



**All-Party Parliamentary Group on
POPULATION, DEVELOPMENT AND REPRODUCTIVE HEALTH**

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**FEMALE GENITAL MUTILATION
SURVEY REPORT AND ANALYSIS**

**REPORT OF THE FINDINGS OF RESEARCH ABOUT
THE WORK OF ORGANISATIONS IN THE UK AND
OVERSEAS ON FEMALE GENITAL MUTILATION**

NOVEMBER 2000

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INTRODUCTION

Female Genital Mutilation (FGM), also known as Female Genital Cutting (FGC) or Female Circumcision, involves procedures which include the partial or total removal of the external female genital organs for cultural or any other non-therapeutic reasons¹. It is estimated that 130 million women and girls have undergone FGM and that 2 million girls are at risk of undergoing the procedure every year. The procedure is usually performed on girls between the ages of 4-13, but in some cases FGM is performed on new born infants or on young women prior to marriage or pregnancy. Most of the women and girls affected live in Africa, although some live in the Middle East and Asia. However, women and girls who have undergone, or are at risk of undergoing, FGM are increasingly found in Western Europe and other developed countries, primarily among immigrant and refugee communities.

To raise awareness of FGM in the UK and abroad and to generate support for FGM prevention and eradication programmes, the All-Party Parliamentary Group on Population, Development and Reproductive Health held two Parliamentary Hearings in May 2000.

The first Hearing was for witnesses from the UK and covered issues such as training, the effectiveness of the law against FGM, support services and care available and work with community based organisations. The second day of the Hearings was for witnesses from Europe and beyond covered overseas activities on FGM.

In preparation for these Hearings a questionnaire was circulated to organisations who were identified working in the field of FGM in the UK, Europe, Africa and the USA. To get a picture of the FGM policy and issues in UK, questionnaires were also sent to local health and education authorities, social service departments and refugee councils.

The responses to the questionnaire are analysed here and presented as an additional source of information and an accompaniment to the "Parliamentary Hearings on Female Genital Mutilation" Hearings Report, November 2000.

The All-Party Parliamentary Group would like to thank the UK Department for International Development for sponsoring the research analysis and production of this report.

Christine McCafferty MP
Chair

¹ WHO classification of the four types of FGM are: Type I: Excision of the prepuce, with or without excision of part or all of the clitoris (clitoridectomy). Type II: Excision of the clitoris with partial or total excision of the labia minora (excision). Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Type IV: Unclassified: including pricking, piercing or incising of the clitoris and/or labia etc.

KEY FINDINGS

1. BACKGROUND

- Responses to the FGM Questionnaire were received by 52 UK respondents and 45 overseas respondents. 45% of all respondents classified themselves as "Non-Governmental Organisations", among UK respondents another popular response was "Local Health Authority."
- "Advocacy and campaigns" and "Education and training" were the most popular FGM related activities cited by respondents.

2. ISSUES

- FGM was the preferred terminology of respondents (85%).
- The vast majority of respondents were opposed to the medicalisation of FGM (94%) and expressed that there should be a general code of conduct for health professionals (91%).
- When asked what they thought should be the role of Government in addressing the eradication of FGM, a sizeable majority of respondents (75%) mentioned issues relating to the provision and implementation of a legal framework.
- Less than half (46%) of the UK respondents mentioned an awareness of the UK Prohibition of Female Circumcision Act 1985.
- The majority of the respondents cited pressure from the family or community, which is closely associated with a lack of evidence, as an obstacle for prosecution on FGM.
- 25% of UK respondents surveyed expressed a fear of being perceived as racist or culturally insensitive when dealing with FGM issues, in Europe 8% expressed a concern.

3. SERVICES

- The most popular activities that the respondents were engaged with were activities to raise awareness of the issues of FGM, the provision of information about FGM and promoting understanding of FGM. Health and education service provision was popular in the UK, which reflected the composition of questionnaire respondent.
- Of the respondents that provided services, the vast majority (90%) answered that their services were provided free of charge.
- In the UK 77% of respondents said their services were confidential. In Europe 54% and in Africa 64% of respondents said their services were confidential.
- The most frequently mentioned problems encountered by respondents were the objections from religious and cultural groups and the barrier to discussing sexual taboo subjects. Other common issues cited included a lack of funding, particularly among African respondents, and the related obstacles of limited awareness and denial of the problems of FGM.
- A wide variety of "Countries of Origin" African community groups were represented in the survey. The most common group in the UK was the Somali community.

4. FUNDING

- Most respondents currently spend less than 5% of their budgets on FGM.

- For all types of funding source, respondents had difficulties raising funds because they perceived that potential donors regarded FGM as less important than other priorities.
- In both UK and Europe the three most important sources of funding were seen as national Governments, the EU and trusts/foundations. However, in Africa, there was an increased emphasis on trusts and foundations relative to Government and EU sources.

SURVEY DETAILS

Sampling frame

Following a full review of NGO's and other contacts in the field, survey questionnaires were sent to organisations who were identified as playing a role in FGM policy and issues in the UK, Europe, Africa and the USA. In the UK, questionnaires were also sent to local health and education authorities, social service departments and refugee councils.

A total of 240 questionnaires were sent out to UK addresses, and a further 140 were sent to overseas addresses. Responses were received from 52 UK respondents and 45 overseas, although it should be noted that 23 (31%) of these were sent back by the original questionnaire recipient and in fact the questionnaires may have been passed on by the original recipients to a more appropriate respondent.

The low response rate from the UK can partly be explained by the number of organisations in the UK who probably do not address FGM as a primary area of concern, whereas the overseas recipients had already been identified as taking an interest in FGM activity.

	UK	OVERSEAS	TOTAL
Sent	240	140	380
Received	52	45	106
Response rate	22%	32%	28%
Received from list	39	35	74
Received from other	13	10	23

Questionnaire design

The questionnaire was organised into 4 main sections, and this analysis has been prepared accordingly:

1) Background

- a) organisation contact details
- b) type
- c) objectives

d) target group

2) Issues

- a) descriptive term used
- b) alternative practices
- c) health response
- d) legislative response
- e) research

3) Services

- a) activities
- b) community work
- c) problems and achievements
- d) training
- e) collaboration

4) Funding

- a) budgeting
- b) fundraising

The following report synthesises responses to all relevant questions in the survey, with the one exception of a question on human rights, that was later deemed ambiguous (question 3 in the section of Issues) - see Appendix III for the questionnaire that was received by all survey respondents. Unless otherwise stated, respondents were asked open-ended questions with the opportunity to provide a freely worded response. After the completion and collection of all survey entries, these answers were assessed and coding frames were developed. Every open-ended questionnaire response was assigned one or more codes according to pre-determined categories. Questionnaire responses were double entered and cross-checked using the QPS MR suite of programs and data analysis was carried out using SPSS v10 statistical software.

SURVEY ANALYSIS

1) BACKGROUND

a) **Organisation contact details**

i. Geographic distribution of respondents

97 valid questionnaire responses were received and subsequently analysed below. Of these, 52 responses (54%) were from organisations located within the UK, 18 (19%) were from other European countries, three (3%) were from the USA and 24 (25%) were from countries in Africa. The distribution of countries and regions of response is shown below:

region

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid UK	52	53.6	53.6	53.6
Europe	23	23.7	23.7	77.3
Africa	19	19.6	19.6	96.9
USA	3	3.1	3.1	100.0
Total	97	100.0	100.0	

Europe		Africa	
	Frequency		Frequency
Belgium	1	Côte d'Ivoire	1
Denmark	2	Ghana	2
France	4	Kenya	3
Germany	5	Mauritania	1
Greece	2	Nigeria	1
Italy	2	Republic of Congo	1
Netherlands	1	Senegal	1
Portugal	1	Sierra Leone	1
Spain	2	Sudan	3
Sweden	3	Tanzania	1
		The Gambia	2
		Togo	1
		Uganda	1
Subtotal	75	Subtotal	19

b) Type of respondent

Organisations were offered a choice of 11 different responses from which to choose the best description of their type of organisation. The most popular response, given by 43 respondents (45%) was "Non-governmental Organisation". Among UK organisations, other popular responses were "Local Health Authority" (11 responses) and "Health Facility, e.g. specialist care or antenatal care clinic" (11 responses). Responses classified as "Other" included: Individual (4 responses, UK and Europe); Area Child Protection Committee (2 responses, UK) and Trade Union/Professional Association (4 responses, UK).

