Policy Regimes toward Female Genital Mutilation:

A comparative analysis of the strategies for eradication in France and The Netherlands

By

Sinéad Costelloe

B.A., University of the West Indies, 1998

A Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of

MASTER OF ARTS

Department of Political Science

University of Victoria

British Columbia, Canada

© Sinéad Costelloe, 2010
University of Victoria

All rights reserved. This thesis may not be reproduced in whole or in part, by photocopy or other means, without the permission of the author.

Policy Regimes toward Female Genital Mutilation:

A comparative analysis of the strategies for eradication in France and The Netherlands

By

Sinéad Costelloe

B.A., University of the West Indies, 1998

Supervisory Committee

Dr. Amy Verdun, Supervisor
(Department of Political Science)

Dr. Oliver Schmidtke, Department Member
(Department of Political Science)

Supervisory Committee

Dr. Amy Verdun, Supervisor
(Department of Political Science)

Dr. Oliver Schmidtke, Department Member
(Department of Political Science)

Abstract

Female genital mutilation, or FGM, is a harmful traditional practice that was brought to Europe by immigrants from practising regions in Africa. Despite numerous approaches to the eradication of FGM, the tradition perpetuates within the immigrant communities in several European countries. Drawing on the available literature, film and interviews, this thesis presents a comparison of the French and Dutch strategies to tackling the problem of FGM. The thesis argues that the Dutch preventative approach could benefit from adopting particular features of the French punitive approach. The thesis concludes by proposing that strong legislative measures that apply to the discovery, investigation and prosecution of FGM cases have contributed significantly to the decline of FGM among practising communities in France, and as such, would have similar results if incorporated into the Dutch strategy for the eradication of FGM.

Table of contents

Supervisory Committee ii
Abstract iii
Table of contents iv
List of Acronyms vi
Preface vii
Chapter 1: Introduction 1
Structure 6
Literature Review 7
Methodology 14
1. Hypothesis 14
2. Research design 19
a) Criteria for comparison: France and the Netherlands 19
b) The French case study: Defendant Mme Hawa Gréou 22
c) The French case study: Prosecutor Mme Linda Weil-Curiel 24
3. Interpretation of the findings 27
Chapter 2: Case Study of Mme Hawa Gréou, Part 1 33
The prosecution of an excisor 33
The case study as a social indicator 34
Chapter 3: Female Genital Mutilation 36
The procedure 36
Justifications for the practice of female genital mutilation 38
Health implications 42
Female genital mutilation as a violation of human rights 43
Legislation against female genital mutilation 45
Socio-economic implications 47
Chapter 4: The "French Model" 50
Migration of the practice of female genital mutilation to France 50
Key features of the French punitive approach 54

Chapter 5: The strategy for eradication in the Netherlands *56*

Migration of the practice of female genital mutilation to the Netherlands *56*

Key features of the Dutch preventative approach *57*

Chapter 6: Case Study of Mme Hawa Gréou, Part 2 *63*

Lessons learned from the "French model" *63*

Transferability of the "French model" to the Netherlands *65*

Chapter 7: Concluding Observations and Recommendations *71*

Appendix *74*

Addendum – First case of FGM in the Netherlands *76*

Annex 1: Note on terminology *78*

Interviews *80*

Bibliography *81*

List of acronyms

CAMS	Commission pour l’Abolition des Mutilations Sexuelles
CEDAW	Convention on the elimination of all forms of discrimination against women
CRC	Convention of the Rights of the Child
ECOSOC	International covenant on Economic, Social and Cultural Rights
EU	European Union
FSAN	Federation of Somali Associations in the Netherlands
HIV	Human immunodeficiency virus
IAC	Inter African Committee
ICRH	International Centre for Reproductive Health
IOM	International Organisation for Migration
NGO	Non-governmental organisation
OFPRA	Office Français de Protection des Réfugiés et des Apatrides
OHCHR	Office of the High Commissioner for Human Rights
UNAIDS	The Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Progamme
UNECA	Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization

Preface

My interest in female genital mutilation had an unexpected beginning in that I first learned of the practice 'in my own back yard' on the island of Tobago. In 1992 I graduated from high school in Trinidad and decided to work for a year at a hotel in Tobago. During a conversation with one of my colleagues from the hotel, the topic came up about traditional practices in Tobago that had been introduced by Africans during the era of the trans-Atlantic slave trade. Many of these customs were still prevalent in the islands, passed down from generation to generation, enriching our local culture and language. One colleague then told me about a certain African tradition that she was relieved was no longer in practice, but that had been prevalent in rural Tobago, and to which her own great-grandmother had been subjected. This practice was female genital mutilation, and it was the first time I had ever heard of the tradition. Female genital mutilation had been continued by the African community in Tobago as a means of maintaining their cultural identity and connection to mother Africa, even after the abolition of the slave trade and slavery.

I became particularly interested in the history of this harmful traditional practice, reading whatever literature I could find on the subject, and I was intrigued by the fact that it had been passed down through descendants of slaves to a point within the living memory of my colleague and her family. The eventual eradication of the practice had been achieved through the combined factors of the efforts of missionaries, the tide of modernization, better integration of the rural communities into mainstream society, and to a lesser degree through the awareness of women's

and children's rights and the law. More or less, the practice of female genital mutilation in Tobago simply died out.

In 2008, as part of an internship in Austria, I found myself working on a project proposal to prevent and eradicate female genital mutilation in Europe, where the practice had travelled from regions in Africa via the migration process. Unlike the situation in Tobago, female genital mutilation was still being performed, illegally, on young girls and women within the immigrant communities in the destination country, or during trips back to the country of origin in Africa. How could such a horrific practice persist in what I considered to be the first world countries of the European Union?

By the time the project proposal was complete, I had a deeper understanding of the factors that contribute to the persistence of female genital mutilation among immigrants in Europe, and a renewed appreciation for the challenges inherent in addressing such a socially sensitive issue. I chose this topic for my thesis as a means to gain deeper insight into policy development and the transferability of policy regimes, focussing on France and the Netherlands in this case. These two countries form a particularly neat comparative study in that the context of female genital mutilation is similar in both, but they differ in terms of methods of discovery, investigation and prosecution of FGM cases. This distinction identifies the French policy as punitive, and the Dutch policy as preventative. This thesis explores this distinction. It contributes to the debate by suggesting that the Dutch policy objective of eradicating female genital mutilation in the Netherlands would be well served by incorporating key features of the French strategy.

Chapter 1: Introduction

Female genital mutilation, or FGM, is a harmful traditional practice that was brought to France and the Netherlands by immigrants from practicing communities in Africa.[1] Though both France and the Netherlands have taken similar steps to eradicate FGM within their borders, the Netherlands has developed policies along a mostly preventative path, whereas France has added punitive measures to its approach to FGM. These punitive measures are based on key legislation that specifically address the methods of discovery and reporting of cases of FGM and has contributed to the decline of the practice of FGM in France. This research proposes that if the Netherlands adopts similar legislation, the resulting increase in prosecution of FGM cases will then lead to a speedier decline in the rate of the practice.

In the Netherlands, FGM has been criminalized under the Dutch Penal Code, but to date there have been no prosecutions of FGM cases. Under the Penal Code, FGM constitutes child abuse and grievous bodily harm. However, the Dutch policy toward FGM remains strongly preventative through targeted campaigns, in particular, health, education, human rights, religious, social and legislative awareness-raising campaigns. Though the effects of prevention are difficult to quantify in terms of FGM, social workers and health care providers who constitute some of the first responders[2] engaged in the eradication of FGM have indicated that

---

[1] www.tegenvrouwenbesnijdenis.nl/content/upload/doc/Vgvrapport.pdf. Page 11 accessed June 11th 2010.

[2] First responders refer to individuals, groups, organizations, government and non-government employees, professionals and police officers who come into contact with or work with victims of FGM

prevention has led to a decline in the rate of FGM in the Netherlands. However, when new cases of FGM emerge and gain widespread publicity, usually due to a medical emergency or death of a child as a result of FGM, pressure mounts to develop a stronger Dutch policy toward FGM. These demands are mostly based on the premise that prevention alone is inadequate for accelerating the decline of FGM.[3]

Support for strong legislation points to the French policy regime toward eradication of FGM, specifically to the mandatory health checks of pregnant women and children less than six years old, and the legal obligation to report cases or suspected cases of FGM to the relevant authorities. These legislated measures are the most effective methods of discovery of FGM cases and apply to all French permanent residents and citizens, though they are aimed at communities that contain a high concentration of immigrants from regions in Africa where the practice was, or still is, prevalent. However, the French policy regime toward the eradication of FGM, or "French model", is not without criticism. The Dutch first responders to FGM-related issues would prefer to incorporate the best practices of the "French model" into the Dutch preventative policy to a wholesale adoption of such a punitive strategy. This research presents a case study of the "French model" that examines selected practices then supports their transferability to the more preventative Dutch policy regime toward the eradication of FGM.

---

or any issues related to FGM. As such, first responders can be teachers, health care providers, immigration officials, social workers, NGOs, etc.

[3] Please see the Appendix on page 81 for a sample of the estimated rates of FGM in France and the Netherlands.

The main flaw in the "French model", or any strategy against FGM, is that due to the clandestine nature of the practice, it is difficult to gather and quantify the direct results of punitive and preventative measures. Not all instances of families abandoning the practice, nor why they chose to do so, will show up in the data. As such, estimates on rates of decline tend to be conservative even when there is a significant shift in the numbers of reported FGM cases. [4] The introduction of strong legislation against FGM in France has led to better quantitative data collection by facilitating an increase in the number of successfully prosecuted cases.[5] The information gathered from these cases indicates that the rate of FGM has significantly declined since the adoption of strong legislation against the practice.

The lack of complete data on the effects of preventative measures on the occurrence of FGM does not imply that prevention has had no effect at all only that information on the impact of prevention is limited. Information that indicates a decline in the practice of FGM can be anecdotal and collected as qualitative data. A woman who has been excised but chooses not to submit her daughters to the practise is under no obligation to explain her decision to any of the first responders, such as teachers or health care providers. Nevertheless, such information can contribute to the data being gathered on rates of decline that are attributable to preventative measures.[6] First responders involved in FGM-related issues in both France and the Netherlands have provided strong evidence to suggest that

[4] See note on Appendix, p. 81.
[5] Successful prosecution of FGM cases refers to cases that result in the conviction and/or fining of excisors and/or those who assisted in the mutilation of the victim, such as parents, relatives or guardians.
[6] Rates of FGM presented in the Appendix are taken from the most reliable source for this data from what data is available.

preventative measures such as health, education, human rights, legislation and social awareness-raising campaigns have had a notable impact in the strategy for eradication of FGM. These measures are in place in both countries, but France has taken the extra step with legislated methods of discovery and reporting of cases, or suspected cases of FGM.

In most other regards, the context of FGM in both countries is very similar, and the legislative distinction has led to increased pressure in the Netherlands to incorporate similar features into their preventative strategy, thereby taking a more punitive approach to the eradication of the practice. This push towards a more punitive approach has been met with resistance in the Netherlands mainly on the basis that such legislation undermines other policies and will lead to discrimination. However, by examining the "French model" that also had these concerns, the research supports the position that a prevention strategy is not enough to accelerate the decline of FGM, and incorporating strong legislation will improve such a strategy more than undermine it.

This thesis examines the French policy regime toward FGM, or "French model", through a case study that serves as a typical example of the successfully prosecuted French cases of FGM that have been brought before the courts. As such, this case study presents the extent of the impact as well as the limitations of both prevention and strong legislation against FGM. The similarity of the issues related to FGM in both the French and Dutch contexts allow for exploration of the feasibility of transferring the "French model" into the Dutch policy regime toward the eradication of FGM. The emerging theory seeks to improve the predictability of

measures for the eradication of FGM in the most effective manner. The underlying assumption of the research is that strong legislation against FGM is essential to speeding the complete eradication of the practice.

Besides reviewing the differences between the Dutch and French policies on FGM, this thesis also seeks to offer an in-depth study of FGM to readers who have never heard of female genital mutilation or are unaware that the practice continues in both the developed and developing world. Not all readers are familiar with the situation or the circumstances surrounding the practice, and why it persists. The lack of open dialogue on the subject within the target group[7] is attributed to the culturally taboo nature of discussing the female genitalia and "women's issues" in general. In wider society, open discussion of the issue is hindered by the fact that many who are in a position to speak out do not want to be seen as culturally insensitive or as interfering with cultural traditions of a minority group. 'Political correctness' in this sense, forms a powerful undercurrent of policy reform, and the development of policy regimes toward the eradication of FGM. In France, debate on strategies to eradicate FGM was initiated in the 1970s by the medical community, along with the demand for stronger legislation against the practice. More recently, open dialogue on the subject of FGM is being encouraged on all levels of the Dutch strategy for eradication (as explored later in the section on key features of the Dutch preventative approach in Chapter 5). Between the two countries, the usual publicity and media attention that surrounds prosecution of the French cases contributes to the pressure to discuss, develop and implement a stronger Dutch

[7] See Annex 1 for an explanation of the "target group".

policy regime toward eradication of the practice. Yet, in general, the topic of FGM and the issues surrounding the practice are not commonly understood in France or the Netherlands, and as such, this thesis intends to stimulate debate or provide a better understanding of the subject in as much as it may contribute to public policy.

In the remainder of this chapter I provide an outline of the structure of the thesis in chapters. Next, I offer a literature review that explores the main debate on the feasibility of adopting the "French model" into the Dutch policy regime toward the eradication of FGM in the Netherlands. Finally, in the methodology section I seek to explain the process by which the research was conducted.

Structure

In Chapter 2, I introduce the case study of a French-Malian excisor ,[8] Mme Hawa Gréou, who was successfully prosecuted for performing female genital mutilation in Paris. This case study embodies the main policy issues of prevention and prosecution addressed in the thesis. As such, the case study is threaded through the thesis, and is referred to again in Chapter 6 in greater detail.

