Study to map the current situation and trends of FGM
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Country reports
The publication presents national reports on female genital mutilation, covering EU-27 and Croatia. This is one of the products developed by Ghent University — ICRH and E.A.D.C. (Yellow Window Management Consultants) who were commissioned to carry out EIGE’s study ‘Study to map the current situation and trends of female genital mutilation in 27 EU Member States (MS) and Croatia’.

The contents of this publication do not necessarily reflect the position or the opinion of the European Institute for Gender Equality.

Neither the European Institute for Gender Equality nor any person acting on its behalf can be held responsible for the use made of the information contained in this report.
Methodology of the study
BRIEF INFORMATION ABOUT THE STUDY

The main objective of the study, commissioned by the European Institute for Gender Equality (EIGE), is to support and contribute to the future development of strategies for the elimination of different forms of violence against women, by assessing and analysing the current situation of FGM in the EU-27 and Croatia, notably on prevalence, policy and legal framework, actors dealing with this issue and approaches. Finally, the study provides recommendations on data collection and policy approaches to FGM in the EU.

The overall goal is broken down into five specific objectives:
• map existing information and data on female genital mutilation, available through open sources and including prevalence, policies, actors dealing with this issue and approaches (tools and methods), in the European Union and Croatia;
• analyse the collected information and assess the accessibility, reliability and comparability of data on the prevalence of female genital mutilation;
• provide in-depth qualitative data regarding FGM, in the selected Member States (decided in agreement with EIGE), including analysis of the practices in terms of FGM, their causes and outline possible future trends;
• identify gaps in the data collection and provide good (promising) practices on dealing with FGM;
• give recommendations on how to improve data collection based on the identified good practices and other information collected in this study.

METHODOLOGY OF THE STUDY

The study methodology consisted of two main parts: a desk study and an in-depth phase.

The first part, the desk study, started late December 2011 and ran until April 2012. This desk research included a web-based search along with e-mail contacts and enquiries by phone (and, in some cases, in person) in order to collect all the information and data available on FGM relating to the themes mentioned above, in all EU Member States and Croatia. All data collected were then classified and stored in an Excel file and in an Endnote library (for academic publications). A pool of native-speaking researchers performed the national desk research in 28 countries (in 24 different languages), after which they compiled an analytical report of their desk study, resulting in 28 country reports that provided detailed insights into the situation of FGM in their respective country.

In the framework of this study, FGM has been considered from six angles that are highly relevant to FGM. According to international standards, a human rights approach (that takes into consideration prevention, protection and prosecution) seems to be adequate to develop policies on FGM. The specificities of this phenomenon and the particular needs of those affected by FGM, as well as the information collected during the study, emphasise the pertinence of complementing the standard human-rights framework with provision of services for the victims and those at risk of FGM, and partnerships with different organisations from distinct policy sectors. Prevalence estimates of FGM are also crucial for this approach in order to allow drafting better policies within the other previously identified areas. These areas (described in the report) were the guiding starting point for the in-depth phase of this study.

After collecting, mapping and analysing the national data collected in the EU-27 and Croatia, nine countries were selected for a qualitative in-depth study, namely France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the UK. The EU level perspective was also included in this phase in order to deepen the knowledge about the views of European and international institutions on the European approach to FGM. The in-depth study aimed at assessing successes and challenges in the work on FGM in these nine countries and at the EU level, and establishing past and present good practices in relation to prevention, protection, prosecution, provision of services, and partnerships. Nine native-speaking researchers were selected for conducting the fieldwork in each country. The in-depth phase was undertaken between the end of April 2012 and mid-September 2012, and consisted of six in-depth semi-structured interviews in each of the nine countries. Based on the information collected, an analytical report was drawn up by the national researchers, after which a comparative analysis was done of the nine country reports.
STUDY TEAM

The study has been carried out by a core team, 31 national researchers and was guided by four advisors.

**Core team:**

(whole project duration)
- Els Leye, project leader (ICRH)
- Lut Mergaert, project leader (Yellow Window)
- Catarina Arnaut (Yellow Window)

(part of the project)
- Jessika Deblonde (ICRH)
- Annemarie Middelburg (Intervict, University of Tilburg)
- Siobán O’Brien Green
- Anke Van Vossole (ICRH)

**Advisory Board:**

- Elise Johansen, WHO, Geneva
- Rianne Letschert, Intervict, University of Tilburg, Netherlands
- Christine Loudes, End FGM European campaign
- Naana Otoo-Oyortey, Forward, UK

ACKNOWLEDGEMENTS

The team acknowledges the contributions of Presage-Science Po (Paris, France) and the All-Party Parliamentary Group on FGM (London, UK) for hosting the experience exchange meetings (EEM), the participants in these EEMs and the interview respondents for sharing their experiences and expertise, the European Commission and Marcel Zwamborn (Human European Consultancy, Netherlands) for granting and facilitating access to the country reports produced in the context of the Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence (2010).

LIST OF NATIONAL RESEARCHERS

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Country report

Austria
Country report: Austria

1. IDENTIFICATION

Country: Austria
Researcher: Elke Beneke

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The following search tools form the basis for the data research:

- web search: searching the websites of the stakeholders of FGM. These sites are predominantly websites that are relevant in Austria:
  - http://www.fgm-hilfe.at
  - http://www.stopfgm.net
  - http://www.desertflowerfoundation.org
  - http://www.african-women.org
  - http://www.schwarzefrauen.net
- telephone research: telephone interview with a member of the national assembly;
- search of studies published focused before 2005 (it was easy to find studies published after 2005, but it was hard to find studies published before 2005, so we put a focus on studies published before 2005);
- academic databases: all databases listed in the ‘Guidelines for national data collection’. Unfortunately I was refused access to three databases (access being only available to academic personnel) so external support was obtained from a lecturer at the Department of Sociology at the University of Vienna.

The studies/articles found in the academic databases search are included in the ‘Endnote’ file (15 studies/articles).

Challenges:

- access to the academic database was difficult;
- appropriate statistical material barely exists;
- as was mentioned in the Migrants report 2007, there are only estimated figures and there are no recorded definitive statistical materials for Austria. (This was the reason for not putting the Migrants Report 2007 in the Prevalence section).

2.2. Nature of prevalence studies/FGM registration systems

The African Women’s Organisation in Vienna (NGO), which has published the study ‘A study of female genital mutilation in Austria: the use of female genital mutilation (FGM) on migrants in Austria’, is very prominent in Austria. Two other very high-profile organisations, the Institute for Parents’ and Children’s Rights, and the Women’s Health Organisation FEM South, have also each published a study (‘Female genital mutilation: what knowledge do doctors have about it? A study by the Austrian Institute for Child Rights and Parents Education’; ‘Female genital mutilation (FGM) — Female genital mutilation guidelines for dealing with affected girls and women’).

However, only the asylum statistics of July 2011 were included, which was one of the basic data used for the extrapolation of women affected by FGM.

As can be seen from the Migrants report 2007, there is no statistical basic material that shows a clear number of those affected, and so we can only refer to estimated figures.

The abovementioned studies recorded FGM primarily amongst female migrants and used questionnaires, almost without exception. Aside from people in healthcare, women with a migrant background were also interviewed. The figure that was given, of approximately 8 000 women and girls in Austria who are said to be affected by FGM, is therefore an estimated figure.

The high feedback rate in all collected studies was surprising.

A database to record cases of FGM hosted by the Federal Minister for Women and Civil Service was established in Austria in 2006 (http://www.datenbanken.at). However, this was closed down in 2007 as no entries had been made by the deadline for entries.

This research highlights a correlation between political interest and the frequency/number of publications. The then Health Minister, Maria Rauch-Kallat, put the topic of FGM on the political agenda, following which several publications and studies were published. Mrs Rauch-Kallat published documentation regarding the EU conference ‘Joint action of Member States against harmful traditional practices’ (25 January 2006, Brussels). For that conference she wrote in her opening speech: ‘All these forms of violence are punishable in European States and are subject to prosecution. We have
not been able to present them because of the fact that the issue is a taboo in the groups affected. One main problem when it comes to harmful traditional practices is the fact that very little basic data is available. These crimes do take place directly before our eyes. But at the same time they go on unnoticed. A number of spectacular individual cases are publicised, but they are really only the tip of the iceberg. The issue is broadly subject to a taboo in the groups themselves. Mostly as a result of fear people tend to remain silent.’ She pointed out that this was one of the reasons for putting the fight against FGM on the agenda in Austria.

2.3. Findings from the prevalence studies/registration systems

Basically, there are no official figures on girls and women affected in Austria. The estimate, based on a study by the African Women’s Foundation entitled ‘A study of female genital mutilation in Austria: the use of female genital mutilation (FGM) on migrants in Austria’, is somewhere between 6 000 and 8 000 victims.

There was no data available on the number of FGMs on asylum-seeking women, girls at risk of FGM, or non-registered female migrants in Austria.

2.4. Reflection on prevalence studies

As mentioned above, only approximate figures exist. No detailed census exists in Austria, but the estimation is between 6 000 to 8 000 cases. The studies are solely of a qualitative character, but, as the data collected is of an extremely intimate nature, it cannot be obtained by way of a census. However, the large feedback rate shows that women affected by FGM would like to talk about or discuss their situation.

Most studies were carried out in 2006. The Minister, Maria Rauch-Kallat, was instrumental in this. She put the discussion of FGM on the political agenda in her capacity as Minister for Health and Women, and commissioned and/or supported relevant studies (‘Genital mutilation in Austria — a survey established within gynaecologists and paediatricians and among hospitals’ and ‘On the situation of genital mutilation among migrants in Austria’). In spite of the fact that no relevant studies have been commissioned since 2006, earlier studies influenced the increase of the number of tools and instruments after 2006.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

The parliamentary discussions, resolutions and enquiries in Austria (published on the website: http://www.parlament.gv.at) have been an important resource. As a second source, the various national action plans (national action plan for gender equality, national action plan for integration, national action plan for social inclusion), found on the ministries websites or sent by e-mail from personal contacts, were researched. The third source was studies commissioned by Austrian ministries (found on the ministries’ web pages), and which formed the basis for political strategies.

In 2005 and 2006, Maria Rauch-Kallat was a pioneering force as Minister for Health and Women. She put the subject of FGM on the political agenda and, in her political capacity, commissioned various studies (‘Genital mutilation in Austria — a survey established within gynaecologists and paediatricians and among hospitals’ and ‘On the situation of genital mutilation among migrants in Austria’).

3.2. Policies on FGM

The most important resources are the parliamentary discussions. They demonstrate that FGM is often discussed in connection with forced marriages. Although all questions and answers in the Austrian parliament are published (mostly by the ministry responsible), only the questions were used, because the answers were sometimes too detailed and sometimes too general. These questions show that the member of the Social Democrats, Petra Bayr is very committed to this subject, as she has put many questions and resolutions. It also shows that the subject is being discussed by all political parties. As a result a Cross-party parliamentary initiative to stop violence against women and female genital mutilation’ was created. The action plans show that the fight against FGM in Austria is expressly contained as a measure in the new action plan for integration.

The National action plan for prevention and elimination of FGM in Austria 2009–11 was drawn up by the African Women’s Organisation and can be found under Tools. This action plan was drawn up in close cooperation with the Austrian ministries and forms the basis of countless discussions in the Austrian parliament.

3.3. Reflection on policies on female genital mutilation

Even though FGM was already under discussion in migrant communities and other NGOs as early as the 1990s, the subject didn’t make it into political debates until 2005. As already mentioned, the first political initiatives started in 2005 with the help of the then Women and Health Minister, Maria Rauch-Kallat. This was also when the first studies were carried out. The merger of the Ministry for Women and the Ministry of Health helped raising awareness in the health sector.

In 2006 a database to collect FGM cases was established, but was later closed due to a lack of reported cases.

On the initiative of national assembly member Petra Bayr, the platform ‘Stop FGM’ came into existence and numerous NGOs and political organisations have joined this platform.

The Migrants report 2007 showed that the numbers for women and girls affected by FGM are simply estimates and there is no precise data available. This subsequently led to the statutory period of limitation being changed (so that it starts at the time of reaching the age of legal majority).
The New integration report (2007) also expressly refers to FGM, demonstrating that awareness at a political level is considerably higher now than it was a few years ago.

It is unfortunate that there is no information available in Austria on reported cases, court judgments etc., as this would also help to raise awareness considerably.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

In order to illustrate the legal position in Austria, we studied expert literature and technical articles on the legal situation. After we identified all relevant laws, we looked at the details. All statutes, legal commentary and guidelines — the entire Austrian law can be found on the homepage of Prof. Dr. Norbert Gugerbauer. (http://www.jusline.at). Another source was the legal information system of the Austrian Federal Chancellery (http://www.ris.bka.gv.at). Any unanswered questions could be clarified by telephone with experts at the Federal Ministry of Justice and the Federal Ministry of Economy, Family and Youth.

4.2. Criminal law

The legal position in Austria is clear — since 2001 FGM is treated as criminal grievous bodily harm and offenders can be sentenced for up to 10 years imprisonment, even if the victim consented to the FGM or if it was carried out abroad.

In 2006 FGM became a criminal offence and the statute of limitations only starts when the victim reaches legal majority.

Since 2012 genital mutilation carried out abroad is a criminal offence, under Paragraph 90, Section 3 (Amendment to the Penal Code 2011), if the offender or the victim is Austrian, or their place of residence is in Austria. The offender can be prosecuted irrespective of the law of the country where the offence was perpetrated (Austria Penal Code, Paragraph 64 Section 1 Z 4a). This also applies if, as a result of the offender’s action, other Austrian interests are violated, or if the offender has, at the time the offence is carried out, foreign citizenship but is resident in Austria and cannot be extradited. The extraterritorial criminal liability has been expanded. Offenders as well as those helping them can be held liable. There has already been one prosecution, but the judgment is not known to the experts, as it has not been possible to access the court records.

The Ministry of Internal Affairs keeps a record of criminal cases that have been brought by the victims of violence, but cases of FGM are allocated to the category of ‘Criminal actions against sexual integrity’. In the records of criminal offences/reported offenders and victims, there are no separate entries and no separate records of FGM cases. (http://www.gewaltinfo.at/fachwissen/ausmass/statistiken.php)

Aside from criminal law, FGM/C is also governed by the law for the medical profession (Ärztegesetz) 1998 (see 754 BlgNR21, GP), which means that acting medical staff are answerable to the Austrian Medical Association (Ärztekammer). (http://www.frauen.bka.gv.at/studien/tgf2008/kapitel2.html)

4.3. Child protection laws/provisions

Austria ratified the CRC in 1992 and is therefore obliged to adopt only laws that correspond to the convention. In order to strengthen the position of children in our society, the rights of children were enrolled in the Federal Constitution. The Federal Constitutional Law on the Rights of Children (Federal Law Gazette I No 4/2011) which was adopted in 2011 by the National Council only includes eight articles. Nationally there are many critics. Genital mutilation, like other forms of ‘harmful traditional customs’, breaches KRK-Article 19 (protection against violence) and Article 37 (prohibition of torture and inhumane treatment). Article 24(3) sets out effective and appropriate measures to abolish old customs that are damaging to children’s health. However, very few cases are reported by advice centres and there is no central recording system.

4.4. Asylum law(s)/provisions

Although in Austria important legal measures have been put in place for the fight against FGM, this has not directly been integrated in the legal system for immigration and asylum. Refugees, who are fleeing the danger of FGM/C are not eligible for asylum on this ground, because gender-specific persecution was not included when AsylG 1997 (immigration law for asylum seekers) was amended and replaced by AsylG 2005 (123). However, adjudication on asylum applications does take into account the threat to refugees of FGM.

There are four reported cases of women who have been granted asylum in Austria because of FGM. There are said to be 20 women in total who have been granted asylum in Austria on the grounds of threatened mutilation. (Source: http://www.frauen.bka.gv.at/studien/tgf2008/kapitel2.html).

Two of the granted asylum cases are described on the website of Profrau.

(First case: 21.3.2002, asylum was granted due to fear of infibulation to a woman from Cameroon; second case: asylum for a little girl, born 9.3.2011, threat of genital mutilation, and the mother was a member of the persecuted minority of Òmoro); (Source: http://www.profrau.at/de/genitalverst/oesterreich.htm).

A refugee is defined as a person who ‘… is outside his/her country of origin, of which he/she is a citizen due to justified fear of persecution on the grounds of race, religion, nationality, social affiliation of political conviction, and who cannot draw on the protection of that country …’.

4.5. Professional secrecy provision(s)

Medical staff, care workers and nurses, midwives, social workers, etc., are bound by the obligation of confidentiality (both under criminal law and ‘Ärztegesetz’ (medical professional’s law in Austria) which can only be overruled
in certain exceptional cases. In cases of grievous bodily harm there is an obligation to report. However, since this obligation to report is not really monitored there are no sanctions.

4.6. Reflection on legal framework

In Austria FGM/C counts as ‘grievous bodily harm’ and is a criminal offence. The prohibition of FGM/C is contained in the penal amendments act 2001, under which ‘mutilation or other injury of genitals is a criminal offence that must be punished’ (Paragraph 90 Section 3 Penal Act).

The following improvements have been made to Austrian law:
- An offender can be prosecuted for carrying out FGM even if the victim does not consent to the prosecution.
- The threat of violence within the family has been a criminal offence since 2006.
- The limitation period doesn’t start until the victim reaches legal majority.
- The offence is liable to prosecution even if it is carried out abroad.

Improvements needed:
- Although Austria has an important legal framework for the fight against FGM/C, this is not included in the asylum legislation.
- The Federal Constitutional Law on the Rights of Children is incomplete.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

Initially, the Internet was used for searching relevant protagonists in Austria, and the websites of known organisations, such as the ‘Desert Flower Foundation’, ‘African Women’, as well as the platform ‘Stop FGM’ were researched first. A general search showed that several organisations in Austria deal with the subject of FGM. They mainly carry out information and awareness-raising campaigns for countries where FGM is being practised. However, due to the increase of migrants coming from countries where FGM is practised, some of these organisations now also offer campaigns in Austria.

Other important resources were studies and publications on FGM, which list — usually in the last chapter — contact persons for FGM. In this way, more than 70 organisations were found and then checked on the Internet.

The following criteria were used to find the most relevant organisations:
- Do the organisations still exist?
- What do they really offer?

This left us with less than 40 organisations named in publications or studies. Some of the organisations have since closed down (no contact dates available), some have changed their activities and are not involved with FGM, some were included in the list, but are working for women or female migrants in general (female counselling centres). The relevant data for the database was researched on these organisations’ websites. It is important for Austria that mostly women and girls’ advice centres deal with the subject of FGM in their advice portfolio, even though they do not expressly document this. Therefore the relevant advice centres were also included on the database.

5.2. Actors

There are five types relevant of players:
- Ministries and parliament
- Organisations who expressly take a stand against FGM
- Organisations involved in third world development
- NGOs
- International organisations.

