CONTEXTUALIZING STRATEGIES OF ELIMINATING FEMALE GENITAL MUTILATION: A COMPARATIVE STUDY OF KENYA, THE UNITED KINGDOM, AND SWEDEN

By Lavender Namdiero

MA HUMAN RIGHTS LONG THESIS

PROFESSOR: Judit Sandor

Central European University

1051 Budapest, Nador utca9.

Hungary

ABSTRACT

This study provides a comparative analysis of strategies for eliminating Female Genital Mutilation (FGM) which in turn work to reinforce anti-FGM laws in the three countries. Even in the 21st century, the effective elimination of the practice continues to elude policymakers. Although anti-FGM legislation exists in most of the practicing countries or has recently been adopted, there are however very few reported cases of prosecutions, and the prevalence rate indicates the practice still continues. While some eradication strategies have proven successful in some regions, other regions have not welcomed these initiatives and have therefore led to little behavioral change. With the increase of refugees migrating to the West, FGM has become a global problem that has proven to be highly complex to eliminate. The research seeks to analyze the various strategies employed in the three jurisdictions by assessing their successes and challenges. The study aims to review the lessons learned from Kenya and whether similar plans can be adopted in the UK and Sweden. The assumption would also follow that strategies adopted in the UK and Sweden may also have a positive impact in Kenya, in regions where previous plans have failed. In essence, there is no "one size fits all" solution. Nevertheless, laws against FGM can be reinforced when there is political will and when accompanied by approaches that are culturally sensitive and country or region specific. The study will address ways in which the local community and government have come up with the means to protect girls from undergoing the practice. It also proposes ways of improving existing mechanisms to strengthen legislation within the three countries.

Table of Contents

LIST OF ABBREVIATIONS

ARP	Alternative Rite of Passage
AWWC	Africa Well Woman Clinics
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CoE	Council of Europe
COVAW	Coalition on Violence Against Women
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EIGE	European Institute for Gender Equality
FAWE	Forum for African Educationalists
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FORWARD	Foundation for Women's Health Research and Development
HIAS	Hebrew Immigrant Aid Society
ICCPR	International Covenant on Civil and Political Rights
NBHW	National Board of Health and Welfare
NGO	Non-Governmental Organization
PATH	Program for Appropriate Technology in Health
UDHR	Universal Declaration of Human Rights
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

CHAPTER I - INTRODUCTION

A harrowing experience of FGM as summarized by Karen Hughes:

> The child, completely naked, is made to sit on a low stool. Several women take hold of her and open her legs wide…With her kitchen knife, the operator first pierces and slices open the hood of the clitoris. Then she begins to cut it out. While another woman wipes off the blood with a rag, the operator digs with her sharp fingernail a hole the length of the clitoris to detach and pull out the organ. The little girl held down by the women helpers, screams in extreme pain…[1]

1.1 BACKGROUND ON FGM/C

Female Genital Mutilation/Cutting (FGM/C) has caused contentious debate among scholars, policymakers, human rights advocates and anthropologists about its origin, purpose, and strategies for its elimination. FGM is defined by the World Health Organization (WHO) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons."[2] The practice is mostly performed on girls from the age of infancy up to fifteen years. However, there are those above eighteen years who also undergo the cut. The practice is prevalent in Africa and some parts of the Middle East, Asia, Europe and Latin America.[3] The harmful nature of the practice is not the only concern for anti-

[1] Rosemarie Skaine, "A Traditional Practice," in *Female Genital Mutilation : Legal, Cultural, and Medical Issues* (Jefferson, N.C. : McFarland, c2005. n.d.), 11.
[2] "WHO | Female Genital Mutilation," *WHO*, accessed March 24, 2016, http://www.who.int/mediacentre/factsheets/fs241/en/.
[3] "WHO | Sexual and Reproductive Health," *WHO*, accessed March 25, 2016, http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/.

FGM activists, the lack of consent or coercion of most victims has driven for more stringent measures to be taken to eradicate the practice.

1.1.1 Origin of FGM/C

Locating the origins and reasons behind FGM/C is an important aspect of establishing an effective way of ending the practice. Many scholars have asserted that establishing the roots will not add any value in curbing the practice because the problem should be viewed in light of present conditions.[4] This researcher disagrees with this approach. Consider this example of a practice in Kenya (of knocking down the front teeth of a particular ethnic group) where understanding its origin is said to have initiated behavioral and attitude change among community elders. It led to establishing a less intrusive alternative practice rather than the painful teeth removing, which for a long time was believed to symbolize a rite of passage. The origin of the practice had nothing to do with tradition or culture but was rather used for medical purposes to administer medicine when someone contracted tetanus and developed a 'jaw lock.'[5] Understanding the origin behind a harmful traditional practice can, therefore, be used as a tool to persuade communities on a grassroots level.

At this point, it is safe to assume that the origin of the practice can be differentiated from the reason for its maintenance.[6] Determining its source is difficult because of different opinions from scholars. Some scholars maintain that the practice predates Islam and Christianity.[7] Other scholars trace the tradition to ancient Egypt. A Greek papyrus in a British Museum, for instance,

[4] Bettina Shell-Duncan and Ylva Hernlund, "Female 'circumcision' in Africa: Dimensions of the Practices and Debates," in *Female "circumcision" in Africa: Culture, Controversy, and Change. Ed. Bettina Shell-Duncan, Ylva Hernlund* (Boulder & London: Rienner, 2000), 13.
[5] H. J. Diesfeld and H. K. Hecklau, *Kenya*, vol. 5, Medizinische Länderkunde / Geomedical Monograph Series (Berlin, Heidelberg: Springer Berlin Heidelberg, 1978), 66, http://link.springer.com/10.1007/978-3-642-66935-4.
[6] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 13.
[7] Ibid.

makes reference to girls in Egypt being circumcised to obtain dowry.[8] There are also reports of archeological findings of well-preserved mummies that showed some types of FGM had occurred.[9] Other authors, on the other hand, claim the alleged origins are speculative, and the practice may have originated from more than one place.[10]

1.1.2 Different Types of FGM/C

The WHO classifies the various types of FGM/C into four categories; "(i) Clitoridectomy, (ii) Excision, (iii) Infibulation and (iv) 'Other."[11] Clitoridectomy comprises of the "partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce."[12] In the Islamic culture, this type of cut is called *Sunna* which translates to "tradition" in Arabic.[13] The second category is Excision which involves the "partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora."[14] This type is called *khafd* in Islam which translates to "reduction" in Arabic.[15] Infibulation which is considered the most extreme form involves the "narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris."[16] The term infibulation originates from the Latin word *fibula.*[17] The fourth category comprises of all other techniques to the female genitalia such as "pricking, piercing, incising, scraping and cauterizing the genital area."[18]

[8] Skaine, "A Traditional Practice," 16.
[9] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 13.
[10] Skaine, "A Traditional Practice," 16.
[11] "WHO | Media Center. Female Genital Mutilation," *WHO*, accessed March 24, 2016, http://www.who.int/mediacentre/factsheets/fs241/en/.
[12] Ibid.
[13] Skaine, "A Traditional Practice," 8.
[14] "WHO | Media Center. Female Genital Mutilation."
[15] Skaine, "A Traditional Practice," 8.
[16] "WHO | Media Center. Female Genital Mutilation."
[17] Skaine, "A Traditional Practice," 9.
[18] "WHO | Media Center. Female Genital Mutilation."

1.1.3 Reasons behind Practicing FGM/C and its Consequences

Socio-cultural and religious factors are some of the justifications for the practice. Under the socio-cultural realm, one of the reasons for the practice is to prepare girls for adulthood and marriage. Other causes include "taming" the girl or woman, so she is not promiscuous during her marriage. Regarding religion, many have the notion that the practice is predominantly Islamic, but this is a false assumption. Even though communities practicing may turn to religion as a justification, there are no religious texts that support the practice.[19]

FGM has both short term and long term complications depending on the type performed. Some of the short-term risks include shock, extreme pain, excessive bleeding, urine retention, tetanus, open sores around the genital region and sepsis. Long-term risks include recurrent bladder and urinary tract infection, infertility, cysts and increased complications during childbirth.[20] In addition to these health complications, there are also social issues that arise as a result of the practice for example in Kenya, some of the communities that practice FGM do so to prepare girls for marriage. Once these girls are married off at a young age, they no longer continue to attend school. There is, therefore, a significant drop-out rate among girls compared to boys of a similar age group.

1.2 JUSTIFICATION FOR THE COMPARATIVE STUDY

The UK and Sweden were chosen because they are two of the top five asylum countries with the highest number of females expected to be affected by the practice.[21] Many of the asylum seekers come from countries such as Somalia, Ethiopia, and Eritrea. Sweden is also of interest

[19] Ibid.
[20] Ibid.
[21] "Too Much Pain. Female Genital Mutilation & Asylum in the European Union. A Statistical Overview" (United Nations High Commissioner for Refugees (UNHCR), February 2013), 14, http://www.unhcr.org/531880249.pdf.

because it is the first Western country to enact laws prohibiting FGM.[22] Kenya was chosen as a non-western comparison, as it is one of the countries where the practice is prevalent in Africa.

1.3 SCOPE AND LIMITATIONS

The study relies primarily on the research carried out by scholarly experts. Academic experts of FGM include Bettina Shell-Duncan, Rosemarie Skaine, Efua Dorkenoo and Martha Nussbaum. This thesis comprises of a literature review of the mentioned authors and others. The WHO is the primary source of FGM statistics and prevalence data. Sources from the internet mainly refer to WHO sources and reports from the United Nations governmental bodies and non-governmental organizations (NGOs). The principal basis for selecting these sources was reliability and credibility. The reliability of the sources was a primary concern, especially regarding statistics. Therefore the statistical data on prevalence rate should only be read as estimates. As for the scholarly experts, their credibility was evaluated by assessing whether their studies have been cited in other research, or whether the information provided can be verified. In addition to prevalence rate, the study will also examine reported criminal court cases. These have been documented through legislative institutions such as European Court of Human Rights (ECtHR), public NGO reports and research institutions.

1.4 METHODOLOGY

The primary research question seeks to find out how relevant scholarly approaches (e.g. human rights/legal approach, cultural approach, and the social change theory) are in helping to facilitate the enforcement of anti-FGM laws in Kenya, the UK, and Sweden. The research question

[22] Sara Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law" (Department of Sociology, Lund University, 2004), 8, http://lup.lub.lu.se/record/528291.

builds on existing literature and applies the same principles in a non-western context. Most of the existing literature indicates the practice as a "third world problem." However based on the increase of migrants to the UK and Sweden from countries where the practice is prevalent, the fundamental assumption behind the research question is that the practice is still ongoing in the host countries and that the implementation of legislation and policies is not effective based on the estimated prevalence rate.

In addressing the research question, the following factors will be examined:

- Whether strategies like community-based education and raising awareness would be useful in the UK and Sweden as it would in Kenya.
- Whether there is political will from governments of the three jurisdictions in designing and implementing strategies for FGM elimination.
- What are the obstacles preventing prosecutions and convictions of the practice?
- Whether the eradication strategies reflect cultural differences, what the biggest challenges are for implementation, and to what extent social and cultural factors play a role in its elimination.

1.5 THE SITUATION AND PREVALENCE RATE OF FGM IN KENYA, THE UK, AND SWEDEN

In Kenya 29 out of 34 ethnic communities practice FGM.[23] The country's estimated FGM prevalence rate in 2001 was said to be 38 percent of females between the ages of 15-49 years.[24] The rate in Kenya suggests a decrease from 1998 to 2009. According to a 2005 United Nations

[23] "Joint Evaluation of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C): Accelerating Change" (UNFPA-UNICEF, 2013), 6, http://www.unicef.org/evaldatabase/index_FGMC.html.
[24] Rosemarie Skaine and James C. Skaine, "Prevalence," in *Female Genital Mutilation : Legal, Cultural, and Medical Issues*, by Rosemarie Skaine (Jefferson, N.C. : McFarland, c2005. n.d.), 43.

Children's Fund (UNICEF) report, the prevalence rate declined from 38 percent in 1998 to 32 percent in 2003.[25] The WHO reported a further decrease in 2009 with a prevalence rate of 27.1 percent.[26] A more recent report by UNICEF reveals a further reduction of the prevalence rate from 27.1 percent in 2009 to 21 percent in 2016. The prevalence rate represents girls aged 15-49 years.[27]

Establishing the prevalence rate of FGM in Europe is a challenge mainly due to the assumption that the rate in Europe is the same as in the country of origin.[28] A limitation of this hypothesis is that FGM prevalence in Europe is often not scrutinized in "culturally sensitive studies" regarding the focus group.[29] Other factors affecting the collection of accurate prevalence rate include the fact that victims are hesitant to reveal this information because of its intimate nature. One of the studies on FGM estimating prevalence rate was published by Equality Now and the City University London in July 2015. The two countries in focus were England and Wales.[30] According to the study, the number of girls and women between the age of 15-49 who had undergone the cut and living in England and Wales had increased from an estimated 66,000 in the year 2001 to an estimated 103,000 in 2011.[31] If the age groups of 50 years and above and between the ages of 0-14 years are taken into account, the total females to have undergone or are likely to undergo FGM in 2011 increased to 137,000 from the 66,000 of 2001.[32] Statistics for women migrating from FGM practicing countries to the UK, birth registration data and data from the 2001

[25] "Female Genital Mutilation/Cutting: A Statistical Exploration," *UNICEF*, accessed March 25, 2016, http://www.unicef.org/publications/index_29994.html.
[26] "WHO | Sexual and Reproductive Health."
[27] "Statistical Profile on Female Genital Mutilation/Cutting. Kenya" (UNICEF, 2016), http://data.unicef.org/child-protection/fgmc.html.
[28] Dineke Korfker et al., "The Lower Prevalence of Female Genital Mutilation in the Netherlands: A Nationwide Study in Dutch Midwifery Practices," *International Journal of Public Health* 57, no. 2 (April 2012): 414.
[29] Ibid.
[30] Alison Macfarlane and Efua Dorkenoo, "Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates" (London: City University London and Equality Now, July 2015), http://www.trustforlondon.org.uk/research/publication/prevalence-of-female-genital-mutilation-in-england-and-wales-national-and-local-estimates/.
[31] Ibid., 23.
[32] Ibid.

census have been used to determine estimated prevalent rate from 2001 to 2004.[33] This method has however presented several limitations. For example, the statistics failed to take into account females born in countries other than their parents' birthplace.[34] The data collection strategy changed in 2014 following the limitations presented in the 2001-2004 data collection plan. The new data collection policy derived its estimates from health services, and it expanded the scope of data collection in 2015 to include mental health services and GP practices.[35] There is still a need for new prevalence estimates because there are women who have not used the health services.[36]

In Sweden, there has been no representative FGM study to determine prevalence rate since February 2012.[37] The previous studies were done by health professionals in 2004, 2005 and 2006 to evaluate the number of women who had undergone the procedure.[38] The studies, however, had their limitations and could therefore not provide reliable FGM prevalence data in Sweden,[39] for example, irregular migrants were not accounted for in the statistics. The number of migrants residing in Sweden, who were born in countries where FGM was practiced was 91,420 in December 2010.[40] The figure provided by the European Institute for Gender Equality (EIGE), however, does not make any distinction regarding the age groups. Studies conducted in 2011 concluded that there was a total number of 59,409 girls between the ages 0-18 years, originating from FGM risk countries who were residing in Sweden.[41] Given the lack of central registration systems of recording FGM, Sweden has developed systems for possible data collection. The four

[33] Ibid., 14.
[34] Ibid.
[35] Ibid.
[36] Ibid., 15.
[37] EIGE, "Current Situation and Trends of Female Genital Mutilation in Sweden," May 2013, http://eige.europa.eu/rdc/eige-publications/current-situation-and-trends-female-genital-mutilation-sweden.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] EIGE, "Estimation of Girls at Risk of Female Genital Mutilation in the European Union: Report," June 2015, 69, http://eige.europa.eu/rdc/eige-publications/estimation-girls-risk-female-genital-mutilation-european-union-report.

core systems include the Swedish medical birth register where the status of the woman is recorded during delivery; the Swedish patient register where patients seeking help with medical complications after FGM are registered, Child health services, and School health record systems.[42] It should, however, be noted that data has not been aggregated at the national level. It would be tempting to assume that the figures in Sweden suggest a decline in the practice. There is a split belief in Sweden of whether FGM is practiced among the immigrant community.[43] On the one hand, some believe that the practice is ongoing however there is a scarcity of reports and court cases due to the state's inability to discover cases.[44] On the other hand, some believe that FGM has become partly abandoned especially among well-established immigrants.[45]

Despite the fact that the UK portrays an increase in the practice based on the estimated figures, there has been a general change of attitude experienced since 2010. The primary shift is caused by the awareness of the health risks and also criminalization of the practice by law.[46] Both victims and those at risk now have a platform to address their concerns and voice their opposition toward the practice. The attitude shift can also be attributed to the declining attachment of the practice to religion.[47] The case is similar in Sweden. A focus group discussion among females residing in the country or awaiting approval to live in Sweden was carried out in 2014.[48] The findings of the focus group discussion revealed that the primary agent of the change in attitude towards FGM included the criminalization of the practice through the Swedish law and a deeper knowledge, and understanding of the Quran.[49] There was also increased knowledge about the

[42] "Study to Map the Current Situation and Trends of FGM. Country Reports" (European Institute for Gender Equality, 2013), 467.
[43] Ibid., 468.
[44] Ibid.
[45] Ibid.
[46] Macfarlane and Dorkenoo, "Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates," 6.
[47] Ibid.
[48] EIGE, "Estimation of Girls at Risk of Female Genital Mutilation in the European Union."
[49] Ibid., 75.

adverse health consequences following the practice, awareness raised by civil society and encountering other women from practicing countries who had not undergone the procedure.[50]

Despite the fact that there are those opposed to ending the practice in Kenya, there has been a positive response in some communities to stop the practice. The shift in attitude towards FGM is partly attributed to the enactment of the Children Act of 2001 and an increase in educational programs whose aim is to raise awareness of health risks and complications of the practice.[51] In light of the background information on FGM discussed in this chapter, it is now possible to provide a detailed analysis of the legal measures in place to eradicate the practice. The next chapter discusses the legislative framework in detail including case law addressing the fight against FGM.

