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FEMALE GENITAL MUTILATION AND ITS EFFECTS ON WOMEN

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INNITIALS

ECOSOC- United Nations Economic and Social Council

CEDAW- Convention on the Elimination of Discrimination Against Women

FGM – Female Genital Mutilation

IAC - Inter-African Committee on Traditional Practices

IOM – International Organization for Migration

NGO – Non-Governmental Organization

UN – United Nations

UNESCO- United Nations Educational, Scientific and Cultural Organization

UNFPA- United Nations Population Fund

UNICEF – United Nations International Childrens' Emergency Fund

UNFPA – United Nations Population Fund

WHO – World Health Organization

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1. INTRODUCTION

Female Genital Mutilation (FGM) is any kind of procedure that comprises the removal of the external female genitalia or another injury to the female genital organs for non-medical reasons. This practice has severe negative consequences that vary from health and physiological trauma to the discrimination of women and girls all around the world. It has been internationally recognized as a violation of individuals' health, integrity, and human rights, and the 6th of February has been marked as the International Day of Zero Tolerance for Female Genital Mutilation. For these reasons, the UN has deemed it a harmful practice that must be eliminated to achieve The Sustainable Development Goal number 5 of the United Nations of obtaining gender equality and empowering all women and girls (United Nations, 2022).

FGM is a reality that has affected individuals for many years. Millions of women and girls have undergone this practice, and according to the End FGM European Network, if no action is taken, an estimated sixty-eight million girls will be in danger of facing FGM by 2030 (End FGM European Network, 2020). Consequently, it is necessary to find effective strategies that will contribute to the abolition of this practice.

There are many women who are aware of the risks of FGM, either because they have been victims or because they are against this practice, which has led to an increase in the fight to criminalize anyone who performs it on any woman or girl whatever the reason for doing so might be. Furthermore, feminist activists have pointed out FGM as a form of violence and oppression against women that must end to achieve equality between the sexes. However, in many places, the violation of the integrity of a woman's body is socially accepted and justified because it is a tradition that is part of their culture. Individuals who support this practice and voluntarily submit to it claim that no one should interfere in their autonomous decisions, which has led to a cultural debate over who should have the authority to decide over the legalization or criminalization of FGM.

2. TERMINOLOGY

The terminology employed to refer to Female Genital Mutilation is crucial because it can reflect the severity and harmfulness of the practice and can aid in raising awareness and

efforts to prevent and end this practice. In addition, the correct use of terminology can differentiate it from other traditional practices that may have fewer harmful effects and discourage possible cultural or religious justifications for the practice. However, it is also important to use culturally appropriate and respectful language that avoids stigmatization or demonization of individuals or communities affected by this issue while promoting gender equality and human rights.

Consequently, since there are many terms that have been used to refer to this practice, there has been a debate over which term best describes it and is least harmful to victims. In the past, the term "female circumcision" was commonly used by activists as it was considered a correct translation of the term used by some practicing groups. However, the term "circumcision" raised concerns because it could imply an equivalence to male circumcision, which has nothing to do with the issue at hand, as will be explained further in this essay. It was in the late 1970s that the term "female genital mutilation" gained popularity and was officially adopted by international bodies such as the World Health Organization in the late 1990s. Nevertheless, some deemed this term as condemnatory towards practicing communities, as the term "mutilation" could suggest a deliberate purpose to harm individuals and some opposed it by stating that in many cultures parents subject their daughters to the procedure because they truly think that it is beneficial for their daughters and as part of their culture, rather than with the intention of causing them harm. This is why some scholars believed that "female genital cutting" was a more objective term that should be employed (Cloward, 2016, pp. 23-25). However, while this term has gained prevalence among academics, it is not that popular with activists, which is why in line with the author Karisa Cloward, I will use the term "Female Genital Mutilation" or FGM for short throughout this essay to refer to this practice, as I believe that it is the one that will draw more attention from the public and best reflects the negative aspects it causes.

3. THEORETICAL FRAMEWORK

The theoretical framework for FGM can be drawn from a variety of disciplines which have studied this issue throughout the years, such as medical and health scientists who have studied the anatomical, physiological, and health consequences of FGM, including research on the prevalence, distribution, and determinants of it; scholars from social

sciences disciplines, such as anthropology, sociology, and psychology, who have studied the social, cultural, and gender dynamics of FGM; religious scholars who have studied the cultural and social aspects of the practice in certain contexts, for example scholars of Islamic studies have examined the practice of FGM among Muslim communities, or scholars of African traditional religions have studied the role of religion in shaping FGM practices in certain African societies; human rights and legal disciplines scholars who have studied the legal frameworks, policies, and interventions aimed at addressing FGM; and scholars from gender studies and feminist perspectives have examined it as a gendered form of violence against women and girls. While there are many scholars from different disciplines who have created literature on this issue, the following are the most pertinent examples to be highlighted for this paper.

Firstly, there are the anthropologists Ylva Hernlund, who focuses on sociocultural anthropology, and Bettina Shell-Duncan, who focuses on biocultural anthropology. They were members of the Society for Applied Anthropology, and after its annual meeting they decided to gather to discuss their different perspectives of the issue and finally committed to study the topic. They did this in a multidisciplinary manner by compiling points of view of different scholars to create the book called “Female “Circumcision” in Africa: Culture, Controversy and Change” (2000). Among them is Lynn M. Thomas, historian of politics and gender in East and Southern Africa who has undergone thorough research on FGM in Africa and wrote a chapter for this book called "Ngatiana (I Will Circumcise Myself): Lessons from Colonial Campaigns to Ban Excision in Meru, Kenya” (pp.129-132). In this chapter she gathers information regarding the first religious leaders who began opposition against FGM in Kenya. It occurred during the early 20th century, when Protestant missionaries from the Church of Scotland Mission (CSM) in British East Africa (present-day Kenya), campaigned against FGM which was a greatly rooted practice among the Kikuyu ethnic group in the region and seen as an important cultural label. Starting in 1925, several missionary churches, including the CSM, declared FGM as prohibited for African Christians, and those who practiced it would be banned from the community, turning FGM into a focal point of the Kenyan independence movement. Recompilations such as this one is crucial in understanding how FGM was not supported as a religious tradition by some communities (Hernlund, Shell-Duncan, 200).

Secondly, research conducted by members of UNICEF, such as Claudia Cappa in a report called "Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change" (2013), have gathered very important information regarding medical and health scientists who began to denounce the negative health consequences of this practice, starting off from the first known campaign against FGM in the 1920s in Egypt, where The Egyptian Society of Physicians released a proclamation that detailed its adverse health consequences and gained support from the Ministry of Health, the press, and religious scholars and led many other medical scholars to investigate the health consequences of FGM (Cappa, 2013).

In this direction, another important theory is the one that was created by authors Ngianga-Bakwin Kandala and Paul Nzinga Komba in their book called "Female Genital Mutilation around The World: Analysis of Medical Aspects, Law and Practice" (2018). It is the first book to offer a comprehensive global synthesis of evidence on the prevalence of FGM, specifically in relation to medical and legal aspects of the issue. It argues that traditional statistical methods used to measure the decline in prevalence of FGM worldwide may not fully capture regional and subregional variations and proposes the use of spatial analysis methods. It also discusses international and regional human rights remedies for victims of FGM and the importance of access to health care for repairing the physical and psychological damage caused by it. It aims to contribute to the literature by examining household data on the prevalence of FGM worldwide and building an evidential basis for effective legal action against governments (Kandala, Komba, 2018).

Overall, the book offers an up-to-date and comprehensive analysis of the prevalence, medical interventions, and legal aspects of FGM, in a global, national, and supranational context, and aims to assist professionals in advising and representing victims of FGM in legal proceedings, and is based on previous publications on FGM which include data and statistics from the institutions of UNICEF in its report "Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change " (2013) and UNFPA in its report of "Demographic perspectives on female genital mutilation" (2015) and of scholar Shell-Duncan et al. in their report of "A State-of-art synthesis of female genital mutilation/cutting: What do we know now? Evidence to end FGM/C: Research to help women thrive". This book also acknowledges other publications that have examined the legal aspects of FGM such as the interviews conducted by scholar Skaine (2005) in

Tanzania to highlight the psychosexual issues related to FGM, offering valuable insights for birth caregivers, or scholars Rahman and Toubia (2000) who have also compiled significant information on international and regional standards aimed at protecting human rights and addressing FGM in their book published in the year 2000 called: “Female genital mutilation: A guide to laws and policies worldwide” (Kandala, Komba, 2018).

Thirdly, the feminist work conducted over the years of this issue holds an important part of its literature. Feminists began focusing on this issue in the 70s and two of the most remarkable feminist authors will be highlighted. Firstly, there is Nawal El Saadawi, an Egyptian physician and feminist, who voiced her criticism of FGM in her book “Women and Sex” (Saadawi, 1972), and in the one called “The Hidden Face of Eve: Women in the Arab World” (Saadawi,1980), in which she dedicated a chapter titled "The Circumcision of Girls" to describe her personal experience of undergoing clitoridectomy. Secondly, there is the author Rose Oldfield Hayes an American social scientist and first female scholar to publish a detailed account of FGM in 1975 in her article “Female Genital Mutilation, Fertility Control, Women's Roles, and the Patrilineage in Modern Sudan: A Functional Analysis", she was the first to officially employ the term “mutilation” and brought the issue to a larger academic attention (Hayes, 1975).

Finally, there is Mary Nyangweso, author of the book “Female Genital Cutting in Industrialized Countries: Mutilation or Cultural Tradition” which fills a significant gap in the academic literature by examining the persistence of FGM in industrialized societies and by bringing attention to the voices of women and girls affected by this practice. Drawing on theoretical perspectives such as cultural relativism, moral universalism, diffusion of innovations theory, and empowerment theory, the study transcends ethnocentric and imperialist approaches by incorporating women's agency and experiences into the discourse. The study utilizes a mixed-methods approach, including quantitative and qualitative analysis, and involves a sample of 113 participants from various ethnic communities in industrialized countries. The findings confirm the occurrence of FGM among immigrant communities in industrialized countries, with some parents citing cultural rights and identity as reasons for demanding less dangerous forms of the practice. Finally, the study enhances the need for intervention programs that are tailored to the specific cultural contexts and experiences of immigrant girls and women (Nyangweso, 2014).

Consequently, the theoretical framework that is used to study the issue FGM recognizes the need for a multifaced approach that addresses these complex factors while also prioritizing the health, safety, and autonomy of women and girls, which is why this essay will take into account the cultural, social, psychological, and human rights dimensions of the practice in order to develop effective interventions and policies to prevent and address this issue. In doing so, the information analyzed will be derived from the main international bodies that have carried out studies on the case in question, in addition to the main authors and activists concerning the subject.

4. OBJECTIVES

I have selected this topic for my final degree essay in order to determine if it is possible to justify the continuance of this practice without it being punishable by law in those communities who choose to follow this tradition as a part of their culture.

For the purpose of answering this research question in an informed matter, the objectives that have been established are to examine the prevalence and types of FGM is a global context, as well as in the target country of Spain, to identify the social and cultural factors that contribute to the persistence of this practice; to assess the physical, psychological, and sexual health consequences of FGM for women and girls; to study the different approaches that diverse disciplines have had towards the issue, from international human rights law to cultural relativism, and the individual experiences of members of communities where FGM persist; and finally, to identify effective strategies and interventions for preventing it and supporting those who have undergone the procedure.

The hypothesizes that have been established are that the prevalence of FGM is higher in communities where it is deeply rooted in tradition and culture, and intersectionality factors such as socioeconomic status, age, and religion can affect the continuation of this practice in different communities. Specifically in Spain, the prevalence of FGM is higher among immigrant communities who do not have proper access to educational and health resources. Moreover, it is a practice that has negative physical and psychological consequences for women and girls, which perpetuate gender inequality and violate their human rights. Therefore, cultural relativism cannot justify the continuance of this practice and the correct term that should be employed to refer to this practice is “genital

mutilation", and the enforcement of legal prohibitions on FGM is necessary to effectively put an end to it and protect the rights of women and girls. Finally, community-based education programs and targeted interventions that engage local leaders and promote alternative cultural practices can effectively reduce the incidence of FGM in Spain and other parts of the world where it still prevails.