Ministries and parliament

Ministries
- Federal Ministry of the Interior: one of their responsibilities is the administration of the legal system for immigration and asylum.
- Federal Ministry for Health: this is relevant regarding the practice of FGM in Austria as well as creating the basic for FGM in Austria (doctors, hospitals), as well as for the legal definition of doctors’ confidentiality and the practice of FGM under the pretext of ‘plastic surgery’.
- Head of Department of criminal law in the Ministry of Justice: for the possibility of criminal sanctions.
- OEZA — Austrian Development Corporation, which initiates and conducts important development projects.

Parliament
- The national assembly deals with resolutions and debates laws broaching the issue of FGM. However, it must to be noted that two important players against FGM in Austria sit in the national assembly:
  - Petra Bayr, in her capacity as a member of the national assembly and Manager of the platform ‘Stop FGM’, and
  - Barbara Prammer, in her capacity as President of the Austrian national assembly and a goodwill ambassador against FGM.

Organisations that devote themselves expressly to the fight against FGM

- Platform ‘Stop FGM’
- FGM Help
- FGM Advice Centre ‘Bright Future’
- Desert Flower Foundation

These organisations orchestrate a battle against FGM, broach the issue of FGM and conduct campaigns, as well as raising public awareness.

Organisations for Development in the Third World
Eight organisations are summarised here. Their core interest is mostly on the subject of development aid and partly on the fight against FGM. They carry out various campaigns in Austria in order to receive donations e.g. awareness workshops in schools. To a certain extent they devote themselves to the fight against FGM in Austria, as for Austrian women with a migration background there is also the threat of undergoing FGM procedures during a trip/holidays abroad.

**NGOs**

Women and girls’ advice centres, women’s refuge centres, children’s refuge centres, etc. are not directly involved in the fight against FGM, but are usually the first contact for women and girls who are affected by FGM.

**International Organisations**

Organisations such as Unicef, Amnesty International also press ahead with the subject in Austria.

5.3. **Reflection on actors on female genital mutilation**

The subject of FGM has been broached in Austria since the 1990s. One of the first facilities was ‘FGM Help’ which was founded in 1999. Waris Dirie was instrumental in contributing to public awareness to FGM through her prominent status and presence in Austria. The former Minister for Health and Women, Maria Rauch-Kallat, supported this issue and put it on the political agenda.

The platform ‘Stop FGM’ was founded in 2003 and now includes numerous organisations that have devoted themselves to the fight against FGM on a political as well as civil basis. It was founded as an NGO with members of organisations close to the Social Democratic Party in Austria. However, now it is an independent NGO with members from all parts of the political and social spectrum. The head of this NGO is the member of the national parliament Mrs Petra Bayr.

The fact that the president of the national assembly is also available as a goodwill ambassador greatly supports the cause. This underlines again the importance of support from public figures.

We can see that in order to promote a topic such as FGM, it is useful to use both a top-down strategy and a bottom-up strategy at the same time.

It is also useful to have representatives such Mrs Rauch-Kallat, Mrs Barbara Prammer and Mrs Petra Bayr who can take leadership. However, it is important to involve the grass root organisations which are in contact with the victims. They know what is helpful for them. As a third factor we note that public interest increases when a popular person is put at the forefront.

6. **TOOLS AND INSTRUMENTS**

6.1. **Methodological approach for collecting information on tools and instruments**

A database search was carried out according to the ‘Guidelines for national data collection’. The search in the recommended databases proved difficult because it offered mainly scientific articles and publications. Further information was found via the individual websites of the relevant stakeholders.

It was difficult to select relevant tools because some videos or events (e.g. women’s race against FGM) appeared interesting but the information was insufficient to be included in the database.

6.2. **Tools and instruments on FGM**

There are different tools available in Austria, from leaflets, documentations and handbooks to action plans.

Most of the tools concentrate on specific target groups, amongst which the most prominent are journalists, medical staff and migrants. However, general instruments for raising awareness of the general public can also be found. The most impressive is the national action plan against FGM (National action plan for prevention and elimination of FGM in Austria 2009–11) and the guidelines for healthcare professionals.

6.3. **Reflection on tools and instruments on female genital mutilation**

Most of the tools were created after 2005. This could be attributed as a reaction to the basis formed by established studies published before 2006. Many of the tools targeted medical staff, but there are also tools for journalists, to raise awareness of/give information on FGM. This is a fact we find very interesting.

Almost all the tools and instruments were developed by civil society organisations, principally organisations whose main aim is the fight against FGM. It was noted that, among the public organisations, it is mainly the City of Vienna that has taken steps to inform and educate the health sector (The City of Vienna is the biggest city in Austria, most of the migrants from countries where FGM is practised live there).

Conferences are predominantly organised by public organisations.

7. **FINAL CONSIDERATIONS**

**Prevalence**

Studies suggest that FGM almost exclusively affects people of African and Asian origins. There has been speculation, although hardly any proof, that the practice is carried out in Austria. More studies would be necessary to show this is the case. In particular, the fine line between FGM and plastic surgery would need to be examined.
Policy framework

FGM became known in Austria through the Desert Flower Foundation, prominently represented by Waris Dirie. This topic was brought onto the political agenda mainly through the then Minister for Women’s Affairs, Maria Rauch-Kallat. National assembly member Petra Bayr is also always at the forefront in the fight against FGM; she is also Head of the Executive Committee of a network platform in the fight against FGM.

Legal framework

Since 2001, FGM is treated as criminal grievous bodily harm and since 2006 it has become a criminal offence. Although important legal measures have been put in place for the fight against FGM in Austria, this has not directly been integrated in the legal system.

Actors

The actors are predominantly NGOs and international organisations. These organisations offer development aid in cooperation with others, or as migration organisations. Where public organisations are concerned, the City of Vienna is represented prominently alongside the appropriate ministries.

Tools and instruments

We have found mainly studies, basic groundwork, information documentation, awareness measures for journalists and medical staff.

Conclusion

The overall view is that the problem of FGM cannot be solved just by a bottom-up approach. The first initiatives were taken as early as in the 1990s, but the subject of FGM only started to be discussed publically when the book Desert flower by Waris Dirie was published in 1997.

The first political initiatives were taken as late as 2005/06 and this led to a rising number of studies being carried out on the subject. As a result, tools and instruments have been developed.

At a legal level, the government is abiding to the implementation of the international position (see the Geneva Refugee Convention) and its legal establishment in Austria. The highlight has been the national establishment in Austria of the Children’s Rights Convention 2011 and from 2012 enabling prosecution for FGM which has been carried out abroad.

It is significant that the topic of FGM has been expressly covered in the Migrants report 2007 (with its own chapter) and that it has been included in the national action plan for integration (2012).

Unfortunately, the National action plan for the prevention and elimination of FGM in Austria 2009–11, created out by an NGO, was not dealt with at parliamentary level where it would have received the status of NAP.
1. IDENTIFICATION

Country: Belgium

Researchers: Els Leye, Anke Van Vossole

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

To collect data on the prevalence of FGM in Belgium, a web-based research was combined with research of materials available in the FGM library of the International Centre for Reproductive Health (ICRH).

The web-based research consisted of a search on academic databases for articles reporting on prevalence of FGM in Belgium. This search was performed following the ‘guidelines for national researchers’, and included the following databases: PubMed, Web of Science, SSRN and Sociological Abstracts, completed by a search on Google Scholar and Google.

All relevant search terms were used in English: FGM, female genital mutilation, female mutilation, FGC, female genital cutting, female cutting, female genital circumcision, female circumcision, female genital excision, female excision, female genital surgery, in combination with Belgium, or the three Belgian regions: Flanders, Wallonia and the German-speaking part of Belgium.

Because of the existence of three official national languages in Belgium (Dutch, French and German), the search was repeated using:

- Flemish: VGV, vrouwelijke genitale verminking, vrouwelijke verminking, seksuele verminking, vrouwenbesnijdenis, meisjesbesnijdenis;
- French: MGF, mutilations génitales féminines, mutilation féminine, mutilation sexuelle, circoncision féminine, excision féminine;
- German: Weibliche Beschneidung, Verstümmelung.

Since the selected academic databases mainly publish English articles, a broad search was done outside these databases, for example in Google Scholar and Google. Reference lists of relevant documents on FGM in Belgium were also searched to check on publications on prevalence data in Belgium.

Given the recent study done on prevalence of FGM in Belgium no additional e-mails or phone calls were done to obtain prevalence data material.

2.2. Nature of prevalence studies/FGM registration systems

In total nine studies or documents were found, reporting on prevalence of FGM in Belgium. They are listed chronologically below.

- Leye E., Deblonde J. (2004), ‘Belgian legislation regarding FGM and the implementation of the law in Belgium’.

Prevalence studies were done by universities, the French department of Child and Family, a professional organisation of gynaecologists and the Royal Tropical Institute. One study was commissioned by the Federal Government and one by Fedasil, the Federal Agency for Asylum.

The 2003 study extrapolated prevalence data from Africa on the population register and foreigners register, to estimate the number of women with FGM in Belgium. Data were disaggregated by nationality and age. One study calculated the number of registered births in families from
FGM risk countries, for the French region only. Surveys among health professionals were done three times: in 2003, in the French region, in 2006, in the Flemish region and again in the French region. These surveys aimed at assessing the number of women with FGM, the number of requests for (re)infibulations, the consequences of FGM, etc. In 2009, a study was done at the reception centres for asylum seekers by the Federal Agency for Asylum (Fedasil), to assess the number of women with FGM in those centres. Eventually, the study published in 2011 used a mixed method, combining the abovementioned methods. Prevalence was estimated, based on the number of registered births in families from FGM risk countries, the foreigners register, data from the National Office of Statistics (population register) and registers from the asylum centres.

A number of limitations were mentioned in each of the studies, and have all been included in the database.

There are no registration systems in Belgium on FGM. An NGO keeps records of women who contact their organisation, but not on a systematic basis. In hospitals, gynaecologists and health professionals do not register systematically, although specific codes are attributed for the four types of FGM (but these codes do not record repair surgeries or ambulatory care), they are not applied systematically.

2.3. Findings from the prevalence studies/registration systems

The study among health professionals in the French region showed that 45.5 % of the respondents had encountered one or more cases of FGM during the two previous years, and that requests for (re)infibulations were done. The study among Flemish gynaecologists showed that 58.4 % (195/334) of respondents had seen one or more women, or girls, with FGM during consultations. Request to perform FGM or reinfibulation were equally noticed in that study.

The most recent study, using a mixed method, calculated the female migrant population originating from countries where FGM is practised at 22 840. From these 6 260 have most probably undergone FGM and 1 975 are thought to be at risk of FGM. Some 80 % of the women concerned are from 10 African countries: Guinea (1 812), Somalia (912), Egypt (694), Nigeria (651), Ethiopia (645), Côte d’Ivoire (521), Sierra Leone (370), Senegal (331), Burkina Faso (307) and Mali (286). The study also identified the areas where most women and girls live: the Province of Antwerp (Flemish region), the Province of Liège (French region) and Brussels Capital region. This is to a large extent related to the fact that 60 % of migrants in Flanders originate from countries with a very high overall prevalence (above 70 %).

2.4. Reflection on prevalence studies

The prevalence studies in Belgium are done either at national level or at regional level. At regional level, they focus mainly on prevalence of women addressing health services. No prevalence studies were found for the German-speaking part of Belgium. Agencies that perform those studies are research institutes, professional organisation or the Federal Agency for Asylum. The most recent and complete study was commissioned by the Ministry of Health, who expressed the wish to meet the recommendation of the European Parliament to gather statistics on FGM.

The methodologies used in these studies all suffer from limitations. Since there are no centralised registration systems available, studies use either small databases from health systems (ONE, K&G, hospitals) or data from the National Office of Statistics, which have their own limitations. The limitations for the extrapolation method mentioned in that study are:

- Estimations were based on numbers of the National Institute of Statistics (NIS), disaggregated by nationality. This does not reveal the ethnic groups to which these women belong, although ethnicity or the region where women come from would give a much more accurate picture on the prevalence of FGM. These statistics do not take into account asylum seekers, women living in Belgium illegally, or African women and girls who obtained Belgian nationality.
- The figures of the NIS do not reflect changes in migration flows.
- Apart from these limitations, which stem from the nature of the statistics, there is also a limitation linked to the figures used for extrapolation. The percentages of women with FGM in the African countries of origin are based on the WHO estimations, which vary in quality.
- Finally, girls born in Belgium and who have Belgian nationality are not taken into account.

One main limitation for the survey carried out by health professionals is the low response rate (written questionnaires were used). One study was qualitative in nature, and as such could not account for estimating prevalence. The most recent study mentioned that there is a lack of information on the ethnicity of women who migrate to Belgium. This study did not take into account the influence of migration on the practice of FGM. Another limitation is the lack of information on people living illegally in Belgium, and on the number of women enrolled in the Waiting Register. Finally, for the years prior to 1998, there are no comprehensive data on all female children with Belgian nationality at birth, whose mothers originate from a country where FGM is being practised.

Registration systems in Belgium

The Office of the Commissioner General for Refugees and Stateless Persons in Belgium also registers the number of asylum cases founded on the fear of FGM. This information is included in the legal framework on asylum cases. Mention is made that GAMS, a civil society organisation fighting for the abolition of FGM, recorded information on women seeking support regarding FGM in 2009. It is not clear whether this is done systematically.

In the study, all Belgian prosecutors were contacted directly and asked if they had any registered cases on FGM. No cases were registered at that time (2003–04). It was not feasible, nor the purpose of this study to repeat this
exercise. However, at the request of the College of General Prosecutors, the Prevention and Qualification Code 43K has been added to the Register (nomenclature) in order to register FGM, and according to the Ministry of Health in 2009, the Central Penal Register and the Service for Penal Policy are working together to add FGM to the conviction statistics (see: http://www.senaat.be/www/?MIval=/index_senate&SMENUID=12420&LANG=nl).

At the request of the Ministry of Health, ICRH is currently performing a pilot study to assess the efficacy of the use of the codes for FGM in hospitals, and will formulate later this year recommendations for a new coding system. Assessing reliable accurate data on the number of women with FGM, girls at risk, or women addressing health services, is not easy, since registers where such data can be obtained are very rare and, if such data are found, they are scattered, making comparisons problematic as a wide variety of methods are used.

It would be useful if a common framework for collecting prevalence data in Europe could be developed. Developing registers might also be considered. However, given the fact that keeping records (especially in health sector) depends on individuals, it would be necessary to train professionals in using registers and risk-assessments/assessments for all types of FGM (including incisions, clitoridectomies).

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

To collect data on policies on FGM in Belgium, a web-based research was combined with research of materials available in the FGM library of the International Centre for Reproductive Health (ICRH).

The web-based research consisted of a search on academic databases for articles reporting on the prevalence of FGM in Belgium. This search was done following the ‘guidelines for national researchers’, and included the following databases: PubMed, Web of Science, SSRN and Sociological Abstracts, and completed with a search on Google Scholar and Google.

In addition, websites of all relevant Belgian policy bodies and actors were scrutinised, including the federal parliament (459 hits), the regional parliaments of Flanders, the Walloon region, the Brussels Capital Region and the German-speaking region, the Ministry of Social Integration, Poverty Relief and Social Economy, the Ministry of Internal Affairs, the Ministry of Foreign Affairs, the Ministry of Justice, the Ministry of Health, the High Council for Health, the Ministry of Equal Opportunities, the Council of Equal Opportunities, the Institute for Equality of Women and Men, and the Office of the General Commissioner for Refugees and Stateless Persons.

The UN Secretary-General database on violence against women’s website and the websites of civil society organisations were also consulted.

The search on these websites specifically focused on resolutions, proposals for resolutions, recommendations, advices, guidelines and action plans. Websites of federal bodies were searched using search terms in the three national languages: Dutch, French and German.

All relevant search terms were used in English: FGM, female genital mutilation, female mutilation, FGC, female genital cutting, female cutting, female genital circumcision, female circumcision, female genital excision, female excision, female genital surgery, in combination with Belgium, or the three Belgian regions: Flanders, Wallonia and the German-speaking part of Belgium.

Because of the existence of three official national languages in Belgium (Dutch, French and German), the search was repeated using:

• Flemish: VGG, vrouwelijke genital vermindering, vrouwelijke verminking, seksuele verminking, vrouwenbesnijdenis, meisjesbesnijdenis;
• French: MGF, mutilations génitales féminines, mutilation féminine, mutilation sexuelle, circoncision féminine, circoncision sexuelle, excision féminine;
• German: Weibliche Beschneidung, Verstümmelung.

A total of 16 policy documents, issued by national or regional authorities, were included in the database.

3.2. Policies on FGM

In Belgium, the Council for Equal Opportunities developed its first policy document in 1997. It requested the creation of a specific law on FGM, in order to develop protection measures for girls at risk, and stressed the role of child protection and medical doctors in detecting FGM.

In 2009, the High Council of Health issued an advice, recommending reimbursing costs for reconstructive surgery after FGM, and, in 2011, the General Commissioner for Refugees and Asylum Seekers published a guideline on asylum policy for women and girls, in which FGM is recognised as a form of persecution for women, girls and their parents and therefore a recognised ground to be granted refugee status. The guideline includes the policy to check a girl’s genitals, when asylum is requested on grounds of fear of FGM for that girl.

Belgium developed a national action plan (NAP) on violence against women, which also tackles honour-related violence and female genital mutilation, besides domestic violence. This action plan covers the period 2010–14. In the NAP, FGM is explicitly recognised as a form of domestic violence. The overall objectives are threefold: (1) to reach better knowledge with regard to FGM in Belgium; (2) to inform and involve selected categories of professionals in the prevention of FGM; (3) to ensure a global approach to take care of mutilated girls and their entourage.

The NAP, with its specific chapter on FGM, is the result of policymaking at the parliament. Belgian Senators have introduced nine proposals for resolutions since 2004, and the 2008 proposal for resolution specifically requested the inclusion of FGM in the NAP on violence against women.
The proposals for resolutions have resulted in three adopted resolutions so far: Resolution 3-523/2 from 2004, 4-533/6 from 2009 and 5-896/4 from 2011. The first resolution requested for prosecution of those performing FGM, to FGM in asylum policy, for more education and information campaigns, and to pay attention for FGM in development cooperation programmes. The second resolution recommends including FGM in the national action plan on violence against women, to develop a protocol for the protection of girls from FGM, to sensitize professionals, to support organisations working on FGM, to reimburse medical costs, and to conduct research on the prevalence of FGM in Belgium. The third resolution requests the Federal Government to implement the measures relating to FGM, which are foreseen in the national action plan to fight partner violence and other forms of domestic violence, so as to ensure a coherent prevention policy and to integrate the topic of FGM in bilateral cooperation agreements with relevant countries.

3.3. Reflection on policies on female genital mutilation

Policy development in Belgium started around 2004, with a number of proposals for resolutions that were introduced in the parliament. This resulted in the three adopted resolutions. The national action plan, with its specific chapter on FGM, has already resulted in a number of initiatives, including the prevalence study, the study to assess the efficacy of the FGM registration in hospitals (see Section 2), and the training of health professionals in hospitals.

