

Good practices in combating female genital mutilation



This publication presents good practices on combating female genital mutilation identified during the implementation of the 'Study to map the current situation and trends of female genital mutilation in

27 EU Member States and Croatia. The consortium composed of the Ghent University — ICRH and E.A.D.C. (Yellow Window Management Consultants) was commissioned to carry out the study in 2012.

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Methodology for the selection of practices

The criteria for the identification of practices with potential for this study were based on the action plan on good practices of the European Institute for Gender Equality (EIGE).

National researchers were given information about this plan during a briefing in June 2012. Questions on practices with potential were included in all in-depth interviews in the nine countries included in Phase II of the study. Key informants in all interviews were asked to describe examples of practices they considered to have good potential in relation to the work on female genital mutilation (FGM) in their countries. The national researchers selected the most promising practices and incorporated them into their country reports.

The practices identified were presented in each of the country reports, using a standard table template to allow for ease of comparison between countries and practices. National researchers were asked to consider and discuss each practice, reflecting on how it responded to: needs identified; results achieved; integration within a wider strategy; actors involved; availability of resources; monitoring and evaluation of the practice; and sustainability and possible transferability to other contexts, regions and/or countries. Researchers were also asked to identify which of the 'six Ps' — namely prevalence, prevention, protection, prosecution, provision of services and partnerships — the practices related to; in many cases it was more than one.

Selected practices covering the different Ps were presented and discussed at an experience exchange meeting entitled 'Towards good practices in prevention, protection, prosecution, provision of services and partnerships in the area of FGM' in London on 13 September 2012, attended by experts from different Member States representing a range of backgrounds and organisations. The experience exchange was an opportunity to explore, analyse and discuss the practices presented and to share learning and experiences. The presentations and subsequent discussion at the meeting enabled additional details and information to be added to each practice table.

It is important to note that this initial assessment of practices with potential for the purposes of this study is based on the analytical country reports from the nine EU Member States and the discussions and presentations at the experience exchange meeting. It does not constitute a formal evaluation but is a compilation of practices suggested by national researchers who have followed EIGE's action plan on good practice indicators as far as possible, which have then been collated by the core team. While other practices have emerged in the course of the study that also seem relevant and interesting and show potential, it may be too early to assess their significance.



Prevention

The chain approach (Ketenaanpak), the Netherlands

Background and general information

Name of the organisation	Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport, the Netherlands) in cooperation with GGD, FSAN and Pharos
Contact person	Claire Hostmann
Period	2006 to date, following three different stages over time: <ol style="list-style-type: none"> 2006–09: pilot, coordinated at national level; 2010–11: roll out, coordinated at national level; 2012 to date: responsibility at municipality level.
Context analysis, with specific focus on (!): <ul style="list-style-type: none"> sustainability impact effectiveness efficiency relevance 	<p>Following the publication of the research report of 2003 ‘Strategies to prevent circumcision in girls’, an FGM policy brief was issued in 2004 that recommended the establishment of the Commission Fighting FGM, whose reports have triggered a succession of actions. The most important consequence of the reports was the initiation of pilot projects in six cities in 2006, and the subsequent roll out of the pilot projects at national level in 2010 and 2011. The pilots were developed in big cities where most of the communities from countries where FGM is practised were living (Rotterdam, Amsterdam, The Hague, Utrecht, Eindhoven and Tilburg). A very important factor in this process was that the issue was taken up by the State Secretary for Health, Welfare and Sport, who issued policy briefs that detailed a clear policy on FGM and financed the pilots. The clear choice to favour prevention, rather than prosecution, has led to a series of initiatives and interventions to intensify the prevention of FGM and the protection of girls and women from FGM. The chain approach was used during pilot projects and after the projects finished the approach was instrumental in sustaining the benefits and experiences.</p> <p>The chain approach is a method of collaboration between a number of key actors dealing with FGM. It is relevant when the issue of FGM touches several sectors and structures that do not fall under the responsibility of only one agency. Since FGM is a complex issue that requires actions and services such as prevention initiatives, child protection measures, prosecution, healthcare for children and older women, and psychosocial care, the collaboration between the actors from different sectors is important in order to provide adequate prevention, protection, prosecution and care. Moreover, the strong cultural anchoring of the practice of FGM necessitates the inclusion of communities of migrants from FGM-practising countries living in the Netherlands to provide adequate services and protection, which is done through key persons who are members of the communities. The chain approach is further characterised by the use of protocols for each sector to guide the work of actors involved. Moreover, the protocol for Youth Health Care (child protection) is monitored by the highest health authority.</p>

(!) The concepts adopted are consistent with the approach provided by the European Commission. See ‘Aid Delivery Methods — Vol. 1 — Project cycle management guidelines’, European Commission, 2004.

Sustainability: The chain approach is currently financed by each Dutch municipality, as they are expected to foresee a budget to tackle FGM. Nevertheless, each municipality has its own policies and different sizes of communities from FGM-practising countries. Therefore, budgets are also supposed to target the needs of each municipality. The chain approach (especially through the key persons) is expected to progressively change the behaviour of practising communities residing in the Netherlands. This implies that the results already achieved within these communities will be continued.

Impact: This approach is supported within the wider policy framework regarding FGM. The results of the evaluations performed proved that this approach is effective. Nevertheless, its impact remains difficult to measure since no baseline assessment was performed.

Effectiveness: All actors involved know their roles in the process and their counterparts in the chain. The approach was tested and proved to be effective towards achieving the objectives proposed. The approach and its instruments were adapted based on what could be learned from the pilots.

Efficiency: There is no information available regarding this criterion.

Relevance: The objectives, measures and specific activities address, in a consistent way, the problems related to the reality of FGM in the Netherlands, as well as the target groups' needs and priorities, respecting and including the legal and political framework. The reports prove that the target groups were successfully reached.

Evaluation criteria

1. 'Works well'

(Gender equality) objectives	The chain approach aims at making relevant actors collaborate in an integrated way with regard to the practice of FGM, whereby activities are adjusted to complement each other, resources are shared and actors bear a joint responsibility for the outcome. In the chain approach the actors and chain members get to know each other so the threshold for asking questions and inter-referring cases is lowered.
Outcome/specific changes as an actual result of the process/activity	The chain approach uses existing structures to deal with FGM from a child protection and healthcare perspective and involves key persons from communities that practise FGM as a liaison between these communities and professionals. This approach has developed new instruments that can guide professionals on how to deal with cases of girls at risk or girls and women who already have undergone FGM.
Target groups	All relevant professionals with regard to FGM protection, prevention, prosecution, and provision of services. Chains consist of: key persons; Youth Health Care (YHC); police; schools; medical professionals (midwives, maternity care, GPs, gynaecologists, paediatricians); child protection (Youth Care (YC)); migrant organisations; and advice and reporting points on child abuse.



