. Highlighting the asymmetries between countries in the global arenas of definition and lobbying, Merry demonstrates how the global notions of justice and rights are promoted against cultures (producing essentialised and unhistorical representations) and against subaltern people's meanings and practices. The resulting human-rights approach hampers the understanding of the meanings and the dialogue with 'target' groups, often remaining hostage to a blind moralist attitude. The human-rights regime is a moral one, and transnational humanitarian actors, NGOs and advocacy groups are exploiting 'moral sentiments' in their work (Fassin 2012, 1), conveying the idea of a single, universal ethical subject and producing moral 'intolerable'.

From an anthropological perspective, we cannot speak in terms of a 'universal intolerable'. Only 'the universality of the intolerable' can be ascertained (Fassin 2005, 47). Each human society produces its intolerable 'because each human society refers to a universe of values embedded in sensibilities', on the basis that 'they make a line that can't be passed without renouncing to what is its founding' (Fassin 2005, 47). Anthropologists, in studying this production of intolerables, have to assume that '*our* moral sense does not correspond to *their* social sense' (Fassin 2005, 29), and they also have to understand the social and cultural basis on which each intolerable is elaborated. This implies an understanding of the very reason why leaving female genitals untouched could be locally considered unbearable (e.g. risking fertility or women's health, subverting gender- and generation-based social hierarchies, etc.). Moreover, it implies an understanding of the deeper social and material causes that lie beneath, such as not having access to water, and thus to cleanliness, women's dependence on their husbands' incomes, structural poverty, and so on. This ethnographic and hermeneutical work is crucial if we want to efficaciously engage with promoting the abandonment of these practices.

The WHO's categorisation of FGM/C should be reconsidered as the outcome of a transnational moral economy with hegemonic and sometimes colonial aspirations that have to be socioculturally and historically sited. In the last decade, the notion of a 'moral economy' has been redefined as the circulation of values and intolerables in the social worlds (Fassin 2009). Through this notion, Didier Fassin underlined the imbrication of moral intolerables and social indignation with humanitarian and state governmentalities vis-à-vis women, children and, in general, groups that bio- and necropolitics consider victims. These kinds of governmentalities, Fassin maintains, are producing an ontology of inequality that hierarchises people on the basis of the value attributed to their life (Fassin 2012). One declination of this kind of politics is the 'compassion and repression' paradigm of government (Fassin 2012, 133-160), which European states have vis-à-vis women asylum seekers coming from countries highly rated in terms of their FGM/C risk (see Falcão, III.3., 'Migration, migratory movements and ethnicity,' in the third common chapter of this guide). This rating should be understood, not as neutral data, but as dispositive of those governmentalities (Foucault 2007; Fusaschi 2014; Merry 2016).

### 3.3. Researching the humanitarian and moral object of 'FGM/C'

From several perspectives and different forms of fieldwork, some anthropological researchers have been studying how moral economies shape FGM/C as a humanitarian object and a local state matter. These studies unveil the power relations, the dynamics of exclusion, and the epistemic violence (e.g. a Eurocentric bias) at stake in anti-FGM policies. Some theoretical questions that arise in this context also have ethical and political significance.

One research strand analyses the value difference between humans (Fassin 2005; Butler 2004) that such kinds of policies instigate, particularly when they are applied in European countries. One question could be: how are interventions on children's genitals in Europe framed and 'treated'? It is from this perspective that Fusaschi (2015) discusses two cases of intervention in Italy, one regarding a girl's genitals and one regarding a boy's. She demonstrates how the juridical and media treatment of the two cases revealed how gender, religion, community belonging and skin colour are essentialised and, precisely because of the state biopolitics against FGM/C, have become axes of social hierarchy and the exclusion of migrant populations. Another theoretical approach regards the link between body politics (Scheper-Hughes and Lock 1987) and consent. Concerning body politics, we can easily recognise the discrepancy in Western societal attitudes towards female genital cosmetic surgery and 'ethnicised' and 'discriminated' female genital cutting (Johnsdotter and Essén 2010). With the latter, an 'alien' immigrant body is constructed in order to be domesticated and ascribed to subalternity (Fusaschi 2014).

Regarding the issue of consent, anthropologists acknowledge that it is a problematic and ambiguous matter (Godelier 1986; Mathieu 1991). The liberal, Western notion of consent considers it a neutral 'universal', erasing the fact that only some women have the right to consent. For example, there are mothers who are allowed to decide on their daughters modifying their genitals (e.g. in the UK, with young girls undergoing intimate piercing) and others who are not (e.g. in the case of a young girl asking to receive Sunna in Djibouti). In this way, hierarchies are institutionalised. Furthermore, what about acknowledging the agency of children? Studying the part of Kenyan history related to the ban of FGM/C, Thomas (1996) focuses on girls' subjectivity, and highlighting the relationships of power between generations at stake, she describes girls' attempts to take control over elders precisely by defying the ban and attempting to excise each other.

Another approach to the matter is questioning the category of 'victims', the cornerstone of the policies on women's bodies, where they cross the speeches and rhetoric involved in the humanitarian field and by part of the old Eurocentric feminism. Anthropological fieldwork and 'methodological relativism' (Jackson 2005), casting girls and women as actors, highlight the complex relationships of power at stake between genders and generations. Moreover, this reflexive and ethnographic-based theoretical standpoint problematises Eurocentric and essentialist feminist discourses. This acknowledges that, far from being a simple sign of an overwhelming patriarchal regime, 'circumcision and its social implications' can be even 'strategically used by women as bargaining tools with which to negotiate subaltern status and enforce their complementarity with men' (Boddy 1989, 319). From her fieldwork in northern Sudan, Janice Boddy ascertains that 'most view circumcision less as a source of oppression (after all, none has experienced adulthood intact) than one of fulfilment' (Boddy 1989, 319).

Female genital-cutting practices are the very locus of the dynamics of power and, in this sense, we should have no ethical fear in acknowledging that they could be used as a tactic. Rather, we are compelled to understand how they assume this configuration. Besides, discrimination and state violence with regard to FGM/C did not end with colonialism, but they are still going on, as the Swedish cases of compulsory gynaecological examinations of migrant girls indicate (Johnsdotter 2009). Anthropological research ascertains that active adoptions of such practices are also correlated to campaigns and policies aimed at eradicating female genital cutting with victimising and neocolonialist approaches.

### Evaluation

The following articles are based on the analysis of projects and campaigns promoting the abandonment of the so-called FGM/C practices in some African countries. Discuss the theoretical approaches proposed by the authors and the social, moral and political stakes that emerge in each local field.

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## Chapter VIII.

### Feminist and gender studies

#### Didactic objectives:

1. To raise knowledge about FGM/C and other harmful practices among students of gender, feminist and women's studies.
2. To develop students' capacities to approach and analyse a patriarchal practice like FGM/C from a gender-sensitive, intercultural and non-ethnocentric perspective.
3. To provide theoretical concepts, tools and methods developed by a wide range of diverse, renowned feminist authors and scholars to critically address FGM/C.
4. To help students reflect on the sociocultural construction of gender, genitalia and sexuality, and its relationship to gender inequality.