The NAP was also developed following the adoption of a resolution, and parliamentarians keep on putting FGM on the agenda and requesting the implementation of the NAP. The agency responsible for implementing the NAP is the Institute for Equality between Women and Men; and it is mainly the Ministry of Health that implements these initiatives. The NAP was developed in collaboration with the experts in the field, and is therefore a document that is in coherence with the needs identified by those experts.

Very few policies, if any, were found on child protection, nor do the Protocol Child Abuse (2010, issued by the Flemish Minister for Welfare, Public Health and Family), the Flemish Forum Child Abuse (established in 2011) or the Child Rights Commissioner pay attention to FGM.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

To collect data for the legislative framework in Belgium, a web-based research was combined with research of materials available in the archives of the International Centre for Reproductive Health (ICRH).

The web-based research was performed following the ‘Guidelines for national data collection’, and included the following databases: PubMed, Web of Science, SSRN and Sociological Abstracts, completed by a search on Google Scholar and Google. The report ‘Responding to female genital mutilation in Belgium: striking the right balance between prosecution and prevention’ by Leye and Sabbe was particularly relevant as a starting point. This study presented an overview on the legal situation in Belgium until 2009. The web-based search focuses therefore on updates of legal provisions after 2009.

Additionally, the websites of the following relevant legal bodies and actors were searched: the Ministry of Justice, research institutes, organisations who support (potential) victims of FGM or professionals who work with (potential) victims of FGM, and organisations providing legal information for minority communities or asylum seekers. Websites were searched using search terms in the three national languages: Dutch, French and German. The search also focused on the different areas provided in the database: criminal law provisions, professional secrecy, child protection and asylum laws/provisions.

The following websites or documents produced relevant information on the legal situation in Belgium.

- Intact vzw’s website. Intact provides legal information concerning FGM. Intact also published a brochure on professional secrecy and FGM, which provided relevant information.
- Leye, Els and Deblonde, Jessika (2004), ‘Belgian legislation regarding FGM and the implementation of the law in Belgium’, ICRH Publications No 9, Ghent: ICRH.
- Groenen Anne (2010), Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission.
- The website and annual reports of the Office of the Commissioner General for Refugees and Stateless Persons. They provide information on asylum cases submitted on the grounds of FGM, and asylum cases recognised on those grounds.
- Some additional information on asylum cases was retrieved from a document distributed during a press conference for the International Day of Zero Tolerance to FGM, organised in Brussels on 3 February 2012.

4.2. Criminal law

In 2001, a specific criminal law on FGM was adopted. Before that date, FGM was punishable under general criminal provisions to address acts of violence causing bodily harm and serious bodily injury. However, female genital mutilation has never been subject to prosecution under either of the criminal law provisions (specific or general).

Article 409 of the Code of Criminal Law prohibits any form of mutilation of female genitals. Consequently it concerns all
forms of FGM, ranging from clitoridectomy to infibulation. According to the preparatory works of the law, piercing and tattoos are excluded. Transsexual operations are also excluded as they are considered as lawful acts of medical care (1). Article 409 is gender specific. It does not apply to genital mutilation of boys: this criminal law provision only concerns the physical and sexual integrity of women.

The criminal offence consists of the performance of FGM, the participation in the performance of FGM, the facilitation of the performance of FGM and the attempt to perform FGM. The penalty consists of an imprisonment from three to five years in case of performance of FGM and of an imprisonment from eight days to one year in case of attempt to perform FGM.

Article 409 of the Code of Criminal Law does not mention age, but committing the offence on a minor is considered an aggravating circumstance that increases the penalty. Other aggravating circumstances are: an offence committed with lucrative intentions; an offence performed by a parent or by any person having authority or custody of the minor; an offence causing permanent loss of working capacity, permanent and incurable corporal lesions, or the death of the victim.

The law is not very clear on two issues: the practice of re-infibulation, and genital changes on non-African women. The preparatory works of the law define ‘mutilation’ as the complete or partial removal of female genital organs. The practice of re-infibulation is not explicitly mentioned in this context. As this practice does not remove an organ but restitches the vulva after childbirth to make it resemble the former state of infibulation, it is not clear whether the legislator considers it as an illegal mutilation or rather as a re-storing of the pre-delivery state (Leye and Sabbe, 2009) (2).

Since the law does not mention ethnic background, Article 409 of the Code of Criminal Law could also apply to the practice of genital mutilation on non-African women. Nevertheless, making reference to ‘traditional practices that damage the child’s and woman’s health’, the preparatory works of the law indicate that this criminal law provision is essentially addressed to African women who believe that it is required as a matter of custom or ritual.

However, a new trend, mostly required by non-African women, in cosmetic surgery described as ‘designer vaginas’ is a practice that consists of reducing the labia and narrowing the vaginal orifice. The end results are in no way different from the results of some types of female genital mutilation. It is not clear whether this specific criminal law provision outlaws these kinds of genital changes (Leye and Sabbe, 2009).

The consent of the victim does not affect the legal qualification of the act. The principle of extraterritoriality, making FGM punishable, is applied even if it is committed outside the borders of that country. According to the preparatory works of the law, there is no intention to pursue, prosecute and punish immigrants and refugees arriving from countries where the practice is prevalent. The objective is rather to avoid that young immigrant girls, residing in Belgium, are taken ‘on holiday’ for the operation to be performed abroad (3). In case of FGM, the period of prescription of the criminal proceedings, covering a lapse of time of 10 years, only starts on the day that the victim has reached the age of 18 years.

4.3. Child protection laws/provisions

The Belgian child protection law, adopted on 8 April 1965 and revised several times, provides protective procedures and preventive measures towards minors’ welfare, sometimes without the legal intervention of a judge. The Belgian Child Protection Law does not specifically mention the practice of female genital mutilation.

Officials on youth assistance administer child protection and try to prevent harm to the child through the voluntary participation of their parents or guardians. References concerning a pending risk of female genital mutilation could be followed up by visiting the family, counselling them on the issue, and by stressing that the practice is illegal in Belgium and that legal action would be taken should an offence be committed. Should the health, security or morality of a minor be endangered by the behaviour of their parents or guardians, prosecution authorities may request the intervention of the youth court, based on Article 36.2 of the Child Protection Law. In this context, the judge can organise a hearing with the parents and decide on further investigations. A variety of measures (voluntary or compulsory) can be taken in order to protect the child, such as the transfer of the child to another home, if possible the home of another family member, suspension of parental authority, and organising hearings with the family.

4.4. Asylum law(s)/provisions

There are no specific asylum law provisions for FGM. The Alien’s Law of 15 December 1980 is however an important addition to the Geneva Convention. This law was changed by the law of 15 September 2006, in which Article 48/3 is referring to ‘acts of persecution’, such as (a) acts of physical or psychological violence, including sexual violence and (b) acts of gender-specific or child-specific nature (see: http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&cn=1980121530&table_name=wet). This change in the law was implemented in 2006, following the European Guideline of 2004 regarding the requirements for obtaining refugees status.

With regard to the law on reception of asylum seekers, there is no specific mentioning of FGM, but the law deals with ‘vulnerable groups’ under which women with FGM can be considered. The procedure for urgent medical care

(1) Handelingen Kamer 1998–1999, 4 januari 1999, 15. This is based on Leye, Sabbe (2009), ‘Striking the right balance’.
and reimbursement of medical costs, are guidelines which have not been developed specifically for women with FGM, but which could be considered for this particular population group.

In 2009, a special department for the homeless and refugees was established within the Commission, who is monitoring the special procedure for young girls whose asylum application is based on their fear of FGM. Any new personnel working on these cases receive a general training on gender, and a specific training on FGM. Since 2008, girls who have received the refugee status based on their fear of FGM are being followed up and have to submit a yearly medical statement, to provide evidence that they have not been subjected to FGM and that their claim to obtain asylum based on fear of FGM is still valid.

4.5. Professional secrecy provision(s) (*)

In Belgium, the principle of professional secrecy is stipulated in Article 458 of the Code of Criminal Law, and elaborated in Article 458bis concerning the professionals’ right to report, under restricted conditions: if s/he knows that a crime of FGM has been committed against a minor.

According to Article 458, confidential information may only be disclosed when the professional bound to secrecy is required to witness in court or when the law imposes disclosure. Article 29 of the Code of Criminal Procedure determines that public officials, such as police staff, have a duty to report any knowledge about a crime to the prosecution authorities. Healthcare providers are specifically mentioned in Article 458, although other professionals bound to secrecy, such as police officials, education staff, officials on youth assistance and social workers are also concerned.

According to jurisprudence the duty to secrecy as described in Article 458 of the Code of Criminal Law relates to facts that could cause damage to the person consulting the professional in confidentiality. For example, a professional is held to secrecy when the offender of a criminal act consults him/her, and disclosure of confidential information could lead to the arrest and prosecution of the consultant. When the victim of a crime consults the professional, the professional has no duty to secrecy related to the criminal acts. However, if the victim is accompanied by the offender when consulting the professional, the latter will be held to secrecy. In the context of Article 458 of the Code of Criminal Law, the general principle of ‘emergency’ can be applied. This means that any professional who is bound to secrecy can disclose confidential information as an ultimum remedium in order to prevent an immediate and serious threat to another right that outweighs the duty to professional secrecy. Appealing to this principle, a professional who is bound to secrecy can disclose information with the objective to protect the physical or psychological integrity of a girl at eminent risk of genital mutilation, on condition that there is an immediate danger and there is no other way to protect her.

De facto, Article 458bis of the Code of Criminal Law does not add anything to the right to disclose secret information as foreseen in Article 458 of the Code of Criminal Law. On the contrary, Article 458bis exemplifies one condition for disclosure that was already covered by the general principle of ‘emergency’.

Article 458bis of the Code of Criminal Law is supplementary to Article 458 and states that each professional bound to secrecy in their work, has the right (and not the obligation) to report to the prosecution authorities: (1) if they know for sure that a crime as described in Article 409 of the Code of Criminal Law has been committed against a minor, either because they diagnosed the genital mutilation, or because the victim told them in confidence; (2) if there is a serious danger for the psychological and physical integrity of the victim; (3) and if the can’t insure the psychological and physical integrity of the minor. This criminal law provision cannot be used if there is a suspicion that a girl is at risk of mutilation: the crime has to be committed. It does not matter if the crime has been committed in Belgium or abroad. This right to report does not release the professional of his duty to help a person in great danger, as described in Article 422bis of the Code of Criminal Law. According to the preparatory works of this law, the legislator aims to find a balance between the obligation to help a person in danger in an environment of confidentiality and the subsidiary right of the professional to report a crime (†).

A new law on sexual abuse was adopted on 13 January 2012 and came into force on 30 January 2012. This law stipulates an extension of the right to report as stated in Article 458bis. Article 458bis was changed to extend the law to vulnerable adults and not just to minors; to extend it to secrets disclosed by perpetrators or persons other than the victim; and to situations where other minors or adults are in danger.

4.6. Reflection on legal framework

The change of law, from making FGM punishable under the general criminal law, to the specific criminal law, took place in 2001. In August 1996, the notorious Dutroux scandal (paedophilia) occurred, and triggered a project of law concerning the criminal protection of minors. In this legal project, crimes against minors are emphasised, including the violation of the psychological and sexual integrity of minors. FGM on (minor) women is considered to be part of this item (†). Until now there have been no court cases on FGM.

There are no specific child protection laws or guidelines dealing with FGM. We did not obtain any information on the number of investigations on child protection on FGM.

(*) This section is extracted from the following publication: Leye E, Sabbe A., ‘Striking the right balance between prosecution and prevention’, Ghent: International Centre for Reproductive Health (ICRH).


Asylum has gained specific attention, since 2009, with the creation of a special department within the Commission for Homeless and Refugees which monitors asylum applications based on the fear of FGM.

Professional secrecy provisions were adapted, in early 2012, extending the disclosure of information to include vulnerable adults (and not only minors), among others.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

The relevant actors were collected, following the ‘Guidelines for national data collection’. To collect data on actors on FGM in Belgium, a web-based research was combined with research of materials available in the FGM library of the International Centre for Reproductive Health (ICRH). The web-based research consisted of a search on academic databases and included the following databases: PubMed, Web of Science, SSRN and Sociological Abstracts, completed by a search on Google Scholar and Google.

Each individual or organisation directly involved in FGM work, either in the health sector, police department, asylum sector, community-based organisations and non-governmental organisations, social services, child protection sector, academic research, etc., was identified as a relevant actor. The actors’ sheet was the last to be completed, based on the information that was gathered in all other sheets in the database.

The entire BE database was screened page by page to identify relevant actors. All individuals or organisations involved in the performance, publication or ordering of a study, government bodies issuing policies on FGM, organisations providing legal information, national bodies for asylum seekers, non-governmental organisations and civil society organisations developing and distributing tools and instruments, sensitising the public, providing information on their websites, providing support for victims and training materials for professionals, were identified as actors. By visiting the websites of each actor, contact details and relevant activities on FGM work were added.

5.2. Actors

A total of 30 actors (organisations and individual experts) were identified. Actors mainly belonged to government bodies, civil society organisations and academic institutions. Authorities involved include the Ministry of Health, the Ministry of Internal Affairs, two equal opportunity bodies (the Institute for the Equality of Women and Men and the National Council for Equal Opportunities for Men and Women), the authorities for asylum seekers and refugees (the Office of the Commissioner General for Asylum Seekers and Stateless Persons and the Federal Agency for the Reception of Asylum Seekers), the Flemish and Walloon Agency for Child and Family Welfare (K&G, ONE), the Child Rights Commissioner and the Trust Centres Child Abuse, as well as the Support Point Youth Care and a fund that provides financial support for research to support children with difficulties, including FGM, in the French community.

Four research institutes have focused on FGM, with Ghent University’s International Centre for Reproductive Health as the most active actor. This centre performed a multitude of research and subsequent publications on FGM prevalence, policies and legislation in Belgium.

The main NGOs in Belgium working specifically on the issue are GAMS and Intact. GAMS focuses on the prevention of FGM, by providing support for victims of FGM, various activities, individual psychological consultations; whilst Intact provides legal information and support to individuals (frontline) or their carers and lawyers on FGM and other ‘harmful traditional practices’, training courses and conferences on legal aspects of FGM, professional secrecy, and international protection.

5.3. Reflection on actors on female genital mutilation

The main actors in Belgium are civil society organisations and research institutes. Few governmental authorities are involved in FGM, but the Ministry of Health is the main actor. Child protection actors are lacking.

Activities of civil society organisations, in particular GAMS, have preceded any policy development. Policies started around 2004, while GAMS was created much earlier, in 1996. However, GAMS is involved in policymaking by the authorities, as well as other institutions with a proven track record, such as ICRH.

The asylum sector has also paid particular attention to the issue of FGM, from the creation of a special department at the High Commissioner for Refugees and Stateless in 2009, to conducting the special procedure for young girls whose asylum application is based on their fear of FGM. The High Commissioner has also been an active stakeholder on the subject of FGM.

A main problem in Belgium is the fact that responsibilities for FGM-related issues are scattered at federal and regional levels, making a coherent approach towards FGM in Belgium problematic. GAMS, the main NGO and lobbyist in Belgium, focuses mainly on the French-speaking part of Belgium. This causes imbalances in policy development and prevention activities. Given that Antwerp has been identified as the province with the highest proportion of women with FGM, policymakers should take this into consideration. The development of a Flemish branch of GAMS in Antwerp might be worth considering. This could only be done if sufficient resources to GAMS were provided.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

To collect tools and instruments on FGM in Belgium, a web-based research was combined with research of materials available in the FGM library of the International Centre for Reproductive Health.
for Reproductive Health (ICRH). The web-based research consisted of a search on academic databases following the ‘Guidelines for national data collection’, and included the following databases: PubMed, Web of Science, SSRN and Sociological Abstracts, completed by a search on Google Scholar. All relevant search terms were used in English, in combination with Belgium, or the three Belgian regions: Flanders, Wallonia and the German-speaking part of Belgium. Because of the existence of three official national languages in Belgium, the search was repeated using Dutch, French and German key terms.

Since many tools and instruments might not be included in academic databases, an extensive search was done on Google using the same search terms used for the academic databases. This produced a lot of information and was completed by a targeted search of the websites of all relevant institutions, bodies and organisations that were known to be active in the field of FGM, or that were encountered through the search for prevalence, policies and legal framework. Subsequent fields were screened producing other relevant tools and instruments.

6.2. Tools and instruments on FGM

A total of 29 tools and instruments were identified.

Research institutions have produced a number of tools and instruments. Research studies were conducted on FGM in Belgium on legislation, among health professionals or among communities practising FGM, or tackled a range of FGM-related issues in Belgium. They also organised conferences and seminars on FGM, and produced technical guidelines for professionals.

Non-governmental organisations and civil society organisations who are specifically and exclusively active on the subject of FGM, such as GAMS Belgium and Intact vzw, or others who have a broader scope but include FGM in their field of activity, such as Sobsi or Amnesty International, have all produced various tools and instruments. These include awareness-raising tools like fact sheets, website information, or brochures to inform victims, the general public and professionals.

Government bodies, such as the Ministry of Health and the Institute for the Equality of Women and Men, are mainly involved in ordering studies to assess prevalence of FGM or financially supporting publications, conferences or the development of tools. A number of handbooks and manuals were produced for professionals, health professionals in particular or the general public.

6.3. Reflection on tools and instruments on female genital mutilation

The first guidelines for health professionals were developed only in 2001. There has been a notable increase in the number of tools and instruments since 2007, when other civil society organisations working on FGM were created.

The main target populations seem to be (health) professionals, the general public and practising communities. There does not seem to be any tools or instruments developed for the child protection sector or schools. Many of the tools seem to be produced in either French or Dutch. No tools developed in the third Belgian official language, German, were identified.

It would be advisable that some of the tools and instruments should be translated into French and Dutch, so that they could be passed on to all the regions in Belgium. A noticeable gap in instruments has also been noticed in the child protection sector. Specific instruments are however necessary, in particular with regard to assessing girls at risk of FGM, for the child protection officers in Trust Centres Child Abuse.

We were not able to identify any evaluations of the tools and instruments used to train and inform professionals and practising communities. It would be a good idea to perform such evaluations before translating or producing tools and instruments.

7. FINAL CONSIDERATIONS

The prevalence study published in 2011 combined several methods to estimate the prevalence of women with FGM and girls at risk of FGM living in Belgium. Others have used these methods in the past, but we found that by combining the methods, some of the limitations were lessened.

Policy development in Belgium started around 2004, with a number of proposals for resolutions that were introduced in the parliament, and which resulted in three resolutions adopted between 2004 and 2011. The adoption of the 2008 resolution resulted in developing the national action plan which includes a chapter on FGM. The national action plan, with its specific chapter on FGM, is pivotal in spurring actions in the field, notably on estimating the prevalence, providing training courses for professionals or performing a study on the FGM registration in hospital settings.

Very few, if any, policies, tools and instruments were found on child protection. This seems to be a major gap in protecting children from FGM.

