



AGENCY FOR CULTURE AND CHANGE MANAGEMENT

Company by Guarantee Number: 3603632

Charity Status Number: 1080561

FGM CONFERENCE

LONDON, THURSDAY 13 – 05 – 2004

Scripts and Speeches
Workshops

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**FEMALE GENITAL MUTILATION CONFERENCE
LONDON – THURSDAY, 13 MAY 2004**

Speech by Mrs Marion Roe Mp

Good afternoon, everybody and welcome to our afternoon session!

I do hope that you had an enjoyable lunch and were able to use the opportunity to mingle amongst friends.

My name is Marion Roe. I have been the Conservative Member of Parliament for Broxbourne, in Hertfordshire, for the past 21 years, and I am delighted to be chairing this second session of today's important conference on Female Genital Mutilation.

The silence that surrounds many forms of abuse and discrimination against women and girls is slowly lifting in a number of societies. Subjects long considered sensitive, or beyond debate are being objectively and critically assessed. Among these subjects is female genital mutilation.

I first heard about Female Genital Mutilation or Female Circumcision as it was known in those days, in the late 1970s, when I was a member of the Greater London Council.

As a local government representative in London, I became aware that Female Genital Mutilation was being practised in the United Kingdom by certain refugee and immigrant communities; it horrified me ! It is not only a violation of every child's rights; it is physically harmful and has serious consequences for a girl's health.

As soon as I became a Member of Parliament in 1983, I began to seek support from other parliamentarians of all Parties, as well as the Conservative government, for a Private Members Bill to prohibit female circumcision in the United Kingdom.

Although there was much pressure from the immigrant communities affected, - I was called "a racist", I was accused of intervening in religious freedoms, cultural traditions etc, my Bill, the Prohibition of Female Circumcision, became law in 1985, - 19 years ago, - one of the first pieces of legislation on this issue in the world.

In formulating my Bill, for which I received full co-operation from all sides of the House, I was at great pains to block every avenue whereby those wishing to continue FGM in the UK could not obviate the law, - I was into groundbreaking territory.

For example, a great deal of pressure was exerted on me not to have explicit wording on a surgical operation by a registered medical practitioner on a girl for her mental health, - obviously, the intent being to use the stress on a girl who is not conforming to a traditional practice as an excuse to find a gap in the legislation.

SPEECH BY MRS MARION ROE MP

I strongly believed that making FGM unlawful was only a first step, - more needed to be done to persuade those parents and family members involved to change their behaviour, so, whilst my Bill was proceeding through its parliamentary stages in Committee, I persuaded the Conservative government to guarantee funding for educational purposes, not only in the United Kingdom, but also internationally, to eliminate this practice.

I am pleased to say that the present Labour government has continued to honour that commitment, providing hundreds of thousands of pounds for educational programmes and research, including partly financing the All-Party Parliamentary Group Report on Population, Development and Reproductive Health Report, which produced many worthwhile recommendations to the government on this issue.

I should also like to take this opportunity to pay tribute to the many excellent voluntary and charity groups, such as Rain-bow and FORWARD, as well as UNICEF, which do magnificent work at the grass-roots level amongst the communities; their efforts are vital.

The European Parliament has also considered this issue and made NINE recommendations to all member states on the 20 September 2001 to condemn FGM as a violation of human rights and as a crime.

It is very important that not only is FGM made illegal and educational programmes initiated but also social workers, teachers and the medical profession are included in the fight to eliminate the practice. Their participation is crucial.

My All Party friends and I, having taken the Bill through Parliament in 1985 and seen it become an Act, believed that we had done something worthwhile and that in time FGM in the UK would become a thing of the past.

It was, therefore, a grave disappointment to my Parliamentary colleagues and me to discover that no prosecutions were being brought under the 1985 Act.

When I questioned why this was the case, I was told that it was impossible to persuade children to testify against their parents and family but it also seemed to me that a conspiracy of silence amongst certain members of the refugee and immigrant communities was difficult to break. It then became apparent that children from immigrant communities were being sent back to their country of origin for a so-called holiday for FGM to take place.

My Prohibition of Female Circumcisions Act of 1985 made FGM illegal if it took place within the jurisdiction of the United Kingdom. A person would have been guilty of conspiracy if they had conspired in the United Kingdom to commit FGM in a country where it is illegal also. However, a person cannot be guilty of conspiracy if the FGM occurred in a country where it is legal. It is not an offence to conspire in the United Kingdom to commit an act abroad which is not illegal both in the UK and in the country for which it is planned.

SPEECH BY MRS MARION ROE MP

The question of a prosecution being brought under UK law on the family's return from abroad has been a matter that has concerned me greatly and I was delighted that this whole issue was addressed in the Bill, introduced by Ann Clwyd last year, of which I was one of the sponsors.

As this morning's programme demonstrated, a positive approach to this issue is evident in the UK and we must continue our commitment to women's rights with dedicated perseverance.

This morning's speakers gave an in-depth perspective on what is happening in the United Kingdom. Now we move onto the international stage and it gives me the greatest pleasure to introduce to you Maggie Baxter, Executive Director of WOMANKIND Worldwide, an organisation doing a fantastic job.

Maggie has been in this post since May 1999, prior to which, she was Deputy Chief Executive and Grants Director at Comic Relief, which she joined in 1991. During her time there, she was seconded as Acting Chief Executive of the Diana, Princess of Wales Memorial Fund, from 1997-98. Margie is the Chairman of the City Parochial Foundation Trust for London and a Trustee of Hilden Charitable Trust and Dance United, along with being an Association Member of OXFAM. Maggie is obviously a lady who is very busy and also has enormous experience and expertise in charitable work.

Maggie Baxter.

Thank you very much indeed Maggie for your excellent presentation. We all admire the work that you and your organisation do and wish you continuing success in your labours. You have certainly given us plenty to think about. We are most grateful to you for giving time from your busy schedule to be with us today.