#### Summary:

1. Gender hierarchy and FGM/C
  - 1.1. Patriarchal systems (Laura Nuño Gómez, URJC)
  - 1.2. Gender and genitalia (Magaly Thill, URJC)
  - 1.3. Control over women's sexuality (Laura Nuño Gómez, URJC)
  - 1.4. The androcentric human-rights framework (Laura Nuño Gómez, URJC, and Magaly Thill, URJC)
  - 1.5. Violence against women (Sonia Núñez Puente, URJC)
  - 1.6. Gender, coercion and consent (Sonia Núñez Puente, URJC)
2. FGM/C and other gendered practices
  - 2.1. Some practices under FGM/C type IV, the harmful aspect of which is questionable (Michela Fusaschi, Roma3).
  - 2.2. Linkages between FGM/C and other harmful practices (Laura Nuño Gómez, URJC, and Magaly Thill, URJC)
  - 2.3. Differences and similarities between male circumcision and FGM/C (Gily Coene, VUB)
  - 2.4. Genital cosmetic surgery in Europe (Michela Fusaschi, Roma3)
  - 2.5. Intersectionality and stigmatisation of FGM/C survivors in the European Union (Gily Coene, VUB)
3. Women's involvement, voices and empowerment
  - 3.1. The status of women excisors (Michela Fusaschi, Roma3)
  - 3.2. The voices of Southern feminists in preventing FGM/C (Gily Coene, VUB)
  - 3.3. Why and how to involve men in counteracting FGM/C (Gily Coene, VUB)
  - 3.4. FGM/C and the perspective of empowerment (Sonia Núñez Puente, URJC, and Magaly Thill, URJC)

**Boxes:**

Ethnographic text box: Interview excerpts (Bagaglia et al. 2014)  
 Practical exercises to be used in the classroom  
 Evaluation exercises

**Audio-visual resources****Bibliographic references****1. GENDER HIERARCHY AND FGM/C****1.1. Patriarchal systems**

Laura Nuño Gómez (URJC)

The concept of patriarchy refers to a system of interrelated social structures and practices of cultural, ideological and institutional nature, which have historically established and maintained masculine domination, oppression and exploitation of women in the family and society (Lerner 1986, 239; Walby 1990, 20). This interclass and metastable masculine pact to keep women subordinated (Amorós 1997, 27), which is not static nor monolithic, allows women to exert some power over other members of the family, like small children or adolescent girls, and have apparent control over gender-specific tasks, fundamentally related to reproductive activities. Additionally, most patriarchal systems enable women to occupy positions of power in the public sphere, provided that this presence does not threaten males' prevalence and dominance. It must also be said that some theorists prefer the concept of a *sex/gender system* to highlight that the 'empirically oppressive ways in which sexual worlds have been organized' are not ineluctable (Rubin 1975, 168).

Three interrelated dimensions of social agreement have underpinned gender stratification, allowing for the permanence of patriarchy: gender ideology, which legitimates males' authority; gender norms, of overriding importance for women; and gender stereotypes, which reinforce gender hierarchy under the cover of determinist explanations (Saltzman Chafetz 1990). In societies where *logos* is dominated by men, androcentric construction of the meaning has set up the *phallus* as a universal signifier – a phenomenon that, after Derrida, has been referred to as *phallogocentrism* by feminist authors like Cixous, Irigaray and Braidotti, condemning women to otherness and objectification (Beauvoir 1949), exclusion from the status of individuals (Pateman 1988), defectiveness and lack (Irigaray 1985), heterodesignation

(Amorós 1997) and a subaltern status, which is the product of both patriarchy and imperialism (Spivak 1998).

## 1.2. Gender and genitalia

Magaly Thill (*URJC*)

Feminist theory has evidenced how, in most cultures, institutions, narratives and practices have divided society into two dichotomous, complementary and hierarchised genders (Millet 1970). Building critically on the anti-essentialist idea that gender is a social construction, while sex refers to biological differences (Oakley 1972), material feminism and queer theory have affirmed that hierarchy is prior to division, and there is nothing about a binary gender system that is given or necessary (Delphy 1993; Butler 1988, 531). According to this postulate, men's and women's bodies are the products of a social construction that emphasises anatomical differences and scotomises similitudes between the male and female sexual organs, with the purpose of providing a natural justification to the difference socially established between genders, and since, to the sexual division of labour and masculine domination (Bourdieu 1998). Whether sex comes first or gender precedes sex, the fact is that sexual dichotomy has been socially bolstered through the accentuation of anatomical characteristics – an exacerbated requirement for women, whose essence is constructed as a (hyper) sexualised body.

On the basis of this hegemonic sexual binarism, intersex children are submitted to surgery with the purpose of conforming their genitalia to societal expectations, imposing on them a normative body and gender identity. These interventions have been defined as genital mutilation due to their seriously negative impact on sexual function and physical and psychological well-being (Ehrenreich 2005, 74). Another manifestation of this normative dichotomy can be found in the belief that the clitoris can grow, rival the man's penis and harm it during sexual intercourse, which is a reason used to justify FGM/C, for instance, in Sudan (Lightfoot-Klein 1989).

In parallel, androcentric narratives about sexuality (found in a wide range of disciplines, from literature to psychoanalysis) have conceptualised female genitals as an otherness, a non-penis or emptiness –when they are not a complete taboo (Irigaray 1977)– and given rise to myths and stereotypes that describe them as mutilated, disgusting or dangerous, suggesting that they should be small, hidden and sealed (Millet 1970; Bourdieu 1998). Clitoridectomy, removal of the labia, infibulation and, to some extent, vaginal narrowing respond to an androcentric and heteronormative construction of women's anatomy and identity, whether practised on traditional grounds or in the context of a Western, neoliberal 'porno-chic' culture (Jeffreys 2005, 82-86).

### **1.3. Control over women's sexuality**

Laura Nuño Gómez (*URJC*)

Patriarchal socialisation imposes strict mandates on females' sexuality in order to keep their bodies available for males' sexual and reproductive uses, according to patriarchal standards of domination (MacKinnon 1989, 188). Among practising communities, FGM/C is also believed to restrain females' 'excessive' sexual appetites as a means to ensuring their virginity until marriage, especially in the case of infibulation, and fidelity to a husband from then on, protecting *his* lineage in this way (El Saadawi 1980).

Clitoridectomies were also performed in Europe and the United States in the nineteenth and twentieth centuries by doctors and psychiatrists, on androcentric and misogynistic grounds, under the pretext of 'saving' women from hysteria and other mental/gender-specific 'diseases', or to eradicate behaviours considered 'deviant', like masturbation, lesbianism or pretensions of greater autonomy, including political activism and seeking divorce (Showalter 1985). The difference between FGM/C and these other reasons for excision lies in the ritualistic aspect of the former (Zabus 2004) and in the arguments used to justify both phenomena: the respect of traditions that enforce women's chastity versus the application of a pseudoscientific 'cure' for women's subversive conduct.

### **1.4. The androcentric human-rights framework**

Laura Nuño Gómez and Magaly Thill (*URJC*)

The inclusion of women in the group of rights' holders, from which they had been initially excluded, came with their identity homologation, with the hegemonic, neutral and universal standard of the white Western heterosexual male/individual without functional diversity. Women's needs, stemming from their subordinate position in patriarchal societies, were ignored, blurred and denied in the two main international conventions on human rights (the International Covenant on Civil and Political Rights, or ICCPR, and the International Covenant on Economic, Social and Cultural Rights, or ICESCR), which reinforced the liberal, public-private opposition and kept power relations arising from the sphere of family, intimacy and sexuality out of the scope of human rights (Charlesworth 1994). Women's rights were therefore regarded as a particularism, specificity or privilege (Nuño Gómez 2013).

Despite the androcentric bias and the limited effectiveness of human rights, feminist activists on a global level used this conceptual and institutional framework to advance their claims because it represented strong leverage to advance a culture of justice and equality and to engage states in the enforcement

of those values. Two main landmarks must be highlighted on this path: the adoption of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which has been used to challenge discrimination against women in UN declarations and conventions; and the definition of gender-based violence, which includes FGM/C, as a violation of human rights. Much still needs to be done in recognising women's rights, from the acknowledgement of reproductive work as labour, to women's rights to sexual pleasure and autonomy.