Organisation Type	UK	Europe	Africa	US	Total	% respondents
NGO	13	14	14	2	43	45.3%
Research Institution	1	2			3	3.2%
Local education authority	3		1		4	4.2%
Church Group			1		1	1.1%
Governmental Body	1	4			5	5.3%
Academic Institution	1	2	1		4	4.2%
Local Health Authority	11				11	11.6%
Health Facility	11		1		12	12.6%
International organisation	3		2	2	7	7.4%
Advocacy group	3	2	2		7	7.4%
Local authority	7	1			8	8.4%
Other	14	1	3	2	20	21.1%
Total responses	68	26	25	6	125	
Total cases	52	23	17	3	95	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

c) Organisational objectives of respondents

Survey respondents were questioned about the general objectives of their organisation and how they relate to FGM in two separate open-ended questions. Responses from these questions were combined and categorised into 8 types of objectives relating to their work on FGM. The most popular responses given to these questions cited objectives relating to "Advocacy and campaigns" and "Education and training" (listed by 53 and 41 respondents respectively). Common responses among UK organisations, which were predominantly local health and social services authorities, were objectives relating to "Counselling and social support" and "Welfare and Child protection"; while African and European respondents, which were mainly NGOs, listed goals relating to "Research" and "Women's empowerment". This may reflect the continuing importance of community-based women's empowerment groups as a priority in developing countries.

FGM Objectives	UK	Europe	Africa	USA	Total	% cases
Education and training	14	12	12	3	41	43.6%
Advocacy and campaigns	20	12	18	3	53	56.4%
Women s empowerment	6	7	10		23	24.5%
Research	3	10	5		18	19.1%
Medical Services	19	1	6		26	27.7%
Counselling and social support	17	4	1		22	23.4%
Welfare and Child protection	12	3	3		18	19.1%
Legal enforcement	2	4	2		8	8.5%
Other		1			1	1.1%
Total responses	93	54	57	6	210	
Total cases	49	23	19	3	94	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

d) Target group of respondent's services

Survey respondents were offered a choice of 10 options to describe the target group of their services and activities. By far the most popular response across all regions was "Women", to whom 73 respondents (81%) aimed their services. Migrant and Refugee work were more frequently mentioned in the UK and Europe which indicates that these are the communities where there is a prevalence of FGM, but could also indicate that refugee migrant communities moving to other African countries are not seen as a priority.

Target group	UK	Europe	Africa	USA	Total	% cases
Women	36	19	18		73	81.1%
Children	23	8	12		43	47.8%
Adolescents	17	12	14		43	47.8%
Refugees	21	10	4		35	38.9%
Migrants	13	12	5		30	33.3%
Social Services	13	14	4		31	34.4%
Local Education Authority	9	8	4		21	23.3%
Local Authority	10	6	5		21	23.3%
Local Health Authority	14	10	3		27	30.0%
Professional Health Association	16	11	4	1	32	35.6%
Other	11	2	6	3	22	24.4%
Total responses	183	112	79	4	378	
Total cases	47	21	19	3	90	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

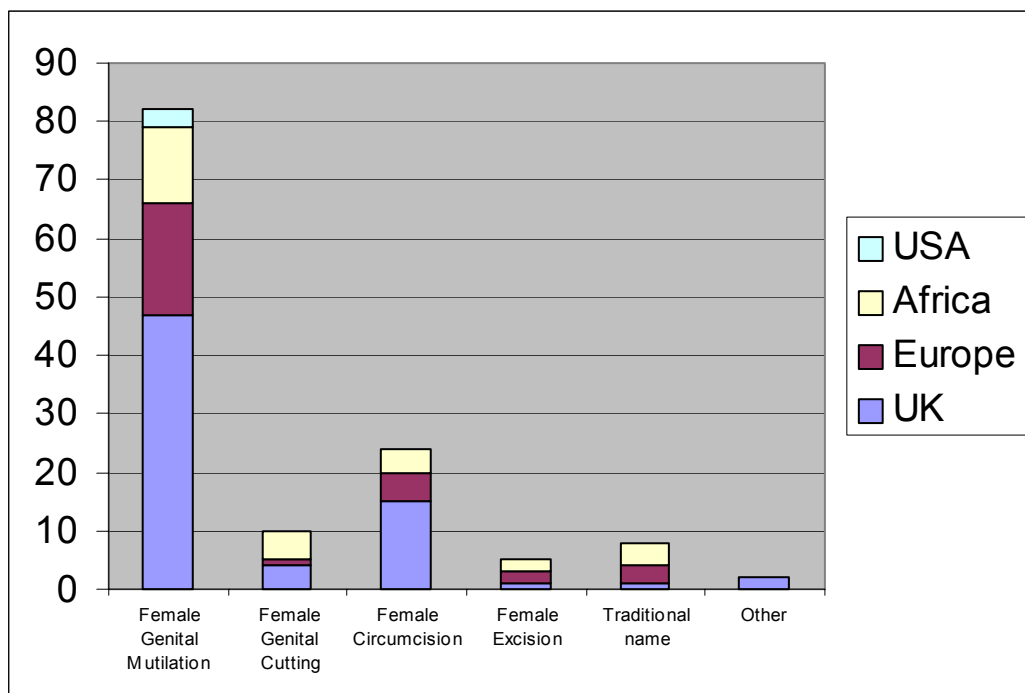
2) ISSUES

a) Descriptive term used

Survey respondents were asked what name they use to refer to the cutting of female genitalia, and offered a choice of four commonly used terms, as well as traditional local names. The phrase "Female Genital Mutilation" has gained popular currency as both a descriptive term and a political lobbying tool among international organisations and is evidently the most popular term used (n=82, mentioned by 85% of respondents). However, use of the term "Female Circumcision" still remains common in the UK (mentioned by 15 out of 52 UK respondents: 29%), where even the relevant law is named The Female Circumcision Act. Traditional and "other" responses included two European organisations that used the term "Gudniin" (country of origin: Ethiopia, Somalia and unspecified), a Nigerian organisation using the term "Ibeugwu", a Kenyan organisation using "Mutata Tipin" and a Tanzanian organisation using "Ukeketaji". The use of different terminology in these answers reflected the overall need to be sensitive in addressing FGM at all levels.

Call the practice	UK	Europe	Africa	USA	Total	% cases
Female Genital Mutilation	47	19	13	3	82	84.5%
Female Genital Cutting	4	1	5		10	10.3%
Female Circumcision	15	5	4		24	24.7%
Female Excision	1	2	2		5	5.2%
Traditional name	1	3	4		8	8.2%
Other	2				2	2.1%
Total responses	70	30	28	3	131	
Total cases	52	23	19	3	97	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.



b) Alternative practices

A total of twenty-nine organisations (36% of respondents, of which 10 were from the UK, 8 European, 9 African, 2 USA) answered "Yes" to the question "Do you think there is a good alternative to the tradition of FGM?" Half of all 18 African organisations providing a response to this question answered "Yes", compared to 25% and 40% in the UK (n=40) and Europe (n=20) respectively.

Is there an alternative to FGM?

	UK	Europe	Africa	USA	Total	% respondents
Yes	10	8	9	2	29	35.8%
No	30	12	9	1	52	64.2
Missing	12	3	1	1	17	

Alternative, non-mutilating rites of passage initiation ceremonies were identified as being a viable option in Kenya, Uganda, Ghana, The Gambia, and Senegal. Symbolic ritual celebrations suggested for such ceremonies included the giving of gifts (Uganda, Ghana), placing stones or seeds (Kenya), cutting a chicken (Côte d'Ivoire) and throwing a party (Ghana). "Ntanira na Mugambo" (Circumcision through words) was an example used in a Kenyan community group to mark a girls passage to womanhood. Other respondents identified other forms of circumcision (eg sunna) as a suitable alternatives to FGM (Somalia and Egypt) – whereas this is actually considered by the WHO to be a sub-classification of FGM (see footnote 1) so is not seen as an acceptable alternative. One UK recipient mentioned the practice of "pricking the clitoris" as a suitable alternative, but FGM remains illegal in the UK.²

c) Health Response

i. Medicalisation of FGM

The vast majority of respondents (93.5%, n=87) were opposed to any attempts by health professionals to engage in the cutting of female genitalia. A small minority of respondents (6.5%, n=6), were in favour of the medicalisation of FGM. Those who supported medical professionals carrying out the procedure cited hygiene and safety as the main reasons.

The most commonly given reason against health professionals carrying out FGM (used by 61% of medicalisation opponents, n=47) was that the practice

² For a Review of alternative practices and FGM programmes currently in operation see WHO Publication: "Female Genital Mutilation Programmes to date: What Works and What Doesn't" Department of Women's Health 1999

could not be medically justified. Other popular responses were phrased in terms of a human rights argument (used by 27.3% of opponents to medicalisation, n=21). A further 28 responses (36.4% of medicalisation opponents) claimed that to allow medical professionals to carry out the practice of FGM even under hygienic conditions, would be equivalent to legitimising or sanctioning the practice: giving it credibility as a medical practice, whereas in fact FGM has no medical benefits.