Aims, methods and tools used	<p>In each municipality, a chain has to be determined, and the way to deal with FGM has to be defined. All relevant actors need to be involved. These are Youth Health, key persons, midwives, maternity care, GPs, gynaecologists, paediatricians and advice and reporting points on child abuse (i.e. medical and juridical chain and communities). Moreover, experts need to be found for the preparation of the agreements (guidelines), and umbrella organisations should be involved for their implementation. Chain partners (including members of practising communities) need to have a clear idea of the role of each stakeholder in the case of a report of FGM or a girl at risk. All actors are trained.</p> <p>Protocols are developed to explain in detail the roles and responsibilities of each actor in the chain, as well as instruments to support their activities. For instance, the ‘Standpunt’ (for Youth Health Care) or protocols for Youth Care and medical care (including the minimum care level for FGM and background information on FGM) and FGM risk indicators for teachers have been developed.</p> <p>Regular meetings are organised so that each stakeholder knows the role of the other stakeholders. At the municipality level, chain meetings take place to encourage networking.</p> <p>The main activities of the chain approach are:</p> <ul style="list-style-type: none">• developing and implementing guidelines;• training professionals (YHC staff, YC staff, Council for Child Protection, midwives, gynaecologists; e-learning for YHC and midwives);• training key persons from risk communities in order to promote their skills in conducting home visits and information sessions.
Evaluation of good practice	<p>Two evaluation reports were produced which evaluated the pilot projects in the six cities in which the chain approach was used. The main conclusions are as follows.</p> <p>1. With regard to providing individual information and early detection of risk situations to Youth Health Care (YHC), the pilots invested a lot in capacity building of YHC (doctors and nurses), developed educational materials and made efforts to embed capacity building and training into regular programmes and courses. YHC has successfully managed to reach the target group. Following the evaluation, the conversation protocol was reworked into the ‘Standpunt’, taking into account the recommendations made by the evaluators.</p> <p>2. With regard to enhancing the chain approach, the pilots aimed at improving detection, reporting and dealing with FGM within the chain of child abuse. The pilots succeeded in appointing focal persons and providing information, training and capacity building, in order to make (structural) agreements with organisations from various sectors. The pilots provided knowledge about stimulating and obstructing factors when enforcing the chain, which are detailed in the evaluation report ⁽²⁾.</p> <p>The evaluation reports also provide a list of recommendations for future project leaders on FGM. The fact that FGM has now been mainstreamed and integrated at municipal level proves that the authorities have actively sought to make the outcomes of the pilot projects sustainable.</p>

(2) Van Burik, A. E., Gerritsen, A. D. and Ramos, C. P., ‘Resultaten analyse meldingen VGV — Een onderzoek naar de kenmerken en de afhandeling van adviesvragen en meldingen vrouwelijke genitale verminking binnengekomen bij het AMK en de Raad voor de Kinderbescherming’, Adviesbureau Van Montfoort, 2008 (<http://www.rijksoverheid.nl/ministeries/vws/documenten-en-publicaties/kamerstukken/2009/02/03/resultaten-analyse-meldingen-vgv.html>).

Ways in which the good practice/ activity could have been improved	<ul style="list-style-type: none"> • The key persons are a key success factor within the chain approach, as they are anchored within the communities and have easy access to them. As such, they are well-placed to detect signs of families at risk. A challenge with key persons is their high turnover, which necessitates the frequent training of new ones. This is why structural embedding and financing of key persons is very important, not only for the work they do with regard to prevention, but also to empower and remunerate them. • Furthermore, if a chain approach is organised, it should involve all actors from prevention to prosecution. All these actors should be trained and there should be no gaps in chain.
Plans to gather financial resources and/or institutional arrangements	<p>The pilot projects were financed by the Ministry of Health, Welfare and Sport. They were planned to run from 2006 to 2009, after which the municipalities were supposed to have included the issue of FGM in the GGDs (community health services), with budgets from the municipalities. However, since municipalities were not aware that budgets had to be set aside for this, the pilots were extended twice, until March 2010. The Secretary of State for Health, Welfare and Sport agreed with the municipal authorities that they should plan to budget for the embedding of the pilot projects during these extensions. However, by March 2010, the pilots were still not structurally embedded. The Secretary of State then decided to give a budget to GGD Nederland, the association of GGDs, for 2 years to make sure that the 'Standpunt' approach and its use were embedded at municipal level, within Youth Health Care. The concept was that after these 2 years, the municipalities should really have the pilots embedded. Since the implementation of FGM policies has now been decentralised to the municipalities, the financing of the key persons has been dropped.</p>

2. Transferability

Success factors	<ul style="list-style-type: none"> • Involving practising communities through the key persons because information and sensitisation provided by people from their own community is very different from that given from a western perspective. Professionals acknowledge this and use the key persons very frequently and willingly. • The inclusion and collaboration in the chain of actors from sectors that deal with prevention, prosecution, protection and provision of services, which forms a unique partnership. • The development of protocols, in particular: <ul style="list-style-type: none"> – the 'Standpunt' to guide Youth Health Care in assessing risk and taking action; – the acting protocol for cases of FGM practised on minors, for the juridical chain; – the medical model protocol for health professionals. • The monitoring of the 'Standpunt' by the Health Care Inspectorate (IGZ). • The training of key persons and professionals in the chain. • Sufficient resources provided for the pilots. • The registration of FGM in some data systems (perinatal registration and digital files of Youth Health Care). • Personal contacts between the actors and chain members so the threshold for asking questions and inter-referring cases is lowered.
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Main obstacles	<ul style="list-style-type: none"> • Measuring effects without baseline data. • Lack of financial support for continuing the project, especially for key persons. • Insufficient involvement of the education system and of general practitioners. • Imperfect collaboration between the medical and juridical chains; many actors are involved and each has its own way of making decisions and taking action, which can hamper an effective prosecution. • Movement of people within the network, which requires more training. • The fact that peer educators/key persons regularly meet families experiencing multiple problems, with FGM being only one of these many problems.
Actual replication or spin-off effects	The pilot projects were subsequently rolled out at national level in 2010 and 2011.
3. Learning	
Lessons learned from the process	<ul style="list-style-type: none"> • Involvement of key persons from practising communities as change agents within their own communities. • Cooperation between different sectors relevant for tackling FGM. • Pilot test of the practice and subsequent roll out at municipal level. • Training of key persons and professionals. • The job of key person needs to be (well) remunerated in order to prevent a high turnover and thus an over-investment in constantly training new key persons. • The youth population at risk is being monitored.
Sources	<p>Handelingsprotocol vrouwelijke genitale verminking bij minderjarigen — Uitleg en handvatten bij Ketenaanpak (Action protocol on FGM for minors — Explanations and references about the chain approach) (available in Dutch) http://www.pharos.nl/documents/doc/handelingsprotocolupdateapril2010.pdf</p> <p>Standpunt Preventie VGV door de JGZ (available in Dutch) http://www.pharos.nl/documents/doc/standpuntvgv.pdf</p> <p>Modelprotocol medische zorg voor vrouwen en meisjes met vrouwelijke genitale verminking (VGV). Preventie, begeleiding en behandeling van vrouwen met status na vrouwelijke genitale verminking (available in Dutch) http://www.pharos.nl/documents/doc/modelprotocolversie2.pdf</p> <p>Several materials (publications, declarations, fatwas, brochures).</p>