1.6 GENERAL FRAMEWORK

The first chapter of the thesis provides detailed background information on the practice including a scope of its origin, the reasons behind the practice and its health consequences. The section further addresses the core problem of FGM from a cultural perspective and the estimated prevalence rate in Kenya, the UK, and Sweden. The statistical data provided covers the last ten years and is derived from the WHO. The data will provide an estimated overview of the growth or decline of the practice in the three jurisdictions.

The second chapter focuses mainly on a comparative analysis of the existing FGM-related legislation in the three jurisdictions. The section includes criminal law provisions and other legislative texts, directly and indirectly, addressing the practice. Both criminal law and child protection law concerning FGM is examined together with the criminal procedures involved. For

[50] Ibid.
[51] L Livermore, R Monteiro, and J Rymer, "Attitudes and Awareness of Female Genital Mutilation: A Questionnaire-Based Study in a Kenyan Hospital," *Journal of Obstetrics and Gynaecology* 27, no. 8 (November 2007): 816.

a long time, the practice has been referred as '*Female Circumcision.'* This chapter discusses the cause of the shift of this term from '*Circumcision*' to '*Genital Mutilation'* and what implications this change may have in the human rights discourse.

The third chapter describes the different eradication strategies and policies currently implemented in the three jurisdictions. It further analyzes the successes and challenges of these policies. Factors inhibiting the practical implementation of legislation such as reporting of cases, inaccurate prevalence rate figures, ineffective criminal investigations, the lack of knowledge by medical practitioners and the lack of awareness of the legal aspect and referral procedures have been explored. The chapter will further present a holistic comparative analysis of the proposed approaches and models within the three jurisdictions. The comparative analysis includes an evaluation of whether the policies are context specific and what changes can be made to render them applicable to other jurisdictions where necessary.

The fourth chapter analyzes alternative methods that have turned out to be relatively successful in other countries such as France and Senegal and how these methods can be applied in Kenya, the UK, and Sweden. The chapter concludes by proposing policy recommendations based on a combination of socio-cultural, human rights and legal perspectives.

CHAPTER II - LEGISLATION AGAINST FGM

2.1 OVERVIEW

The terminology of the practice has changed within the years bringing about different reactions with anti-FGM advocates, those advocating for cultural tolerance and among those responsible for drafting legislation. Establishing an accurate terminology for the practice plays a significant role in setting up mechanisms for its eradication or management. According to one community in Uganda, the practice is locally known as a *circumcision rite*.[52] This term can be problematic, as it seems to place cultural traditions on a pedestal while downplaying the actual physical, physiological and psychological trauma women and girls undergo as a result of FGM.

Female Circumcision was frequently used in the past as the general term to denote collectively all procedures involved in the practice.[53] The name was established out of sensitivity and respect for women who do not consider the process as mutilation but rather a rite of passage. With the increased involvement of the anti-FGM movement, the term became less and less popular. According to Shell-Duncan and Herlund, the term Female Circumcision grew unpopular due to its "laissez-faire" nature of de-sensitizing the severity of most forms of the practice which had been compared to male circumcision.[54] Other terms used to define the practice include female surgeries, traditional female surgeries, cutting, and excision.[55] The terms have however caused debate among scholars because the use of different terminology causes misinformation.[56] The different use of language, in turn, can alter the severity of the practice and ultimately affects the urgency of finding means of eradicating it. For example, the term "female surgeries" makes the

[52] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 6.
[53] Ibid.
[54] Ibid.
[55] Skaine, "A Traditional Practice," 7.
[56] Ibid.

practice sound medical, while others have claimed that the terms "mutilation" and "circumcision" are political and inaccurate respectively.[57] In fact, many scholars have used alternating terms in their literature depending on particular contexts.

Establishing an accurate terminology was essential in drafting legislation against FGM. Activists advocated for the term "Female Genital Mutilation" as some maintained that the permanent removal of a perfectly healthy organ connotes to mutilation.[58] This definition, however, came with much resistance from local communities who claimed that the West was insensitive to those who had already undergone the procedure and that it came with excessive judgment.[59] Regardless of this resistance, the international conventions addressing the practice defined it as mutilation. The same terminology is used in domestic legislation in the three jurisdictions, expounded below, in which the shift from circumcision to mutilation brought with it severe consequences. For purposes of the following chapters, the practice will be referred to as FGM unless otherwise stated.

2.1.1 International Legislation

The law against any practice or behavior is a fundamental ingredient in the social construction of reality and it further bolsters the perception of an international consensus to eliminate, control or prohibit a practice.[60] It further invites international activists to work in collaboration with such countries to eradicate a practice as is the case with FGM in Kenya, the

[57] Ibid.
[58] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 6.
[59] Ibid.
[60] Elizabeth Heger Boyle and Sharon E. Preves, "National Politics as International Process: The Case of Anti-Female-Genital-Cutting Laws," *Law & Society Review* 34, no. 3 (2000): 704, doi:10.2307/3115141.

UK, and Sweden. Each of the three countries has shown commitment in the fight against FGM by enacting laws which will be discussed in detail in the following section.

Despite the enactment of anti-FGM law and policy, few FGM cases have resulted in criminal prosecutions or even convictions. For example, the UK has reported one prosecution only since the enactment of its anti-FGM laws, where the accused was later acquitted.[61] The law can act as a double-edged sword by the fact that it can work to protect those at risk and victims of FGM, but at the same time, serve as a deterrence for women and girls seeking medical help following complications arising from FGM due to fear of prosecution.

This section begins by addressing the relevant international conventions and declarations which in one way acknowledge FGM as a harmful practice. All the conventions and declarations mentioned have been ratified by Kenya, Sweden, and the UK. The Universal Declaration of Human Rights (UDHR) has acted as the foundation for most human rights conventions and legislation which strive to end FGM due to the UDHR's core principle of "human dignity for all."[62] The issue of harmful religious and cultural practices is however not explicitly addressed in the UDHR provisions.[63] FGM is understood to fall within the scope of some of the articles in the UDHR such as Article 7 which states, "All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination."[64] There is also Article 5, "No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment."[65]

[61] "Doctor Found Not Guilty of Performing FGM," *BBC News*, February 2015, accessed March 24, 2016, http://www.bbc.com/news/uk-england-31138218.
[62] Rosemarie Skaine, "Globalism and Law," in *Female Genital Mutilation : Legal, Cultural, and Medical Issues* (Jefferson, N.C. : McFarland, c2005. n.d.), 59.
[63] "The Universal Declaration of Human Rights | United Nations," accessed March 26, 2016, http://www.un.org/en/universal-declaration-human-rights/index.html.
[64] Ibid.
[65] Ibid.

Classifying FGM as a form of torture is debatable especially when some women who have been cut are the same people advocating for the practice to continue. It is simply unimaginable that someone would advocate for a form of torture for themselves let alone his or her children. Cultural relativists would also disagree with this categorization as it seems to target certain non-western cultural practices while neglecting other western societal practices that are equally harmful such as plastic surgery. Another factor to be considered in claiming that FGM is a form of torture is the fact that the prohibition of torture is an absolute right as recognized under all conventions addressing it. Therefore viewing both "the ban on harmful cultural practices" and "freedom from torture" under the same scope of absolute rights would imply that states have the same obligation to prohibit FGM as they do for torture, which is not the case in reality. Furthermore, the term torture might seem justifiable to use with regards to FGM but might be deemed problematic with regards to circumcision. If simple terminology can alter whether the practice falls under torture or not, this obviously poses an obstacle in implementing such Conventions.

If one is to continue along the avenue of FGM as a form of torture, the International Covenant on Civil and Political Rights (ICCPR) acts as a supporting legal platform under Article 7.[66] Ratified by Kenya (1972), Sweden (1971) and the UK (1976), the ICCPR addresses discrimination on the grounds of gender and advocates for adequate remedies for any persons whose rights have been violated.[67] This would also mean that the countries that have ratified this Covenant and are part of the countries that practice the cut should show more political will to protect those girls at risk. The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), which was ratified by Kenya, Sweden, and the UK in 1984, 1980 and

[66] "International Covenant on Civil and Political Rights," accessed March 26, 2016, http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx.
[67] "OHCHR Status of Ratification Interactive Dashboard," accessed March 26, 2016, http://indicators.ohchr.org/.

1986 respectively, does not exclusively mention FGM.[68] Article 5 (a) of CEDAW however, places an obligation on state parties to strive in changing the social and cultural behavior and attitude of members of society, to effectively eliminate discriminatory customary practices that assign inferiority or superiority roles based on gender.[69] In many cultures, FGM is mostly driven by the masculine domination of women by men, with men wanting to ensure and maintain dominance and chastity over women. This inferiority/superiority relationship is understandably addressed in CEDAW. The idea of virtue attained through FGM is something so deeply ingrained culturally that communities submit to it without questioning its origin or why other communities from the same country do not practice it.

The General Recommendation No.19 by CEDAW, which addresses violence against women, acknowledges in Article 12, that some states do take part in harmful traditional and cultural practices like female circumcision and genital mutilation which are detrimental to women and girls.[70] This approach builds on the framework of CEDAW in its goal of eliminating all forms of gender discrimination. The CEDAW Committee in 2007 commended Kenya for enacting the Children Act of 2001, which prohibits FGM. The Committee, however, raised concern regarding the continued prevalence of the practice and the notion that it is "legal" to perform FGM on women above 18 years, therefore leaving many women vulnerable to the practice.[71] Similar observations were noted in the UK and Northern Ireland by the UN Committee. They acknowledged and commended the different initiatives adopted such as The Preventing Sexual Violence Initiative

[68] Ibid.
[69] "Convention on the Elimination of All Forms of Discrimination against Women," accessed March 26, 2016, http://www.un.org/womenwatch/daw/cedaw/.
[70] United Nations High Commissioner for, "CEDAW General Recommendation No. 19: Violence against Women," 1992, http://www.refworld.org/docid/52d920c54.html.
[71] UN Committee on the Elimination of Discrimination Against Women (CEDAW), "Concluding Comments of the Committee on the Elimination of Discrimination against Women: Kenya," August 10, 2007, http://www.refworld.org/docid/46d280ff6.html.

and The Crown Prosecution Service in the UK.[72] The Committee, however, raised concern regarding the persistence of the practice and that no convictions had taken place. The Committee called for the full implementation of domestic legislation and for the State party to provide necessary support to the Crown Prosecution Service to enable the efficient prosecution of offenders.[73] Without any enforcement mechanisms from CEDAW, it is hard to ensure that state parties abide by the recommendations of the Committee.

The Convention on the Rights of the Child further addresses the protection of children. It touches on issues such as legal capacity, torture and degrading treatment, and protection from "injury and abuse."[74] Article 24, in particular, places an obligation on state parties to take adequate and appropriate measures to (or "intending to") abolish traditional practices prejudicial to the health of children.[75] The Committee on the Rights of the Child has been active in monitoring state conduct concerning the implementation of the rights addressed in the Convention. The Committee, for instance, issued concluding observations to some member states explicitly calling an end to the practice.[76] For example, in 2007, it urged Kenya to put extra effort in its attempt to eradicate the practice. It commended the joint effort of the administrative officers and civil society in working to protect young girls from FGM and early marriages. The Committee, however, noted that FGM was still widely practiced and called for the government to conduct campaigns to raise awareness about the harmful effects of this and other traditional practices.[77]

[72] UN Committee on the Elimination of Discrimination against Women, "CEDAW Concluding Observations on the Seventh Periodic Report of the United Kingdom of Great Britain and Northern Ireland," CEDAW/C/GBR/CO/7, July 26, 2013, http://www.wrda.net/Documents/CEDAW%20Committee's%20examination%20of%20the%20UK%20government%202013.pdf .
[73] Ibid.
[74] UN General Assembly, "Convention on the Rights of the Child," Treaty Series, vol. 1577, p.3, (November 20, 1989), http://www.refworld.org/docid/3ae6b38f0.html.
[75] Ibid.
[76] UN Committee on the Rights of the Child, "UN Committee on the Rights of the Child: Concluding Observations, Kenya," CRC/C/KEN/CO/2, June 19, 2007, http://www.refworld.org/docid/4682102b2.html.
[77] Ibid.

Article 2 of the Declaration on the Elimination of Violence Against Women expressly acknowledges FGM to constitute violence against women.[78] In general, the UN General Assembly (UNGA) has advocated for the elimination of the practice in member states for example through the General Assembly Resolution on Traditional or Customary Practices Affecting the Health of Women and Girls Report of the Third Committee.[79] These international legal provisions are non-exhaustive, but they reflect the global commitment to eradicating the practice. However, with the lack of enforcement measures, the international treaties do not offer an assurance that practicing member states will adhere to the recommendations and mandates of the conventions and treaties.

2.1.2 Regional Legislation

Both the UK and Sweden are member states of European treaties which call for an end to violence against women. One such treaty is the European Convention on Human Rights (ECHR) which even though does not explicitly mention FGM, prohibits all forms of torture, cruel and degrading treatment under Article 3.[80] Resolution 1247 of the Council of Europe (CoE) Parliamentary Assembly regards FGM as "inhuman and degrading treatment" within the meaning of Article 3 of the ECHR and calls for member states to distinguish between tolerating and protecting minority cultures and "turning a blind eye to inhumane or barbaric treatment."[81] The CoE's Convention on Preventing and Combating Violence against Women requires member states

[78] UN General Assembly, "Declaration on the Elimination of Violence against Women," December 20, 1993, http://www.refworld.org/docid/3b00f25d2c.html.
[79] UN General Assembly, "Resolution Adopted by the General Assembly. Traditional or Customary Practices Affecting the Health of Women and Girls," A/RES/56/128, January 30, 2002.
[80] *European Convention on Human Rights - Official Texts, Convention and Protocols*, accessed March 26, 2016, http://www.echr.coe.int/pages/home.aspx?p=basictexts.
[81] Parliamentary Assembly, "Resolution 1247. Female Genital Mutilation," May 22, 2001, 12, http://www.assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=16914&lang=en.

under Article 38 to adopt necessary legislation and measures to criminalize all forms of FGM including facilitation, coercion, and procurement of the procedure.[82]

The cases brought before the European Court of Human Rights (ECtHR) concerning FGM mostly relate to applicants seeking asylum in Europe for fear of being subjected to the practice upon returning to their country of origin. However, all asylum seeking cases brought before the Court related to FGM have been considered inadmissible. For instance, in the *Izevbekhai and Others v. Ireland* case, the court was not convinced that there was a real risk of the applicant (from Nigeria) being subjected to FGM upon her return, and, therefore, the case was manifestly ill-founded.[83] A similar holding was issued in the *Collins and Akaziebie v. Sweden* case in which the applicants (Nigerians) were seeking asylum in Sweden for fear of being subjected to FGM upon their return to their country of origin. The Court, however, did not find any real risk and the case was consequently declared inadmissible.[84] Other cases that experienced the same fate of rejection on admissibility include the *Ameh & others v. the UK*[85], *Omeredo v. Austria*[86] each case involving a Nigerian applicant, *Sow v. Belgium*[87] with the applicant from Guinea and *Bangura v. Belgium*[88] where the applicant was from Sierra Leone. Considering that FGM is an international problem, judicial bodies such as the ECtHR are encouraged to work in coordination with other legal and immigration authorities of the applicant's country so as to establish a stable platform to monitor the practice and protect those who are at risk of FGM.

[82] "Convention on Preventing and Combating Violence against Women and Domestic Violence," May 11, 2011, http://europa.eu/epic/news/2012/20121010_convention_on_preventing_and_combating_violence_against_women_and_domestic_violence_en.htm.
[83] Izevbekhai and Others v. Ireland, Application no. 43408/08, 17 May 2011.(European Court of Human Rights)
[84] Collins and Akaziebie v. Sweden, Application no. 23944/05, 8 March 2007 (European Court of Human Rights)
[85] Ameh and others v. the UK, Application no. 4539/11, 30 August 2011 (n.d.). (European Court of Human Rights)
[86] Omeredo v. Austria, Application no. 8969/10, 20 September 2011 (n.d.).
[87] Sow v. Belgium, Application no. 27081/13, 19 January 2016 (European Court of Human Rights)
[88] Bangura v. Belgium, Application no. 52872/10, 15 April 2014 (n.d.).