We will now have a quarter of an hour break for tea and coffee and I look forward to you all returning at 2.45 pm, so that we can set up our workshops in which we shall be discussing Primary Care Settings, Community Settings and Legal and Child Protection.

Workshops

We shall now split into three groups for our workshop tasks.

The Primary Care Settings Group will be chaired by Dr Harry Gordon and, and will gathering here in Lecture Theatre 2, to undertake their work.

The Legal and Child Protection Group will be chaired by Adwoa Kluitse and they will be working in Seminar Room G4 upstairs.

I shall be chairing the Community Settings Group and we shall gather in Seminar Room G3 upstairs.

I now invite you all to move to your respective groups, returning to this Hall at 4 pm.

Welcome back from your workshops.

I am sure that you have all enjoyed the opportunity to have your say and exchange ideas with colleagues.

I now invite Comfort Momoh (Primary Care), Adwoa Kluvitse (Legal) and Julie Matthew (Community Settings) to give us feedback from the workshops, so that we can all hear the results of the discussions that have taken place this afternoon.

May I thank our rapporteurs for their reports and you all very much indeed for the magnificent contribution that you have made during the workshop sessions. I think that there are some very important conclusions on which we need to focus in our quest to eliminate FGM.

Just a few points -

First, awareness and advocacy.

This is a theme that has been repeated many times. Raising awareness at all levels within the community with particular emphasis on religious leaders, social services and schools, which are best placed to watch children develop through their school life and pick up signs of a child that may be in distress.

Health visitors are very important as they support the new mother until the child is aged 4. They can have a serious influence on providing education and information on health and legal implications and, of course,

GPs, as they are the first point of contact, when children present themselves with FGM-related illnesses. And, let us not forget,

Midwives, who see pregnant women and deliver babies.

All have a role to play in spreading information and providing feedback.

Secondly, education.

We need to encourage culturally sensitive education programmes and services, targeting relevant communities, especially school-age children. I cannot over-emphasise how important this work is.

Thirdly, monitoring.

This is vital. I think we all feel that agencies should get together locally to develop a more appropriate method on how they will undertake monitoring to ensure that children are protected. We need to make sure that FGM is taken seriously and investigate whenever necessary. If it is required, prosecution should follow.

We must not forget local and central governments' role. Both should be fully supportive of the work that is being undertaken by organisations such as the Agency for Culture and Change Management, FORWARD, London Black Women's Health and Welfare Association, and others.

And finally, funding and resources to make all of this really work. I think we all realise that short-term funding will not solve the problems as work towards the elimination of FGM is a long-term process.

I should just like to say a few words about the international scene. I have been pursuing my quest to eradicate FGM beyond our shores.

I have been representing the UK with other MPs of all parties at Inter-Parliamentary Union conferences for over 6 years, where I have been raising issues of concern relating to children, - for example, child soldiers, child labour, child health, child trafficking, commercial sexual exploitation of children and, of course, FGM.

The Inter-Parliamentary Union is an organisation to which 140 countries belong and there are two conferences a year to which they send their Parliamentarians to debate current issues.

The Inter-Parliamentary Union organised a panel discussion on the topic "Violence Against Women – FGM" during its 106th conference in Burkina Faso in September 2001; its purpose was to make Parliamentarians aware of the importance of eliminating this harmful traditional practice. The session was well attended by men and women MPs who wished to take this matter further.

A further brainstorming session was organised at the next IPU annual conference in Marrakech, Morocco in March 2002, when a Parliamentary think-tank for the eradication of FGM was created. There were five members of this panel, comprising a Member of Parliament each from: Kenya, Nigeria, Norway, UK and Uganda. I am the UK member.

We know that FGM is a violation of inherent human rights and is condemned in both the Convention on the Rights of the Child and in the Convention on the Elimination of All Forms of Discrimination against Women.

We were mandated to study the possibility of:

- Working towards a possible international convention on the eradication of FGM;
- Organising, if need be, a Parliamentary Conference on Parliamentary action to eradicate FGM, which should be convened jointly by the IPU and the African Parliamentary Union, and should bring together MPs, Inter African Committee representatives, religious and traditional leaders, NGOs and former practitioners of FGM, together with many others involved in this issue.

Another meeting of our Parliamentary think-tank was held at the following IPU conference in Santiago, Chile, in April 2003, where discussions resulted in the presentation of recommendations to the full International Council of the IPU on this issue and future work to be done in this field by the IPU in co-operation with the African Parliamentary Union and by national governments with the hope that an international conference can be organised in the near future on the FGM issue alone.

Last May, I had a long briefing session with the Head of the Human Rights Policy Department at the Foreign and Commonwealth Office on our plans and sought British Government assistance in funding an international convention in order to raise the profile of FGM at international Ministerial level.

The IPU has also set up sections on FGM on the IPU website (www.ipu.org), which includes details of countries throughout the world where this is practiced and what action, if any, governments have taken to eliminate it.

The idea of the website is to disseminate information to anybody and everybody who has an interest in eradicating FGM so that the wheel is not reinvented and good practice is spread. Many African countries have found these web pages extremely helpful.

I also attended a conference called "Zero Tolerance to FGM" in Addis Ababa in February 2003, which was organised by a non-Governmental organisation, the Inter African Committee on Traditional Practices affecting the Health of Women and Children.

I listened with great interest to the presentations and comments from young and old representing NGOs and voluntary organisations from countries throughout Africa, as well as UNICEF and the WHO, describing plans for mobilising religious leaders, community leaders and youth with projects for entrepreneurial training for former circumcisors, so they can find new employment, as well as awareness programmes. I would remind you that every year two million young girls are estimated to be at risk of this harmful practice. For example, in the Sudan, over 70% of women are affected by the most severe forms of FGM, - in Somalia, 97% of women are subject to FGM.