In the last few decades, there has been an increasing (ab)use of the discourse of human rights, and, more particularly, women's rights, as an alibi to justify political, cultural, economic and militaristic/imperialist interventions in the global South (Abu-Lughod 2002). As a result, multiculturalist, postmodern and post-colonial scholars have expressed criticism towards the viability of universal norms and a Western monopoly to 'right the wrongs' (Spivak 2004). While all cultures deserve to be recognised as equally valuable, we should nevertheless remember that, due to power relations of patriarchy, the precedence of so-called 'group rights' over individual rights (based on the 'untouchability' of cultures, the superiority of religious precepts or cultural relativism) is likely to reinforce women's subaltern position therein (Moller Okin 1998).

A promising way to effectively address and promote the human rights of all women of the world in their diversity, of all the *concrete others* (Benhabib 1992), is to overcome the epistemologically erroneous dichotomy between individual autonomy and cultural rights through intra- and intercultural dialogue (Benhabib 2004, 148), or in the words of Ugandan feminist Sylvia Tamale's, "to bypass the polarity between 'rights' and 'culture' in order to achieve social transformation" (Tamale 2007, 157). That is to combine, instead of oppose, the policies of *redistribution* and *recognition*, while ensuring the *participatory parity* of women, both within the minority or dominated group and in relation to the majority or dominant group (Fraser 2013, 168-70).

### 1.5. Violence against women

Sonia Núñez Puente (*URJC*)

Conceptualised as a human-rights violation and an obstacle to gender equality, gender-based violence is a widespread structural phenomenon. The common denominator of sexual hierarchy, and the use of violence to demonstrate, ensure and reinforce it, can be found across cultures. Millions of women, from north to south and east to west, experience different types of violence simply because of their gender. Being born a girl puts one at a higher risk of physical, psychological, economical, sexual, spiritual and symbolic violence, with the ultimate goal of maintaining the mandate of subordination, gender inequality and patriarchal control over women's bodies, decisions, identities and lives.

It is sometimes erroneously argued that FGM/C is not a form of gender-based violence, under the allegation that most excisors are women. This is to forget that the international definition of violence against women relies on five elements, and none of them is the perpetrator's gender: the gender of the victims ('women'), the kind of acts ('any act [...] including the threats of such acts, coercion or arbitrary deprivation of liberty'), the cause of these acts ('gender based'), their consequences ('that results in, or is likely to result in, physical, sexual or psychological harm or suffering') and the context in which they occur ('in public or private life'). Violence against women does not only involve the aggressor and the victim: its eradication, which is impossible without addressing gender inequality and empowering women, is a state's obligation and a responsibility that should be borne by society as a whole.

### 1.6. Gender, coercion and consent

Sonia Núñez Puente (*URJC*)

While girls under the age of majority commonly lack the legal capacity of consent – that is, to give a free decision with the full understanding of the health consequences of that decision – some countries, under the argument of respect for women's autonomy, do not criminalise FGM/C in a medicalised environment when an adult woman gives her informed consent, for instance, in the case of reinfibulation after delivery. A critical feminist perspective shall nonetheless analyse how autonomy might be curtailed by cultural mandates and women's social and economic dependence (Rahman and Toubia 2000, 65-66; Fraisse 2007).

In this sense, the distinction between two types of patriarchies, of coercion and consent, is very useful, as it provides a theoretical framework for analysing the functionality of gender-based violence (Puleo 1995; De Miguel 2015). Under the premise that every patriarchal system is based on both strategies, the difference is that the coercive model sanctions, in a strict manner, what is allowed and what is forbidden to women, while its correlative scheme of consent apparently promotes gender equality, but, in reality, builds inequality through binary narratives that leverage gender roles in a rigid way.

It has been demonstrated how dominated groups' thoughts, perceptions and actions are constructed through socialisation, following the structures of domination. The concept of *habitus*, which is not the product of a conscious and rational decision, nor imposed by force or coercion, but rather acquired through example and practice, can explain women's acquiescence to male domination and their participation in patriarchal rites (Bourdieu 1998). It can also be useful to understanding why women socialised in cultures where FGM/C is valued as a rite of passage that increases girls' marriageability are strong supporters of the practice, even when they themselves have suffered its negative health and sexual consequences.

It is also of great importance to analyse how FGM/C and, to some extent, violence against women at large are conceptualised in the discourse of the media in the West, under the cover of commitment to gender equality, re-victimising women and girls through stereotyped images that close any possibility of agency for victims (Boltanski 1993; Núñez Puente 2015).

### Ethnographic text box: Interview excerpts (Bagaglia et al. 2014)

Zema, an Ethiopian woman, 38 years old:

*'Our people say that, in this way, you are calmer. They say the girl is calmer and she won't have too many children. [...] Parents, especially, are very happy because they feel protected because the girl is calmer, she remains at home, she is not looking for men, she is not nervous, and, therefore, her parents are happy.*

*'They cut you, and then you feel nothing – it's evident. We will be more ... you know, you'll need more time. You can have sex, but you are not so much ... it takes time. Because your partner – OK, he knows you, he understands you – but if you are with someone who doesn't understand you, oh well!*

*'They cut the tip of your clitoris, you know, they cut you right [on] that one, where the [sensitivity] is, so a man who knows you, yes, he goes to look for the right point, but [he] who doesn't know you, well, he has troubles! With time, you learn, your partner gets to know you better and learns, he understands how to do [it], but with someone who doesn't know, you cannot reach orgasm.'*

Maryam, an Egyptian woman, 44 years old:

*'Oh, I screamed, screamed a lot, and I cried, and I asked my parents, "Why?! Why have you done this?"; and they told me many lies because I was just a child. My mother told me I behaved like everyone else. "It is normal." I had to behave like that. "If not, you will be unpleasant. If not, it won't be normal. Otherwise, you'll remain like males – you'll be like a male. If you don't do this, you'll remain like males!"'*

Faizah, an Egyptian woman, 33 years old:

*'Girls who are not circumcised want more sex than others. One feels pleasure, but if the husband is far from her, she cannot have this will because he's abroad. For example, she remained in Egypt, away from him – he went to Libya – but she had no will, and she said she was circumcised for this reason, because she won't have the will when the husband is away from her, but when he's close, she feels the will, and she also feels pleasure, like all other women.'*

Adisa, an Eritrean man, 27 years old:

*In Africa, they have this tradition: they do circumcision because if they don't do it, women become a little strange, they want more men, you know. They do this before the wedding, so – families, they believe this – that's why they behave like that. But I don't think it's right. [...] They behave like that because parents in Africa are worried, because a woman before marriage cannot go with men. When she goes with men before marriage, she is not worth anything to the family.*

Josette, an Ivorian woman, 44 years old:

*'A Somalian friend told me, "I am alone [not married] for this reason. This is why I don't go with other men – because they made me marry at 16, and when I had sex for the first time, I suffered so much! The man, bit by bit, has to open you, to open everything! Bit by bit ...!" Finally, she ran away and never came back home. She never had men again. She remained without children, completely alone.*

*'There is nothing to be ashamed of. If we want to remove this thing, we need to talk. Because it's like if your husband has beaten you and you don't want to tell anyone, but if you don't tell, nobody will defend you! If you keep it to yourself, that's not good.'*

Samia, a Chadian woman, 26 years old:

*In some areas, as soon as the girl gets menstruating, she undergoes circumcision. It's a habit, a tradition – maybe they don't know the reason themselves. It is a habit, everyone does it, so they also do the same. [...] Males, they do, they have to be circumcised, but females, why do they do it? Males, for hygienic reasons, and because when they become men, they will have their women ... circumcision has to do with sex, with sexual relations between husband and wife.'*

A Somali woman, 70 years old:

*'The first time I went for a visit, immediately as I lay down, the gynaecologist got shocked and exclaimed, "Oh, madam! What happened to you?! Have you been burnt?!" And I said, "No! It's been sewn! Isn't that written in your books?! You are a doctor – they talk about this in the manuals," because my husband was a doctor, and he told me about it. I said, "Isn't there any manual regarding this African issue?!" And he replied, "No, I never heard about this!" "OK, it's time to do it because we are many now here in Europe!"'*

## 2. FGM/C AND OTHER GENDERED PRACTICES

### 2.1. Some practices under FGM/C type IV, the harmful aspect of which is questionable

Michela Fusaschi (*Roma3*)

The term 'female genital mutilation (FGM)' according to WHO, comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. In 2007, the World Health Organization redefined type IV FGM, stating that in this category must be included 'all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization' (WHO et al. 2008, 4).

Before that date and since 1997 (WHO, UNICEF and UNFPA 1997), WHO included labial elongation/stretching and the introduction of substances or herbs into the vagina within type IV (just think of the introduction of vaginal lubricant so commercialised in the Western world). Several anthropological and medical

studies ascertained that these practices do not have negative consequences and do not violate women's rights, in that they do not involve physical violence (Fusaschi 2012; Bagnol and Mariano 2011). For example, some ethnographic research in the Great Lakes region of Rwanda demonstrates how femininity is embodied through a ritual practice called *gukuna*, which consists of the elongation of the labia minora through a reciprocal massage between young women (Koster and Price 2008). This social construction of the female body, in addition to *kunyaza*, a traditional male sexual technique, is expected to facilitate pleasure during sexual intercourse. This analysis shows how this ritual has persisted in the country despite its condemnation by the Catholic Church since colonial times, and how today it is being reinterpreted by young women as a process of emancipation (Fusaschi 2012).

Nowadays, WHO's official type IV definition still matters, as it includes practices that are socioculturally considered 'mutilation', but only in relation to non-EU citizens, for example, clitoris piercing or other surgical operations made to reduce and reposition the clitoris.

## 2.2. Linkages between FGM/C and other harmful practices

Laura Nuño Gómez and Magaly Thill (*URJC*)

The sensationalism that surrounds FGM/C, as is the case with foot-binding in China, seems irremediably linked to the building of the otherness of women from the Global South. Through the double mutilation of their genitalia, both real and symbolic, African women become absolute others through the combination of androcentric and ethnocentric signification processes: others related to the masculine/dominant gender and to the dominant Western culture. An intercultural feminist approach should break the encapsulation of FGM/C and link it with other discrimination towards women, including the violation of their economic and social rights within the broader dynamics of North-South inequalities (Guerra Palermo 2008). It should unwrap and challenge, in a critical way, meanings and values that underlie harmful practices that are imposed on girls since early childhood to make them fit into gender roles and abide by gender norms, highlighting the transcultural aspect of masculine domination strategies.

A practical example of this can be found in the connections between FGM/C and early marriage. Both traditional harmful practices imposed on girls are often linked and share the same root causes and social drivers (World Vision 2014). They ensure wives' virginity and increase women's marriageability, which can amount to their mere survival in societies where they do not have socioeconomic autonomy or alternatives. The dynamics between both practices explain how programmes that only target the abandonment of FGM/C may adversely affect early marriage. The legal ban on FGM/C may increase the age of girls who are subjected to the practice and

have the side effect of reducing the age of marriage by tempting parents to bring their daughters back to their country of origin to be cut and married at the same time. It also points to the need for critical inter- and intra-cultural debates about the androcentric concept of virginity, which has the capacity to convert women –and only women– into decent or indecent, pure or impure, and/or valuable or valueless persons.

### **2.3. Differences and similarities between male circumcision and FGM/C**

Gily Coene (*VUB*)

Almost one third of the men in the world are circumcised (Wilcken, Keil and Dick 2010). In the US, it has been estimated that more than one billion newborn boys are circumcised every year (Zoske 1998). Men are mostly circumcised for religious and cultural reasons, as an initiation ritual into manhood. In some communities, circumcision functions as a rite of passage from childhood to adulthood for both sexes. Although male circumcision and FGM/C are commonly considered totally different practices, both have some similarities.

In contrast to FGM/C, which has been subjected to scrutiny and severe criticism, male circumcision is largely accepted. The health repercussions from male circumcision are usually minimised, while the damage caused by female circumcision is more often maximised. However, male circumcision –especially when it is performed in non-medical settings– often leads to serious complications, severe pain, and even the loss of the penis or death (Wilcken, Keil and Dick 2010). The attitudinal difference towards male and female genital cutting cannot simply be explained by the different effects of both practices, especially if one considers the different and less intrusive types of FGM/C. According to Kirsten Bell (2005), the widespread inability to conceptualise male circumcision as anything other than beneficial stems from uncritical assumptions about the nature of the male and female bodies and sexuality.

Medical circumcision (the surgical removal of the skin covering the tip of the penis) has also been recommended by WHO as an HIV prevention strategy (Westercamp and Bailey 2007). However, scholars and anti-circumcision activists have demonstrated that this is not necessarily the case, and have pointed to some controversial issues. From a medical perspective, the procedure is not necessary and, in the case of neonatal circumcision, violates the rights of individuals who are too young to consent (Sardi 2016). In this respect, the Parliamentary Assembly of the Council of Europe has declared that male circumcision constitutes a ‘violation of the physical integrity of children’ (Parliamentary Assembly of the Council of Europe 2013).

## 2.4. Genital cosmetic surgery in Europe

Michela Fusaschi (*Roma3*)

In recent years, there has been an alarming increase in the number of women who undergo cosmetic surgery on their genitals for non-medical reasons in Western countries. Female genital cosmetic surgery (FGCS) includes surgical operations advertised as 'rejuvenating' and 'proportionalising', with the alleged purpose of making the genitals more attractive. These actions range from labiaplasty, or reduction of the inner labia, clitoral 'repositioning' or lifting, liposuction of the mons Veneris (the fat tissue covering the pubic bone), vaginoplasty, or vaginal tightening, to hymenorrhaphy, or hymen reconstruction, which is aimed at 'restoring' female virginity (Johnsdotter and Essén 2010).

This sector of intimacy, one to which women turn because their perceived visual inadequacies generate uncomfortableness, is presented as an accessible and affordable support (indeed, payments in instalments have increased) to resolve aesthetic 'problems', but also to improve sexual satisfaction, which, in turn, is related to a general shift in the imagery of a femininity that is surgically 'enhanced'. To legitimate FGCS, promoters have built the image of a woman who gains control over herself and her body through an 'intimate restyling', portrayed as a process of 'self-awareness', in contrast to a traditional feminist dialectic that denounces it as the umpteenth demonstration of a long patriarchal arm.

Without therapeutic indications, other than those established by the applicant, FGCS involves the same body parts and functionalities that, through the means of different modalities, are the objects of FGM/C. The difference lies in the procedures used (high-tech versus ritualistic) (Fusaschi 2011, 2013) and the imageries that surround both phenomena. FGCS conveys 'body images' and new protagonists, who lie beneath a disguised and often confused choice. It actually promotes new cultural patterns of consumption (presented as a form of emancipation), and not only directly related to the male domain (Braun 2009), and towards which, in our view, supervision is necessary, as data shows that some of these operations are carried out on minors, with the explicit consent of their mothers.