Chapter 3 presents an explanation of the procedure and types of female genital mutilation, as many who are unfamiliar with the practice have difficulty in coming to terms with what exactly occurs to the victim during and after the procedure. As such, it is also essential to explore the justifications for the practice and the impact that the practice has on the health and human rights of victims. This

[8] "Excisor" is the term used to refer to the individual who performs the actual procedure of FGM. An excisor is usually from a particular social class and can be either a man or a woman. Parents are not allowed to perform the procedure on their own children, but may assist in restraining the child.

chapter then goes on to present the legislative response to the practice, the value of the practice within the immigrant community and the socio-economic implications of the practice in France and the Netherlands.

Chapter 4 examines the "French model" by first presenting the history of how FGM came to be in France, and then by focussing on the key features of the French approach to the eradication of FGM.

Similarly, chapter 5 examines the Dutch strategy to eradicating FGM by first presenting the migration of the practice to the Netherlands, and then by assessing the Dutch approach to the eradication of FGM.

Chapter 6 takes another perspective on the case study of Mme Hawa Gréou by ascertaining whether the lessons learned are transferable to the Dutch policy regime on FGM and presenting what factors need to be taken into further consideration.

The thesis closes with my Concluding Observations and Recommendations.

Literature Review

The main debate on FGM in the Netherlands centres on whether or not to adopt more legislative measures in the strategy to eradicate the practice. This research focuses on the impact of strong legislation (in terms of the methods of discovery and reporting of FGM cases) and the enforcement of such legislation in contributing to the decline of FGM in France, and is referred to as the "French model". The research then analyses the transferability of the "French model" to the Netherlands where prevention has been the standard approach to the eradication

of FGM. The difficulty of collecting quantifiable data on the effectiveness of punitive versus preventative policy approaches has resulted in a lack of precise information that limits an extensive analysis of which approach has seen better results in the eradication of the practice and which approach should be adopted instead of the other. As a result of this limitation, the primary resources identified for the purpose of this research focus on whether or not adoption of the “French model” will have a significant impact on the decline of FGM in the Netherlands.

The contexts FGM in France and the Netherlands are found to be comparable in most regards. Much of the general literature on FGM-related issues illustrates the parallel circumstances in each country. However, the key pieces of legislation that facilitate the discovery and reporting of FGM cases and contribute most to the success of prosecution in France are absent in the Netherlands. Since 1986, France has been performing mandatory health checks on pregnant women and children less than the age of six, regardless of their ethnic background. This discovery process results in the highest rates of detection of FGM (as compared to other means of detection such as when teachers or friends of the victim are made aware).[9] Furthermore, French health care providers are legally required to report any cases or potential cases of FGM. This legislation facilitates the second step in the discovery and reporting process, which then leads to investigation and prosecution of FGM cases. In the Netherlands, the response to mandatory health checks has been resistance on the grounds that these checks can be considered a violation of privacy. Resistance on the part of the Dutch medical community to the

[9]http://www.lindamaykallestein.com/Linda_May_Kallestein/FGM_Info_files/Background%20info%20FGM.pdf

legal obligation to report cases of FGM have resulted in the limited measure whereby check-ups are only performed when FGM is suspected.[10] Even then, the Dutch health care providers, or anyone who discovers a case of FGM in the Netherlands, only have the right to report it to the authorities, not the legal obligation to do so as in France.

This distinction forms the main basis for contention in the debate surrounding the proposed shift in the Dutch policy regime toward FGM from preventative approach to punitive approach. In her article published in the Utrecht Law Review, Renée Kool thoroughly explores the limits of the current Dutch policy toward FGM and the implications of adopting the "French model".[11] These limits reiterate the argument that prevention can only do so much. The implications of the "French model" that stimulate the most concern refer to the violation of privacy and deterioration in relationships between health care providers and members of the target group, which forms the basis for resistance to the policy shift. Kool reiterates the fact that the French also had to contend with these implications when adopting the punitive approach, but that to continue along a strictly preventative path would not have resulted in the comparatively improved rate of decline of FGM in France.

In the article, Kool only briefly refers to criticism of the accuracy of the reported rates of decline in France, which consistently features in arguments against the adoption of the "French model" in the Netherlands. Due to the difficulty of collecting accurate data on FGM, critics of the punitive approach questioned the validity of such claims of a decline in rates of FGM in France since stronger

[10] www.utrechtlawreview.org/publish/articles/000118/article.pdf
[11] Ibid

legislation was adopted in the 1980s. These are salient points to the issue of the impact of prosecution on rates of FGM, and discussions in this vein tend to lead to the concern that prosecution against FGM may cause rates of the practice to increase through a cultural backlash. Kool's article quickly dispels that concern but goes on to emphasize that legislation and the visibility of prosecution of FGM cases will force the practice further underground and encourage members of the target group to avoid detection. In so doing, reported rates of decline can be considered a poor reflection of actual rates of FGM.[12] As the comparative case in this research, the response in France thoroughly addresses these concerns, confirming or eliminating these outcomes, and overall, resulting in consensus that strong legislation can benefit the Dutch prevention strategy against FGM.

As such, Kool confirms the generally accepted view that prevention is not enough and has a limited effect on the target group. The position that preventative measures must be coupled with legal accountability in order to have greater impact on rates of FGM is gaining support. Though the accuracy of any quantitative data on fluctuations in the rate of FGM after the adoption of the legislation on methods of discovery and reporting may be debated, studies conducted in health care and community centres have clearly indicated that the related prosecution of FGM cases has had the intended impact in France.[13] As the consequences of FGM continue to result in severe health issues and death, especially in cases of young children, supporters for stronger Dutch legislation continue to press for something more to

[12] As stated in the note on the Appendix on p. 81, the data provided in the tables in the Appendix are only samples of the estimated rates of FGM in France and the Netherlands.
[13] Kallestein, L. *Facts and Myths on Female Genital Mutilation.* www.lindamaykallestein.com, accessed 3rd May 2009.

be done in addition to prevention. As the French case study illustrates, the next logical step would be the adoption of legislation that facilitates the discovery and reporting of FGM cases through mandatory health checks and the legally enforced signalling function.

In further response to these concerns, Mme Linda Weil-Curiel, President of the Commission pour l'Abolition des Mutilations Sexuelles (CAMS), and lead French prosecutor in cases against FGM, has pointed to a number of indicators that map the decline of FGM in France since the practice was criminalized in 1979. Mme Weil-Curiel was in a frontline position to observe the impact of initial prosecution of FGM cases under the French Civil Code in 1979, and compare that to the impact of the introduction of the mandatory health checks and legally enforced signalling function in 1986. The significant increase in prosecution of FGM cases after 1986 (to which she contributed as lead prosecutor), and subsequent acceleration of the decline of the practice, is strongly attributed to the impact of the 1986 legislation that implemented the methods of discovery and reporting.[14]

These indicators are further supported by studies from health care centres in communities with a high incidence of FGM that report a significant decline in the rates of FGM since the introduction of the 1986 legislation that facilitated the methods of discovery and reporting. The clearest indicator of the decline in rates of FGM would be the fact that prosecution and incarceration removes an excisor from the community and effectively prevents further cases of FGM by that excisor. When the daily rate of FGM performed by an excisor is considered, the reduction in FGM

[14] Though the Dutch government criminalized FGM under the Penal code in 1993, no data is available on the impact of rates of FGM in the Netherlands subsequent to the criminalization of the practice.

cases in the community that are directly attributable to that excisor is significant.[15] Such a case forms the main source of analysis of the "French model" and is further examined later in the thesis. Suffice to say here that the excisor in the case study was prosecuted for the criminal offence of performing FGM only after the crime was discovered and reported as per the legislation mandating health checks and the signalling function.

The central debate on FGM in the Netherlands returns to the two key pieces of legislation analysed in this research. In France, these pieces of legislation have been highlighted as essential components to most of the successfully prosecuted FGM cases. The case study in this thesis is one such example of a successfully prosecuted FGM case and forms the basis of the analysis of the achievements and limitations of the "French model". This case study explores both sides of the issue from the position of both the excisor (as a key member of the target group and supporter of the practice) and the advocate for the eradication of the practice. Upon completion of her sentence, Mme Hawa Gréou and Mme Weil-Curiel wrote the book "L'Exciseuse" together, which examines the persistence of FGM despite preventative measures and emphasizes the direct effect strong legislation and prosecution have on rates of FGM. Ultimately, the position taken by both prosecutor and defendant (upon her release from prison) reflects the prevailing attitude towards the eradication of FGM in France and the Netherlands, in that prevention is only doing so much. The "French model", with its two key pieces of legislation, is

[15] The case study of Mme Hawa Gréou in the "French model" reveals that hundreds of children were cut by one excisor each year over the course of three decades. Mme Gréou sometimes performed 10 excisions a day.

presented as the most effective collective approach of legislation, prosecution and prevention; a position which Mme Weil-Curiel is well placed to endorse through her extensive experience in issues related to FGM and knowledge of the French Civil Code. What remains open to debate is whether wholesale adoption of the “French model” to the Dutch strategy is feasible, which forms the basis of this thesis.

The paradigm that quickly emerges is that France has adopted a strong punitive strategy whereas Dutch policy seeks to eradicate FGM through prevention, without any strict legal measures. The accepted wisdom in both countries remains the fact that the strongest approach incorporates some degree of both prevention and prosecution. However, the ongoing pressure in the Netherlands to adopt strong legislation similar to that implemented in France has met with resistance. The French experience has been based on the demands from the medical community for the government to take stronger measures to reduce FGM. By contrast, the majority of the medical community in the Netherlands opposes mandatory health checks and a legally enforced signalling function. This opposition is based on the reluctance of health care providers to jeopardize their relationships with their patients, especially those from the target group. The Dutch medical community also contends that FGM victims who require particular health care will avoid the heath care centres out of fear of prosecution of their families. Members of the wider community are also reluctant to endorse such legislation, as the law would apply to all Dutch permanent residents and citizens, thereby infringing on their right to decide whether or not to undergo health checks as well. Also, for many in the Netherlands, the “French model” goes too far, and conflicts with the traditionally

moderate Dutch political culture. The "soft touch" of this political culture can be seen in the Dutch government's approach to casual drug use, euthanasia and prostitution. At the same time, the Dutch preventative policy has been criticized as not going far enough. As such, the parameters of the FGM debate in both countries continue to evolve and present areas of further comparison, but the main trend is directed towards strong legislation against FGM that leads to prosecution.

Methodology

1. Hypothesis

This thesis compares French and Dutch legislation that pertains to issues surrounding female genital mutilation. The research proposes that if the Dutch preventative approach incorporates more legislated action, then the rate of decline of FGM will improve significantly in the Netherlands. The legislation in this case specifically refers to the methods of discovery and reporting of FGM cases through mandatory health checks of pregnant women and children less than six years old, and the legal obligation to report cases, or suspected cases, of FGM to the relevant authorities. The research presents a French case study of the prosecution of an excisor as an indicator of the impact of the methods of discovery and reporting of FGM cases and the limitations of prevention strategies against FGM in France. Although attributing the decline of FGM in France entirely to prosecution is shaky ground in the argument for the adoption of the "French model" by the Dutch, the case study in France points to the fact that legislated methods of discovery and reporting do result in increased prosecution, which in turn has a significant impact

on the rates of FGM. The following diagram illustrates the causal relationship that forms the basis of this research.

France is ideal as a comparative case with the Netherlands as the legal methods of discovery and reporting of FGM cases through mandatory health checks and legally enforced signalling function are in place in France. Also, France has recorded the highest rate of successful prosecution of FGM cases. Furthermore, all outcomes presented in the diagram (a, b and c) have been recorded and examined in the French case. The information gathered from these findings supports the position that legislation and prosecution have a impact on rates of FGM, and that this impact mostly takes the form of c), a decrease in the rates of FGM. Incidence of a), an increase in the rates of FGM, were reported as a backlash to the perceived cultural discrimination inherent in the mandatory health checks. However, this response is closely related to identity politics and the poor integration of the immigrant communities into wider French society. This aspect is addressed further in the context of the limitations of prevention later in this thesis. Where rates of

FGM were interpreted as remaining stable (outcome b), it was found that new cases of FGM had been recorded shortly after the 1979 criminalization of FGM, but a decline could not be measured due to the fact that no records of FGM cases had been kept prior. After 1979, the prosecution of FGM cases led to better recording of the rate of the practice, which improved again after the 1986 legislation on mandatory health checks and signalling function. From 1986, the decline in the practice was more easily tracked due to the availability of records from 1979.[16]

In the Netherlands, legal accountability regarding FGM is noticeably absent from the health care arena, which employs a strong preventative approach. Health checks for pregnant women or children of any age are not mandatory, and healthcare providers have the right to report cases of FGM, but are not legally obligated to do so. The Pharos organization is the knowledge centre for all issues relating to FGM in the Netherlands and the approach taken by this organization focuses on education and awareness-raising campaigns that are threaded through the health care system, the immigration process and the social work in communities populated with a high percentage of immigrants from the target group. The education and awareness-raising campaigns designed for this target group in the Netherlands include information on FGM as a violation of several basic human rights including the rights of the child, the health implications and lifelong damage caused by FGM and information on legislation in the Dutch Penal Code that criminalizes FGM, as it constitutes a form of child abuse and grievous bodily harm. As the target group is primarily Muslim, and FGM has been misrepresented as being

[16] See Appendix, .p. 81.

sanctioned by Islam, local religious leaders are pressed to inform their communities that FGM is un-associated with the Muslim faith.