One main problem in Belgium is the fact that responsibilities for FGM-related issues are scattered at federal and regional levels, which makes a coherent approach towards FGM problematic in Belgium.

It would be helpful if a common framework for collecting prevalence data in Europe could be developed. This would enhance the possibility of comparing data among countries. Developing registers might also be considered; however, given that keeping registers (especially in health sector) depends on individuals, it will be necessary to train professionals in using registers and assessing the risks of all the types of FGM (including incisions, clitoridectomies). It is recommended that some of the tools and instruments find their way to all the regions in Belgium, i.e. by translating them in Dutch and French, and to perform an evaluation of tools and instruments.
1. IDENTIFICATION

Country: Bulgaria
Researcher: Ralitsa Golemanova

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The first step of FGM prevalence search was conducted through academic database search, following the ‘Guidelines for national data collection’. The following databases were consulted for prevalence studies in Bulgaria (BG): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Google Scholar and Google.

Key terms included the Bulgarian terms: женско генитално обрязване, женско обрязване, женско генитално осакатяване, обрязване на жента. The English terms female genital mutilation, female circumcision, female genital cutting were also used to check whether there are relevant documents about Bulgaria in English.

Extensive research online of these academic databases, various relevant institutions’ websites, as well as NGOs and civil society organisations’ websites, did not reveal any original data on prevalence of FGM in Bulgaria at all. Direct contacts with state institutions, agencies and a number of NGOs also confirmed the lack of such data for the country.

Direct contact by phone with the National Statistical Institute, a search of the NSI database online, and a written request for information confirmed that there is no data collection on FGM in Bulgaria. The topics for statistical investigation of the NSI are set by the Council of Ministers, which means FGM has not been suggested for collection of statistical data. The answer of many contacted organisations was that the topic of FGM is not a priority for any institution or NGO, since it is perceived as very rarely occurring in the country, if not a completely non-existent practice. In full honesty, many of the organisations and institutions which were contacted did not really know what FGM actually is. Thus, the present study suggests that the level of awareness is very low. These could be some of the explanations for the lack of prevalence studies on FGM, as well as for the rest of the findings of this study for Bulgaria.

2.2. Nature of prevalence studies/FGM registration systems

As described in the previous section, no actual prevalence studies on FGM were found for Bulgaria. No FGM registration systems have been identified. There is only one study, which briefly mentions the existence of FGM cases in the country. It is called ‘Pilot study on honour-related violence in Bulgaria — the challenge for the intervention institutions’ and was prepared by the NGO Bulgarian Gender Research Foundation (BGRF) in 2005. However, it does not provide any prevalence data on FGM besides one sentence stating that FGM is reported as is being practised in ‘isolated cases’ in Bulgaria and that, like other forms of honour-related violence, it is a rather hidden phenomenon. The methodology of the study is based on 45 in-depth interviews with intervention institutions — representatives of NGOs, state and local institutions, schools and police in seven Bulgarian cities. Thus, it consists of information provided by these actors and not through direct field research. This means that the data on prevalence is not only inconclusive, but also that it does not come from first-hand research. There is no method for collecting prevalence data in Bulgaria.

2.3. Findings from the prevalence studies/registration systems

No prevalence studies or registration systems on FGM were discovered for Bulgaria. The state bodies do not collect data on asylum-seeking women on grounds of FGM. The health services, social services, police and asylum agencies do not collect information on FGM cases. There is no effort in this direction and no actions are foreseen for collecting prevalence data in the future.

The State Agency for Refugees (SAR) confirmed that Bulgaria does not grant refugee status on the basis of FGM. They do not collect information on the topic and do not have the right to ask the refugees such questions in their interviews. However, SAR provided source information on asylum granted to refugee women from countries with high prevalence of FGM. In the period 1993–2011, 182 women from 15 countries with high FGM prevalence (Ghana, Congo, Egypt, Eritrea, Ethiopia, Yemen, Cameroon, Kenya, Côte d’Ivoire, Liberia, Mauritania, Nigeria, Sierra Leone, Somalia and Sudan) requested refugee status in Bulgaria. The first decisions for granting refugee status started in 1995. Fifty nine women were granted refugee status in Bulgaria in the period 1997–2011 from nine countries with high FGM prevalence (Congo: 1, Egypt: 2,
2.4. Reflection on prevalence studies

The present research could not identify any national prevalence studies that deal specifically with FGM in Bulgaria, and all contacted organisations and institutions confirmed the lack of such data. As mentioned above, there is only one pilot study on honour-related violence, produced by the Bulgarian Gender Research Foundation (BGRF) in 2005, which gives some information on FGM in Bulgaria. The data is inconclusive, as it only suggests FGM exists in ‘isolated cases’ in the country. Further investigation with the BGRF, as well as with the Bulgarian Red Cross, which actually provided this small piece of information, proved that there is no elaborate study on FGM and no statistics or documentation of cases. Many of the contacted government and non-governmental actors (potential actors on FGM) suggested that there is no evidence of the existence of the practice, or at least nothing documented, so the need to have special investigations and prevalence studies has not arisen until now. Thus, because of the lack of documented cases of FGM, the widespread opinion that there is no such practice in Bulgaria and the general lack of knowledge about FGM, the institutions and organisations that could have a role in researching and documenting FGM are not currently engaged in such activities.

Some of the organisations that were contacted directly linked FGM with migrants from African countries. They commented that migration from such countries tends not to be family-based. One of the most detailed explanations about this was given by Dr Antonina Jelyazkova, Director of the International Centre for Minority Studies and Intercultural Relations. According to her observations, the migrants from these countries are usually male. The tendency is for them to migrate and get married to Bulgarian women. Cases of women migrating from Africa are very rare, which makes FGM a hidden/non-existent phenomenon for local institutions. There is no data on whether male migrants from countries with high FGM prevalence perpetuate the practice in mixed marriages in Bulgaria. The same observations were shared by Mrs Awanis from the Council for Refugee Women with the Bulgarian Red Cross. She said that there are no documented cases of women with FGM and that it is mostly men who migrate to Bulgaria from the countries with high FGM prevalence. There is no evolution in the number and nature of prevalence studies, as there are none. However, in a phone conversation with Mrs Genoveva Tisheva, Director of the BGRF, she suggested that there is a growing interest in the topic from various actors. Prevalence data is not collected at national level by state agencies or by non-governmental actors. The collection of such data is necessary in the framework of raising awareness of various potentially concerned actors that such a practice exists in certain communities and that it might affect refugees and migrants in Bulgaria, as well as isolated minority groups. However, the feasibility of such data collection is doubtful, as FGM is not recognised as a problem on the state level, which means there is no interest or funding for such studies. Additionally, as non-governmental actors are already struggling to execute projects on more general topics, such as violence against women and domestic violence, they do not seem to currently have the capacity to focus on FGM, especially as it is not perceived as an imminent need.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

The methodology for collecting documents on FGM policies followed the steps set in the ‘Guidelines for national data collection’: academic database search, search of relevant organisations’ websites and phone and e-mail queries to state institutions and civil society organisations. The following databases were searched for policy documents in Bulgaria (BG): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Google Scholar and Google.

Key terms included the Bulgarian terms: женско генитално обрязване, женско обрязване, женско генитално сокатяване, обрязване на жени. The English terms female genital mutilation, female circumcision, female genital cutting were also used to check whether there are relevant documents about Bulgaria in English.

The policy framework in Bulgaria on FGM seems to be almost non-existent. The existing public policies predominantly deal with violence against women and children, but they remain at a general level and do not specifically mention FGM. The UN Secretary-General’s database on violence against women does not reveal any data on policies against FGM in Bulgaria either.

3.2. Policies on FGM

There are no policies on prevention and combating of FGM in Bulgaria until now.

3.3. Reflection on policies on female genital mutilation

There are no trends in policy development on FGM by national authorities, since FGM is not recognised as a problem for the country. As Mrs Genoveva Tisheva states in her report for Bulgaria, ‘There is no recognition in law and in policy in Bulgaria of the notion of harmful traditional practices’ (Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission (2010), Bulgarian national report, Genoveva Tisheva). Due to the perceived small or inexistent number of FGM cases in Bulgaria, the issue has not come up as one for discussion by policymakers. This was evident in the answer of the national assembly when approached on the topic. Mrs Evgeniya Ilieva, Chair of the Cabinet of the National
Assembly, provided an official answer that FGM has not been discussed in the national assembly and there are no resolutions or recommendations on it because ‘the practice is not characteristic for the country.’ Moreover, there is practically no reliable or official information on FGM in Bulgaria or in the Bulgarian language. Thus, the level of awareness of the issue is very low in the public space. Many people who were contacted in the framework of this study, ministry officials and state agencies’ employees included, did not know what precisely FGM was and were happy to confirm that such ‘barbarian’ practices were not identified in Bulgaria. Thus, potential actors on the issue mention the perceived inexistence of the practice in the country as the main reason for the lack of policy on FGM. However, there are two added layers of potential explanations: the low level of awareness of what FGM is in general, as well as the inadequate care and approach towards migrants and refugees in the country.

There are no policy measures against FGM in Bulgaria, which means that they will have to be eventually developed. On the basis of the present research, which reveals there is no information on FGM being practised by Bulgarians or in Bulgaria, it seems that the most important first steps would concern asylum on the basis of FGM, as well as methods to identify and adequately provide assistance, social and health care for migrant or refugee women with FGM. As Bulgaria has signed the Council of Europe Convention on preventing and combating violence against women and domestic violence, the country will have to introduce some measures on the topic because the Convention specifically mentions FGM in one of its articles. Thus, it can be expected that there will be some activities on the issue in the future. This was confirmed in a conversation with Mrs Genoveva Tisheva, who also mentioned that the BGRF, along with other NGOs, will be lobbying for the quick ratification of the convention in Bulgaria.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The research approach for the legal framework on FGM for Bulgaria included academic database searches, search on websites of relevant institutions and non-governmental actors, and phone and e-mail contacts with various organisations. The following databases were searched for legal framework documents in Bulgaria (BG): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Google Scholar and Google. The UN Secretary-General Database on Violence against Women was also consulted. The majority of the information was obtained through direct contacts, as there is almost no data online.

Key terms included the Bulgarian terms: женско генитално обръзване, женско обръзване, женско генитално оскапяване, обръзване на жена. The English terms female genital mutilation, female circumcision, female genital cutting were also used to check whether there are relevant documents about Bulgaria in English.

An important potential actor on FGM in Bulgaria, the Ministry of Justice, did not provide an answer to the official request for information within the time limit stipulated by the Law on Public Information Access.

There is no specific criminal law against FGM, child protection law specifying FGM or specific asylum law for FGM victims or girls at risk in the Bulgarian legislation. The present study confirms the findings of Genoveva Tisheva that ‘there is no specific definition of FGM in Bulgaria and it has not been dealt with through general criminal law and child protection measures’ (Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission (2010), Bulgarian national report, Genoveva Tisheva).

4.2. Criminal law

The present research confirms previous findings that there is no specific criminal law on FGM in Bulgaria. General Articles 128 and 129 of the Penal Code (in force since 1 May 1968) can be used for criminal offence bodily injury, but no such documented cases were discovered. No court cases or investigations on FGM were found. No agency that registers suspected cases or cases of actual FGM at national level exists, thus there is no information-collecting point. There is no synthesised information on the legal framework against FGM in Bulgaria. Thus, the current findings are based on pieces of information from various sources.

Informal conversations with various people at the Ministry of Justice from two relevant departments (‘Council on Legislation’ and ‘International Legal Cooperation and European matters’) revealed that the issue is quite unfamiliar for the Ministry. The informal answers were that there is no specific criminal law against FGM. However, the people we contacted suggested that FGM can be treated under the general provisions against serious and medium bodily injury (Articles 128 and 129 of the Penal Code). Thus, the criminal offence would be bodily injury. The official request for information to the Ministry of Justice did not receive an answer in the time frame of this research.

This information is confirmed by the findings of the national expert for Bulgaria, Genoveva Tisheva, in Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, (European Union, 2010), but only for average or light bodily injury, thus Articles 129 and 130 of the Penal Code. The feasibility study also states that Article 181 of the Penal Code is applied in the prosecution for cases when this injury is inflicted within the family.

4.3. Child protection laws/provisions

There is no specific legislation against FGM under the Child Protection Law. Article 11, Protection against violence, can be potentially used in such cases. Article 25(4) of the Child Protection Law can be used as well — Reasons for removing the child from the family: ‘when the child is a victim of violence in the family and there is a serious
danger of impairing his/her physical, psychological, moral, intellectual or social development.’ There are no documented cases of child protection interventions on the basis of FGM. There is no national agency or register of child protection interventions that deal with FGM, so there is no information-collecting point. As a whole, the FGM practice is completely unknown to the relevant bodies and is not perceived as an issue to be followed and acted on. There is no actual information on FGM in the context of child protection law in Bulgaria.

A detailed phone conversation with a representative of the State Policy for the Children Department at the State Agency for Child Protection, and an internal query in the agency led to the conclusion that they do not have any documented cases of FGM. The agency does not follow the topic and it is not seen as a problem concerning Bulgaria. None of the contacted organisations had any information on the topic.

4.4. Asylum law(s)/provisions

There are no specific asylum provisions in Bulgarian legislation that deal with FGM. The European Migration Network does not examine Bulgaria in its ‘Ad hoc query on female genital mutilation and asylum in the EU from March 2010’ (1). The only article from the Bulgarian Asylum and Refugees Law that could be used in cases of FGM is Article 8(5): ‘The acts of persecution may be physical or psychological violence, legal, administrative, police or judicial measures, which are discriminatory or are applied with a discriminatory aim (…)’.

The definition of a ‘refugee’ in the Bulgarian law is the following: ‘The status of a refugee in the Republic of Bulgaria can be granted to a foreigner, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country or return there because there is a fear of persecution.’ Thus, it is very close to the UN definition of a refugee.

There is no national registration system for asylum cases related to FGM — no information-collecting point. There is no information on asylum cases being requested on the basis of FGM or on asylum being granted on this basis. As FGM is not recognised by state or non-governmental actors as a serious threat in Bulgaria, there are almost no measures against it, or that consider it. The concept of ‘Particular social group’ has not been used either. Thus, asylum on the basis of FGM has not been considered and is not possible, according to the State Agency for Refugees. Bulgaria has a rather under-developed policy towards refugees and migrants and has been criticised on numerous occasions because of its inadequacy to deal with the issue (like temporary homes and ensuring social and health care for asylum seekers and refugees). Sometimes the basic needs of refugees and migrants cannot be met, which makes prevention of FGM an even more unlikely topic to be tackled by the Bulgarian authorities in charge.

The State Agency for Refugees was contacted by e-mail and by phone. An official response was sent by its President, as well as by the Director of the Integration Centre for Refugees. The agency does not collect data on FGM at all. It does not consider it relevant to its functions. A senior expert mentioned that there have been cases of women who have made hints about FGM, but the Agency has no right to require information on this topic or give asylum on basis of FGM. Since 1997, 59 women from the countries with high prevalence of FGM have been granted asylum in Bulgaria.

It is evident from these findings that FGM is a rather hidden phenomenon even for institutions and bodies that are supposed to take actions on the issue, especially in terms of asylum and refugees.

4.5. Professional secrecy provision(s)

There are no legal provisions with regard to professional secrecy concerning FGM specifically, but there are provisions on reporting child abuse. The Child Protection Law stipulates that all citizens, including from professions with secrecy provisions, have the duty to report cases of child abuse (in force since 13 June 2000). On the basis of this law, it follows that health professionals, social workers and teachers have the duty to report cases of child abuse. There are general sanctions against non-reporting stipulated in Article 45(11). However, the practical application of this duty is described as ineffective. No national registration system for reports of FGM or suspected FGM cases by professionals was identified.

The actual enforcement of child abuse reporting of the Child Protection Law is assessed as rather weak in the Unicef study by Nadya Stoykova and Docho Mihallov: ‘Sensitivity of the system for identifying, recording, reporting and referring cases of violence against children in Bulgaria.’ The authors comment that the relevant organisations are not prepared or trained well to identify cases of child abuse, or to report them to the correct authorities, and that the system for enforcing reporting is inadequate. There is a general lack of homogeneity and efficiency of the system for reporting.

4.6. Reflection on legal framework

There is no specific legal framework on FGM in Bulgaria. Different general laws may be applicable to cases of FGM, but there are no registered cases and no information on the applicability of these laws. There is no specific criminal law against FGM and no articles concerning FGM in the Child Protection Law. According to the State Agency for Refugees, asylum cannot be requested on grounds of FGM. There are no special professional secrecy provisions on FGM; however, health professionals, social workers and teachers are under the duty to report child abuse cases, under which FGM might fall. No actual cases of applying any of these general laws to FGM have been identified within the current study.

5. RelevanT Actors

5.1. Methodological approach for collecting relevant actors

A relevant actor on FGM for Bulgaria was defined as any organisation or individual who performed any work on FGM in the country, as was set in the ‘Guidelines for national data collection’. Relevant actors in Bulgaria were listed through a variety of search strategies. The following databases were checked for FGM mentioning Bulgaria: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Google Scholar, as well as Google. Research also included a thorough exploration of civil society organisations, ministries and agencies. In case there were articles on FGM showing in the Google search, their authors or organisations were checked, as well as all possible further links from these websites. The list of potential actors provided by the International Centre for Reproductive Health was thoroughly cross-checked with the organisations in focus. After the examination of the websites of potential relevant actors, e-mail requests for assistance were sent to a long list of institutions and organisations which could be related to FGM or they were directly contacted by phone. Most organisations do not have any data or any activities on the issue, nor can they forward other potential sources. The organisations that did not reply by e-mail were contacted by phone, whenever possible. Official requests were submitted to the Ministry of Justice, the Ministry of Health and the Ministry of Labour and Social Policy. All but the Ministry of Justice provided official written answers to the request, stating they lacked any information on FGM. Thus, the identification of relevant actors was quite challenging and additionally supported the conclusion that FGM is almost unknown in Bulgaria, even to state bodies that should be acting on it.

5.2. Actors

Among the numerous institutions and NGOs researched and contacted in the framework of this study, only one NGO has developed actual material on FGM and has dealt with the topic — the Bulgarian Gender Research Foundation (BGRF). Its director has taken part in other studies on FGM at the European level and thus, has a relative overview on the topic in the context of Bulgaria, and explained that FGM is not recognised as a problem in Bulgaria and thus, there is no action on it. Their opinion is that it is doubtful that funding would be allocated to such an unknown topic at the national level. No national authorities were found to have an activity or information about FGM in Bulgaria.

The Bulgarian Gender Research Foundation deals with ‘prevention and services for interdisciplinary support for victims of domestic violence, research, education programmes, advocacy, proposals for legislative changes, social services for people with disabilities and people from marginalised groups, and youth activities’ (1). BGRF has two activities, which are not specifically dedicated to combating FGM, but include the practice in the framework of honour-related violence or traditional harmful practices. The first one is the ‘Pilot study on HRV/honour-related violence/in Bulgaria — challenge for intervention institutions’ (2) under a joint project with Kvinnoforum, Sweden — ‘Prevention of violence against girls and women in patriarchal families’ within the framework of the Transnational Exchange Programme Phase II. This can be identified as their first activity on FGM, which took place in 2004–05.