It was a very heartening experience to hear religious leaders confirming that there is no religious base to FGM and also to hear young men condemning this abuse of human rights. There were former circumcisors who had abandoned their practice and were now preaching to the communities the error of their ways.

The conference adopted a Common Agenda for Action and concluded that the fight against FGM called for a concerted and coordinated approach with periodic consultation and exchange of information between all those involved in its eradication, including Parliamentarians. It also endorsed the role of advocacy and lobbying to influence policy within Governments at regional, national and international levels.

The common agenda for years 2003 to 2010 comprises 11 objectives and aims to:

- (a) Determine, by means of operational research, the extent and nature of female genital mutilation for purposes of targeted intervention;
- (b) Produce information, education and communication brochures appropriate for the campaign against female genital mutilation;

- (c) Establish training and information campaigns for the groups concerned;
- (d) Organise special programmes for religious leaders;
- (e) Encourage young people to be heavily involved in the process of eradicating female genital mutilation;
- (f) Organise training programmes for information and media professionals;
- (g) Establish retraining programmes for health professionals;
- (h) Identify viable alternatives for former excisers;
- (i) Conduct awareness-raising campaigns among decision makers and facilitate the identification and adoption of laws against female genital mutilation;
- (j) Strengthen cooperation between the government departments concerned, the World Health Organisation, the specialised agencies of the United Nations and other bodies with a view to adopting a comprehensive approach towards the elimination of female genital mutilation;
- (k) Provide assistance and advice to the victims of female genital mutilation.

Also, the 6 February was declared an International Day on Zero Tolerance to FGM.

The target is to eliminate FGM totally by 2010.

I believe that Governments, civil servants and Parliamentarians, male and female, must work together if we are to eradicate FGM. We must give encouragement and assist our international colleagues to make FGM illegal, wherever it is practised. I congratulate those which have already done so, for example, Burkina Faso, where they passed a law declaring FGM illegal in November 1996 and set up a national committee to combat the practice. We must support educational programmes and ensure that adequate funding can be found for awareness projects.

On 11 July 2003, at the second summit of the African Union in Maputo, Mozambique, the African Union adopted the Protocol on the Rights of Women in Africa, a supplementary protocol to the African Charter on Human and Peoples' Rights. It has been seen as a significant step in the effort to promote and ensure respect for the rights of African women.

The Protocol requires African governments to eliminate all forms of discrimination and violence against women in Africa and to promote equality between women and men. It commits governments, if they have not already done so, to include in their national constitutions and other legislative instruments these fundamental principles and ensure their effective implementation.

In addition, it obligates them to integrate a gender perspective in their policy decisions, legislation, development plans, and activities, and to ensure the overall well-being of women. The Protocol will enter into force after fifteen states have ratified.

In Mexico City, in April this year, the Inter-Parliamentary Union, in conjunction with UNICEF launched a handbook for Parliamentarians at this year's Annual Inter-Parliamentary Conference. Within this book, of course, is featured Female Genital Mutilation and recommendations and strategies are outlined for Parliamentarians in order to eradicate Female Genital Mutilation throughout the world.

We are now beginning to achieve our objectives. I am pleased to say that we are in the process of organising a Parliamentary Conference to take place early next year in Africa, where we can bring together MPs, religious and traditional leaders, NGOs and former practitioners and others. This Conference will be a major step forward in persuading national governments to take action against this abhorrent practice.

So I and other like-minded Parliamentarians are doing our bit on an international basis to eradicate FGM.

We must continue the fight until we have achieved our goal of preventing young girls and women from violation and suffering.

Only our determination, our voices and our actions will establish their rights and remove health risks. I trust that Ann Clwyd's Act, - an extension of my Act, - will provide us with a further step forward along the long road to halt the violation of the rights of children and women.

We have had a very constructive debate.

I should like to place on record my sincere thanks to Sarah McCulloch and her team for organising today's conference and for making it such an interesting and productive event. We are most grateful to them for all their hard work.

I am sure that our findings today will make impact and I think we should all demonstrate our deep appreciation to all those involved in making this Conference a success, including our speakers.

I should also like to thank all of you for attending this Conference, demonstrating your commitment to action. We have all learned something from each other.

I shall now hand over to Sarah, who will bring our Conference to a close.

**FEMALE GENITAL MUTILATION CONFERENCE
LONDON – THURSDAY, 13 MAY 2004**

**Speech by Mrs Amina Ahmed
Family Support Worker, Agency for Culture and Change Management**

My name is Amina Ahmed; I am a Development Family Support Worker, for Agency for Culture and Change Management.

I am from Somali where my father and other family members still live.
I am proud to be a Somali and I am proud of my heritage and culture.

We are a proud people who have many good strong values, but we have one practice. Female Genital Mutilation, which causes pain and long term suffering to girls and women. This practice has gone on for years, centuries and is a deeply rooted in the community's way of life.

In my own experience I remember I was playing with my friends enjoying a nice sunny day, when my friends suddenly turned against me and said they did not want to play with me because I was not done, or that I was unclean. I put pressure on my Mother to have myself done so I can be like my friends.

My Grandma and my Mother had often told me that one day I will be done to look like everyone else so I can get married and have children. I believed them since it was common for girls to be done.

One day, I remember I was wearing a beautiful colourful dress when my Mum called me, I was held by the strongest women who sat on my chest holding my legs, hands and leaving me breathless and motionless.

There was an old woman who was holding a small bag containing what I saw was dirty old scissors, sharp knives, sewing thread and thorns.

This woman was the circumciser and she had no medical training or experience and even her eye sight was not good. She cut me up, removed my clitoris and my precious genitals and put them in a bag and threw them away to be eaten by cats.

I remember the painful, harmful and deadly moments and I cried and screamed but could not escape. The scars, the pain and the health problems I suffered are still with me today and will never ever go away. This happened to every girl who went through it.