This preventative approach has been incorporated in the French strategy to eliminate FGM since the 1970s, when French health care providers were being increasingly exposed to women and children from the immigrant communities who had undergone the practice. Prevention through education and awareness is intended to dissuade or deter those who would otherwise choose to perform the procedure, and has had an impact in both France and the Netherlands in as much as anecdotal evidence can be quantified in both countries. In France, noticeable fluctuations in the numbers of cases can be noted and tracked, especially since the legislated methods of discovery and reporting were introduced in 1986. As such, the French authorities have recorded a significant decline in the number of FGM cases.[17] This trend has been linked positively to the high prosecution rate of cases, as well as to the prevention campaigns that have been stepped up over the years, which include information on the legal consequences of performing or facilitating the performance of the procedure (by restraining the victim, etc.). These consequences include stiff penalties, lengthy terms of imprisonment and denial of French citizenship. The recorded decrease in cases of FGM in France has also been attributed to the practice being driven underground as a result of the enforcement of the 1986 legislation, with members of the target group simply avoiding the mandatory health checks, or waiting until the child has passed the age of six to perform the procedure. The clandestine nature of the practice renders the tracking

[17] Kallestein, L. *Facts and Myths on Female Genital Mutilation.* www.lindamaykallestein.com, accessed 3rd May, 2009.

of subtle changes in the rates of FGM difficult, in both the Netherlands and France. However, according to Mme Linda Weil-Curiel, as indicated in her interview,[18] the rate of FGM has noticeably declined since prosecution of FGM cases began in France in 1979.

Of further note is the fact that anecdotal evidence from the health centres reveals the social challenges experienced by the families in the target group that abandon FGM. In many of these cases, the families are rejected by their community or are marginalized within the immigrant society. Members of the families that abandon FGM tend to reveal this decision, and their motives for doing so to first responders such as health care providers, social workers, etc. In this way, the impact of prevention campaigns in deterring the family from FGM can be noted as families indicate whether the decision was based on education on FGM, or the health issues surrounding FGM, or due to the fact that FGM is not endorsed by their religion, etc. In addition, members of the target group are more likely to abandon the practice when the entire community agrees to do so as a whole. By the same token, if prosecution of FGM cases are initiated in the Netherlands subsequent to the adoption the legislation presented in the "French model", first responders are in a position to record decisions by practicing families to abandon FGM on the basis of the threat of prosecution. Families that abandon FGM and comply with legislated methods of discovery and reporting affirm their status as law-abiding citizens of their adopted country and can be reassured that the authorities will support them in the face of rejection from the rest of the target group. Supporting families that

[18] Interview with Mme Linda Weil-Curiel on 7th October 2008. Paris, France

abandon FGM reinforces the effectiveness of counter-FGM campaigns and motivates others to do the same. Once prosecution of FGM cases is initiated in the Netherlands as a result of the adoption of a more punitive approach likened to that of the "French model", families that choose to abandon the practice have a legitimate motive they can point to in the face of pressure from the rest of their community.

2. Research design.

a) Criteria for comparison: France and the Netherlands

The context of FGM in both France and the Netherlands compares well on the basis of strong similarities:

- Both France and the Netherlands have historical and contemporary relationships with African nations that have resulted in a large influx of immigrants from regions in Africa where FGM was or still is practiced.
- Both France and the Netherlands have criminalized FGM as child abuse and grievous bodily harm.
- Both France and the Netherlands have adopted the principle of extra-territoriality whereby prosecution of cases of FGM can occur when the procedure takes place abroad.
- Both France and the Netherlands have taken strong preventative measures against FGM through health, education, human rights, religious and social awareness-raising campaigns. In addition, information on the legal consequences of performing FGM is widely disseminated in both countries.

Unlike France, the Netherlands has not adopted a punitive position against FGM, rather it maintains a preventative stance, and to date has had no prosecution of FGM cases. Research material gathered from the Dutch frontline organization Pharos indicates that although preventative measures have some effect as a deterrent to the practice, decline in the rates of FGM cases is slow. According to the Dutch Council for Public Health report, there are an estimated 50 new cases of FGM in the Netherlands every year.[19] As such, the main distinction between France and the Netherlands in the context of FGM is that France has taken the further step of enforcing two additional pieces of legislation in the form of mandatory health checks and the legally enforced signalling function. This legislation facilitates the discovery and reporting of FGM cases, within the health care sector in particular. These methods of discovery and reporting of FGM cases support the investigation process and allows solid evidence to be introduced during the prosecution of the case. To illustrate: a child or pregnant woman from the target group is required to visit the health care provider in her community for the mandatory health check. During the procedure, the healthcare provider discovers that the patient has been subjected to FGM. The health care provider is legally required to report this discovery, and may take additional steps to counsel the patient at this point. The report is placed with the relevant medical authority that forwards it to the police. Based on this legitimate report, the police can begin a criminal investigation of the

[19] Based on two representative studies in Amsterdam and Tilburg of immigrant communities from Saharan countries where FGM is still prevalent.
Http://www.bmj.com/cgi/conyent/full/330/7497/922-a

case of FGM as a criminal offence of suspected child abuse or grievous bodily harm under the French Civil Code. During the investigation, the excisor and/or parents and/or relatives of the victim are identified as the perpetrator. Appropriate charges are placed and the case brought before the court. Upon conviction, the victim may be granted compensation, and the perpetrators are served with their sentence. The successful prosecution of the perpetrator hinges on the methods of discovery and reporting that have been legitimized through supporting legislation and the laws that criminalize FGM. The enforcement of such legislation also removes FGM from the cultural sphere and it is treated, appropriately, as a crime.

The research supports the view that adopting strong legislation is the next logical step in the Dutch policy regime towards FGM.[20] The complete lack of prosecution of FGM in the Netherlands, despite the evidence of FGM occurring on Dutch soil for at least the past two decades, and despite the criminalization of FGM for just as long, leaves an opening for comparison to the "French model" in the pursuit of a more effective strategy for eradication. At the very least, if not the wholesale adoption of the "French model" then the development and implementation of legislation that supports the laws that protect women and children that are already in place in the Netherlands would be a legitimate process for the initiation of prosecution of FGM cases in that country.[21] The tally of prosecution of FGM cases between France, at 37 successfully prosecuted cases, and the Netherlands at none, points to the fact that the French are doing something right and that the Dutch strategy for eradication of FGM would do well to learn from

---

[20]www.humanrightsimpact.org/.../FGM_in_the_Netherlands_english_summary_final_version.pdf
[21] Interview with Mme Linda Weil-Curiel. Paris, 7th October, 2008.

the “French model”. With both countries lacking explicit laws against FGM, and both countries criminalizing FGM as child abuse and grievous bodily harm, yet France having the highest rate of prosecution of FGM cases in the world, the contrast hinges on the legislated methods of discovery and reporting of FGM cases in the “French model”. These legislated methods of discovery and reporting are the link between the crime of FGM and the prosecution of the crime. The French case study of the prosecution of Mme Hawa Gréou further supports this position and provides a more detailed examination of what is working in the “French model”. By reflecting on the analysis of this case study as a social indicator that illuminates both the perspective of the excisor (as a member of the target group) and the prosecutor (as a member of the “French model” seeking to eradicate the practice), the best practices of the “French model” can be derived. The case study of Mme Hawa Gréou is typical of the FGM cases that have been brought before the French courts and as such, the difficulty of comparing the best practices for the eradication of FGM based on aggregate data from both countries is circumvented, especially as there is no such data from the Netherlands. The case study of Mme Hawa Gréou can be held up as an example of how the “French model” works, what approach has been the most effective, and from that, what can be derived and adapted for the Dutch policy regime toward FGM.

b) The French case study: Excisor Mme Hawa Gréou

According to the evidence and testimonials from the defendant in the French FGM case of excisor Mme Hawa Gréou, preventative measures and even awareness

that FGM is illegal in France did not deter her from performing FGM. Her role as an excisor in the immigrant community in Paris where she resided was not only her sole source of income, but also granted her elevated social status within her community. During her trial, the failure of preventative measures to stop her from practicing FGM was revealed. Furthermore, the insular nature of the poorly integrated immigrant community protected her from the legal consequences of continuing FGM in France. Mme Gréou was exposed and brought to trial through the process of the legally enforced signalling function when one of her victims reported her to the local health centre. However, during her trial Mme Gréou expressed no regret at any point for the crimes she had committed as FGM is regarded as a culturally significant practice that she believed (erroneously) was endorsed by her religion. The attitude of Mme Gréou towards FGM only changed after her incarceration and her realization that the practice is not endorsed by her religion. Upon her release, she was unable to claim French citizenship but has remained in Paris where she now advocates against FGM.

The case of Mme Gréou is further elaborated in the main text of this thesis, and it provides a strong base for analysing what is working and what is not in the "French model". The case highlights the impact of strong legislation and prosecution in discovering, investigating and removing a prolific excisor from the community, and the impact of her incarceration in rehabilitating her views in that she now contributes to efforts to eradicate the practice. Her case charts the causal relationship that links strong legislation that facilitates discovery and reporting of FGM cases, to prosecution and the subsequent decline in rates of FGM.

Of further significance to the research is fact that the case of Mme Gréou reflects the prevailing attitude of the target group towards FGM and efforts to eradicate the practice. Overall, new immigrants to France from practicing regions in Africa are often less concerned about the health problems or human rights violations inherent in subjecting their child to FGM, than they are about FGM as a valued tradition, symbol of identity or religious requirement. Mme Gréou was performing FGM for decades in France before being successfully prosecuted and imprisoned for five years. For her, the violation of her civil contract with France, and subsequent inability to secure French citizenship due to her conviction, proved to be the key factor in changing her deeply held perception of the value of FGM in her community. For the target group, the permanent psychological and physical damage inflicted on FGM victims makes little impression. Awareness that FGM is a criminal act under the French Civil code also had little effect as a deterrent, especially when immigrant communities remain poorly integrated. These issues are more thoroughly examined in the main text of this thesis, but for these reasons, the case study of Mme Gréou provides an adequate analysis of the extent of the impact as well as the limitations of strong legislation and prosecution of FGM. In so doing, the case supports the hypothesis that the Dutch policy towards FGM can only be strengthened by the adoption of more legislative measures.

c) The French case study: Interview with Mme Linda Weil-Curiel

Crucial data on the impact of legislation and prosecution on FGM in France was gathered during an interview with Mme Linda Weil-Curiel, conducted in

her office in Paris, on the 7th of October 2008. As the lead prosecutor with the most successful convictions of FGM cases in France, and as President of the Commission pour L'Abolition des Mutilations Sexuelles (CAMS), Mme Weil-Curiel is an expert on FGM-related issues. During the course of the interview, Mme Weil-Curiel expanded the framework of the issues surrounding FGM from the specific legal discourse, which is her forte, to the manner in which the "French model" evolved (with her considerable contribution) to incorporate both prevention and prosecution, to the broader scope of addressing FGM on the European level as a crime against women in children in all countries of the European Union.

The interview consisted of a semi-structured conversation that ranged from her opinion on the demand for an explicit law against FGM, to the case study of Mme Hawa Gréou, and to other significant efforts to eradicate FGM among the target group in France. Mme Weil-Curiel was one of the lead proponents for strong legislation against FGM in the late 1970s and her own cases against FGM in the subsequent decades have been widely publicized. Through this experience, Mme Weil-Curiel has been able to track the decline of FGM cases more precisely than most other first responders involved in efforts to eradicate FGM in France.

The insights obtained through this interview align with the findings of the literature review, namely that strong legislation leads to prosecution that in turn contributes to the decline of FGM. Of particular importance to Mme Weil-Curiel is the emphasis on FGM as a crime against women and children that cannot be tolerated. Mme Weil-Curiel frames the issue within the realm of child abuse and grievous bodily harm, which removes the practice from the cultural sphere and the

grounds for cultural discrimination are invalidated. Maintaining her position within the legal parameters of the issue of FGM, Mme Weil-Curiel emphasized the significance of the legislation on mandatory health checks and the legally enforced signalling function. Without these key pieces of legislation that facilitate the discovery and reporting of FGM cases, many would go undetected or unreported and the victims of FGM would have little legal recourse. For Mme Weil-Curiel, the lack of legislation to facilitate the discovery and reporting of FGM is tantamount to a lack of legislation that facilitates the discovery and reporting of child abuse or grievous bodily harm. Within the legal framework, the laws that are already in place for the protection of children in both France and the Netherlands must not only be upheld, but also supported by further legislation that enhances the application of such laws.

Mme Weil-Curiel also recognized the necessity for measures that surround and enhance the legal framework of the strategy to eradicate FGM, in the form of prevention campaigns and better integration of immigrants from practicing regions. These measures contribute to the overall approach of the "French model" that is both preventative and punitive. As illustrated by the case of Mme Hawa Gréou, illiteracy, marginalization and the insular nature of immigrant communities contributed to her ability to continue to practice of FGM for decades.

Furthermore, Mme Weil-Curiel supported the transferability of effective legislation against FGM from France to other EU member states by pointing to the fact that the basis for continuing the practice remains the same worldwide. At its core, FGM represents control of female sexuality. As long as this control is socially

acceptable, FGM will continue. However, where FGM is legally unacceptable, and legislation against the practice is effectively implemented, the social circumstances surrounding the practice are forced to comply. To refrain from prosecuting cases of FGM is to tolerate violence against women and children in the form of child abuse and grievous bodily harm.

3. Interpretation of the findings

The "French model" ultimately emerges as an approach that incorporates all the widely accepted preventative measures that are already in place in both France and the Netherlands, but that has a strong legal foundation as well. In the Netherlands there have been attempts in parliament to call for adoption of the "French model".[22] However, the particular method of discovery of FGM cases in the form of mandatory health checks are seen as a violation of the right to privacy and a vehicle for racial stereotyping. In terms of the legally enforced method of reporting in the form of the signalling function, concerns have been raised about not only violating the patient's right to privacy, but also undermining the relationship between the patient and the health care provider. There is also a concern that such a legislation would not only drive the practice further underground, but may also encourage the members of the target group to support FGM in defiance of what is perceived as an attack on their cultural identity. However, the legislation that criminalizes FGM also removes it from the cultural sphere and places it firmly in the realm of child abuse and grievous bodily harm. This serves to counteract the

[22]Poldermans, Sophie. *Combating Female Genital Mutilation in Europe.* www.stop**fgm**.net/dox/SPoldermans**FGM**inEurope.pdf, p. 22, accessed 3rd June 2010.

argument that legislation that prohibits FGM is discriminatory. Subsequent prosecution of FGM cases sends the clear message that the practice will not be tolerated under any circumstances, and underscores the fact that FGM is a crime against women and female children.

