

Health and human rights

Funding squeeze forces UNHCR cutbacks

In a move he described as “painful but absolutely necessary”, UN High Commissioner for Refugees, Ruud Lubbers, is being forced to cut more than 900 jobs and some aid projects because of lack of funds.

UNHCR plans to save US\$95 million this year, but its hopes that the budgetary situation will improve next year have been hit by the terrorist attacks on the USA and their potential repercussions. “Obviously in the immediate aftermath of the tragic events in the USA, we are concerned about continuing support for humanitarian help to asylum seekers and refugees worldwide”, UNHCR spokesman Ron Redmond told *The Lancet*. “We’ve seen signs of a xenophobic backlash in the USA against Muslim and Arab groups. At the same time, there have been many comments made about tightening immigration and asylum policies. How this all fits in with continued funding remains to be seen.”

UNHCR has a staff of around 5000 people based in 120 countries, caring for some 22 million people. Its budget declined from \$1.3 billion in 1995 to \$931 million in 2000. It expects some \$810 million in government contributions this year—far below its planned budget of \$955 million. The agency has provisionally budgeted for \$825 million in 2002. More than 90% of UNHCR funding comes from just ten countries, with the USA providing 35% of donations last year.

Donor fatigue has mainly resulted from the lack of high-profile refugee crises, such as those in Bosnia, Kosovo, and East Timor. Long-running problems in West Africa and the Horn of Africa receive far less public comprehension and sympathy.



UNHCR education programme in Angola

The appalling humanitarian situation in Afghanistan, which has almost 1 million internally displaced people and 3.3 million refugees in neighbouring Pakistan and Iran, is now attracting renewed media attention. But many aid workers fear that this interest will not translate into increased funding and that the Afghan people will pay the price of the ruling Taliban’s perceived support of terrorism.

UNHCR says that it will make some savings by a long-planned winding down of operations in the Balkans and East Timor. But the agency fears that in some areas cutbacks on education and health-care

programmes may be necessary. Other agencies are not likely to be able to step into the breach. Walter Fuelleman, head of fund-raising at the International Committee of the Red Cross, says that the Red Cross is burdened with a budget deficit from last year and so has also had to restrict some programmes. Fuelleman says that it is too early to predict what will happen next year, but he is concerned that humanitarian spending will be squeezed further by anticipated increases in spending on anti-terrorism security. “We also fear western governments will be less willing to fund operations in Afghanistan, Sudan, and Iraq”.

Médecins Sans Frontières has fared better than many humanitarian agencies because private donations account for nearly 75% of its budget. But MSF International President Morten Rostrup bemoans the fact that there are “an increasing number of forgotten conflicts such as Liberia, Angola, and Congo” that receive little political interest.

Rostrup is concerned about the implications of the UNHCR financial woes. “UNHCR is the only organisation with a full mandate to give protection and nobody can replace them. Lack of protection is a growing problem in the field. Both legal protection and pure physical protection.”

Clare Kapp

Female genital mutilation in developed countries

On August 20, 2001, the British Medical Association (BMA) published comprehensive guidelines on female genital mutilation for UK doctors (www.bma.org.uk/public/ethics.nsf/ [accessed Sept 19, 2001]).

In 1998, WHO estimated that almost 137 million women of all ages had undergone female genital mutilation (also termed female circumcision). Every year a further 2 million girls are thought to be at risk.

Although the problem exists primarily in 28 African and certain Asian and Middle Eastern countries, recent trends in international travel and emigration have brought the practice to the awareness of an increasing number of physicians and public policy agencies in developed countries.

About 27 000 women from countries in which female genital mutilation is a common practice are living in Sweden and 30 000 in Italy. In the

UK, although data on prevalence are scarce, there are thought to be 3000–4000 new cases every year (BMA guidelines). Female genital mutilation in the UK is seen mainly in immigrants and refugees from Eritrea, Ethiopia, Somalia, and the Yemen. Under the UK Prohibition of Female Circumcision Act (1985), a person found guilty of the practice could be imprisoned for up to 5 years.

Female genital mutilation can take

several forms, the most common being type II—excision of the clitoris with partial or total excision of the labia minora. The most severe form is type III, an infibulation in which the clitoris and some or all of the labia minora are amputated, and the labia majora are fused. In addition to impairing labour and causing many organic and psychosexual complications, mutilation might have a substantial role in facilitating HIV transmission by the use of one instrument on several girls.