I could not escape and was told afterwards not to discuss what had happened to me, because was for my good, my secret, belief, culture and for the dignity of our future and my family. I was told that everyone had this done to them.

I realised FGM was rootless, baseless and had no benefit for the women nor their lives after leaving Somalia. When I found out that not girls are circumcised I started to ask questions to find out more about this culture which I had been told was part of my religion and yet other Moslem communities were not doing it!

Today, it is a different century and I am campaigning against FGM, whether it is done for dignity, belief, beauty or pleasure. I am fighting the practice to protect girls and women so they do not go through what I went through.

FGM is against the law, human rights and is violence against girls and women. I beg all of you here today to - Please and please let us work together and stop this practice. Talk to parents, community leaders and all those you feel can make a difference - just changing the attitude of one mother will save a whole generation.

I would like to call upon the government and those in power to provide the support and funding resources needed to help fight to eliminate the practice in the UK and abroad. I would like to request professionals not to shy away from raising issues or asking questions. It is the only way we can get the message across to communities who practice FGM.

I would like to thank our funders and everyone who supports us with our work and campaign towards the elimination of FGM. I also thank my colleagues for the courage braveness to standing up to the hostile community to continue the campaign.

Please take back the information and help us with our fight against FGM.

Thank you

Amina Ahmed

**FEMALE GENITAL MUTILATION CONFERENCE
LONDON – THURSDAY, 13 MAY 2004**

Diana Symonds
Legal and Human Rights

Slide 1

I've been asked to talk to you today about human rights and the law on Female Genital Mutilation. You might think that this is quite a different topic from those we have discussed so far this morning. But in fact I do not think I will be moving far from the messages of the previous speakers. The raising awareness of FGM; how prevalent and how harmful it is; the need to reach out to the practising communities; and the need for us all to work together; these are all important messages. But I am going to talk about a slightly different aspect of fight to eradicate FGM - the law itself.

The legal framework is the foundation for all the other work we have been discussing this morning. If we want to eradicate FGM and change society's attitudes towards it, then the first step should involve the law. We look to the law to set the boundaries of acceptable behaviour, and we look to law enforcement to make sure that we are all protected against harm and against violation of our rights. So it is important we get the law right, both nationally and internationally. And it is important that people know exactly what the law says and why.

Slide 2

Here is a quote which illustrates what we as a unit of the Home Office aim to achieve - clear well defined offences - and why we think that is important.

So what exactly does the law say, and what are we doing to make sure we have got it right?

Let us start with the bigger picture - what does the international law - the treaties and conventions which govern the relationship between countries - what does that say about FGM?

Slide 3

There are three major treaties which I would like to mention. The European Convention on Human Rights was first open for signature in 1950. It is the foundation of much of the international work on human rights and embodies some of the most important and basic rights. The Convention on the Elimination of all forms of Discrimination Against Women, commonly known as CEDAW has been open for signature since 1979. Finally the UN Convention on the Rights of the Child was first open for signature in 1989. The UK have signed and ratified all these Conventions, so it is worth us looking briefly at what they say and what bearing they have on the practice of FGM.

Slide 4

The European Convention on Human Rights was designed to protect human rights and fundamental freedoms and to maintain and promote the ideals and values of a democratic society. It deals with some of the most basic rights. It places an obligation on each signatory state to protect those within its jurisdiction from 'inhuman or degrading treatment or punishment.' I think we have heard enough today to persuade us that the practice of FGM is physically harmful, inhuman and degrading for those who undergo it. The Convention and Convention caselaw say nothing specific about FGM. However, States have a positive duty under the Convention to put in place "effective criminal law provisions to deter the commission of offences against the person".

Slide 5

The second Convention that I want to mention is the Convention on the Elimination of all forms of Discrimination Against Women. Its aim is straightforward - to eliminate discrimination in all its forms and manifestations. You may wonder how this can be relevant. FGM can only be performed on a girl or a woman, so where is the discrimination? Unlike male circumcision, FGM is not justified for any medical or religious purpose. Its only justification is in the subjugation of women - the denial to them of choice, health, freedom from pain, self respect and a proper place in society. The Convention aims to eliminate 'any distinction, exclusion or restriction which has the effect of impairing or nullifying the exercise by women ..of human rights and fundamental freedoms.... ' I mentioned earlier that one of the most fundamental freedoms is to be free from inhuman or degrading treatment. So this convention is very relevant.

Slide 6

Our third and final convention is the UN Convention on the Rights of the Child. The aim of the Convention is to protect children from discrimination, neglect and abuse. It requires states who are party to it to take 'all legislative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse...' And to take 'all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.'

Pretty clearly the practice of FGM is a form of physical abuse. We now know much more than we did in the past about the damage and suffering which FGM can cause. The immediate health consequences can include severe pain, haemorrhage, infection, or even death. The longer term consequences can include pelvic infections (which can cause infertility) painful sexual intercourse and sexual dysfunction. Women who have been mutilated may be twice as likely to die in childbirth and three or four times as likely to have stillborn children as those who have not been mutilated. Those are frightening statistics.

Article 24 of the Convention on the Rights of the Child calls on states to abolish traditional practices prejudicial to the health of children. This is a clear acknowledgement that some practices like FGM may have been going on for generations, and may be widely accepted and deeply ingrained in the behaviour of communities. But these practices are harmful, - prejudicial to the health of children - and communities should not force such practices on the young and defenceless.

Slide 7

Let us turn now to the position in the UK. As I think we were told earlier, female genital mutilation was probably never legal in this country; it would almost certainly constitute an offence against the person, and would have been an offence under the Offences Against the Person Act of 1861. The first time the practice was made explicitly illegal was in 1985 when Marion Roe MP introduced what became the Prohibition of Female Circumcision Act 1985.