5. METHODOLOGY

For this final degree project, a qualitative research method was employed to gain a deeper understanding of the complex social and cultural factors that contribute to the continuation of FGM and the approaches that have existed towards it of different disciplines. Specifically, the research has included document analysis of reports and articles written by experts in this field, from survivors of FGM to scholars of different specializations, such as doctors, historians, feminists, social workers and human rights activists who have contributed to the creation of a solid literature of this issue over the years as it has recently become a focus point for many scholars. Moreover, legal documents such as resolutions, recommendations and protocols drafted by international bodies and the legislators of Spain have been examined to assess the legal approach of the international community and of the Spanish country of this issue and how these bodies proceed in their goal of eradicating this practice. Moreover, these documents have provided insights into the prevalence of this practice in different regions and information about which age groups are most affected by it as well as the different types of FGM that have been classified by the extent and type of cutting performed, and the cultural and social justifications individuals may have for this practice.

On the other hand, case studies have been used to examine individual experiences of communities were FGM prevails, such as in the country of Kenya, to learn the social, cultural and psychological impacts, the context in which it is performed, and how the social pressures or cultural beliefs have led to the evolution of this practice. Additionally, specific interviews conducted by bodies such as the United Nations and the press have been analyzed as they have recorded one-on-one interviews with women who have undergone the procedure and are from communities where this practice prevails. In these interviews they have shared their individual experiences, attitudes, and beliefs on the matter which have also contributed to the assessment of the social, cultural, and

psychological impacts of the practice. This has been a crucial part of the investigation as learning first-hand accounts from survivors can help humanize the issue and make it more relatable to individuals who have never experienced FGM, as well as motivate them to take action against it.

6. ORIGINS AND EVOLUTION OF FGM

Female genital mutilation has been practiced for centuries, which is why its origins can be hard to determine. Nonetheless, thanks to historical and anthropological studies there is evidence that it emerged even before Islam or Christianity was established, dating back to the fifth-century BC around the regions of Egypt and the west coast of the Red Sea. There have been findings of Egyptian mummies of women whose genitalia appear to have been mutilated and of a Greek papyrus from 163 BC held in a British Museum that describes how groups of people from that area followed this tradition (28 Too Many 2013)[1].

Moreover, its origins have been associated with slavery. Many slave owners on the Red Sea Route located between Asia and Africa would mutilate women to prevent them from becoming pregnant or to preserve their chastity. This has led researchers to believe that there is a connection between slavery and the spread of FGM throughout many ethnic groups in different territories who have conducted the practice up to this day. Additionally, it has been proven that women from ethnic groups in Eastern Africa whose ancestors were sold in the slave trade back then are more likely to be subjected to this practice (EDI, 2020)[2].

Nowadays, FGM is a practice that can be found in the roots of many diverse cultures, and because of institutions such as The Women Stats Project, or the UN and UNICEF, which have conducted studies and collected data of the issue, the geographical distribution of this practice can be found. The results show that most women suffering from FGM are located in 30 countries in Africa and the Middle East. However, this practice is most

[1] 28 Too Many is a campaign founded by Ann-Marie Willson in 2010 to study and aid the fight to end FGM in Africa. Learn more at https://www.28toomany.org/about-us/.
[2] Economic and Development Institutions (EDI) was set in motion in 2015 and funded by the United Kingdom's Foreign, Commonwealth & Development Office with the purpose of conducting collaborative research on institutional changes in economic growth and development. See more at https://edi.opml.co.uk/.

extensively conducted in countries such as Ethiopia, Kenya, Tanzania, Uganda, and Somalia (the country where most women have been cut in the world, 98%).Nonetheless, it is also practiced in most parts of the world, like in countries of Asia, Latin America, Western Europe, North America, and Australia, where immigrants from African ethnic groups have continued this practice (Ontiveros, 2019)[3].

On another note, FGM procedures have been classified into four different groups which I will briefly describe: type I, also known as clitoridectomy, which is the partial or total removal of the external part of the clitoris and/or its prepuce; type II, also known as excision, which is when the external part of the clitoris and the labia minora are partially or totally removed; type III, known as infibulation, which is the narrowing of the vaginal orifice with creation of a covering seal, only leaving a small opening for urinal and menstruation discharge; and type IV, which includes all other forms of mutilation for non-medical reasons (End FGM European Network, 2022). Moreover, the type of procedure that is performed depends on the ethnicity and culture the women and girls belong to, but it is estimated that 90% of them have undergone types I, II, and IV, and only 10% of type III (WHO, 2008).

Moreover, many international bodies have conducted joint research to create an interagency statement on FGM which collects data from surveys performed on women and girls aged between 15 and 49 years which show that between 100 and 140 million women around the world have been submitted to FGM. Additionally, the studies show that this procedure is mostly carried out on women in African countries, especially on girls between the ages of 0 and 15 years. They calculated that around 3 million girls in this continent risk being submitted to this practice every year (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, 2008, pp. 4-5)[4].

Nonetheless, these numbers are not as exact as one might think as they are only an estimation. It is complicated to obtain precise numbers of victims because for many

[3] *See* Maps of the Woman Statistics Project of the prevalence of FGM around the world in Figure A, Appendix.

[4] *See* Map of Prevalence of Female Genital Mutilation in Africa and Yemen (women aged 15-49) in Figure C, Appendix.

individuals from cultures that follow this practice, speaking about FGM is considered a "taboo" and many women and girls are intimidated to come forward with their experiences due to the judgment they can receive from their family members and from people who do not understand their traditions, or because of fear of the consequences it could have on their families if they spoke up about it in countries where FGM has been criminalized, as perpetrators, who are usually the individuals' family members, can face legal consequences (Ontiveros, 2019) .

Additionally, even though most world leaders and the United Nations have stated that FGM violates human rights and have implemented methods to eliminate it, there are many gaps in legislations that criminalize FGM, especially in African countries where there is no effective enforcement of the law and offenders are generally not prosecuted (28 Too Many, 2018). More specifically, 24 of the 29 countries in Africa and the Middle East have made it illegal to carry out this practice, however, this has had little impact on the goal of putting an end to this practice, as it is still performed extensively and individuals who suffer from it hardly denounce it (Ontiveros, 2019).

On the other hand, the significance behind the practice also varies from one ethnicity to another. For some communities, it is a social convention accepted by families and imposed on children to ensure chastity, for others it symbolizes a celebration of womanhood or adulthood, and for others, it is performed as a birth ritual. Additionally, some communities carry it out to express what sexual behavior is considered appropriate, and others are influenced by the cultural beliefs of power structures, such as local authorities or religious leaders. Furthermore, the age at which women and girls submit to the practice also varies, in some cultures it is performed before menstruation begins, in others before they get married, or during or after pregnancy (28 Too Many, 2013).

Moreover, the country they live in, and their socio-economic background also play a role in finding the way the practice is performed. For example, in countries where it is illegal, it is conducted secretively, in contrast with countries where it is legal and can be performed in sanitary centers. In these cases, a traditional practitioner is usually in charge of the procedure and uses a sharp object such as a knife, razor blade, or broken glass to carry it out, and the wound is cleaned by using different means, such as lemon juice, herbs, or cow excrement. However, for type III procedures women and girls usually have

their legs tied together until the wound has cicatrized, a process that usually lasts between two and four weeks (Cloward, 2016, pp. 113-121).

7. CONSEQUENCES

Once the context and background of the issue have been established, it is important to explain the consequences of FGM. There are several negative aspects that must not be overlooked, such as all the severe health and psychological effects that put the lives of women and girls at risk. Moreover, their human rights and integrity are targeted.

Firstly, causing injury or removing genital tissue that is healthy for non-medical reasons alters the natural course of bodily functions and can lead to immediate and even long-term physical and psychological consequences. FGM has no benefit for the health of women and girls and there is an extensive list of possible outcomes which depend on the type of mutilation that is practiced (type III being the most dangerous), and the conditions under which it is performed. If it is conducted in unhealthy, poorly sanitized, and precarious environments with surgical materials that are poorly sterilized, the outcomes and complications that can arise could be more adverse. However, in many countries it is conducted by trained professionals; according to UNICEF an estimated 1 in 4 women were cut by health professionals. Specifically, 34% of girls between 15 and 19 years of age and 16% of women between the ages of 45 and 49 underwent medicalized FGM. Nonetheless, this does not imply that if performed under these circumstances the process can be safe, these girls still risk the same consequences (UNICEF, 2020).

Immediate and short-term physical consequences of FGM encompass intense pain and discomfort; bleeding that can end in hemorrhagic shock; complications or pain when releasing urine; numerous infections, such as infection of the bloodstream (septicemia); wounds to nearby tissues; and most importantly, it can cause death. After the procedure is completed women and girls face more pain until the wound is healed and risk further infections if it does not cicatrize properly. Additionally, the period of recovery also varies, but it can last for over a month (28 Too Many, 2013).

Long-term physical consequences include chronic infections of the pelvis; persistent pain; forming of superfluous scar tissue; a higher risk of contracting blood and sexually

transmitted diseases, like HIV; complications and pain when menstruating; damage of the reproductive system leading to infertility or health complications when childbearing for the mother and the child (who also risks death); loss of sexual satisfaction or painful sexual intercourse; and the necessity of new surgical interventions to correct the prior mutilation to facilitate sexual relations or childbirth (Reisel, Creighton, 2015, pp. 48-51).

Additionally, there are many psychological consequences for women and girls throughout the entire process. Firstly, many do not voluntarily submit to the procedure, it is usually their parents who force them into it without preparing them for the act nor explaining the possible outcomes it can have for their health. Furthermore, when the procedure is being performed girls are held or tied down and it is mostly done without the use of anesthesia. This makes it a very traumatic and stressful experience. Furthermore, psychologists have studied the long-term effects these individuals are subjected to, and the possible outcomes can be post-traumatic stress disorder, anxiety, depression and loss of identity; cultural shock if they are exposed to cultures in which this practice is looked down on; and sense of regret, humiliation, and discomfort towards themselves and their families (28 Too Many, 2016).

7.1 CONNECTION BETWEEN FGM AND MIGRATION

FGM and migration are connected in complex ways. Firstly, migration is one of the main causes which has led to the expansion of this practice to Western countries where these traditions were not followed in the past. Instead, the scarce statistical data available of the prevalence of this practice in these countries reveal that it is immigrant communities the ones who continue to follow the cultural traditions from their predecessors in the countries they have immigrated to, and even influence their descendants to continue with the practice. This is because it is a deeply rooted tradition in some cultures, so many individuals voluntarily choose to continue this tradition, while others may feel pressured by their families to uphold this practice. Nonetheless, this poses a big issue for these communities since in many cases these practices have been deemed illegal in the countries they migrate to and therefore they face possible legal persecution and stigmatization from individuals who are not a part of their communities (IOM, 2009).

Moreover, migration can increase the likelihood of FGM, as girls who descend from migrant communities are vulnerable to what is known as “vacation cutting” which consists in their families sending them on a trip to their parents’ or grandparents’ home countries where FGM may be legal so that they can be subjected to this practice (Shahawy, Amanuel, Nour, 2019 p.336).

Therefore, FGM poses a substantial integration issue, because in most instances the integration of immigrants in new societies is not trouble-free, instead there are many deficiencies for host countries when designing integration policies, such as the risk of the efforts to increase awareness to come across as offensive towards migrants, or the fact that access to health and other kinds of services may be harder for these individuals. Furthermore, service providers might find it difficult to understand this practice as they may have little experience with individuals who have faced this cultural tradition. This can be dangerous because if integration measures are not effective, it can lead to the disengagement of these communities from their host countries and may lead to an even stricter adherence to cultural practices and a will to preserve their ethnic identity to differentiate from the host society (IOM, 2009, p.2).