In Kenya, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (also known as the Maputo Protocol) is the most recent legal instrument created in the African region that addresses FGM.[89] The protocol was adopted in 2003, and entered into force in 2005 but is yet to be ratified by some African countries. Kenya, however, signed and ratified the protocol in 2003 and 2010 respectively.[90] The Maputo Protocol explicitly calls for state parties to prohibit all forms of harmful practices through legislative measures under Article 5. The harmful practices consist of all forms of FGM including medicalization.[91] State parties are additionally required to provide necessary support to victims of FGM through basic health care services, legal support and psychological counseling. Providing vocational training is also a state obligation to enable victims to help themselves.[92] The Protocol has however come under heavy criticism for its lack of directive on how to combat FGM, making enforcement of the Protocol futile.[93] Also, the Protocol was previously expected to strongly condemn FGM as a harmful practice. The practice is however only mentioned once in one sentence in the entire Protocol under Article 5 (b).[94]

The 2003 Cairo Declaration on Elimination of FGM is another regional instrument that calls for African member states to establish legislation and for the close coordination between the government and civil society to strive at changing perceptions and attitudes towards FGM.[95] Another regional instrument applicable to FGM in Kenya is the African Charter on Human and Peoples' Rights which calls for the elimination of discrimination against women and the protection

[89] "Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa," *African Commission on Human and People's Rights*, accessed March 26, 2016, http://www.achpr.org/instruments/women-protocol/.
[90] "African Commission on Human and People's Rights," accessed March 26, 2016, http://www.achpr.org/instruments/.
[91] "Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa."
[92] Ibid.
[93] "About the Protocol | Maputo Protocol," 2011, http://www.maputoprotocol.com/about-the-protocol.
[94] "Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa."
[95] The National Council for Childhood and Motherhood, "Cairo Declaration for the Elimination of FGM" (Cairo, June 23, 2003), http://www.childinfo.org/files/fgmc_Cairodeclaration.pdf.

of women and children.[96] There is also the African Charter on the Rights and Welfare of the Child which prohibits harmful customs, traditions, cultural and religious practices.[97] Furthermore, there is The African Union: Solemn Declaration on Gender Equality in Africa which seeks to promote and protect human rights for women and girls.[98]

2.1.3 Domestic Legislation

Civil society including religious groups, human rights activists, and NGOs have played a significant role in putting pressure on the respective governments to take action in the eradication of FGM. For example, the urge to develop anti-FGM laws in the UK grew as a result of pressure from the Minority Rights Group following the increase in African students and migrants to the UK.[99] This group published a report advocating for a particular criminal law against the practice which contributed to the House of Lords enacting the Prohibition of Female Circumcision Act in 1985 in England, Wales, and Northern Ireland.[100] The provisions of the Act were repealed in 2003, and 2005 and the Female Genital Mutilation Act and the Prohibition of Female Genital Mutilation (Scotland) Act were enacted respectively.[101]

In Sweden, the call for the government to take legislative action against FGM arose from pressure from the media after a series of articles were published in a weekly magazine.[102] The

[96] "African Charter on Human and Peoples' Rights," *African Commission on Human and People's Rights*, accessed September 26, 2016, http://www.achpr.org/instruments/achpr/.
[97] "The African Charter on the Rights and Welfare of the Child (ACRWC) | African Union," accessed September 26, 2016, http://pages.au.int/acerwc/documents/african-charter-rights-and-welfare-child-acrwc.
[98] "Declaration on Gender Equality in Africa" (Addis Ababa, Ethiopia: African Commission on Human and People's Rights, 2004), http://www.achpr.org/instruments/declaration-on-gender-equality-in-africa/.
[99] Julie Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK" (London: The New Culture Forum, 2014), 14, http://www.justiceforfgmvictims.co.uk/the-report/.
[100] Ibid.
[101] *The United Kingdom Female Genital Mutilation Act 2003*, 2003, http://www.legislation.gov.uk/ukpga/2003/31/contents; *Prohibition of Female Genital Mutilation (Scotland) Act 2005*, *2005 Asp 8*, accessed March 24, 2016, http://www.legislation.gov.uk/asp/2005/8/contents.
[102] Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law," 4.

items highlighted female circumcision as a traditional practice after a Swedish gynecologist performed it on immigrant women.[103] The first law to be passed against the practice was the Act Prohibiting Female Circumcision in 1982.[104] This Act was later changed to the Act Prohibiting Female Genital Mutilation in 1998, and in 1999 extraterritoriality was added and brought with it severe penalties.[105]

In Kenya, there had been several attempts at banning FGM from as early as the 1950's.[106] The name "Ngaitana" meaning "I will cut myself" resonates well with the Meru people who are an ethnic group in Kenya that defied the ban on excision in 1956 by threatening the government and encouraging the girls to circumcise themselves.[107] The 2011 Prohibition of Female Genital Mutilation Act of Kenya came seemingly late. Historically, there was little support from political leaders to outlaw FGM. The country's first president Jomo Kenyatta, for instance, defended the practice[108], therefore, rendering eradication efforts ineffective. However, the next president, Daniel Arap Moi, called for the practice to be outlawed in 1982.[109] Before the enactment of the 2011 Act, the Children Act of 2001 was adopted, which explicitly prohibited the practice and any other harmful traditional practices performed on children.[110] It was however limited in scope because it only addressed children.

The 2011 Kenyan Act shares similarities with its former colonial ruler (the UK) and that of Sweden for example with regard to the types of FGM prohibited. It, however, holds more

[103] Ibid.
[104] *Sweden Prohibiting Female Genital Mutilation,1999, SFS*, 1999. Sweden
[105] Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law," 8.
[106] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 132.
[107] Ibid., 137.
[108] 28 Too Many, "28 Too Many, Country Profile: FGM in Kenya," 32, accessed March 24, 2016, http://www.refworld.org/docid/54bcdfdf4.html.
[109] Skaine, "Globalism and Law," 63.
[110] *Kenya Children Act, 2001, L.N. 23/2002*, 2001, http://www.kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=CAP.%20141.Kenya

criminal offences of the practice than the UK and Swedish Acts, including making it an offense to undergo a course of training on how to perform FGM, to be found in possession of tools used in the practice and to use derogatory or abusive language toward individuals who have not undergone the cut.[111] Under the 2003 UK Act, performing the procedure on a girl with exceptions to surgical operations necessary for a girl's physical and mental health or purposes connected with labor or birth constitutes an offense.[112] These exceptions are also provided in the Kenyan Act.[113] In the UK, it is an offense for a girl to perform the procedure on herself and for aiding and abetting UK nationals to procuring the procedure abroad.[114] The maximum penalty for such offenses in the UK upon conviction was increased from a prison sentence of 5 years to 14 years.[115] Like the Swedish Act[116], the Kenyan Act punishes anyone who has knowledge about performed FGM and fails to report and also who facilitates the procedure.[117]

The Acts in the three jurisdictions recognize the four forms of FGM namely Clitoridectomy, excision, infibulation and all other forms. Defibulation is however not explicitly mentioned as illegal in all three Acts.[118] Defibulation involves the exposure of the vaginal opening, the urethral meatus, and the clitoral tissue and is usually performed to "promote women's health by allowing for gynecological screenings."[119] Re-infibulation on the other hand which involves sewing the vagina together after childbirth remains prohibited by law in the UK[120] and Sweden[121].

[111] *Kenya Prohibition of Female Genital Mutilation Act 2011*, vol. 32, accessed March 24, 2016, http://www.kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=CAP.%2062B.
[112] *The United Kingdom Female Genital Mutilation Act 2003*. United Kingdom
[113] *Kenya Prohibition of Female Genital Mutilation Act 2011*.
[114] *The United Kingdom Female Genital Mutilation Act 2003*. United Kingdom
[115] Ibid.
[116] Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law," 8.
[117] *Kenya Prohibition of Female Genital Mutilation Act 2011*. Kenya
[118] Ibid.; *Sweden Prohibiting Female Genital Mutilation,1999*; *The United Kingdom Female Genital Mutilation Act 2003*.
[119] Jasmine Abdulcadir et al., "Care of Women with Female Genital Mutilation/Cutting," *Swiss Medical Weekly* 140 (2011): 5, doi:10.4414/smw.2010.13137.
[120] "UK Law | About FGM," accessed September 19, 2016, http://about-fgm.co.uk/about-fgm/human-rights/uk-law/.
[121] "Female Genital Mutilation" (Stockholm Sweden: National Board of Health and Welfare Customer Service, 2003), 12, https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/10668/2003-114-9_200311491.pdf.

The Kenyan law on re-infibulation is rather vague. The Act states that FGM does not include "a sexual reassignment procedure or a medical procedure that has a genuine therapeutic purpose."[122] This vagueness can lead to interpreting the Act as allowing for re-infibulation. In cases where the woman requests to have the vaginal area "re-closed," the medical personnel instead restores the genital anatomy to its most physiological form.[123] Clear legislation is required to guide medical professionals on how to deal with FGM-related cases appropriately. This will help in reporting and recording incidences of FGM to the authorities and also provide the necessary emotional and medical support for victims.

The prison sentence for crimes committed related to FGM is also different in the three jurisdictions. Persons convicted of performing FGM in the UK are to be imprisoned not more than four years.[124] In Sweden also, persons convicted face a prison sentence of not more than four years.[125] There is, however, a different term of imprisonment for cases that are considered "grave," in Sweden i.e. cases that have caused danger to life, serious illness or involve conduct of an unusually ruthless character to some extent. In such cases, the sentence is not less than two years and not more than a decade.[126] There are no exceptions if the offenders or victims are non-Swedish citizens.[127] The Kenyan law is stricter and places a life sentence for offenders when the procedure leads to death. Regarding other offenses, an offender can serve not less than three years and may be liable to pay a fine of not less than two hundred thousand Kenya shillings (approximately 1,800

[122] *Kenya Prohibition of Female Genital Mutilation Act 2011*.
[123] Abdulcadir et al., "Care of Women with Female Genital Mutilation/Cutting," 6.
[124] *Sweden Prohibiting Female Genital Mutilation,1999*. Sweden
[125] Ibid.
[126] Ibid.
[127] Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law," 8.

€) in Kenya.[128] With regards to the principle of extra-territoriality, all three pieces of legislation would punish offenders,[129] with Sweden reformulating the Act in 1999 and the UK in 2004[130] to accommodate this provision.[131]

Sweden has additional legislation designed to protect children from FGM. The Social Services Act [*SoL, Socialtjänstlagen*] for example places an obligation on all Swedish citizens to report to the social authorities any information of performed or fear of future FGM.[132] The Swedish Board of Health and Welfare provides guidelines to officials in the social sector on how to respond to situations involving FGM for instance when faced with a real risk that the practice is about to be performed.[133] Care of Young Persons (Special Provisions) Act [*LVU, Lag (1990:52) med särskilda bestämmelser om vård av unga*] is a supplementary protective Act, which is only applied when social services intervention cannot be provided under the Social Services Act.[134] This Act entails taking into care or protection of a young person without his or her consent. The Act follows specific criteria to determine whether intervention is necessary and its primary aim is to protect girls from the risk of mutilation.[135] The Secrecy Act [*Sekretesslag 1980:100*] obliges professionals in the social welfare sector to observe secrecy in their work. Some offenses involving children negate this obligation including FGM. In general, professionals in the area of health have a duty to report cases of FGM to the social authorities who in turn may report it to the police.[136] The Act

[128] *Kenya Prohibition of Female Genital Mutilation Act 2011*. Kenya
[129] Ibid.; *Sweden Prohibiting Female Genital Mutilation,1999*; *The United Kingdom Prohibition of Female Circumcision Act 1985*, 1985, http://www.legislation.gov.uk/ukpga/1985/38/section/2.
[130] Els Leye, Jessika Deblonde, and Marleen Temmerman, "Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK" (Belgium: International Center for Reproductive Health - Gent University, April 2004), 9.
[131] Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law," 8.
[132] Ibid.
[133] Ibid., 9.
[134] Ibid., 10.
[135] Ibid., 11.
[136] Ibid.

regarding Special Representative for a Child [*Lag (1999:997) om särskild företrädare för barn*] allows for physicians to conduct genital examinations even with the objection of the child's parents. The prosecutor heading the police investigation appoints an individual representative who can allow a medical review of the girl.[137]

Like the Swedish Act (Special Representative for a Child) , a medical examination of a child can be carried out together with suspending parental authority on suspicion of abuse under the Kenya Children Act.[138] Similarly, the UK Children Act of 2004 places emphasis on the need to protect children from harm and to promote physical and mental health and the emotional well-being of children.[139]

Cases of prosecutions and convictions in the three jurisdictions remain scarce. In Sweden, the police registered 46 cases of suspected FGM in October 2010 with the earliest case reported and investigated in 1999.[140] Since the enactment of the Swedish Act, there have been only two court cases which have resulted in the conviction of the perpetrators. The first occurred Mölndal in 2006 where an elderly woman was charged with performing FGM and severe violation of bodily integrity to a 16-year-old girl and was served with a prison sentence of three years.[141] The second case occurred in Gothenburg in the same year where a father of a 14-year-old girl had been condemned to two years in jail for allegedly allowing his daughter to be cut.[142] Kenya also displays a relatively small number of convictions of FGM cases. There have been only 16 convictions between 2011 and 2014 where 71 cases were brought forward to court.[143] The first and only

[137] Ibid.
[138] *Kenya Children Act, 2001*.
[139] *Children Act 2004*, United Kingdom 2004 c. 31, accessed March 27, 2016, http://www.legislation.gov.uk/ukpga/2004/31/contents.
[140] "Study to Map the Current Situation and Trends of FGM. Country Reports," 455.
[141] Ibid., 456.
[142] Ibid.
[143] "Kenya Battles Female Genital Mutilation," *Institute for War and Peace Reporting*, accessed September 14, 2016, https://iwpr.net/global-voices/kenya-battles-female-genital-mutilation.

prosecution since the enactment of FGM laws in the UK involved Dr. Dhanuson Dharmesena. The doctor performed a re-infibulation procedure on a patient who was previously mutilated in an attempt to save her life after she gave birth at the hospital.[144] The doctor's acquittal relied on a number of systematic failures which found no fault in him. For instance, the hospital ought to have recognized immediately upon examination of the patient that she had undergone FGM and specialized treatment was needed.[145] The doctor further claimed that he did not acknowledge the patient had previously undergone FGM and he performed the procedure to prevent her from excessive bleeding.[146]

In the UK, the issue of prosecutions is very complicated because of the numerous elements required to make a case including the initial reporting and acquiring substantive evidence.[147] In a European Institute for Gender Equality (EIGE) report, several reasons were cited for the difficulty in prosecution in the UK. One challenge was the reluctance to report the crime to the police authorities.[148] It is highly unlikely for a girl to report her family members to the police. There are also too many legal requirements that need to be met for FGM to fall under the law. For instance with extraterritorial FGM offenses, the offender must be a UK national or permanent UK resident.[149]

One of the challenges faced in Sweden regarding prosecutions is the over-sensitivity and tendencies of stereotyping where prejudices and stereotyping sometimes leads to an over-sensitive judicial system.[150] For instance, there is a strong belief that men are the prominent offenders of

[144] Sandra Laville, "Doctor Found Not Guilty of FGM on Patient at London Hospital," *The Guardian*, February 4, 2015, sec. Society, https://www.theguardian.com/society/2015/feb/04/doctor-not-guilty-fgm-dhanuson-dharmasena.
[145] Ibid.
[146] Ibid.
[147] "Study to Map the Current Situation and Trends of FGM. Country Reports," 521.
[148] Ibid.
[149] Ibid.
[150] Ibid., 473.

FGM because they are readily associated with violence against women. In reality, however, FGM offenders are mostly women.[151] There is, therefore, a tendency to release the actual perpetrator (women), while the man is convicted of FGM and serves time in prison.[152] An additional challenge regarding prosecution in Sweden is determining whether FGM has been performed or not especially with regard to the type (type I, II and IV).[153] Collecting evidence that can stand in court is difficult considering victims decline to report the crime. The same is true in Kenya where girls have been reported to be threatened by their parents not to come forward to the authorities.[154] Determining when FGM was performed is another challenge faced.[155] This is important because it will determine whether FGM was legal or illegal depending on whether it was conducted before or after the enactment of the law. Another issue is about how to discover cases of FGM. A criminal investigation can only commence once a report has reached the police authorities.[156] There is simply a large estimated number of unknown cases.

The advantages of the legal approach in all three jurisdictions to eliminate FGM is that it provides a formal platform for action. Women and children can be legally protected, and it sometimes acts as a deterrence to excisors due to fear of prosecution.[157] Implementing these provisions, however, cannot be enforced in isolation without taking into consideration social and cultural factors. The different approaches currently adopted in all three countries to boost or

[151] Ibid., 521.
[152] Ibid., 473.
[153] Ibid.
[154] "Kenya Battles Female Genital Mutilation."
[155] "Study to Map the Current Situation and Trends of FGM. Country Reports," 473.
[156] Ibid., 474.
[157] Els Leye, "Female Genital Mutilation. A Study of Health Services and Legislation in Some Countries of the European Union," *ResearchGate*, February 8, 2008, 35, https://www.researchgate.net/publication/245023567_Female_Genital_Mutilation_A_study_of_health_services_and_legislation_in_some_countries_of_the_European_Union.

supplement the existing legal provisions are discussed in the following chapter together with the challenges faced with each approach.

CHAPTER III – FGM ELIMINATION STRATEGIES IN KENYA, THE UK, AND SWEDEN

3.1 OVERVIEW

Attempts to eliminate FGM were present in some parts of Africa during the colonial era before the human rights approach was adopted. For instance, the intervention from early colonialist centered their method on the grounds of "adverse health effects" and termed FGM as "uncivilized, barbaric and unacceptable" according to Christianity.[158] The global campaign for opposing the practice took on a health/medical approach which was meant to raise awareness in communities through education. This effort, however, failed to provoke behavioral change because in practicing communities, the people were often conscious of the potential adverse health risks, and they valued their culture more than the risks.[159] A human rights approach consequently emerged in the early 1990's. This approach gave way to the enactment of legislation in most countries.[160] The human rights approach considers FGM as a human rights violation. The practice is classified under human dignity, the "right to be free from all forms of discrimination against women, the right to health, the right to life and physical integrity including freedom from violence, freedom from torture and the right of the child."[161]

Human dignity is an important element when viewing FGM as a human rights violation and is linked to the Kantian principle of "Kingdom of Ends." This principle proposes that humans should be treated as an end and not a means.[162] FGM undermines human dignity and the Kantian

[158] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 24.
[159] Philip Alston and Ryan Goodman, *International Human Rights* (Oxford : Oxford University Press, 2012. n.d.), 568.
[160] Ibid., 569.
[161] UN Women, "Sources of International Human Rights Law on Female Genital Mutilation," *Virtual Knowledge Center to End Violence against Women and Girls*, 2012, http://www.endvawnow.org/en/articles/645-sources-of-international-human-rights-law-on-female-genital-mutilation.html.
[162] Immanuel Kant et al., *Groundwork for the Metaphysics of Morals*, ed. Allen W. Wood (Yale University Press, 2002), 438, http://www.jstor.org/stable/j.ctt1njjwt.

principle because girls and women are treated as a cultural object (a means). Guaranteeing chastity of girls is one of the purposes behind the practice and is designed to be in the best interest of the man. Furthermore, other cultures that practice FGM do so in order to heighten the sexual pleasure of the man. This undermines a girl's human dignity because her sole purpose is seen as appeasing the man without having any benefit for herself. According to the Kantian principle, humans should never be treated for our own selfish ends but rather as ends in themselves.[163]

With regard to the right to health, FGM violates human rights because it interferes with healthy organ tissue without any medical purpose and it can lead to severe complications of girls' and women's mental and physical health.[164] The right to life is violated by the practice when it leads to death.[165] It is protected by several international instruments including the ICCPR and UDHR. Under Part III Article 6 of the ICCPR, "Every human being has the inherent right to life."[166] Article 3 of the UDHR guarantees the right to life to everyone.[167] Even though the number of deaths as a result of FGM is unknown, there are reported cases of deaths as a result of hemorrhage and infections. The most recent report that made international headlines was from Egypt where a 17-year-old girl died from complications of FGM.[168]

The right to liberty and security is often associated with the right to physical integrity.[169] International instruments such as Article 9 of the ICCPR[170] and Article 3 of the UDHR[171] guarantee

[163] Ibid.
[164] "Eliminating Female Genital Mutilation: An Interagency Statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO" (World Health Organization, 2008), 9, http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.
[165] "WHO | Media Center. Female Genital Mutilation."
[166] "International Covenant on Civil and Political Rights."
[167] "The Universal Declaration of Human Rights | United Nations."
[168] Salma Abdelaziz and Sarah Sirgany CNN, "Egypt Teen 'Dies in Illegal Genital Mutilation,'" *CNN*, accessed November 7, 2016, http://www.cnn.com/2016/06/01/health/genital-mutilation-abdelaziz/index.html.
[169] Anika Rahman and Nahid Toubia, eds., *Female Genital Mutilation: A Guide to Laws and Policies Worldwide.* (London & New York: Zed Books, 2000), 23.
[170] "International Covenant on Civil and Political Rights."
[171] "The Universal Declaration of Human Rights | United Nations."

the right to liberty. Most often, girls and women who come from FGM practicing communities lack the autonomy of deciding their marriage partner. Girls are forced to marry at a young age which defiles their right to liberty. Furthermore, when the practice is carried out under coercion, the right to physical integrity of the girl is violated.