Introducing that Act was a radical step at the time, and must have taken considerable courage and determination. The 1985 Act was one of the first pieces of legislation on female genital mutilation in the world. Many others of course followed, and the practice is now explicitly illegal in many countries. As well as bringing debate about FGM into the open and into the public forum, the legislation has led the way to major changes in attitude, both in the UK and worldwide. As we said before, legislation is not a complete answer, but it is the basis on which all our activities depend. So the 1985 Act is an important milestone.

In 2000 the All Party Parliamentary Group on Population, Development and Reproductive Health did a survey about FGM which explored the work being done by organisations in the UK and overseas. Their report made interesting reading. For example, they pointed out that there had been no prosecutions under the 1985 Act and the survey attempted to explore why this was. Amongst the main reasons cited was lack of awareness of the legislation, pressure from family and the wider community to remain silent, and the fear of being labelled racist or insensitive to other cultures.

There could be a variety of reasons, and combinations of reasons, for the lack of prosecutions. Child Protection Agencies always face a difficult dilemma with FGM. There may be little warning that a child is about to undergo the operation. And the parents often do not intend to harm the child. So the agencies do not want to over-react. Similarly the police would not want to punish otherwise loving parents for doing something which their culture and experience make them believe is right and necessary. But the fact that we have had no prosecutions under the Act does not necessarily mean that the Act is a failure. The Act underlines that as a society we believe it is unacceptable to perform or to facilitate FGM. And it allows us to prosecute someone if in future a case should warrant it.

Slide 8

Coming right up to date, the Parliamentary Group's recommendations were the spur and foundation for the 2003 Act. The Act updated and revised the 1985 Act, and came into force on 3 March this year. It is the usual practice to have a gap between Parliament passing an Act and its implementation. It allows some time to make sure the police and courts, and most of all the public, are aware of the new legislation before it comes into force.

The 2003 Act started as a Private Members Bill introduced by Ann Clwyd MP and supported by the Government. The change in the title of the legislation makes it clear that it is about female genital mutilation and not female circumcision. Of course, we are talking about the same procedure, but the change is not entirely cosmetic and irrelevant. It was one of the recommendations of the All-Party Parliamentary Group which I mentioned just now. 'Genital mutilation' describes the procedure in a way which make it clear that what is being done is harmful and unacceptable. And the change emphasises that there was no comparison between male and female circumcision.

The 2003 Act makes it an offence for the first time for UK nationals or permanent UK residents to carry out female genital mutilation abroad. It is also an offence for them to aid or abet the carrying out of female genital mutilation abroad, even in countries where the practice is legal. This is necessary because evidence gathered by the All Party Group suggested that in some practising communities people were evading the law by taking their daughters abroad to have this procedure performed. The new law closes that loophole. Some people wanted to make it an offence for anyone living here to perform FGM abroad, or aid and abet those carrying it out abroad. But this would have been too wide. By 'Permanent UK residents' we mean people who ordinarily live in this country without being subject under the immigration laws to any restriction on the period for which they may remain. The Act will therefore catch those with a substantial connection to the UK but not those who are here temporarily, for example foreign students or visitors.

It is unusual in international law terms for a State to take jurisdiction over acts committed abroad by its residents (permanent or otherwise) as well as its nationals unless required to do so by an international agreement. Particularly when that jurisdiction is taken with no requirement for the act to be illegal in the country where it is committed. The extent to which this Bill takes jurisdiction is arguably unprecedented.

To reflect the serious harm that female genital mutilation causes, the 2003 Act also increases the maximum penalty from 5 to 14 years' imprisonment. Some thought this was harsh. In reality very few people will get the maximum penalty for the offence. This is the same with any offence. Maximum penalties are set so that they are available for the most serious cases. But in most cases an offender is sentenced to much less than the maximum. But we need in this case to set the maximum penalty quite high to reflect the seriousness of the offence.

I want to stop there, because we have other speakers waiting. We have looked briefly at how international and national law have developed and how they might relate to FGM. And we have looked at the main provisions of the new Act. It has been warmly welcomed. It should lead to a greater awareness of the problem posed by FGM. Indeed, it has been one of the spurs for today's conference. And I hope it will be a foundation for continued positive work in the future.

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WOMANKIND WORLDWIDE

Maggie Baxter
Executive Director
Vision

The creation of a just, equitable and peaceful world in which women are equal partners with men in determining the values, direction and governance of their societies for the benefit of all

Mission

To enable women in developing countries to voice their concerns and claim their rights, and to work globally for policies and practices which promote gender equality

Strategic Aims

- To advance women's well being through political and civil participation
- To reduce violence against women
- To inform and influence policy and practice at local, regional and international levels

General Statistics**Estimated that:**

- 130 million girls/women worldwide have undergone FGM
- 2 million girls are at risk of undergoing some form of the procedure every year
- 6,000 girls/women undergo the procedure everyday
- 10% of women who have had FGM die from the short-term effects (haemorrhaging)
- 25% die from recurrent problems (urinary infection, childbirth complication)
- FGM doubles the chance of women dying in childbirth

FGM practice

- **Age range affected:** Most commonly between 4 and 8. (But also from shortly after birth to some time during the first pregnancy)
- **Performed by:** older women, a traditional midwife or healer, a barber, or a qualified midwife or doctor
- **Takes place in:** girl's home, relative/neighbours home, health centre, or if part of initiation at a ceremonial site.
- **Mutilation carried out using:** broken glass, a tin lid, scissors, a razor blade or other cutting implements

Factors perpetuating FGM practice

- FGM is a cultural practice deeply-rooted in many African traditions
- Practice often condoned by parents and family
- Private issue/domain/actors (domestic domain)
- Risk of human rights intervention being perceived as cultural imperialism

WOMANKIND's approach: a human rights issue

International framework

- 1993 UN Vienna declaration and platform for action
- CEDAW (Convention on the Elimination of all forms of Discrimination against Women)
- 1995 UN Beijing declaration and platform for action
- Convention on the Rights of the Child – Article 24
- African Charter on the Rights & Welfare of the Child

Support women in countries to

- End the practice
- Develop alternative rituals
- Campaign for resources for education, changing attitudes, provision of alternative livelihoods

East Africa Programme Objectives

- Support and develop grassroots programmes for women and their communities.
- Enhancing the capacity of women to change attitudes and participate in decision-making.
- Supporting, training and increasing the capacity of CBOs and NGOs working on women's rights.
- Strengthening networking, sharing experiences, information and strategies.