Should health professionals engage in cutting

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	6	6.2	6.5	6.5
	No	87	89.7	93.5	100.0
	Total	93	95.9	100.0	
Missing	System	4	4.1		
Total		97	100.0		

Why health professionals should cut	Count	% Cases
Hygiene, safety	3	75
Other	3	75
Total responses	6	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

Why health professionals should not cut	Count	% Cases
Medical	47	61
Legal	2	2.6
Human Rights	21	27.3
Psychological	8	10.4
Legitimises practice	28	36.4
Other	4	5.2
Total responses	110	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses

ii. Code of Conduct

82 respondents (91.1% of all who answered the question) were of the opinion that there should be a general FGM Code of Conduct for health professionals. By far the most popular justification for this response (given by 79.2% of respondents, n=57) was that it would be advantageous to formulate practical guidelines for the provision of information and treatment in order to standardise practice among health professionals. Other reasons given in favour of a Code of Conduct included opening up the option of legal enforcement and the promotion of education that will encourage behaviour

Should there be a FGM code of conduct

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	82	84.5	91.1	91.1
	No	8	8.2	8.9	100.0
	Total	90	92.8	100.0	
Missing	System	7	7.2		
Total		97	100.0		

change eventually leading to the prevention of FGM.

8 respondents replied that there should *not* be a Code of Conduct specifically for FGM. These included two respondents citing inevitable practical difficulties in the implementation of such a Code, especially in the light of such a wide variety of practice and context. A further two respondents were opposed to singling out the practice of FGM for such special attention, which may stigmatise women who have undergone FGM. These respondents favoured FGM Guidance incorporated in a general Health Code of Conduct.

Why there should be a code	Count	% Cases
Guidelines and standardisation of practice	57	79.2
Legal enforcement	13	18.1
Prevention of FGM	16	22.2
Education and behaviour change	11	15.3
Total responses	97	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

Why there should not be a code	Count	% Cases
Practical implementation difficulties	2	40
Should integrate into general settings	2	40
Other	1	20
Total responses	5	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

d) Legislative response

i. Role of Government

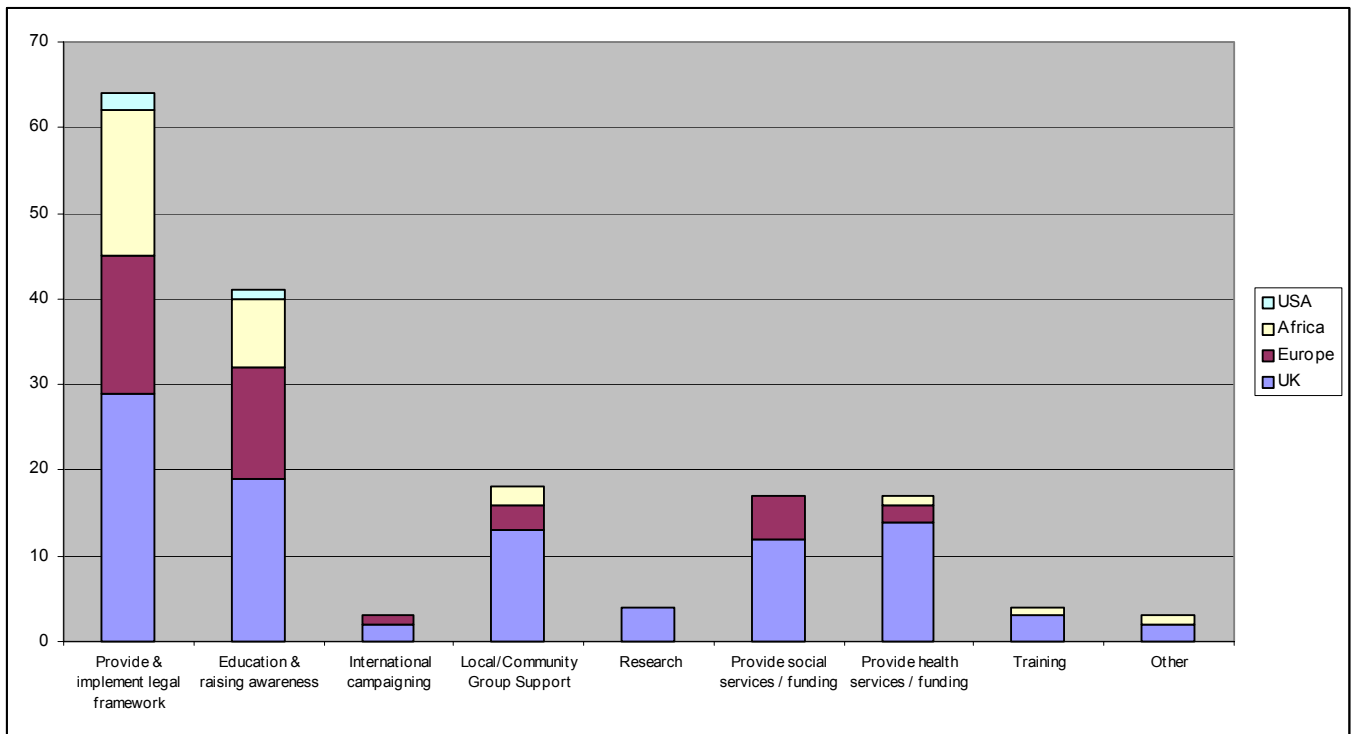
When asked what they thought should be the role of Government in addressing the eradication of FGM, a sizeable majority of respondents (75%, n=64) mentioned issues relating to the provision and implementation of a legal framework. This may not be surprising considering that this question was headed "a legislative response to FGM", already raising the issue in the minds of respondents. The second most popular response mentioned was domestic activities relating to education and awareness-raising (n=41, 48%). Both of these roles were mentioned by respondents from the UK, Europe and Africa. Proportionately more UK respondents than European groups answered that there was a role for the Government in the provision of social and health services, although this may reflect the organisational composition of the respondents. The provision of health and social services as a responsibility of the Government was barely mentioned by African respondents, perhaps reflecting the growing dependence on NGO activities and international aid. Few organisations from either the UK or Europe listed

international campaigning among countries where FGM is commonly practised as a role for Government.

Role of government	UK	Europe	Africa	USA	Total	% cases
Provide and implement legal framework	29	16	17	2	64	75.3%
Education & awareness-raising (national)	19	13	8	1	41	48.2%
International campaigning	2	1			3	3.5%
Local/Community Group Support	13	3	2		18	21.2%
Research	4				4	4.7%
Provide social services and/or funding	12	5			17	20.0%
Provide health services and/or funding	14	2	1		17	20.0%
Training	3		1		4	4.7%
Other	2		1		3	3.5%
Total responses	98	40	30	3	171	
Total cases	45	20	18	2	85	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

Role of Government



ii. Prosecutions

Survey respondents were asked to provide information about the legislation regarding FGM in their country of operations and whether or not any prosecutions had taken place. These questions were not intended to provide a factual analysis of the legal situation in each country - rather they were intended to provide an indication of respondents' level of awareness of the legal restrictions and developments regarding FGM. Thus the following information should be read in the context of other published material on the legal implications of FGM.³

United Kingdom

Among the 52 UK respondents, the 1985 Prohibition of Female Circumcision Act⁴ was mentioned by 24 (46%). As all of the UK organisations have a remit to work in this area in the UK, the awareness of the law is surprisingly low. The 1989 Children Act was also mentioned by 8 although it was frequently misnamed or incorrectly dated. At the local level, 10 UK respondents mentioned the Child Protection procedures - this is perhaps unsurprising since many of the UK respondents were local social services providers especially primed to deal with such issues.

One respondent reported that in the late 1990s, a doctor was fined £1000 for carrying out an FGM operation, although it was unclear who had instituted this disciplinary procedure. Another respondent believed that a prosecution had taken place in the UK 1999. There have been no prosecutions under the UK Prohibition of Female Circumcision Act 1985.⁵

Some UK organisations were well informed about FGM legislation overseas: five UK organisations were aware of prosecutions that had taken place in France, and some organisations were aware that FGM had been criminalised

³ See "Female Genital Mutilation - A Guide to Laws and Policies Worldwide" (Anika Rahman and Nahid Toubia; Zed Books; 2000) for an up-to-date survey

⁴ Prohibition of Female Circumcision Act 1985

⁵ Female Circumcision Hansard, 18 May 2000:

Ms McCafferty: To ask the Secretary of State for the Home Department (1) how many (a) arrests and (b) convictions have been made under the Prohibition of Female Circumcision Act 1985; (2) how many (a) arrests and (b) convictions have been made under (i) the Children Act 1989 and (ii) the Criminal Justice (Terrorism and Conspiracy) Act 1998, in relation to the practice of female genital mutilation in the UK and abroad ?

Mr. Charles Clarke: Arrest data are not collected centrally by individual offence. The Home Office Court Proceedings Database show no defendants proceeded against under the Prohibition of Female Circumcision Act 1985. Information collected under the Children Act 1989 and the Criminal Justice (Terrorism and Conspiracy) Act 1998 does not distinguish such offences from others within these Acts.

in a number of African countries, eg Sudan, Burkina Faso, and in certain US states.