Special protection is granted to children through several international instruments. As discussed in chapter two, the three jurisdictions have adopted laws that protect children. Article 3 of the Convention on the Rights of the Child places the interest of the child under primary consideration. The Convention further obligates institutions, services, and facilities responsible for protecting children to conform to the standards established by competent authorities in the areas of safety and health.[172] The rights of the child are especially necessary because of the lack of informed consent from children. In most cases, the parents of the girls are responsible for making the informed consent. The Convention, therefore, ensures parents' decisions are made with the best interest of the child as outlined in the Convention.

The WHO asserts that reproductive rights should guarantee the provision of appropriate health care services for women to go safely through pregnancy and have safe childbirths. This includes giving the best chance of having a healthy infant.[173] Studies have revealed that FGM has an adverse effect on newborn babies.[174] In particular, it was found that death rates among babies during and immediately after childbirth were greater for those born to mutilated mothers. Furthermore, it was estimated that 1-2 babies per 100 deliveries died as a result of FGM.[175] The complications of FGM in the rural setting are expected to be more life threatening because women

[172] UN General Assembly, "Convention on the Rights of the Child."
[173] "WHO | Reproductive Health," *WHO*, accessed November 7, 2016, http://www.who.int/topics/reproductive_health/en/.
[174] "Eliminating Female Genital Mutilation: An Interagency Statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO," 11.
[175] Ibid.

do not always have access to adequate healthcare services. They are likely to suffer from complications including postpartum hemorrhage, caesarean section, and extended maternal hospital stay.[176] The practice, therefore, violates reproductive health of women.

Viewing FGM as a human rights violation has drawn many critics which as a result, has hampered the efforts to eradicate the practice. The critics mainly assert that women have a free choice and should therefore not be viewed as victims or as being vulnerable. Cultural relativists who oppose the universalistic approach to human rights have especially heavily criticized the way the western world analyzes the practice, and that different cultural practices and traditions should be equally respected. For example, it has been questioned why the Western practice of cosmetic surgery such as labial reduction and breast enhancement are not considered as mutilation to the body, whereas in the global south, the practice of FGM is quickly condemned as a human rights violation.[177] Moreover, there are currently western television shows which desensitize and almost promote cosmetic surgery such as breast enlargement or the use of Botulinum toxin commonly known as Botox.[178]

Martha Nussbaum has challenged four critical ethnocentric claims which are relevant to the scope of this study. The claims take up a cultural relativist perspective. One claim holds that, unless one is ready to be critical of harmful practices that occur in their culture, it would be morally wrong to criticize a comparable practice in another's culture.[179] Nussbaum agrees with this notion

[176] World Health Organization, Department of Reproductive Health and Research, "WHO | Female Genital Mutilation and Obstetric Outcome," *The Lancet*, no. 367 (2006): 1840.
[177] Moira Dustin, "Female Genital Mutilation/Cutting in the UK Challenging the Inconsistencies," *European Journal of Women's Studies* 17, no. 1 (February 2010): 12.
[178] "BOTOX® Cosmetic (onabotulinumtoxinA) Official Site. Welcome!" accessed March 24, 2016, http://www.botoxcosmetic.com/.
[179] Martha C. Nussbaum, "Judging Others Cultures: The Case of Genital Mutilation," in *Sex and Social Justice* (New York, Oxford, 1999), 122.

that one should be critical of their culture. Indeed, charity does begin at home. She, however, warns of the problem of over-focusing on one's culture to the point of neglecting the others.[180]

The second claim holds that criticizing the practices of another culture is morally unfitting before one has eliminated all evils of a similar kind in their culture.[181] This application bears a resemblance to the famous sacred saying "…first take the plank out of your eye, and then you will see clearly to remove the speck from your brother's eye."[182] Nussbaum holds a different viewpoint. She questions whether it would be morally right, had there been no U.S intervention to end the Holocaust or the South African Apartheid because the U.S was at the time experiencing its discriminating practices namely anti-Semitism and racism respectively. She stresses that failing to acknowledge a human being's plight because of other priorities is the "very height of moral obtuseness and parochialism."[183]

The third view claims that the practice in the west of "body shaping and dieting" is comparable to FGM and, therefore, efforts placed to eliminate FGM should be channeled to local problems. Nussbaum firmly rejects this by claiming that the two practices are not similar.[184] There is usually no consent offered with FGM, in contrast, women can choose whether or not to do a diet or go for body shaping. She also highlights the fact that FGM is irreversible compared to body shaping and dieting which can be reversed without necessarily going through harm.[185]

The fourth claim suggests that westerners have placed disproportionate attention on women as "sexual beings" concerning "Clitoridectomy."[186] Nussbaum agrees that FGM has received

[180] Ibid.
[181] Ibid.
[182] "Matthew 7:5 NIV," accessed March 24, 2016, http://biblehub.com/niv/matthew/7.htm.
[183] Nussbaum, "Judging Others Cultures: The Case of Genital Mutilation," 122.
[184] Ibid. 123.
[185] Ibid.
[186] Ibid., 127.

disproportionate attention compared to other harmful experiences women face for instance domestic violence and gender inequality. She, however, maintains that opposing FGM has more to do with enabling normal sexual functioning for females rather than imposing one's values of sexual pleasure on another culture.[187] It is evident with Nussbaum like other scholars and advocates that it is important for cultural relativists to make a distinction between respecting one's culture and taking the stance to prevent blatant human rights violations. They warn of an attitude of absolute tolerance to other cultures which are prone to turning a blind eye to apparent harmful practices.

In the African context, women are the primary driving force of the community despite the fact that they are treated inferior to men. In the traditional setting, women are expected to care for the household, be active on the farm to ensure food is provided for the family and even walk for miles in search of water for the home. Girls in this setting are brought up with this mindset in which they are expected to be submissive to culture without questioning its legitimacy. In FGM practicing communities which believe that an uncircumcised girl is not fit for marriage, the girls are under extreme pressure to undergo the cut to fulfill the status of a "good wife." It is believed that the decision to stop the practice can, therefore, be initiated by women if they are empowered with the right information for instance, about the lack of benefits of the practice and offering them opportunities to develop economically. Empowerment is said to give the girls the autonomy to decide their future. The "development and modernization" approach, supports this and suggests that by improving the education and socio-economic status of women, in particular, it will produce social effects such as a decline in the demand for the practice.[188] The empirical evidence supporting

[187] Ibid.
[188] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 34.

the development and modernization approach is however not convincing. Therefore the study will not address it.

Besides the development and modernization approach, another strategy for the eradication of FGM is the social change theory. It consists of "basic education, public discussion, and public declaration."[189] While this approach has been applied and had some positive effect in Senegal,[190] this study seeks to implement the same model in the three jurisdictions. An additional approach supported by some anti-FGM advocates is compensating the circumcisers. Replacing the only source of income of cutters through compensation is believed to cause a ripple effect in the reduction of the practice.[191] With cutters not having to rely on the practice anymore, the supply will be reduced and therefore causing the demand to decrease as a result. This approach while it seems sound, fails to acknowledge that the practice of FGM is culturally engrained and is not so simple to change. Parents who believe deeply in practicing FGM will go to lengths to ensure their culture is preserved. Whether this approach has been successful in some communities will be addressed in the study together with assessing it in the light of the three jurisdictions.

One method which has been practiced in some African countries involves mimicking the initiation ceremony without cutting the girl. The idea behind this is to remove one element of the culture without altering it all together which consequently preserves the tradition. The method is referred to as the Alternative Rite of Passage (ARP) which was launched in Kenya in 1996.[192] It

[189] Gerry Mackie, "Female Genital Cutting: The Beginning of the End," in *Female "circumcision" in Africa: Culture, Controversy, and Change. Ed. Bettina Shell-Duncan, Ylva Hernlund*, ed. Bettina Shell-Duncan and Ylva Hernlund (Boulder & London: Rienner, 2000), 253–82.
[190] Ibid., 270–77.
[191] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 36.
[192] Jane Njeri Chege, Ian Askew, and Jennifer Liku, "An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya" (Frontiers in Reproductive Health, September 2001), 3, http://pdf.usaid.gov/pdf_docs/Pnacm865.pdf.

is also known as the alternative initiation ritual and has been carried out in Gambia.[193] The successes and challenges of this approach are explained further in this chapter.

Some scholars have proposed moving away from the socio-cultural perspective of eradicating the practice. Julie Bindel, for example, asserts a legal and policy-based approach especially for the Western Hemisphere as an effective strategy for eliminating the practice.[194] Strengthening the rule of law by using a "real threat of prosecution and prison" could have a deterrent effect which seems to work in France.[195] Bindel also champions the reframing of the practice from a "cultural issue" to a "human rights violation" to stress the urgency. France is used as one of the successful models in managing FGM.[196]

The strategies highlighted above are not exhaustive. These approaches were typically tailored to the global South, especially Africa, however, with the increase in migration and technology, more innovative ways of tackling FGM continue to be developed to target both non-western and western countries. This study does not attempt to offer a simplistic solution for the eradication of FGM. It, however, seeks to compare these different current strategies in each jurisdiction and suggests ways on how to improve them within a contextual framework to reinforce existing laws. This stance has also been supported by *28 Too Many*, a charity working to end FGM, which recognizes that all affected countries are unique and it calls for an individualized strategy for the efficient elimination of the practice[197] rather than a universal or "one size fits all" solution.

This chapter continues by analyzing FGM elimination frameworks currently implemented in Kenya, the UK, and Sweden. It addresses their successes and challenges. It also includes a

[193] Shell-Duncan and Hernlund, "Female 'circumcision' in Africa," 37.
[194] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK."
[195] Ibid.
[196] Ibid.
[197] 28 Too Many, "28 Too Many, Country Profile," 44.

holistic comparative analysis of the frameworks and whether they are country specific or are applicable in other jurisdictions.

3.2 ELIMINATION STRATEGIES IN KENYA

FGM elimination strategies were initiated in Kenya as early as the colonial period by both local and international organizations. A range of interventions currently in place includes the health risk/harmful traditional practice approach, educating traditional FGM/C practitioners while offering an alternative income and introducing an ARP. There is also the human rights approach, promoting girls' education to oppose FGM, supporting girls escaping from the practice and media influence.[198] These methods, however, tend to be applied in isolation and are usually not coordinated, therefore making it difficult to assess their full impact as will be discussed further.[199]

3.2.1 The Health Risk/ Harmful Traditional Practice Approach

The health risk approach is the most widely used strategy for FGM elimination globally. It is intended to cause a shift in attitude toward the practice by raising awareness of the risks involved such as infections, excessive bleeding and difficulty in childbirth depending on the type of FGM performed. The health risk approach has been said to hold less value judgment and is easier for local people to accept.[200] This method was successful in some communities in breaking the taboo surrounding the practice. However, it led to increased medicalization of FGM.[201] In other communities, the minimum behavioral change was observed because the community members

[198] Ibid., 33–34.
[199] Ibid., 33–34.
[200] Anna Winterbottom, Jonneke Koomen, and Gemma Burford, "Female Genital Cutting: Cultural Rights and Rites of Defiance in Northern Tanzania," *African Studies Review* 52, no. 1 (April 2009): 59.
[201] Leye, "Female Genital Mutilation. A Study of Health Services and Legislation in Some Countries of the European Union," 36.

often saw complications such as difficult childbirth and long post-partum recovery periods as the norm. They, therefore, failed to attribute these complications to FGM.[202]

3.2.2 Alternative Rite of Passage (ARP)

The Alternative Rite of Passage was introduced in Kenya in 1996 by a women's group called *Maendeleo ya Wanawake* and Program for Appropriate Technology in Health (PATH). This was done in close consultation with female leaders coming from families which agreed to stop the practice.[203] With the understanding that FGM is deeply ingrained in cultural roots, community members who decided to stop the practice faced a dilemma with what to do as an alternative traditional rite of passage.[204] Communities that associate FGM with ceremonies or other participatory events are more likely to embrace ARP.[205] This is because ARP offers a ceremonial aspect which can naturally be embedded into the culture to imitate a rite of passage. Furthermore, it has been shown through a 2001 evaluation that ARP is more likely to be effective when preceded or accompanied by a process of participatory education which engages the whole community in collective reflection.[206] This means that initiatives engaging with only at risk girls rather than the entire community did not promote collective reflection and therefore no changes in social attitudes and norms.[207] Another aspect of making ARP more useful is to allow the community to participate wholly in deciding what the alternative rite should entail. This bestows on the community a sense of ownership of their culture without imposing outside values and traditions. Hebrew Immigrant Aid Society (HIAS) Refugee Trust of Kenya, uses this mechanism to introduce alternative means

[202] Winterbottom, Koomen, and Burford, "Female Genital Cutting: Cultural Rights and Rites of Defiance in Northern Tanzania," 59.
[203] Leye, "Female Genital Mutilation. A Study of Health Services and Legislation in Some Countries of the European Union," 43.
[204] Ibid.
[205] "The Dynamics of Social Change towards the Abandonment of Female Genital Mutilation/Cutting in Five African Countries" (UNICEF Innocenti Research Centre, 2010), 47, https://www.unicef-irc.org/publications/pdf/fgm_insight_eng.pdf.
[206] Ibid.
[207] Ibid.

to the rite of passage and has proven more efficient rather than having "outsiders" suggest on the alternative.[208] The introduction of the ARP was a tool to retain the element of the rite to passage while discarding the cutting procedure. The element of the rite to passage includes educating the girls on women's roles in the family.[209]

In 1996, *Tharaka Nithi* district in Kenya saw the first ARP ceremony in which 28 girls were initiated into adulthood.[210] The same ceremony was later replicated in 9 other districts with over 10,000 girls initiated through this alternative process.[211] To mimic the ritual of FGM, the ARP incorporates three components namely seclusion, training and a public ceremony.[212] The girls participating in the ARP are placed in isolation for 3 to 5 days. During this period, they are trained on community values, family life skills, and reproductive health.[213] The public ceremony is carried out in the context of the particular culture. It usually takes place right after the seclusion and training process. Both the girls and parents are expected to attend, and it involves traditional singing and dancing, the offering of gifts and a public declaration from the girls that they have not been and will not be circumcised.[214]

A study conducted in three districts in Kenya where the ARP was introduced revealed that there had been attitudinal and behavioral changes towards the abandonment of FGM.[215] There were, however, some implementation concerns regarding the method of approaching different practicing communities, the involvement of parents in decision making and whether a public

[208] George Odhiambo, Hebrew Immigrant Aid Society (HIAS) and Female Genital Mutilation, Personal Interview, August 18, 2016.
[209] Chege, Askew, and Liku, "An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya," 3.
[210] Leye, "Female Genital Mutilation. A Study of Health Services and Legislation in Some Countries of the European Union," 43.
[211] Ibid.
[212] Chege, Askew, and Liku, "An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya," 17.
[213] Ibid.
[214] Ibid.
[215] Ibid., i.

ceremony with formalized training was the way forward.[216] Concerning approaching various communities, not all communities in Kenya have welcomed this ARP initiative. For example, in 2015, Maasai women from Narok County demonstrated by demanding to be allowed to circumcise their girls because they consider an uncircumcised girl as "dirty and not worth attracting suitors."[217] The women furthermore displayed hostile behavior by attacking activists who had attempted to rescue some of the girls in danger of being cut.[218] The ARP efforts in the community's eyes do not serve the purpose of maintaining the girl's chastity. The alternative method approach is complex and requires a deeper understanding behind the different reasons communities practice FGM. Nevertheless, the ARP approach has proven to be effective when applied through a sensitive cultural lens because it works to prevent altering the entire culture of the practicing community while removing the harmful elements.

3.2.3 The Human Rights Approach

The human rights approach is usually not applied in isolation but together with other strategies to increase its effectiveness. The components of these additional strategies include a non-judgmental aspect, community awareness raising elements, collective decisions of abandonment from the community and providing a supportive change-enabling environment.[219] One such strategy is the value-centered approach. The value-centered approach works by creating a safe environment in which individuals are free to make their decisions to abandon FGM and are also free from societal judgment and pressure. The approach functions to promote personal development and alter attitudes to facilitate community-wide abandonment of FGM.[220] It was

[216] Ibid., 46.
[217] George Sayagie, "Chaos as 500 Women Demand 'cut' for Girls," *Daily Nation,* January 17, 2015.
[218] Ibid.
[219] 28 Too Many, "28 Too Many, Country Profile," 36.
[220] "The Dynamics of Social Change towards the Abandonment of Female Genital Mutilation/Cutting in Five African Countries," 37.

applied in the Fulda-Mosocho[221] Project in 2002 in Kenya by two organizations based in Fulda, Germany. A unique feature about this project is the fact that the parents of Mosocho in Kisii County in Kenya initiated the project following the growing concern of FGM.[222] The project not only engaged the girls at risk but the community as a whole including leaders of women's groups, school personnel, health officials, government officials, clan elders, former practitioners and social workers.[223] The project conducted awareness raising activities and educational programs which encouraged dialogue, reflection, and personal development through a three and a half year program addressing sexual and reproductive health, HIV and AIDS, human rights and the effects of FGM.[224] Instead of applying a top-down approach by imposing "outside" values on the community, it focused on addressing human rights and local cultural values by discussing individual and social problems. It was furthermore conducted in a non-judgmental manner through a non-coercive environment.[225]

The project functioned by guiding people first to consider new perspectives for themselves and then take responsibility to involve their communities. Through this approach, the sphere expanded from the individual level to the wider community.[226] This initiative saw the acceptance of approximately 2,000 uncut girls as full members of the Kisii community, and by 2009, there was evidence suggesting that 16,500 girls who were at risk of FGM had not been cut.[227]

A second approach initiated in Kenya which accompanies the human rights approach is the public declaration to abandon FGM. This initiative was introduced in 2011 by the Pokot Council

[221] Mosocho Division is one of the seven divisions within the Kisii Central District with approximately 130,000 inhabitants
[222] "The Dynamics of Social Change towards the Abandonment of Female Genital Mutilation/Cutting in Five African Countries," 37.
[223] Ibid.
[224] Ibid.
[225] Ibid.
[226] Ibid., 38.
[227] 28 Too Many, "28 Too Many, Country Profile," 36.

of Elders.[228] The Pokot community in Kenya has one of the highest prevalence rates of FGM at 73%.[229] Furthermore, there is an emerging trend of young men increasing to speak out publicly of their preference to marry women who have not undergone FGM.[230]

3.2.4 Educating Traditional FGM Practitioners/ Alternative Income

This strategy has not produced satisfactory results as previously anticipated. This is because offering an alternative income encourages a self-perpetuating cycle because the social convention that created the demand for the service is not changed.[231] Instead of discouraging practitioners to stop FGM, more women are drawn to the practice so they can benefit from financial assistance.[232] This is a classic example of a strategy which cannot be effective when applied in isolation. If the approach does not address the demand for FGM, applying it by itself will not be effective in ending the practice.