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Protection

The Catalan protocol for the prevention of FGM

Background and general information

Name of the organisation	Generalitat de Catalunya — Dirección General de Atención a la Infancia y la Adolescencia (DGAIA) (Government of Catalonia — Child and Adolescent Care Authority)
Contact person	Montserrat Sabate Pilar Aldea
Period	2002 to date
Context analysis, with specific focus on ⁽³⁾ <ul style="list-style-type: none">• sustainability• impact• effectiveness• efficiency• relevance	<p>In 2001, the Parliament of Catalonia passed Resolution 832/VI of 20 June adopting measures against the practice of FGM and urging the Government of Catalonia (Generalitat de Catalunya) to adopt preventive and welfare measures within the areas of health, education and social services. Following this resolution, the Catalan protocol aimed at preventing FGM was passed in June 2002, addressing health professionals, primary care social services, schools, police and other preventive associations. This protocol was updated in December 2007, following other legal modifications adopted in 2003 and 2005 in Spain. Later on, the Parliament of Catalonia passed Law 5/2008 to eradicate violence against women. This law takes into consideration several resolutions of the European Parliament and addresses FGM as a form of gender-based violence. More recently, in 2010, a specific law that establishes prevention, care and protection for girls who have been subjected to FGM or are at risk of undergoing the procedure has been passed (Law 14/2010 of May 27 on Rights and Opportunities for Children and Teenagers).</p> <p>Sustainability: The abovementioned laws establish the actions for prevention, assistance, protection and public prosecution with regard to FGM in Catalonia. The protocol is based on interdepartmental cooperation, ensuring a comprehensive intervention by different services and departments involved in the eradication of FGM. The professionals targeted by this protocol are aware of FGM and the procedures to act upon when confronted with cases of performed FGM or risk of FGM. In addition, since the professionals involved work directly with families, in some cases, behavioural change may be achieved, which means that families will not subject their daughters to FGM and, hopefully, the children will not continue the practice either. Although there is no information or evaluation that assesses the behavioural change of the parents with regard to the practice of FGM, there is evidence that the parents who signed the informed consent (see below) stating that they will not subject their child to FGM have complied with it; no paediatrician has so far informed the DGAIA that the consent form was not respected (i.e. that FGM was practised), which would set off criminal procedures to prosecute on the grounds of FGM.</p>

⁽³⁾ The concepts adopted are consistent with the approach provided by the European Commission. See 'Aid Delivery Methods — Vol. 1 — Project cycle management guidelines', European Commission, 2004.

	<p>Impact: An evaluation of the protocol has not yet been undertaken. However, the outcomes of the protocol include the adaptation of computer programmes and training activities to tackle FGM.</p> <p>Effectiveness: The protocol deals specifically with FGM and has modified previous models of intervention, in accordance with the abovementioned laws.</p> <p>Efficiency: Despite the lack of information on the efficiency of the protocol, having specific and cooperative measures to deal with different FGM situations can be considered to improve the efficiency of the work that has to be performed. Moreover, the fact that professionals are aware of FGM can also contribute to a more efficient approach to detect cases and act accordingly.</p> <p>Relevance: The protocol is in line with the policy and legal framework at national and regional levels. The protocol's objectives are appropriate to the problems that it is supposed to address.</p>
Evaluation criteria	
1. 'Works well'	
(Gender equality) objectives	The main goal of this protocol is to establish a coordinated intervention by several departments of the public administration of the Government of Catalonia in FGM cases, detailing the steps to be taken by each actor in each type of FGM case (non-urgent, urgent and mutilated). The ultimate goal is to promote behavioural change in practising communities.
Specific/outcome changes as an actual result of the process/activity	<ul style="list-style-type: none"> • Provision of protection to girls at risk of being subjected to FGM. • Prosecution of FGM crimes. • Provision of adequate social, educational, physical and psychological support. • Provision of treatment for deinfibulation. • Promotion of behavioural change among families from FGM-practising communities for the abandonment of the practice.
Target groups	Professionals dealing with FGM cases: healthcare professionals, police, people involved with minors' protection, social services, etc. and immigrant associations.
Aims, methods and tools used	<p>The protocol details the procedures regarding situations where FGM has been performed or where girls/women are at risk.</p> <p>In cases in which FGM has already been performed, the protocol distinguishes the following situations:</p> <ol style="list-style-type: none"> 1. girls who have undergone FGM arriving in Catalonia from a country where legislation forbids FGM; 2. girls who have undergone FGM arriving in Catalonia from a country where legislation allows mutilation; 3. girls living in Catalonia, mutilated after a trip to their country of origin where legislation allows mutilation.



When one of these situations is detected (by health, educational or police services), health practitioners are asked to diagnose FGM and to submit a medical report and a judicial statement and inform the court or the public prosecutor's office and the DGAIA. Several actions are initiated afterwards: the DGAIA, in coordination with social, health and educational services, must ensure that the girl who was subjected to FGM receives adequate social, educational, physical and psychological support and, if necessary, treatment for deinfibulation. For the first and third situations, if there is evidence that the crime has been committed, the DGAIA must report this to the court and urge the initiation of proceedings. The DGAIA must also ask for precautionary measures, such as a prohibition on leaving the country, withdrawal of passport and prohibition on issuing another passport, and must report to the embassy or consulate. In spite of the risk of FGM, the DGAIA strives to keep the girl with her biological family, on the condition that the parents follow all care and protection measures required by the institutions.