Europe

All four of the French respondents showed good awareness of the fact that there is no specific law on FGM in France, but that FGM is illegal in France under Article 222 of the Penal Code.⁶ French respondents were also aware that a large number (20-25) of prosecutions had taken place.

Respondents in Germany⁷, Italy⁸, Denmark⁹ and Greece were also aware that there was no specific law in their respective countries on FGM, but were aware of the articles of their Penal Codes under which the practice of FGM could be prosecuted. However, they did not mention specific prosecutions. France remains the country with the best prosecution record, and data collection in other European countries is not as readily available.¹⁰

All three of the Swedish respondents mentioned that there is a specific national law prohibiting FGM in Sweden¹¹ and were also keen to mention their child protection procedures at the local level.

A Spanish respondent reported that there had been 2 cases of FGM prosecution, and an Italian respondent reported that there had been one and a further five were still pending.

A German organisation was aware that Pharonic FGM has been illegal in Sudan since 1946, when the British colonial administration began to prosecute a midwife but public demonstrations made them drop the proceedings.

Africa

African respondents reported laws against the practice of FGM in Côte d'Ivoire¹², Senegal¹³, Togo¹⁴, Ghana¹⁵, Kenya¹⁶, Tanzania¹⁷ and Uganda.¹⁸

⁶ Code Penal 1992, Article 222.

⁷ Articles 224 ("Serious Bodily Harm") and 226 ("Grave Bodily Harm") of German Penal Code.

⁸ Article 582 ("Personal Injury") Italian Penal Code.

⁹ Paragraph 245 of Danish Penal Code ("Assault and Health Provision")

¹⁰ "Female Genital Mutilation - A Guide to Laws and Policies Worldwide" (Anika Rahman and Nahid Toubia) op.cit.

¹¹ 1992 FC/FGM Law in Sweden, revised in 1998 to make penalties more severe and also provides for the prosecution of any resident in Sweden who arranges for FGM to take place in another country.

¹² Specific Law Prohibiting FGM 1998

¹³ 1999 Law amended to prohibit FGM

¹⁴ Specific Law 1998

¹⁵ 1994 Criminal Code amended to incorporate FGM

¹⁶ 1996 Specific Law against FGM defeated in Parliament

¹⁷ 1998 Penal Code amended to incorporate FGM

¹⁸ Formulating Law in Penal Code

A Sudanese respondent reported that although the practice had theoretically been outlawed, in practice it was neither enforced nor effective. Another Sudanese respondent reported that cases were generally carried out by parents against circumcisers in the event that something has gone wrong with the procedure, and mentioned three instances of such prosecutions being brought to trial.

Two respondents were aware of at least one prosecution that had taken place in Ghana, and one Kenyan respondent reported that there had been about three cases between 1990-1999.

USA

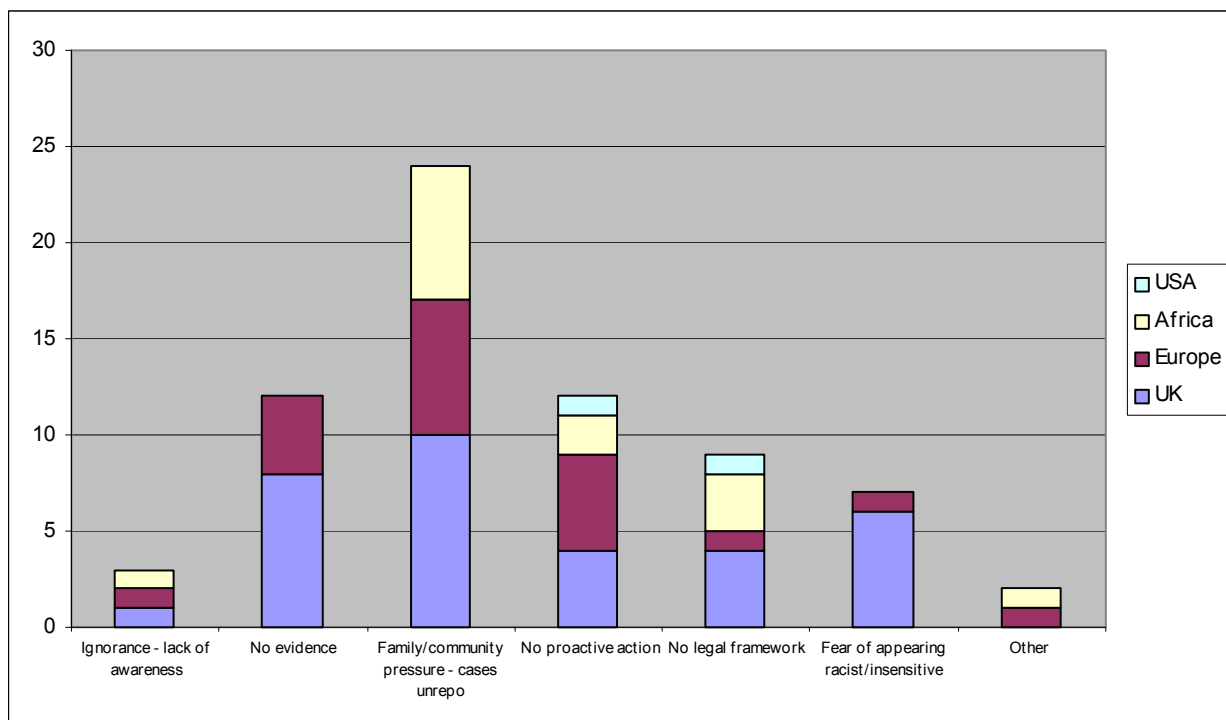
The US respondents were aware of the 1997 Schroder bill preventing FGM on minors, and one mentioned a 1999 case in Minnesota under trial.

iii) Obstacles to prosecutions

Respondents were also asked for their opinion regarding any obstacles that may have prevented more cases from coming to trial. By far the most frequently-mentioned response among respondents in all three main regions was the pressure from the family or the community that leads to cases going unreported (n=24, 50% of respondents who listed obstacles to prosecution). A related and also frequently mentioned reason was the lack of evidence available to enable FGM cases to reach the courts system (n=12, 25%). However, this is closely linked with willingness of people to come forward and pressure of families or communities. It is notable that among UK respondents, the fear of being regarded as racist or culturally insensitive was mentioned by 6 of 24 respondents (25%), whereas only 1 of the 12 European respondents chose to bring up this issue (8%). This obstacle was not mentioned at all by African organisations, even those that were local branches of international organisations. The lack of a legal framework within which to operate was also mentioned more frequently by UK respondents than European. This is consistent with the UK perceived as failing to bring prosecutions under the specific law on FGM.

Obstacles to prosecution	UK	Europe	Africa	USA	Total	% cases
Ignorance / lack of awareness	1	1	1		3	6.3%
No evidence	8	4			12	25.0%
Family/community pressure	10	7	7		24	50.0%
No proactive action	4	5	2	1	12	25.0%
No legal framework	4	1	3	1	9	18.8%
Fear of appearing racist / insensitive	6	1			7	14.6%
Other		1	1		2	4.2%
Total responses	33	20	14	2	69	
Total cases	24	12	11	1	48	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.



Obstacles to prosecutions

e) Research

46 of the respondents surveyed (50%) stated that they carried out research of some type. Of the various types of research into which these activities were categorised, the most popular type (n=30, mentioned by 73% of respondents) was social or anthropological research (e.g. into community members' knowledge and attitudes towards FGM).

CARRY OUT RESEARCH?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	46	47.4	49.5	49.5
	No	47	48.5	50.5	100.0
	Total	93	95.9	100.0	
Missing	System	4	4.1		
Total		97	100.0		

Research activities	UK	Europe	Africa	USA	Total	% cases
Prevalence	6	1	5	0	12	29.3%
Medical efforts and procedures	4	3	4	0	11	26.8%
Psychological	1	2	2	0	5	12.2%
Social/Anthropological	9	9	12	0	30	73.2%
Strategy/policy/legal	1	3	5	0	9	22.0%
Other	0	0	2	0	2	4.9%
Total responses	21	18	30	0	69	
Total cases	14	12	15	0	41	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

3) SERVICES

a) Organisation activities

Survey respondents were offered a choice of 12 response categories to the question “What activities are you engaged in?” among which the most popular options were activities to raise awareness of the issues of FGM, the provision of information about FGM and promoting understanding of FGM.