A further point in the argument against adopting the "French model" by introducing more legal accountability in the healthcare arena is the fact that cases that are recorded under these legal obligations come after the fact when it is too late for the victim. Although, discovery of a case of FGM indicates that prevention has failed as well. Nevertheless, as the case of Mme Hawa Gréou clearly illustrates that prosecution as a result of effective legislation is able to prevent FGM from being performed on potential victims. Holding the parents equally accountable is also seen as serving the important function of a deterrent to others, while providing a strong foundation for those who want to refuse being subjected to the procedure. Cases against the parents or guardians of the victim are strengthened by the fact that FGM is almost always premeditated.[23] By treating FGM as a crime, and enforcing criminal law through effective prosecution, those seeking to escape the threat of FGM, or victims who seek justice, can find legal recourse and support.[24]

Mandatory health checks and a legally enforced signalling function are the next logical step in speeding the decline of the practice of FGM in the Netherlands. Cases cannot be prosecuted if there is no legal obligation for those who discover

---

[23] The risk of additional trauma to underage victims by incarcerating the parents is given the same consideration as in cases of child abuse. Interview with Mme Linda Weil-Curiel. Paris, 7th October, 2008.

[24] Of further note, victims of FGM in France are entitled to free reconstructive surgery, covered by French National healthcare provisions.

FGM to report these instances of child abuse and/or grievous bodily harm to the authorities. In France, teachers and social workers are also legally bound to report cases, or suspected cases of FGM. However, health centres and hospitals are the usual arenas for cases to be discovered, whether during mandatory health checks or when health complications arise, usually during pregnancy or childbirth, which force the victim to seek medical attention. The highest rates of cases in France are reported by health care centres and hospitals located within communities that are densely populated with immigrants from regions of origin in Africa where the practice was common. In France, it was the medical community that approached the government to take stronger action against FGM in the form of legislation. As Mme Linda Weil-Curiel explained in her interview, the 1960s and 1970s saw a significant rise in immigration from former French colonies in Africa that also were regions where FGM was prevalent. As a result, health care centres and hospitals in France were seeing increasing numbers of cases of FGM of girls and women from this target group. Health care providers were also encountering large numbers of cases of FGM during the regular health checks within the immigration process. As the medical community had little previous knowledge of FGM, many were not prepared to handle the serious health problems associated with the practice. The numbers of cases of health complications and deaths related to FGM became so severe that the medical community was forced to press the French government into action. As Mme Weil-Curiel goes on to state in the interview, rates of FGM in France began to decline after prosecutions of excisors and the parents of victims began to be made public in 1979. Whether this can be entirely attributed to the legal

implications cannot be fully determined as the practice was pushed underground once prosecution came into effect. Fluctuations in immigration and the eradication of the practice in regions of origin, as well as better integration of immigrants into French mainstream culture and society through an extended immigration process[25] may also have had some effect in the numbers of cases seen by the medical community. Anecdotal evidence from members of the target group indicate that preventative measures, such as education on the health implications of FGM, have prompted some families to refuse to submit children to the procedure. Nevertheless, as Mme Weil-Curiel reiterated in her interview, many in the target group have indicated that the high visibility of prosecution of FGM in France has been the strongest deterrent.

The connection between rates of decline and prosecution of FGM cases in France continues to be disputed on the basis of the clandestine nature of the practice, and the very plain fact that cases of FGM in France continue to emerge.[26] In situations where immigrants and their descendants experience marginalization or prejudice because of their ethnic background, FGM has been performed as an assertion of identity that serves as a connection to the region of origin (even if FGM is no longer practiced there). As a result, the Dutch position becomes more entrenched as one of prevention rather than prosecution. However the Dutch authorities must be seen to act on FGM as a violation of their general criminal laws

[25] During the same period, France began to adopt increasingly strict integrative measures into its immigration policy. These measures require immigrants to learn to speak, read and write basic French, to be aware of their rights as French citizens and to recognize and adopt French values.

[26] Armelle, A et Lesclingand, M. 'Les mutilations sexuelles féminines: le point sur la situation en Afrique et en France', *Populations & Société*, numéro 438, Octobre 2007, p. 3.

in the Penal code. Without legislated methods to discover and report FGM cases through mandatory health checks or a legally enforced signalling function, the Dutch authorities are hard pressed to do so.

Those who are determined to continue the practice of FGM would do so whether there are legal consequences or not, however this does not detract from the fact that FGM constitutes a crime in both France and the Netherlands and measures to prevent this crime through education and awareness are not enough. The data that has been collected from cases where FGM was averted, such as in the Mme Hawa Gréou case, points to the legal consequences of the practice as the strongest motivating factor for those who sought protection from FGM. Still, the highest rates of decline were recorded in areas in France where entire communities were motivated to abandon the practice through awareness-raising campaigns that included a combination of health, human rights, religious and legislative measures. The connection that binds these measures and underscores the strength of each of them is legal accountability and threat of prosecution. The fact remains that the permanent physical damage of FGM, regardless of the motivation to perform the procedure, can legally implicate the excisor, parents and guardians of the victim. However, prosecution is more likely to occur when those who frequently come into contact with victims of FGM, in this case health care providers, are legally obligated to report it to the authorities.

The "French model" is not without weakness. In specific situations in France, the practice is driven underground and victims are mutilated at an older age. In the Netherlands, FGM remains a clandestine practice with cases being discovered 'by

accident' when, for example, health complications force the victim to seek medical attention. Such weakness can apply to the preventative approach as well. However, analysis of the "French model" clearly illustrates that more legal accountability can strengthen preventative measures and speed the decline of rates of FGM in the Netherlands. The linchpin of a strong and effective consolidated approach is the unifying element of legal accountability that leads to prosecution of cases of FGM.

Chapter 2: Case Study of Mme Hawa Gréou, Part 1

The prosecution of an excisor

In 2004, Malian immigrant Mme Hawa Gréou was released from a French prison after serving a five-year term for illegally performing female genital mutilation in her home in Paris. Mme Gréou had moved from Mali to France in 1979 and quickly gained a reputation as France's best *exciseuse*[27] as she had never had a baby die under her knife. Mme Gréou performed the procedure approximately 16 times a day on babies and young girls from the African immigrant communities across France, until her conviction in 1999.[28] Although she lived in a predominantly Malian community in Paris that shielded her from the police, her illicit activities as an excisor were revealed to the authorities through a girl who had been excised by Mme Gréou and who had sought help to prevent her younger sisters from undergoing the procedure. The parents of the victim had waited until she had passed the age limit for mandatory health checks, in order to evade detection. However, as a result, the victim was old enough to remember the ordeal, as well as who had performed the procedure and at what location. The victim approached the health care provider at the clinic where she had received her mandatory health checks until she was six years old and explained her ordeal. The healthcare provider examined the victim, confirmed the incidence of FGM, and reported the case to the relevant medical authority. The medical authority forwarded the report

[27] '*Exciseuse'* is the French term for excisor or a traditional practitioner of female genital mutilation. In this paper 'excisor' will be used to describe this role, whether they be women or men.
[28] To grasp the volume of excisions performed by one excisor, even with 'time-off', at an even lower rate of ten excisions a day, five days a week, fifty weeks a year, an average excisor can mutilate 25,000 girls over the course of ten years.

to the police who opened an investigation into Mme Gréou's activities as an excisor. Mme Gréou was subsequently arrested and charged with the criminal offence of child abuse. With the victim's testimony the prosecutor[29] was able to secure a sentence of five years for Mme Gréou, which was served for the full term.

The case study as a social indicator

The prosecution of Mme. Gréou can be taken as a sample of the successfully prosecuted FGM cases in France that gauges the effectiveness of prevention and punitive policies in the eradication of the practice. Evidence taken from the trial provides a strong base for analysing what is working and what is not in terms of the French strategy to eradicate FGM. During the course of the trial, the extent of the insular nature of the Malian immigrant community was revealed. Many of the witnesses from the community claimed no knowledge of the illegal status of female genital mutilation, and even if they did know, they would close ranks against the police to frustrate any investigations. For many in the immigrant community, being 'French' and observing French law or social mores are secondary considerations to being from a particular tribe or region in Africa to which they pledge primary allegiance. These priorities are compounded when practicing Muslims (who form the majority of the target group) observe Islamic law before any other laws. This religious observation frustrates counter-FGM measures as the practice is misrepresented as being endorsed by Islam.

Despite legal measures, social and health programs, and an increased awareness of the rights of women and children among African immigrants in France, harmful traditional practises such as female genital mutilation are still prevalent. Practitioners of female genital mutilation continue their work as excisors throughout France within immigrant communities that have a high concentration of

[29] The prosecutor was Mme Linda Weil-Curiel, who I interviewed in Paris in October 2008. In the course of the interview, Mme Weil-Curiel relayed the story of Mme Gréou's case to me and added that she not only co-authored a book with Mme Weil-Curiel on the story of her life as an excisor but also collaborated closely with her former prosecutor, after her incarceration, on counter-FGM activities.

residents who originate from practicing regions in Africa. Mme Gréou's case is only exceptional in the sense that she was successfully convicted. The longitudinal view on prosecutions that followed Mme Gréou's case capture the effects of the "French model" as it evolved from prevention to incorporate more legal accountability.

The trials of FGM cases in France provide a direct source of information on the impact the "French model" has had on the target group, which, based on the case study, points to a decline in the prevalence of the practice. This decline underlines the impact of the "French model" and justifies further investment in this direction. In any event, case studies regularly provide significant qualitative research material in the development of policy in a wide range of policy regimes; the contribution of the case of Mme Hawa Gréou as an example of the "French model" would be no less significant to the development of the Dutch strategy for eradication of the practice. However, the complete lack of prosecution in the Netherlands impedes further comparative analysis of common responses to legislation with the cases in France. Nevertheless, the similarity of the context of FGM in France and the Netherlands strongly suggests that adoption of the "French model" would benefit the Dutch policy regime towards FGM.

Chapter 3: Female Genital Mutilation

The procedure

Female Genital Mutilation or FGM[30] comprises 'all procedures that involve partial or total removal of female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reason.'[31] There are four classifications of the procedure to which the victim[32] can be subjected:

- Type I - partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
- Type II - partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)
- Type III - total removal of the clitoris, labia minora and labia majora and then sealing the area by stitching the edges of the gaping wound together to create a smooth surface with a small hole left open for passage of urine and menstruation (pharaonic infibulation)
- Type IV - scraping, burning or cauterization of the clitoris and surrounding tissue or any other harmful procedure carried out for non-medical purposes.[33]

---

[30] 'Female genital mutilation' is the term recognized by the Joint Statement on Female Genital Mutilation issued by the World Health Organisation (WHO), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) in 1997. For a further explanation of this terminology, see Annex 1.

[31] "Female Genital Mutilation: Report of a WHO Technical Working Group, Geneva, 17-19 July 1995." World Health Organization: Geneva, 1996.

[32] Most practicing cultures do not view those subjected to the procedure as 'victims', however to be concise I will use that term throughout the thesis to denote those who have undergone the procedure.

[33] WHO interagency statement, 2008. P. 4.

These procedures are usually carried out with crude instruments such as a sharp stone, a broken shard of glass or a razor blade, or with a special knife or pair of scissors used only for the purpose of FGM. Conditions are generally unhygienic with the same instrument used repeatedly without being sterilized. Some excisors apply a herbal ointment or salve to speed healing, but neither anaesthetic nor antiseptic is used. In cases of Type III, the legs of the victim are bound together following the procedure and she is kept immobile for two to four weeks so that the scar tissue forms a smooth surface. The excisor would usually be a woman from a particular group or class within the community, such as a traditional birth attendant or a woman from the blacksmith class, though in some ethnic groups male barbers perform the procedure (such as in Nigeria and Egypt). Mothers are prohibited from excising their own daughters; however they may be present to assist in restraining the victim. Around the world, an estimated 130 million women and girls have been subjected to FGM, and an additional two to three million are at risk every year of undergoing the procedure. Of the female immigrants from Africa to the European Union, approximately 160 000 women and girls have been mutilated, or are at immediate risk of being mutilated.[34]

In France and the Netherlands, the age of the victim varies according to the predilections of the practising community, and can vary from newborn babies of seven to eight days old to mature women after their first childbirth.[35] Infants are

---

[34] United Nations Population Fund (UNFPA), *The State of the World Population 1999: 6 Billion, A Time for Choices,* New York: UNFPA, 1999, p. 2.

[35] Even though annual health checks are compulsory for children in France until the age of six. To avoid detection, many family members will either avoid the health checks or wait until the child has passed this age before subjecting her to the procedure. In addition, it is often the case that women

splayed naked and an ointment to help control excessive bleeding is applied prior to cutting (this ointment has no anaesthetic effect). As in the country of origin, young girls between ages of four to ten are more commonly subjected to the practice, as they are in no position to refuse, are still easy to restrain and often are considered ready for an arranged marriage or initiation into a more mature social role. Individual operations can take place in the family home or that of the excisor. In cases where the procedure forms part of an initiation rite, a group of girls of close but varying ages will undergo FGM in a central location specially chosen for the ritual, along with much ceremony and celebration. There have been cases of health professionals such as doctors or nurses who have been motivated by bribes or social pressure to perform the procedure in their homes in France and the Netherlands. Regardless of the classification of the procedure (Type I, II, III or IV), the external female genitalia that are affected (clitoris, prepuce, labia minora, labia majora, urethra, vaginal opening, perineum) are very sensitive and any tampering with them will have immediate and long-term effects. In the most extreme cases, the victim will lose all proper functioning and services of these vital organs.