The court must persecute, prosecute and criminally punish the perpetrator of FGM, whether by commission or omission, if s/he is found in Catalonia, due to the principle of extraterritoriality which is applicable. For the second situation, however, FGM cannot be persecuted, prosecuted or punished by Spanish jurisdiction because FGM is not considered a crime in the girl's country of origin and the girl does not have residence status in Spain.

The protocol establishes the key elements for identifying an **FGM risk situation** and defines the intervention actions to be undertaken by professionals to protect a girl. The key elements for identifying an FGM risk situation refer to: girls whose mothers or aunts have been mutilated; girls whose parents want to travel to their countries of origin where FGM is practised; girls whose parents refuse to sign an informed consent preventing the girl from undergoing FGM; girls whose parents sign the informed consent without much conviction; and when there is a suspicion that parents may prevent the girl from returning to Catalonia. The informed consent is a document that explains to the parents the juridical consequences of practising FGM. If the family rejects signing it, judicial precautionary measures are then requested to avoid the girl leaving Catalonia.

For each identified situation, the risk level must be assessed (urgent or non-urgent) and protection actions must be carried out:

- **Non-urgent** (situation identified by the school or by health institutions): A coordinated action with the social services will be carried out to initiate a socio-educational intervention with the family.
- **Urgent:** Health institutions ask the family for the informed consent form where they state that their daughter will not be mutilated.

Evaluation
of good practice

An evaluation of the protocol has not been undertaken yet.

Ways in which the good practice/activity could have been improved	<ul style="list-style-type: none"> • Development of data collection systems to allow for an estimate of the number of girls (and women) subjected to FGM, or those at risk, in order to: <ul style="list-style-type: none"> – improve preventive, assistance and protection measures; – assess the effectiveness of the services and measures foreseen in the protocol. • Evaluation of the protocol and, in particular, the services and measures foreseen. • Improvement of the level of awareness, and training the professionals involved (e.g. compulsory training on FGM for paediatricians). • Explicit inclusion of FGM in the educational programmes of schools targeting girls and boys about gender equality and zero tolerance towards violence against girls/women.
Plans to gather financial resources and/or institutional arrangements	The protocol has never had a specific budget, as it relies on the inputs of all the departments involved in it. As long as all the departments involved remain concerned about FGM, the sustainability of the protocol is ensured.
2. Transferability	
Success factors	<ul style="list-style-type: none"> • The awareness about the consequences of FGM for girls, paving the way for the approval/publication of an acting protocol in Catalonia in 2002; this protocol has been always in line with the policy and legal framework and as such was updated in 2007 to reflect legal changes. • The interdepartmental and cooperative approach of the protocol, in which different departments and professionals are called upon to act. • The integration of detailed, specific measures into a policy document that guides the action needed depending on the characteristics of the situation.
Main obstacles	<ul style="list-style-type: none"> • The absence of an information recording system to collect feasible data on girls who have been subjected to FGM or are at risk of undergoing the procedure; therefore, it is difficult to know the impact of the measures adopted in Catalonia in the last 10 years. • Incoherence, in the sense that, in 2011, 10 cases were reported to the DGAIA, although it is considered that this number does not seem to be in accordance with the population that might be at risk. • Overriding of the protocol measures: It has been recognised that the protocol measures are not always followed because there were girls identified as being at risk of undergoing FGM who were, in the end, subjected to the procedure of FGM.
Actual replication or spin-off effects	The Government of Aragon has included elements of the Catalan protocol in the implementation its own regional protocol.



3. Learning

Lessons learned from the process	The importance of having an acting protocol that follows the national and regional policy and legal framework, detailing the procedures to be taken on board by each department and professionals envisaged, depending on the identified situations (if FGM has already been performed or if there is a risk situation).
Sources	<p>Child and Adolescent Care Authority (available in Catalan) http://www20.gencat.cat/portal/site/bsf/menuitem.7fca6ecb84d307b43f6c8910b0c0e1a0/?vgnextoid=4e0622a30e5a4210VgnVCM1000008d0c1e0aRCRD&vgnnextchannel=4e0622a30e5a4210VgnVCM1000008d0c1e0aRCRD&vgnnextfmt=default</p> <p>Action protocol for the prevention of FGM (2007) (available in English) http://www20.gencat.cat/docs/dasc/03Ambits%20tematics/05Immigracio/08recursosprofessionals/02prevenciomutilaciofemenina/Pdfs/Protocol_mutilacio_angles.pdf</p>
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The asylum policy instruction: Gender issues in the asylum claim	
Background and general information	
Name of the organisation	UK Border Agency (UKBA)
Contact person	Ian Cheeseman
Period	2004 to date
Context analysis, with specific focus on ⁽⁴⁾ <ul style="list-style-type: none"> • sustainability • impact • effectiveness • efficiency • relevance 	<p>There is no specific UK national asylum legislation dealing with FGM, besides the UK's obligations under the 1951 Refugee Convention and the European Convention on Human Rights (ECHR), and the minimum standards for protection set by the EU qualification directive. However, there are international and national legal instruments which impose obligations on the UK to eliminate discrimination and gender-based violence. These include the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) ratified by the UK in 1986, the ECHR as implemented by the Human Rights Act 1998 and the Gender Equality Duty introduced into the Sex Discrimination Act 1975 by the Equality Act 2006.</p> <p>Women and girls fearing FGM can base their application for asylum on well-founded fear if they are from countries where FGM is knowingly tolerated by the authorities, or on their membership of a particular social group amongst which FGM is practised. Nevertheless, if a woman applicant has already been subjected to FGM, the UK Border Agency (UKBA) would not consider that she would face a risk of persecution on the basis of FGM in the future. However, this can be considered if there is substantial proof that there might be a risk of forced marriage, that the woman might be at risk of having the procedure redone after delivering a baby, or if there might be a risk of FGM being performed on the daughters of women who have already been genitally mutilated.</p> <p>In 2004, the Home Office issued an asylum policy instruction which is followed by asylum caseworkers (or case owners, i.e. the official or civil servant in the UKBA who is assigned the individual asylum case) within the UKBA. The asylum policy instruction contains guidance on how caseworkers should address asylum cases with relation to gender, including issues of gender-based violence and the need to utilise gender-sensitive procedures. FGM is specifically mentioned numerous times within the instruction. The UKBA recently introduced gender training for its staff to enhance their existing knowledge. The asylum policy instruction was revised in 2006 and reviewed again in 2010. During the last review process, a number of organisations were consulted, including Asylum Aid, the UN High Commissioner for Refugees (UNHCR) and the Immigration Law Practitioners Association (ILPA). The asylum policy instruction is considered to be a very strong policy document that includes suggestions made during this consultation process.</p>

⁽⁴⁾ The concepts adopted are consistent with the approach provided by the European Commission. See 'Aid Delivery Methods — Vol. 1 — Project cycle management guidelines', European Commission, 2004.