Another activity of BGRF, which briefly touches on FGM, is their cooperation within Rapvite. There were 120 participants from Bulgaria, representatives of the Bulgarian Judicial System, the State Ombudsman, the Municipal Ombudsman, the National Commission for Combating Trafficking in Human Beings, the municipalities, the State Agency for Child Protection and NGOs, who were trained in the online distance learning platform, Rapvite, on the issues of human trafficking, forced marriages and crimes of honour (3). BGRF was the Bulgarian partner in the European project ‘Research and participated action regarding the victims of trafficking in human beings, crimes of honour and forced marriages within the African and Eastern European immigrant communities’ (Rapvite). It took place in 2010–11 and was supported by the EU Daphne programme. The project explored topics including ‘Fundamentals and characterisation of human trafficking in Europe’, ‘Anthropology of the societies of central and eastern Europe’, ‘Instruments to detect human trafficking’, and ‘Forced marriages and honour crimes’. It is apparent that in both projects dealing in some way with FGM, there was external funding and expertise.


Inexistence of data is due to a complex mixture of social, economic and historical reasons. The issue of FGM has not been discussed by relevant organisations and institutions because the phenomenon, like other honour-related violence, is rather hidden in Bulgaria. This leads to practically no attention and no social awareness being given to the topic. The long period of Communism in the country has certainly had an influence on the lack of information, as there was no research on any such issues during the decades of Communist rule. A framework for preventing and combating FGM was not created then; nor in the last 20 years of democratic transition. Bulgaria is imitating and borrowing from the EU many methods to tackle certain problems, thus it is likely that it will, eventually, find a way to create a framework on FGM, once the issue is recognised as imminent or is imposed as such by external authorities. The most important points would be to introduce the possibility to request asylum on the basis of FGM and to ensure the adequate care for women refugees and migrants with FGM.

2

3

4
5.3. Reflection on actors on female genital mutilation

There are no trends in actors and their activities over the years, as there is only one actual relevant actor that has developed activity on FGM — the BGRF. Since there are no existing policies on FGM, created or enforced by Bulgarian authorities, such activity on FGM is funded by foreign programmes and is an external initiative — it does not appear from a perceived internal need. The lack of any state actors is disturbing, and so is the complete lack of information on FGM, even within state institutions that should actually be developing activity or writing policies. Consequently, no activity can be developed by NGOs, as there is no state funding allocated to tackling the issue.

All of this means that activity and awareness raising in Bulgaria needs to start from scratch. The most important potential actors include the Ministry of Justice, the Ministry of Health, the State Agency for Refugees, professional organisations (gynaecologists, midwives) and other state institutions that should provide the legal and practical framework for preventing and combating FGM, as well as providing social and health care for women with FGM.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

The methodology for collecting information on tools and instruments on FGM in Bulgaria followed the steps set in the ‘Guidelines for national data collection,’ including academic database search, search of relevant organisations’ websites and phone and e-mail queries to state institutions and civil society organisations. The following databases were checked for tools and instruments on FGM for Bulgaria: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Google Scholar, as well as Google.

The conclusion is that there are no tools and instruments developed by Bulgarian actors on FGM, as there are no policies on the topic in the country or actors developing activity specifically on FGM.

6.2. Tools and instruments on FGM

There is only one document that can be considered as a tool on FGM, which is translated in Bulgarian, but is not originally produced by Bulgarian bodies. It is called ‘Manual for social and health care teachers’ and was prepared by Helsinki University in 2010, in consultation with a Bulgarian doctor for the Bulgarian edition. The document does not focus specifically on FGM, but it mentions it in the framework of violence against women. Within the UN definition of violence against the intimate partner, the manual provides a reference to FGM as a harmful practice against women. Although there are no practical measures suggested for tackling FGM, the manual acknowledges the existence of the practice and places it in context. Thus, it potentially raises the awareness of social and health care teachers about this phenomenon, which is the first step towards recognition and prevention of FGM.

6.3. Reflection on tools and instruments on female genital mutilation

There are no trends in development of tools and instruments, as there are no such documents in Bulgaria. This relates to the fact that there are no existing policies on FGM from national authorities and there are no active relevant actors on FGM in the country. There are obvious gaps in tools and instruments for all relevant fields — in the legal framework, in the policy framework, in social and health care, in education, and in asylum and migration bodies. Once a policy framework has been developed, it is likely that the necessary tools and instruments will be prepared as well, but this remains as an inconclusive supposition.

7. FINAL CONSIDERATIONS

The Bulgarian term for female genital mutilation has a couple of variants. These include женско генитално осакатяване (female genital mutilation), женско обрязване (female circumcision), женско обрязване на гениталиите (female circumcision of genitalia) and обрязване на жени (circumcision of women).

After thorough research through the various databases for academic journals, as well as through search engines like Google and Google Scholar, both in English and Bulgarian, no academic journals on FGM that mention Bulgaria on the topic (international ones) or that are written in Bulgarian and are dealing with the issue in Bulgaria were discovered. Thus, it can be concluded that the topic has not been treated by Bulgarian academia and that the country has not been considered in the international research on FGM because it is not perceived as being practised in the country, at least not by the local population and as far as the available information shows. The term FGM is sometimes mentioned in articles and blog posts on NGOs’ and other websites, but it is in the context of European Parliament’s resolutions on the topic, thus a part of the ‘news digest’ sections. The information such articles contain does not pertain to actual activity in Bulgaria.

There are no adequate prevalence studies on women with FGM or girls at risk of FGM. No statistics are being collected. The only information about prevalence of FGM in Bulgaria is that it is practised in isolated cases and mainly by migrants.

A policy framework has not been developed by national authorities, nor has it been discussed in the parliament. Relevant national policymakers do not seem to have much awareness of FGM, as it is not recognised as an imminent problem in Bulgaria. Thus, there no attention is given to the topic whatsoever. It is possible that FGM might surface in discussions in relation to the Council of Europe’s Convention on preventing and combating violence against women and domestic violence, which Bulgaria has signed.
No specific criminal law, child abuse law, asylum law or professional secrecy provision on FGM has been developed or foreseen for the moment. General provisions might be used for the prosecution of FGM, but there have not been such cases documented until now.

No state institutions, such as the Ministry of Health, the Ministry of Justice, the State Agency for Refugees, have any activity or information on FGM. There is only one NGO actor that could be identified as having some activity on FGM — the BGRF, although its studies simply mention FGM and do not focus particularly on it.

As far as tools and instruments are concerned, none have been developed in Bulgaria. There is one tool prepared by a Finnish university that mentions FGM, but again, the issue is not the focus of the tool.

The main conclusion of the present research is that there is barely any information in Bulgaria and in the Bulgarian language on the topic of FGM. There is almost no awareness among relevant potential actors about the issue.
1. IDENTIFICATION

Country: Croatia
Researcher: Maja Mamula, Women’s Room

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

In order to find data on the prevalence of female genital mutilation (FGM) in Croatia, the available information was searched in the academic databases and on relevant websites. I requested information via direct contact (telephone, e-mail, post) from the relevant government institutions and bodies, as well as from individual experts (Table 1 and 2).

<table>
<thead>
<tr>
<th>Academic databases</th>
<th>Information obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Google Scholar</td>
<td>n/a</td>
</tr>
<tr>
<td>Social Science Research Network Web of Science PubMed</td>
<td>n/a</td>
</tr>
<tr>
<td>Heinonline The United Nations Secretary-General’s database on Violence against Women</td>
<td>n/a</td>
</tr>
<tr>
<td>Sociological Abstracts EBSCO</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Websites</th>
<th>Information obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Nations Development Programme <a href="http://www.undp.hr">http://www.undp.hr</a></td>
<td>n/a</td>
</tr>
<tr>
<td>Unicef <a href="http://www.unicef.hr">http://www.unicef.hr</a></td>
<td>n/a</td>
</tr>
<tr>
<td>The UN Refugee Agency <a href="http://www.unhcr.hr">http://www.unhcr.hr</a></td>
<td>n/a</td>
</tr>
<tr>
<td>UN Women <a href="http://www.unwomen.org">http://www.unwomen.org</a></td>
<td>n/a</td>
</tr>
<tr>
<td>World Health Organisation <a href="http://www.who.int">http://www.who.int</a></td>
<td>n/a</td>
</tr>
<tr>
<td>UN Educational, Scientific and Cultural Organisation <a href="http://www.unesco.org">http://www.unesco.org</a></td>
<td>n/a</td>
</tr>
</tbody>
</table>

Key terms included the Croatian terms: genitalno sakaćenje žena, obrezivanje žena, obrezivanje djevojaka, sakaćenje ženskih genitalija. No documents were retrieved.
Table 2

<table>
<thead>
<tr>
<th>Relevant institutions, governmental bodies and independent experts</th>
<th>Contact</th>
<th>Information obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent expert, Clinic for Women’s Diseases and Childbirth</td>
<td>phone</td>
<td>Stated that during 30 years of practice she did not have any cases of FGM.</td>
</tr>
<tr>
<td>Independent expert, School of Public Health, Department for Social Medicine and Organisation of Healthcare, University of Zagreb, School of Medicine</td>
<td>phone</td>
<td>Stated that in many years of work she did not have any cases of FGM.</td>
</tr>
<tr>
<td>Independent expert, Policlinic for Gynaecology and Obstetrics</td>
<td>phone</td>
<td>In her private practice she did not have any cases of FGM.</td>
</tr>
<tr>
<td>Independent expert, Institute of Social Sciences</td>
<td>phone</td>
<td>No information on the prevalence of FGM in Croatia</td>
</tr>
<tr>
<td>Independent expert, Centre for Women War Victims</td>
<td>phone</td>
<td>No information on the prevalence of FGM in Croatia and she did not have any cases of FGM in her work.</td>
</tr>
<tr>
<td>Croatian Bureau of Statistics</td>
<td>e-mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Office for Gender Equality</td>
<td>regular mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Parliamentary Committee for Gender Equality</td>
<td>regular mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Ombudsperson for Gender Equality</td>
<td>regular mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Ombudsperson for Children</td>
<td>regular mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Office for Human Rights</td>
<td>regular mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Ministry of the Interior, Department for Administrative and Financial Matters, Department for Administrative Affairs, Foreigners and Citizenship</td>
<td>regular mail</td>
<td>No information on the prevalence of FGM, but stated that one person sought asylum on the basis of the risk of FGM in her country.</td>
</tr>
<tr>
<td>Ministry of Justice</td>
<td>regular mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Women’s Network of Croatia</td>
<td>e-mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Independent expert, Documenta, Coordination for Integration of Asylum Seekers</td>
<td>phone</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Independent expert, former expert in IOM</td>
<td>phone</td>
<td>No information on the prevalence of FGM</td>
</tr>
<tr>
<td>Independent expert, Doctors Without Borders</td>
<td>e-mail</td>
<td>No information on the prevalence of FGM</td>
</tr>
</tbody>
</table>

The greatest challenge in terms of finding information on the prevalence of female genital mutilation in Croatia was that nobody has specifically dealt with this problem. Although there are studies on the prevalence of various forms of violence against women, data on cases of female genital mutilation are unfortunately absent. It is also interesting to note that a large number of contacted people from the competent state bodies and institutions could not exactly understand, to begin with, what we were asking them about. Such lack of recognition of the terms or issues among representatives of institutions and/or bodies is an indicator of the level of neglect on the issue of FGM in the Republic of Croatia.

2.2. Nature of prevalence studies/FGM registration systems

The analysis of available data from relevant institutions, bodies, independent persons, and civil society organisations has shown that there is no data on the prevalence of FGM in Croatia.

2.3. Findings from the prevalence studies/registration systems

As already stated in Section 2.2, the analysis of available data from relevant authorities, institutions, independent experts, and civil society organisations found that no data exist on the prevalence of FGM in Croatia. Thus, the working group for the analysis of situation and development of an action plan to combat all forms of violence against women (2007–10), established by the Office for Gender Equality, whose work had included work on harmful traditional practices, found that FGM is not considered to be a problem in the Republic of Croatia and that not a single victim could be identified among asylum seekers or refugees. Data obtained from the competent institutions and bodies with regard to this study confirmed the conclusion of the working group for the analysis of situation and development of an action plan to combat all forms of violence against women.
2.4. Reflection on prevalence studies

There are no studies about FGM in Croatia, hence there were none conducted on a representative sample. The term first began to emerge through various public policies, such as the national policy for the promotion of gender equality 2006–10, when measures were adopted to conduct research on the prevalence of violence against women, including all forms of harmful traditional practices. Unfortunately, we can observe that the new national policy for gender equality (2011–15) included the same measure again, which testifies that no steps have been taken with regard to this issue.

I think that it is necessary for such research to be conducted in Croatia as soon as possible in order to gain insight into relevant information that could be used to impact the introduction of necessary changes to the law, develop necessary services to help women who have experienced such violence, develop further public policies, and sensitize and educate all people working on combating violence against women, including female genital mutilation.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

In order to gather information about the existence of public policies that pertain to or include FGM, I contacted the following relevant state bodies, institutions and experts (Table 3):

<table>
<thead>
<tr>
<th>Relevant institutions, governmental bodies and independent experts</th>
<th>Contact</th>
<th>Information obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office for Human Rights</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Office for Gender Equality</td>
<td>regular mail, phone</td>
<td>Referred us to the national policy for gender equality 2006–10, the national policy for gender equality 2011–15 and the new Criminal Code</td>
</tr>
<tr>
<td>Ombudsperson for Gender Equality</td>
<td>regular mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Parliamentary Committee for Gender Equality</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Ministry of the Interior, Department for Administrative and Financial Matters, Department for Administrative Affairs, Foreigners and Citizenship</td>
<td>regular mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Ministry of Justice</td>
<td>regular mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Ministry of Social Policy and Youth</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Croatian Medical Chamber</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Croatian Chamber of Midwives</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Croatian Nursing Council</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Ombudsperson for Children</td>
<td>regular mail</td>
<td>No information provided on documents or policies</td>
</tr>
<tr>
<td>Croatian Psychological Association</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Independent expert, Institute of Social Sciences</td>
<td>phone</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Independent expert, Documenta, Coordination for Integration of Asylum Seekers</td>
<td>phone</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>NAHT web page</td>
<td>web page</td>
<td>No information provided on documents or policies</td>
</tr>
</tbody>
</table>

3.2. Policies on FGM

When reviewing public policies in Croatia, I identified two national documents that included the problem of FGM. They are: the national policy for the promotion of gender equality 2006–10 and the national policy for gender equality 2011–15. Both national policies, in the chapters on combating violence against women, explicitly emphasise FGM as a harmful traditional practice. The national policy for the promotion of gender equality 2006–10 states that Croatia will join the International Network for the Fight against Harmful Traditions (NAHT) and conduct research to define measures for combating harmful traditional practices. When checking the website of NAHT, we did not
find information on Croatian membership, but only that the director of the Office for Gender Equality participated in the meeting of the network.

The second national document, the national policy for gender equality 2011–15, includes an action plan to combat all forms of violence against women and outlines plans for conducting research on the prevalence of all forms of violence against women, including harmful traditional practices for planning and implementing activities aimed at combating violence against women and improving their position.

Furthermore, I think the actual implementation of the abovementioned research is likely to happen, taking into account that a working group to analyse the situation and develop an action plan to combat all forms of violence against women was set up and operated from 2007 to 2010 in connection with the Office for Gender Equality.

In both national policy documents, the following institutions and bodies are identified as key actors: the Office for Gender Equality, the Office for National Minorities, and the Ministry of Health and Social Welfare, in collaboration with civil society organisations.

It should be noted that, in December 2011, the new government came into power and there has been a reorganisation of ministries (e.g. the Ministry of Health and Social Welfare has been divided into two separate ministries: the Ministry of Social Policy and Youth and the Ministry of Health). Also, it is important to note that representatives of state institutions, bodies and representatives of civil society organisations participated in the development of both national policy documents.

3.3. Reflection on policies on female genital mutilation

Despite the fact that FGM is addressed in national policies, there have been no other significant changes. Both national policies identify the need to research all forms of violence, including harmful traditional practices but, so far, no actions have been taken for the research to be conducted. In addition, except for the Office for Gender Equality, no other government body has addressed FGM, included it in their policy, or encouraged dealing with the problem in any other way.

Conducting this research could be the first extremely important step in mapping out the prevalence of the problem. However, Croatia being a country with significant economic problems, my belief is that it might not be a country of interest for women who are migrating or seeking asylum. I assume that awareness about the prevalence of FGM will increase only upon joining the European Union.

I hope the research planned by the national policy for gender equality 2011–15 will serve as a step towards the introduction of necessary changes (from training of relevant staff to educating the public about the problem).

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

In order to gather information about the existence of legislative framework pertaining to FGM, I contacted the following relevant state bodies, institutions, and experts (Table 4).

<table>
<thead>
<tr>
<th>Relevant institutions, governmental bodies and independent experts</th>
<th>Contact</th>
<th>Information obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office for Human Rights</td>
<td>regular mail</td>
<td>No information on public policies</td>
</tr>
<tr>
<td>Ministry of the Interior, Department for Administrative and Financial Matters, Department for Administrative Affairs, Foreigners and Citizenship</td>
<td>mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Ombudsperson for Gender Equality</td>
<td>mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Ombudsperson for Children</td>
<td>mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Office for Gender Equality</td>
<td>mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Office for Human Rights</td>
<td>mail</td>
<td>No information on legislative framework</td>
</tr>
<tr>
<td>Ministry of Justice</td>
<td>mail</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Independent expert, Institute of Social Sciences</td>
<td>phone</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Legal experts</td>
<td>phone</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Independent expert, Coordination for Integration of Asylum Seekers</td>
<td></td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
<tr>
<td>Legal expert for human rights</td>
<td>phone</td>
<td>Referred us to Article 116 of the new Criminal Code</td>
</tr>
</tbody>
</table>
4.2. Criminal law

In Croatia, there are still no articles in the Criminal Code that directly relate to FGM. For now, cases of FGM can be criminally prosecuted through the following articles: serious physical injury (Article 99) and arbitrary treatment (Article 241, paragraph 3). So far, no such case has been initiated in Croatia.

One extremely relevant fact is that on 1 January 2013 the new Criminal Code, which was adopted by the Croatian parliament on 21 November 2011, will be entering into force. The new Criminal Code was developed and adopted because of the country’s forthcoming membership in the European Union. Since Croatia will be an EU Member State from July 2013, the Croatian Government wanted to give plenty of time for the preparation of relevant institutions. The new Criminal Code contains Article 116 ‘mutilation of female genital organs’, which reads ‘whoever completely or partially removes or permanently changes the external genitalia of a female person shall be punished by imprisonment from six months to five years. In case of a child or family member, the penalty will be from one to eight years.’