WOMANKIND's partners

Ethiopia

- Kembatta Women's Self Help Centre, Women's Association of Tigray, Integrated Community Educational & Development Association (ICEDA)

Sudan

- Babikir Badri Scientific Association for Women's Studies

WOMANKIND WOLDWIDE

Egypt

- Centre for Women's Rights, Care for Girls

WOMANKIND partners cont:**Kenya**

- Pokot Kiletat Women Group, Gender & Development Centre

Somalia

- Barako Family Health & Education Centre

Somaliland

- Save Somali Women & Children

Other

- Gem TV Ethiopia

WOMANKIND partners approach

- Raising public awareness, information & mass media campaigns, advocacy & campaigning
- Reproductive health programmes including mobile clinics and training around HIV/Aids, STDs
- Credit & savings schemes and alternative income generating schemes for circumcisers
- Rights education, understanding the law, monitoring violations
- Encouraging greater participation in decision making
- Training for local religious leaders and other community leaders
- Literacy and informal education programmes

Case Studies

- The Kembatta Women's Self-Help Centre
- The Sudan National Committee on Traditional Practices, Khartoum

Personnel Stories

Halimo Osman Suleiman

Sohra Ali Bullale

Final Comment

- Global connections and Diaspora communities

To enable women in developing countries to voice their concerns and claim their rights, and to work globally for policies and practices which promote gender equality

International framework

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- CEDAW (Convention on the Elimination of all forms of Discrimination against Women)•1995 UN Beijing declaration and platform for action
- Convention on the Rights of the Child – Article 24
- African Charter on the Rights & Welfare of the Child
- End the practice
- Develop alternative rituals
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EAST African campaign

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Kenya

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Somalia

- Barako Family Health & Education Centre

Somaliland

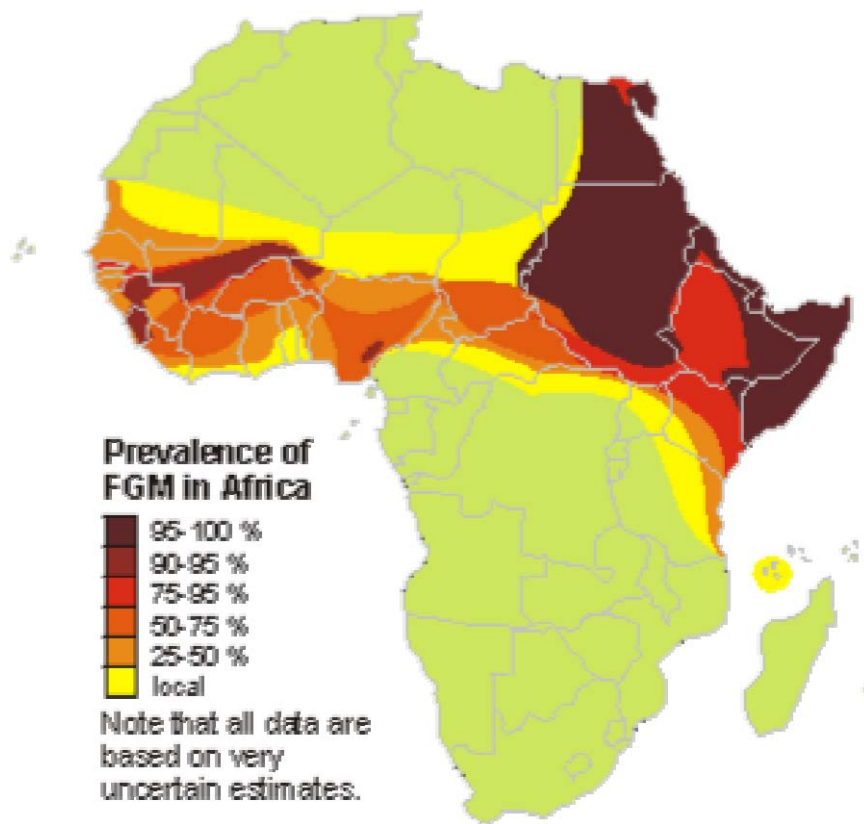
- Save Somali Women & Children

Other

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Womankind partnership approach

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**FEMALE GENITAL MUTILATION CONFERENCE
LONDON – THURSDAY, 13 MAY 2004****Comfort Momoh****Senior Midwife, FGM Specialist Guys and St Thomas Hospital****ASSESSING WOMEN**

- Individual care -having different needs
- Being aware and being informed
- Being sensitive and not superior
- Assessing individual needs - do not expect women to volunteer information about their FGM
- Assessing sexual and psychological needs

REFERRALS

- Pregnant-Important to identify at booking ask about general well being and if having related problems.
- Non-pregnant-can be referred by GP, other social/health or other professionals, self-referral or from organisations.

COUNSELLING

- First find out what current and previous problems are and deal with accordingly.
- Counsel re:
- Micturition
- Menstrual Flow
- Intercourse
- Give information about the law in Britain
- If FGM 3 counsel regarding: de-infibulation (reversal) by explaining the procedure, this is either done under local or general anaesthesia
- Give information about useful other agencies where she can get further help from.

SAMPLE QUESTIONS TO ASK CIRCUMCISED WOMEN

- I am aware that in some African countries, women are circumcised
- Have you been circumcised or closed?
- Do you have any problem passing urine or does it take you a long time to pass urine?
- Do you have any pain with menstruation?