	<p>Sustainability: This practice is sustainable as long as the asylum policy instruction is available for consultation and is adapted and updated across the years. Moreover, it was issued by a public institution and financial resources are being invested to regularly train UKBA’s staff.</p> <p>Impact: There is no information available regarding this criterion.</p> <p>Effectiveness: There is no information available regarding this criterion.</p> <p>Efficiency: There is no information available regarding this criterion.</p> <p>Relevance: The gender-sensitive asylum policy instruction is in line with the UK’s policy and legal framework. It consistently addresses the gender equality needs and priorities of both UKBA’s staff and asylum claimers.</p>
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Evaluation criteria

1. ‘Works well’

(Gender equality) objectives	The aim of the guidance is to ensure that all caseworkers are gender sensitive, including the introduction of gender-sensitive procedures, as well as awareness of gender-based violence, including FGM, which might affect women seeking asylum. FGM is specifically mentioned numerous times within the instruction.
Specific/Outcome changes as an actual result of the process/activity	There is a policy document that details the procedures and exemplifies situations in which gender should be taken into consideration to analyse an asylum claim, including FGM-related claims. Moreover, caseworkers and staff at the UK Border Agency have received training on this matter. Both the document and the training will potentially promote a gender-sensitive analysis of asylum requests.
Target groups	Caseworkers and staff at the UK Border Agency.
Aims, methods and tools used	<p>The asylum policy instruction should be read in full to better understand its aims, methods and methodologies. Specific references to FGM are, nevertheless, presented hereafter to exemplify the pertinence of this policy document.</p> <ul style="list-style-type: none"> • FGM is identified as a form of gender-specific persecution and as a form of harm that is more frequently or only used against women and that can occur in the family, the community or at the hands of the state. • ‘The fact that violence against women is common, widespread and culturally accepted in a particular society does not mean that protection on an individual basis is inappropriate. FGM, for example, is widely practised in some societies but it is a form of gender-based violence that inflicts severe harm, both mental and physical, and amounts to persecution. Each case should be considered on its own merits in the light of country of origin information and guidance’. • In cases of failure or inadequacy of state protection, ‘the state may make illegal an act that can amount to persecution, such as FGM, but continue to condone or tolerate the practice or be unable to put an effective end to the custom because of its widespread cultural acceptance. It is not always reasonable or possible for a woman to alert the authorities to her need for protection. This may be because protection is not forthcoming or because by requesting protection she risks violence, harassment, rejection by her society or even further persecution. In some societies it may not in fact be possible for a woman to approach the authorities, for example, without being accompanied by a male. The ways in which particular laws, social policies or practices (including traditions and cultural practices) are implemented may constitute or involve a failure of protection’.

Evaluation of good practice	<ul style="list-style-type: none"> The UKBA is audited by the quality audit team, which is responsible for auditing asylum decisions, interviews and monthly reports. Caseworkers are supervised by their managers. The asylum policy instruction is revised regularly to ensure that it is kept up to date.
Ways in which the good practice/activity could have been improved	No information available.
Plans to gather financial resources and/or institutional arrangements	The Home Office has issued this policy document and ensured that all staff were trained.
2. Transferability	
Success factors	<ul style="list-style-type: none"> The training of staff working in migration and border services, as well as easily available instructions which take into consideration gender issues on asylum claims. The accessibility of the instruction to CSOs, legal staff, potential asylum seekers, etc. as it is in the public domain (available on the UKBA website). This results in a level of transparency in relation to gender and asylum claims in the UK.
Main obstacles	No information available.
Actual replication or spin-off effects	Staff across the UKBA are familiar with issues related to gender, including gender-based violence, as they relate to asylum claims.
3. Learning	
Lessons learned from the process	<ul style="list-style-type: none"> To have gender-sensitive instructions that detail the procedures to be taken on board when analysing asylum claims and provide clear examples of gender-specific situations that can justify an asylum request. To provide training to all staff working in migration and border services related to gender issues in asylum claims.
Sources	<p>UK Border Agency http://www.ukba.homeoffice.gov.uk/</p> <p>The asylum policy instruction: Gender issues in the asylum claim http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumpolicyinstructions/apis/gender-issue-in-the-asylum.pdf?view=Binary (available in English)</p>
Contacts	Home Office — UK Border Agency lan Cheeseman: lanR.Cheeseman@homeoffice.gsi.gov.uk



Prosecution

Commission for the Abolition of Sexual Mutilations (Commission pour l'abolition des mutilations sexuelles)

Background and general information

Name of the organisation	Commission pour l'abolition des mutilations sexuelles (CAMS) (Commission for the Abolition of Sexual Mutilations)
Contact person	Linda Weil-Curiel
Period	1982 to date
Context analysis, with specific focus on ⁽⁵⁾ <ul style="list-style-type: none"> • sustainability • impact • effectiveness • efficiency • relevance. 	<p>CAMS was founded by Awa Thiam, an author and activist of Senegalese origin in March 1982. Linda Weil-Curiel, a lawyer who has been part of every FGM criminal procedure initiated (with the exception of two court cases at the provincial level), is the current director.</p> <p>In France, there seems to be a particularity that has, since the 1980s, played an important role in prosecuting FGM cases. Although criminal procedures have to be initiated by public prosecutors (who represent society), a civil society organisation (CSO) that defends children from ill-treatment can take the role of 'civil party' in a trial. In order to take advantage of this possibility, Linda Weil-Curiel sought out a CSO on behalf of which she could pledge against FGM. She started to litigate on behalf of the Women's Rights League and was subsequently asked by the founder of CAMS to succeed her.</p> <p>Prosecution has assumed a major role in raising awareness within families and the general public regarding the harmful consequences of the practice of FGM. According to police investigations, the number of mutilations has decreased since the 1980s due to the criminal trials and prevention initiatives that have taken place. To date, no study has been published that would provide a fully reliable and exhaustive chronology of FGM court cases since the first one reported, in 1979. Linda Weil-Curiel is, therefore, the most reliable source of information regarding the prosecution of FGM in France.</p> <p>Sustainability: A particularity of the French legal framework (as explained above) plays a fundamental role in contributing to the sustainability of prosecuting crimes of FGM.</p> <p>Impact: There is no information available regarding this criterion.</p> <p>Effectiveness: CAMS has successfully contributed to the prosecution of FGM crimes in France.</p> <p>Efficiency: There is no information available regarding this criterion.</p> <p>Relevance: Taking into account that FGM is considered a violation of human rights and that the crime of FGM falls under bodily injuries, the successful approach of CAMS has been in line with the policy and legal framework and has consistently contributed to the implementation of laws prohibiting bodily injury.</p>

⁽⁵⁾ The concepts adopted are consistent with the approach provided by the European Commission. See 'Aid Delivery Methods — Vol. 1 — Project cycle management guidelines', European Commission, 2004.

