Malians in Paris

PANOS/GILING

the high incidence of caesarian section among these women and the worrying fact that they sometimes refused, despite difficult labour, to undergo such sections because of their fear of having to restrict the number of their pregnancies afterwards.

The second method of action was penal repression. In France female genital mutilation falls under Article 312 of the Penal Code: "grievous bodily harm to a minor under 15"; but it was not until a white French woman mutilated her daughter's sexual organs in a fit of dementia and was sentenced that female genital mutilation of African girls too was accepted as grievous bodily harm by the judicial system. Sentences can be from three months upwards in prison with fines.

The first case came before court in 1982. At the request of African women's associations the family planning association brought a civil suit; it was a difficult decision to make for the association, whose activities are generally educative and preventive rather than repressive. But the African women's associations were afraid of losing credibility among their compatriots if they were on opposite sides at court, and they pointed out that we would be racist to accept female genital mutilation for black girls and not for white girls. Since then, several cases have been before the courts, and sentences have been passed on excisers as well as fathers—not, as previously, only on mothers.³

Why the problem continues in Britain

Rupert Walder

Female genital mutilation has been outlawed in Britain for nearly 10 years, and yet there are an estimated 10 000 girls and young women still at risk of the dangerous practice in this country. Why?

According to its proponents, female genital mutilation is a traditional or cultural practice. Irrespective of the fact that there seems to be little or no justification for it in religious texts, this does leave anyone dealing with the problem in Britain with a dilemma. Am I being racist or culturally insensitive if I choose to outlaw or criticise this practice? Beyond the fear of cultural steamrolling, there is also the very nature of the practice which is, in the minds of many, inextricably linked with sex, sexuality, and reproduction. This has provided a second barrier both to discussion and finding a solution. In the predominantly white, middle class, British medical and legal

Systems and scale

Today, ministries and public institutions feel directly involved. Prevention kits (posters and leaflets) have recently been published and distributed by the prefecture of the Ile de France as a result of the work of several associations. Now used only in the Paris area, this material will soon be available all over France.

Medical and social teams can and do report children at risk or who have suffered female genital mutilation through the normal channels for cases of child abuse; magistrates are increasingly prepared to take such cases seriously. Priority aspects of care when a child appears at risk are support of and information for the parents or mother, alerting school authorities when the child is of school age, and avoiding "holidays" in the country of origin.

At the moment an estimated 100 000 immigrants live in the Paris region. This figure is based on numbers of relevant immigrant residence permits for 1989. Studies of national figures give 40 000 women and 14 000 young girls from cultures practising female genital mutilation in France in 1989; the predicted figure for girls in 1993 was 25 000.⁴

If only half of these women are excised it can be said that 20 000 women and 12 500 girls living in France have either suffered female genital mutilation or will do so. Of these, 90% live in the Ile de France (Paris region); most are from Mali, a few from Senegal.

In April 1994 I was present as the government funded representative of the French family planning association at a conference organised at Addis Ababa by the Inter-African Committee against Traditional Practices Harmful to Women's and Children's Health. The French speaking states whose immigrants brought the problem to France were among the 24 African states who manifested concern by their presence. During the meeting they exchanged their experiences on means of prevention of female genital mutilation, with the target of total eradication for the year 2000.

I felt that this unanimous aim was the clearest demonstration of the progress achieved through years of action and of intense effort to raise awareness in the countries where female genital mutilation is carried out and among their nationals living in France.

1 Hosken F. *Le livre d'images universel de la naissance*. Lexington: Women's International Network, 1994.

2 MFPF Documentation Centre. *Mutilations sexuelles en France—juin 1993*. Paris: Mouvement Français pour le Planning Familial, 1993.

3 *L'excision et sa présence en France*. Editions GAMS.

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professions it has been all too convenient to ignore or avoid female genital mutilation because it is a private, difficult, or sensitive issue.