The BMA guidelines include dealing with patients at risk of female genital mutilation, girls being taken out of the UK to undergo this practice, child protection, requests for mutilation including reinfibulation (after childbirth), reversal of infibulation (deinfibulation), and services for patients and asylum seekers. Reinfibulation is illegal under the UK Act, and the BMA guidelines caution that this “must be explained to the woman” and, if she agrees, to her husband, “although the main impetus for mutilation often comes from female members of the community”. Deinfibulation is a traditional practice that is sometimes done immediately after marriage; the BMA recommends that information about reversal procedures offered by some UK centres should be made available to communities prone to practise female genital mutilation.

The reasons offered to justify female genital mutilation are commonly related to tradition, power inequalities, and the resulting compliance of women with the dictates of their communities. From a socio-economic perspective, mutilation, which is practised across all ages (from infants to women) is a practice that forms an important part of girls’ socialisation¹ in societies in which women’s social acceptance and access to resources are secured through marriage and childbearing.

Since the early 1980s, WHO has proposed that laws and professional codes should prohibit female genital mutilation in all countries. Encouragingly, the governments of several African countries have already ruled against the practice. In May, 2000, in Guinea Conakry, only 1 year after the government approved a law banning female genital mutilation, the excisors abandoned their working

tools during a public and symbolic ceremony. In Europe, in addition to the UK, the practice is banned in Sweden, Belgium, and Norway, but anecdotal evidence suggests that laws are flouted by practitioners. There have been no prosecutions in the UK under the 1985 Act (BMA guidelines). In Italy and Spain, no specific law explicitly prohibits the practice, but several cases of mutilations in both countries have led politicians to introduce bills specifically forbidding female genital mutilation and punishing practitioners.²

In July, 2001, the European Parliament Women’s Rights Committee adopted a report to condemn all forms of female genital mutilation, describing it as a “serious violation of human rights and an act of violence against women which directly affects their integrity as people” (Valenciano Martinez-Orozco E. Report on female genital mutilation. European Parliament, 17th July, 2001). The committee called on European Union (EU) countries to classify any form of this practice as a crime, and to prosecute and punish any EU resident who has taken part in it, even if the offence was committed outside Europe. “It [the committee] wants the Member States’ authorities to have the right to intervene, where there is a risk of female genital mutilation, to take girls into care or, for example, to suspend social benefits”. Other recommendations included programmes to educate communities at risk by providing information on arrival, in an immigrant’s native language, about the EU country’s policy on genital mutilation. The committee also asked the European Commission and Council to ensure the protection of victims of female genital mutilation, and to guarantee a right to asylum to women at risk.

The BMA also proposes that refugee and asylum status should be granted to women and girls fleeing their country to escape genital mutilation. As for specific action for child protection, the BMA report says “there should be a designated senior doctor and nurse in each health authority area to provide help and advice”. It also recommends that if doctors believe that a child “may be suffering, or may be at risk of suffer-

ing, significant harm, they should refer these concerns to the local authority social services department”. And if there has been “a criminal offence against a child, it is the responsibility of the social services department . . . to inform the police at the earliest opportunity”. The report says that assessment by social services must be done within 7 days and that, according to its outcome, it may be necessary to order immediate protection (where there is a likelihood of serious immediate harm) and emergency action that may involve removing the child to a safe place.

Education, although insufficient as a sole measure, is thought indispensable for eradication of female genital mutilation. In member states of the EU, networks and organisations are currently involved in informing and educating immigrant communities in which mutilation is practised.² The BMA emphasises that family practitioners or other doctors (eg, community paediatricians) caring for girls at apparent risk of genital mutilation must ensure that there is discussion with the family about related health and legal issues.

In spite of efforts to combat the practice in developed countries, few immigrant women are prepared to talk about female genital mutilation outside their own communities. Further complicating the issue are strong negative feelings that most western health-care workers have about genital mutilation. These feelings may clash with those of their female immigrant patients, who might regard the practice as normal and desirable. Medical and cultural information are needed to allow doctors to treat medical problems arising from female genital mutilation, and to maintain a good relationship with the patient.³ The BMA report, in addition to supporting an effective enforcement of the 1985 Act, states that “all medical personnel must be trained on cultural sensitivity and how to meet the needs of women who have undergone female genital mutilation . . . matters of female genital mutilation must be handled sensitively taking into account differing cultural issues, but the child’s welfare is paramount”.