Evaluation criteria	
1. 'Works well'	
(Gender equality) objectives	<p>CAMS differs from other organisations working in the field of FGM in the importance that it places on the juridical aspects of the practice (by successful prosecution of FGM as a crime).</p> <p>The aims of CAMS include:</p> <ul style="list-style-type: none"> • assisting research by French and foreign students; • contributing to the training of professionals in the areas of health, social affairs, education and justice; • taking part in civil judicial cases related to FGM (and, if necessary, forced marriages); • taking part in international conferences.
Specific/Outcome changes as an actual result of the process/activity	<ul style="list-style-type: none"> • CAMS has contributed to establishing jurisprudence to criminalise FGM and to inform envisaged professionals about relevant documents as well as their duties with regard to FGM. • CAMS has taken several criminal cases involving FGM to court.
Target groups	Girls and women subjected to FGM.
Aims, methods and tools used	No information available.
Evaluation of good practice	CAMS has not been evaluated.
Ways in which the good practice/activity could have been improved	The records of prosecutions involving FGM in France should be collated so that other countries can learn from the experience of CAMS.
Plans to gather financial resources and/or institutional arrangements	No information available.
2. Transferability	
Success factors	<ul style="list-style-type: none"> • Existence of provisions allowing CSOs to sue. • Commitment and extensive experience and expertise developed by Linda Weil-Curiel during the last 20 years.



Main obstacles	<ul style="list-style-type: none">• The reluctance of magistrates to prosecute FGM perpetrators or facilitators and to address FGM as a criminal offence.• ‘Cultural relativism’ as a general cultural feature or background variable, against which the understanding of potentially harmful traditional practices is framed.• The tensions between FGM prosecution and prevention.• The absence of collaboration from parents.• The lack of international cooperation (or the lack of willingness to implement extra-territoriality).• The lack of willingness of social, health and educational workers to report cases of FGM, depending on their conception of their mission and professional secrecy provisions.
Actual replication or spin-off effects	Other countries and legal jurisdictions look at France as an example due to its number and level of prosecutions for FGM.
3. Learning	
Lessons learned from the process	<ul style="list-style-type: none">• The possibility for CSOs to sue has led to successful prosecutions in France.• CAMS’ approach to bringing together different points of view from actors working on FGM in France has also proved to be successful.
Sources	Commission pour l’abolition des mutilations sexuelles http://www.cams-fgm.net/
Contact	Commission pour l’abolition des mutilations sexuelles 6, place Saint-Germain-des-Prés 75006 Paris FRANCE Tel. +33 145490400 Fax +33 145491671 E-mail: w113111@club-Internet.fr

Provision of services

African Well Woman Clinics	
<i>Background and general information</i>	
Name of the organisation	African Well Woman Clinics
Contact person	Comfort Momoh MBE
Period	1993 to date
Context analysis, with specific focus on ⁽⁶⁾ <ul style="list-style-type: none"> • sustainability • impact • effectiveness • efficiency • relevance 	<p>One of the responses to migrant women with FGM in the UK was the establishment of a specialised service to cater for the health needs of these women. As a result of this, in 1993, the first African Well Woman Clinic was opened by Harry Gordon in Northwick Park hospital. The main aim of the clinic was to provide obstetric and gynaecological care to women affected by FGM. In 1997, the second clinic was established at Guy's and St Thomas' Hospital by Comfort Momoh. Initially, women used to come to her clinic from other cities. As the distances were great, she trained and encouraged other midwives to open their own clinics. By 1999, there were four clinics operating in the UK to attend to the needs of migrant women with FGM, and a total of 15 clinics are currently fully operating in England, with a 16th clinic in Manchester that has still not opened to the public. It is noted that Scotland and Wales have no specialist FGM clinics. London, where a large percentage of the migrant population resides, has the largest number of clinics, with a total of 11 clinics. Birmingham, Bristol, Liverpool and Nottingham have one clinic each. The clinics are all run by doctors and midwives.</p> <p>Sustainability: Taking into account that the clinics are within the National Health Service, they have the resources to be sustainable. Nevertheless, it has been noted that some clinic staff are not well supported.</p> <p>Impact: The African Well Woman Clinics have responded to the specific needs of girls and women affected by FGM. Besides the provision of healthcare, they have contributed to advocating against FGM and to policymaking, as well as engaging and empowering the affected communities.</p> <p>Effectiveness: The beneficiaries of these clinics have taken advantage of the services provided and the objectives of these clinics have been achieved.</p> <p>Efficiency: A cost-effective model of care can be identified in some of the clinics (e.g. Guy's and St Thomas') due to the provision of a 'one-stop clinic' where women who need deinfibulation are seen for counselling and have the surgery on the same day. This saves time and money and avoids waiting lists.</p> <p>Relevance: The objectives of this practice are consistent with the health and psychological needs and priorities of girls and women who have been subjected to FGM.</p>

⁽⁶⁾ The concepts adopted are consistent with the approach provided by the European Commission. See 'Aid Delivery Methods — Vol. 1 — Project cycle management guidelines', European Commission, 2004.