Justifications for the practice of female genital mutilation

The practice of female genital mutilation in France and the Netherlands is not dependent on a single factor, but on an entire belief system and the values that support it. Invariably, practising families belong to communities that manifest gender inequality that is deeply entrenched in their social fabric, regardless of the

---

who have been excised at a young age repeat the procedure after the birth of each of her children (re-infibulation).

status of women in wider society. In simple terms, FGM represents control over women and women's sexuality. Where the tradition is pervasive or in a slow rate of decline the tendency is for both men and women to support FGM as an ancient social custom that is beyond dispute. The perpetuation of the practice is guaranteed by a system of punishments and rewards making it almost impossible for individuals or families to abandon the practise without community support. When the decision is made to subject a child or woman to the procedure (a decision usually made by the extended family) it is considered something for her own good, as the social benefits are seen to outweigh any disadvantages.[36] Some of the most common justifications for FGM that have been recorded from cases in France and the Netherlands include:

- As a rite of passage from childhood to womanhood and an assertion of African identity - thereby socializing the young girl into the expected role of a woman in the community and preserving cultural identity and connection with the region of origin in Africa. Girls themselves may ask to undergo the procedure rather than face rejection from their peers and prospective husbands. Adult women may choose FGM in order to distinguish themselves in the face of rejection by the wider society. In cases where the victim is rewarded with gifts the practise is highlighted as an important part of cultural identity, imparting a sense of pride and community membership. The environment in close-knit communities that are slow to integrate into the host society creates intense pressure in which the practice is necessary for

[36] http://www.unicef.org/publications/files/FGM-C_final_10_October.pdf

social acceptance among their own kind; pressure that is intensified by marginalization of immigrant communities within French and Dutch society.

- As a means to control female sexuality – thereby ensuring clan or family honour by curtailing premarital sex and preserving virginity. In this way the marriage-ability of the victim is improved. A suitable marriage is essential to fulfilling perceived ideals of womanhood and is often the only route available to local women to economic and social security. Some men proclaim to marry only women who have been excised, especially when the altered genital condition is purported to not only curtail deviant sexual behaviour in the wife, but also to enhance the husband's sexual pleasure. Excision also ensures a higher bride price, and many families are financially motivated to perform the procedure, especially when the bride is a citizen of a European Union member state.

- As a purification ritual ordained by religion- thereby complying with perceived religious mandates. Though also practised by Christians and Jews, FGM is considerably more common among Islamic communities. Nevertheless, the practise of FGM pre-dates all established religious systems and none of the monotheistic holy texts explicitly prescribe FGM.[37] Many families and excisors (such as Mme Hawa Gréou) who endorse FGM are illiterate, and rely on the guidance of their elders and religious leaders to interpret the teachings of the Koran.

Regardless of the specific justification, those in power and authority in the immigrant community such as traditional elders within the tribal hierarchy,

[37] WHO Interagency statement 2008. P. 8.

religious leaders and excisors, usually uphold the practise of FGM. The authority of the legal system, which criminalizes FGM, is seldom considered. When in dispute in the household, the final decision to continue FGM lies with the men in the family. In any case, women in the immigrant community do tend to support the practice, even if they themselves have been subjected to it, becoming in their turn the 'gatekeepers' of the tradition and cultural identity associated with FGM. In this way, the process becomes cyclical; the belief that FGM is necessary for social homogeneity, continuity of tradition, respect for religion and identity fosters the importance and relevance of the practice. This firmly-held belief is more deeply ingrained in the practising communities in the Diaspora as the target group is outside of its familiar environment of the region of origin in Africa. It is hardly surprising then, that such communities will adhere more strictly to the tradition as a means of preserving a sense of security and identity, even if FGM has been abandoned in the region of origin. Efforts to eradicate FGM in both France and the Netherlands are largely frustrated by the target group as their community tends to close in on itself when under a perceived threat, pushing the practise underground. Attempts to approach the eradication of FGM through deeper integration are faced with the reaction that such efforts infringe on the immigrant's right to cultural identity. An unfortunate consequence to these eradication efforts is a defiant and renewed determination to preserve the practice in the face of strategies to eliminate it. The most effective means of undermining the cultural argument for the practice is to emphasize and strengthen the criminalization of FGM as child abuse

and grievous bodily harm. In such a way the practice is removed from the cultural sphere and viewed strictly as a crime.

Health implications

From a health perspective, female genital mutilation has varied and severe risks and repercussions for those who undergo the procedure. Depending on the age of the victim, the intervention, physical restraint and sense of betrayal by family members makes the first impression. Once the cutting begins, immediate symptoms are pain, shock and trauma with bleeding that can be moderate to excessive. Uncontrollable bleeding frequently leads to death. Long term physical symptoms include chronic pain, repeat infections, menstrual problems, difficulty in passing urine, human immunodeficiency virus (HIV), incontinence, keloid scarring, infertility, psychological trauma, anxiety, depression, post-traumatic stress disorder, aversion to sexual activity, painful sexual intercourse, serious complications with pregnancy and childbirth, fistula and infant mortality.[38] In cases of pharaonic infibulation, the physical and psychological trauma is re-visited every time the wound is re-stitched after opening through intercourse and childbirth (re-infibulation). This list of complications is not exhaustive as symptoms are only documented when emergency medical help is sought, and so the true number of deaths and the full degree of physical and psychological damage and trauma attributed to FGM is unknown.

[38] WHO Interagency study, 2008. Annex 5.

Female genital mutilation as a violation of human rights

There has been a visible shift in international opinion and approach at the higher political level with regard to the practice of female genital mutilation. This perspective focuses more on the human rights implications of FGM. Regardless of where or why it occurs, the cutting of healthy genital tissue for non-medical reasons constitutes a violation of the basic human rights of women and girls and is a breach of a number of human rights covenants, declarations and charters on national, regional and international levels. With regard to the practicing immigrant community in France and the Netherlands, FGM violates the following:

- Universal Declaration of Human Rights
- Convention on the Elimination of Discrimination against Women
- Convention against Torture
- Convention on the Rights of the Child
- Civil and Political Rights Covenant
- Economic, Social and Cultural Rights Covenant
- European Parliament Resolution 2001
- European Convention[39]

Under human rights law, the government is held accountable and is bound to uphold the rights of women and children by preventing, investigating and

[39] Rahman and Toubia, p. 100.

punishing violations, which include cases of female genital mutilation. Even though FGM is performed by individuals and not the government, national authorities must undertake long and short term strategies to eradicate the practice through legal, regulatory and policy measures that can not only help prevent the practice, but also effectively shape the social perception of FGM. As human rights mean very little to those who are not aware of them, it is up to the State to guarantee that immigrants are fully informed of their migrant rights, and their rights as citizens of France and the Netherlands. There are also sufficient instruments outside the migration sphere which, if put into action, could protect women from FGM and speed its eradication. Such instruments, recommendations and campaigns include: The United Nations Charter; the Council of Europe Recommendation of the Committee of Ministers to Member States on the Protection of Women against Violence; the European Commission declaration that FGM violates and impairs or nullifies the human rights of women and girls; national canvassing in European Union member states such as the 'Campaign to Combat Violence against Women, including Domestic Violence'; the Millennium Development Goals (namely, the promotion of gender equality and empowerment of women, the reduction of infant mortality and the improvement of maternal health); the World Health Assembly (WHA) resolution of May 2008 that urges Member States to work with governments, international agencies and NGOs in support of the abandonment of the practice; the Maputo Protocol; and the Banjul Charter.

Ultimately, female genital mutilation violates “girls’ and women’s right to life, right to physical integrity and right to health.”[40] The most effective means of upholding these basic human rights is full awareness on the level of the individual and the community, coupled with legal accountability for any violations. In such a way, the effective implementation of the human rights approach to preventing and eradicating FGM would have real results and speed the rate of decline of the practice among the target group in France and the Netherlands.

Legislation against female genital mutilation

Of the European Union member states where female genital mutilation has been reported, Austria, Belgium, Denmark, Italy, Spain, Sweden and the United Kingdom have passed specific criminal law provisions against FGM. In France, prosecution of FGM cases falls under the general criminal law provisions in Articles 222-9 and 222-10 of the Penal Code.[41] Although France has yet to adopt specific legislation against FGM, there have been more cases brought against excisors and the parents of victims in France than any other country in Europe. Successful prosecutions carry a sentence of up to 20 years imprisonment. As FGM is also considered a form of child abuse, and Child Protection laws exist in France as in all European Union member states, cases can be brought forward where FGM has not yet been performed but the child is at risk of being subjected to the practice.[42] In

[40] WHO Interagency statement 2008, p. 11.
[41] Leye, E. et al. *An analysis of the implementation of laws with regard to female genital mutilation in Europe.* Crime, Law and Social Change, Vol. 47, No.1, February 2007. P. 4. Penalties are increased when the offence is committed against a minor and/or when committed by parents or guardians.
[42] Article 375 of the French Civil Code.

the particular case of Mme Hawa Gréou, the victim in her prosecution case was seeking to prevent her younger sisters from having to undergo the procedure. This testimonial confirmed that they were children at risk of abuse, which strengthened the prosecutor's position.

In the Netherlands, FGM is outlawed under Articles 300-306 of the Dutch Penal Code as (serious) physical abuse and carries a penalty of at least three but no more twelve years.[43] Some Dutch parliamentarians argue that current legislation is adequate when these Articles are positioned alongside the human rights instruments mentioned in the previous section. This approach is typical for the Netherlands in that generally, the Dutch government prefers a lighter touch in many social policy areas, such as those that relate to 'soft' versus 'hard' drugs; euthanasia; implementing jail sentences, etc. However, as FGM directly affects mainly female children and youth, the obligation of the Dutch government to provide adequate protection is more pressing and requires a more stringent response.

In general, legal measures to counteract the practice of FGM are frustrated by the fact that most of the estimated thousands of excisions performed in France and the Netherlands are simply not reported.[44] In France, perpetrators have been released or given light sentences as the defence claims there was no criminal intent in following a custom that reputedly helps young girls integrate into society and find husbands. According to attorney Mme Linda Weil-Curiel, who secured the

---

[43] www.utrecht**law**review.org/publish/articles/000118/article.pdf

[44] See Appendix, p. 81.

judgement against Mme Hawa Gréou, judges and juries are often reluctant to be seen as interfering with traditions of the immigrant community, and sympathise with parents who believe that they are doing the right thing and are unaware or reluctant to accept that FGM is illegal. In the Netherlands, such reluctance to be seen as interfering with cultural norms or the way in which parents of a particular ethnic group care for their children extends to the health care providers who include this argument in their position against more legal accountability in the health care sector. Such positions reveal the need for a broad approach that is not limited to only prevention or only enforcing legislative measures against FGM, and the myriad concerns that must be addressed for campaigns to alter the deeply-ingrained social value and wider perception of the practice.

Socio-economic implications

Many social programs that seek to inform immigrant communities about female genital mutilation seem to overlook the fact that the supporters and practitioners of FGM are usually very well aware of the health and legal implications involved. Mme Hawa Gréou's estimable reputation as an excisor was based on the fact that she had been performing FGM for years without apprehension by the authorities and without a child ever dying under her knife. In most cases, the practising community considers that the benefits gained by genitally mutilating females outweigh the consequences for the victim, even when members of the community are fully aware of the law, human rights abuse and health hazards involved. When a child bleeds excessively and dies as a result of

FGM, the death is seldom if ever attributed to the practise itself. Rather, it is more readily accepted that the child was a witch, or possessed by bad spirits, or had died from some other complication. The ordeal for those that do survive does not end with the completion of the procedure. The ramifications of the multiple psychological and physical effects are echoed throughout adolescence and adulthood, with mutilated women being reluctant to seek education or work opportunities as a result of their deep trauma and self-identification as being 'different.' The feminization of migration[45] has revealed numbers of female migrants who are impeded from making social and economic contributions to the country of destination due to the restrictions or stigma placed on them by female genital mutilation. At the same time that FGM ensures acceptance in the practising immigrant community, it marginalises the victim in the wider society of the destination country. On the other side of the issue, excisors have little incentive to 'put down the knife' as not only do they lose their social standing in the practising community, for many of them it is their sole means of earning a living.

Cultural practices that are deeply ingrained in the social fabric are usually too complex to be resolved through a simple one-dimensional strategy. What seems to be more effective is a culturally sensitive approach that takes into consideration the attitudes and values of the practising community by providing viable options to the practice (in the form of other culturally significant rites of passage for young girls or alternative sources of income for excisors), coupled with real legal consequences for violation of the law. Publicity surrounding trials and successful

[45] The 'feminization of migration refers to the increasing numbers of female migrants relocating on their own and not necessarily through family reunification programs, for example.

convictions of guilty individuals contribute to discouraging the practice, whereas pretending to ignore its existence encourages its perpetuation. Furthermore, by empowering women in the migrant communities with opportunities to act as wage earners in their families the social requirements of the practice may diminish in favour of viable financial incentives. Women in immigrant cultures who have not undergone FGM are far more likely to integrate further into the host society as they feel less stigmatized or 'different.' As culture is a body of learned behaviours that is taught and reproduced, the malleable nature of tradition could allow for culture to evolve and some harmful traditions to be discarded when they are no longer useful or economically viable. However, social change is difficult to effect as long as the beneficiaries are the least powerful social, economical and political group within those societies where FGM is practised. For some women in the target group, marriage is the sole means of survival. The pressure to conform to expectations of what constitutes a favourable bride includes financial incentives and social security. When excision is also expected, and the consent of the bride seldom considered, there is little option for refusal. The most effective means for the victim or potential victim to gain leverage would be access to legal recourse through effective legislation.

Chapter 4: The "French Model"

Migration of the practise of female genital mutilation to France

The practice of female genital mutilation is thought to have originated in Eastern Africa, and was prevalent in many ancient cultures. Currently, the practice can be found in 28 African states in the sub-Saharan and North-eastern regions of the continent, and of these countries, 18 have a prevalence rate of 50% or higher.[46] There are disparities within the countries themselves depending on whether regions are inhabited by indigenous or migratory groups that may or may not engage in the practice. In Europe, FGM was routinely performed on women and girls regardless of background or status as recently as the 1950s. In these cases, Western physicians were performing FGM as a "treatment" for hysteria, lesbianism, masturbation and other so-called "female deviations".[47] Nowadays, cases of FGM in Europe are concentrated in the immigrant communities that have a high percentage of migrants from regions in Africa where the practice is still prevalent.[48] Over the course of the 1990s, approximately 200,000 immigrants arrived in France from 16 African countries where FGM is practiced - Benin, Burkina Faso, Cameroon, Central Africa Republic, Chad, Côte D'Ivoire, Democratic Republic of the Congo, Djibouti, Egypt, Ghana, Guinea, Mali, Mauritania, Niger, Senegal, and Togo.[49] Many of these immigrants generally follow a reverse pattern of the historical French colonial

---

[46] Most figures rely on anecdotal evidence, but increasingly, more reliable data is being gathered from demographic and health surveys. In this case, the source is Rahman and Toubia, *Female Genital Mutilation*, p. 7.