3.2.5 Promoting Girls' Education to Oppose FGM

Just like the health risk approach, promoting girls' education is also considered as a best long-term strategy of eliminating FGM. Many girls who undergo FGM are forced to drop out of school soon after the procedure is performed because an arranged marriage in many times follows the procedure. Cut girls are compelled to leave their homes and become young wives. The approach, therefore, works to encourage girls to remain in school and also to speak out against the practice.[233] This tactic was applied by Forum for African Educationalists (FAWE) – a pan-African NGO operating in thirty-two African countries. Through gender responsive education, the NGO

[228] Ibid.
[229] Ibid.
[230] Ibid.
[231] Ibid., 34.
[232] Ibid.
[233] Ibid., 36.

has been able to empower girls and women.[234] The Center for Excellence model was adopted by FAWE which sees ordinary schools transformed to "gender-responsive" schools where quality education is offered, and the physical, academic and social dimensions of both boys and girls are taken into consideration.[235]

There are currently two schools in Kenya in which the program tries to sensitize the community on FGM where there is a combination of awareness raising on sexual maturation and FGM. These schools are in Kajiado district namely AIC Girl's Primary Kajiado and Athwana High School.[236] The program encourages girls to speak out against the practice by using the medium of drama.[237] There is also the provision of a rescue center for girls escaping the practice. The rescue center approach is further expounded below. The strategy boasts a success in an increase in the retention rates of the girls in school standing at over 90 percent in this region.[238]

3.2.6 Supporting Girls Who Escape from FGM or Child Marriage

This approach aims at protecting children from undergoing both FGM and child marriage as they are closely linked. Girls who are brought to the rescue centers also need to be reconciled and reintegrated back into their communities.[239] The rescue centers work in facilitating this as well. One of the rescue centers is the Tareto Maa in Kajiado district which was founded in 2007 by members of the local community.[240] The center works with the local police. When the girls are brought to the center, they must be registered as either being circumcised or not.[241] The parents of the girls are also involved as the center tries to reunite the girls back to them. It is made clear to

[234] Ibid., 37.
[235] Ibid., 36.
[236] Ibid.
[237] Ibid., 37.
[238] Ibid.
[239] Ibid.
[240] Ibid.
[241] Ibid.

the parents of the harmful consequences of performing FGM together with the legal repercussions that can befall any perpetrator.[242]

The ARP has also been introduced to the center which makes combating the practice even more successful and has caused behavioral change with the local community. The Tareto Maa Center further addresses issues such as children's rights, sexual and reproductive health and child health.[243] For this approach to be effective, there should be the involvement of local authorities who inform community members and parents regarding the harmfulness of the practice and the consequences of performing FGM. Other examples of initiatives working to protect girls at risk of FGM include the Maasai Evangelistic Association (MEA) and Naserian Girls Rescue Initiative. Both initiatives provide a place of refuge for girls at risk and support them by proving means to continue their education.[244]

3.2.7 Media Influence

Media campaigns are the most widely used form of communication by NGO's, governmental organizations and other international organizations to raise awareness of FGM and other forms of child abuse. The use of radio, print media, theater, and social media are a preferred means of information dissemination by local organizations. Global media campaigns are also useful in addressing FGM such as the Girl Generation campaign[245], 28 Too Many Campaign, [246]and the Coalition on Violence against Women (COVAW).[247] With the innovations surrounding technology, NGOs and charities take advantage of social media to reach out to all age groups to

[242] Ibid.
[243] Ibid.
[244] Ibid., 41.
[245] http://www.thegirlgeneration.org/
[246] http://28toomany.org/
[247] http://covaw.or.ke/

educate them about FGM and its complications. One weakness of using the media to disseminate information on FGM is that it does not usually reach communities living in rural areas where they are the most affected by the practice. The low literacy capacity of rural communities might also be an issue in the effective campaigns against FGM.

3.2.8 Action Plans and Policies

Action plans and policies have also been adopted to combat FGM in Kenya. These include "Sessional Paper No. 5 on the National Population Policy for Sustainable Development (1999), the National Reproductive Health Policy Enhancing Reproductive Health Status for all Kenyans (2007) and the National Plan of Action for the Elimination of Female Genital Mutilation (FGM) in Kenya (2008-2012).[248] There is also the Adolescent and Reproductive Health Policy and Plan of Action (2005-2015), Vision 2030, and the draft Reproductive Health and Rights Bill (2008).[249] The National Plan of Action for the Elimination of FGM in Kenya works in reducing the prevalence rate, increasing community participation by working to change attitudes, beliefs, behavior and practices and improving health care facilities which provide care, counseling, and support to victims of FGM. [250] It furthermore increases advocacy and technical capacity of institutions, agencies, and communities in the management and elimination of the practice.[251]

3.2.9 Challenges in Kenya

One issue facing anti-FGM initiatives in Kenya is the dilemma with the medicalization of FGM. Medicalization was thought to offer a solution to the unhygienic and crude method of FGM performed by traditional cutters. It was intended to provide a controlled environment where health

[248] "Joint Evaluation of the UNFPA-UNICEF," 7.
[249] Ibid.
[250] Ibid.
[251] Ibid.

practitioners can cut girls with the use of an anesthetic to control the pain and sterile tools to prevent complications like infections. However, keeping in mind that FGM serves no medical purpose, the medicalization of the practice fails to rid of long-term gynecological and obstetric complications including increased risk of miscarriage, congenital disabilities, child and maternal mortality, life-long emotional, psychological and sexual problems.[252] In addition to this, the medicalization of FGM further violates the principle of professional health ethics of "do no harm."[253] The WHO first condemned medicalization of FGM by health-care providers in 1979.[254] The World Medical Association in 1993 together with other medical professional associations and international agencies joined in support by reiterating the WHO's stance on medicalization.[255]

A 2004 study in Kenya revealed that health caregivers were involved in the medicalization of FGM. The study was conducted among the Abagussi people (an ethnic group in Kenya).[256] Medicalization became illegal soon after the enactment of the 2011 Prohibition of Female Genital Mutilation Act.[257] It is however still practiced discreetly and continues to act as an obstacle in eradicating the practice because it does not encourage behavioral change and attitude in the community. It further continues to constitute a violation of a girl's right to bodily integrity.[258] The issue with medicalization is complex because it casts a moral dilemma between anti-FGM activists. On the one hand, there is the need to protect the health of women and girls, but at the expense of legitimatizing a cruel practice. On the contrary, there is the struggle to eradicate the

[252] "WHO | Media Center. Female Genital Mutilation."
[253] Louise Robertson and Michelle Szaraz, "The Medicalisation of FGM" (28 Too Many, 2016), 4, http://28toomany.org/media/uploads/report_final_version.pdf.
[254] "Global Strategy to Stop Health-Care Providers from Performing Female Genital Mutilation UNFPA, UNICEF, UNHCR, UNIFEM, WHO, FIGO, ICN, IOM, WCPT, WMA, MWIA" (World Health Organization, 2010), 4.
[255] Ibid.
[256] "WHO | Female Genital Mutilation and Other Harmful Practices," *WHO*, accessed March 24, 2016, http://www.who.int/reproductivehealth/topics/fgm/medicalization_fgm_kenya/en/.
[257] *Kenya Prohibition of Female Genital Mutilation Act 2011*.
[258] Ian Askew, "Methodological Issues in Measuring the Impact of Interventions against Female Genital Cutting," *Culture, Health & Sexuality* 7, no. 5 (September 1, 2005): 469, doi:10.1080/13691050410001701939.

practice but at the cost of allowing women to die from conditions that can be prevented.[259] Also, even if medicalization plays a role in minimizing immediate pain and infections, it is not accessible to a majority of women living in poor rural communities.[260]

There is a general lack of political will from some influential political and community leaders in Kenya which impedes the initiatives of eradicating FGM.[261] A lack of national coordination of anti-FGM activities has also acted as a significant barrier. Given the vast geographical area in Kenya, there are many areas of isolated populations who have not been reached. This is especially important when using media influence to promote behavioral change. The firm cultural and religious beliefs further hampers efforts made to eliminate FGM. Identifying the appropriate entry into communities is also a challenge because it neglects cultural sensitivity.[262] The deep cultural sensitivities surrounding FGM and the highly influential positions of elders and traditional leaders impede eradication efforts.[263] Rescue shelters for girls escaping FGM are also few compared to the number of girls at risk.[264]

Statistics indicate that the illiteracy level of the Kenyan adult population lies at 38.5 percent, however, these figures do not account for the wide regional disparities.[265] In the regions most affected by FGM, the literacy levels are the lowest at 8.0 percent while the literacy standards of the capital city lie at 87.1 per cent.[266] Given that education and awareness campaigns are used as a means of eradicating FGM, the high illiteracy rate of the affected community further acts as a hindrance for the effective dissemination of information. Another problem Kenya faces is the lack

[259] Ibid. 469
[260] Robertson and Szaraz, "The Medicalization of FGM," 17.
[261] 28 Too Many, "28 Too Many, Country Profile," 44.
[262] Ibid., 42.
[263] Ibid., 44.
[264] Ibid.
[265] "Kenya National Adult Literacy Survey Report - Eldis," accessed September 25, 2016, http://www.eldis.org/go/home&id=31868&type=Document#.V-evLDU50s8.
[266] Ibid.

of sustainable funding for research studies and programs to eliminate FGM. Financing in Kenya is prioritized to programs related to poverty and health, and less is allocated to FGM research.[267]

3.3 ELIMINATION STRATEGIES IN THE UK

With the increase of immigrants from practicing countries to the UK, law and policy makers have had to engage with different organizations to come up with additional measures to tackle the increasing cases of FGM. The elimination strategies in the UK approach FGM through the "six Ps" Prevention, Protection (entails child welfare and asylum protection), Prosecution, Provision of Services, Partnership, and Prevalence (discussed in Chapter Two).[268]

3.3.1 Prevention

Prevention work in the UK includes awareness-raising campaigns and development of educational materials and resources.[269] The development and teaching materials include leaflets, posters, documentary films and educational DVDs for example DVDs on how to carry out a surgical defibulation.[270] The awareness raising campaigns work at the community level and also targets professionals. At the community level, women, girls, men and religious leaders are provided for information about myths and misconceptions linked to FGM.[271] Some of the innovative methods used in the campaigns are providing space for communities to speak openly about the practice. As for professionals, the campaigns provide a forum for training courses, workshops, and seminars about FGM which equip professionals with a deeper understanding of how to respond to the practice.[272]

[267] 28 Too Many, "28 Too Many, Country Profile," 44.
[268] "Study to Map the Current Situation and Trends of FGM. Country Reports," 514.
[269] Ibid., 515.
[270] Ibid.
[271] Ibid.
[272] Ibid.

The FGM special initiative is one example of a preventive strategy run by three main independent charity organizations namely Esmée Fairbairn Foundation; Trust for London; and Rosa (the UK fund for women and girls).[273] The three agencies provide funding for other bodies working with communities to protect women and girls from FGM. Trust for London was lobbied by the Foundation for Women's Health Research and Development (FORWARD) and was deemed as a success in vigorous funding and engaging organizations working with communities on FGM.[274]

The second initiative in the UK is the Bristol FGM community development project which delivers a community-based approach.[275] The project works with African FGM-practicing communities and is based on three core principles. The first principle affirms that women's leadership and empowerment is crucial for change.[276] The second shows that it is more sustainable to establish partnerships between individuals and community organizations. The third principle calls for training, mentoring and capacity development for both individuals and community organizations.[277]

3.3.2 Protection

The key areas of protection in the UK is child protection and asylum protection.[278] The child protection laws classify FGM as a cause of significant harm to the child. The law further obliges professionals to report to social services or the police authority when there are suspected cases of FGM.[279] The key actors involved in child protection are, therefore, the police, children's

[273] Ibid., 516.
[274] Ibid.
[275] Ibid.
[276] Ibid.
[277] Ibid.
[278] Ibid.
[279] Ibid.

social services, educational and health services and organizations working to safeguard children.[280] One of the issues of child protection concerning FGM is that it is hardly treated as a safeguarding issue despite policies including it in their documents.[281] This means that FGM does not fall under categories such as sexual abuse, physical abuse/injury and neglect and is therefore overlooked by local safeguarding children's board.[282]

Concerning asylum protection, the UK has shown progress and good development out of other European countries in adopting asylum and gender policies such as compulsory training of all UK Border Agency staff on FGM-related matters.[283] One issue faced in asylum protection is that women and girls seeking asylum because of FGM are often not believed by the UK Border Agency. There is also the problem of selecting information on country of origin together with the lack of understanding of the concept of a "particular social group."[284]

3.3.3 Prosecution

Despite strengthening the new legislation from the Prohibition of Female Circumcision of 1985 to the FGM Act of 2003, the UK is not showing progress in prosecutions of FGM cases.[285] One dilemma the UK faces is that it is trying to toughen the law, but at the same time, it is being careful not to offend practicing communities. The issue, therefore, is that the existing legislation fails to set an example to others.[286] There is also the misconception that prosecuting someone will not solve anything.[287] A report published in 2013 by the Royal College of Pediatrics and Child Health revealed two ways of reinforcing anti-FGM laws i.e. through the strategy of tackling

[280] Ibid.
[281] Ibid., 528.
[282] Ibid.
[283] Ibid.
[284] Ibid.
[285] Ibid., 520.
[286] Ibid., 521.
[287] Ibid.

violence against women and girls and focusing on the obstacles to prosecution for FGM.[288] One of the initiatives focused on reducing prosecution barriers is the Director of Public Prosecutions (DPP) Action Plan on FGM which advocates for better ways to gather evidence to support prosecutions.[289] Health practitioners, social workers, and teachers usually lack the proper guidelines on what needs to be done to prevent and care for girls affected by FGM in the UK. For instance, there has been a failure of professionals to intervene when presented with a victim who may be at risk of FGM.[290] In addition to this, many cases of FGM go unreported due to the stigma that comes with the procedure making it difficult to build up a prosecution case.

3.3.4 Provision of Services

Most of the services provided in the UK about FGM is healthcare services. The African Well Woman Clinics (AWWC) was perceived to be successful as it offered specialized health services.[291] The UK was the first country in Europe to establish a specialized service for women with FGM in 1993. The 15 AWWC provide obstetric and gynecological care to women and girls affected by FGM.[292] A second clinic was established at Guy's and St Thomas in 1997 with four other clinics opening after that.[293] The clinics have however come under heavy criticism for lacking FGM specialists in some of the clinics. The irregular operating times and the lack of comprehensive services were listed as some of the difficulties of this project.[294]

3.3.5 Partnership

[288] "Tackling FGM in the UK - Intercollegiate Recommendations for Identifying, Recording and Reporting" (London: The Royal College of Midwives: RCM, RCN, RCOG, Equality Now, UNITE, 2013), 13.
[289] Ibid.
[290] Ibid.
[291] "Study to Map the Current Situation and Trends of FGM. Country Reports," 521.
[292] Ibid.
[293] Ibid.
[294] Ibid., 522.

Partnerships at the local, national and international level are key in the fight against FGM. At the local level, a multi-agency approach to FGM was implemented in Bristol in 2009. The partnership worked with the African FGM-practicing communities living in Bristol to safeguard girls by empowering them to end FGM.[295]

Project Azure is an example of partnership at the national level. It is a UK initiative established by the Metropolitan Police Service's Child Abuse Investigation Command (SCD5) in 2006 to try and prevent the occurrence of FGM in London through training and community partnership.[296] The main scope of the initiative is to "develop prevention strategies and initiatives, raise awareness and educate police, professionals, and communities, provide advice, support, and guidance for referrals and investigations, and, develop intelligence opportunities."[297] Despite the progress made by the central government on FGM issues, Project Azure acknowledges that there are significant challenges faced with regards to investigating and reporting FGM cases.[298] The barriers cited by Project Azure for lack of prosecutions include the inability of some of the victims to accurately recall the practice being carried because they were very young at the time.[299] There is also the fact that before the 2003 FGM Act, jurisdictional issues arose because it only became illegal in 2004 to take a girl abroad to have FGM. Proving FGM occurred before then by using age scar tissue and injury is problematic.[300] Also, it is highly unlikely for girls and women to approach and report their family members to the authorities.[301]

[295] Ibid., 524.
[296] "Female Genital Mutilation - MPS Project Azure," November 4, 2010, http://www.policeauthority.org/Metropolitan/committees/cep/2010/101104/08/index.html.
[297] Ibid.
[298] Ibid.
[299] Ibid.
[300] Ibid.
[301] Ibid.