Female genital mutilation is not comparable with conventional child abuse. Parents who put their children through this procedure may honestly believe that they are doing the right thing. Some assert that western countries should eliminate their own cultural idiosyncrasies before presuming to intervene in the practices of others. It has been argued that to address this

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Circumcised woman with sealed vaginal opening

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issue in an informed way, there should be greater research into whether affected women view themselves as victims of assault or as active and willing participants in a necessary social act. As J Tim Scott reasoned in a letter to the *British Medical Journal* (www.bmj.com/cgi/eleter/321/7256/262#EL3 [accessed Sept 25, 2001]), some supporters of the educative approach rather than a total ban may argue that allowing some licensed medical practitioners to provide minimal forms of circumcision such as “token nicks” to satisfy “honour” could prevent much greater harm

than permitting unlicensed operators to perform radical excisions. The BMA considers, however, that health professionals should not carry out female genital mutilation and that the practice constitutes “a clear breach of human rights”. The BMA report also recalls the WHO statement that “the medicalisation of the procedure does not eliminate this harm and is inappropriate for two major reasons: genital mutilation runs against basic ethics of health care whereby unnecessary bodily mutilation cannot be condoned by health providers; and, its medicalisation seems to legitimise the

harmful practice”. In any circumstance, all women must have the right to be protected against any form of genital mutilation.

- 1 Andersson C. Female genital mutilation—a complex phenomenon. *Lakartidningen* 2001; **98**: 2463–68.
- 2 Bosch X. Spain considers improving law on female circumcision. *Lancet* 2001; **357**: 1510.
- 3 Richards D. Controversial issues: female genital mutilation. *Med Ref Serv Q* 2000; **19**: 79–88.

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Tackling female genital cutting in Somalia

Before the collapse of the Somali government in 1991, there was support for elimination of female genital cutting; the practice was banned from hospitals and health research was conducted. But a decade of civil war put a stop to any attempts at coordinated national action of any kind, and today Somalia has one of the highest rates of genital cutting of any country—98% according to WHO.¹

The most extreme form of cutting is practised in Somalia, and involves removal of the clitoris, the labia minora, and the labia majora, and subsequent rejoining the cut edges of the labia (infibulation). This is a pre-Islamic custom dating from the time of the Pharaohs and is also found in Christian and Jewish women in other parts of the Horn of Africa. This procedure is associated with significant morbidity: 39% of women in Somalia are reported to have immediate substantial complications. Haemorrhage, infection, tetanus, and septicæmia are among the immediate health consequences; long-term effects include impaired urinary and menstrual function, chronic genital pain, cysts, neuromas, ulcers, incontinence, and infertility. Childbirth requires cutting and repairing the infibulation, which causes additional morbidity and increases the chances of maternal and child mortality.

At the maternal child health centre in Galcayo, northeastern Somalia, Médecins Sans Frontières (MSF) noted that more than a third of all admissions to the regional hospital maternity ward between April, 1998, and August, 2001, were for complications of pregnancy. Maternal mortal-

ity among women admitted to the hospital is alarmingly high, at 31 deaths in 734 deliveries (4223 in 100 000). All women seen had extensive excision and infibulation—known to increase maternal and perinatal mortality—and all deliveries required an inverted Y incision to open the infibulation, with subsequent repairs in all cases.

MSF opposes female genital cutting, taking all steps to ensure that it is not undertaken in facilities where the agency works, and that instruments supplied are not used for the procedure.² While it could be argued that the provision of surgical instruments is a trade off for a less destructive form, such “medicalisation” does not prevent many of the serious health consequences, and is no less a violation of human rights; the practice contravenes human rights laws and conventions, including the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and the African Charter on Human and People’s Rights.

MSF has joined forces with women’s groups in Somalia. Health education about female genital cutting, delivered through training given to midwives and traditional birth attendants, has met with some success in parts of the Galcayo community: cutting is now talked about openly as a reason for problems in childbirth. Traditional birth attendants are aware of the health effects and several have said that they would be glad to see the practice stopped; furthermore, the local ministry of

health has made infibulation illegal but there is no enforcement of the law. However, birth attendants say that most parents continue to ask for their infants to undergo the larger excisions. Parents who are more aware of the health issues or of the requirements of Islam do not have their daughters infibulated, but they remain a minority.

The practice of female genital cutting is centuries old and persists because it satisfies the interests of people in the societies within which it is practised. Advocacy directed towards eradicating the practice is a cultural negotiation in which the language used is important. It has been suggested that calling the practice mutilation might antagonise the population against any initiative. “Is it helpful”, asks one Islamic scholar “to tell a mother that she is mutilating her daughter, or is it better to say that this cutting is harmful because of the health consequences?”³ A focus on the health consequences provides a fairly uncritical and culture-neutral framework for discussion. Health workers must continue to record women’s experiences and use this information to advocate for change at various levels to work towards eradicating the practice.

- 1 WHO. Female genital mutilation, an overview. Geneva: WHO, 1998.
- 2 Female genital cutting policy paper. Amsterdam: MSF, 1999.
- 3 Abdullahi An-Na’im. In: Ford N, Bedell R, eds. Intentions and consequences: human rights, humanitarianism and culture. Amsterdam: MSF, 1999.

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