[47] *African Journal of Reproductive Health, Vol. 10, No. 2, August, 2006, pp. 37-47*

[48] Cases of FGM have also been found in immigrant communities in Canada, America, Australia and among certain ethnic groups in Asia and the Middle East.

[49] Rahman and Toubia, p. 151.

presence in Africa. The former French domain extended from the West coast through sub-Saharan Africa: areas that have the highest concentrations of immigrant communities that continue to practice FGM in Europe. From this region, the majority of immigrants to France originate from former French colonies of Senegal, Mali, Mauritania and Guinea, countries that have some of the highest prevalence rates of FGM in Africa.[50] In Mali, the country of origin of Mme Hawa Gréou, the estimated rate of women and girls who undergo the procedure is 93.7%.[51] In the case of Mme Hawa Gréou and many of her compatriots from Bamako,[52] she was following her husband who had French citizenship as he had migrated to France during the economic boom of the sixties and seventies. Her marriage had been arranged in Mali in 1961, prior to her husband's departure, when she was just fifteen (he was 26). When she arrived in Paris in 1979, she moved into a sort of mini-Mali where familiar customs were preserved within an entirely Malian community.

Over the years, migration from Africa to France continued to be shaped by a number of other push and pull factors - disparities of economic development, population trends, migratory networks already in existence, access to information,

---

[50] Boussuge and Thiébaut, *Le Pacte d'Awa.* There are large numbers from other African States as well and not all citizens of former French colonies in Africa practice FGM. It is more likely that an immigrant to France from Senegal practices FGM because of the high concentration of practicing ethnic groups in Senegal. An immigrant to France from Algeria or Tunisia, which are the African States with the highest rates of migration to France, would be less likely to practice FGM as there are no known groups in these states that follow the tradition.

[51] Former French colonies in Africa have some of the highest rates of FGM on the continent: Senegal – 20%, Mauritania – 25%, Guinea – 90%, Mali – 93.7%, Côte d'Ivoire- 60%, Benin- 50%, Niger- 5%, Chad- 60%, Central African Republic- 50%, Republic of Congo- 5%, Djibouti – 98%. Rahman and Toubia.

[52] There are disparities within Mali – less than 10% prevalence rate in Timbuktu and Gao region but 95% in Bamako and Koulikoro. Rahman and Toubia, p. 193.

ease of travel, armed conflicts, environmental deterioration and human rights violations. The feminization of migration, whereby an increasing number of female migrants are moving from their countries of origin, has led to the demand for a review of migration and asylum procedures in order to take into account the special needs of some of them.[53] While many female migrants continue to follow migration networks for family reunification, there have been more cases of migrant women seeking better opportunities, or escaping conflicts or repressive social systems on their own. When escaping violence on the regional, national or domestic level, many seek refuge in France as all forms of violence against women and children are punishable in the European member states and are subject to prosecution. It is ironic then that many immigrants who arrive in France under such conditions bring violence against women and children with them in the form of female genital mutilation. Though migration and integration procedures may make them aware of the legal implications[54] of continuing the practise of FGM in France, or at least give them a better understanding of their human rights, the insular nature of the immigrant community undermines the effectiveness of these efforts. Nevertheless, FGM remains a concern for migration policy-makers as the impact of the practice can be felt across several migratory dimensions such as: some victims of FGM or those under threat of the practice seek to move away or seek asylum from the country where it is prevalent; migrant women and girls within the Diaspora are still subject to FGM performed illegally within the community or during trips back to the

[53] World Migration Report 2008: Managing Labour Mobility in the Evolving Global Economy, International Organisation for Migration, pp. 9-11.
[54] There is no specific law against FGM in France – the practice falls under the Penal Code of the existing Criminal and Child Protection laws.

country of origin; and FGM is a stigma that marginalizes female members of the immigrant communities, counteracting integration efforts in countries that promote values of democracy and gender equality. Considering the increase in women migrating to Europe from African countries where FGM is practised, poor integration is having economic repercussions through the underutilized potential of FGM victims. Though counter-FGM activities such as the 'Roadmap to eradicate FGM'[55] have been gaining ground in the regions of origin in Africa, there has been an oversight in terms of measures taken to address the eradication of FGM within the immigrant communities across Europe. When practising immigrants living in Europe are asked about the validity of FGM outside Africa the general reasoning is the maintenance of tradition and identity, with the hope of returning to the motherland one day. The sense of insecurity in a foreign country and the looming rejection by the host society are negative forces for Africans living outside their own country. These forces push them to adhere to their traditions and strongly maintain their identity, and consequently many appear to be more conservative than those in Africa. Though efforts to counteract FGM usually begin in the region of origin, they must be emphasized throughout the entire migration process, continuing after arrival in the country of destination. In this regard, prevention measures and awareness of the prosecution of FGM have a strong role to play in eradicating female genital mutilation in France.

[55] Launched by UNFPA.

Key features of the French punitive approach

France has the highest rate of prosecution of FGM cases out of all the countries where the practice continues. As previously mentioned, most of the prosecution of FGM cases in France leads from the methods of discovery and reporting of FGM cases through mandatory health checks and legally enforced signalling function. Embedded in the French punitive approach or "French model" are strong preventative measures against FGM in the form of education, health, human rights and awareness-raising campaigns within the communities of the target group. However, according to frontline organizations such as the Commission pour l'Abolition des Mutilations Sexuelles (CAMS), adopting a strictly preventative position or a strictly punitive position is too narrow a strategy and will not overpower the social and cultural pressure to continue the practice within the target group.

In France, due to the legal requirement of pregnant women and all children less than the age of six to undergo annual health checks, and the legal obligation of all health care providers to report any cases or suspected cases of FGM, noticeable fluctuations in the numbers of cases have been noted and tracked. As a result, the emerging trend points to a decline in the number of reported cases of FGM since these legal requirements came into force in 1986.[56] This trend has been linked positively to the high prosecution rate of cases, and the awareness on the part of the target group of the legal consequences of performing the procedure. These

[56] This decline has been noted despite the increase in the overall numbers FGM cases in France, which has been attributed to the increase in immigrants from practicing regions who have already been excised. The decline has been tracked through the observation of excised mothers who do or do not subject their daughters to the procedure once they take up residence in France.

consequences include stiff penalties, lengthy terms of imprisonment and denial of French citizenship. First responders in France have also examined the competing explanations for the recorded decrease in cases of FGM. These competing explanations include the fact that the practice is being driven underground by the threat of prosecution and members of the target group simply avoiding the mandatory health checks, or wait until the child has passed the age of six to perform the procedure. The difficulty of gathering information on specific or subtle changes in the rates of FGM relates to the secrecy implicit in avoiding detection. However, anecdotal evidence or informed opinions from first responders have been given equal consideration to those presented in official reports from health care providers. When this information is added to the mix of data gathered from other sources such as teachers, immigration officers, social workers, co-workers, religious leaders or grass-roots campaigners the trend indicates a clear relationship between the decrease in FGM rates since the introduction of stronger legislation and prosecution. The case study presented in Chapters 2 and 6 of this thesis further support these findings and forms the main basis for analysis of the “French model”.

Chapter 5: The strategy for eradication in the Netherlands

Migration of the practice of female genital mutilation to the Netherlands

The migration of FGM from Africa to the Netherlands took a different route, and transpired under different circumstances, from that of the French situation. Dutch colonial efforts in Africa were concentrated mostly in South Africa, with other territories in the continent being established more as trading posts than colonies.[57] Notably, there was a stronger Dutch colonial presence in Indonesia, which is a region that has reported a high prevalence of FGM. The practice is said to have travelled to Indonesia from Eastern Africa with the spread of Islam. FGM continues to be practiced in Indonesia under the erroneous belief that Islam endorses the practice. After Indonesia gained official independence from the Netherlands in 1945, many Indonesians chose to migrate to the Netherlands, and this group remains the second largest ethnic minority in the Netherlands.[58] However, very little information is available regarding the continuation of the practice of FGM among the Indonesian community in the Netherlands. As such, Dutch first responders to issues related to FGM continue to identify immigrants from Eastern Africa, and Somalia in particular, as the target group for FGM education and awareness-raising campaigns in the Netherlands.

From Eastern Africa, female genital mutilation travelled with immigrants, refugees and asylum seekers to the Netherlands within the past two decades - more recently than in the French situation. These migrants consisted mostly of Somali refugees escaping conflict in the area, which encompasses Eritrea, Ethiopia and the Sudan in addition to Somalia. This area been identified as the possible origin of the practice of FGM, and has one of the highest rates of prevalence of FGM. Among these four countries, an average of 90% of female children, youth and women are subjected to FGM every year.[59] In Somalia the average is even higher, at 98% prevalence.[60] Somali immigrants and their descendants form the largest group

[57] According to the UNHCR, South Africa does not have a significant rate of FGM. http://www.unhcr.org/refworld/type,QUERYRESPONSE,,ZAF,3f7d4e3e2a,0.html
[58] Dutch Bureau of Statistics, cbs.nl.
[59] http://www.measuredhs.com/topics/gender/FGC-CD/countries.cfm
[60] Ibid.

within the immigrant communities in the Netherlands that have confirmed cases of FGM. From this point, the similarities of the Dutch context of FGM with that of the French re-emerge. As in France, immigrants in the Netherlands from the target group continue the practice as a means of preserving their identity and connection with Africa, while conforming to social expectations and tradition within their ethnic community. They also continue to practice FGM as a means of complying with the perceived Islamic requirements of 'sunna'.[61] Though the means of arrival in the Netherlands may differ from that of France, and the particular ethnic composition of the target group reflect different regions of origin in Africa, the ongoing issues surrounding the practice of FGM in both France and the Netherlands, and the challenges they face to eradicate it, are very similar.

Key features of the Dutch preventative approach

Since 1993 in the Netherlands, the practice of FGM has been prohibited under the Dutch Penal code as (serious) physical abuse. According to immigration statistics, immigrant communities from regions in Africa where FGM continues to be practiced are concentrated in pockets throughout the urban areas in the Netherlands. Social workers and health care providers within these communities confirm that FGM is most prevalent among members of this target group. As such, preventative measures are geared towards this target group, and information on the status of FGM as serious physical abuse is widely disseminated. However, to date, there have been no prosecutions of cases of FGM in the Netherlands. With every new case of FGM emerging, usually publicized as a result of the death of a child who was subjected to FGM, pressure to strengthen the preventative policy towards FGM increases. The demand for a stronger Dutch policy toward FGM

[61] Almost all Somalis are Sunni Muslims, with less than 1% practising Christianity or 'Other'. http://lcweb2.loc.gov/cgi-bin/query/r?frd/cstdy:@field(DOCID+so0055)

centres on the effects of the “French model” with specific reference to mandatory health checks for pregnant women and children less than six years old, and the legally enforced signalling function whereby cases or suspected cases of FGM are reported to the relevant authorities. These legislated methods of discovery and reporting of FGM cases are conspicuously absent from the Dutch policy regime towards FGM.

Currently in the Netherlands, health checks for children of any age are not mandatory, and healthcare providers have the right to report cases of FGM, but are not legally obligated to do so. The Pharos organization is the knowledge centre for all issues relating to FGM in the Netherlands and the approach taken by this organization focuses on education and awareness-raising campaigns that are threaded through the health care system, the immigration process and the social work in communities populated with a high percentage of immigrants from the target group. The education and awareness-raising campaigns designed for the target group include information on FGM as a violation of several basic human rights including the rights of the child, the implications for the victim’s health and lifelong damage caused by FGM and information on legislation in the Dutch Penal Code that criminalizes FGM. As the target group is primarily Muslim, and FGM has been misrepresented as being endorsed by Islam, local religious leaders are pressed to inform their communities that FGM is un-associated with the Muslim faith.

The Dutch government renewed its commitment to reducing FGM in 1997 with the development of the protocol for discussing FGM (Gespreksprotocol or

preventative 'conversation protocol'). This protocol was developed for use by the Youth Health Service as a guideline for social workers and health care providers to raise the subject of FGM and hold a structured conversation with families in the target group. The protocol focuses heavily on motivating the target group to alter attitudes towards FGM. Together with education and awareness-raising campaigns, the taboo of discussing the topic of FGM has been broken, and these campaigns have been incorporated into strategies by organizations with close ties to the target group, such as the Federation of Somali Associations in the Netherlands (FSAN). However, such organizations with 'inside knowledge' of the target group have cautioned that the eradication of such an ancient custom will not happen overnight, as evidenced by the fact that the most recent statistics indicate a conservative estimate of 50 girls are subjected to FGM in the Netherlands every year.[62]

The most significant measure taken by the Dutch government in its strategy to combat FGM came in 2005 with the designation of Pharos as the national knowledge centre for FGM. As the national organization that specializes in health care for refugees, migrants, asylum-seekers and undocumented migrants, Pharos is well-placed to deploy existing information and develop new strategies to combat the practice of FGM in the Netherlands. Pharos acts as the focal point for all issues related to FGM in the Netherlands and has adopted an approach that reflects the position of the Dutch government, which emphasizes prevention. Pharos also seeks to increase the expertise of first responders and collaborates with organizations

---

[62] This estimate has been widely criticised as being extremely low. See Appendix on p. 81, and http://www.humanrightsimpact.org/fileadmin/hria_resources/FGM_in_the_Netherlands_english_summary_final_version.pdf

that are closely connected to the target group, such as FSAN. Pharos has been appointed the task of developing government action plans towards FGM that will formulate frameworks for collaboration among various partners in a multi-faceted approach to ending the practice. Of particular significance in the Pharos approach is the involvement of the target group in developing strategies for eradication, and the empowerment of women in the target group. Pharos acknowledges that prevention alone cannot succeed in eradicating FGM if implemented in a vacuum. As such, the involvement of the target group in developing what works best, and provisions for empowering women in the target group communities will provide more long-term results. Pharos has also placed considerable emphasis on presenting FGM as a form child abuse, and relating it to provisions in the Penal Code. As Pharos reports directly to the Ministry of Health, Welfare and Sport, which in turn presents these reports to the Dutch House of Representatives, Pharos is in a strong position to influence decisions on the transferability of key features of the "French model" to the Dutch preventative approach.