Evaluation criteria	
1. 'Works well'	
(Gender equality) objectives	<ul style="list-style-type: none"> To provide support, information/advice and counselling to women who have undergone FGM, and to offer surgical intervention (reversals) where appropriate. To provide a synchronised service for women. To provide support and education to the communities affected.
Specific/Outcome changes as an actual result of the process/activity	<ul style="list-style-type: none"> The clinics provide an adequate response to women who have been subjected to FGM at different levels, including the health and psychological levels. Expertise in FGM cases has been developed and shared internationally. Within the different clinics, the patient data is not compiled routinely or consistently. However, some figures have been provided by the following clinics: <ul style="list-style-type: none"> University College London Hospital (2009 and 2010): 169 cases, with 97 cases being new referrals and 72 follow-up patients; Whittington Hospital: 120 cases over a 1-year period in 2004/05 and 194 cases in 2007/08.
Target groups	Girls and women, both pregnant and non-pregnant, who have undergone FGM. The clinics also target the families of these girls and women, as well as the communities, with a view to behavioural change.
Aims, methods and tools used	<p>As all the clinics are National Health Service clinics, treatment is free, and in the majority of cases referral was either by a midwife, nurse, social services or GP. The services provided include:</p> <ul style="list-style-type: none"> deinfibulation (under local or general anaesthesia); psychological and psychosexual counselling support; clinical management of complications due to FGM, such as cysts, abscess and infections; interpretation services; sexual health services; provision of advice; provision of family planning advice. <p>Moreover, the clinics also develop the following activities:</p> <ul style="list-style-type: none"> advocacy and policy; research and review of knowledge; engaging and empowering communities; negotiating ancient traditions/beliefs; training for professionals.
Evaluation of good practice	<ul style="list-style-type: none"> At the Acton African Well Woman Clinic, regular audits are conducted to assess the number of operations and enquiries and the number of women and girls seen, including their age, age at circumcision, country of origin and duration of stay in the UK. The clinic received the Guardian Public Services Award in 2011 for 'Innovation and progress: Diversity and equality'. Research was conducted by Forward by using a 'mystery shopping model' where they requested two young women to access the African Well Woman clinic services and afterwards to give their views on their perceptions and the attitudes of providers. This revealed the following: <ul style="list-style-type: none"> All the clinics had different operating times and were difficult to access for illiterate people.

	<ul style="list-style-type: none"> Referral pathways were quite difficult, with some patients having to go through their GP, some being self-referrals and some unable to access the services because they lived outside the borough (the service catchment area). Many of the services only focused on antenatal services. As such, quite a lot of young women felt that they did not have a voice and did not know where to go to use the services. Not all the clinics provided comprehensive services. Having a community support worker enhanced women's access and enabled them to feel more at ease in accessing the services.
Ways in which the good practice/activity could have been improved	<ul style="list-style-type: none"> Keeping records of all the cases observed in every clinic. Opening the clinics on a continuous basis, based on the needs of the city (a study of these needs should be conducted to assess the human and financial resources required).
Plans to gather financial resources and/or institutional arrangements	No information available.
2. Transferability	
Success factors	<ul style="list-style-type: none"> The provision of health and psychological services tailored to the needs of girls and women who have been subjected to FGM. The provision of holistic care to girls and women who have undergone the procedure. The provision of free treatment to girls and women who have been subjected to the practice.
Main obstacles	<ul style="list-style-type: none"> Limited opening hours of the clinics: some of the clinics open only once every 4 weeks. Lack of consistency in terms of opening times: the clinics are open on an ad hoc basis, not as a structured service (with the exception of Guy's and St Thomas', which provides daily services for girls and women, such as the 'one-stop clinic', and counselling). Deficient accessibility of many clinics. The lack of routinely or consistently compiled patient data within the different clinics.
Actual replication or spin-off effects	Based on the experience of the first and second clinic, 13 other clinics were opened in different cities in the country.
3. Learning	
Lessons learned from the process	<ul style="list-style-type: none"> To include clinics with specialised services to address within the National Health Service the needs of girls and women who have been subjected to FGM. To ensure the completion of administrative data sets in order to provide information to better assess the services provided and the existing needs and to estimate the prevalence of FGM.
Source	
Contact	Comfort Momoh MBE: comfort.momoh@gstt.nhs.uk



Partnership

Intersectorial group on FGM (Grupo Intersectorial sobre MGF)

Background and general information

Name of the organisation	Comissão para a Cidadania e Igualdade de Género (CIG) (Portuguese Commission for Citizenship and Gender Equality)
Contact person	President of the CIG
Period	2007 to date
Context analysis, with specific focus on (?) <ul style="list-style-type: none"> • sustainability • impact • effectiveness • efficiency • relevance 	<p>FGM started to be tackled at the policy level in 2003, when it was included in a national plan against domestic violence. In 2007, an intersectorial group was created in the framework of the European Commission's Daphne programme to develop national action plans to address FGM. During the implementation of this project, an NGO, the Family Planning Association (APF), presented its contribution to this project to the former Secretary of State of the Presidency of the Council of Ministers (Jorge Lacão) and to the President of the CIG at that time (Elza Pais) and proposed the creation of a working group on FGM. The Secretary of State welcomed the idea and became the mentor for this group, which was then composed of actors from several sectors and with different expertise relevant for tackling FGM in Portugal. Due to the diverse composition of the intersectorial group, FGM can be tackled from different perspectives including health, reproductive and sexual rights, justice, immigration, gender equality, development cooperation and education. Members of the group come from public administration bodies, international organisations and NGOs.</p> <p>The initial goal of the group was to develop and implement a programme of action for the elimination of FGM in Portugal. Since the creation of the intersectorial group, two action programmes have been developed. The first was implemented between 2009 and 2011 and the second is currently being implemented (2011–13). The intersectorial group on FGM is responsible for developing and implementing policy measures with regard to FGM that are integrated in the national programmes of action for the elimination of FGM. The intersectorial group and the programmes of action can be considered as complementary and interconnected aspects of the work on FGM in Portugal.</p> <p>Sustainability: The programmes of action for the elimination of FGM have the support of the Presidency of the Council of Ministers and are coordinated by a public institution that is responsible for the implementation of public policies addressing citizenship and the promotion and defence of gender equality (CIG). Although there is no specific budget attributed to either the programmes of action or to the intersectorial group responsible for the implementation of the measures included in the programmes of action, the annual budget endorsed to the CIG and the resources made available by the members of the intersectorial group ensure its sustainability. Although the measures contemplated in the programmes of action are expected to progressively change the behaviour of practising communities residing in Portugal, this has not been assessed yet.</p>

(?) The concepts adopted are consistent with the approach provided by the European Commission. See 'Aid Delivery Methods — Vol. 1 — Project cycle management guidelines', European Commission, 2004.

Impact: Despite the inexistence of formal evaluations of the programmes of action (and of the intersectorial group), this practice is supported within the wider national gender equality policies. Two internal interim reports and a final report are planned to be developed to assess the execution and impact of the second programme of action for the elimination of FGM (2011–13).

Effectiveness: According to an internal assessment of the second programme of action, nearly 50 % of the activities outlined within the programmes of action have been completed.

Efficiency: There is no information available regarding this criterion.

Relevance: The objectives, measures and specific activities address, in a consistent way, the problems related to FGM in Portuguese territory (including international cooperation actions), respecting and including the legal and political framework.