Organisation activities	UK	Europe	Africa	USA	Total	% cases
Awareness raising	36	21	15	2	74	86.0%
Lobbying/Advocacy	10	8	14	2	34	39.5%
Research	14	9	12	1	36	41.9%
Information Provision	31	18	12	2	63	73.3%
Production of health education materials	16	10	11	2	39	45.3%
Support of organisations in Africa & M. East	12	7	5	1	25	29.1%
Campaigning	10	8	13	1	32	37.2%
Working with the media	9	15	9	3	36	41.9%
Networking	20	10	10	3	43	50.0%
Raising funds and commitment	11	6	10	1	28	32.6%
Promoting understanding	29	15	16	2	62	72.1%
Other	11	2	1		14	16.3%
Total responses	209	129	128	20	486	
Total cases	42	22	19	3	86	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

i. Services and support

Respondents were offered a choice of 5 options in response to the question “What services and support do you provide?”, of which the most popular were Education and Counselling. Responses of Health and Education service provision were particularly high in the UK due to the composition of questionnaire respondents as noted earlier (page 6 type of respondent).

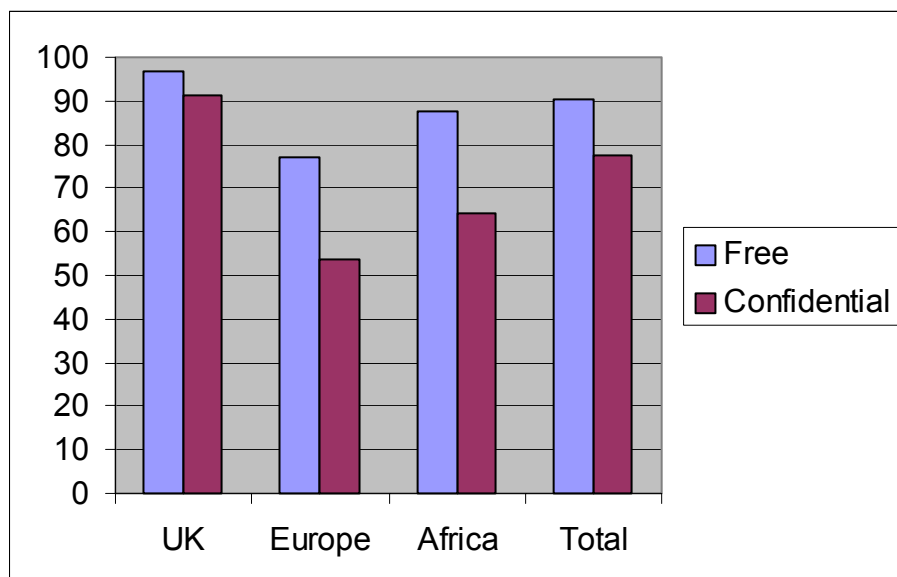
Services and support	UK	Europe	Africa	USA	Total	% cases
Counselling	16	14	14		44	59.5%
Education	25	12	14	1	52	70.3%
Legal advice	2	4	1		7	9.5%
Health/Medical treatment	17	1	4		22	29.7%
Other	8	4	3	2	17	23.0%
Total responses	68	35	36	3	142	
Total cases	37	18	17	2	74	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

ii. Cost and confidentiality of services

Questionnaire respondents were asked whether their services were provided free of charge and whether they were confidential. Of those who provided services relevant to this section of the questionnaire, the vast majority (90.3%, n=56) of respondents' services were provided free of charge. Within the UK, only one organisation responded that not all services were free of charge at the point of use but in fact incurred variable charges, while in Europe and Africa three and two respondents respectively reported the existence of a fee structure for the use of their services. Overall, 77% of respondents claimed that the services they provided were confidential, although this masks wide regional variation as shown in the graph below. The level of confidentiality was highest in the UK, which could be explained by the composition of respondents being dominated by Social Services organisations.

	Are services free?			Are services confidential?		
	Total respondents	Yes (n)	%	Total respondents	Yes (n)	%
UK	33	32	97.0	35	32	91.4
Europe	13	10	76.9	13	7	53.8
Africa	16	14	87.5	14	9	64.3
Total	62	56	90.3	62	48	77.4



b) Community work

Survey respondents were questioned regarding their community activities and collaborations with community groups. The most popular responses were IEC/Training activities (n=18, mentioned by 46% of respondents to this question), Networking (n=14, 36%) and the provision of health or medical services (n=12, 31%).

Community work	UK	Europe	Africa	USA	Total	% cases
Health/medical services provision	8	2	2		12	30.8%
Capacity building	2		2		4	10.3%
IEC/Training	6	4	6	2	18	46.2%
Networking	5	6	3		14	35.9%
Women s empowerment	4	1	2		7	17.9%
Mobilisation of community leaders	2		2		4	10.3%
Developing FGM alternative practices	2	1	1	1	5	12.8%
Research	1		5		6	15.4%
Other	1	1			2	5.1%
Total responses	31	15	23	3	72	
Total cases	16	8	13	2	39	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

c) Problems and Achievements

Respondents were asked to list separately any problems they had encountered and any achievements that they had made while working with FGM-related issues.

The most frequently-mentioned problems encountered by respondents were the objections from religious and cultural groups and the barrier to discussing sexual taboo subjects. Other common issues cited included a lack of funding, particularly among African respondents, and the related obstacles of limited awareness and denial of the problems of FGM. Responses categorised as "other" included difficulties encountered in engaging men in FGM-related activities, heavy handedness by Social Services and the problem of FGM being driven underground by the introduction of legislation. Further mention was made of opposition from medical personnel and hostile responses from FGM practitioners (circumcisors) because of loss of revenue.

By far the most popular response among the achievements listed were various developments towards the goal of improving in the profile of the respondent organisation and awareness of the issues relating to FGM. Also frequently mentioned as an achievement was the positive effect of changes in behaviour, especially in Africa, including drops in the incidence of FGM and increased incidence of alternative practices. Not a single UK respondent mentioned media attention as one of their achievements, while this was a popular response from European respondents. "Other" responses included successful prosecutions and a mention of medical reversals performed.

Problems	UK	Europe	Africa	USA	Total	% cases
Lack of knowledge/awareness/data	12	1	2		15	22.1%
Denial/indifference	2	7	3	2	14	20.6%
Limited availability of funds	5	1	10	1	17	25.0%
Address culturally sensitive topic	6	3			9	13.2%
Lack of co-op Govt/Legal System			6		6	8.8%
Religious/cultural groups object	11	5	11		27	39.7%
Lack of collaboration/networks	4				4	5.9%
Prevention vs treatment priorities	2			1	3	4.4%
Sexual taboos	15	2	7		24	35.3%
Language / illiteracy	3	3	1		7	10.3%
Other	7	4	7		18	26.5%
Total responses	67	26	47	4	144	
Total cases	34	12	19	3	68	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

Achievements	UK	Europe	Africa	USA	Total	% cases
Improved profile/awareness/data	17	11	12	2	42	62.7%
Production of publications	7	2	4	1	14	20.9%
Development of strategy	17	1	4		22	32.8%
Media attention		4	1	1	6	9.0%
Research findings	2	1	1		4	6.0%
Collaboration and networking	7	1	1		9	13.4%
Government action	2	2	4	1	9	13.4%
Behaviour change	10	5	14		29	43.3%
Other	1	1			2	3.0%
Total responses	63	28	41	5	137	
Total cases	32	14	18	3	67	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

d) Training

63 survey respondents provided a positive response to the question "Do you provide training or education on FGM issues?" Respondents were asked to name groups, if any, to whom training was provided, and if it was provided free of charge. Only 8 organisations reported that they charged participants for involvement in their training activities.

Provide training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	63	64.9	76.8	76.8
	No	19	19.6	23.2	100.0
	Total	82	84.5	100.0	
Missing	System	15	15.5		
Total		97	100.0		

Training	UK	Europe	Africa	USA	Total	% cases
Medical personnel	19	9	3	1	32	55.2%
Education staff	3	3	2		8	13.8%
Legal		2	1		3	5.2%
Social workers/counsellors	12	5	2		19	32.8%
Relevant community groups	6	3	6		15	25.9%
Women only (community)	2	2	7		11	19.0%
Men only (community)			1		1	1.7%
Youth/students	1	1	8		10	17.2%
Community/religious leaders	1		5		6	10.3%
Community Health Workers/TBAs	4	1	4		9	15.5%
NGOs	2		3		5	8.6%
Circumcisers	2		4		6	10.3%
Other	2		2		4	6.9%
Total responses	54	26	48	1	129	
Total cases	29	12	16	1	58	

Note: percentage column totals may exceed 100% since respondents were permitted to give multiple responses.

Medical staff was the highest recipients of training in the UK, which reflects the number of health authority respondents. Likewise social workers would receive training by social services. UK NGO's working in the UK also run training programmes for these professional groups. In Africa training is not as targeted to professional groups but is provided directly to youth and students and women. In Africa 4 organisations provided training directly to circumcisers and 2 in the UK.