BARRIERS TO SUCCESSFUL COMMUNICATION

- Language
- Patient and/or provider modesty
- Perceptual differences
- Professional-Patient-Family power dynamics
- The professional's sex

AIMS OF THE CLINIC

- To provide support, information/advice and counselling to women with circumcision and to offer surgical intervention (reversal) where appropriate.
- To provide synchronised services for women
- To provide support and education to the communities affected.
- To facilitate health promotion needs holistically.
- To network and refer women to other health/social professionals where necessary.
- To increase awareness of the practice among professionals
- To support work at grass roots level.

CONCLUSION

- It is the responsibility of all care professionals to protect future generation of women from the practice of FGM.
- Hence it is important to be aware of FGM and identify women with FGM during antenatal period (at booking) so that a plan of care can be arranged and agreed.
- As well as protecting children at risk.

ROLE OF PROFESSIONALS

- Be aware and informed
- Be sensitive and not superior
- Assessing individual needs
- Involving partners and families
- Involving and informing other care professionals (e.g child protection team).
- Providing continuous support at all time.

WORKSHOPS

How could the conference be improved?

- Working with Govt. in order met to totally eradicate physical examination of children by health visitors (in relation to FGM).
- Actual figures instead of estimate figures of area where the practice is carried out.
- More practical advice and service development.
- It is great.
- Probably needs to hold a forum for practitioners in international as well or balance it with more international perspectives.
- Sending letters before hand to state venue and time.
- Delegates could be more diligent in timekeeping – I felt that we were very rude in interrupting lectures.
- (Some) delegates encouraged to adhere to time keeping.
- Time management.
- Stalls of relevant organisation that can provide help, resources, training etc.
- More efficient use of mikes and audio-visual equipment.
- Input from males re: attitudes to wives, daughters, marriage ability, sexual life etc.
- Ground rules – time keeping, phase's etc – too many disturbances from other participants.
- Give information about setting up work shops within each hospital setting.
- Time keeping.
- Overall, very informative and excellent training on FGM. Good forum for raising, sharing and creating awareness.
- Reversal workshop demonstration.
- The conference could be improved by making it dear that delegates should arrive before 10.00am Baroness Scotland speech was disturbed in the first 15 minutes by late comers arriving and searching for seats.
- Time keeping could be improved. (Better control from chair)
- Too much emphasis/focus on the Somalia community – need to centre the debate on encompassing all of the African communities that are affected (especially during the workshop)
- Maybe a little more time allocated to workshop, as can get a lot of valuable info from these.

Has anything been missed out?

- Gender perspective – More about the integration of men into the question? Dealing with their issues such as immigration so that FGM is not of marginal importance in the lives of Somali women.
- There is not yet clear way/means/method to identify a child that has had FGM especially if no previous history of FGM in the family, as there is no more physical exam on children in relation to FGM.
- Approaches used in eliminating FGM.
 - No
 - No
 - None
 - No

- Can't put everything one needs to know in a day; but there was a good variety of areas covered in the time available.

Has anything been missed out? Continued

- Not that I know of opinions of community leaders-mother in-law, male leader, religious – 5 mins each, thought provokes, discussion instigators-advocates? Controversial opinion we'll face in practice from both sides of the fence.
- No
- Sexual health, sexuality, today image changes what is normal.
- Mental health issues
- We need to look at health promotion in schools, churches community organisations.
- Good lunch

What would you like to see as a result of today?

- That every health professional is working in partnership with others to reduce/eradicate this criminal act.
- FGM knowledge increased throughout the professions.
- This to be rolled on to schools and communities-giving children especially the knowledge and its implications-training all professionals.
- A follow up competence in a year's time to assess the impact of the New Act.
- A change in my history in AMC labour
- Better informed healthcare workers.
- More education in care of women in labour-in schools of midwifery (with FGM) training of midwives.
- Summary publication of key points in prominent, relevant journals.
- Establishment of a forum of key stakeholders who provide good practices.
- An update on the monitoring of the new law. Follow-up to Beijing platform for action.
- Well, its changed my practice, or at least influenced it already more GP's, teachers, police etc, widening the influence.
- Increased awareness of law to professionals and public – increased confidence of practitioners.
- Improved networking.
- I have learnt a lot – especially legal issues. These need to be disseminated much more widely.
- More FGM in midwife education.
- Hospital education for midwives.
- More awareness in communities schools in fact all professionals dealing with protection of children.
- More links with statutory organisations, so that we can all work together to protect children.
- Training in all areas on a multi professional scale, there should be health promotion delivered in schools as part of PHSE.
- Charges within each hospital to reflect what was discussed today.
- More lectures/conferences about FGM. Access to school for children (girls) to be made aware of FGM.

- FGM given a higher profile nationally.
- MP to discuss this issue in parliament.
- Participate in the prevention of FGM whenever faced with this in future.
- Recommendations taken forward.
- Greater awareness.
- Strategic thing to encourage joint working on FGM.
- Health care professionals taking what learnt. Disseminating this widely and acting to influence change in their workplace.

Did the conference meet your expectations:-

Yes 33 No 1

Why

- I hoped there would be more strategy advice and service development.
- Exceeded then well organised presented.
- Exceptional day. Extremely enlightening & informative.
- The afternoon workshop developed ideas for dissemination but could have been more needs based.
- Didn't expect such high profile input, MP's etc and such a wide or broadly based group in the 'audience' to draw knowledge from. So better than expected really.
- It was very informative and I am more aware of FGM and can spread this information.
- I think it's very positive and education is the way forward. E-mailing GP's and people community settings to inform them about conference and workshops.
- Emphasis on importance of the work done so far and the need for everyone involved, to work together.

Any further comments?