8. APPROACHES TO FGM

Based on FGM’s varied context and background, and because of all the grave negative consequences this practice has brought and continues to bring to individuals, different theories and approaches have developed over time to study this issue and serve different purposes in understanding the practice and in developing effective strategies to address it. Some of the ones which have been of great relevance in defining how FGM is perceived and acknowledged will be examined profoundly hereunder.

8.1 FEMINIST APPROACH

The feminist theory offers a critical lens through which to understand FGM as a form of gender-based violence and a violation of women's human rights. This practice is often seen as a way to control women's sexuality and reinforce patriarchal gender roles, and feminist theory highlights the need to challenge these power dynamics and promote gender equality.

There are many scholars and activists who have contributed to the development of this theory, such as Amina Mama, a Nigerian and British feminist activist and professor who has authored several books in which she enhances the importance of addressing women's empowerment and the cultural and political dimensions of FGM. Specifically, she specializes in African studies and addresses the gender role perspective stating that violence against women is the clearest expression of their oppressed status in many countries. Moreover, she maintains in one of her books that colonialism and imperialism of Western European countries, which replicated racial hierarchy, gender politics, and paternalistic manners in the colonies, are also to blame for the continuation and reinforcement of gender roles in these territories, as she believes that the violent treatment white colonialists of African women in the past has influenced how African men continued to treat them once the imperialist era was over and how it affected their social development. Consequently, these historical aspects should be deeply taken into account when addressing the continuance of violence against women as they set the example of how gendered violence has endured in many African countries over the years up to contemporary times (Mama, 2007, pp 36-40).

Patriarchy has created hierarchical societies in which men have occupied the dominant position of power and women have historically been excluded and undervalued to a point that this practice has not until recently been considered a violation of a fundamental human right. It was not until the 70s that the feminist movement gained a stronger voice and the conflict of excluding women from fundamental rights became visible and an object of research and social and political concern, and as stated in the Amnesty International Report on Female Genital Mutilation it is necessary to place FGM in the broadest context of violence and discrimination against women in different cultures (Amnesty International, 1998, pp. 10-14).

Lastly, one of the main aspects of feminist theory is the importance of women's empowerment, which according to feminist scholars such as Rosalind Pollack, must be linked with the reinforcement of their decision-making capacity in all aspects of their lives which will lead to a transformation in the persistent power gender relations in society. Also, the voices and experiences of individuals who are directly affected by this practice should be considered when addressing the issue (Pollack, 1995, p.153).

Because of the consequences this practice has, I agree with feminist theories in terms that FGM is a clear manifestation of violence against women that aims to control their behavior and reinforces inequality by nullifying their decision-making and expression capacity, therefore harming women's human rights and children's rights and presenting clear discrimination against these individuals. Consequently, there should be intervention in those patriarchal societies in which male dominance has set up cultural guidelines and norms that persist nowadays and continue to allow violence against women and girls.

8.1.1 Comparison with Male Circumcision

Some oppose feminist theories by stating that in many cultures men are also circumcised, equating it to FGM. While it is true that there are similarities between the two, since they can both be performed for cultural or religious reasons and on individuals that are too young to young or ignorant to consent and understand the reality of the process[5], there is evidence that suggests that male circumcision may provide medical benefits, such as a decreased risk of contracting HIV and other sexual and urinary infections, but there is no relevant evidence of possible negative physical or psychological effects that derive from this practice nor does it affect sexual satisfaction or intercourse. In contrast, as previously stated, FGM can result in far more extreme types of cutting and potential health complications and many individuals are subjected to it under false pretexts that fail to acknowledge the dangers it comes with (Gee, Kraus, Bilyeu, 2019).

Furthermore, there is an important moral difference between the two procedures, as FGM reflects an underlying message about how women and girls are the only ones who are subjected to these kinds of procedures because of their gender and therefore discriminated against, turning it into a matter of human rights, while in contrast male circumcision has nothing to do with the status of men in comparison to women and is just performed for religious and cultural reasons (Gee, Kraus, Bilyeu, 2019). Therefore, comparing the two creates a false equivalence that undermines the gravity of female mutilation.

[5] For example, this is what led Germany to briefly ban male circumcision in 2012 due to concerns that it violated a child's right to bodily integrity and self-determination, an issue also present in FGM.

Lastly, this evidence has been supported by figures such as the ex-President of Burkina-Faso, Thomas Sankara[6], who stated that female excision (the term he used to describe FGM), is a mark that attempts to remind women that they are inferior to men and that they do not have any right over their bodies or to fulfill themselves as they wish. He also declared that male circumcision can be considered a measure of hygiene, while in contrast excision can only be conceived as a measure designed to impose women's inferiority (Amnesty International, 1998, p.50).

8.2 HUMAN RIGHTS LAW APPROACH

The Human Rights perspective falls in line with the feminist approach, as it deems FGM as a form of violence against women that causes inequality, sex-based discrimination, and violates women's rights. Moreover, since it is also performed on minors, it violates the rights of the child. Additionally, it violates many other human rights, including the rights to health, physical integrity, and security of the person, the right to be free from torture and cruel or degrading treatment, and the right to life, because some cases result in the death of the individual who has undergone of this practice (WHO, 2008).

FGM is an issue that has been addressed by the United Nations for many years, however, its most relevant intervention was in 2012 when the Assembly passed a resolution that demanded global action to eliminate this practice. It also designated the 6th of February as the International Day of Zero Tolerance for Female Genital Mutilation with the aim of protecting women and girls under international law and raising awareness about the states' obligation of protecting them (Resolution of the United Nations, 2012). Moreover, in 2015 it was included in the Sustainable Development Goals under Target 5.3 which demands the abolition of all harmful practices, including Child and Female Genital Mutilation (Sustainable Development Goals, 2015).

Many international human rights bodies have supported the idea of criminalizing FGM and have contributed to this cause by issuing observations and recommendations on how countries

[6] Thomas Sankara was President of Burkina-Faso from 1983 to 1987 and is internationally recognized for his politics oriented towards promoting the rights of women by illegalizing FGM and other forms of discrimination against women, and his other politics aimed at the fight against hunger, corruption…etc. See more at https://www.casafrica.es/es/persona/thomas-sankara.

should implement measures to eradicate this practice. Some international treaties include The Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), which condemns FGM in its General Recommendation Nº 14 (CEDAW, 1990). Furthermore, the Committee on the Rights of the Child, which provides children with special protection under the law for their vulnerability, is also against this practice. Other international treaties that support this cause are the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (United Nations, 1984), the Covenant on Civil and Political Rights (United Nations, 1966) and the Covenant on Economic, Social, and Cultural Rights (United Nations, 1966).

Regional treaties have also joined this cause, such as the African Union's Solemn Declaration on Gender Equality in Africa, and its Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Union, 2003), which has comprised a major contribution to the promotion of gender equality and the elimination of female genital mutilation.

Lastly, Consensus Documents have been emitted, such as the UNESCO Universal Declaration on Cultural Diversity (Lamotte, 2002), and the United Nations Economic and Social Council Commission on the Status of Women, which emitted the Resolution on Ending Female Genital Mutilation (ECOSOC, 2007).

Under international human rights law, FGM is seen as a criminal activity, even in cases in which women voluntarily consent to be cut. This is where the first major conflict when analyzing FGM appears because international law also protects an individual's right to freely participate in any religion or cultural traditions, which leads to the collision of two opposing rights. Consequently, doubt arises when figuring out which right should outweigh the other, but international authorities have determined that FGM cannot be justified by alleging cultural practices. Therefore, the right to manifest one's religious beliefs or cultural traditions can face restrictions to protect the fundamental rights and freedoms of others (WHO, 2008).

A primary reason for this decision could be the fact that many believe that cases in which individuals (especially girls) who voluntarily consent to this procedure, do so without having been educated on the adverse consequences, and even if they have, many others

face social pressures and are expected to act in ways their culture demands them to in order to fit in their communities, and therefore fear facing exclusion or retaliation by their family members. This leads to the consideration that in most cases individuals are coerced into making decisions, which excludes any possibility of their choices being free or autonomous.

The decision to criminalize this practice on an international level can also be based on statistics, such as a study made by UNICEF in which 7 out of 10 women and girls from countries that are affected by FGM believe that it should be abolished. This study also shows that in the past two decades, the proportion of girls and women from those countries who oppose the practice has doubled, symbolizing growth in the opposition to FGM (UNICEF, 2020).

International Human Rights action has led many countries in the world to follow treaty recommendations and to criminalize this practice, especially western countries. Moreover, some countries in Africa, where FGM is statistically more predominant, have also passed laws that prohibit this practice, such as Nigeria, Egypt, or Ethiopia. However, even though most countries in Africa have passed resolutions against it, there are other countries such as Sierra Leone, which have not attempted to criminalize it, ignoring international and regional treaties. This has led countries to provide aid to individuals living in African countries that have not criminalized FGM and where it is still being widely carried out, to provide health and educational resources and setting an example for others to follow. However, there is still no unified legislation that has been created to combat FGM, and even though national laws and legislation to prevent this practice are very significant, there is still much to be done, since the rates of women and girls that risk FGM every year is still very high even in those countries where it has been criminalized (Batha, 2018).

8.3 CULTURAL RELATIVISM APPROACH

I have stated many negative consequences FGM has on women and girls, so a rational first impulse would be to support the criminalization of this practice and follow the recommendations set by the human rights approach and look for effective measures that contribute to its elimination. However, to reach the best outcome, it would be wrong to

just consider the negative perspectives Western individuals (including myself) have had over the issue. In contrast, it is necessary to take into consideration everyone's experiences, specifically those of women and girls who have gone through FGM, in order to truly understand the root of the problem. This is because even though many have reported the horrors they have suffered due to forced FGM, other women challenge those who want to criminalize a practice of their culture which they are proud to voluntarily submit to.

This led me to question who should have the right to determine which cultures could express their traditions and which could not, especially when it comes to challenging women's autonomous decisions, which is why I deem it necessary to examine cultural relativism. This theory states that there are many diverse cultures that change from place to place or over time, and therefore, individuals from different cultures can differ in what they consider to be right or wrong, symbolizing that there cannot be a universal standard. Consequently, they emphasize that a certain culture should not be used to decide if the moral values of another are correct or not. If this theory is applied to FGM, it can be seen that Western cultures denounce it, but that other African cultures find it legitimate; therefore, this practice is neither right nor wrong (Wilkinson, 2014).

Furthermore, when questioning how important cultural values should be when making policies, cultural relativism determines that it should have the same weight as any other element that is considered (Suzumi, 2002). Therefore, should we follow this theory? Should the answer to this issue be to contribute to creating a safe environment in which this tradition can be practiced preserving the cultural values many call for?

To answer these questions, it is necessary to compare the two different views of women who have been subjected to FGM. On one hand, we have the experiences of women like Pruitive Soinato Oivie. She is from an ethnic group called Maasai[7] from Kenya and she was the first person in her community to refuse FGM and seek the help of authorities when her father made that choice for her when she was around 10 years old to make her fit to marry a much older man. She is now a women's rights activist and one of many women who are leading the movement to end this practice. She believes that no child should be forced to go through this process, and that young girls who consent to it have a

[7] African tribe located in Kenya and Tanzania, learn more at http://maasaiwilderness.org/maasai/

false notion of what freedom, choice, and autonomy is; they are children who have not been educated on the possible outcomes nor have been shown that they have other options aside from following what their family mandates. She believes that anyone who is properly educated in the matter would not choose to continue this tradition (Oivie, 2018).

Additionally, Oivie understands the difficulty of the situation because she has lived firsthand how deeply rooted this tradition is in the culture she comes from, which is why her goal is to push legal and social reform by fomenting the need to provide education in areas where individuals do not have access to it and are unaware of FGM effects, because it is these individuals who are more likely to have been cut or to face this risk. Her goal is to empower girls and especially parents to reject this practice since they are the ones who force or influence their children into submitting to the procedure (Oivie, 2018).