The Dutch government has also adopted a version of the French *'Attest du* Voyage', or 'Declaration against Female Genital Mutilation', which has gained widespread support from Dutch first responders to FGM-related issues.[63] Parents of children from the target group are approached by an employee of the Youth, Health and Welfare Department and invited to sign the document without obligation, as a declaration that they will not subject their daughters to FGM abroad. The parents are expected to take the signed declaration with them when they travel as it serves

[63] www.tegenvrouwenbesnijdenis.nl/content/upload/doc/Vgvrapport.pdf

as a tool to resist pressure from the community in the region of origin to perform the practise. The signing of the document also provides an opportunity to reinforce the commitment of the family to abandon the practice through the dissemination of information on all issues related to FGM.

Further activities to eradicate the practice of FGM in the Netherlands have been implemented independently of the central Dutch government. These activities include pilot projects initiated by the municipal health agencies in cities with high concentrations of the target group, namely Amsterdam, The Hague, Rotterdam, Eindhoven, Tilburg and Utrecht. These agencies are coordinating their activities with Pharos and FSAN. Information is also widely disseminated through the refugee camps in the Eastern region of the Netherlands, with particular attention paid to members of the target group.

Still, rates of decline of FGM remain slow in the Netherlands.[64] Social programs within the prevention strategy have stepped up their campaigns to include elements from campaigns that have successfully eradicated the practice in regions of origin. Such activities are usually at the grassroots level and include mobile theatre or catchy songs against FGM that are sung in the dialect of the target group. The aim of the grass roots approach is to encourage the abandonment of the practice by the community as a whole. Though this approach has had a significant impact in the regions of origin, challenges faced by the target group within the Diaspora, such as marginalization and prejudice, prove to be more difficult to overcome and serve to embed the practice more deeply within the immigrant

[64] See Appendix, p. 81.

community. As in the French context, traditions practiced by the immigrant group that feels isolated and fragile in a foreign environment tend to gain importance as a link with their heritage and identity. To break through the cultural barrier and speed the decline of FGM, the Dutch preventative strategy will need to emphasize the legal implications of continuing to practice FGM, placing FGM squarely in the context of child abuse, and support this position by exercising the relevant legislation through prosecution.

Chapter 6: Case Study of Mme Hawa Gréou, Part 2

Lessons learned from the "French model"

Excisor Mme Hawa Gréou embodies the multiple challenges that face the "French model" of counter-FGM efforts. A combination of factors upheld her conviction that FGM was the right thing to do, not least of which was the mistaken belief that the practice was mandated by the Koran, coupled with the sheer weight of centuries of the tradition being passed down from generation to generation. That she was doing irreparable harm to children did not disturb her and at no point during her trial did she agree that FGM was morally wrong. Mme Hawa Gréou only changed her mind about the practice when she accepted the fact that her residence in France constituted a civil contract that required her to obey the laws of a country regardless of her opinion of them. Had immigration policies at the time of her arrival in France required her to learn to read and write French she may have learned that the Koran does not prescribe FGM and that conviction of a crime precludes the possibility of ever becoming a French citizen. Literacy and awareness of her legal status would have also spared her the ordeal of her polygamous relationship with her husband, who favoured his third wife over her. Had she been aware of the law, and her rights as a French citizen, Mme Hawa Gréou would have been the only wife recognized under French law and she would have been able to claim French citizenship after only five years residence, regardless of her husband's consent. Living in a country within a country has had many unforeseen consequences for Mme Hawa Gréou, and just as deficiencies in prevention strategies failed to stop her from performing FGM, poor integration into wider

society gave her no other choice. Of the policy regimes that evolved during her years of residence in France, Mme Hawa Gréou would have benefitted most from a campaign to empower immigrant women, or a strong integration policy, that would have provided her with education, job training, legal recourse to escape an abusive, polygamous relationship, awareness of her rights as a French citizen and her rights as a woman, and respect for the consequences of violating her civic contract with her adopted country. Had Mme Hawa Gréou abandoned her vocation as an excisor in favour of options that she would have had through such policies, thousands of girls may have been spared the ordeal of FGM.[65]

The overarching lessons to be taken from the "French model" are that prevention alone is only going halfway, that legislation too is not enough, and that better integration and empowerment of the perpetrators and the victims can alter the decision to perpetuate FGM from within the target group. Underlining this assumption is the necessity for cases of FGM to be discovered through legitimate channels and investigated as a crime. Subsequent prosecution is facilitated by the appropriate legislation and system of accountability. When prevention fails, first responders cannot rely on accidentally discovering FGM cases before they are empowered to act. Mme Hawa Gréou's prosecution, which received widespread exposure, granted immigrant women and girls in France a further degree of awareness of French law, and the consequences of breaking it. However the case also alerted other excisors and families to the reach of the law, and pushed the practice further underground. As illustrated in the previous chapters, aggressive

[65] Though it may be fair to assume that their parents would have found another excisor to cut them.

legislation and taking a hard line against immigrants can and does provoke a backlash of resentment against what is perceived as an attack on cultural identity. Tension remains between the wider French society that continues to marginalize the same demographic group that is being hard pressed to integrate. Stricter counter-FGM initiatives can easily trample what remains of cultural sensitivity, which can become particularly raw in times of social upheaval, such as during the '*l'affaire du foulard'* in 1989.[66] A multi-pronged policy against FGM must be applied in a way that such a consolidated approach does not play into the fear and anxiety already present in immigrant communities. Nevertheless, a firm stand against FGM as a crime removes the practice from the sensitive cultural sphere and, as demonstrated in the case study, reaffirms the primacy of civil law among the practicing communities.

Transferability of the "French model" to the Netherlands

As mentioned in Chapter 5, in the section on "Key features of the Dutch preventative approach", the Dutch policy regime towards FGM is typical for the style of the political culture in the Netherlands, which tends to prefer moderate strategies in most policy areas. The Dutch political culture must also contend with balance between policy areas, which is proving to be especially challenging with regard to FGM. In considering the implementation of methods of discovery and reporting of FGM cases based on the "French model", the mandatory health checks

[66] The Islamic scarf controversy in France arose when three Muslim girls were suspended from school for not removing their headscarves. The controversy sparked debates on Islamophobia in France, and exposed the social problems surrounding marginalization of immigrants, multiculturalism, integration and identity.
http://en.wikipedia.org/wiki/Islamic_scarf_controversy_in_France. Accessed 14th July, 2009.

and the legally enforced signalling function countervails against the right to privacy and the confidentiality between health care provider and patient. In order to justify a breach of professional confidentiality, the health care provider must substantiate the report with factual evidence and reasonable grounds to indicate a victim or potential victim of FGM. Tipping the balance in favour of arguments against strong legislation is the fact that there is no legal obligation to report child abuse or suspected child abuse in the Netherlands.[67]

Additional resistance to the adoption of the "French model" is based on the demographic differences in the French and Dutch contexts of FGM. The number of immigrants from regions in Africa where the practice was or still is strong is considerably higher in France than in the Netherlands due to the historical relationships between these countries and Africa. The comparatively low numbers of persons practicing FGM out of the entire Dutch population (less than 8% of the total Dutch population originate from practising regions in Africa)[68] makes it difficult to justify mandatory health checks for all children in the Netherlands based on such a tiny percentage of the population. When the invasive nature of the mandatory health checks are considered, with the inspection of the genitals of female children who may be psychologically unprepared for such a procedure, the implementation of these health checks for all, based on the infractions of a very few, is difficult to justify. Cultural sensitivity towards the religious aspect of the issue may also be a consideration in this context. A large number of Muslims living in the

---

[67] There is a reporting code whereby health care providers must use their discretion regarding whether or not reporting the case to the authorities is in the best interest of the child. http://www.youthpolicy.nl/eCache/DEF/1/05/814.html

[68] cbs.nl, 2009.

Netherlands do not practice FGM but will be held accountable for the enforcement of unpopular measures that apply to all Dutch citizens.

Furthermore, the population density of the Netherlands, which is four times the population density of France,[69] together with settlement regulation by the Dutch authorities, bring the target group into closer proximity with the wider Dutch society, facilitating easier integration and boosting the effectiveness of prevention campaigns. These demographic circumstances prevent the target group from forming dense, insular communities as extensive or impenetrable as those of the French *banlieues.*[70] The case study in Chapters 2 and 6 of this thesis indicates that integration of the target group is one of the surest means of eradicating the practice of FGM. By regulating areas of settlement, which is an entirely different consideration in the Netherlands than in France due to the lack of space, the Dutch authorities are able to facilitate smoother integration of both newly arrived immigrants from regions of origin in Africa where the practice is prevalent, and the descendants of the target group.

Dutch immigration authorities in particular are well placed to monitor newly arrived families from the target group whose members may or may not have been excised in their country of origin, or who may be flagged as likely to continue the practice once settled in the Netherlands. Any cases of FGM in these families can be discovered during the general health inspections during the immigration

---

[69] cbs.nl, 2009.

[70] Dutch settlement regulations are a contributing factor to the decline in immigration rates to the Netherlands. Countries without such regulations, such as the UK, are seen as more attractive. In the UK, immigrants can live wherever they choose and many seek the familiarity and support of their own ethnic community, thereby contributing to the concentration of insular immigrant neighbourhoods throughout the UK.

process, with education and awareness of the implications of continuing the practice in the Netherlands being then applied accordingly. Relative to the situation in France, the arrival of FGM in the Netherlands is a more recent development, giving the immigration authorities a greater advantage in "heading-off" the practice at the border.

This monitoring feature is of particular importance due to the emergence of a disturbing new trend of manipulation of the Dutch and French immigration process in favour of the continuation of FGM. This trend indicates that the more difficult it becomes to excise a female child, the more financial incentive the parents have to subject her to the practice. The bride price of an excised girl increases in relation to the difficulty of performing the procedure and as a result a ruthless cycle of manipulation and exploitation has been reported in both France and the Netherlands.[71] In some cases, the cycle begins when the parents of the child seeks asylum in Europe in order to escape the likelihood of their daughter being excised in their region of origin in Africa.[72] Asylum is granted and as the parents must accompany their child, all members of the immediate family can eventually become citizens in their country of destination. In France, the child is subjected to compulsory health checks every year until the age of six years old, and so FGM is deferred until she passes this age. In the meantime, a prospective husband is being arranged in Africa, and the bride price negotiated on the basis that the young girl is now a citizen of a European country. The child is then taken to the region of origin

Mme Linda Weil-Curiel commented that the trend is being reported in all European countries where FGM occurs. Interview with Mme Linda Weil-Curiel 7th October, 2008. Paris, France.

[72] FGM, or the threat of FGM, constitutes grounds for asylum in both France and the Netherlands.

on holiday, where extended family members ensure that she is excised. The bride price increases, she is married and then returns to Europe. The parents can then claim compensation on behalf of the child as she had been mutilated 'without their knowledge'. Compensation is granted (though the child seldom, if ever sees this money) and when she attains the legal age for marriage in her adoptive country, her husband joins her under a family reunification program. The parents of the child consider this method to be a valid way to conform to the social and cultural expectations for their daughter and believe that they have acted in the best interest of their daughter, with minimum interference by influences outside their immigrant community. At no point in this plan is any consideration or choice given to the wishes of the child. African immigrant families commonly have at least five children; therefore this system can prove to be a very lucrative plan. Practicing families are even less likely to be held accountable if they live in deeply insular immigrant communities, to which many newly migrated families gravitate, or when the means of discovery through deeper integration of the family into wider society (health checks, school attendance, etc.) can be avoided.

As a result of these considerations, the wholesale adoption of the "French model" in the Dutch strategy against FGM is unlikely, despite the similarity of the contexts of FGM in both countries. Organizations such as Pharos, and other first responders in the Netherlands, continue to research and develop the best approach for the Dutch policy regime towards FGM, all factors considered, without entirely discounting the "French model". No plan is foolproof, as evidenced by the fact that FGM persists in both countries, however the Dutch preventative approach towards

FGM can only be strengthened, and the rates of decline of FGM accelerated, by treating the practice as a criminal offence that will not be tolerated. To do so would be to legitimize (through legislation) the means of discovering and reporting the crime, and taking the relevant steps to prosecute it. What may be more realistic is the development of a Dutch strategy that incorporates legislated methods of discovery and reporting that cannot be interpreted as infringing upon the rights of Dutch citizens, but what these methods look like remains to be seen.

Chapter 7: Concluding Observations and Recommendations

The reasons for female genital mutilation are complex, related to each other and woven into the beliefs and values of practising immigrant communities in France and the Netherlands. Ultimately, FGM is a grim illustration of the gendered approach to female sexuality and the violent actions taken to control it. Immigrants from regions in Africa where the practice was or still is prevalent brought this harmful tradition with them to France and the Netherlands through the migration process. French and Dutch policy regimes towards the eradication of FGM both include strong preventative measures, and both countries have criminalised the practice under their respective civic laws as child abuse and grievous bodily harm.

However, France has taken the added step to legislate the methods of discovery and reporting of cases of FGM. This legislation has contributed to the decline of the practice of FGM in France, as it constitutes the main link between discovery of the crime and prosecution of the perpetrator(s). This research proposes that the Dutch policy regime towards the eradication of FGM would be well served by adopting and incorporating similar legislation. As there have been no prosecutions of FGM cases in the Netherlands to date, and France has a track record of the highest number of successful prosecutions of FGM cases, the two policy regimes make a neat comparison for discovering the best approach to eradicating FGM. The French case study presented in this thesis forms a detailed illustration of strengths and the weaknesses of the “French model”, and supports the position of strong legislation as being the most effective approach, especially when incorporated into a preventative strategy. In so doing, the contribution of

prevention campaigns to the decline of the practice in both France and the Netherlands is acknowledged. However, when new cases of FGM emerge and gain widespread publicity, pressure mounts to develop a stronger Dutch policy toward FGM by specifically looking towards the "French model".