Do you charge for training

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	8.2	12.9	12.9
	No	54	55.7	87.1	100.0
	Total	62	63.9	100.0	
Missing	System	35	36.1		
Total		97	100.0		

e) Origin of community

Although survey respondents were not explicitly asked to provide details of the geographical origin of the communities with whom they work, this information was usually immediately apparent from the description of activities. Among UK groups, the Somali community is most frequently mentioned (n=10, mentioned by 19% of respondents), followed by the Sudanese community (n=5, 10%). A broad selection of countries of origin across Africa was represented among respondents:

	Frequency
UK	
Burkina	1
East Africa (region)	1
Kenya	2
Mali	1
Nigeria	1
Sahel (region)	1
Senegal	1
Somalia	10
Sudan	5
Total	23
Europe	
Burkina	1
Eritrea	1
Ethiopia	2
Gambia	1
Kenya	1
Mali	1
Sierra Leone	1
Somalia	4
Tanzania	1
Total	13
Africa	
Burkina	1
Djibouti	1
Egypt	1
Ethiopia	1
Gambia	2
Ghana	2
Kenya	3
Mali	1
Mauritania	1
Nigeria	1
Republic of Congo	1
Somalia	1
Sudan	2
Tanzania	1
Togo	1
Total	20
USA	
Kenya	1
Senegal	1
Total	2

4) FUNDING

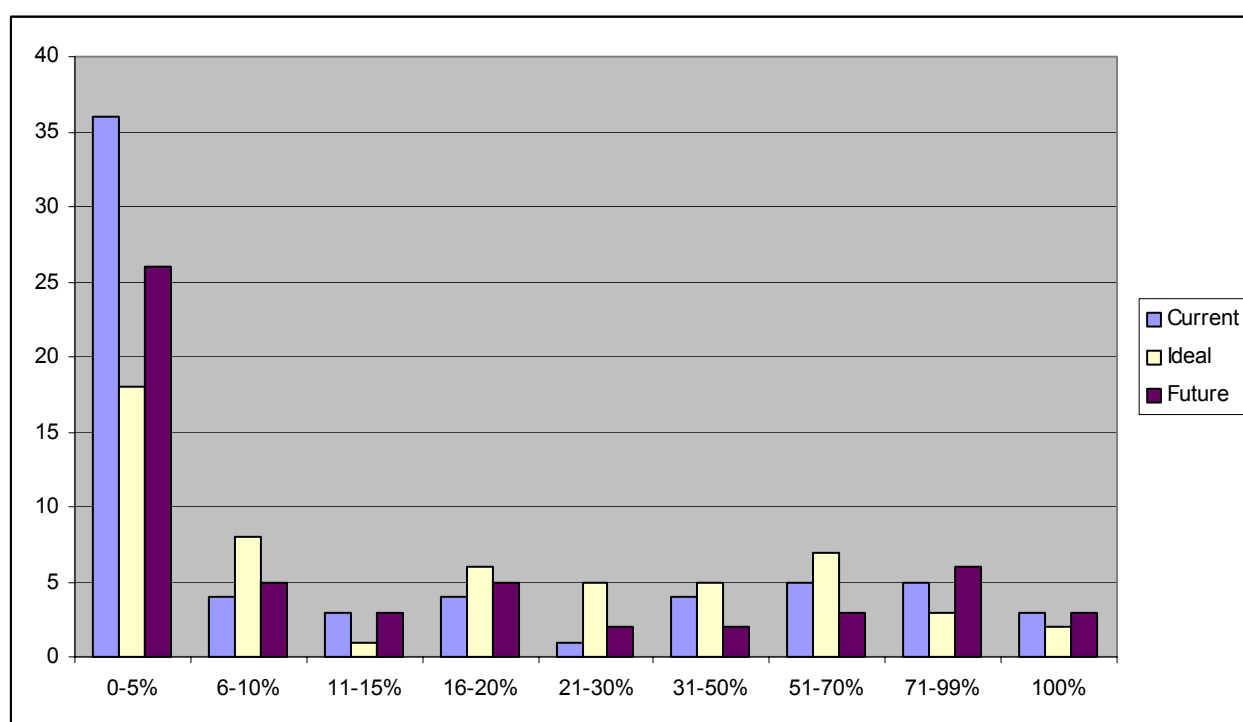
a) Budgeting

Survey respondents were asked what percentage of their total budget (excluding core costs) was used for FGM-related work, and offered a choice of 9 categories for their answer. They were further asked what percentage of their budget they would ideally like to be spending on FGM, and what percentage they could realistically expect to be spending on FGM in five years time.

Most respondents (n=36, 55%) currently spent less than 5% of their budget on FGM-related work which is unsurprising considering the different types of organisation to which questionnaires were sent (see Section 3: Background). Although it seemed that many respondents would like to be increasing the amount of funding devoted to this area, realistically it seemed that limited funding changes would take place.

Budget plans

	Current	%	Ideal	%	Future	%
0-5%	36	55.38	18	32.73	26	47.27
6-10%	4	6.15	8	14.55	5	9.09
11-15%	3	4.62	1	1.82	3	5.45
16-20%	4	6.15	6	10.91	5	9.09
21-30%	1	1.54	5	9.09	2	3.64
31-50%	4	6.15	5	9.09	2	3.64
51-70%	5	7.69	7	12.73	3	5.45
71-99%	5	7.69	3	5.45	6	10.91
100%	3	4.62	2	3.64	3	5.45
Total	65	100.00	55	100.00	55	100.00



Three organisations reported that 100% of their budget was currently devoted to FGM-related issues:

- FORWARD (Germany);
- The Gambia Committee on Traditional Practices (The Gambia); and
- Association Mauritanienne des Pratiques ayant effet sur la Sante des Femmes et des Enfants (Mauritania).

A further 5 organisations reported that 71-99% of their budget was currently devoted to FGM-related issues:

- London Black Women's Health Action Project (UK);
- Dept of General Psychology, University of Padua (Italy);
- Ghanaian Association for Women's Welfare (Ghana);
- The Foundation for Research on Women's Health, Productivity and the Environment (The Gambia); and
- Women's International Network Inc. (USA).

b) Fundraising

i. Difficulty in obtaining funding

	Frequency	Percent
Public	39	40.21
Private	31	31.96
Other	36	37.11
Total	97	100

Survey respondents were asked if they had had difficulty in raising funds from public and private sources. All three types of funding source received approximately the same number of responses indicating that they were difficult.

ii) Limitations on funding sources

Survey respondents were further questioned about the restrictions on their potential sources of funding, if public disapproval of spending this area might be identified as a potential barrier or if other issues took priority on the funding agenda. For all types of funding source, it seemed that FGM was regarded as less important than other priorities.

	Public disapproval	Other priorities	Other	Total
Public	30	54	35	119
Private	26	44	24	94
Other	29	39	24	92
Total	85	137	83	305

Other priorities felt to be of more pressing relevance than funding FGM included: education, public health (e.g. HIV/AIDS and other epidemics), income generation projects and the consequences of Civil War.

Other limitations restricting spending on FGM included ignorance of and indifference to the problem, and a lack of political will. In addition, various organisations reported that FGM was not perceived as a priority concern due to its perception as "merely" a non-life threatening, cultural issue, affecting only a small percentage of the population.

iii) What are funding sources?

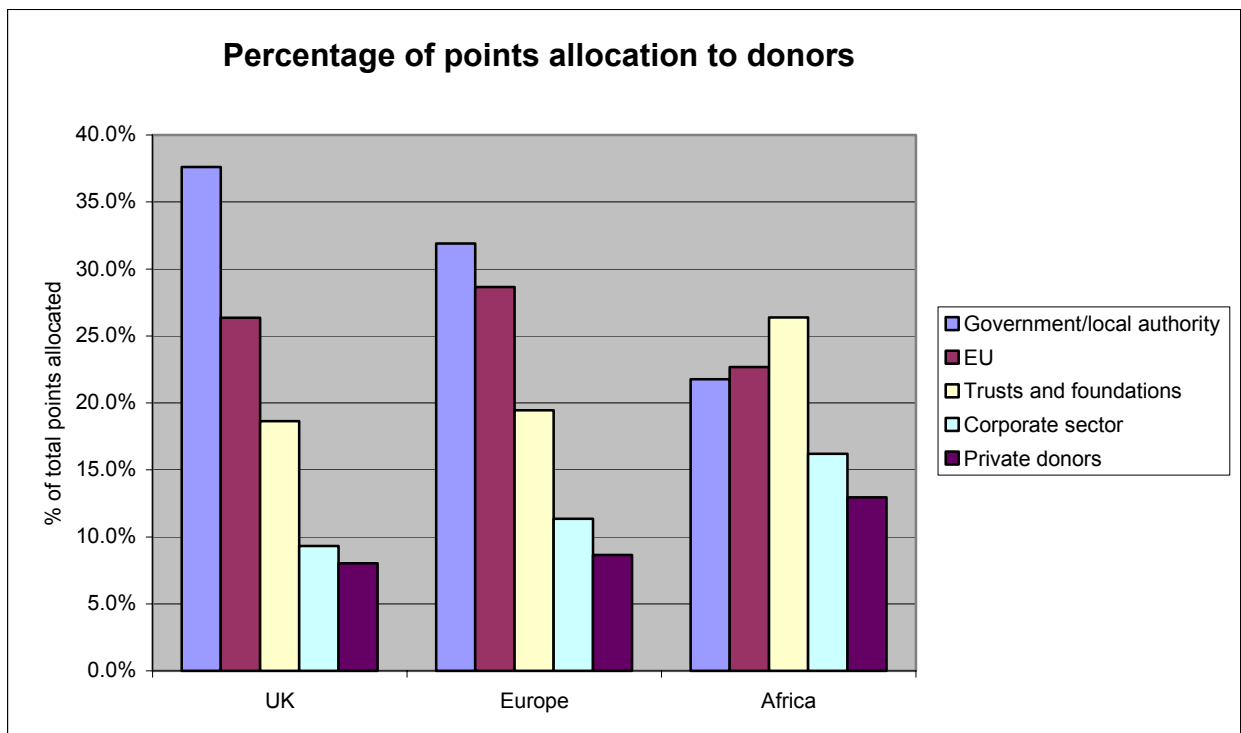
Survey respondents were asked to prioritise potential funding sources in order of importance, from a choice of five categories. By far the most popular choice for the first priority, chosen by 26 respondents (67% of respondents who answered this question) was "The Government / Local Health Authority / Local Authority". No respondents felt that private sources should be the first priority for seeking funds.