Like many others, she believes that through the commitment of communities to eliminate FGM change can be achieved. There is evidence that this theory can succeed, for example, in 1997 the Tostan organization began to motivate women from villages in Senegal who were suffering from FGM effects to make a public and collective commitment to put an end to the practice, and studies have shown that it has had a positive outcome with FGM decreasing significantly in these areas (Wilkinson, 2014).

In contrast, there are women like Fuambai Ahmahu who believe that FGM's cultural value is misunderstood on many levels and that its health and sexual consequences are often exaggerated. She is part of the Kono ethnic group in Sierra Leone which offers women the chance of entering what is called the "Bundu secret society" by performing type 2 excision, which she voluntarily chose to submit to. She stands against the view the UN has on FGM, and instead celebrates and fights to preserve African heritage and supports women who are or wish to be circumcised. Her goal is to advocate for circumcised women's equality, dignity, and autonomy to preserve cultural and religious traditions, which is why she founded SiA Inc. Therefore, she conflicts with Oivie's view because she believes that there is no clash between being an educated woman and supporting FGM. Nevertheless, she does admit that children should not be forced into this practice and that all women who choose to pursue it should know the consequences they face (Ahmahu, 2016).

Furthermore, she claims that this practice should be called “female circumcision” or “female genital cutting” instead of “female genital mutilation” because it creates a judgmental connotation of the practice that is not accurate. She does not believe that her body was mutilated when she went through this process but instead recalls it as a celebration and expression of her culture. Therefore, she also condemns Western policies that criminalize this practice for creating a negative view of women who are circumcised and goes as far as to say that it causes discrimination because of their social, ethnic, and cultural identity (Ahmahu, 2016).

Ahmahu proposes that Western and non-Western women should come together to understand how this practice can be culturally meaningful and an acceptable choice for women; and once this is achieved, effective policies can be designed to prevent secretive dangerous procedures to be performed. Consequently, the scholar has made efforts to change western’s negative perspectives by making a comparison between FGC and labiaplasty, which is a surgical procedure that reduces the size of the labia minora for cosmetical reasons that are well seen by most Western countries (Ahmahu, 2016). Moreover, like scholar Davis states, the reason FGM is not as well seen as labiaplasty is because it has been influenced by racial, national, and global hierarchies which have deemed it to be something different (Davis, 2002).

Additionally, she attacks Western feminists’ belief that this process affects sexuality by saying that there has been a western social construction of what a woman’s sexual life should be like by spreading beliefs like that it is through sexual pleasure that a woman can truly be free. She argues that many women including herself who have experienced cutting still feel sexual pleasure and that it is up to each person to determine how to define their sexuality (Ahmahu, 2016).

After having explained these two testimonies, there can be a deep understanding of the different perspectives surrounding this matter, and I must conclude by stating that even though I agree with Ahmahu that women should have the right to make their own choices and that cultural beliefs should not justify discrimination against anyone, due to all the grave physical and mental consequences, the lack of education, and the coercion or social pressure many women who are presented with FGM face, I believe that no weight should be given to the cultural value of this practice and that it is right to call it a human rights

violation that should be eliminated. Cultural Relativism should not define the way in which policies are made because if that were the case, any kind of conduct that is associated with a type of culture could pass as valid, which would obstruct society's goal of reaching a consensus in making sure that every individual is guaranteed basic human rights. While it is hard to determine what morality is and who should define it, it is unmistakably clear that there has been progress in the quality of lives of many individuals with the abolishment of past traditions, which can be seen with examples like the abolishment of slavery which was connected to past cultures.

I agree with researcher and professor Dominik Wilkinson that cultural traditions are not immutable; they can change as well as the way these values are perceived by individuals. Therefore, individuals have the possibility of converting the way in which they follow traditions; they can still feel connected to their cultures and keep parts of their rituals while renouncing genital mutilation (Wilkinson, 2014). This idea is supported by actual evidence, which can be seen in the case of Sarah Tenoi, a Maasai woman and project manager for S.A.F.E. organization and co-designer of the charity's project to end female circumcision in her community in Kenya. She has accomplished development in the way many Maasai women celebrate their culture by performing all traditional ceremonial elements of FGM without the actual cutting (S.AF.E.).

This organization utilized traditional Maasai songs and stories as a culturally sensitive and non-judgmental approach to educate the community about Female Genital Mutilation. They performed songs that represented both sides of the debate (those who were in favor of it and those who opposed it) encouraging open discussions among community members. Once the harmful effects of FGM were understood, community members expressed a willingness to abandon the practice, but concerns were raised about losing their cultural traditions. Therefore, in collaboration with the community's circumcisers, who are also known as the Traditional Birth Attendants (TBAs), SAFE Maa developed an Alternative Rite of Passage (ARP) called the Loita Rite of Passage (LRP), which involved using cow's milk as a substitute for cutting. The TBAs actively supported and promoted the LRP, and it gained popularity in the community over time (S.AF.E.).

However, external factors such as police crackdowns led to secret cutting without proper ceremony, prompting SAFE to engage with cultural leaders for a Declaration of

Abandonment. After discussions, the Cultural Leaders agreed to lead the community in abandoning FGM and approving the LRP as a cultural graduation ceremony for girls. Since the declaration, there has been an increase in the social status of women who were not submitted to the procedure, and more families are publicly celebrating the LRP. Currently, SAFE Maa is working closely with TBAs and Cultural Leaders to sensitize the community about the Declaration of Abandonment and gain community-wide acceptance for the blessing of the LRP (S.AF.E.).

This initiative can be seen as an advancement in the cause of ending the practice and can set an example for many other communities without making it seem like they are being discriminated against because of their culture and by making them understand human rights and that they can preserve their culture without cutting women. If FGM is not targeted, it is likely that many girls will never be correctly educated on the consequences of this practice and that health risks will perdure.

9. CASE STUDY: FGM IN SPAIN

FGM is a reality that has been present in Spain for many years, because just like for many other countries, from the 80s onwards, it began to be a country of destination for migrant flows which introduced new cultures and religions which Spanish society had to get accustomed to. However, some of the traditions that were continued being practiced by immigrants were deemed contrary to national law for violating fundamental rights, as is the case with FGM, which is why the Spanish government has implemented various methods to abolish it and ensure the proper integration of immigrants in the country (UNAF, 2016).

9.1 STATISTICS OF PREVALENCE OF FGM IN SPAIN

It can be complicated to determine how many women who have suffered FGM reside in Spain because of the lack of reliable data, except for some autonomic studies which have attempted to create Protocols for FGM. However, there are studies that prove to be effective for the assessment of the evolution of this practice in Spain. Specifically, the geodemographic study of the Wassu Foundation from the “Universitat Autònoma of Barcelona” (UAB) will be analyzed. Their work is based on the identification of the

territorial distribution of the immigrant population in Spain who have migrated from countries in Africa where FGM is practiced[8]. According to the 2021 report, there were more than 286.000 individuals from sub-Saharan Africa residing all over Spain, especially in the autonomous communities of Cataluña (where almost one-third of the mentioned population resides), Madrid, and Andalucía. Moreover, more than 80.000 of these individuals are women. Moreover, even though the crisis caused by the pandemic showed a decrease in the percentage of migration of individuals from these communities, since 2021 there has been a rise of 3.4% in the number of women who have immigrated to Spain. Additionally, the main nationalities recorded were Senegalese, Nigerian, and Malian. Lastly, the majority of minors whose origins are countries where FGM is practiced are born in Spain (Kaplan, Kosp, López-Gay 2021)[9]. Consequently, these numbers are important to determine which women and girls are at potential risk of facing FGM.

Moreover, it is important to highlight that prevention methods are crucial to detect possible cases of women who have suffered FGM, either because they have suffered it before settling in Spain, or because they are born in Spain but are taken on vacation to the country of origin of their parents so that they can be submitted to FGM, or because they are subjected to it directly within Spanish territory; however, regarding this last scenario, they are very few reported cases of the procedure of FGM occurring in Spain, as the most common performance of this practice is in the country of origin (Kaplan, Kosp, López-Gay 2021).

9.2 FGM AS A CRIME

In Spain, this practice is considered illegal, as it has ratified many international treaties, such as CEDAW, and has followed recommendations to amend national law and create legislation to eliminate FGM. Therefore, there are several Spanish norms that regulate this issue, and some of them will be examined hereafter. The first applicable law would be the Spanish Constitution of 1978 as it establishes in Article 10 as a fundamental right and a foundation of the political order *"the dignity of the person, the inviolable rights that*

[8] Every 4 years since 2001 this Foundation updates the map of FGM in Spain based on the collected data.
[9] *See* Tables of data of the evolution of population of FGM origin in Spain according to country of origin. Figures D, E and F, Appendix.

are inherent to him, the free development of personality, and the respect for the law and the rights of others". Moreover, article 15, states that everyone has the right to life and to *"physical and moral integrity without, in any case, being subjected to torture or to inhuman or degrading punishment or treatment"* (Spanish Constitution, 1978).

Additionally, the Organic Law 1/1996 on the Legal Protection of Minors in Article 13 calls for the intervention of the Public Administration in cases when the neglect of minors or other risks towards them are detected to provide them with assistance (Organic Law 1/1996).

However, it was not until the Organic Law 11/2003, of September 29 was passed that the issue of genital mutilation was specifically addressed. This law was passed in order to amend the Spanish Penal Code to incorporate the crime of genital mutilation[10] into the already existing article 149 which penalizes the most serious cases of injury. With this amendment, FGM became a crime punishable by law, meaning that anyone who performed this practice in any of its manifestations would be sentenced to six to twelve years in prison. Furthermore, it adds an aggravation of the sentence in cases in which the victim were to be a minor or disabled by allowing the judge to determine if it is necessary to impose a penalty of disqualification for the exercise of parental authority, guardianship, curatorship, or foster care for a period of four to ten years (Marín, 2017, pp. 306-307).

In addition, based on the principle of universal justice, in 2005 a reform was made to Article 23.4 section g) of the Organic Law of the Judiciary Power to confer jurisdiction over the crime of FGM to Spanish Courts in cases in which perpetrators were within the country's borders even if the crime had not been committed in such territory since in many cases the procedure is committed outside of Spain when families travel to other countries of origin (Organic Law of the Judiciary Power, 2005).

Lastly, in 2022 the term "female genital mutilation" was finally adopted by the Spanish legal framework with the amendment of the Organic Law 10/2022, of September 6, on the guarantee of sexual freedom with the purpose of preventing and criminalizing any act

[10] Interestingly, unlike other European penal codes, the Spanish legislature did not employ the term "female" when referring to "genital mutilation" in its legal framework for this offense. Consequently, this provision also applies to male victims, protecting both genders under the same law. However, Spanish courts have never encountered male genital mutilation, just female genital mutilation of minors.

of sexual violence that violates the right women have of sexual liberty. Specifically, it is in Article 22 where it states that *"Public powers will establish action protocols that allow the detection and care of cases of female genital mutilation, women trafficking for the purpose of sexual exploitation and forced marriage, for which the specific training necessary for professional specialization will be sought, which may include specific actions within the framework of international development cooperation"*(Organic Law 10/2022 of September 6).

Nonetheless, in order to address the fact that this practice is not always intended to be a harmful act against women by the perpetrators, but instead a form of following their culture or religion; and the necessity of integrating immigrants who may not be aware of the laws of the country which forbid FGM, Spanish courts examine each case in search of possible mitigating causes that may result in the reduction of the penalty of perpetrators. An example of such a mitigation cause would be instances in which perpetrators may have acted without knowing a crime was being committed. Moreover, a reduction of penalties can also be applied to mothers who submit their daughters to the procedure if they themselves have been cut in the past as this way the tradition can clearly be seen as deeply rooted in their way of life. However, these instances of mitigation of penalties do not apply if it is proven that the immigrant perpetrators have been effectively socially and culturally integrated over an expanded period of time in the country (Marín, 2017, p. 309).