- It was a very enjoyable and informative day extremely well organised one of the best conferences I have ever attended.
- Could it be possible to have a yearly update on issues on FGM and practical steps to move it further.
- My knowledge of FGM was limited believe the conference I feel that I am not confident to feedback to my team.
- This information to be advertised especially the Act 2003 – to be on media, newspapers, if possible included on TV soaps as well that nationally everyone can be aware.
- It is very well organised, led by knowledgeable experts participatory. Well done.
- Well done.
- I hope this topic will be included in mandatory study days in instituted e.g. hospitals, schools.
- Thank you – Excellent venue, excellent, catering and handouts.
- Prosecutions needs to happen as possibly the most effective way to reduce the practice of FGM.
- People generally remained engaged throughout. Excellent confidence. Congratulations.
- A useful day need to follow up with some action.

- Thank you, superb day, well-organised and planned, friendly and open-helpful organisers. Highly recommended.
- I found the conference very useful and informative. A good range of speakers-thanks.
- PM chair's remarks superfluous repeated what had been said before.
- I really enjoyed this day very interesting speaker and good involvement of audience.
- With colleagues in my area since this is not talked about at all in this area.

Any further comments? Continued

- Really informative-will impact on practice-lots of info to feedback to colleagues.
- Well done-presentation of packs, illustrations-substance good.
- As above. We need to treat parents with sensitivity where they resist change and not treat them as criminals.
- Informing them of changes in the law and everyone's obligation to work towards eradicating this problem is the way forward.
- Plentiful questions asked time for discussion is short (far too short) for the topic (legal & child protection settings)
- More informed able the after-care (post-up) supports that's available at specialist centres & agencies until now refer for support & send leaflets to patients should they fail to attend follow-ups. Excellent chair by Mario Roe and congratulate and thank her for her dedication and contribution.
- Adwoa's presentation was excellent punctuated by H – kept everyone's attention just before lunch.
- I would like to be informed of future conferences. Thank you.
- To many speakers could have had more time in different workshops.
- The presence of Marion Roe and Christine McCafferty served to highlight the importance & senior nature of the issue.

WORKSHOPS
Primary Care Settings Workshop
Thursday 13 May 2004, New Hunts House, London

Chaired by: Harry Gordon Facilitator: Comfort Momoh

Problems?

- Lack of understanding
- Language barrier
- Failure to identify FGM
- Imp to assess/examine the perineum.

Reversal @ 2 weeks – if early – can have implication -Not after 34 weeks.

Questions asked and some answers

- Healing – take about a week
- Kelloids
- What anaesthetics – should be on patients’ preference
- One stop clinic
- What stage do you reverse during labour? Early!!!
- What instrument do you use for reversal ---- scissors etc
- Cyst – If a woman comes in labour with a big cyst what do you do? – It depends “In general deal with it outside pregnancy”
- What has been done to inform GP’s
- Is FGM incorporated in M/W training?
- Training materials of reversals – Difficulty in getting consent.
- Issues around travelling to Africa or certain European countries (i.e. Holland)
- Family planning issues
- DNA – Beware of other problems that they may have.
- Big gap in health care services – nothing for men or children.
- Mobilising men (Committing suicide, not feeling important anymore, unable to cope)
- Eating “Grant”? Strong effects –tranquillising effect.
- Do not use male relative as interpreter.

WORKSHOPS
FGM & Child Protection Settings Workshop
Thursday 13 May 2004, New Hunts House, London

Chaired by: Adwoa Kluitse Facilitator: Anne

How do we follow up Child Protection cases?

- Role of health visitors and genital mutilation/examinations on babies.
- Social services to work in partnership with communities
- Put resources into communities.
- Midwives to role FGM on discharge summary.
- DSS to be aware of practising communities in their areas.
- Health Visitors feel concerned that they may lose their clients.
- The law implications for confidentiality – action.
- Prosecutions can be done no matter how old female is.
- Refer female for counselling
- FGM + schools must be fully aware of FGM issues and communities
- Criminal justice system + FGM.
- Interpreters: FGM trained + female.

WORKSHOPS
Community Settings Workshop
Thursday 13 May 2004, New Hunts House, London

Chaired by: Marion Roe MP Facilitators: Julie Mather and Abigail Dawes

1. What things need to be in place to ensure community education & services?

- Open communication
- Developing trust within the communities
- Involve communities (at all levels)
- “FGM Aware” / culturally aware
- Funding
- Correct use of terminology
- Effective partnerships
- Credibility / purpose
- Work with community leaders / Religious leaders
- Be respectful of other communities.

2. What things could go wrong or be a problem?

- Lack of awareness / support
- Cultural ignorance in not wanting to raise the issue
- Fear of ‘upsetting’ community
- Imbalance between education and income and ritual
- Language barrier – use ‘trusted’ interpreters
- Political barriers
- Community educated about interpreters.
- Poor planning
- Cross cultural communications
- Identity ‘Gate keepers’
- Fear from accessing services
- Double standards
- Time limited funding
- Need to identify with culture.

3. Who can help you gain community trust?

- Local MP’s
- Male community leaders
- Interpreters
- Faith leaders

- Link in with agencies
- Acknowledge communities are 'helping' themselves
- Other Organisations
- Mother-in-law / matriarchal figures in families
- GP's
- Support of Primary Care Trust
- Give community time to change
- Empathy

4. What way can you think of to approach FGM in a culturally appropriate way?

- Women's health days – what is important to community *Steering Groups
- Use of arts
- Cross gender
- Training staff – Don't be afraid to approach the subject
- Women only groups
- Community groups – to develop resources
- Peers educators
- Culturally sensitive media
- Teachers

Community working key points: Partnership between agencies

- Involving the community from the beginning and keep on consulting them.
- Training all professionals about FGM & cultural awareness.
- Support needs to come from the top levels
- Continued support for professionals & the community.
- Funding
- Know & use well trained interpreters
- Sympathetic press
- Creative & innovative commitment
- Mainstreaming – 50 subjects raised from labour, through midwives, health visitors & schools & GP's.