Judicial relevancy in traditional phenomenon, for which there is penal action (in contrast to similar non-therapeutic operations in FGCS), also contributes to building two different images of women and their femininity. While in FGM/C it is believed that women are the victims of culture, in FGCS, they are the absolute protagonists of culture, or rather 'our' civilisation – the last and desired stage, evolved to an anachronistic, but unfortunately present, vision of progress. The 'victim body' is always identified with the others, and the 'liberated body' is always ours. As a first, non-ethnocentric step, we could also bring into discussion some of our 'anchor points' with regard to women who are too often trapped

in the dichotomy between the right to change their body versus the duty not to harm it.

## **2.5. Intersectionality and stigmatisation of FGM/C survivors in the European Union**

Gily Coene (*VUB*)

Intersectionality is a concept rooted in Black feminist theory that was introduced by Kimberlé Crenshaw (1991) to explain how racism and sexism simultaneously influence the lives of Black women in the US. Intersectional approaches offer a more comprehensive understanding of the experiences of discrimination and exclusion to which minority women are subjected. Individuals are always positioned in society on a range of axes of difference, such as gender, ethnicity, class and sexuality. With regard to migrant women, different types of discrimination interact and shape their experiences and opportunities. In this regard, migrant women may simultaneously suffer from gendered oppression within their minority community and from class oppression and/or ethnic discrimination within the dominant society (Anthias 2014).

In recent years, practices like FGM/C have been at the core of political and popular debates on multiculturalism in Europe (Coene and Longman 2005). By referring to practices like FGM/C, migrant men are stereotyped as backward, violent and patriarchal. In the same regard, migrant women became stereotyped as voiceless victims who need to be saved from their inherently oppressive communities and traditions (Longman and Bradley 2015). This has led to inefficient top-down strategies for tackling FGM/C, lacking sufficient sensitivity for women's feelings, perspectives and possibilities for change within their communities (Phillips and Saharso 2008).

### **3. WOMEN'S INVOLVEMENT, VOICES AND EMPOWERMENT**

#### **3.1. The status of women excisors**

Michela Fusaschi (*Roma3*)

The person who 'cuts' is an 'initiator', a ritual operator who 'transforms' the physical body into a symbolic one. In general, the performer carries out the 'cutting' and organises the coming-of-age celebrations that follow.

If we look at the ritual operators in female genital modification across various societies, we find that they are quite always women, with different cultural and economic backgrounds, depending on the area in which they are operating (rural or urban). They are often elderly women, more broadly responsible for a continuum of

practices on women's and children's bodies and health (e.g. labour and childbirth). Their knowledge passes down over time, and usually from mother to daughter. In the last few decades, legal prohibition and the penal pursuit of practitioners has depleted the ceremonies and created hidden settings of operation. The social characteristics of the operators have also changed (Gosselin 2000).

Thanks to some cooperative projects positioning FGM/C as a health matter, the practice has been progressively biomedicalised in several geographical contexts, not only in Africa, but also in Indonesia (Shell-Duncan, Obungu and Muruli 2000; Cavatorta 2015, 32). It is important to stress that, even if – especially in urban areas – practitioners are people with at least a basic biomedical knowledge and sometimes a salary (but one insufficient for living), in this 'modernised' ritualistic pattern, the economic dimension is very significant. In geographical contexts of structural impoverishment, such as in the Horn of Africa, the excisor has to be paid, constituting a very meagre subsistence. Intervention programmes focused on 'retraining' the practitioners (e.g. through microcredit projects) often failed in granting them a sustainable alternative to work (Fusaschi 2003, 147; Diop and Askew 2007).

### **3.2. The voices of Southern feminists in preventing FGM/C**

Gily Coene (*VUB*)

Activists from the global South have been working to prevent FGM/C for a very long time. Since the UN organised world conferences during its Decade for Women (1975-1985), FGM/C has been an issue of global solidarity, but also one of disagreements between and among Western feminists and those from the Southern Hemisphere. Chandra Mohanty, in her influential and classic essay 'Under Western Eyes: Feminist Scholarship and Colonial Discourses' (Mohanty 1991), criticises a number of Western feminist texts for portraying an 'ethnocentric universalist' and 'colonial' image of the 'average third world woman'. Likewise, Wairimu Ngaruiya Njambi (2004) argues that anti-FGM/C discourse not only replicates colonial 'civilising' presumptions, but also homogenises very diverse practices, constructs dichotomies between mutilated and non-mutilated female bodies, and represents the women involved without a sense of agency.

Cross-culturally, post-colonial feminists have thus become highly critical of victimising discourse in which the oppressed woman from the global South is constructed as the mirror image of the agentic Western woman, who is supposed to be free of any culture or tradition, or capable of emancipating herself from them (Harcourt 2009; Moghadam 2005; Mohanty 1991, 2003; Gruenbaum 2000). When defensive of a practice like FGM/C, the voices of the women in the South are dismissed as the result of a false consciousness and the internalisation of oppressive and static cultural norms (Khamasi 2015). When critical of the practice, women are celebrated as liberated individuals within a backwards population.

Southern grass-roots activists are often caught between Western anti-FGM discourses, which frame it as a harmful cultural practice, and local power elites and nationalist movements, which emphasise its importance as a cultural tradition (Narayan 1997). Therefore, they often emphasise a more pragmatic and dialogical approach, in particular, the need to understand the complexity of FGM/C and its multiple meanings and functions within a community (Hernlund and Shell-Duncan 2007; Khamasi 2015).

### **3.3. Why and how to involve men in counteracting FGM/C**

Gily Coene (*VUB*)

Female genital mutilation cannot be considered an issue for women alone (GAMS 2016). Men – as fathers, husbands, and community and religious leaders – play an important role in counteracting FGM/C (Al-Khulaidi et al. 2013). However, research reveals that men are not only badly informed about the practice, but they also often have an ambiguous attitude towards it. Many men wish to abandon the practice because of the physical and psychosexual complications to both women and men (Varol et al. 2015). Some studies have pointed to male complications resulting from FGM/C, such as difficulty in penetration, wounds/infections on the penis, and psychological problems (Almroth et al. 2001).

Most men are also aware of the female complications resulting from FGM/C. Nevertheless, social rules and gender roles make it difficult to discuss these issues and, consequently, hinder change. Men who support the abandonment of the practice are influenced by notions of social obligation, religion, education, ethnicity, urban living, migration, and an understanding of the negative consequences of FGM/C. The project Men Speak Out, co-funded by the DAPHNE programme of the European Union, aims to engage men in ending FGM/C by training peer educators.

### **3.4. FGM/C and the perspective of empowerment**

Sonia Núñez Puente and Magaly Thill (*URJC*)

The key issue regarding the definition of empowerment is the way in which it should be perceived as a token of the mode of possibility, at the same time addressing its tension with the mode of necessity (Claramonte 2016). The mode of possibility refers to the actual possibilities that agency means for the subject, without accounting for the reasons and purposes of the very same possibilities that are laid out by the concept of agency (Hartmann 2015).

Postmodernity allows for the discussion of the notion of possibility itself, but it does not allow for the process(es) of meaning-making, falling short when

it comes to addressing the reasons why we, as postmodern subjects, do the things we do. The mode of necessity explains what makes a certain repertoire coherent. The tension built up between both modes constitutes, and, at the same time, broadens, the proper concept of empowerment. However, empowerment is useless in itself if it does not account for the repertoires or stable modes of agency of which the subject is able to make use. This is pivotal in the case of FGM/C because if we claim an empowering perspective, we cannot do so without first dealing with the inherent possibilities that the category of 'repertoriality' offers as a source of autonomy for the victims or survivors.