9.2.1 Case analysis: Sentence nº31/2019, National Court, Chamber Roll 10/2018, Summary 9/2018, Central Court of Instruction No. 3.

This case will be analyzed to set an example of how procedures of detection of FGM function in Spain, concretely in the region of Catalonia. In January of 2016 the General Directorate of Police from the Department of the Interior of the Generalitat of Catalonia, took legal action for the alleged commission of a crime of FGM, criminalized in Art. 149.2 of the Spanish Penal Code, against Crescencia, mother of two girls who moved from The Gambia to Catalonia through a family reunification process, since the husband who had already traveled to the region and obtained Spanish residency had obtained the necessary administrative authorization for his family to join him (Wassu- UAB Foundation, 2020).

At the time, the daughters were 8 and 5 years old, respectively, and during a routine medical check-up, it was discovered that both had undergone FGM. According to the defendant, the practice was legal in The Gambia at the time it occurred and that the culprit of these actions had been the grandmother of the children, as she was the one who performed the mutilation when the first daughter was just a few weeks old since she wanted to follow the cultural traditions of their home country. However, the mother stated that she was opposed to the practice and was unaware that her own mother was going to practice it as well on her second daughter while she had left them under her care after she had gone shopping. Moreover, the suture of the second daughters' wound after the mutilation was done incorrectly and required a later operation of reconstruction (Wassu-UAB Foundation, 2020).

Consequently, the Prosecutor's Office accused the mother of not having prevented the practice on her second daughter in The Gambia and requested a six-year prison sentence because they did not support the argument of the defendant that she was ignorant of the possibility of the procedure of FGM being performed on her second daughter. Moreover, they stated that if the judge considered it appropriate for the well-being of the minor, a penalty of special disqualification for the exercise of parental authority, guardianship, curatorship, guardianship or foster care could also have been applied for a period of 4 to 10 years (Sentence nº31/2019).

Nonetheless, the Public Prosecutor finally decided to file charges of commission of the crime of FGM by omission, punished in article 11 of the Spanish Penal Code because, on one hand, it was true that at the time the events occurred, 2008 and 2011 respectively, FGM was not considered a crime in The Gambia; in contrast, it was a widespread cultural and religious tradition throughout the country. On the other hand, the defendant had never been in Spain before these events occurred and, therefore, she could not know that the practice was illegal and disapproved from a legal point of view in our country. Moreover, there was no conclusive evidence that it was the mother herself who carried out the practice, since only her own statements were the only proof available indicating that it was the maternal grandmother who carelessly took the girl and performed FGM on the child. However, since they were not able to prove that the defendant was guilty beyond reasonable doubt, the case was ultimately acquitted by the Spanish Court for the reasons stated above (Sentence nº31/2019).

10. GOOD PRACTICE PROPOSALS AND STRATEGIES

I have investigated different approaches to find what practices and strategies should be implemented or reinforced to eliminate FGM to prevent women and girls from being forced or socially pressured into this practice and exposed to negative health consequences because of it. The approaches that will be explained hereunder have been based on the UNFPA-UNICEF Joint Program on the Elimination of Female Genital Mutilation and the Inter-African Committee on Traditional Practices (IAC); on the Analysis of Medical Aspects, Law and Practice conducted by authors Ngianga-Bakwin Kandala and Paul Nzinga Komba; and on the studies performed by the Catalan Spanish Foundation Wassu-UAB that were promoted and coordinated by the Spanish Government's Delegation against Gender Violence, and on my personal opinion.

There are many obstacles states have faced when designing policies to confront FGM, including: a lack of understanding of the symbolism this practice has for too many cultures and inadequate training in a cross-cultural approach; language barriers that make it complicated to address the issue with dialogue and a respective angle towards practitioners; the lack of counseling resources, and the ethical dilemma over criminalization and stigmatization versus integration of these communities. In order to overcome these issues, states must establish guidelines and protocols that describe in depth what methods of action professionals must follow when confronting FGM.

These protocols should have the ability to eliminate ethnocentric tendencies and highlight intercultural values to help communities from diverse cultures. The first step for Western states is to target the problem in their own countries where immigrants from practicing cultures have continued to practice FGM. In doing so, they must acknowledge the difficulties immigrants face, as many of them might not be familiar with the legal or administrative system of these countries or could feel targeted by the disrespect many have towards their cultures. Furthermore, many face language difficulties and lack support networks.

If countries where FGM is present because of immigrants who have brought this tradition from their home countries are able to focus on the awareness-raising of professionals from different fields and practicing communities, it will be easier for these individuals to

transfer the knowledge acquired to their communities of origin, promoting a respectful change (Kandala, Komba, 2018).

In 2021, the UNFPA-UNICEF Joint Program on the Elimination of Female Genital Mutilation and the Inter-African Committee on Traditional Practices (IAC) cooperatively launched the theme: "No Time for Global Inaction, Unite, Fund, and Act to End Female Genital Mutilation". They call for States to work together, especially in times of Covid 19, which has led to an obstruction of the process to confront FGM, in order to abolish FGM by 2030. It is necessary that states create an interdisciplinary network in order to combine resources and achieve the best outcome possible. Interdisciplinary work is crucial for addressing this issue because it is of such a complexity that it requires a comprehensive and multi-faceted approach (UNFPA-UNICEF, IAC, 2021).

As I have explained, FGM is not only a health issue but also a social, cultural, and human rights issue, and addressing it effectively requires expertise and collaboration from various disciplines, which should involve collaboration among government agencies, health, law, and social services professionals, NGO activists, civil society, communities, and other stakeholders to ensure a coordinated and sustained effort to end FGM. Consequently, effective action of health and law professionals, and services and NGO activists will be proposed.

Firstly, health professionals must ensure access to quality health services and create a relationship based on trust with families that are part of cultures that practice FGM, and avoid applying immediate punitive measures so that women are not scared of seeking help when their health is at risk for fear of being interrogated and taken to the police, which could negatively affect themselves or their families.

Furthermore, there should be an organized approach to clinical interventions for FGM patients, and the approach proposed by Creighton and Hodes, holds great initiatives for health professionals. They emphasize the importance of taking a thorough history and presentation of the patient, including identifying any signs of acute blood loss or sepsis, which may indicate an evasive form of FGM. In such cases, appropriate interventions such as antibiotics, analgesia, tetanus toxoid, and urinary cauterization may be prescribed as applicable. Moreover, Genital examination is a critical step in the approach, and it

involves screening for risk factors and establishing the presence or absence of FGM in the patient. However, it is recommended that there is a multidisciplinary team and women experts to conduct this procedure because for some individuals this procedure can be traumatic (Creighton, Hodes, 2014).

Additionally, recording and coding the diagnosis of FGM is also highlighted as an important aspect of clinical care. Some health organizations, such as the UK Royal College of General Practitioners, have discussed the need for specific codes to record FGM diagnosis, which can help increase awareness and understanding of the condition in a clinical setting. This can also aid in securing funding and resources for special services for FGM patients. Moreover, in cases where FGM is detected, the management of professionals may involve various interventions depending on the specific condition suffered by the patient. Treatment options may include surgical procedures, psychological support, and addressing related health issues. Finally, monitoring and follow-up of FGM patients are important to ensure ongoing care and address any complications or issues that may arise (Kandala, Komba, 2018, p. 106).

On the other hand, law professionals and policymakers must be educated on sexual and reproductive health law and create laws that focus on the detection, prevention, psychological support, and health care women need. It is essential to focus on the prevention rather than on the punishment of mothers who have influenced their children to submit to FGM because the ones responsible for it are mostly women who have been victims of this practice in the past, which is why it is important to understand that each case can be different and should be treated differently. Law and policymakers must participate hand in hand with women from these communities to achieve successful results since their perspectives of FGM are not homogeneous; not all communities practice it the same way or for the same reasons. Studying diversity and being able to understand the changes and continuities of the practice is essential to work on its abandonment. Therefore, protocols must be evaluated and adapted periodically, not expecting to always follow them in the same way for all cases that aries, as this would not suit reality and it can generate frustration among professionals and migrant families (Kandala, Komba, 2018).

Finally, the role of social services and NGO activists is extremely important as they are the services that may appear less threatening to individuals that are seeking help but are too afraid to turn to health or law professionals. These are some of the contributions these institutions can provide for the fight against FGM: they can raise awareness and provide education about FGM to communities, including migrants from affected countries and mobilize communities and their religious or cultural leaders to challenge harmful social norms. They should also provide comprehensive training for healthcare professionals, social workers, law enforcement officers, and other stakeholders on identifying, preventing, and responding to FGM cases and ensure accessible and culturally sensitive support services for girls and women who have undergone or are at risk of FGM. Moreover, it is important that they advocate for and support strong legal and policy frameworks that criminalize FGM and protect the rights of girls and women is essential. Lastly, they can contribute to the improvement of data collection and research (UNICEF, 2020).

Overall, if change can be achieved in migrant communities, it will be easier to promote change in their countries of origin. However, governments, national and international organizations, and practicing communities must also work together to try and eradicate this practice directly in African countries where FGM is most widely spread. The key to doing so is through health and education services directed to women, girls, parents, community leaders, and health facilities. Punitive measures are necessary when this practice has the gravest consequences or is performed on children, but they should not be the first option to result too. Through education, dialogue, preventive measures, and means to empower women and girls, change can be achieved, as can be seen in the example given earlier on with the achievements of Sarah Tenoi in Maasai communities.

10.1 EXAMPLES OF PROMESSING INITIATIVES IN SPAIN TO END FGM

In line with the country selected to examine this issue for this paper, Spain, I believe it is important to highlight its success in implementing effective strategies to combat FGM, such as the elaboration of the Report in 2019 on the use, applicability, and impact of the “Preventive Commitment”, prepared by the Wassu-UAB Foundation within the framework of the project «Intercultural dialogue for the prevention and care of FGM in Spain", supported by the Ministry of Labor, Migration and Social Security, and co-

financed by the Fund for Asylum, Migration and Integration of the European Union. It includes an analysis of the Protocols and guides of performance for different professionals available to the Autonomous Communities in which the Spanish state territory of governance is divided (Wassu-UAB Foundation, 2019).

The "Preventive Commitment" document was originally created in 1998 by an interdisciplinary group of professionals under guidance of Dr. Adriana Kaplan with the goal of obtaining compromised prevention of FGM. It was meant to be given to parents that reside in Spain but are originally from cultures that practice FGM, as well as to those families that travelled abroad to visit their families living in countries where FGM is practiced. Moreover, it included different sections for the personal data of their daughter, where she is enrolled in school, the guidelines of the Spanish Protocol for the protection of children, the legal framework of FGM in the Spanish State, and the certificate that the child does not have any lesions on her genitals. This document is an effective tool as it serves as an additional argument for parents in their decision to not perform FGM on their daughters, relieving them of the pressures of their culture and avoiding questioning from their elders, since it shows that they are not the ones who penalize the practice, in contrast it is truly the State's jurisdiction under which they live in who does, and who will be the one taking legal action against perpetrators. This way, families will be educated not only on the negative health consequences this practice can have on their daughters, but on the legal consequences it could have for the whole family (Wassu-UAB Foundation, 2019).

Its effectiveness was empirically verified through the study of 11 families from 6 different villages who were planning to travel to Senegal and Gambia with their daughters. Moreover, as part of the study, Dr. Kaplan conducted follow-up visits with the families during their trip to examine how they used the document, and after its effectiveness was confirmed, it was incorporated into the national Protocol for Health Action for Female Genital Mutilation (FGM) by the Ministry of Health, Social Services and Equality of Spain in 2015. This document has also been included in various protocols of autonomous communities of Spain and in municipal protocols, and as stated before, is intended for its use by professionals as well as by families who may be traveling to their countries of origin. Moreover, this document model has also been replicated in other countries, such as Belgium (known as Stop FGM Passport) and the United Kingdom (known as Statement Opposing FGM) (Wassu-UAB Foundation, 2019).