4.3. Child protection laws/provisions

In Croatia there is no separate law that specifically pertains to protecting children’s rights, except for the Family Law. This law does not mention FGM either, but in consultation with lawyers I found out that, in theory, Article 114 ‘Gross violation of child rights’ would be applicable.

Also, there is no national/central agency or register of child protection interventions that deal with FGM in Croatia.

4.4. Asylum law(s)/provisions

The Asylum Act does not specifically mention FGM, but, in the process of gathering information, I was told that Articles 2, 74 and 91 that pertain to potential vulnerable groups could be applied in past or future cases of FGM.

According to the Asylum Act, ‘A refugee is an alien who is not in the country of his/her citizenship and based on the well-founded fear of persecution because of race, religion, nationality, membership to a particular social group or political opinion, is unable, or because of such fear, is unwilling to put her/himself under the protection of that country, or a stateless person who is outside the country of regular residence, who cannot or is unwilling because of a well-founded fear, to return to that country.’

The state body responsible for refugees in Croatia is the Ministry of the Interior, the Department for Administrative and Inspection Matters, the Department for Administrative Affairs, Foreigners and Citizenship. The Department for Administrative Affairs, Foreigners and Citizenship was founded by the Ministry of the Interior and it is part of the Department for Administrative and Inspection Matters (this is the full name of the competent Department).

However, there is no separate national/central registration system for asylum cases related to FGM.

According to the official data, no case of FGM has been documented.

Since the number of foreigners in Croatia is generally low, and so is the number of asylum seekers, the problem of FGM is not mentioned at all. However, as the Republic of Croatia is preparing for its imminent entry into the European Union, the problem will require attention and work on its prevention, not only in terms of legislation, but also in educating people working with foreigners and asylum seekers/refugees, so as to recognise and properly respond to cases of FGM.

As a step forward, several civil society organisations initiated the Initiative for the integration of refugees into Croatian society, which calls for the adoption of the integration protocol and the establishment of a contact person in each competent ministry, the establishment of an operational working group to include representatives of civil society organisations, and the financial support for CSOs that work directly with refugees.

4.5. Professional secrecy provision(s)

In the law, there is an article directly related to professional secrecy concerning FGM. Articles 89, 132 and 300 of the Criminal Code indicate that the obligation of professional secrecy rests with lawyers, attorneys, notaries, physicians, dentists, midwives or other health professionals, psychologists, guardians, religious confessors and other persons when performing their vocations. However, all these professions shall be criminally prosecuted if they fail to report serious crimes, of which they learned about while performing their duty, and if the offence is of a sort for which criminal proceedings are not left to private complaint or to a motion. Furthermore, a person who is entrusted with the upbringing and education of children at an appropriate institution, a public notary or a guardian, shall be criminally prosecuted if they do not report an offence that is committed against a child or a juvenile.

There are no national/central registration systems for reports of (suspected) FGM cases by professionals.

4.6. Reflection on legal framework

On analysing the law, it is apparent that in the last few years there have been some changes related to the protection of human rights, women’s human rights and laws related to combating violence against women. The main indicator of these changes is the introduction of the article on FGM in the new Criminal Code of Croatia, which will take effect on 1 January 2013. Changes to the Criminal Code were developed by a special working group, led by Professor Turkovic, which was established solely for this task. The process of drafting proposals lasted about two years.
Given that Croatia does not have any documented cases of FGM, neither by the police, legal bodies (State Attorney’s Office, courts), nor hospitals, there was no significant pressure to change legislation. As already mentioned, there is generally only a small number of foreigners and refugees in Croatia, and there is no recorded data on FGM. All the abovementioned reasons may justify why this form of violence against women is systematically out of focus.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

In order to gather information about relevant actors, I contacted the following relevant state bodies, institutions, organisations and experts (Table 5).

### Table 5

<table>
<thead>
<tr>
<th>Relevant institutions, governmental bodies and independent experts</th>
<th>Contact</th>
<th>Information obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of the Interior</td>
<td>regular mail</td>
<td>Referred us to the Department for Administrative and Financial Matters, the Department for Administrative Affairs, Foreigners and Citizenship</td>
</tr>
<tr>
<td>Ombudsperson for Gender Equality</td>
<td>regular mail</td>
<td>No information on relevant actors</td>
</tr>
<tr>
<td>Ombudsperson for Children</td>
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<tr>
<td>Ministry of Justice</td>
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</tr>
<tr>
<td>Croatian Medical Chamber</td>
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</tr>
<tr>
<td>Croatian Chamber of Midwives</td>
<td>regular mail</td>
<td>No information on relevant actors</td>
</tr>
<tr>
<td>Croatian Nursing Council</td>
<td>regular mail</td>
<td>No information on relevant actors</td>
</tr>
<tr>
<td>Department of Social Welfare City of Zagreb</td>
<td>regular mail</td>
<td>Referred us to the Department for Administrative and Financial Matters, the Department for Administrative Affairs, Foreigners and Citizenship, the Ministry of the Interior</td>
</tr>
<tr>
<td>Croatian Psychological Association</td>
<td>regular mail</td>
<td>No information on relevant actors</td>
</tr>
<tr>
<td>Women’s Network of Croatia</td>
<td>e-mail</td>
<td>No information on relevant actors</td>
</tr>
<tr>
<td>Independent expert, Coordination for Integration of Asylum Seekers</td>
<td>phone</td>
<td>No information on relevant actors</td>
</tr>
<tr>
<td>Former employee of IOM, independent expert</td>
<td>phone</td>
<td>No information on relevant actors</td>
</tr>
<tr>
<td>Independent expert, Centre for Women War Victims</td>
<td>phone</td>
<td>No information on relevant actors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Websites</th>
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</thead>
<tbody>
<tr>
<td><a href="http://www.ured-ravnopravnost.hr">http://www.ured-ravnopravnost.hr</a></td>
</tr>
<tr>
<td><a href="http://www.ljudskakprava-vladarh.hr">http://www.ljudskakprava-vladarh.hr</a></td>
</tr>
<tr>
<td><a href="http://www.uzuvrh.hr">http://www.uzuvrh.hr</a></td>
</tr>
</tbody>
</table>

5.2. Actors

There is no specific institution or state body in Croatia that coordinates the referral centre for collecting data on cases of FGM. Also, none of the civil society organisations deals specifically with this form of violence against women, although there are more than 40 NGOs that systematically work with women victims of violence (shelters, counselling). Some of the organisations, such as the Women’s Room, the Centre for Education, Counselling and Research (CESI), and the Centre for Women War Victims address FGM through their direct work; although they only do so in the framework of education or through articles on their websites. However, no organisation has ever provided help and support to women who are threatened by FGM, or had FGM performed on them.

Several individual experts have to some extent and through their work, become aware of the problem, but only at the level of providing information.

5.3. Reflection on actors on female genital mutilation

Unfortunately, we cannot determine that there is a trend of significant changes with regard to FGM, either from institutions or civil society organisations. Given that there is no recorded case, it is difficult to even raise the issue of
FGM as a relevant problem, because the first reaction of most competent bodies and institutions is that FGM is not a burning issue for the Republic of Croatia. On the other hand, civil society organisations are aware of the problem, but have no direct experience.

As already mentioned, considering the Croatian accession to the European Union, as well as important changes in the legislation, I believe that in the future there will be more discussions about the problem of FGM, an increase of work on awareness raising of the problem, and thus identification of potential and/or actual victims.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

In order to gather information on tools and instruments, I contacted the following relevant state bodies, institutions, and experts (Table 6).

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<thead>
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<tr>
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<tr>
<td>Ombudsperson for Children</td>
<td>regular mail</td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>Office for Gender Equality</td>
<td>regular mail</td>
<td>The only tool that is translated in the Croatian language and can be used as a tool is Recommendation Rec(2002) 5 of the Committee of Ministers to Member States on the Protection of Women against Violence</td>
</tr>
<tr>
<td>Office for Human Rights</td>
<td>regular mail</td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>Ministry of Justice</td>
<td>regular mail</td>
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<td>Websites</td>
<td></td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>United Nations Development Programme</td>
<td>web</td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>Unicef</td>
<td>web</td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>Government of Croatia</td>
<td>web</td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>The UN Refugee Agency</td>
<td>web</td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>Office for Human Rights</td>
<td>web</td>
<td>No information provided on tools and instruments</td>
</tr>
<tr>
<td>Office for Cooperation with NGOs</td>
<td>web</td>
<td>No information provided on tools and instruments</td>
</tr>
</tbody>
</table>

6.2. Tools and instruments on FGM

In Croatia there is currently only one translated tool on FGM — Recommendation Rec(2002) 5 of the Committee of Ministers to Member States on the protection of women against violence and explanatory memorandum. In the Recommendation there is a concrete definition of FGM, obligations for country members including changes in Criminal Code and other legislative changes, organising public campaigns for awareness raising, education of representatives of relevant institutions (e.g. medical doctors). It also includes indicators to measure different forms of violence against women, it provides guidelines for monitoring positive developments and additional
measures needed to combat FGM (e.g., collection of statistical data, necessary national laws) and identifies the state as a key actor. This tool is important for our country because it is the first document of that kind about FGM in Croatia. The document was distributed to all relevant institutions, bodies and organisations of civil society by the Office for Gender Equality.

Except for this document, there are none originally written in the Croatian language. Even in the manuals on violence against women there is no specific part that deals with this problem.

6.3. Reflection on tools and instruments on female genital mutilation

In Croatia, unfortunately we cannot speak about the trend related to tools and instruments on FGM, because there are no such materials except the Recommendation Rec(2002) 5.

Taking into consideration that in the scope of public policy FGM is mentioned only as one form of harmful traditional practices, that the actual prevalence of the problem is yet to be determined in Croatia, and that all institutions and authorities agree that there are no documented cases, this situation is not surprising. In fact, from experience in dealing with violence against women, it is evident that a certain period of time is required from the moment when the problem is introduced, to the development of important tools and instruments.

7. FINAL CONSIDERATIONS

The situation regarding relevant data on FGM in the Republic of Croatia is not reconcilable. Specifically, there are no studies on the problem or on the prevalence of FGM. However, the desire for the implementation of such research does exist, which is evident from the national policy for promotion of gender equality 2006–10 and the national policy for gender equality 2011–15. These are the only two national policies that address FGM, and they place it in the framework of violence against women and harmful traditional practices. Only one document, from the Council of Europe, has been translated into Croatian — Recommendation Rec(2002) 5 of the Committee of Ministers to Member States on the Protection of Women against Violence and explanatory memorandum, which clearly defines and discusses FGM.

In Croatia there is not even one scientific paper on the problem of FGM. Although sometimes, we can find references on FGM in newspaper articles, all of them refer to FGM only in relation to countries in which it is widespread. Not one of them talks about FGM in Croatia.

Concerning legislative changes, there are noticeable changes with regard to FGM. The new Criminal Code, which will come into force on 1 January 2013, criminalises the offence of female genital mutilation in Article 116.

Nevertheless, this does not change the situation regarding the low level of awareness and information about FGM, which is still prevalent among representatives of the competent institutions and bodies. Educating the specialists on that subject requires the attention of the major stakeholders. The fact that there are no officially reported cases of FGM explains why there are no tools and instruments; and it is hard to expect them to exist since the Republic of Croatia does not recognise FGM as a social problem.

However, Croatia is bound by international and national conventions, declarations and other documents on combating violence against women. Despite the fact that Croatia has no registered cases of FGM at this point, it is extremely important to be aware of the extent of the problem in the EU, but also the liability to potential and/or existing victims after the accession of the Republic of Croatia to the EU.

For the abovementioned reasons, the research planned by the national policy for gender equality 2011–15 will definitely contribute to emphasising this problem, because, as it turned out, most of the contacted bodies, institutions, and civil society organisations were extremely eager to cooperate in the research, as well as interested in the obtained data.
1. IDENTIFICATION

Country: Cyprus
Researcher: Maria Kyprianou

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The research for prevalence data was initiated through academic database search, following the ‘Guidelines for national data collection’. The following databases were searched for prevalence data in Cyprus (CY): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Cylaw (1) and Google Scholar.

Key terms included the Greek (2) terms: κλειτοριδεκτομή, Ακρωτηριασμός Γυναικείων Γεννητικών Όργων, AΓΓΟ and the English terms: FGM, female genital mutilation, and female genital cutting.

Unfortunately, no documents were retrieved to include representative or reliable prevalence data. The only reference to one or two incidents of victims of FGM recorded in Cyprus were made in newspaper articles and through e-mail communication with a non-governmental organisation, hereafter an NGO, which will be further discussed.

Apart from the above databases, the Ministry of Health was contacted through e-mail as well as the Mediterranean Institute for Gender Studies, hereafter referred as MIGS. The Ministry of Health responded to the request for information stating that they deal with FGM as part of fighting violence against women, but there is no database at the time. Nevertheless, all gynaecologists in the public domain have been instructed to register and declare all incidents of women with FGM.

MIGS was deeply interested in the study and provided some information for this purpose; nevertheless, no consistent studies were concluded at the time to include prevalence data of FGM cases in Cyprus.

MIGS is presently the partner of the End FGM campaign (3) in Cyprus, hence studies are currently underway. MIGS plans to commence studies on FGM in general, including a study on prevalence, in the near future. At the moment, there is no research on prevalence data dedicated to FGM available.

An e-mail was equally sent to the National Statistical Service in order to collect official statistical documents, however no such data were collected and no study was conducted on FGM by the National Statistical Service.

2.2. Nature of prevalence studies/FGM registration systems

As aforementioned, no documents including prevalence data on FGM in Cyprus were retrieved from the above desk research.

The only reference to one or two incidents of victims of FGM recorded in Cyprus were made in newspaper articles and through e-mail communication with an NGO, the Association for the Prevention and Handling of Violence in the Family.

A newspaper article by journalist Marilena Panayi, published on 25 February 2010 in Phileleftheros Newspaper, presented an interview of an FGM victim. The 29-year-old woman visited Cyprus in order to participate in an event organised by MIGS in cooperation with the European Parliament Office in Cyprus, about the project ‘End FGM’.

In this interview she talks about her terrible experience when she was seven years old. As a British citizen, and therefore as an EU citizen, she believes that the EU and Cyprus should and could develop a common strategy in order to end FGM. According to her, around 500 000 women who suffered FGM live in Europe; hence this is a European and an international problem.

In the same article, the Cypriot President of the Parliamentary Committee on Equal Opportunities, Mrs Dina Akkelidou, states that, as an EU Member, Cyprus is especially

(1) Cylaw (http://www.cylaw.org/) is an online, state-owned legal information portal which includes laws, case-law and academic legal articles.

(2) One of the two national official languages which is mainly used in the Republic of Cyprus official documents and websites is Greek. The other official language according to Article 3 of the Cyprus Constitution is Turkish. Nevertheless, the English language is also widely used in Cyprus, both in government websites but also in research.

(3) For more information on the End FGM campaign, please visit http://www.endfgm.eu/en/
concerned with this issue, which she describes as the most grotesque form of violence against women.

According to Mrs Dina Akkelidou, the number of refugees and migrants has increased in Cyprus and it seems very likely that there are victims of FGM living in Cyprus.

The need to combat FGM in Cyprus is now starting to grow. At least one woman who came to Cyprus was reported to experience complications because of FGM and due to this she claimed asylum. However, there is no further official information on the outcome of her case (*)..

2.3. Findings from the prevalence studies/ registration systems

Mr Marios Nicolaou, who has been working at the Association for the Prevention and Handling of Violence in the Family for the last eight years, stated that the Association has dealt with two women from Iraq, who suffered FGM.

MIGS made a rough estimation of 1 500 women from FGM-practising countries living in Cyprus in 2010. This estimation was the result of a limited number of data that MIGS managed to collect from the Migration Department with the help of the Asylum Office. This is not considered to be an academic study on prevalence of data on FGM in Cyprus; it was therefore not included in the Excel database.

2.4. Reflection on prevalence studies

Cyprus only began research and data collection on FGM in 2010, under the initiation of the End FGM campaign and the initiative undertaken by MIGS in cooperation with the European Parliament Office in Cyprus and the Parliamentary Committee on Equal Opportunities.

There are currently no representative or reliable data on FGM prevalence in Cyprus.

There has been a general action plan on domestic violence, the equality between genders and the promotion of human rights; however, FGM has not yet been recorded as a major problem in the country.

In conclusion, having received limited publicity, FGM and specifically prevalence data on FGM in Cyprus, remain issues to be yet explored in the years to come.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Only one document on policies developed in Cyprus was finally included in the database.

Nevertheless, many policy documents dealing with violence and gender issues in general were retrieved through researching the websites of government ministries and other relevant departments, as well as websites of civil society organisations and NGOs. The aforementioned policy documents were not found to be relevant for the scope of this study, as it focuses especially on policies developed towards the fight against FGM in Cyprus and the protection of victims of FGM.

The start of our research on policy documents was done from academic databases, following the ‘Guidelines for national data collection’. The following databases were searched: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Cylaw and Google Scholar.

Key terms included the Greek terms: κλειτοριδεκτομή, Ακρωτηριασμός γυναικείων γεννητικών οργάνων, ΑΠΟ and the English terms: FGM, female genital mutilation, and female genital cutting.

Unfortunately, no policy documents were retrieved from the academic databases.

In search for policy documents, the Ministry of Foreign Affairs, the Ministry of the Interior and the Asylum Service were contacted by e-mail.

None of the above government services replied to the request for information at the time, or since. The contacts were followed by phone calls, but due to the limited time frame of the research there is still no response, as questions to Government departments in Cyprus usually take some time to be answered.

The European Parliament Office in Cyprus was also contacted by e-mail, due to being the co-organiser of events for the End FGM campaign. They responded by referring the researcher to MIGS for further information.

3.2. Policies on FGM

As aforementioned, only one document on policies developed in Cyprus was finally included in the database.

The above document is the ‘National action plan promoting equality (2007–13)’. This national action plan was issued by the Ministry of Justice and Public Order in 2007. This policy document was issued in the Greek language and it deals with issues concerning equality on a general basis rather than granting special importance to FGM.

The National Machinery for Women’s Rights under the Ministry of Justice and Public Order, which in Cyprus is the competent ministry for the overall promotion of gender equality and the protection of women’s rights, has prepared a ‘national action plan on gender equality’, in collaboration with all government departments, NGOs, local authorities, academic institutions and human rights bodies.

The plan was adopted by the Council of Ministers on 29 August 2007 and covers the period of 2007–13. One of
the main areas the action plan focuses on is the ‘Combating of all forms of violence against women’.

According to the action plan, gender violence is presently considered to be found in the working place, in the family and at events that concern matters of pride and tradition.

The victims of gender violence, and more specifically of FGM, often tend to accept and internally incorporate this form of violence, due to poverty, insecurity, manipulating ideologies, lack of education, fear and tradition.

The action plan refers to the situation of domestic violence in Cyprus and states that domestic violence in minority groups living in Cyprus is considered to be a matter strictly between the families, hence under-reported. According to the document, violence in minority groups is connected with social superstition towards reporting crimes. Since the practice of FGM is not considered to be a crime by some minority groups, reporting it as a domestic violence incident is even rarer in Cyprus.