Ranking	UK	Europe	Africa
First	Government/local authority	Government/local authority	Trusts and foundations
Second	EU	EU	EU
Third	Trusts and foundations	Trusts and foundations	Government/local authority
Fourth	Corporate sector	Private donors	Corporate sector
Fifth	Private donors	Corporate sector	Private donors

In order to examine other priorities beyond the first choice, a 5-point ranking system was devised in which points were allocated to the funding sources in the order of priority given by the respondent. Where boxes had merely been ticked with no priority order given, a points value half-way through the scale was allocated. This scoring system allowed each funding source to be allocated an ordinal ranking in order of perceived importance. The resulting ranking system revealed that in both the UK and Europe the three most important sources of funding were seen as national Governments, European Union and trusts/foundations. The pattern that emerged in Africa was markedly different, with increased emphasis on trusts and foundations relative to Government and EU sources.

points	UK	Europe	Africa
Government/local authority		117	59
EU		82	53
Trusts and foundations		58	36
Corporate sector		29	21
Private donors		25	16
Total		311	185

% points	UK	Europe	Africa	
Government/ local authority		37.6%	31.9%	21.8%
EU	26.4%		28.6%	22.7%
Trusts and foundations	18.6%		19.5%	26.4%
Corporate sector	9.3%		11.4%	16.2%
Private donors	8.0%		8.6%	13.0%
Total	100.0%		100.0%	100.0%



APPENDICIES

Appendix I:

Survey Analysis and Report Compiled by:

Katie Schenk, Consultant, Reproductive Health Alliance Europe
Vanessa Haines, Parliamentary Advisor APPG

Members of the Female Genital Mutilation Hearings Steering Group:
(Preparation of Questionnaire)

Christine McCafferty MP, Chair All-Party Parliamentary Group on
Population, Development and Reproductive Health
Dilys Cossey OBE, International Planned Parenthood Federation (IPPF)
Trudy Davies, Research and Liaison Officer, APPG
Shamis Dirir, Director of the London Black Women's Health Action Project
Florence Harding, Commonwealth Secretariat
Naana Otoo-Oyortey, Chair FORWARD

Appendix II: List of Organisations returning questionnaires

UK

African Clinic, Central Middlesex Hospital
African Well Women's Clinic
Agency for Culture and Change Management
Association of Teachers & Lectures (AIL)
Barnet Health Authority
Brent Childrens Social Work
Calderdale and Kirklees health Authority
Care International in Sudan
Centre for Inherited Blood Disorders, Abercromby health Centre
Children With Disabilities Team, Sandwell MBC
Community Health. London Health Trust (Family Planning)
Coombes women's Hospital
Derby City Council – Social Services
EAL Support Service
Enfield and Haringey health Authority
Forward foundation for Women's Health Research and Development
GBMB Trade Union
Harrow social Services
Health Unlimited
Hounslow and Spelthorne Community and mental health NHS Trust
International Planned Parenthood Federation
Jessop Hospital for Women
Kensington, Chelsea and Westminster Health Authority
Lambeth, Southwark and Lewisham Health Authority
Liverpool Women's hospital
London Black Women's Health Action Project
London Borough of Hammersmith and Fulham
London Borough of Southwark Social Services Department
Maternity Unit, Northwick Park Hospital
Medical Ethics Department, British Medical Association
Midland Refugee Council
North Mersey Community NHS Trust
North Tyneside Council NHS Trust
Northwick Park hospital (maternity)
PLAN International UK
Population Concern
Rainbow
Ravensbourne NHS Trust
Ravensbourne Trust Family Planning Service
Royal College of Obstetricians and Gynaecologists
Sheffield City Council Social Services
Sheffield Education Authority
Social Service Liverpool Child Protection

**Support The Fight Against Female Genital Mutilation-London Black
Women's Health Action
Tees Health Authority
UNISON
Unison Trade Union Regional
Walsall MBC Social Services
Whittington Hospital
Women's National Commission**

Europe

**AIF International Alliance of Women, France
AMAM, Catholic institute, Spain
AME Association Centre la Mutilation des Enfants, France
Bundesministerium fur Familie, Senioren, Frauen und Jugend,
Germany
Centre D'estudis Demografics, Spain
City of Goteburg Immigration Services Administration, Sweden
Commission Pour L'Abolition des Mutilations Sexuelles (CAMS),
France
Danish Medical Women's Association, Denmark
Defence for Children international, Netherlands
Dept of General Psychology, University of Padua, Italy
FORWARD, Germany
Foundation of Women's Forum, Sweden
Gabinete de Documental e Ditrecto Compardo, Portugal
Group for the Abolition of Sexual Mutilation and other Traditional
practice, France
Institute of Equality (IN.IS), Greece
KULeuven (Catholic University of Leuven), Belgium
NAGA Associazione Volontaria di Assistentia, Italy
National Board of Health, Denmark
National Board of Health and Welfare, Sweden
Research Centre of Women's Affairs, Greece
Terre Des Femmes (TDF), Germany**

Africa

**African Medical Research Foundation, \Kenya
African Medical Research Foundation, Tanzania
Ahfad university for Women, Sudan
Amnesty International, Togo
Amnesty International, Cote D'Ivoire
Association Mauritanienne des Pratiques ayant effet sur la Sante
des Femmes et des Enfants, Mauritania
Babiker Badri Scientific Association for Women Studies (BRSAWS),
Sudan**

**BAFROW (The Foundation for Research on Women's Health,
Productivity and the Environment), The Gambia**
Ghanian Association for Womens Welfare (GAWW), Ghana
Le Comite national des Droits de la Femme, Republic of Congo
National Committee on Traditional Practices (NCTPU), Uganda
Pathfinder international, Kenya
Pokot Kiletat Women Group (Community Based organisation), Kenya
Population Council, Senegal
Rural help integrated, Ghana
**Sudan national Committee on harmful Traditional practices (SNCTP),
Sudan**
**The Gambia Committee on Traditional Practices (GAMCOTRAP), The
Gambia**
Village Life Panorama Projects, Nigeria

USA

Doctors Opposing Circumcision (DOC)
Wallace Global Fund
Women's international network Inc.

CONFIDENTIAL

**Questionnaire for
Non-Governmental
Organisations (NGOs), local
health
and education authorities on
Female Genital Mutilation (FGM)**

ALL-PARTY PARLIAMENTARY GROUP ON POPULATION, DEVELOPMENT AND REPRODUCTIVE HEALTH

APRIL 2000

BACKGROUND INFORMATION

1. Details of your organisation

Name and mailing address of your organisation:

a. Name and title of person completing the form:

b. Telephone Number:

c. Facsimile Number:

d. E-mail address:

2. Type of organisation

a. What type of organisation are you? (Please tick ✓ the box that applies)

Non-governmental organisation

Governmental Body

International organisation

Research Institution

Academic Institution

Advocacy Group

Local education authority

Local health authority

Local authority

Church Group

Health Facility, e.g. specialist care or ante-natal care clinic

Other, please specify
E.g. Community Group?

Please provide name:

b. What are the objectives of your organisation?

c. What are the specific objectives of your organisation in FGM?

ISSUES

1. What do you call it?

What is the name that you use to refer to the action of cutting female genitalia?

- Female Genital Mutilation Female Genital Cutting Female Circumcision
 Female Excision Traditional Name Other (Please specify:
(please specify):

2. Alternatives to FGM practice

Do you think there is a good alternative to the tradition of FGM? **Yes/No (Circle one)**

If so, please state these alternatives and give countries in which these alternatives are practised.

Alternative Practice to FGM	Country practised

3. A human rights approach to FGM

Do you think there is a human rights argument to make for FGM? **Yes/No (Circle one)**

If so, how do you think this argument should be stated?