Developed by Paulo Freire and adopted with resounding enthusiasm by feminist scholars, the perspective of empowerment is especially important when it comes to women from the Global South addressing their double condition of female individuals in patriarchal societies and colonial subjects under Western cultural imperialism. The reluctance of some African women towards international efforts to end FGM/C is not against the desirable goal of abandoning the practice, but against the strategies and the methods used, the process of dehumanisation, infantilization and objectification to which they are submitted, and the ways that their bodies are used to represent the 'barbaric nature' of African cultures in opposition to Western 'civilisation' (Thiam 1983, 753; Nnaemeka 2005, 30; Tamale 2011, 20).

In this context, based on the humanistic concept of power embraced by Black feminism as self-actualisation, self-determination and self-definition (Hill Collins 1991, 224), the empowerment of women of the Global South is intimately linked with their awareness, agency and freedom to bring about their self-representation as collective and individual subjects who are culturally contextualised. Therein lies an opportunity for African feminists to transform culture favouring 'the linkages between its positive aspects and the emancipation of women' (Tamale 2007, 164). In other words, to depatriarchalise their own cultures.

### Practical exercises to be used in the classroom

Exercise 1. The students will be divided in four groups. Each group will prepare a comparative analysis of FGM/C and the hijab (Islamic veil), using the conceptual tools developed by one of the following feminist authors: Nancy Fraser (participatory parity), Geneviève Fraisse (consent theory), Gayatri Spivak (subalternity) or Patricia Hill Collins (empowerment). After the presentation of each group's work, students will defend their positions in a debate moderated by the professor.

Exercise 2. Two documentary films will be screened: one on FGM/C, as practised in Kenya (*The Cut*), and the other on FGCS, as performed in the UK (*The Perfect Vagina*). The students will then analyse the arguments used to justify both practices, their signification, and the consequences that they have on health, sexuality and gender equality. The following questions can then be asked to encourage the debate: Do both practices involve the same organs? Are their consequences comparable? Do they have different significations? Which elements are common to both significations? Which recommendations should be raised?

### Evaluation exercises

Exercise 1. Choose three testimonies from FGM/C survivors (in the ethnographic text boxes) and analyse them using the conceptual and theoretical tools introduced in this chapter.

Exercise 2. Watch the documentary film *Women talking about their personal experiences of female genital mutilation (FGM)*, produced by the National Health Service in the UK. Choose the testimony of one of the survivors therein and use a theory developed by an author cited in this chapter to assess effective protection and assistance programmes adapted to the experience of the woman whom you have selected.

Exercise 3. Discuss how the perspective of intersectionality is helpful in developing gender-sensitive policies for enforcing the rights of girls born in Europe to families from communities that practise FGM/C.

### Audio-visual resources

**The Cut:**

<https://www.youtube.com/watch?v=rmcqq-tbhpa>

**The Perfect Vagina:**

<http://topdocumentaryfilms.com/perfect-vagina>

**Women talking about their personal experiences of female genital mutilation (FGM), produced by the National Health Service in the UK:**

<https://www.youtube.com/watch?v=531rxhalkui>

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## Chapter IX.

### Communication and media

#### Didactic objectives:

1. To raise awareness among communication students, as future professionals, on how FGM/C is portrayed in/by the media;
2. To understand the different dimensions represented in different media contexts (film, news, etc.);
3. To make students, as future professionals, aware of the silence and taboos regarding media coverage of FGM/C;
4. To be conscious of the ethical dimensions of how cultural practices are represented in the media; and
5. To avoid stigmatisation and victimisation of particular groups through prefabricated narratives.

#### Summary:

1. An approach to communication (Lidia Fernández Montes, URJC)
2. Mediation: The media as a socialising agent, identity-builder and experience mediator (Lidia Fernández Montes, URJC)
3. How FGM/C is addressed in the media: Hegemonic stories, perspectives, frameworks of meaning, and dominant imagery regarding FGM/C (Ricardo Falcão, CEI-IUL)
4. The mapping of voices, actors, scenarios and storylines (Diana Fernández Romero, URJC; and Sonia Núñez Puente, URJC)
5. Figurativisation: The representation of the victim (Diana Fernández Romero, URJC; and Sonia Núñez Puente, URJC)
6. Mass-cultural narratives: FGM/C, cinema and advertising (Diana Fernández Romero, URJC; and Sonia Núñez Puente, URJC)
7. The stigma: Taboos, invisibilities and silence regarding FGM/C (Sonia Núñez Puente, URJC)
8. Displacements of conventional representations (Sonia Núñez Puente, URJC)
9. Approaching FGM/C from a gender perspective and the defence of human rights (Diana Fernández Romero, URJC; and Magaly Thill, URJC)
10. The ethical dimension (Lidia Fernández Montes, URJC)

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*‘Change can happen through sustained media attention on the damaging public health consequences of FGM, as well as on the abuse of the rights of hundreds of thousands of women and girls around the world.’*

**Ban Ki-moon, Secretary-General of the United Nations**

## 1. AN APPROACH TO COMMUNICATION

Lidia Fernández Montes (URJC)

This sectoral chapter is intended to be a tool for communication students, to help enhance the coverage given to the consequences of the practice of female genital mutilation/cutting (FGM/C) on women and girls, their families and communities.

The media can and must play a fundamental role in increasing awareness about, and committing to the abolition of, FGM/C. We will therefore focus on a non-directive approach, based on dialogue and debate, and create a space for learning and an attitudinal change, as a way of contributing to the protection of women’s and girls’ rights and well-being.

Raising awareness involves knowledge and a deep comprehension of the practice of FGM/C and its contextualisation. Therefore, networking with different stakeholders is key to developing our work as communicators.

## 2. MEDIATION: THE MEDIA AS A SOCIALISING AGENT, IDENTITY-BUILDER AND EXPERIENCE MEDIATOR

Lidia Fernández Montes (URJC)

Today, nobody questions the hegemony of mass-media culture, and therefore, in this guide, it is fundamental that we deal with how it builds our reality.

The media has a growing influence as a cultural instructor, since it determines, to a large extent, our ideas, habits and customs. It suggests, proposes

and ascribes models, values and ideals that can impose themselves with a great amount of force or persuasion, when presented in a dramatic or emotional context that contributes to inhibiting a critical judgement (Rocher 1972).

As an institution with a high level of credibility, the media generates ideas and thoughts that are strongly inscribed in the public conscience, constituting a knowledge that is reaffirmed in the cultural fabric of society (Thompson 1998).

The media not only provides information. It also offers a selective construction of the knowledge of society, pointing out what is important and what is not. As Margarita Rivière (2003) opines, 'The media, in my opinion, don't inform anymore or, if they do, this is a secondary goal. The media, although they refuse to recognise it because they probably don't have time to dwell on it, educate. This is the media's mission: the permanent education of people, by creating preferences, values, cultural habits, myths and antimyths, and customs.'

However, we must not forget that, in some cases, the media can fall for the seduction of sensationalist journalism, often associating FGM/C with negative opinions on immigration and religion, and hiding the reality of this harmful practice. This is why a good framing from the media is so important.

### 3. HOW FGM/C IS ADDRESSED IN THE MEDIA: HEGEMONIC STORIES, PERSPECTIVES, FRAMEWORKS OF MEANING, AND DOMINANT IMAGERY REGARDING FGM/C

Ricardo Falcão (*CEI-IUL*)

As a mediatic subject, FGM/C sparks very affective reactions on its reception, but we should look closely at the dimensions of the practice that are normally represented in/by the media, and which ones might be excluded or less visible than others. Is it seen as the transversal phenomenon that it is, or are some dimensions more elicited than others?