Nevertheless, the thesis finds that the wholesale adoption of the "French model" into the Dutch policy regime is not feasible. The transferability of the "French model" is impeded by the particular nature of Dutch political culture that prefers a lighter touch on social issues, as well as by demographic composition and concentration of the target group that contrasts with that of France, and concerns over privacy issues and discrimination implicit in the French legislated methods of discovery and reporting of FGM cases. Conflict with existing Dutch policy regimes would also make for a difficult fit. Nevertheless, the French have had a longer history of attempts to eradicate FGM and the research presented in this thesis supports the position in the discussion on policy regimes toward FGM that the Dutch strategy can develop a broad approach that is influenced by the legal framework of the "French model".

Lastly, this thesis agrees that prevention strategies alone are not enough to accelerate the decline of FGM, and incorporating strong legislation will improve such a strategy more than undermine it. Though the same legislated methods of discovery and reporting may be too abrasive for the Dutch policy regime, laws to protect women and children from the crime of serious bodily harm and child abuse are in place and can be more stringently applied in FGM cases. Legislation that supports these laws can be developed as part of a strategy more closely tailored to

the Dutch context of FGM. As such, the thesis supports the view that a specific law against FGM is not necessary for an effective strategy to eradicate the practice, as long as the laws that are already in place that criminalize FGM are honoured, enforced and supported by additional legislation that facilitates their application. By upholding the laws that protect all Dutch women and children, the Dutch authorities can take the position that the crime of FGM will not be tolerated and FGM cases will no longer go unpunished.

Appendix

Rates of female genital mutilation in France and the Netherlands

At present, there are no known quantitative statistics known to the author that are reliable in that they provide an accurate picture. The estimated rates of FGM in France and the Netherlands, in terms of girls and women that have been subject to FGM and those at risk of being subjected to FGM, can at best be extrapolated from existing qualitative information. This information has been gathered from multiple sources such as anecdotal evidence from first responders, health check-ups during immigration procedures, census surveys of the target group within the wider population, evidence presented at court during FGM trials, etc.

From such methods, for example, the estimated number of girls at risk of being subjected to FGM in France ranges from 4500 to 7000.[73] In just one city in the Netherlands, Rotterdam, unofficial estimates of new cases of FGM performed annually range from 50 to 500.[74] The wide range of these figures renders the gathering of hard data difficult. Furthermore, the figures are influenced by significant limitations such as fluctuations in immigration (and illegal immigration) from regions of origin within countries that report a wide range of levels of prevalence of FGM. For example, a census of the Somali Diaspora in 2000 estimated that 25,000 Somalis are settled in the Netherlands.[75] Even though Somalia has an overall prevalence rate of FGM of 98%, there are regions within the country that have a much lower prevalence rate (such as urban areas). Immigrants from such regions of origin are less likely to engage in the practice of FGM once settled in the Netherlands, yet the target group is included in estimates for girls at risk. Aside from the problem of cases of FGM going undiscovered and unaccounted for in estimated prevalence rates of FGM, the effectiveness of measures to eradicate FGM in France and the Netherlands is rendered even more difficult to ascertain when families who choose to abandon the practice do not report the reason for their decision. As such, strategies for eradication do not benefit from information on what are proving to be the most effective measures to counter FGM. Furthermore, methods of gathering information on FGM differ between France and the Netherlands.

---

[73] Els Leye, 'Female Genital Mutilation, A study of health services and legislation in some countries of the European Union,' ICRH 2008, p. 45. http://www.icrh.org/files/academia-doctoraat%20els%20leye_18x25_1.pdf, accessed 17th July, 2010.
[74] J. van der Kamp, 'Improving the Combating of FGM,' Metro, 14th February 2009, http://www.pvdarotterdam.nl/nieuwsbericht/4058, accessed 21st June, 2010.
[75] Joakim Gundel, 'The Migration-Development Nexus: Somali Case Study,' p. 263, http://www.somali-jna.org/downloads/Gundel%20-%20Dev%20Mig%20Nexus%20Somalia%20.pdf, accessed 3rd July, 2010.

When compounded with the general unavailability of reliable data, compilation of precise rates of FGM in either country, and any cross-national comparison of strategies for the enhancement of eradication measures, are compromised and lead mainly to hypothetical deductions. Such a hypothetical deduction may be derived as follows: during the prosecution of the excisor Mme. Hawa Gréou, she admitted to performing FGM on as many as ten girls a day. Although she could not remember how many girls she excised in total, this rate can result in a conservative estimate of 2500 a year for one excisor. When the number of excisors in Paris is deduced from the target group population, a rate of 2500 per excisor per year, at 10 excisors per 500 members of the target group can result in a figure that far exceeds estimates of the number of girls at risk of FGM in France. As such, it is fair to conclude that not only are prevalence rates of FGM in France and the Netherlands subject to debate, but that they are too low in most instances.

Addendum – First case of FGM in the Netherlands

According to the 2009 report on the response in Europe to female genital mutilation presented by International Centre for Reproductive Health,[76] the overall number of cases against FGM in European countries has risen significantly over the past five years. Notably, criminal court proceedings have also been on the rise in countries with general court provisions, and now include the first such case in the Netherlands. Not only do these findings confirm that specific laws against FGM are not necessary for more prosecutions, but of most relevance to this thesis is the indication that the Netherlands has begun to take steps in a punitive direction. Upon closer examination of the case, the details may not seem as encouraging at first glance. While judges in the case confirmed that FGM had been performed on the victim (a fact difficult to deny given the physical evidence), the Dutch court cleared the father of performing FGM on his daughter. The reason for this decision was given as a lack of evidence to lead to a conviction. Nevertheless, the case was brought forward on the basis of FGM and child abuse. The father was convicted of beating and biting his daughter, for which he was sentenced to a three-month prison sentence. The significance of this conviction in terms of FGM is that by including the practice with other instances of child abuse, the practice is removed from the cultural sphere and placed, appropriately, in the context of child abuse.

[76] ICRH_rapport 2009_def - high resolution.pdf

At the time of writing this thesis, there were 37 criminal investigations of FGM underway in the Netherlands. However, as of June 2010, there are still no convictions explicitly on the grounds of FGM in the Netherlands.

Annex 1: Note on terminology

Female Genital Mutilation (FGM) - The terminology for the procedure now commonly known as female genital mutilation has been edited and adjusted over the years to facilitate better understanding of the practise, while maintaining fidelity to the gravity of the consequences of the practise and adhering to certain cultural sensitivities. During the first years of the discussion on the practise, 'female circumcision' was the general reference; however this term misrepresents the procedure as being similar to male circumcision. In the 1970s 'female genital mutilation' was proposed as a more appropriate representation of the harm of the act, and added suitable 'gravitas' to the subject. In 1990 this term was formally adopted by the Inter African Committee on Traditional Practices Affecting the Health of Women and Children and in 1991 the WHO recommended that the United Nations also adopt this term. 'Female Genital Mutilation' has subsequently been widely used in United Nations documents and is the term used by the WHO.

Also in the 1990s, the terms 'female genital cutting' and 'female genital mutilation/cutting' were proposed by some agencies and researchers due to some dissatisfaction with the negative or insensitive connotation of the word 'mutilation'. This proposal emerged after some practising communities felt estranged or offended by the perceived judgemental term of 'female genital mutilation'. However, all United Nations agencies have agreed to use the term 'female genital mutilation' and so it is the term used in this paper.

Target group – In the context of this thesis, the target group refers to immigrants (in France and the Netherlands) from regions of origin in Africa where

FGM is or was practiced, with a high prevalence rate. The target group also extends to the descendants of these immigrants who may have been born in the country of destination, but who continue to support the practise and/or have been subjected to FGM.

Interviews

Kul, Bafing. Interview with the author, Paris, France, 7th October 2008.

Thiébaut, Élise. Interview with the author, Paris, France, 7th October 2008.

Weil-Curiel, Linda. Interview with the author, Paris, France, 7th October 2008.

Bibliography

Andro, Arnelle and Marie Lesclingand. 'Les mutilations sexuelles féminines: le point sur la situation en Afrique et en France.' *Populations & Société*, No. 438, October 2007.

Boussuge, Agnès and Élise Thiébaut. *Le Pacte D'Awa.* Syros 2006.

Favell, Adrian. *Philosophies of Integration: Immigration and the Idea of Citizenship in France and Britain.* Palgrave, 2001.

De Boer, Margreet and Alem Desta. 'Female Genital Mutilation in the Netherlands, A matter of human rights? The policy on combating Female Genital Mutilation assessed according to human rights obligations.' VON (Refugee Organizations in the Netherlands), 2007: 1-6.

Gundel, Joakim. 'The Migration-Development Nexus: Somali Case Study,' p. 263, http://www.somali-jna.org/downloads/Gundel%20-%20Dev%20Mig%20Nexus%20Somalia%20.pdf, accessed 3rd July, 2010.

Haimé, Marilyn. '[Harmful Cultural Practices as they relate to the Integration Process.' Keynote speech, EU-Conference. *Joint Action of Member States against Harmful Traditional Practices, Tome 3.* EU-Conference Brussels: 25 January 2006: 20.

Leye, Els. "Female Genital Mutilation, A study of health services and legislation in some countries of the European Union," International Centre for Reproductive Health 2008, p. 45. http://www.icrh.org/files/academia-doctoraat%20els%20leye_18x25_1.pdf, accessed 17th July, 2010.

Leye, Els and Alexia Sabbe. 'Responding to female genital mutilation in Europe: Striking the right balance between prosecution and prevention – A review of

legislation.' International Centre for Reproductive Health, Ghent University, June 2009.

Leye, Els. and Jessika Deblonde, José García-Añón, Sara Johnsdotter, Adwoa Kwateng-Kluvitse, Linda Weil-Curiel, Marleen Temmerman 'Analysis of the implementation of laws with regard to female genital mutilation in Europe,' *Crime, Law and Social Change*, Vol.47, No. 1, February 2007:1-31.

Mestries, Francis. 'The French Autumn Riots of 2005 and the Crisis of Republican Integration.' Migración y Desarrollo, 2007: 117-133, meme.phpwebhosting.com/~migracion/rimd/revistas/rev9/e7.pdf. Accessed on 2nd January 2010.

Okonofua, Friday. "Female genital mutilation and reproductive health in Africa." *African Journal of Reproductive Health*, Vol. 10, No. 2, August 2006: 7-9.

Pimsleur, Julia and the Commission pour L'Abolition des Mutilations Sexuelles (CAMS). 'Le Pari de Binto.' DVD. Viewed on 7th October 2008, Paris, France.

Rahman, Anika and Nahid Toubia. 'Female Genital Mutilation: A Guide to Laws and Policies Worldwide.' Zed Books, 2000.

Poldermans, Sophie. 'Combating Female Genital Mutilation in Europe
A Comparative Analysis of Legislative and Preventative Tools in the Netherlands, France, the United Kingdom, and Austria.' University of Vienna, 2006. http://www.stopfgm.net/dox/SPoldermansFGMinEurope.pdf, accessed 4th September 2009.

Rapport de Mission – Mali. 'Les mutilations génitales féminines au Mali.' Office Français de Protection des Refugies et Apatrides (OFPRA). Vol. 1. November 2008. http://www.ofpra.gouv.fr/documents/Rapport_Mali.pdf, accessed 3rd May 2010.

Ras-Work, Berhane. 'Female Genital Mutilation – Achievement and remaining Challenges.' Keynote speech, EU-Conference. *Joint Action of Member States against Harmful Traditional Practices, Tome 3.* EU-Conference Brussels: 25 January 2006: 33.

Todd, Emmanuel. 'Le Destin des immigrés. Assimilation et ségrégation dans les démocraties occidentals.' *Revue Européenne de migrations internationals*, Vol. 12, No. 12-2, pp.304-307. Seuil, 1996.

Van der Kamp, J. 'Improving the Combating of FGM,' Metro, 14th February 2009, http://www.pvdarotterdam.nl/nieuwsbericht/4058, accessed 21st June, 2010.

World Health Organization. 'Eliminating female genital mutilation: an interagency statement.' UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. World Health Organization, 2008. http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

World Health Organization. 'A systematic review of the health complications of female genital mutilation, including sequelae in childbirth.' Geneva: World Health Organization 2000. http://whqlibdoc.who.int/hq/2000/WHO_FCH_WMH_00.2.pdf

Websites consulted:

Answer given by Mrs. Reding on behalf of the Commission, http://www.europarl.europa.eu/sides/getAllAnswers.do?reference=E-2010-1039&language=EN

BSA Institute survey on level of racism in France, http://en.wikipedia.org/wiki/Islamic_scarf_controversy_in_France#cite_note-fifth-4

European Union: Fgm Discussed In European Parliament - female genital mutilation - Brief Article, http://findarticles.com/p/articles/mi_m2872/is_/ai_71563356

Facts and Myths on female genital mutilation, http://www.lindamaykallestein.com/Linda_May_Kallestein/FGM_Info_files/Background%20info%20FGM.pdf

FGC Data from DHS Surveys, 1990-2004, http://www.measuredhs.com/topics/gender/FGC-CD/countries.cfm

Programme to combat violence against children, young people and women, http://www.daphne-toolkit.org

Resolution on female genital mutilation in Egypt, http://www.derechos.org/nizkor/europa/parlamento/egype.html

1995 World Health Organization (WHO) Classification of FGM, http://www.fgmnetwork.org/eradication/state/who.php

South Africa: Reports on female genital mutilation (FGM) and or female circumcision; where practised (urban and/or rural areas); the tribes, religions and cultures that practise it, whether it is legal or not; the government's position and availablility of state protection, http://www.unhcr.org/refworld/type,QUERYRESPONSE,,ZAF,3f7d4e3e2a,0.html

The French Civil Code,

http://www.legifrance.gouv.fr/html/codes_traduits/code_civil_textA.htm#%A7%204%20-%20Of%20the%20Intervention%20of%20Third%20Persons