However, even though it has given good results and is valued as a tool that can be of great help for families, the government has raised caution of the need to use this tool correctly, preserving the purpose for which it was created and avoiding a controlling and punitive use of it, which is why the Wassu-UAB Foundation created in 2019 a Guide for the “Preventive Commitment” available online for all and aimed specifically towards primary healthcare professionals that synthesizes the main considerations that should be taken into account before using the tool and proposing it to the families (Wassu-UAB Foundation, 2019).

Furthermore, the Wassu-UAB Foundation also highlights the importance of the worked performed by researchers Adriana Kaplan and Antonio López, who every four years publish a map that provides information on the territorial distribution by age and origin of migrant populations from countries where FGM is performed and the percentage of the population susceptible to suffering or who have suffered FGM. This information is segregated by sex, age, and country of origin and is a very useful tool to adapt the state’s approaches to the needs of the communities, as well as to obtain more statistics on the prevalence of the issue, since this has been one of the main problems when addressing FGM in most countries (Wassu-UAB Foundation, 2019). Some of these Maps have been included in the Appendix section of this essay as has been stated before.

11. CONCLUSION

The use of qualitative research methods, including interviews, document analysis, case studies, and the examination of different theories of the issue allowed for a deeper understanding of the experiences of women and girls who have undergone FGM and the social and cultural factors that contribute to the persistence of the practice. The results of the study supported the hypotheses stated in the beginning of this paper to prove that the prevalence of FGM is higher in communities where it is deeply rooted in tradition and culture, and it is a practice that has severe health and social consequences for its victims who see their human rights violated in many parts in the world, including in Spain, which was the country selected to analyze this issue more closely. Consequently, this practice cannot be permitted, and it is important to call it “mutilation” as it accurately reflects the severe nature of the practice and the harm it causes, as opposed to "circumcision," which typically refers to a medically accepted practice. Too many girls are mutilated or face that

risk, too many individuals suffer physical and physiological effects because of it, and too many are pressured by their communities to continue with this practice.

Therefore, the continuance of this practice cannot be justified, not even by cultural relativism, because even though this theory protects all cultural systems by establishing that each culture should establish its own limits of what should be considered right or wrong, and that no other culture has the right to interfere in those limits, it still has extreme negative consequences as it does not allow for the application of a universal standard of justice which is much needed to ensure that everyone, regardless of their background, is treated fairly and justly under the law and the same standards and principles of justice. Without such a standard inequalities and injustices in society can arise, as well as perpetuate discrimination and marginalization of certain groups which continue to perform FGM. Moreover, the cultural relativism argument does not necessarily allow women to make free autonomous decisions about FGM. Women who grow up in cultures where FGM is practiced may feel pressure from their families, communities and religious leaders to undergo the procedure in order to conform to social norms and expectations, as this theory does not enhance individual rights but the rights of the community as a whole.

For all these reasons, it is important to work on the elimination of this practice, especially through the human rights approach because it ensures that the rights and well-being of girls and women are at the forefront of efforts to eliminate this harmful practice, and that cultural relativism is not used to justify violations of human rights. This approach provides a comprehensive, universal, and empowering framework to address FGM and promote gender equality, health, and human dignity. However, this may not be sufficient on its own to combat this harmful practice, and other approaches and strategies may also be needed to effectively eliminate FGM. The elaboration of preventive and awareness measures, created through a multi-dimensional and multi-sectoral approach that considers cultural sensitivity, health and education interventions, and community engagement combined with legal enforcement are necessary.

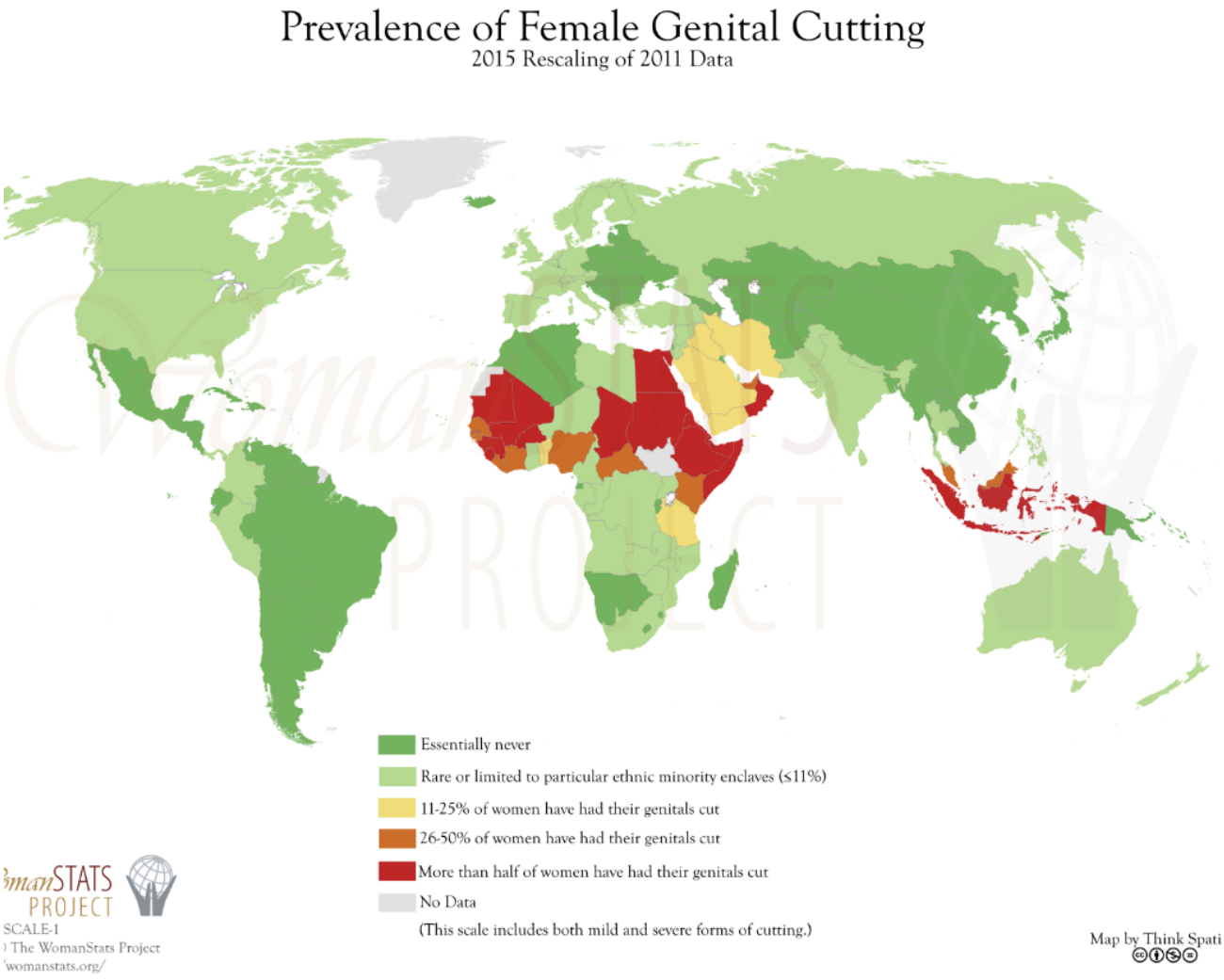
Moreover, it is critical to give voice to victims of FGM in order to raise awareness and empower marginalized communities who may need healing and recovering from trauma, and to promote accountability and justice. Women must be empowered and educated on their human rights, and preventive measures should not just be targeted at women who

have not gone through FGM, but also towards women who have been victims and all other members of their communities to prevent further cases.

Lastly, all States should work together to collectively reinforce human rights and share the best practices, exchange information, and develop strategies to prevent FGM, provide appropriate health care and support for survivors, and amplify their efforts to promote gender equality and challenge harmful gender norms. Moreover, if everyone follows international and regional treaty recommendations that contribute to the achievement of SDG 5.3, it will ensure that many women, children, and human rights are protected. Furthermore, putting an end to this practice can also further the progress of accomplishing other SDGs that fight for women's equality and focus on the protection of other kinds of human rights.

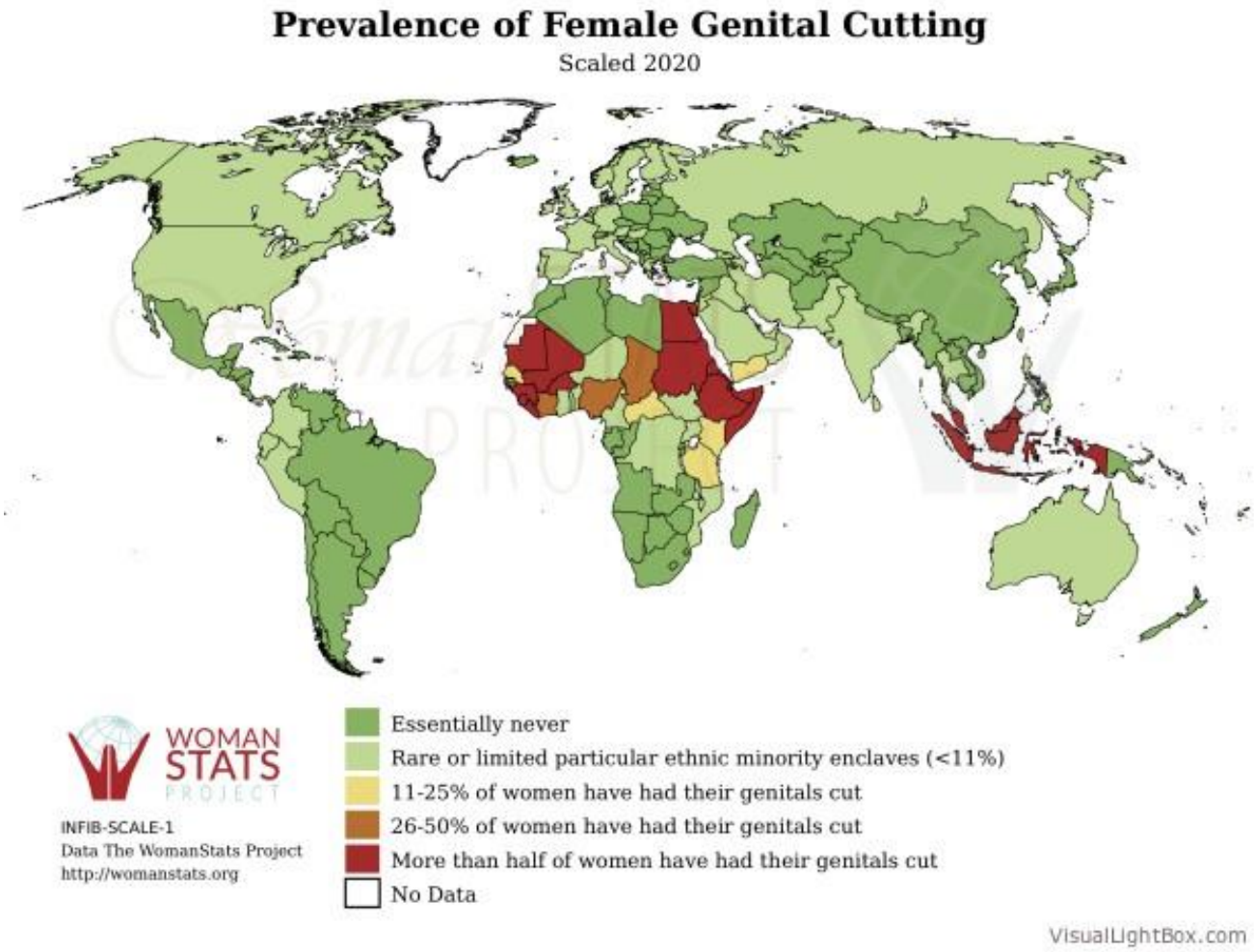
12. APPENDIX

12.1 Figure A. Map Comparison of the Prevalence of Female Genital Mutilation scaled in 2015 and 2020.



Source: Woman Stats project, scaled 2015 and 2020.