First, we should decide the extent of what we consider 'the mediatic production' around the subject of FGM/C. As this is a communication module, it is in our best interests to maintain a wide approach, considering both newspaper articles and documentaries, as examples. They convey different dimensions of FGM/C, but they are both powerful communicative tools easily shared today. One is, preferably, informative, and the other, due to its temporal dimension, is also experiential. These different dimensions also determine the stories, as do the institutions that communicate them, be they generalised national newspapers, ethnographic documentaries, or institutional video-documentaries, whether graphic or focused on narratives in the first or third person.

Generally speaking, we should consider the differences in format in line with the audiences targeted by the institutions that produce content.

Take the newspapers *El País* (Spain), *Jornal Público* (Portugal) and *Corriere della Sera* (Italy) as examples from different European countries. These newspapers inform readers about the practice of FGM/C, essentially by linking the news they publish on the subject to specific events (e.g. cases in respective countries, deaths by FGM/C, condemnations based on the practice), while also giving a prominent place to the agenda against FGM/C, informing readers about official statistics when they are published, both locally and internationally (coinciding with wide-reaching campaigns), and public announcements at a political level, and nationally, when specific studies and countrywide programmes are announced.

There is a specific focus on girls and women at risk, but also on 'cases referenced', if we take the example of news published in the last couple of years in *Jornal Público* (Portugal). This focus only allows for a few personal accounts to be heard through the voices of women, who are often describing the horror of the moment when they underwent FGM/C, the sounds of the cutting, being held, the pain, the social pressure, the trauma revisited throughout their lives, or even the negative health consequences. These experiential dimensions contribute to creating the background imagery against which normative anti-FGM/C discourse is legitimised, creating a framework in which communicating about the practice is concomitant with the setting of agendas.

On the other hand, in newspapers, there seems to be a noticeable scarcity of perspective on the ethnological dimension of FGM/C, i.e. local meanings attributed to the practice. The contradictions associated with the representation of FGM/C as a human-rights issue are also under-represented. This also impacts on the visibility of the multiple challenges in the fields of action against FGM/C. Much more common are the institutional approach to tackling FGM/C, statistics, and debates around human rights.

On the contrary, and preferably, documentaries focus on dimensions that are absent from the mainstream horror stories of FGM/C and their counterparts, steps to eliminating barbarism. In documentaries, we are often taken directly to the field, be it in communities (mostly in Africa) or through the work of NGOs and governmental organisations in the health sector. The voices of women are heard, and their stories try to explain the local implications, often personifying the refusal to undergo a harmful tradition through the perspective of girls at risk.

A general overview will also tell us that the depiction of FGM/C conveys a very poignant sense of gendered bodily horror and the subjugation of women to culture, but also their claim for freedom from it. In a wider sense, though, it is remarkable to note the amount of communication focusing on the practice through a set of well-defined lenses that divide the subject into 'traditional South' and 'health consequences in the North', protective of women's and children's rights.

Resistance to change is confronted by resistance to a harmful tradition, thus creating powerful stories of individuals confronting society and the many pressures being exerted upon them. The identity of specific communities is then often questioned in a mainstream mediatic approach, and the narrative is often voiced by individuals refusing to undergo the practice or campaigning against it.

The image created by/in the media contributes to the rhetoric against FGM/C, focusing on the practice, why it exists, and how it produces victims and perpetrators, but, unfortunately, rarely contextualising the deeper implications and less straightforward resistance.

Finally, the imagery used by/in the media is rarely graphic, as it is widely assumed that the ceremonies associated with FGM/C might upset and cause violent rejection and/or strong emotional responses on the part of spectators. On the contrary, the dimension of sound, often undervalued in moving pictures, normally conveys strong meaning through screams, anxious gasping, crying, and the final silence.

#### 4. THE MAPPING OF VOICES, ACTORS, SCENARIOS AND STORYLINES

Diana Fernández Romero and Sonia Núñez Puente (*URJC*)

It is fundamental that we identify the actors, and, thus, the voices, that articulate the storylines of FGM/C if our aim is to strive for the media's narrative to change and activate a transformation of the political and social responses to FGM/C.

A social actor can be defined in a relationship between communicative interaction and a specific narrative scenario. Even though a social actor can be collective or individual, his or her essential characteristic is the specific position that he or she has in the narrative scenario, and, so, his or her specific interests in this scenario (Carballeda 2008; Jensen 1997).

The mapping of social actors who intervene in the construction of a particular media narrative on FGM/C allows us to establish what influence it has on the discursive axis, determining the interests and influences of the actors and voices related to FGM/C. This enables the transformation of the narrative scenario in the media and, ultimately, facilitates a changed approach to the invisibilities and silences of FGM/C victims, who cannot establish their own narrative scenarios.

## 5. FIGURATIVISATION: THE REPRESENTATION OF THE VICTIM

Diana Fernández Romero and Sonia Núñez Puente (*URJC*)

The general representation of women who have suffered from FGM/C has deep implications on the public image of the victims of this practice. The hegemonic figurativisation of the victim, which generally follows the media's logic of spectacularisation (a young black girl or woman, with African clothing, with her face sufficiently hidden), implies the shaping of a common sensibility and an ethical position, agreed on by public entities regarding the victim, who is put forward for these representations. In a lot of cases, the victim of FGM/C is characterised in stories as the 'other', the subordinate, named and built in a discourse that inspires compassion, distancing oneself from the mutilated/cut women at the same time.

The representation of subordination can be a source of distance and stigma for the victims, for whom there is empathy, but, at the same time, from whom we distance ourselves. However, these representations can also bring women to resist and break from this subordination and call on the public by promoting alternative practices and emotions regarding the problem. As Judith Butler (1997) argues, a subject called out in a narrative with prejudicial terms can embrace these terms, since they constitute the social subject, but it is also because the subject has embraced these terms that he or she can resist or oppose them.

In the representation of women who have suffered FGM/C, ethnicity, race, gender, religion and age interact as variables that are incarnated in the bodies of the victims in processes of embodiment (Romero Bachiller and García Dauder 2003). This is the crystallisation, or the fixation, of the marks of exclusion and inclusion in the figurative and emotional repertoires inscribed on the bodies of the subjects (Sáiz Echezarreta 2008).

## 6. MASS-CULTURAL NARRATIVES: FGM/C, CINEMA AND ADVERTISING

Diana Fernández Romero and Magaly Thill (*URJC*)

The cinematic treatment of FGM/C offers interesting examples on how it is possible, within mass-cultural narratives, to condemn and raise awareness on this practice, which violates women's rights.

Perhaps the most well-known recent documentary film is *Desert Flower* (Sherry Hormann; United Kingdom, 2009), which tells the true story of Waris Dirie, a Somali model, writer and activist, the daughter of African nomads, who

was genitally mutilated/cut at three years of age. There is a particularly poignant moment in the film, when the main character explains to the United Nations (for which she was a special ambassador against FGM/C at the time) that her two sisters died from the practice, saying that it is not only extending within Africa, but to other parts of the world through migration.

Another cinematic example of African women's fight against FGM/C is portrayed in the fictional film *Moolaadé* (Ousmane Sembène; France, Senegal, Burkina Faso and Cameroon, 2004). The main character, Collé Ardo, is an African woman who has suffered mutilation/cutting, refuses to let her daughter go through what she has suffered, and takes in other girls escaping ablation. She thus practises *moolaadé*, or right of asylum, as opposed to *salindé*, or the ritual of 'purification'. Ardo provokes a crisis in her village in Burkina Faso and unleashes the rebellion of other women who refuse to let their daughters be mutilated/cut.