Evaluation criteria

1. 'Works well'

(Gender equality) objectives	The intersectorial group on FGM is responsible for developing and implementing policy measures with regard to FGM that are integrated in national programmes of action for the elimination of FGM. The second programme of action for the elimination of FGM aims at promoting behavioural and attitudinal changes in practising communities. Therefore, it is expected that these communities will progressively abandon and condemn the practice.
Outcome/specific changes as an actual result of the process/activity	<ul style="list-style-type: none"> • Sensitisation, awareness-raising and prevention of FGM. • Development of support for and integration of measures targeted at girls and women who have been subjected to FGM or are at risk of undergoing the procedure, as well as their families and immigrant organisations. • Training of different types of professionals regarding FGM. • Advocacy against FGM.
Target groups	Public at large; girls and women subjected to FGM, girls and women at risk of undergoing the procedure and their families; immigrant communities; professionals (health, education, media, justice, security forces, workers in sociocultural mediation, cooperation, call-centre operators and researchers); policymakers; students and students' associations; youth organisations; civil society organisations, immigrant associations and/or organisations that work with them, universities and international organisations; religious leaders.
Aims, methods and tools used	The intersectorial group brings together different expertise and knowledge due to its diverse composition of actors, so that FGM can be combated from different perspectives including: health, reproductive and sexual rights; justice and immigration; equality; development cooperation; and education. The group is composed of public administration bodies, international organisations and NGOs (including an immigrant organisation). Each governmental body and organisation has identified a person (or more than one) to be responsible for participating in the meetings and ensuring that the tasks that are assigned to the entity are performed.



	<p>Taking into consideration that Portugal has a national commission, under the direct administration of the state, responsible for the implementation of public policies addressing citizenship and the promotion and defence of gender equality, the CIG assumes a coordinating role for this group. The CIG is responsible for ensuring the implementation of the measures listed in the programmes of action for the elimination of FGM. In addition, the government is currently actively involved in the group at a high level as the current Secretary of State for Parliamentary Affairs and Equality (Teresa Morais) presides over the meetings of the intersectorial group. The intersectorial group meets regularly (approximately every 2 months) upon the CIG's request. The meetings take place at the CIG's offices to discuss and organise the activities that are planned to take place, assigning tasks to each member that should be completed by the next meeting. The group also monitors work undertaken to date.</p>
<p>Evaluation of good practice</p>	<ul style="list-style-type: none"> • The first programme of action for the elimination of FGM has not been evaluated. • An assessment of the impact of the policies developed and implemented under the second programme of action for the elimination of FGM is going to take place in order to incorporate the lessons learned from its implementation in the following programme of action. • Two internal interim reports are planned to assess the execution of the second programme of action. These reports are the CIG's responsibility and are not to be publicly disclosed. The first internal interim report concluded that 46.6 % of the measures have been already executed in 2011. The second interim report is expected to be available in the first trimester of 2013 and will be presented to the national parliament by the Secretary of State for Parliamentary Affairs and Equality.
<p>Ways in which the good practice/ activity could have been improved</p>	<p>Defining a specific budget for the programme of action for the elimination of FGM, as well as for the intersectorial group.</p>
<p>Plans to gather financial resources and/or institutional arrangements</p>	<p>There is no specific budget attributed to either the intersectorial group or the implementation of the programmes of action. The CIG has an overall budget to implement the three current national action plans (i.e. equality, domestic violence and human trafficking) of approximately EUR 75 000 (in 2012). Therefore, some of the measures contemplated under the second programme of action will be funded by the CIG and others through the budgets of the organisations that make up the group (e.g. expenditure on personnel). In addition, a prize fund was created to support financially the three best projects to intervene inside practising communities ('Change the future now'). The budget for this prize derives from a percentage of the profits of social games (i.e. lotteries) that was attributed in 2012 to the governmental area of equality.</p>

	<p>Simultaneously, the intersectorial group has been encouraging immigrant associations to ask for financial support to develop projects on FGM within the National Strategic Reference Framework (QREN) (Human potential thematic operational programme (POPH) — Axle 7. Gender equality — Intervention typology 7.7. Intervention projects on the fight against gender-based violence). The last call for applications for funding took place from 15 June to 23 July 2012.</p>
<h2>2. Transferability</h2>	
Success factors	<ul style="list-style-type: none"> • Involvement of public administration bodies, international organisations and NGOs in a working group responsible for putting into practice the policy measures regarding FGM. • Importance of the support and an active role of the government in pushing FGM onto the political agenda and in implementing the policy measures. • Importance of having national programmes of action containing the policies to address FGM that were developed together with an intersectorial working group of a diverse composition that is also responsible for implementing it. • Regular and compulsory meetings of this group, which allow momentum to be kept up and the coherence of the measures established to be maintained.
Main obstacles	<ul style="list-style-type: none"> • Lack of monitoring and evaluation of the execution of the first programme of action for the elimination of FGM. A second programme was developed without a clear analysis of the previous one. • Absence of time limits to implement the measures set out in both programmes of action. • Lack of concrete evaluation indicators to assess the execution of the activities of each measure. • Dependence of the implementation of the programmes of action and the monitoring exercises on strong coordination skills. • Low involvement of practising communities in the development and implementation of the programmes of action.
Actual replication or spin-off effects	No information available.



3. Learning

Lessons learned from the process	<ul style="list-style-type: none">• Creating a group that brings together public administration bodies, international organisations and NGOs, with different expertise and knowledge. The members of the group work together to develop and implement policies to tackle FGM, and learn from each other's experiences.• Having a public institution responsible for coordinating the group and the programme of action.• The members of the group regularly attend meetings and have to report to the CIG their progress regarding the activities and tasks that were assigned to them.• Monitoring and evaluation exercises are essential and are now being contemplated within the implementation of the second programme of action for the elimination of FGM.• The importance of involving practising communities (e.g. through immigrant organisations) in the development and implementation of policies.
Sources	<p>The CIG's website (available in Portuguese) http://www.cig.gov.pt/</p> <p>Second programme of action for the elimination of FGM (available in Portuguese) http://195.23.38.178/cig/portalcig/bo/documentos/II_Programa_Accao_Mutilacao_Genital_Feminina.pdf</p>
Contacts	<p>Comissão para a Cidadania e Igualdade de Género Sede — Av. da República, 32 — 1º 1050-193 Lisbon PORTUGAL Tel. +351 217983000 Fax +351 217983098 E-mail: cig@cig.gov.pt Contact person: President of the CIG</p>

European Institute for Gender Equality

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