The action plan sets out the government goals to mobilise the public about violence against women while providing incentives for women who wish to report it.

More analytically, the relevant implementation actors include the Ministry of Labour and Social Insurance, the Ministry of Education, the Ministry of Health, the Ministry of Justice and Public Order, the police, the Association for the Prevention and Handling of Violence in the Family, the National Mechanism for the Rights of Women, the media and other NGOs.

Some of the most important actions to be implemented through the action plan include: informative public campaigns, campaigns providing incentives for women to report crimes, educational actions about existing legal framework for the protection of women against violence and FGM, as well as educating police personnel, health practitioners, judges, lawyers and other professionals.

3.3. Reflection on policies on female genital mutilation

As demonstrated above, although the national action plan does not deal specifically with the issue of FGM, it sets out, in principle, a number of very important actions and measures to deal with FGM and other forms of violence against women.

The first time FGM was mentioned in the House of Representatives (parliament), the initiative was made by a member of the parliament (hereafter MP) from DISI (1), the major right-wing political party of Cyprus. The aim was to amend the Criminal Code, Cap 154, in order to include FGM as a crime in Cyprus.

Since 2003, and until 2007, there has been no further special reflection on FGM. Article 233A of the amended Criminal Code still remains unused and we will further discuss this in the next section.

It is however important to stress the significant connection between policy and law, as usually policy and law have to correlate and synchronise in their application, in order to be effective. It seems evident from this research that, as far as policy and legal documents are concerned, this is not the case in Cyprus.

In 2010, MIGS started to research and conduct events on FGM, as a research partner to the End FGM campaign. Although the above action plan covers the period from 2007 to 2013, action for FGM only emerged in 2010.

In conclusion, it is important to reiterate the fact that research and policy are currently being implemented in Cyprus, although with a slight delay, in contrast with other European countries.

However, an important recommendation is that FGM should be treated with special care, being a particularly grotesque manifestation of violence against women, through a consistent and comprehensive policy framework, specifically addressed to FGM.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Data for this section were retrieved from the following websites:

• UN Secretary-General’s database on violence against women (VAW) for information regarding the general legal framework in Cyprus concerning violations against women’s rights
• Leginet’s website, the Cyprus online legal portal: http://www.leginetcy.com
• Commissioner for the Protection of Children’s Rights (http://www.childcom.org.cy/), containing all legislative documents concerning children as well as some information on true stories and the way to report.

The coordinating team also informed the researcher about the following document, which was included in the desk study:

• Hagemann-White, C., Kelly, L., Romkens, R. (coord.), Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence; Dutch national report — van der Aa, S. and Romkens, R., European Commission, 2010.

An e-mail was sent to Prof. Nicos Trimikliniotis (Professor of Sociology at the University of Nicosia in Cyprus), who was also the author of the above study for Cyprus, in order to obtain any further information available on FGM in Cyprus. However, at the time of compiling this report, no reply had been received. The e-mail was not followed by a phone call because it was not easy to get Prof. Trimikliniotis’ phone number.

(1) More information on this political party can be found in English, on their website (http://www.disy.org.cy/default.asp?id=24).
4.2. Criminal law

As briefly mentioned above, FGM was initially mentioned in the House of Representatives (parliament), in March 2003. The initiative was made by a member of the parliament (MP) of DISI, Mr Soteris Sampson. The amendment was implemented on 13 March 2003, and the main purpose for the proposition was “to include in the Criminal Code, provisions to safeguard and protect Cyprus’ national and sacred symbols from disrespectful, offensive and improper conduct” (1).

During the parliamentary discussions, the amendment (by Law 48(I)/2003) included the aim to amend the Criminal Code, Cap 154, in order to include FGM as a crime in Cyprus. The relevant report was issued by the Parliamentary Committee on Legal Affairs on 21 May 2003, but it is only available in Greek.

The report of the parliamentary committee was very brief and stated that the act of FGM is inhuman and constitutes a violation of the human right to safeguard the physical integrity of the human person. FGM should be criminalised as a request from the Council of Europe and the United Nations.

According to the representatives of the Ministry of Justice and Public Order, although there are no such practices of FGM in Cyprus, they welcomed the criminalisation of FGM, as it could be practised by refugees or migrants, or other people who visit Cyprus.

Hence, since 2003, there is a specific criminal prohibition for FGM in Cyprus, namely Article 233A of the amended Criminal Code, Cap 154. Nevertheless, as abovementioned, Article 233A has never been used in a single court case since its enactment!

Article 233A states that any person who commits the offence of female genital mutilation, any accessory, advisor to the perpetrator, and any person inducing another person to commit FGM is guilty of this offence. FGM is defined as the cutting or in any other way the mutilating of the major lip (labia majora) or the minor lip (labia minora) or the clitoris of a woman’s genitalia.

The action of FGM is not an offence if committed by a medical practitioner for reasons necessary for the woman’s health and, or when, this procedure takes place at labour or after the birth of a child. FGM can only be conducted to a woman after the expert opinion expressed by two doctors. The consent of the woman who is subjected to FGM is neither used as a defence to this crime, nor used as a mitigating factor to reduce the penalty.

The Cypriot Courts are empowered to adjudicate and decide in cases where the offence of FGM was committed by Cypriot citizens and non-citizens, for FGM committed to Cypriots and non-Cypriot citizens. The maximum criminal penalty that may be imposed is imprisonment for five years.

It is however important to stress that Article 233A has since 2003 remained an idle criminal provision which was incorporated in the Criminal Code in order to satisfy the request of the United Nations and the Council of Europe, only in principle but not in practice.

The main reason that Article 233A is not used is neither due to parliamentarians’ or government’s incompetence nor to unwillingness to deal with FGM, but the fact that it is commonly accepted that FGM is not known to take place in Cyprus.

4.3. Child protection laws/provisions

There are no specific law provisions protecting minors from FGM in Cyprus. Nevertheless, the general legislative framework appears to cover cases of FGM as a form of child human rights violation or child abuse.

In Cyprus, the national child protection service is by provided the Commissioner for the Protection of Children’s Rights. This office is independent and the Commissioner has the right to intervene and protect a child and represent the child’s interests. This is a very general provision that can be applied in FGM cases.

There are two main legislations dealing with child protection in general that could be applied to cases of FGM: the 1959 Children’s Law, Cap. 352, as amended, which is partially in English and partially in Greek (2) and the Commissioner for the Protection of Children’s Rights Law, L. 74(I)/2007.

Neither of the above two laws expressly deals with the issue of FGM. The 1959 Children’s Law generally prohibits cruelty to children under 16. Cruelty is defined, under Article 54, as wilful assault, ill-treatment, neglect, abandonment, exposure likely to cause the child unnecessary suffering or injury to health including injury to or loss of sight, hearing or limb or organ. The penalty foreseen by the law is one year’s imprisonment and/or a fine of CYP 100 (EUR 170).

The relevant reporting agency could either be the Police Domestic Violence and Child Abuse Office, Department C, or the Commissioner for the Protection of Children’s Rights directly. However, there were no reported cases of children with FGM.

4.4. Asylum law(s)/provisions

The relevant law dealing with asylum seekers is the Asylum Law 2000 L. 6(I)/2000, which was last amended in 2009. There is no specific provision dealing with FGM; nevertheless, provision 3(c) can be used in a procedure to obtain the status of refugee in Cyprus, for a woman, or a child, who has either undergone FGM, or is in fear of undergoing FGM if returned to her country of origin. Provision 3(c) of the said Law describes the criteria under which persecution can be inferred.

(1) Unofficial translation of the officially deposited proposition in Greek, for the amendment of the Criminal Code, Cap 154, No 2, 48(I)/2003.

(2) Children’s Law Cap. 352 was enacted in 1959, which is before Cyprus was declared independent from British rule in 1960 and this is why the main body of the legislation remains in English.
Cyprus law definition of ‘refugee’ is a translation of the 1951 Convention’s definition in Greek: ‘The term “refugees” shall apply to persons who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, are outside their country of nationality and are unable or, owing to such fear, are unwilling to avail themselves of the protection of that country, or who, not having a nationality and being outside the country of their former habitual residence as a result of such events, are unable or, owing to such fear, are unwilling to return to it.’

In cases where a woman fears persecution if returned to her country of origin, because of her belonging to a particular social group which practices FGM, she could claim asylum on this basis.

The practice of FGM itself could be interpreted as persecution, since FGM is defined as a cruel, inhuman and, to some, an act of torture. Although not officially reported by the Asylum Service, there has been at least one case of a woman seeking asylum after having complications due to FGM. In that particular case, if returned to her country of origin, the FGM victim would most probably not have been able to seek and receive proper medical care for her complications.

It is the opinion of some refugee law experts that Article 3 of the European Convention on Human Rights, prohibition of torture or inhuman or degrading treatment or punishment, would be breached by the Republic of Cyprus if the victim was sent back to her country of origin. Another reason for following the non-refoulement principle and not returning the FGM victim to her country of origin would be to grant her asylum status on a humanitarian basis. To illustrate the above point, asylum is often granted to asylum seekers on humanitarian grounds which cover issues that are not covered by the 1951 Convention; being a victim or potential victim of FGM could form one of the grounds to obtain the refugee status, for humanitarian reasons, or at least for the victim to obtain the humanitarian leave to stay in the safe third country.

4.5. Professional secrecy provision(s)

Criminal Code provision 135 sets a high threshold of professional secrecy; all public officers, including medical practitioners, police officers, legal officers of the Service of the Attorney General, are bound by this provision not to disclose state or official (service) information.

State or official (service) information includes work and cases that are encountered by the above professionals during their work. The medical practitioners may well be doctors working at state hospitals. State hospitals are the most prominent hospitals to be visited by asylum seekers, recognised refugees or migrants, originating from an FGM-practising country, since they are free of charge to people who are entitled of free healthcare because of their status or economic state.

There is, however, an exception to disclosing information after authorisation, in extreme cases, where it is proportionate and necessary.

The above law as well as Public Service Law, L. 1/1990, Article 69A, state that officials have a duty to report any abuse from other public officers or act of corruption. In practice, however, this is rarely done.

The maximum penalty for breaching the Criminal Code provision is two years imprisonment or EUR 2 543.88, or both sanctions.

Information on the abuse of secrecy is usually collected by the Cyprus Medical Association, if the perpetrator is a doctor. The relevant department of the perpetrator will also keep a record and if the administration finds it appropriate, they will also conduct a disciplinary investigation within the department.

4.6. Reflection on legal framework

As a general observation, I notice that legal provisions to deal with FGM in Cyprus are in place.

Nevertheless, it is important to stress that Article 233A, which was incorporated in the Criminal Code in 2003 in order to deal with FGM as a criminal offence, remains an idle criminal provision which has never been used in practice.

The main reason for this is the fact that it is commonly accepted that FGM is not known to take place in Cyprus. Victims of FGM may, however, live in Cyprus and perhaps the law should focus on their protection rather than on the criminalisation of the perpetrators of an act that does not commonly take place in Cyprus.

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(2) A ‘particular social group’ is defined under provision 3D(1)(d) of the Asylum Law L. 6(I)/2000, as a group comprising persons of similar background, habits or social status.

(3) The Cyprus Asylum Service is under the Ministry of the Interior and it is the government service responsible for dealing with all asylum claims, argued on the basis of one of the five grounds of the refugee definition.

(4) Please refer to the Philileftheros Newspaper article mentioned in section 2.2.

(5) Prof. Satvinder Juss, King’s College London, Prof. Guy S. Goodwin Gill, Prof. James Hathaway.

(6) ‘The principle of non-refoulement is the cornerstone of asylum and of international refugee law. Following from the right to seek and to enjoy in other countries asylum from persecution, as set forth in Article 14 of the Universal Declaration of Human Rights, this principle reflects the commitment of the international community to ensure to all persons the enjoyment of human rights, including the rights to life, to freedom from torture or cruel, inhuman or degrading treatment or punishment, and to liberty and security of person. These and other rights are threatened when a refugee is returned to persecution or danger’. For more information please refer to UN High Commissioner for Refugees, UNHCR Note on the Principle of Non-Refoulement, November 1997, (available at: http://www.unhcr.org/refworld/docid/438c6d9f72.html).
As aforementioned, there are no specific law provisions protecting minors from FGM in Cyprus. Nevertheless, the general legislative framework seems to cover cases of FGM as a form of child human rights violation or child abuse. The protection of minors and mostly unaccompanied minors is vital for a state that claims to protect and endorse human rights values. Therefore, if the need to protect child-victims of FGM emerges, which does not currently seem to be the case, Cyprus should legislate specifically for their protection.

As far as asylum cases are concerned, it is commonly the international refugee law trend to find the practice of FGM itself, and to constitute persecution. Cyprus Asylum Service personnel, who deal and decide at first instance whether to grant or deny the refugee status to asylum seekers, should be educated about FGM.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

According to the ‘Guidelines for national data collection’, an actor is any organisation or individual who performs any work on FGM in Cyprus.

Relevant actors in Cyprus were found through a variety of search strategies:

The research for actors was initiated through academic database search, following the ‘Guidelines for national data collection’. The following databases were searched for prevalence data in Cyprus (CY): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Cylaw and Google Scholar.

Key terms included the Greek terms: κλειτοριδεκτομή, Ακρωτηριασμός Γυναικείων Γεννητικών Οργάνων, ΑΓΟ and the English terms: FGM, female genital mutilation, and female genital cutting.

Relevant actors, such as FGM experts or institutions that appeared in the database search, were included in the database, as well as other organisations which were found through personal knowledge.

The authors of documents that were studied, as well as those who issued the documents and those who commissioned the publication of the documents, were considered as actors and included in the database.

A web-based search was then performed to include all the details that were requested to compile the actors’ sheet in the database.

The number of actors in Cyprus who have worked and/or are still working on FGM is limited, since research and action on FGM only started in 2010. It is, however, important to notice that due to the limited time frame of this desk study, it cannot be guaranteed that the relevant actors included in the Excel database are exhaustive.

5.2. Actors

Actors in Cyprus include a research institute within a private university, a political party, two civil society organisations and the European Office of Cyprus, a decentralised EU agency.

Activities include research, the creation of informative strategies, prevention activities and developing policies at national level.

The Mediterranean Institute of Gender Studies (MIGS) has been one of the most important actors in the field of research on FGM, taking an active role in the European End FGM campaign, and cooperating with other actors, such as the European Office of Cyprus, in the organisation of events.

The Green Party of Cyprus has been supportive to the actions of MIGS and the European Office of Cyprus by declaring its support publicly and promoting the events organised by MIGS.

The Association for the Prevention and Handling of Violence in the Family has generally supported victims of violence and still offers support to women who suffered FGM, although according to their records there have been only a small number of victims.

HFC ‘Hope for Children’, a UNCRC policy centre, and the Unit for the Rehabilitation of Victims of Torture, which is under the Humanitarian Affairs Unit of Future Worlds Centre, are both civil society organisations conducting academic research and supporting victims when necessary.

5.3. Reflection on actors on female genital mutilation

The work on FGM in Cyprus is currently only at an early stage. As demonstrated above, there are only a few actors dealing with FGM in Cyprus, but their work is neither limited to FGM, nor exclusively dedicated to it.

Fortunately, there seems to be a trend towards acknowledging the existence and the seriousness of the act of FGM in Europe but there is also some concern that this grotesque manifestation of traditional cruelty may in fact exist in Cyprus, although it is not commonly known to be practised here.

Government ministries are not mentioned in the Excel file because they do not operate specifically on FGM issues. They do work towards a strategy against violence and equality of the genders, but they do not specifically concentrate on FGM.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

The search for tools and instruments on FGM was performed according to the ‘Guidelines for national data collection’.
collection’. The following databases were searched for prevalence data in Cyprus (CY): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Cylaw and Google Scholar.

Key terms included the Greek terms: κλειτοριδεκτομή, ΑΚΡΩΤΗΡΙΑΣΜΟΣ ΓΥΝΑΙΚΕΩΝ ΓΕΝΝΗΤΙΚΩΝ ΟΡΓΑΝΩΝ, ΑΓΓΟ and the English terms: FGM, female genital mutilation, and female genital cutting.

Relevant tools and instruments include an academic article, a publication promoting the event ‘End FGM in Cyprus’, as well as a professional development workshop on FGM and refugee determination status.

6.2. Tools and instruments on FGM

The first tool presented in the excel file is a press release by the European Parliament on the event ‘Ending female genital mutilation in Cyprus by developing a common European asylum strategy’.

The purpose of the event was to promote the ‘End FGM European campaign’ which covers Ireland, Amnesty International and the presentation of the strategy of the campaign ‘End FGM: a strategy for the institutions of the European Union’. The strategy focuses on five areas: data collection, health, protection, asylum and European development. The event focused on the development of clear guidelines on asylum in relation to FGM.

The event was attended by representatives of local and international organisations, parliamentarians and government officials, as well as Ms Dina Akkelidou, Chair of the Parliamentary Committee on Equal Opportunities between Men and Women. The event was attended by Dr Christine Loudes, head of the End FGM campaign, representatives of the Office of UNHCR, the Asylum Service of the Ministry of the Interior, and the director of the campaign, who presented her own disturbing experience. She suffered genital mutilation when she was seven years old, during a ceremony attended by relatives and friends of the family.

Another instrument was the professional development seminar which took place on 8 and 9 December 2010 under the title ‘Women and refugee status determination: developing quality asylum procedures’.

The professional development seminar was organised by the Mediterranean Institute of Gender Studies (MIGS) and the End FGM European campaign, in cooperation with the UNHCR Cyprus.

The workshop’s aim was to examine and improve asylum procedures and the quality and efficiency of the asylum decision-making in relation to gender-specific claims of international protection. Within the framework of the End FGM European campaign the workshop gave special focus to female genital mutilation (FGM) as a form of gender persecution. Professionals involved in asylum decision-making (asylum officers, social welfare officers, lawyers, police officers, reviewing authority for refugee officers, NGO officers) were given the opportunity to discuss current challenges in the area of women and refugee status determination, as well as to share best practices and lessons learned.

Finally, Nikta Akasereh’s study/survey, ‘Hope for Children’, published by HFC under the title ‘Voice of unaccompanied minor asylum seekers on guardianship: a study on guardians of unaccompanied minor asylum seekers in Cyprus’, presents another tool for the protection of unaccompanied children in Cyprus, including child-victims of FGM. This study does not deal with FGM directly but it is relevant as it stresses out the importance of the state obligation to protect unaccompanied minors including child-victims of FGM.

6.3. Reflection on tools and instruments on female genital mutilation

Tools have only recently been developed and they are limited in numbers. The only academic study found does not focus on FGM specifically. Nevertheless, through the research work of civil society organisations and the End FGM campaign in Cyprus the development of coherent tools and instruments for FGM is expected.

7. FINAL CONSIDERATIONS

As far as prevalence is concerned, it is important to note that Cyprus only begun research and data collection on FGM in 2010. Therefore, there are currently no representative or reliable data on FGM.