Another partnership initiative at the national level is The FGM Forum.[302] The FGM Forum is a government led initiative by the Home Office. The forum consists of different representatives of NGOs, cross-government anti-FGM leads, project Azure and other statutory agencies.[303] The Forum provides a platform for the stakeholders to discuss recent initiatives on FGM. The forum acts as a link between the government and the different stakeholders.[304]

At the international level, the UK FORWARD serves as the partner organization in the "End FGM" EU campaign. The campaign was established by Amnesty International Ireland and works with the several EU Member States to ensure the EU adopts a comprehensive and coherent approach towards ending FGM.[305]

3.3.6 Statement Opposing FGM (Health Passport)

An additional initiative is the Statement Opposing FGM also known as the Health Passport.[306] This document was created by the British Home Office which provides information about FGM on a piece of paper and is aimed at girls traveling abroad, where they can carry and show the health passport attesting FGM is illegal, and offenders risk facing a penalty of up to 14 years in prison, a fine or both.[307] Whether this strategy has been effective is yet to be documented.

[302] "Study to Map the Current Situation and Trends of FGM. Country Reports," 523.
[303] Ibid., 524.
[304] Ibid.
[305] Ibid.
[306] "Statement Opposing Female Genital Mutilation" (Home Office, November 23, 2012), https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation.
[307] Ibid.

3.3.7 Additional Policies

Other initiatives to strengthen the existing anti-FGM legislation in the UK include the Mayoral Taskforce,[308] the FGM helpline[309] and, the Call to End Violence against Women and Girls Action Plan established in 2010.[310] These initiatives are involved in project activities that strive to raise awareness of FGM. They further promote community engagement and educate those at risk.[311] Furthermore, the UK government adopted certain policies that try to address FGM and guidelines on working to safeguard the welfare of children. Working Together to Safeguard Children 2015 sets up guidelines for health professionals, education providers, social workers and the police.[312] The guidelines include, how to disclose cases of FGM and how to handle confidentiality, assessment during a medical examination and provides information regarding the risks faced by individuals who have undergone FGM.[313]

3.3.8 Challenges in the UK

One of the problems affecting the smooth implementation of the mentioned initiatives is the lack of a more holistic approach which involves multiple players of professionals from the legal sector and voluntary sector.[314] The initiatives currently in place are not well coordinated and monitored to ensure implementation is efficient and cohesive.[315] Another challenge observed is the lack of government commitment on how to engage on the issue of FGM.[316] The low prioritizing

[308] "Mayor Brings Thousands Together in Fight against Honour-Based Crime," March 11, 2016, https://www.london.gov.uk/press-releases/mayoral/fight-against-honour-based-crime.
[309] "Female Genital Mutilation (FGM)," *National Society for the Prevention of Cruelty to Children*, accessed March 27, 2016, http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/.
[310] "Call to End Violence against Women and Girls: Action Plan" (Home Office, March 8, 2011), https://www.gov.uk/government/publications/call-to-end-violence-against-women-and-girls-action-plan.
[311] Ibid.
[312] "Study to Map the Current Situation and Trends of FGM. Country Reports," 490.
[313] Ibid.
[314] Ibid., 527.
[315] Ibid.
[316] Ibid.

by the government means that professionals including criminal prosecutors and health care providers rarely receive adequate training to manage FGM.[317] Collecting evidence that is admissible in court remains a challenge due to the lack of appropriate training of the professionals. The lack of sufficient evidence is further exacerbated by the fact that it is hard to get victims to come forward under extreme social pressure.[318]

Even though the government has shown effectiveness in its approach to steer away from violence against women, the same method is not effective with FGM.[319] Another challenge is that front-line professionals dealing with the first contact such as social workers, teachers, and midwives rarely work together, therefore, failing to play their role effectively.[320] The collection of data on FGM by institutions further lacks uniformity.[321] The government has also been criticized for its lack of initiative in engaging with communities efficiently and educating them.[322] There is, therefore, a little forum available to practicing community members to exchange experiences, beliefs, and values surrounding the practice. According to one report, the UK government has been criticized of preaching wine and drinking water. The staff has made statements and speeches on FGM. However, actual practice and development come frequently from charities and NGOs.[323]

The UK, however, boasts on some of its more successful approaches. The AWWCs are perceived as one of the successful strategies because they were viewed as being very strategic in promoting women's well-being and health.[324] Another success is the special FGM initiative which

[317] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 7.
[318] Ibid.
[319] "Study to Map the Current Situation and Trends of FGM. Country Reports," 527.
[320] Ibid.
[321] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 7.
[322] "Study to Map the Current Situation and Trends of FGM. Country Reports," 527.
[323] "28 Too Many - FGM Let's End It - Female Genital Mutilation: Just a Women's Issue? - Guest Blog by Winnie Cheung," accessed September 19, 2016, http://www.28toomany.org/blog/2013/nov/25/female-genital-mutilation-just-womens-issue-guest-/.
[324] "Study to Map the Current Situation and Trends of FGM. Country Reports," 524.

has been seen to support the voluntary sector organizations which work with communities significantly.[325] The UK furthermore hosts several charities and NGOs committed to ending FGM. These include FORWARD, Equality Now, Daughters of Eve, 28 Too Many and the Orchid Project.[326] The research carried out by these charities include prevalence rate, creating networks across education and health, raising awareness through campaigns, offering support to victims (survivors), and providing essential training to health professionals, social workers, and education providers.[327]

3.4 ELIMINATION STRATEGIES IN SWEDEN

Approaches to eliminating FGM in Sweden can also be classified under "five Ps" Prevention, Protection, Prosecution, Provision of services and Partnership.[328] Prevention has gained the most support because rather than relying on legislative measures to combat the practice, there is a general tendency to prioritize NGOs cooperating with practicing communities and grass-root initiatives.[329] Concerning the provision of services, it is also considered as an efficient mechanism which has evolved over the years. This includes capacity-building initiatives which take the form of training courses. They are further involved in distributing handbooks and guidelines such as the Gothenburg Project (discussed further below) which began towards the end of the 1990s.[330] Concerning protection and prosecution, there were already institutional mechanisms such as legal provisions, routines, and methods when the big wave of Somali

[325] Ibid., 525.
[326] "28 Too Many - FGM Let's End It - Female Genital Mutilation: Just a Women's Issue? - Guest Blog by Winnie Cheung."
[327] "16 Organizations, Charities and Grassroots Groups Working to Stop Female Genital Mutilation: The Pixel Project's '16 for 16' Campaign," accessed September 19, 2016, http://16days.thepixelproject.net/16-organisations-charities-and-grassroots-groups-working-to-stop-fgm/.
[328] "Study to Map the Current Situation and Trends of FGM. Country Reports," 468.
[329] Ibid., 525.
[330] Ibid., 468.

immigrants arrived in Sweden in the 90s. As to the partnership, standard procedures of partnering NGOs and practicing communities developed over the years.[331]

Three milestones characterize the timeline for addressing FGM in Sweden. The first milestone is the introduction of legislation as discussed in chapter two. The second involves efforts made at the national level, and the third milestone is characterized by a lack of policy development and implementation.[332] The early attempts in addressing the issue of FGM in Sweden besides legislation began in the 1990s with the use of conferences, circulating leaflets and producing guidelines in the healthcare sector.[333] This came as a result of the influx of Somali immigrants to Sweden in the 1990s as a consequence of the ongoing civil conflict in Somalia. Legislation against the practice was simply not enough to address the rising cases of FGM, therefore, the second milestone was developed. It was through the Gothenburg Project that the preventive work on FGM became more systematized through working with publications, seminars, and other instruments targeting both immigrant groups and professionals. The Gothenburg project was initiated in 1993 by the Swedish Board of Health and Welfare.[334] The idea behind the project was to accelerate the needs of school personnel, healthcare staff and other professionals who dealt with cases of FGM. The project worked to create preventive methods and engaged with circumcised women by providing them with adequate care.[335]

By the late 1990s, the National Board of Health and Welfare (NBHW) were granted with responsibility for developing tools such as national guidelines for professionals in the school,

[331] Ibid., 469.
[332] Ibid., 465.
[333] Ibid., 460.
[334] Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law," 4.
[335] Ibid.

social and healthcare sectors.[336] In Swedish schools, sex education became compulsory where visual aids are used to illustrate mutilated female genitals.[337] Also, the media played an active role in disseminating information regarding the practice. One well-known media production is the television documentary "The Forgotten Girls."[338] The media such as radio and television has however been accused of controversial and stereotypical reporting.[339] NBHW has boasted success in some of its initiatives against FGM such as its involvement of religious leaders. The initiative offered training courses to religious leaders and facilitated dialogue.[340] This strategy is more likely to be effective considering communities that practice it tend to be patriarchal. Therefore, engaging men in dialogue (especially religious leaders) is more likely to persuade the community members and encourage behavioral change.

The third milestone also described as the "quietness" of today, saw a decline in FGM initiatives at the national level. One of the reasons for the decline is the fact that funds allocated to FGM-related NGOs became scarce.[341] Another plausible explanation for the lack of initiatives is that there was a sense that a majority of institutional structures and educational materials currently in place were sufficient to deal with the efficient and successful eradication of the practice.[342] Furthermore following the unwanted "sensationalism" created by the NBHW and the Swedish government about FGM-related issues, both groups (NBHW and Swedish government) decided to keep a lower profile. In replacement of the NBHW and the Swedish government, information on

[336] "Study to Map the Current Situation and Trends of FGM. Country Reports," 460.
[337] Beth Maina Ahlberg et al., "'It's Only a Tradition': Making Sense of Eradication Interventions and the Persistence of Female 'Circumcision' within a Swedish Context," *Critical Social Policy* 24, no. 1 (February 1, 2004): 54, doi:10.1177/0261018304241003.
[338] "Study to Map the Current Situation and Trends of FGM. Country Reports," 465.
[339] Ahlberg et al., "'It's Only a Tradition'," 54.
[340] "Study to Map the Current Situation and Trends of FGM. Country Reports," 469.
[341] Ibid., 465.
[342] Ibid.

FGM which is evidence based rather than sensational was instead preferred and came under demand by university scholars.[343]

Despite the decline in the number of initiatives over the years, the estimated prevalence rate suggest a reduction in the cases of FGM in Sweden. The decrease can be attributed to the fact that Swedish people, in general, and especially in the health care sector, share a common understanding that FGM is a severe crime of which no child should undergo.[344] An additional attributing factor to explain the prevalence rate is the current political will to promote change. The immigration politics in the 1990s following the entry of immigrants led to the firm promotion of social, cultural and religious inclusion.[345]

3.4.1 Challenges in Sweden

Some of the key challenges in Sweden is the lack of coordination at a national level. As previously mentioned NBHW is tasked with the sole responsibility to ensure the work on FGM is effectively coordinated and conducted. NBHW, however, does not have a general overview of various initiatives in the country for instance in the healthcare sector, the education system, the refugee reception unit or the social services.[346] Another challenge is sensationalism in the mass media which has resulted in a "high level of moral panic" where the over-sensitive system has exposed girls to sometimes unjustified or unnecessary genital examinations.[347] A major challenge is establishing trust among the immigrant community where many community members frequently feel there is a hidden agenda of the Swedish authorities.[348]

[343] Ibid., 467.
[344] Ibid., 465.
[345] Ibid.
[346] Ibid., 479.
[347] Ibid.
[348] Ibid.

3.5 COMPARATIVE ANALYSIS OF STRATEGIES IN KENYA, THE UK, AND SWEDEN

A consensus from both professionals and ordinary citizens in Sweden is that FGM is a serious crime.[349] This is on the contrary to Kenya, where local chiefs and some politicians even to date continue to support the practice.[350] The UK government tends to be excessively cultural sensitive for fear of appearing prejudiced or reactionary and therefore tends to show reluctance in its fight against FGM.[351] The well-established social system in Sweden, particularly regarding child protection, fosters an environment that enables the police and social services to coordinate candidly. [352] In Kenya, the social services are not well established, and it is easier for perpetrators to perform the practice "underground" without the knowledge of the authorities. There is a need in the UK for more support for victims of FGM. The social services receive referrals but in many cases do not act upon it. It was reported that 148 referrals of FGM in the UK were made to social services in 2013 however not a single victim was provided for child protection or registered by the police and social services.[353]

There is furthermore a successful implementation of policy through developing guidelines for all professionals groups in Sweden. These guidelines are distributed through handbooks to the healthcare services, police services, school and pre-school sector and the social services.[354] A similar trend is adopted in Kenya through various campaigns where health professionals are issued with guidelines on the prevention and management of FGM cases.[355] The Department of Health in

[349] Ibid., 478.
[350] "Local Kenyan Chiefs in FGM Controversy," *Institute for War and Peace Reporting*, accessed September 26, 2016, https://iwpr.net/global-voices/local-kenyan-chiefs-fgm-controversy.
[351] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 7.
[352] "Study to Map the Current Situation and Trends of FGM. Country Reports," 478.
[353] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 33.
[354] "Study to Map the Current Situation and Trends of FGM. Country Reports," 478.
[355] 28 Too Many, "28 Too Many, Country Profile," 33.

the UK like Sweden and Kenya also publishes multi-agency practice guidelines on FGM for professionals and volunteers.[356] In Sweden, the culture-oriented approach is used in conducting preventive work such as the Gothenburg project. It enables people from the community to own the project by giving them key roles in the design and management.[357] This is similar to most of the approaches in Kenya that involve taking culture into account while developing different strategies such as the use of ARP. The use of native language in awareness-raising is similarly effective in bringing about behavioral change in the communities in Kenya.[358] The UK, on the other hand, focuses less on cultural-oriented strategies and more on policy reform such as Project Azure.

The described strategies in the three jurisdictions are non-exhaustive with new initiatives developing constantly. However, from these facts mentioned, a particular trend in the policy framework in all three jurisdictions can be distinguished. In the UK, the framework, for instance, seems to focus less on efforts in directly changing attitudes and beliefs of the practicing communities. The framework rather focuses more on improving protection measures through policing and engaging the social sector and community at large in efforts such as reporting cases of FGM to authorities and training health professionals in identifying cases of those at risk of undergoing the practice.

Another notable difference is the lack of use of ARP in the UK and Sweden. Scholarly literature supporting the utilization of the alternative ritual approach has not been found in Sweden and the UK. There has been a zero tolerance for proposing alternative rituals to FGM. There are however at least four cases from Western countries where symbolic procedures have been carried out for example in Florence, Italy where a prick with a small needle was made on the skin covering

[356] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 16.
[357] "Study to Map the Current Situation and Trends of FGM. Country Reports," 478.
[358] 28 Too Many, "28 Too Many, Country Profile," 39.

the clitoris under local anesthesia.[359] The alternative ritual was presented after previous strategies of eradicating the practice proved ineffective such as educating the community.[360]

A unique feature regarding the strategies in Sweden is the high involvement of the government in developing key instruments against the practice. The government involvement has been effective because the tools developed have worked well with existing policies and laws.[361] Sweden and Kenya offer initiatives which provide a framework for more consultation with organizations that work directly with the communities such as the Gothenburg Project and ARP in Sweden and Kenya respectively. This method is not well established in the UK where there is less consultation and therefore a little representation of voices of the immigrant communities as compared to Sweden and Kenya.[362] The FGM policy in the UK is, therefore, more of a top-down approach. Also, the use of education to empower both professionals and immigrant groups is not well established in the UK as compared to Sweden and Kenya. The Gothenburg Project of Sweden and the promotion of girls' education in Kenya offers a forum to exchange experiences, beliefs, and values surrounding the practice.

Based on the analysis above, some lessons can be learned from the three jurisdictions. One such lesson is the development and distribution of handbooks and guidelines.[363] This helps in capacity building initiatives, especially in the health and education sector. The UK and Sweden have established tools such as directives and protocols which target social workers, teachers, health professionals, policy makers and anti-FGM activists.[364] With the constant movement of immigrant communities into the UK and Sweden, there is dire need for an unceasing training, education and

[359] Abdulcadir et al., "Care of Women with Female Genital Mutilation/Cutting," 6.
[360] Ibid.
[361] "Study to Map the Current Situation and Trends of FGM. Country Reports," 456.
[362] Ibid., 492.
[363] Ibid., 479.
[364] Ibid., 460,515.

awareness initiative to be institutionalized. The Gothenburg Project of Sweden exemplifies such an initiative which focuses on preventive work.[365] Knowledge on the management and classification of FGM remains scarce to western gynecologists and obstetricians. It is worth noting that FGM/C is not included in the medical pre-graduate curriculum.[366] The three most critical areas of concern include clitoral restoration/repair, defibulation, and re-infibulation.[367]

Despite the challenges faced with the current strategies, all three countries continue to come up with innovative ways of combating FGM. The dynamic web-based technology has encouraged anti-FGM activists to design campaigns that raise awareness in captivating ways. One recent innovation was developed by a local nurse in Oxfordshire, the UK which was fashioned to target health professionals and victims.[368] The application (App) called "Let's Talk FGM" holds vital information about the practice and is aimed at breaking down misconceptions about it by providing practical and current guidance. The App is especially useful for survivors because it directs them on how to seek help and support.[369] There is also the use of music events to raise awareness. Some examples include FORWARD'S Musicians Unite to End Female Genital Mutilation.[370]

In general, the strategies currently applied in the three jurisdictions have led to some behavioral change. There is also a perceived reduction of prevalence rate for Kenya and Sweden. The following chapter adds other strategies that when applied to the three jurisdictions, can or may intensify the commitment to abandon FGM and therefore reinforce anti-FGM legislation.

[365] Ibid., 480.
[366] Abdulcadir et al., "Care of Women with Female Genital Mutilation/Cutting," 7.
[367] Ibid., 4.
[368] "Campaigners Welcome New App on FGM for Health Professionals," *Bicester Advertiser*, accessed September 19, 2016, http://www.bicesteradvertiser.net/news/14748501.Campaigners_welcome_new_app_on_FGM_for_health_professionals/.
[369] Ibid.
[370] "FORWARD - (Foundation for Women's Health Research and Development)," *FORWARD*, accessed September 22, 2016, http://forwarduk.org.uk/.

CHAPTER IV – PROMISING MODELS OF FGM ERADICATION

Individual strategies for the elimination of FGM are required to be successful, and their success will work to strengthen the existing laws. Different factors such as level of education, health care system, religious beliefs and cultural norms need to be identified to establish a suitable mechanism to deal with FGM in different communities. The study has analyzed various strategies currently in place to fight FGM in Kenya, the UK, and Sweden and has also tackled the successes and challenges of these strategies by carrying out a comparative analysis of the three jurisdictions. Some of the current approaches have borne some fruit. The question then follows: "what more can be done to intensify the ongoing work on fighting FGM which can effectively counteract the core reasons for the persistence of the practice." As mentioned earlier, there is no easy solution to ending FGM. Therefore, a long-standing commitment is required to bring about behavioral change.