A combination of this "not my problem" clause and bureaucracy has also contributed to the perpetuation of the practice in Britain. Social services, child support agencies, refugee support groups, women's groups, human rights agencies, teachers, immigration services, and the medical profession all have a contribution to make but each is possibly too specific to tackle the issue effectively alone. Ideally a multiagency group should be formed, but there is a risk it would never find its way out of the red tape. There are, however, several organisations doing valuable work to publicise the extent and nature of female genital mutilation in this country.

Unfortunately, information that is available on

Eritreans in Asmara

male circumcision—rather like comparing rape with masturbation.

Educate families first

Female genital mutilation affects girls, often too young or scared to fend for themselves, who are almost invariably subjected to vigorous social and family pressure. It is those families that must be educated first, with discretion and sensitivity, and preferably by women from within their own communities. The only way that this harmful and mindless practice will be eradicated—both here and abroad—will be when parents wish to provide their daughters with the freedom, status, and physical safety that they deserve. For this to happen, women within those communities, many of whom will have been subjected to female genital mutilation themselves, must be empowered to speak out for what they want rather than that which they have come to expect.

Legislation against female genital mutilation may well have contributed to the practice going “underground” in this country, but it has not made it disappear. Declarations, discussion, and increasing media interest are making a valuable contribution to the understanding of female genital mutilation, but it will be those who are affected most who will eventually make the choice to eradicate the mutilation on our doorsteps.

Recent Advances

Respiratory medicine

R M du Bois

Clinical and molecular technological advances have transformed our understanding and knowledge of the complexities of respiratory disease over the past 20 years. Set against this background of rapid advances, this review will highlight some of the key recent developments during the past 12 months that are likely to influence clinical practice.

Asthma

Asthma is an important medical and social issue in the community, which will probably continue to have an impact on hospital resources throughout the 1990s. The number of admissions in England and Wales rose exponentially from just under 20 000 a year in the 1960s to about 100 000 in the 1980s.¹ Although the rate now seems to have stabilised, no evidence exists for a decreasing trend in hospitalisation or mortality.

Death rates continue to cause concern. Lang and Polansky reported patterns of mortality in Philadelphia and found an increase in the rate of death from asthma, from 1.68/100 000 population in 1969 to 2.41/100 000 in 1991.² Contrary to common belief, this increase was not related to air pollution, measures of which showed a substantial improvement over the same period. The most important risk factors for death from asthma were being poor and being black. A second study, in contrast, found no increase in the expected number of deaths associated with asthma in residents of Rochester, Minnesota, a community in which 96% are predominantly middle class and white.³ The geographical variation in the prevalence of asthma has been too pronounced and the population increase too rapid for these to be attributable to genetic factors,

suggesting that important environmental influences may be operating. Although multiple factors such as quality of health care, health education, and living conditions are likely to be important, the studies raise important questions about predisposition and causation.

RELEVANCE OF ENVIRONMENTAL FACTORS

If pollution is not the cause of the increased prevalence of asthma then what is? Do environmental factors have any relevance? Studies of asthma caused by agents inhaled at work support the influence of environmental factors.⁴ An investigation of staff working with laboratory animals found a direct relation between the measured concentration of allergens in the air and the incidence of new respiratory symptoms and positive results to skin prick tests for rats' urinary protein.⁵ In particular, there seems to be a “window of susceptibility” of 1-2 years, during which the manifestation of hypersensitivity develops and the modifying effects of smoking (enhancing the likelihood of developing an allergy) are at their peak. These observations are consistent with the knowledge that infant sensitisation may also occur within a critical period after first exposure to ambient allergens. A good example of the value of identifying cause is the prevention of asthma induced by soy beans in Barcelona. The unloading of soy beans in the port caused outbreaks of asthma; identification of the cause resulted in filters being installed in the silos, and this eliminated outbreaks that had previously caused major morbidity including admissions to an intensive care unit.⁶

In the context of an increase in asthma and in deaths

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