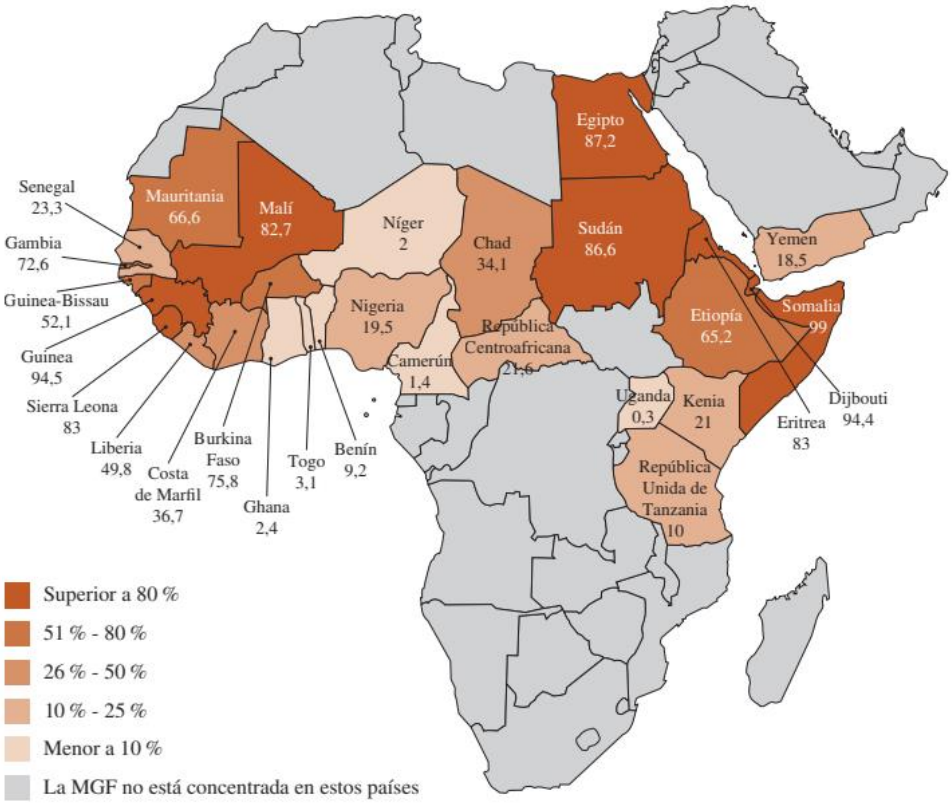
https://www.womanstats.org/maps.html (Retrieved the 15th, 2023).



Source: Woman Stats project, scaled 2015 and 2020.

https://www.womanstats.org/maps.html (Retrieved April 15th, 2023).

12.2 Figure B. Countries in Africa where FGM is practiced, and its prevalence in 2021.



Source: Prepared by the Interdisciplinary Group for the Prevention and Study of Harmful Traditional Practices (GIPE/PTP) from the Department of Social and Cultural Anthropology of the Autonomous University of Barcelona, 2021 based on UNICEF global databases, 2021, based on DHS, MICS. (Retrieved April 13th, 2023).

12.3 Figure C. Evolution of the population of FGM origin in Spain according to country of origin. 2008-2021 (rate of cumulative annual growth).

	2008	2012	2016	2021	TCAA 2008-2012	TCAA 2012-2016	TCAA 2016-2021
Senegal	48.479	67.354	69.505	89.712	8,6 %	0,8 %	5,2 %
Nigeria	38.296	47.697	44.800	43.011	5,6 %	-1,6 %	-0,8 %
Malí	19.859	24.990	24.484	30.440	5,9 %	-0,5 %	4,5 %
Gambia	20.345	24.352	23.305	27.252	4,6 %	-1,1 %	3,2 %
Ghana	13.536	17.797	17.701	22.981	7,1 %	-0,1 %	5,4 %
Guinea	12.541	14.755	13.487	15.077	4,1 %	-2,2 %	2,3 %
Mauritania	10.434	12.392	10.573	11.183	4,4 %	-3,9 %	1,1 %
Camerún	5.263	7.017	6.692	7.510	7,5 %	-1,2 %	2,3 %
Egipto	3.986	4.851	5.425	6.361	5,0 %	2,8 %	3,2 %
Guinea-Bissau	6.961	6.823	6.092	6.072	-0,5 %	-2,8 %	-0,1 %
Costa de Marfil	2.331	3.615	3.506	5.832	11,6 %	-0,8 %	10,7 %
Etiopía	1.735	3.642	4.142	4.234	20,4 %	3,3 %	0,4 %
Iraq	1.734	1.900	2.190	3.073	2,3 %	3,6 %	7,0 %
Indonesia	1.763	2.144	2.156	2.707	5,0 %	0,1 %	4,7 %
Kenia	1.034	1.557	1.574	2.089	10,8 %	0,3 %	5,8 %
Burkina Faso	898	1.389	1.446	1.755	11,5 %	1,0 %	3,9 %
Sierra Leona	1.139	1.099	977	1.035	-0,9 %	-2,9 %	1,2 %
Malasia	500	636	646	825	6,2 %	0,4 %	5,0 %
Liberia	934	806	649	647	-3,6 %	-5,3 %	-0,1 %
Yemen	71	120	197	639	14,0 %	13,2 %	26,5 %
Togo	434	552	545	631	6,2 %	-0,3 %	3,0 %
Tanzania	267	326	405	525	5,1 %	5,6 %	5,3 %
Sudán	454	398	433	512	-3,2 %	2,1 %	3,4 %
Somalia	157	259	359	471	13,3 %	8,5 %	5,6 %
Benín	391	439	440	462	2,9 %	0,1 %	1,0 %
Níger	252	312	312	379	5,5 %	0,0 %	4,0 %
Uganda	150	210	210	303	8,8 %	0,0 %	7,6 %
Rep. Centroafricana	136	154	153	246	3,2 %	-0,2 %	10,0 %
Eritrea	126	123	124	232	-0,6 %	0,2 %	13,3 %
Chad	74	114	106	110	11,4 %	-1,8 %	0,7 %
Djibouti	21	26	25	27	5,5 %	-1,0 %	1,6 %
Sudán Del Sur	0	0	5	10			14,9 %
Total general	194.301	247.849	242.664	286.343	6,3 %	-0,5 %	3,4 %

Source: Adriana Kaplan Marcusán, Marc Ajenjo Cosp y Antonio López-Gay, WASSU UAB Foundation, 2021. (Retrieved April 13th, 2023).

12.4 Figure D. Evolution of the female population of FGM origin in Spain according to country of origin. 2008-2021 (cumulative annual growth rate)

	2008	2012	2016	2021	TCAA 2008-2012	TCAA 2012-2016	TCAA 2016-2021
Senegal	7.862	13.012	15.180	19.823	13,4 %	3,9 %	5,5 %
Nigeria	14.547	19.644	19.248	18.846	7,8 %	-0,5 %	-0,4 %
Ghana	2.050	3.585	4.318	6.251	15,0 %	4,8 %	7,7 %
Gambia	4.848	5.612	5.385	5.899	3,7 %	-1,0 %	1,8 %
Malí	1.403	2.771	3.575	4.829	18,5 %	6,6 %	6,2 %
Guinea	3.969	4.739	4.555	4.488	4,5 %	-1,0 %	-0,3 %
Mauritania	2.118	2.897	2.706	2.959	8,1 %	-1,7 %	1,8 %
Camerún	1.915	2.592	2.497	2.836	7,9 %	-0,9 %	2,6 %
Egipto	1.121	1.466	1.723	2.065	6,9 %	4,1 %	3,7 %
Etiopía	812	1.667	1.892	1.948	19,7 %	3,2 %	0,6 %
Guinea-Bissau	1.371	1.600	1.452	1.725	3,9 %	-2,4 %	3,5 %
Costa de Marfil	615	942	1.043	1.681	11,2 %	2,6 %	10,0 %
Kenia	647	1.082	1.130	1.434	13,7 %	1,1 %	4,9 %
Indonesia	873	1.011	1.032	1.326	3,7 %	0,5 %	5,1 %
Iraq	606	687	801	1.085	3,2 %	3,9 %	6,3 %
Malasia	255	366	372	483	9,5 %	0,4 %	5,4 %
Burkina Faso	228	358	396	475	11,9 %	2,6 %	3,7 %
Sierra Leona	342	330	308	276	-0,9 %	-1,7 %	-2,2 %
Tanzania	115	153	214	253	7,4 %	8,8 %	3,4 %
Liberia	292	265	233	233	-2,4 %	-3,2 %	0,0 %
Togo	112	172	178	216	11,3 %	0,9 %	3,9 %
Somalia	52	94	155	181	16,0 %	13,3 %	3,2 %
Sudán	134	126	156	164	-1,5 %	5,5 %	1,0 %
Uganda	73	104	106	163	9,3 %	0,5 %	9,0 %
Benín	113	123	135	145	2,1 %	2,4 %	1,4 %
Yemen	18	32	57	139	15,5 %	15,5 %	19,5 %
Níger	63	73	83	113	3,8 %	3,3 %	6,4 %
Rep. Centroafricana	64	68	60	108	1,5 %	-3,1 %	12,5 %
Eritrea	44	48	55	80	2,2 %	3,5 %	7,8 %
Chad	27	41	29	44	11,0 %	-8,3 %	8,7 %
Djibouti	10	10	10	12	0,0 %	0,0 %	3,7 %
Sudán Del Sur	0	0	2	2			0,0 %
Total general	46.699	65.670	69.086	80.282	8,9 %	1,3 %	3,0 %

Source: Adriana Kaplan Marcusán, Marc Ajenjo Cosp y Antonio López-Gay, WASSU UAB Foundation, 2021. (Retrieved April 13th, 2023).

12.5 Figure E. Evolution of the female population aged 0-14 in Spain according to country of origin. 2008-2021 (rate of cumulative annual growth)

	2008	2012	2016	2021	TCAA 2008-2012	TCAA 2012-2016	TCAA 2016-2021
Senegal	2.054	3.684	4.092	4.915	15,7 %	2,7 %	3,7 %
Nigeria	2.471	5.089	5.116	4.430	19,8 %	0,1 %	-2,8 %
Malí	542	1.134	1.496	1.906	20,3 %	7,2 %	5,0 %
Ghana	437	992	1.179	1.646	22,7 %	4,4 %	6,9 %
Gambia	2.250	2.168	1.576	1.536	-0,9 %	-7,7 %	-0,5 %
Guinea	770	1.218	1.024	819	12,1 %	-4,2 %	-4,4 %
Etiopía	511	1.241	1.295	815	24,8 %	1,1 %	-8,8 %
Mauritania	629	861	740	662	8,2 %	-3,7 %	-2,2 %
Camerún	339	564	463	438	13,6 %	-4,8 %	-1,1 %
Egipto	261	364	390	371	8,7 %	1,7 %	-1,0 %
Costa de Marfil	114	201	230	347	15,2 %	3,4 %	8,6 %
Guinea-Bissau	381	368	207	181	-0,9 %	-13,4 %	-2,6 %
Iraq	89	79	91	145	-2,9 %	3,6 %	9,8 %
Indonesia	54	53	75	119	-0,5 %	9,1 %	9,7 %
Burkina Faso	64	113	100	89	15,3 %	-3,0 %	-2,3 %
Kenia	38	34	46	89	-2,7 %	7,8 %	14,1 %
Malasia	24	33	30	54	8,3 %	-2,4 %	12,5 %
Yemen	4	9	16	39	22,5 %	15,5 %	19,5 %
Sierra Leona	57	73	63	31	6,4 %	-3,6 %	-13,2 %
Níger	14	20	17	31	9,3 %	-4,0 %	12,8 %
Sudán	24	29	38	30	4,8 %	7,0 %	-4,6 %
Togo	11	33	29	27	31,6 %	-3,2 %	-1,4 %
Somalia	10	8	17	24	-5,4 %	20,7 %	7,1 %
Uganda	4	8	9	16	18,9 %	3,0 %	12,2 %
Benín	19	33	25	16	14,8 %	-6,7 %	-8,5 %
Rep. Centroafricana	4	6	5	16	10,7 %	-4,5 %	26,2 %
Chad	2	10	3	12	49,5 %	-26,0 %	32,0 %
Liberia	28	21	12	12	-6,9 %	-13,1 %	0,0 %
Tanzania	14	9	8	11	-10,5 %	-2,9 %	6,6 %
Eritrea	5	4	3	9	-5,4 %	-6,9 %	24,6 %
Djibouti	3	2	1	0	-9,6 %	-15,9 %	-100,0 %
Sudán Del Sur	0	0	0	0			
Total general	11.227	18.461	18.396	18.836	13,2 %	-0,1 %	0,5 %

Source: Adriana Kaplan Marcusán, Marc Ajenjo Cosp y Antonio López-Gay, WASSU UAB Foundation, 2021 (Retrieved April 13th, 2023).