This chapter applies additional strategies that have proven successful in other countries to the three jurisdictions where necessary by taking into consideration different factors such as the culture fabric, healthcare system and the level of education. It also proposes recommendations for improving the current initiatives in place in the three jurisdictions.

4.1 The Social Change Theory

The social change theory has been used as a way to eliminate the practice of FGM/C following the successful abandonment of foot binding in China.[371] The central idea behind the theory is that a community cannot abandon the practice unless enough other people do so.[372] It is believed that by forming a particular kind of pledge association, this would see the end of the

[371] Mackie, "Female 'circumcision' in Africa," 254.
[372] Ibid.

practice once and for all. The pledge marks a convention shift where each family taking the pledge will come to accept that FGM is wrong.[373] It, however, does not end here because any family leaving the practice on its own would destroy their daughter's future in marriage. Instead, enough families are required to abandon the practice which will secure the daughters future.[374] The pledging against FGM was successfully adopted in Malicounda Senegal whereby it spread to nearby villages.[375] Abandonment of FGM through the pledging technique is effective when a small group who have pledged can persuade others to join them for it will be in their best interest.[376]

The ancient Chinese practice of foot binding is seen as an equivalent practice to FGM based on its extreme nature and reason for performing it, namely to ensure a proper marriage. It, however, ended after the enactment of a legal prohibition.[377] A social change theory was adopted to stop the practice and reinforce legislation.[378] The anti-foot binding campaign was represented in three stages. The first stage consisted of educating the community that members of other countries do not practice foot binding.[379] The second stage explained the advantages of having normal feet together with the health consequences of binding feet. The third stage adopted the pledging technique where a "natural-foot Society" was formed and its members publicly pledged not to continue with the practice. What made this successful is that enough families joined in the pledge enabling their daughters to be marriageable.[380]

In Senegal, the women of Malicounda with the help of an NGO named Tostan declared publicly their decision to abandon FGM. The women persuaded the rest of the village including

[373] Ibid., 255.
[374] Ibid.
[375] Ibid., 253.
[376] Ibid., 255.
[377] Ibid., 253.
[378] Ibid., 256.
[379] Ibid.
[380] Ibid.

traditional and religious leaders.[381] The women further encouraged members of neighboring communities to do the same. One factor that led to the success of the Tostan project is that their message was trusted and considered credible by the rural community rather than coming from "outsiders."[382] Secondly, the education program offered by Tostan provided useful skills and information in an explanatory context allowing for participants to apply it in their daily lives. The third factor is its nondirective nature in which the communities were not told what to do; rather they declared to abandon the practice without coercion or manipulation.[383]

The social change theory is applicable in the three jurisdictions of this study. With regards to Kenya, the pledging technique combined with ARP can have a lasting impact on the eradication of FGM. The social change theory has been observed in Kenya where the Meru community saw the elders of Njuri Ncheke (council of elders) publicly declare their opposition to the practice.[384] The strategy involved the outreach to religious leaders, community members, and government officials. A study showed a decline of the practice in this community.[385] Reflecting back on the Chinese foot binding practice, educating practicing communities that the practice is not conducted by other communities of the same country will contribute to the Convention shift. Most practicing communities believe that women who are not circumcised are not fit for marriage due to their unchaste nature. Behavioral change is expected once the practicing community is made aware that women from other communities are equally respected and deemed marriageable without the practice.

[381] Ibid.
[382] Ibid., 259.
[383] Ibid.
[384] "Joint Evaluation of the UNFPA-UNICEF," 21.
[385] Ibid.

Despite the fact that women are the ones who champion FGM the most, targeting men using the social change approach in Kenya can bring about positive outcomes i.e. by enlightening men that other communities do not practice FGM. The second step is to ensure they are aware of its health consequences. The third step is to have men publicly pledge to marry women who are uncircumcised and not to have their daughters circumcised. Women who support the practice will be forced to abandon the cut so as not to risk having their daughters rejected for marriage. The same method can also be designed to target women. The women after pledging can convince their husbands, religious leaders, or political figures as was observed in Senegal.[386] Religious leaders and politicians can equally be the primary targets because they are respected in the community. They can publicly pledge not to support the practice and encourage others to make the same declaration. The law against FGM can, therefore, be reinforced by punishing any perpetrator. The legal prohibition of FGM is most efficient and appropriate during the pinnacle of the national process of abandonment and not at its commencement.[387]

About Sweden and the UK, the social change theory can equally be applied and is predicted to be more efficient in eliminating the practice. The assumption lies in the fact that the practicing communities in Sweden and the UK are relatively smaller than in their place of origin. One factor to be considered in applying the social change theory in the two jurisdictions is to use a non-directive approach by providing information through education programs similar to the Tostan project of Senegal.[388] Due to the influence and direct exposure to the western culture (in Sweden and the UK), FGM can be assumed to be "shallow" in the sense that practicing communities do not emphasize on chastity and fidelity. This is in comparison to groups where FGM is "deep, " and

[386] Mackie, "Female 'circumcision' in Africa," 256.
[387] Ibid., 278.
[388] Ibid.

chastity or modesty are strongly valued like in non-western countries. It may, therefore, be easier to trigger a behavioral change in the former communities.[389]

Applying the social change theory is complex considering the fear families bear of being ostracized from the community for refusing to perform FGM on their daughters. The two essential elements required to ensure the creation of a new social norm where FGM is abandoned include a significant number of families within the community to make a collective and explicit decision to abandon FGM and the decision must be widespread for it to be sustained.[390] The joint and clear decision will bring about the confidence that others are also abandoning the practice, and the public decision will create a new social norm where marriageability of daughters and social status of families that do not perform FGM is secured.[391] The strategy is community-led therefore the community members are encouraged to define the problem and develop a solution. This, in turn, creates a non-coercive environment which can sustain behavioral change. Forming associations in which members can pledge to abandon the practice is the main key to addressing these fears because the members can rest assured of the proper marriage of their daughters within the association.

4.2 The France Model

France displays tremendous commitment in its prosecution of FGM cases despite having not enacted a specific law against the practice.[392] The country is evident in not tolerating FGM which is treated as any other form of severe child abuse. This intolerance has drawn critics who claim that this system is a form of racism or is culturally insensitive.[393] Regardless, some anti-

[389] Ibid., 279.
[390] "Eliminating Female Genital Mutilation: An Interagency Statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO," 13.
[391] Ibid., 28.
[392] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 37.
[393] Ibid., 39.

FGM activists in France have accused the UK of being too "respectful of immigrants" which results in the authorities turning a blind eye to harmful cultural practices, of which France insists that immigrants be required to integrate and obey their laws.[394] France prosecutes crimes of FGM under their criminal laws such as "offenses against the person", "assault or cruelty" and general child protection laws.[395] According to statistics, France has prosecuted 29 cases in total between 1979 and 2004.[396] The success of the France model can be attributed to a range of interventions including the collaboration between activists and health professionals; emphasis on accountability for practitioners; providing compensation to victims; offering legal protection to victims and using prosecution as a deterrence.[397]

Anti-FGM activists work to ensure that medical professionals understand fully the legal consequences of not reporting a case of FGM to the authority. This has obligated health professionals to report more cases to the authorities.[398] A common tendency observed in the UK is that the responsibility for reporting FGM cases lies mostly on the victim.[399] In France however, the responsibility has shifted to professionals because most minors are too scared to report the crime. Doctors, nurses and teachers are therefore heavily tasked with detecting and reporting when there is a risk of FGM.[400] If authorities in Kenya applied the same "no tolerance" attitude, the issue of medicalization would be resolved, and any medical professionals responsible for performing FGM would face prosecution.

One unique aspect regarding the France model which has not been documented in Kenya, the UK or Sweden is the availability for compensating victims of FGM. During the criminal

[394] Ibid., 38.
[395] Ibid., 37.
[396] Ibid.
[397] Ibid.
[398] Ibid., 38.
[399] Ibid., 21.
[400] Ibid., 39.

prosecution and conviction, fines are imposed and the money allocated to compensation funds of which victims can access upon turning 18 years old.[401] In cases where the parents are unable to pay the penalty due to financial restraints, the state pays, but the parents are obliged to pay back the state eventually.[402] In most cases, the parents are often responsible for carrying out FGM on their daughters. Therefore the compensation strategy is more likely to act as a significant deterrence. The deterrence effect is further reinforced when a prosecution is brought over mutilation of an elder child in the same family. Younger daughters from the same family are unlikely to be mutilated.[403] This method is likely to work in Sweden and the UK where the legal system is more rigid than in Kenya. In the case of Sweden, few cases have been brought to the prosecution authorities, but because of the lack of evidence, the cases are not taken to court.[404] When this set back is improved, cases brought to trial that lead to convictions can use the compensation of victim's strategy to prevent future perpetrators from carrying out the practice. With the increase of impunity in the justice system in Kenya, fines imposed can easily be "paid" off using bribes. Another obstacle in Kenya is the low economic status of the families practicing FGM. Expecting these families to pay the fines (even to the state eventually) is unlikely to happen.

The France model also boasts in its protection of victims of FGM through legal advocacy. The "tutors for minors" is a unique body which offers a safe, legal space for minors who have to stand in opposition to their parents.[405] The investigating judge appoints a tutor, and the tutor designates a legal advocate for the child. [406] The country is a good example of the political will

[401] Ibid.
[402] Ibid.
[403] Ibid.
[404] Johnsdotter, "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law," 5.
[405] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 38.
[406] Ibid., 39.

not to overlook or tolerate child abuse.[407] The firm stance that FGM is a form of child abuse has strengthened the strategies used to combat the practice. The France model is a good example for Kenya, the UK, and Sweden regarding how different bodies are accountable to the criminal law. The model shows that it is not only laws that ensure FGM is not performed, but political will and strong partnerships and coordination with different agencies. Furthermore, it is not only the people performing FGM who are accountable but those professionals who overlook the crime. Despite the fact that this provision is addressed in all three jurisdictions, it fails to be implemented.

[407] Ibid.

CONCLUSION AND RECOMMENDATIONS

There are several suggestions for tackling FGM that can be applied in Kenya, the UK, and Sweden. There is the need for increasing continuous education and training of professionals dealing with practicing communities.[408] In the case of Sweden and the UK, it is of particular importance due to the increase of immigrants from practicing communities and also the growth of new employees entering workplaces such as the health and education sector on a regular basis. Continuous education and training also create a norm in the concerned society, therefore, creating a new "culture" in which FGM is seen as an old practice. In Kenya where some anti-FGM initiatives such as training and education are occasionally faced by hostile responses from the communities, incessant persuasion should be used. The social change theory is an effective way of addressing hostile communities by first targeting a small group of willing and influential community members, for instance, religious leaders.

The education and training should also include a legal approach where the law is clearly explained together with the consequences of breaking it e.g. fine or prison sentence. A study on women's attitudes towards FGM in Kenya revealed that only 57% of the subjects were aware and conversant with the law against the practice.[409] The training and education of professionals further have a spillover effect in strengthening the legislation. The lack of evidence that is admissible in court has been one of the main obstacles in securing a conviction of people accused of performing FGM. With increased training, personnel will be better equipped to gather sufficient evidence to ensure more convictions take place. Increasing the number of prosecutions in all three countries is also important so as to act as a deterrence for others. All three countries have shown relatively few prosecutions with the UK being the lowest with not a single prosecution.

[408] "Study to Map the Current Situation and Trends of FGM. Country Reports," 480.
[409] Livermore, Monteiro, and Rymer, "Attitudes and Awareness of Female Genital Mutilation," 818.

Another step forward is enhancing or establishing a trusting relationship between the practicing community and authorities.[410] Concerning Sweden and the UK, this entails building a trusting relationship between the immigrant groups and social services in the sense that both parties are made aware of each other's perceptions and perspectives of FGM. Concerning Kenya, it involves establishing a suitable entry point into communities. In general, strategies which form a space for open and intercultural dialogue that allow for cultural variations within and between communities have shown to reduce prevalence rate significantly. Such strategies are more efficient when they promote and stimulate discussions on human rights principles compared to those that deny cultural variations.[411]

The fight against the practice is incomplete if anti-FGM bodies and the concerned governments fail to work with men and boys. This strategy has been recognized by many organizations to bring change in social traditions. Given that FGM is mainly practiced to ensure marriageability of daughters, engaging men and boys in education forums and awareness raising projects can have a substantial impact in initiating change. Kenya exemplifies this strategy with its collaboration between sports team (the Maasai Cricket Warriors), sports development charity (Cricket without Boundaries), and 28 Too many. [412] Cricket as a sport has been used as a means of raising awareness of FGM and empower the youth to abandon the practice in the Maasai community which is one of the ethnic groups that practices FGM in Kenya.[413]

The notion of involving men and boys in the fight against FGM through public declarations is applicable also in the UK and Sweden. This involves men and boys originating or born from

[410] "Study to Map the Current Situation and Trends of FGM. Country Reports," 480.
[411] "Eliminating Female Genital Mutilation: An Interagency Statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO," 14.
[412] "Overview of Strategies to End FGM" (28 Too Many, 2015), http://28toomany.org/fgm-research/research/.
[413] Ibid.

FGM practicing communities and living in the UK and Sweden speaking out publicly and declaring their preference to marry daughters who have not undergone the cut.[414] The target can also be specific for example male religious leaders from practicing communities who can influence behavioral change and engage in awareness raising campaigns. The main idea behind engaging men and boys is to emphasize the responsibilities everyone has in society to ensure the rights and freedoms of girls are protected even in the traditional setting.[415]

Some of the recommendations are country-specific. Kenya needs to increase the number of rescue centers for girls at risk. The centers should offer adequate protection to the girls. A program should also be in place for dialogue between the centers and community members where an agreement can be reached to allow for the girls to integrate back into their community without judgment and to face the risk of being subjected to FGM. Impunity continues to impede the protection of girls because elders and traditional leaders within the communities are highly influential.[416]

The other recommendation for Kenya would be to increase the amount of sustainable funding concerning FGM research and programs. Some of the funding can be allocated to sexual and reproductive health education and psychological training to deal with victims of FGM.[417] FGM like poverty and health is a crucial element that requires equal attention and NGOs and charities working to eliminate the practice should receive adequate funding to enable their effectiveness.[418] In Kenya, there are currently many successful anti-FGM programs as mentioned in the study. These programs can be made more efficient and widespread if they formed a coalition and

[414] 28 Too Many, "28 Too Many, Country Profile," 36.
[415] Ibid., 40.
[416] Ibid., 44.
[417] Ibid.
[418] Ibid.

increased dialogue with each other more publicly and collaborated at a project level. This formation will also create a stronger voice regarding lobbying and advocacy and be more successful in obtaining sustainable funding.[419]

The study has also revealed that education is significantly affected by the practice. Most girls who undergo FGM drop out of school at a young age and are not able to obtain basic education thereby increasing the country's illiteracy rate. Basic education needs to be provided to all children so as to end the perpetuating social stigma related to FGM. NGOs, charities, and any anti-FGM program need to place emphasis on advocating for girl's education.[420] Medicalization of FGM in Kenya continues to act as a hindrance to completely eradicate the practice. More training of health providers is required for them to manage FGM cases adequately. Also, authorities should not portray negligence in prosecuting health professionals who carry out the practice.[421]

Concerning the UK, there is a need for more support for victims and girls at risk of FGM. The government needs to establish agencies where the girls can receive confidential support and advice and psychological assessments. Support for victims regarding corrective surgeries should be made available.[422] There is furthermore the need to reframe the practice. FGM should no longer be viewed as a cultural issue but as violence against women and abuse against children.[423] This reframing will help in reducing the level of tolerance toward the practice in the country. There should be better engagement with anti-FGM agencies and communities so as to equip the communities better with information on where to get help.[424] A coordinated multi-agency approach

[419] Ibid.
[420] Ibid.
[421] Ibid.
[422] Bindel, "An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK," 41.
[423] Ibid., 40.
[424] Ibid.

is also needed so as to ensure the adequate information on suspected FGM cases is communicated and action taken appropriately.[425]

Another recommendation for the UK is to enhance the political will of the government in the support against FGM. The situation in the UK revealed that NGOs and charity organizations carry the heavy work on FGM eradication. With the help and full support of the government, there should be stricter migration policies for girls who are sent back to their parents' country of origin during school holidays to have FGM. The same applies in allowing daughters to be sent to the UK to have FGM. One anti-FGM activist in France was appalled by the fact that migrants sometimes opt to take their daughters to Britain for FGM.[426] A strong political will also ensures that the government's commitment to working in collaboration with other agencies fighting the practice, such as religious institutions, charity organizations, and NGOs. The France case is a good example that shows the effect of having a strong political will. Legislation against FGM is a critical component in the fight against the practice. However, when applied in isolation, it rarely leads to behavioral change, and there is usually no will to prosecute perpetrators.

A notable feature in Sweden was that a single state authority, NBHW, was responsible for the national work on FGM. The recommendation would be to have a devolution so as to enable better coordination and evaluation of preventive work. The devolution will also ensure that different bodies will have an overview of each initiative thus promoting comprehensive partnerships with immigrant communities.[427] More needs to be done about data collection to

[425] Ibid., 41.
[426] Ibid., 36.
[427] "Study to Map the Current Situation and Trends of FGM. Country Reports," 478.

ascertain prevalence rate in Sweden. There are no central registers to record data on asylum cases related to FGM, prosecuted cases or police reports and investigations.[428]

In conclusion, the study has revealed the multifaceted nature of tackling FGM in Kenya, the UK, and Sweden. Some of the strategies adopted in the three countries are similar or overlap each other while others remain country specific. It is evident from the study that Kenya and Sweden invest more in community-based approaches. The community-based approaches may be the reason behind the declining estimated FGM prevalent rate in the two countries. The UK government, on the other hand, tends to focus more on policy reform with a relatively little government commitment to tackling the issue.

A framework that includes both preventive measures to encourage abandonment combined with sanctions for those actively involved in the practice is a more efficient means of ensuring behavioral change and thereby strengthening the law. Such a framework should incorporate community-based strategies to bring about a positive change. The fight against FGM is complex and enduring as the study has revealed. Each affected country must continue to adopt specific strategies that address the diverse social, cultural and religious fabrics of their society to tackle the practice better. The fight is therefore not bleak despite claims of strong cultural ties. Culture is a dynamic element and it, therefore, changes according to society's needs. Just like the ancient foot binding practice came to an end, with community-based approaches, enactment of laws, proper awareness, education and political will, so can FGM in the near future.