An example of non-African film is the documentary *Making Pure Girls*, made by Nabaz Ahmed and Shara Amin, two Kurdish filmmakers who interviewed girls, women and men in many places of Iraqi Kurdistan on the impact of FGM/C over a decade. It was adopted by grassroots organisations to change customs towards the practice and ended up playing a key role in the adoption of the ban on FGM/C by the Kurdish government in 2011. A short video made by BBC Arabic and *The Guardian* explains this experience (BBC 2013).

In the area of audio-visual documentation aimed at preventing FGM/C in European countries, we have awareness-raising documentary films made with the testimonies of African migrant women, like *Bref* (Christina Pitouli; Spain, 2013), produced by Médicos del Mundo, or *Women talking about their personal experiences of female genital mutilation (FGM)*, produced by the National Health Service in the UK (National Health Service 2015). We can also find animated videos like the Spanish *Mariama* (Mabel Lozano; Spain, 2016), produced by the Unión de Asociaciones Familiares, or the short creative video talk *Equals? Leyla & Emma*, produced by the British organisation Daughters of Eve (Daughters of Eve 2012).

Additionally, the anthropological aspects of FGM/C have been addressed in documentary films that attempt to raise knowledge and awareness about the practice. An example of this kind of educational film is the Wassu-UAB Foundation's *Iniciación sin mutilación* (Wassu-UAB Foundation 2013).

Advertising is a strong medium with which to convey narratives, images, experiences and shared emotions, and to influence behaviour. That is why it has played a key role in some campaigns against FGM/C, although it might produce negative side effects, due to the harshness of sensationalism used by advertising agencies and the stigmatising subliminal messages that may be embedded against migrant communities. An example of this can be found in the polemic 'It Happens Here' campaign (2015), designed by Ogilvy & Mather, which featured the flags of countries like Germany, the United Kingdom and Switzerland sewn

together as a metaphor for infibulated vulva. This campaign, in spite of being awarded at the Cannes Lions International Festival of Creativity, was heavily criticised by the END FGM network in the following terms: ‘Stigmatising imagery can alienate affected communities even more, and we need to ensure that they are central to ending FGM (Sanghani 2015).’

## 7. THE STIGMA: TABOOS, INVISIBILITIES AND SILENCE REGARDING FGM/C

Sonia Núñez Puente (*URJC*)

The invisible narrative that silences the voices of FGM/C victims in media narratives follows, among other factors, the communicative efficiency of presenting the consequences instead of analysing the causes (Vila-San Juan 1999). The stigma that, in the majority of cases, goes with the media treatment of FGM/C influences, precisely, the narrative silences provoked by the sustained elaboration of a taboo, built around the immanence of the victim’s character, often associated with women who have suffered FGM/C.

The media’s silence around FGM/C contributes to sustaining a generalised taboo and takes away the option of the receptor redefining the narrative, activating a strategy of deviation from the original message. The taboos that articulate the narratives of FGM/C are great in the context of scenarios, actors and voices that constitute their own media representation. To produce a change in the narratives of FGM/C, we must, ultimately, take into account the taboos that are completely logical for the receptor, since, despite the fact that these do not have a direct utilitarian function (Barthes 1975), they express the sociocultural conditions in which a specific narrative is anchored, as is the case for those about FGM/C.

## 8. DISPLACEMENTS OF CONVENTIONAL REPRESENTATIONS

Sonia Núñez Puente (*URJC*)

The conventional representations of FGM/C tend to present the woman as a character with no capacity to act, or with a limited capacity that cannot get her out of a narrative of victimisation. We must explore the communicative practices that take us away from the conventional representation of FGM/C victims, studying, on one side, the roles of the different actors involved, and, on the other side, the voices and scenarios in which FGM/C is narrated as an issue of media interest.

The epistemological approach towards a message for social change manages to overcome representations of the victim as a passive element, to

introduce the vision of an active subject with the capacity to transform the physical and representational violence of FGM/C. For this, we believe it is necessary to look into the communication initiatives of the resignification of victims, involving them in the debate on the place of the political subject in the construction of the collective and individual identity. The campaign launched by Jaha Dukureh in association with *The Guardian* is an example of how to displace hegemonic representations of FGM/C, as it shows the representational transformation of Dukureh from being exclusively considered a victim to being considered one of the most influential women by *Time* magazine.

## 9. APPROACHING FGM/C FROM A GENDER PERSPECTIVE AND THE DEFENCE OF HUMAN RIGHTS

Diana Fernández Romero and Sonia Núñez Puente (*URJC*)

Informing others about FGM/C implies commitment and purpose. To approach FGM/C from a gender perspective and the defence of human rights is fundamental to dismantling the majority narrative of victimisation and promoting respect and dignity for the women who have suffered from the practice.

As the journalist Patricia Simón (2016) points out, the focus on human rights involves dedicating a lot of time to research, to ‘capture undocumented moments’ and give victims ‘the time, space and silence they deserve’. In this sense, Simón proposes avoiding the cliché of the ‘ideal victim’, who fits the stereotype of the passive subject that the public wants. On the contrary, the media must recognise the authority of survivors and let them talk, as long as it is what they want, avoiding colonialist visions and favouring their empowerment. The proposed focus also requires us, according to Simón, to take notice of the legal, social, economic and political contexts in which the violation of human rights takes place, to help understand the phenomenon in all its dimensions.

## 10. THE ETHICAL DIMENSION

Lidia Fernández Montes (*URJC*)

Kelly Oliver (2004) puts forward the concept of ‘ethical witnessing’ after observing that the hegemonic forms on which information/representation is based is an ‘accommodating recognition strategy’, in which one can only understand things with which s/he is familiar.

To address this, Oliver puts emphasis on the ethical and political value of spectatorship, i.e. not only holding the other or oneself accountable, but having an impact on the responsibility towards others or oneself.

As the professors Gámez and Núñez (2013) point out, 'To give ethical testimony, there is a first step, which is, effectively, the recognition of what one sees, but, beyond this, the narrative must activate the necessary mechanisms so that the spectator subject can update his or her responsibility regarding what he or she sees,' in this case, FGM/C.

### Suggestions for analysis in class

- 1) Audio-visual: Check the list of films and documentaries on FGM/C and try to find different subject approaches: first person versus third person; institutional videos versus documentaries; and/or personal or health-centred experiences. Discuss the different temporal dimensions and consequences of these approaches.
- 2) Newspapers: Do a search in the newspapers of your country and check their reports in relation to criminalisation and the publication of statistics. Check for reports on cases/condemnations about FGM/C; asylum demands; and/or countries of origin.
- 3) Source comparisons: Note the scarcity of ethnographic points of view in newspapers, as opposed to their relative abundance in audio-visual materials. Discuss the different implications thereof.

### Evaluation exercises

1. After reading the contents and references in this guide, write a newspaper article on FGM/C in Europe (900 words).
2. Make a comparison between the two following videos taking into account bad and best practices:

Ending Female Genital Mutilation in Côte d'Ivoire (UNICEF): <https://www.youtube.com/watch?v=a3WJsNBaT98>and

African women condemn female genital mutilation (UNICEF): [https://www.youtube.com/watch?v=Tt8\\_TVH14Qg](https://www.youtube.com/watch?v=Tt8_TVH14Qg)

What image of girls and women is given? Are the cultural reasons behind the practice addressed? What aspects of the fight against FGM/C are most emphasised in each video?

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