4. A health response to FGM

Do you think that FGM should be medicalised, i.e. should health professionals engage in the cutting of female genitalia? **Yes/No (Circle one)**

If so, why?

If not, why not?

Should there be a general FGM code of conduct for health professionals?

Yes/No (Circle one)

If so, why?

If not, why not?

ISSUES Continued

5. A legislative response to FGM

a. What do you think the role of government should be in addressing the eradication of FGM?

b. Are you aware of any legislation in your country that makes FGM illegal? **Yes/No (Circle one)**

If yes, please specify.

c. Do you know if there have been any prosecutions? **Yes/No (Circle one)**

d. If yes, please specify year in which prosecution took place and the number of prosecutions.

Year of Prosecution	Number of prosecutions

e. If there have not been any prosecutions, why not?

f. Are you aware of any regulation or legislation at the local authority level on FGM? **Yes/No**

If so, what is it?

6. Research and the ethics of research in FGM

Do you undertake any research in FGM? **Yes/No (Circle one)**

If so, what do you do and how do you approach this?

SERVICES

1. Activities of your organisation

a. What activities are you engaged in?

- | | | |
|--|--|---|
| <input type="checkbox"/> Awareness raising | <input type="checkbox"/> Lobbying/Advocacy | <input type="checkbox"/> Research |
| <input type="checkbox"/> Information Provision | <input type="checkbox"/> Production of health education materials | <input type="checkbox"/> Supporting organisations in Africa & the Middle East |
| <input type="checkbox"/> Campaigning | <input type="checkbox"/> Working with the media | <input type="checkbox"/> Networking |
| <input type="checkbox"/> Raising funds and commitment for the elimination of FGM | <input type="checkbox"/> Promoting understanding of FGM health risks and human rights violations | <input type="checkbox"/> Other (Please specify) |

b. What services and support do you provide?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Counselling | <input type="checkbox"/> Education | <input type="checkbox"/> Legal Advice |
| <input type="checkbox"/> Health/Medical treatment | <input type="checkbox"/> Other (Please specify): | |

If you do provide services, are they free at the point of use? (If your answer is 'variable', please give brief details) **Yes/No/Variable (Circle one)**

c. Are the services you provide confidential? **Yes/No (Circle one)**

d. What is your definition of confidentiality?

e. If your services are confidential, please provide brief details of the mechanisms you use to ensure confidentiality.

SERVICES Continued

2. Experiences of service provision

a. Do you work with any indigenous communities in Africa or Middle East where FGM is practised? **Yes/No (Circle one)**

If yes, please state what you do.

b. Do you work with any communities through organisations, religious groups in your country? **Yes/No (Circle one)**. If yes, please state the name(s) and type of group and what you do

Name of Group	Type of Group E.g. Women's self-help group	What you do

3. What problems have you encountered while working with FGM-related issues? Please continue at the back of the questionnaire or on a separate sheet of paper if necessary.

4. What achievements have you made while working with FGM-related issues? Please continue at the back of the questionnaire or on a separate sheet of paper if necessary

5.a. Do you provide training or education on FGM issues? **Yes/No (Circle one)**. If so, to whom do you provide this training and how often do you make it available?

b. Do you charge recipients for training? **Yes/No (Circle one)**. If so, how much do you charge? _____

6. Do you work with other organisations? **Yes/No (Circle one)**. If so, please state country, specific collaboration and source of funds. Please continue at the back of the questionnaire or on a separate sheet of paper if necessary

Country	Specific Collaboration	Source of Funds

FUNDING

1. Excluding core costs, what percentage of your total budget do you use for FGM-related work? (Include any service provision, education, counselling, awareness raising, advocacy etc.) (Please tick ✓ the box that applies)

- | | | |
|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> 0-5% | <input type="checkbox"/> 6-10% | <input type="checkbox"/> 11-15% |
| <input type="checkbox"/> 16-20% | <input type="checkbox"/> 21-30% | <input type="checkbox"/> 31-50% |
| <input type="checkbox"/> 51-70% | <input type="checkbox"/> 71-99% | <input type="checkbox"/> 100% |

2. What percentage of this money is spent on work with women who have undergone FGM? (Please tick ✓ the box that applies)

- | | | |
|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> 0-5% | <input type="checkbox"/> 6-10% | <input type="checkbox"/> 11-15% |
| <input type="checkbox"/> 16-20% | <input type="checkbox"/> 21-30% | <input type="checkbox"/> 31-50% |
| <input type="checkbox"/> 51-70% | <input type="checkbox"/> 71-99% | <input type="checkbox"/> 100% |

3. What percentage of the money you spend on FGM comes from:

a. Public Sources (i.e. EU, Government, Local Health Authority, Local Authority) (please tick ✓ the box that applies)

- | | | |
|--------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> 0-25% | <input type="checkbox"/> 26-50% | <input type="checkbox"/> Over 50% |
|--------------------------------|---------------------------------|-----------------------------------|

b. Private Sources (i.e. Charitable trusts and foundations / corporate)

(Please tick ✓ the box that applies)

- | | | |
|--------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> 0-25% | <input type="checkbox"/> 26-50% | <input type="checkbox"/> Over 50% |
|--------------------------------|---------------------------------|-----------------------------------|

c. Other Sources (e.g. donations from individuals)

(Please tick ✓ the box that applies)

- | | | |
|--------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> 0-25% | <input type="checkbox"/> 26-50% | <input type="checkbox"/> Over 50% |
|--------------------------------|---------------------------------|-----------------------------------|

4. Excluding core costs, in five years time, what percentage of your total budget do you **expect** to be spending on FGM as a whole? (Include any service provision, education, counselling, awareness raising, advocacy etc.) (Please tick ✓ the box that applies)

- | | | |
|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> 0-5% | <input type="checkbox"/> 6-10% | <input type="checkbox"/> 11-15% |
| <input type="checkbox"/> 16-20% | <input type="checkbox"/> 21-30% | <input type="checkbox"/> 31-50% |
| <input type="checkbox"/> 51-70% | <input type="checkbox"/> 71-99% | <input type="checkbox"/> 100% |

5. In five years time, what percentage of this **total budget** do you **expect** to be spending on FGM related work? (Please tick ✓ the box that applies)

- | | | |
|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> 0-5% | <input type="checkbox"/> 6-10% | <input type="checkbox"/> 11-15% |
| <input type="checkbox"/> 16-20% | <input type="checkbox"/> 21-30% | <input type="checkbox"/> 31-50% |
| <input type="checkbox"/> 51-70% | <input type="checkbox"/> 71-99% | <input type="checkbox"/> 100% |

6. Ideally, what percentage of your budget would you like to spend on work with women who have undergone FGM? (Please tick ✓ the box that applies)

- | | | |
|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> 0-5% | <input type="checkbox"/> 6-10% | <input type="checkbox"/> 11-15% |
| <input type="checkbox"/> 16-20% | <input type="checkbox"/> 21-30% | <input type="checkbox"/> 31-50% |
| <input type="checkbox"/> 51-70% | <input type="checkbox"/> 71-99% | <input type="checkbox"/> 100% |

FUNDING Continued

7. Do you have difficulty in raising funding for FGM work from:

- **Public Sources** (i.e. EU, Government, Local Health Authority, Local Authority) Yes/No (Circle one)
- **Private Sources** (i.e. Charitable trusts and foundations / corporate) Yes/No (Circle one)
- **Other Sources** (i.e. donations from individuals) Yes/No (Circle one)

8. Which of the following factors might be relevant if there are limitations in funding for work in FGM? (Please number from 1-3, in order of importance, with 1 as the most important and 3 as the least important).

For public sources (i.e. EU/ Government, Local Health Authority, Local Authority)

- Public disapproval of spending in this area
- Other priorities are seen as more important given the aims of your organisation
- Other (please specify):

For private sources (i.e. Charitable trusts and foundations / corporate)

- Public disapproval of spending in this area
- Other priorities are seen as more important given the aims of your organisation
- Other (please specify):

For other sources (e.g. donations from individuals)

- Public disapproval of spending in this area
- Other priorities are seen as more important given the aims of your organisation
- Other (please specify)

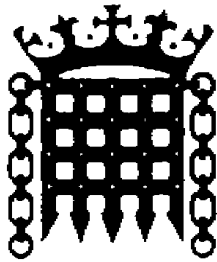
9. If you do feel funding is inadequate for projects in the area of FGM and women, which of the following sources do you think should be expected to make this area more of a funding priority? (Please number from 1-5, in order of importance, with 1 as the most important and 5 as the least important).

- The corporate sector
- Trusts and foundations

Survey Report and Analysis of Questionnaire for Non-Governmental Organisations (NGOs), local Health and Education Authorities on Female Genital Mutilation.

Survey Report published by the All-Party Parliamentary Group on Population, Development and Reproductive Health

Printed in England



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