13. BIBLIOGRAPHY

13.1 Legislation

Resolution 67/146. Intensifying global efforts for the elimination of female genital mutilations, adopted 20 December 2012, General Assembly, A/RES/67/146.

Resolution to Ending Female Genital Mutilation, March 2007, the United Nations Economic and Social Council (ECOSOC), E/CN.6/2007/L.3/Rev.1.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, Assembly of the African Union.

UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 14: Female Circumcision*, 1990, A/45/38.

Convención sobre la eliminación de todas las formas de discriminación contra la mujer, Asamblea General de las Naciones Unidas, 1979.

Constitución española. «BOE» núm.311, de 29 de diciembre de 1978.

Ley Orgánica 1/1996, de 15 de enero, de Protección Jurídica del Menor, de modificación parcial del Código Civil y de la Ley de Enjuiciamiento Civil.
«BOE» núm. 15, de 17 de enero de 1996.

Ley Orgánica 10/2022, de 6 de septiembre, de garantía integral de la libertad sexual.
«BOE» núm. 215, de 07 de septiembre de 2022.

Ley Orgánica 11/2003, de 29 de septiembre, de medidas concretas en materia de seguridad ciudadana, violencia doméstica e integración social de los extranjeros.
«BOE» núm. 234, de 30 de septiembre de 2003.

Ley Orgánica 6/1985, de 1 de julio, del Poder Judicial. «BOE» núm. 157, de 02/07/1985.

UN General Assembly, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85

UN General Assembly, International Covenant on Civil and Political Rights, 1966, Treaty Series, 999, 171.

UN General Assembly, International Covenant on Economic, Social, and Cultural Rights, 1996, Treaty Series, 999, 171.

13.2 Jurisprudence

Sentencia de la Audiencia Nacional número 31/2019, de 15 de noviembre, Centro de Documentación Judicial, Consejo General del Poder Judicial.

13.3 Doctrinal Sources

Amina, M (2007). Sheroes and Villains: Conceptualizing Colonial and Contemporary Violence Against Women in Africa. Alexander M., Talpade C. (ed)., *Feminist Genealogies, Colonial Legacies, Democratic Futures,* (pp. 30-46). Routledge.

Amnistía Internacional (1998), La mutilación genital femenina y los derechos humanos Infibulación, escisión y otras prácticas cruentas de iniciación, *ed. Amnistía Internacional (EDAI),* 1-110.

Cappa, C., et al. (2013) *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*, New York: United Nations Children's Fund.

Cloward, K. (2016). *When Norms Collide: Local Responses to Activism against Female Genital Mutilation and Early Marriage.* Oxford University Press.

Creighton, S. M., & Hodes, D. (2014). Female genital mutilation: What every pediatrician should know. BMJ, 101(3), 267–271.

Reisel, D., Creighton, S. M. (2015). Long-term health consequences of Female Genital Mutilation (FGM), *Maturitas*, vol. 80, Issue 1, pp. 48-51.

Davis, S. (2002). Loose lips sink ships. *Feminist Studies*, 28 (1), 7-35.

Fundación Wassu-UAB (2019), Uso, aplicabilidad e impacto del Compromiso Preventivo, pp 3-30.

Fundación Wassu-UAB (2020). La mutilación genital femenina en España, Delegación del Gobierno contra la violencia de género.

Gee, A., Kraus, E., & Bilyeu, A. (2019). Female Genital Cutting: Considerations for the Western Physician. *Missouri Medicine*, *116*(1), 32-34.

Hayes, Rose Oldfield (17 June 1975). "Female Genital Mutilation, Fertility Control, Women's Roles, and the Patrilineage in Modern Sudan: A Functional Analysis". *American Ethnologist*. 2 (4): 617–633.

Kandala, N., Komba, P. (2018). *Female Genital Mutilation around The World: Analysis of Medical Aspects, Law and Practice.* Springer.

Lamotte, K. (2002). United Nations Educational, Scientific and Cultural Organization (UNESCO): Universal Declaration on Cultural Diversity. International Legal Materials, 41(1), 57-62.

Lozano, I., Crespo, N. (2013). Guía para profesionales. La MGF en España. Prevención e intervención. *UNAF* pp.

Lynn, M. T. (2000). "Ngaitana (I will circumcise myself)': Lessons from Colonial Campaigns to Ban Excision in Meru, Kenya". In Shell-Duncan, Bettina; Hernlund, Ylva eds. *Female "Circumcision" in Africa: Culture Controversy and Change*. Boulder. Lynne Rienner Publishers pp. 129-132.

Marín, E. B. (2017). Derecho Penal y diversidad religioso-cultural los delitos de mutilación genital y matrimonio forzado, *Anuario de derecho eclesiástico del Estado*, Nº 33, 2017, 299-316.

Nawal, S. (2007) *The Hidden Face of Eve*. London: Zed Books.

Pollack, R., (1995). From Population Control to Reproductive Rights: Feminist Fault Lines, Reproductive Health Matters, *Women's Health Policies: Organizing for Change*, Vol. 3, No. 6, pp. 152-161.

Shahawy, S., Amanuel, H., & Nour, N.M. (2019). Perspectives on female genital cutting among immigrant women and men in Boston. *Social science & medicine*, 220, 331-339.

Suzumi, J (2002). Female Genital Mutilation, JAMA, vol. 288, n. 9,1130-1135.

Wade (2009). The Evolution of Feminist Thought About Female Genital Cutting, *dep. soc. Occidental College*, 1-7.

13.4 Internet Resources

28 Too Many (2013). *What are the origins and reasons for FGM?*, retrieved 1 March, 2023, from https://www.28toomany.org/blog/what-are-the-origins-and-reasons-for-fgm-blog-by-28-too-manys-research-coordinator/.

28 Too Many (2016). *The psychological effects of Female Genital Mutilation*, retrieved 1 March, 2023, from *https://www.28toomany.org/blog/the-psychological-effects-of-female-genital-mutilation-research-blog-by-serene-chung/*

28 Too Many (2018). The Law and FGM, an overview of 28 African Countries, *Thomson Reuters*, pp. 1-80, retrieved 9 March, 2023, from https://www.28toomany.org/thematic/law-and-fgm/

BBC news YouTube (2016). *Hard Talk: Female Genital Mutilation Discussion*, retrieved 14 March, 2023, from https://www.youtube.com/watch?v=mV6UfEaZHBE&t=2s

Economic Development and Institutions (EDI) (2020), *Research Insight: Female Genital Cutting and the Slave Trade*, retrieved 11 March, 2023, from https://edi.opml.co.uk/resource/female-genital-cutting-and-the-slave-trade/.

End FGM European Network (2022). *Female Genital Mutilation*, retrieved 2 March, 2023, from https://www.endfgm.eu/female-genital-mutilation/

End FGM European Network (2022). *What is FGM?*, retrieved 2 March, 2023, from https://www.endfgm.eu/female-genital-mutilation/what-is-fgm/

Eva Ontiveros (6 February 2019). What is FGM, where does it happen and why?, *BBC News*, retrieved 5 March, 2023, from https://www.bbc.com/news/world-47131052

IOM (2009). *Supporting the Abandonment of Female Genital Mutilation in the Context of Migration*, *UN Migration*, pp. 1-6, retrieved 10 March, 2023, from https://www.iom.int/resources/supporting-abandonment-female-genital-mutilation-context-migration

Kaplan, A., Ajenjo, M., López-Gay, C. (2021) Mapa de la Mutilación Genital Femenina en España 2021, Fundación Wassu UAB p1-180, retrieved 10 March, 2023, from https://ddd.uab.cat/record/269840

Khaleeli, Homa (15 April 2010). "Nawal El Saadawi: Egypt's radical feminist", retrieved 5 April, 2023, from *The Guardian*. https://www.theguardian.com/lifeandstyle/2010/apr/15/nawal-el-saadawi-egyptian-feminist

S.A.F.E, Female Genital Cutting (FGC) Abandonment, retrieved 17 March, 2023, from https://safekenya.org/our-projects/female-genital-cutting/

Thomas Sankara. (2021, 12 noviembre). Casafrica, retrieved 20 April, 2023, from https://www.casafrica.es/es/persona/thomas-sankara

UN DESA (2022). The Sustainable Development Goals Report 2022, retrieved 1 March, 2023, from https://unstats.un.org/sdgs/report/2022/

UN Women News (2018, 25 of May). From Where I Stand: “What we need is free education for our girls”, retrieved 16 March, 2023, from

https://www.unwomen.org/en/news/stories/2018/4/from-where-i-stand-purity-soinato-oiyie.

UNAF (2016) La mutilación genital femenina en España. Prevención e intervención. Guía para profesionales, retrieved 17 March, 2023, from https://unaf.org/wp-content/uploads/2015/10/Guia-MGF-2015.pdf

UNESCO Universal Declaration on Cultural Diversity was adopted on 2 November 2001, retrieved 17 March, 2023, from http://unesdoc.unesco.org/images/0012/001271/127162e.pdfhttp://unesdoc.unesco.org/images/0012/001271/127162e.pdf

UNFPA (2021), The International Day of Zero Tolerance for Female Genital Mutilation, retrieved 1 March, 2023, from https://www.unfpa.org/international-day-zero-tolerance-female-genital-mutilation

UNICEF (2020), A Decade of Action to Achieve Gender Equality: The UNICEF Approach to the Elimination of Female Genital Mutilation. retrieved 5 April, 2023, from https://www.unicef.org/documents/decade-action-achieve-gender-equality-unicef-approach-elimination-female-genital.

UNICEF (2020). *Female Genital Mutilation: A New Generation Calls for Ending an Old Practice*, United Nations Children's Fund, retrieved 10 March, 2023, from https://data.unicef.org/resources/female-genital-mutilation-a-new-generation-calls-for-ending-an-old-practice/.

United Nations International Children's Emergency Fund (UNICEF) (2016). Female Genital Mutilation/Cutting: A Global Concern, retrieved 18 March, 2023, from https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

United Nations Population Fund (UNFPA) (2019). Female genital mutilation (FGM) frequently asked questions, retrieved 5 April, 2023, from

https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#where_practiced

WHO (2008). *Eliminating female genital mutilation: an interagency statement* - OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, pp 1-40, retrieved 10 March, 2023, from https://apps.who.int/iris/handle/10665/43839

Wilkinson, D (2014). Cultural Relativism and Female Genital Mutilation. *Ethics in the news, University of Oxford,* retrieved 9 March, 2023, from http://blog.practicalethics.ox.ac.uk/2014/02/cultural-relativism-and-female-genital-mutilation/

Woman Stats Project (2023). woman Stats Maps, retrieved 18 April, 2023, from https://www.womanstats.org/maps.html