[428] Ibid., 483.

BIBLIOGRAPHY

"16 Organizations, Charities and Grassroots Groups Working to Stop Female Genital Mutilation: The Pixel Project's '16 for 16' Campaign." Accessed September 19, 2016. http://16days.thepixelproject.net/16-organisations-charities-and-grassroots-groups-working-to-stop-fgm/.

28 Too Many. "28 Too Many, Country Profile: FGM in Kenya." Accessed March 24, 2016. http://www.refworld.org/docid/54bcdfdf4.html.

"28 Too Many - FGM Let's End It - Female Genital Mutilation: Just a Women's Issue? - Guest Blog by Winnie Cheung." Accessed September 19, 2016. http://www.28toomany.org/blog/2013/nov/25/female-genital-mutilation-just-womens-issue-guest-/.

Abdulcadir, Jasmine, Christiane Margairaz, Michel Boulvain, and Olivier Irion. "Care of Women with Female Genital Mutilation/Cutting." *Swiss Medical Weekly* 140 (2011): w13137. doi:10.4414/smw.2010.13137.

"About the Protocol | Maputo Protocol," 2011. http://www.maputoprotocol.com/about-the-protocol.

"African Charter on Human and Peoples' Rights." *African Commission on Human and People's Rights*. Accessed September 26, 2016. http://www.achpr.org/instruments/achpr/.

"African Commission on Human and People's Rights." Accessed March 26, 2016. http://www.achpr.org/instruments/.

Ahlberg, Beth Maina, Ingela Krantz, Gunilla Lindmark, and Marian Warsame. "'It's Only a Tradition': Making Sense of Eradication Interventions and the Persistence of Female

‘Circumcision’ within a Swedish Context.” *Critical Social Policy* 24, no. 1 (February 1, 2004): 50–78. doi:10.1177/0261018304241003.

Alston, Philip, and Ryan Goodman. *International Human Rights*. Oxford : Oxford University Press, 2012., n.d.

Ameh and others v. the UK, Application no. 4539/11, 30 August 2011 (n.d.).

Askew, Ian. “Methodological Issues in Measuring the Impact of Interventions against Female Genital Cutting.” *Culture, Health & Sexuality* 7, no. 5 (September 1, 2005): 463–77. doi:10.1080/13691050410001701939.

Bangura v. Belgium, Application no. 52872/10, 15 April 2014 (n.d.).

Bindel, Julie. “An Unpunished Crime: The Lack of Prosecutions for Female Genital Mutilation in the UK.” London: The New Culture Forum, 2014. http://www.justiceforfgmvictims.co.uk/the-report/.

“BOTOX® Cosmetic (onabotulinumtoxinA) Official Site. Welcome!” Accessed March 24, 2016. http://www.botoxcosmetic.com/.

Boyle, Elizabeth Heger, and Sharon E. Preves. “National Politics as International Process: The Case of Anti-Female-Genital-Cutting Laws.” *Law & Society Review* 34, no. 3 (2000): 703–37. doi:10.2307/3115141.

“Call to End Violence against Women and Girls: Action Plan.” Home Office, March 8, 2011. https://www.gov.uk/government/publications/call-to-end-violence-against-women-and-girls-action-plan.

“Campaigners Welcome New App on FGM for Health Professionals.” *Bicester Advertiser*. Accessed September 19, 2016.

http://www.bicesteradvertiser.net/news/14748501.Campaigners_welcome_new_app_on_FGM_for_health_professionals/.

Chege, Jane Njeri, Ian Askew, and Jennifer Liku. "An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya." Frontiers in Reproductive Health, September 2001. http://pdf.usaid.gov/pdf_docs/Pnacm865.pdf.

CNN, Salma Abdelaziz and Sarah Sirgany. "Egypt Teen 'Dies in Illegal Genital Mutilation.'" *CNN*. Accessed November 7, 2016. http://www.cnn.com/2016/06/01/health/genital-mutilation-abdelaziz/index.html.

Collins and Akaziebie v. Sweden, Application no. 23944/05, 8 March 2007 (n.d.).

"Convention on Preventing and Combating Violence against Women and Domestic Violence," May 11, 2011. http://europa.eu/epic/news/2012/20121010_convention_on_preventing_and_combating_violence_against_women_and_domestic_violence_en.htm.

"Convention on the Elimination of All Forms of Discrimination against Women." Accessed March 26, 2016. http://www.un.org/womenwatch/daw/cedaw/.

"Declaration on Gender Equality in Africa." Addis Ababa, Ethiopia: African Commission on Human and People's Rights, 2004. http://www.achpr.org/instruments/declaration-on-gender-equality-in-africa/.

Diesfeld, H. J., and H. K. Hecklau. *Kenya*. Vol. 5. Medizinische Länderkunde / Geomedical Monograph Series. Berlin, Heidelberg: Springer Berlin Heidelberg, 1978. http://link.springer.com/10.1007/978-3-642-66935-4.

"Doctor Found Not Guilty of Performing FGM." *BBC News*, February 2015. http://www.bbc.com/news/uk-england-31138218.

Dustin, Moira. "Female Genital Mutilation/Cutting in the UK Challenging the Inconsistencies." *European Journal of Women's Studies* 17, no. 1 (February 2010): 7–23.

EIGE. "Current Situation and Trends of Female Genital Mutilation in Sweden," May 2013. http://eige.europa.eu/rdc/eige-publications/current-situation-and-trends-female-genital-mutilation-sweden.

EIGE. "Estimation of Girls at Risk of Female Genital Mutilation in the European Union: Report," June 2015. http://eige.europa.eu/rdc/eige-publications/estimation-girls-risk-female-genital-mutilation-european-union-report.

"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.

"European Convention on Human Rights - Official Texts, Convention and Protocols." Accessed March 26, 2016. http://www.echr.coe.int/pages/home.aspx?p=basictexts.

"Female Genital Mutilation." Stockholm Sweden: National Board of Health and Welfare Customer Service, 2003. https://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/10668/2003-114-9_200311491.pdf.

"Female Genital Mutilation (FGM)." *National Society for the Prevention of Cruelty to Children*. Accessed March 27, 2016. http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/.

"Female Genital Mutilation/Cutting: A Statistical Exploration." *UNICEF*. Accessed March 25, 2016. http://www.unicef.org/publications/index_29994.html.

"Female Genital Mutilation-MPS Project Azure," November 4, 2010. http://www.policeauthority.org/Metropolitan/committees/cep/2010/101104/08/index.html

"FORWARD - (Foundation for Women's Health Research and Development)." *FORWARD*. Accessed September 22, 2016. http://forwarduk.org.uk/.

"Global Strategy to Stop Health-Care Providers from Performing Female Genital Mutilation UNFPA, UNICEF, UNHCR, UNIFEM, WHO, FIGO, ICN, IOM, WCPT, WMA, MWIA." World Health Organization, 2010.

"International Covenant on Civil and Political Rights." Accessed March 26, 2016. http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx.

Izevbekhai and Others v. Ireland, Application no. 43408/08, 17 May 2011 (n.d.).

Johnsdotter, Sara. "FGM in Sweden: Swedish Legislation Regarding 'Female Genital Mutilation' and Implementation of the Law." Department of Sociology, Lund University, 2004. http://lup.lub.lu.se/record/528291.

"Joint Evaluation of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C): Accelerating Change." UNFPA-UNICEF, 2013. http://www.unicef.org/evaldatabase/index_FGMC.html.

Kant, Immanuel, J. B. Schneewind, Marcia Baron, and Shelly Kagan. *Groundwork for the Metaphysics of Morals*. Edited by Allen W. Wood. Yale University Press, 2002. http://www.jstor.org/stable/j.ctt1njjwt.

"Kenya Battles Female Genital Mutilation." *Institute for War and Peace Reporting*. Accessed September 14, 2016. https://iwpr.net/global-voices/kenya-battles-female-genital-mutilation.

Kenya Children Act, 2001. L.N. 23/2002, 2001. http://www.kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=CAP.%20141.

"Kenya National Adult Literacy Survey Report - Eldis." Accessed September 25, 2016. http://www.eldis.org/go/home&id=31868&type=Document#.V-evLDU50s8.

Kenya Prohibition of Female Genital Mutilation Act 2011. Vol. 32. Accessed March 24, 2016. http://www.kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=CAP.%2062B.

Korfker, Dineke, Marlies Rijnders, Sanna Meijer-van Asperen, Lucienne Read, Maylis Sanjuan, Kathy Herschderfer, Simone Buitendijk, and Ria Reis. "The Lower Prevalence of Female Genital Mutilation in the Netherlands: A Nationwide Study in Dutch Midwifery Practices." *International Journal of Public Health* 57, no. 2 (April 2012): 413–20.

Laville, Sandra. "Doctor Found Not Guilty of FGM on Patient at London Hospital." *The Guardian*, February 4, 2015, sec. Society. https://www.theguardian.com/society/2015/feb/04/doctor-not-guilty-fgm-dhanuson-dharmasena.

Leye, Els. "Female Genital Mutilation. A Study of Health Services and Legislation in Some Countries of the European Union." *ResearchGate*, February 8, 2008.

https://www.researchgate.net/publication/245023567_Female_Genital_Mutilation_A_study_of_health_services_and_legislation_in_some_countries_of_the_European_Union.

Leye, Els, Jessika Deblonde, and Marleen Temmerman. "Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK." Belgium: International Center for Reproductive Health - Gent University, April 2004.

Livermore, L, R Monteiro, and J Rymer. "Attitudes and Awareness of Female Genital Mutilation: A Questionnaire-Based Study in a Kenyan Hospital." *Journal of Obstetrics and Gynaecology* 27, no. 8 (November 2007): 816–18.

"Local Kenyan Chiefs in FGM Controversy." *Institute for War and Peace Reporting*. Accessed September 26, 2016. https://iwpr.net/global-voices/local-kenyan-chiefs-fgm-controversy.

Macfarlane, Alison, and Efua Dorkenoo. "Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates." London: City University London and Equality Now, July 2015. http://www.trustforlondon.org.uk/research/publication/prevalence-of-female-genital-mutilation-in-england-and-wales-national-and-local-estimates/.

Mackie, Gerry. "Female Genital Cutting: The Beginning of the End." In *Female "circumcision" in Africa: Culture, Controversy, and Change. Ed. Bettina Shell-Duncan, Ylva Hernlund*, edited by Bettina Shell-Duncan and Ylva Hernlund, 253–82. Boulder & London: Rienner, 2000.

"Matthew 7:5 NIV." Accessed March 24, 2016. http://biblehub.com/niv/matthew/7.htm.

"Mayor Brings Thousands Together in Fight against Honour-Based Crime," March 11, 2016. https://www.london.gov.uk/press-releases/mayoral/fight-against-honour-based-crime.

Nussbaum, Martha C. "Judging Others Cultures: The Case of Genital Mutilation." In *Sex and Social Justice*, 118–29. New York, Oxford, 1999.

Odhiambo, George. Hebrew Immigrant Aid Society (HIAS) and Female Genital Mutilation. Personal Interview, August 18, 2016.

Omeredo v. Austria, Application no. 8969/10, 20 September 2011 (n.d.).

"Overview of Strategies to End FGM." 28 Too Many, 2015. http://28toomany.org/fgm-research/research/.

Parliamentary Assembly. "Resolution 1247. Female Genital Mutilation," May 22, 2001. http://www.assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=16914&lang=en.

Prohibition of Female Genital Mutilation (Scotland) Act 2005. *2005 Asp 8*. Accessed March 24, 2016. http://www.legislation.gov.uk/asp/2005/8/contents.

"Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa." *African Commission on Human and People's Rights*. Accessed March 26, 2016. http://www.achpr.org/instruments/women-protocol/.

Rahman, Anika, and Nahid Toubia, eds. *Female Genital Mutilation: A Guide to Laws and Policies Worldwide.* London & New York: Zed Books, 2000.

Robertson, Louise, and Michelle Szaraz. "The Medicalisation of FGM." 28 Too Many, 2016. http://28toomany.org/media/uploads/report_final_version.pdf.

Sayagie, George. "Chaos as 500 Women Demand 'cut' for Girls." *Daily Nation*. January 17, 2015.

Shell-Duncan, Bettina, and Ylva Hernlund. "Female 'circumcision' in Africa: Dimensions of the Practices and Debates." In *Female "circumcision" in Africa: Culture, Controversy, and*

Change. Ed. Bettina Shell-Duncan, Ylva Hernlund, 1–40. Boulder & London: Rienner, 2000.

Skaine, Rosemarie. "A Traditional Practice." In *Female Genital Mutilation : Legal, Cultural, and Medical Issues*, 7–36. Jefferson, N.C. : McFarland, c2005., n.d.

Skaine Bettina. "Globalism and Law." In Female Genital Mutilation : Legal, Cultural, and Medical Issues, 57–79. Jefferson, N.C. : McFarland, c2005., n.d.

Skaine, Rosemarie, and James C. Skaine. "Prevalence." In *Female Genital Mutilation : Legal, Cultural, and Medical Issues*, by Rosemarie Skaine, 35–56. Jefferson, N.C. : McFarland, c2005., n.d.

Sow v. Belgium, Application no. 27081/13, 19 January 2016 (n.d.).

"Statement Opposing Female Genital Mutilation." Home Office, November 23, 2012. https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation.

"Statistical Profile on Female Genital Mutilation/Cutting. Kenya." UNICEF, 2016. http://data.unicef.org/child-protection/fgmc.html.

"Status of Ratification Interactive Dashboard." *United Nations Human Rights Office of the High Commissioner*. Accessed March 26, 2016. http://indicators.ohchr.org/.

"Study to Map the Current Situation and Trends of FGM. Country Reports." European Institute for Gender Equality, 2013.

Sweden Prohibiting Female Genital Mutilation,1999. *SFS*, 1999.

"Tackling FGM in the UK - Intercollegiate Recommendations for Identifying, Recording and Reporting." London: The Royal College of Midwives: RCM, RCN, RCOG, Equality Now, UNITE, 2013.

"The African Charter on the Rights and Welfare of the Child (ACRWC) | African Union." Accessed September 26, 2016. http://pages.au.int/acerwc/documents/african-charter-rights-and-welfare-child-acrwc.

"The Dynamics of Social Change towards the Abandonment of Female Genital Mutilation/Cutting in Five African Countries." UNICEF Innocenti Research Centre, 2010. https://www.unicef-irc.org/publications/pdf/fgm_insight_eng.pdf.

The National Council for Childhood and Motherhood. "Cairo Declaration for the Elimination of FGM." Cairo, June 23, 2003. http://www.childinfo.org/files/fgmc_Cairodeclaration.pdf.

The United Kingdom Children Act 2004, 2004. http://www.legislation.gov.uk/ukpga/2004/31/contents.

The United Kingdom Female Genital Mutilation Act 2003, 2003. http://www.legislation.gov.uk/ukpga/2003/31/contents.

The United Kingdom Prohibition of Female Circumcision Act 1985, 1985. http://www.legislation.gov.uk/ukpga/1985/38/section/2.

"The Universal Declaration of Human Rights | United Nations." Accessed March 26, 2016. http://www.un.org/en/universal-declaration-human-rights/index.html.

"Too Much Pain. Female Genital Mutilation & Asylum in the European Union. A Statistical Overview." United Nations High Commissioner for Refugees (UNHCR), February 2013. http://www.unhcr.org/531880249.pdf.

"UK Law | About FGM." Accessed September 19, 2016. http://about-fgm.co.uk/about-fgm/human-rights/uk-law/.

UN Committee on the Elimination of Discrimination against Women. "CEDAW Concluding Observations on the Seventh Periodic Report of the United Kingdom of Great Britain and

Northern Ireland." CEDAW/C/GBR/CO/7, July 26, 2013. http://www.wrda.net/Documents/CEDAW%20Committee's%20examination%20of%20the%20UK%20government%202013.pdf.

UN Committee on the Elimination of Discrimination Against Women (CEDAW). "CEDAW General Recommendation No. 19: Violence against Women," 1992. http://www.refworld.org/docid/52d920c54.html.

UN Committee on the Elimination of Discrimination Against Women (CEDAW). "Concluding Comments of the Committee on the Elimination of Discrimination against Women: Kenya," August 10, 2007. http://www.refworld.org/docid/46d280ff6.html.

UN Committee on the Rights of the Child. "UN Committee on the Rights of the Child: Concluding Observations, Kenya." CRC/C/KEN/CO/2, June 19, 2007. http://www.refworld.org/docid/4682102b2.html.

UN General Assembly. "Convention on the Rights of the Child." Treaty Series, vol. 1577, p.3, November 20, 1989. http://www.refworld.org/docid/3ae6b38f0.html.

UN General Assembly. "Declaration on the Elimination of Violence against Women," December 20, 1993. http://www.refworld.org/docid/3b00f25d2c.html.

UN General Assembly. "Resolution Adopted by the General Assembly. Traditional or Customary Practices Affecting the Health of Women and Girls." A/RES/56/128, January 30, 2002.

UN Women. "Sources of International Human Rights Law on Female Genital Mutilation." *Virtual Knowledge Center to End Violence against Women and Girls*, 2012. http://www.endvawnow.org/en/articles/645-sources-of-international-human-rights-law-on-female-genital-mutilation.html.

"WHO | Female Genital Mutilation and Other Harmful Practices." *WHO*. Accessed March 24, 2016. http://www.who.int/reproductivehealth/topics/fgm/medicalization_fgm_kenya/en/.

"WHO | Media Center. Female Genital Mutilation." *WHO*. Accessed March 24, 2016. http://www.who.int/mediacentre/factsheets/fs241/en/.

"WHO | Reproductive Health." *WHO*. Accessed November 7, 2016. http://www.who.int/topics/reproductive_health/en/.

"WHO | Sexual and Reproductive Health." *WHO*. Accessed March 25, 2016. http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/.

Winterbottom, Anna, Jonneke Koomen, and Gemma Burford. "Female Genital Cutting: Cultural Rights and Rites of Defiance in Northern Tanzania." *African Studies Review* 52, no. 1 (April 2009): 47–71.

World Health Organization, Department of Reproductive Health and Research. "WHO | Female Genital Mutilation and Obstetric Outcome." *The Lancet*, no. 367 (2006): 1835–41.