There has been general action planning on domestic violence, equality between the genders and promotion of human rights. Nevertheless, FGM has not yet been recorded as a major problem in the country.

Regarding the policy framework on FGM in Cyprus, although the national action plan does not deal specifically with the issue of FGM, it sets out, in principle, a number of very important actions and measures to deal with FGM and other forms of violence against women. Briefly, some of these measures include informative public campaigns, campaigns providing incentives for women to report the crimes, educational actions about the existing legal framework to protect women against violence and FGM, as well as educating police personnel, health practitioners, judges, lawyers and other professionals.

One important recommendation is that FGM should be dealt with special care, as it is a particularly grotesque manifestation of violence against women, through a consistent and comprehensive policy framework specifically addressed to FGM.

Concerning the legal framework, legal provisions exist to deal with FGM in Cyprus. It is however important to point out that Article 233A remains an unused criminal provision. It is commonly accepted that FGM is not known to take place in Cyprus. There might nonetheless be victims of FGM living in Cyprus and the law should focus
on their protection rather than on the criminalisation of the perpetrators of an act that does not commonly take place in Cyprus.

As aforementioned, there are no specific law provisions protecting minors from FGM in Cyprus, therefore, if the need to protect child-victims of FGM emerges, the Cypriot parliament should legislate specifically for their protection.

As far as asylum cases are concerned, the practice of FGM could itself constitute persecution. It is important to note that Cyprus Asylum Service personnel should be educated about FGM being the first to deal with asylum seekers and decide on whether to grant or to deny them refugee status.

As for the actors, it should be noted that civil society organisations and other actors have started to play an important role in the publication of information on FGM and the elaboration of some presently incoherent strategies.

Strategies, tools and instruments are expected to start to emerge and multiply in numbers as soon as the government starts taking an active role in the development of an FGM-specific and coherent policy. Currently, not much is being done or said; hence the major lack of tools and instruments concerning FGM in Cyprus.
Country report

Czech Republic
Country report: Czech Republic

1. IDENTIFICATION

Country: Czech Republic
Researcher: Maxime Forest

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

First we attempted to find prevalence studies through academic database search, following the ‘Guidelines for national data collection’. The following databases were searched for prevalence studies in the Czech Republic (CZ): Social Science Research Network, Sociological Abstracts (1), PubMed and Google Scholar. Key terms included, in Czech: ženská obřízka, mutilace, sexuální mražení žen a dívek. No valid entry could be retrieved through this research, as most research institutions in the Czech Republic, especially in the fields of social sciences and humanities, do not have full access to these tools and since databases include a limited number of references in the Czech language. We were also limited in our access to these databases, as our French institutions of affiliation (Sciences Po Paris and the University of Nice) don’t have full access to all the databases listed in the ‘Guidelines for national data collection’, usually privileging national databases on international networks.

Additionally, we carried out a keywords search (using the same entries in Czech mentioned above), through the following national websites:

http://www.migraceonline.cz
Website of the Multicultural Centre for Critical Discussion of Migrations in the Czech Republic and Central and Eastern European Countries, located in Prague, providing general information on migratory flows in the Czech Republic, sociological, anthropological and statistical studies references, a monitoring of domestic legislation on migration and asylum, etc.

http://www.domavCR.cz
Web page of the Prague’s office of the International Organisation of Migration (IOM).

Web page of the Ministry of the Interior of the Czech Republic dedicated to information on asylum, assistance to refugees, and cooperation within the Dublin system and Schengen.

http://www.cizinci.cz
Web page jointly updated by the Ministries of Interior, of Employment and of Social Affairs, providing basic information on migration and assimilation process in the Czech Republic.

Web page of the Ministry of the Interior, providing statistics on criminality, as well as migration flows and international protection.

This additional research matched no valid result as regards FGM.

In order to complete our desk research on prevalence studies in the Czech Republic, several actors were contacted through e-mail and by phone, including the following:

- A respondent from Charles University Prague, Faculty of Humanities, with whom we already had long-term professional contacts. This respondent confirmed that, as far as she knows, there are no prevalence data nor study on FGM currently available in the Czech Republic, as indicated in: Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010, Czech national report.

- A second respondent from Charles University Prague, Faculty of Humanities. She is carrying out the first PhD thesis on FGM in the Czech Republic. Within the framework of her survey, this respondent contacted a number of Czech NGOs and institutions potentially aware of FGM cases and prevalence data. She has confirmed that none of the contacted organisations had any record of such cases (2).

(1) None of my affiliation institutions has access to the Web of Science database.

(2) Apart from the actors we contacted for the purpose of this study, institutions contacted by Lucie Poláčková, included the Consortium of Organisations Assisting Migrants in the Czech Republic (Konsorcium nevládních organizací pracujúcich s migranty v ČR, http://www.konsorcium-nno.cz) and the Society of Citizens Assisting Migrants (Sdružení občanů zabývajících se emigrant (http://www.soze.cz), Libor Studený).
• The Head of the Gender Studies Department at the Institute of Sociology of the Czech Academy of Science, who indicated that no study on FGM had been carried out, so far, in the Czech Republic.
• A respondent from the Institute of Sociology, Department of Gender Studies. She has been a national post-doctorate researcher for the Femcit project (Gendered Citizenship in Multicultural Europe, FP6th, http://www.femcit.org), investigating the issue of bodily integrity (abortion, trafficking and prostitution) in the Czech Republic since 1945. She also confirmed that she had no information that such prevalence study existed for this country.

In the absence of valid outputs, we expanded the scope of our research to statistical figures on migration and international protection provided by the Czech Statistical Office (http://www.czso.cz) and by the annual reports on migration and international protection submitted within the framework of the European Migration Network (http://emn.intrasoft-intl.com/html/index.html).

2.2. Nature of prevalence studies/FGM registration systems

No prevalence study was found and the national experts who were contacted confirmed that, to date, no study on FGM had been carried out in the Czech Republic, emphasising that to their knowledge, no case of FGM had been reported so far in this country.

In the absence of prevalence study, we decided to collect demographical data on the foreign population living in the Czech Republic, in order to make a rough estimate of the population groups potentially at risk, due to their country or ethnic group of origin. The result of this additional research is reported in Section 2.3.

2.3. Findings from the prevalence studies/registration systems

Indications about the migratory context of the Czech Republic:

Data collected by the Czech Statistical Office within the framework of the national census and periodical updates (latest update: November 2011) are relatively comprehensive and exhaustive as regards the structure of the population of the country, with largely sex and age disaggregated data collected on a wide variety of issues/topics. Data collection is regulated by a domestic act on national statistics services passed in 1995, and the EU framework on data collection.

In November 2011, the legal alien population living in the Czech Republic — excluding asylum seekers and persons placed under temporary protection — was 406 211, for a population of 10 548 527 in September 2011, which only accounts for 3.85 % of the whole population living in the country (6).

In 2008 (last available update), 2 110 people enjoyed international protection (asylum or subsidiary protection) in the Czech Republic (7). For information, in 2010, 210 new international protection statuses were granted (8).

In 2011, no country where FGM is currently performed was listed among the top 25 nationalities living in the Czech Republic. The 10 most represented nationalities were the following (9):
• Ukraine (106 040)
• Slovakia (80 967)
• Vietnam (55 585)
• Russia (27 321)
• Poland (19 048)
• Germany (15 702)
• Bulgaria (7 387)
• Moldova (6 732)
• United States (6 385)
• China (5 040).

In 2010, 833 people applied for international protection in the Czech Republic. This represented an annual decline of 33.8 % as compared to 2009 (1 258). The most represented nationalities among applicants for international protection were the following: Ukraine (115), Mongolia (96), Belarus (56), Russia (51) and stateless (50). By comparison with previous years, nationals of Myanmar were in the top 10 of the most represented nationalities (42 people), due to their involvement in resettlement programmes (10).

As regards citizens from countries presenting significant to high FGM prevalence rates, in 2009 the most represented among asylum applicants originated from: Nigeria (41), the Democratic Republic of the Congo (18) and Guinea (9). The total number of applicants from Africa was 105 (8 %). Besides, out of 75 asylum status granted in first instance jurisdictions, in 2009, only five were granted to African applicants (all men, for political, religious and humanitarian reasons) (10).

2.4. Reflection on prevalence studies

The absence of prevalence data on FGM in the Czech Republic is enlightened by the statistics on alien populations living in the country: less than 4 % of people residing in the Czech Republic are foreign citizens, or were born as such. Moreover, most of this population is of European or western origins (Russia included).

The basic features of immigration in the Czech Republic are strongly anchored in the recent history of this country. As part of the Soviet sphere of influence between 1948 and 1989, Czechoslovakia admitted a very limited number of migrants. By the late 1980s, with the exception of the


Soviet occupation forces, the most numerous foreign communities came from Vietnam, within the framework of a bilateral cooperation agreement, and from other socialist countries, including Cuba, Angola and the Arab socialist countries. In this case, most of the residents came to study and did not stay beyond the completion of their curricula.

After 1989, Czechoslovakia and later the Czech Republic featured at quite a marginal place on the European map of migrations, mainly as a transit country for illegal migrants from the Middle East, Central and Eastern Asia. While quite a significant number of new residents came from the west (USA and Europe) as part of the economic development of the country, the major concern with respect to migration flows was the growing presence of criminal organisations involved in human trafficking and prostitution (mainly from the Balkans). Nevertheless, during the wars in former Yugoslavia, the Czech Republic took part in providing relief to displaced populations from Bosnia and Kosovo.

Since joining the European Union (2004) and the Schengen Area (2007), the Czech Republic has seen its foreign population change (Darley, 2010, 2008). Along with the still strong presence of Ukrainians and Slovaks, who are part of a work migration (dominantly male and partly seasonal), there is a growing presence of Vietnamese (who have long established relatives in the country). Some exceptions have been made to the restrictive implementation of legal provisions on international protection for the benefit of citizens from countries under dictatorships, such as Cuba, Myanmar and Syria to a lesser extent.

Given the structure of its population, which is strongly homogenous and includes few people from countries where FGM is performed, it is understandable that the Czech Republic has not carried out any study on this topic.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

As for prevalence studies, we initially attempted to retrieve policy documents on FGM using an academic database search, following the ‘Guidelines for national data collection’. The following databases were searched for policies carried out in the Czech Republic (CZ) on FGM: Social Science Research Network, Sociological Abstracts, and Google Scholar (Pub med was not included as it was considered irrelevant for this topic). Key terms included, in Czech: ženská obrázka, mutilace, sexuální mrzačení žen a dívek. This research yielded no valid entry.

Additionally, we carried out a keywords search, using the same entries in Czech mentioned above, and broadening the scope of the research to related policies, such as children’s protection, and domestic violence (in Czech: Domácí násilí, péče o ohrožené děti, prevence násilí na dětech, prevence domácího násilí). This additional research was carried out through the following national websites: http://www.migraceonline.cz

Website of the Multicultural Centre for Critical Discussion of Migrations in the Czech Republic and Central and Eastern European Countries, located in Prague, providing general information on migratory flows in the Czech Republic, sociological, anthropological and statistical studies references, a monitoring of domestic legislation on migration and asylum, etc.

http://www.psp.cz

Website of the lower house of the Czech parliament, including a database containing the minutes of all the legislative debates since WWII and of all the bills passed before the Chamber, including under their preliminary versions.

http://www.mpsv.cz

Web page of the Ministry of Employment and Social Affairs, which historically has been responsible for gender equality policies and for the coordination of children’s protection policies.

http://www.mvcr.cz

Web page of the Ministry of the Interior, in charge of the police, including the alien police and the border police who take charge of migrants and asylum seekers. This web page also provides valuable data on criminality and the state of the general criminal law.

http://www.vlada.cz

Web page of the office of the Czech government, answering for interministry coordination and policy action plans carried out on a variety of issues. The major gender equality machinery established in the Czech Republic, the Equal Opportunities Committee, which includes since 2008 a subcommittee on domestic violence, is placed under the supervision of the Office of the Government.

In order to make our research as exhaustive as possible, numerous other websites were consulted, notably on the indications of contacted national experts, through which enlightening comments on existing legal provisions could be retrieved. In total, four documents were included in the POL sheet of the database, consisting in a national strategy on violence against children, and three action plans implemented in 2009–14.

3.2. Policies on FGM

To date, no specific policy has been adopted, in the Czech Republic, to address the issue of FGM, and no mention of FGM or any kind of sexual mutilation was made in any of the policy documents we could retrieve.

This is consistent with the absence of prevalence data and with the general structure of the Czech population in terms of origins.

However, we opted to include in the POL sheet of our database, four policy documents that provide a general framework in which specific prevention or monitoring actions on FGM could be implemented in the future, in case they would be put on the agenda.
These four policy documents have been adopted recently, since 2008, and account for the growing relevance of two policy issues: domestic violence and children's protection.

Domestic violence has received increasing public attention since 2004. It is understood not only as violence against women perpetrated by their partners or ex-partners, but contemplates different situations of risk, including violence against descendants or adopted children, and other physical assault and, to a lesser extent, psychological abuses between family or household members. Therefore, the parliament, who legislated on this issue in 2004 and 2006, and the government, who adopted two action plans in 2006 and 2010, do not implement an approach in terms of gender, in which violence against women would be analysed in a structural way and be strongly linked to gender inequalities. However, as result of this gender blindness, the comprehensive approach that was adopted includes protection measures for children in case of intra-family violence or suspected abuses. This concept is notably at stake in the national action plan against domestic violence for the years 2010–14. This plan aims at improving and systematising the implementation of existing provisions in the area of domestic violence, which, in the Czech Republic not only covers violence against women, but also violence against children at home — either as witnesses of violence against women or as victims. Adopted as part of the national strategy on domestic violence, this document pays specific attention to children, including as potential victims. It encourages the legislator to more specifically address violence against children in the legislation and to improve data collection as well as assistance services and the training of professionals.

Children's protection also caught the attention of policymakers, especially in response to sexual abuses, paedopornography and the consequences of social exclusion for vulnerable families. As a result, the legislation on children's protection was modified in 1999 and the National Strategy to Prevent Violence against Children in the Czech Republic (2008–18), was adopted. Issued by the office of the Czech government, it develops a transversal (mainstream) strategy to eradicate violence against children, including annual action plans, a permanent committee, and listing a series of priorities addressing data collection, procedures, and awareness raising. Although it does not refer to FGM, this document provides a broad definition of violence against children in the domestic space and of abuses against children. Two action plans were adopted: the national action plan for the Implementation of the National Strategy to Prevent Violence against Children in the Czech Republic (2009–10) details measures to be taken to implement the national strategy; and the National Action Plan for the Transformation and Unification of the Public System of Care for Endangered Children (2009–11) aims at coordinating and improving the work of the various institutional actors intervening in the reporting, monitoring and treatment of situations in which children are endangered within their family or school environment. It recommends the introduction of guidelines and protocols for different categories of educational, healthcare and social workers working with children, to identify and report abuses or situations of risk. This document applies a relatively broad definition of ‘endangered children’ that would enable social services and other public services to adequately monitor situations of risk, including FGM, which are not mentioned in this document.

3.3. Reflection on policies on female genital mutilation

Although there is no policy designed to tackle FGM in the Czech Republic, a few elements of analysis deserve to be mentioned.

In the Czech Republic, most of the policies adopted and machineries put in place in the field of gender equality resulted from policy transfers (Marsh, Dolowitz, 1996) that find their origins at the supra-national level (the UN and the EU in the first place). As shown in Forest (2006a, 2006b), between 1995 and 2011, several institutions have been created and new legal acts have been adopted to tackle gender inequalities and other discriminations, notably as a result of the ‘Europeanisation’ of Czech policies. These policy transfers, however, have paid little attention to gender-based violence. In the meantime, along with parity in politics and equal pay, ‘domestic violence’ nevertheless emerged as a policy issue in the country. Unlike for general gender equality policies, this topic has triggered policy developments that are specific to the Czech context. As a consequence, legislation and policies adopted in this field have implemented an extensive definition of domestic violence, including violence and abuses perpetrated at home against children, in a variety of configurations. These policy developments include the implementation of protection measures which apply both to women as victims, and children as victims or witnesses. This framing of the issue of domestic violence provides an inclusive framework through which other kinds of abuses or violence could be addressed.

As regards children’s protection, the origin of policy trends in the Czech Republic is mostly to be found in two factors:

- the political willingness to reform a system inherited from the socialist era, in which vulnerable families and endangered children had little to say whereas state authorities had the final word;
- the emergence of issues that had long remained disregarded under state socialism and/or during post-socialist transformation, such as trafficking, prostitution or paedophilia.

To address these challenges, the Czech authorities have developed a transversal approach which aims at a better coordination of the social, healthcare, police and justice sectors in preventing, monitoring and adequately addressing situations of risk for children.

It should be emphasised that the new system of children’s protection which is being implemented in the Czech Republic covers migrants and asylum seekers.
4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The main sources of information on legislation we used are the website of the Official Journal of the Czech Republic (http://aplikace.mvcr.cz/sbirka-zakonu), and the website of the lower house of the Czech parliament, including a database containing the minutes of all the legislative debates since WWII and of all the bills passed before the chamber, including in their preliminary versions (http://www.psp.cz).

We focused the desk research on the policy developments mentioned in the previous section, which we had already identified in our own research on policy transfers in the Czech Republic (Forest, 2006a, 2006b).

As regards professional secrecy, which has been legislated very recently and which is regulated mostly by corporatist bodies, we also referred to the website of the Czech Ministry of Health (https://www.mzcr.cz), and to one of the main Czech healthcare professions’ governing body (Ceská lekařka Komora: http://www.likr.cz) that contains updated information on the ethical code.

As for the legal provisions on asylum, our research was completed by direct contact, through e-mail, with Mathilde Darley, PhD, researcher at the Centre National de la Recherche Scientifique (CNRS), who carried out field researches on asylum seekers in the Czech Republic (Darley, 2010, 2008).

As regards professional secrecy provisions, as this issue was recently subject to changes in the legislation, we asked (by phone) for confirmation of the data found through the desk research, to several doctors exerting in Prague.

In total, our research was able to identify 15 relevant acts, codes and recommendations documenting the legal framework.

4.2. Criminal law

There is no specific provision in the Czech Republic, addressing FGM or any other type of mutilation. Similarly, we found no indication that any FGM case was reported to the police or to the justice, or brought before a Czech jurisdiction.

The Penal Code (Trestní zákony) adopted under the Stalinist era, in 1961, remained into force until 2010. It included three provisions under which sexual mutilations could have been prosecuted; paragraph 145 mentioned that acts causing ‘serious harm to bodily integrity’ were punished by sentences of three up to 10 years of imprisonment, and paragraph 146, indicated that (simple) ‘harm to bodily integrity’ could be punished by sentences of six months up to three years. No aggravated sentence was mentioned if those acts were perpetrated on under-age victims. Besides, the old Penal Code also stipulated in paragraph 215 that physical abuses against individuals placed under the offender’s responsibility or care (including descendants and legally adopted children) could be punished by sentences from six months up to three years.

In 2004, an amendment to the Penal Code was passed (Act No 91/2004) that creates a new criminal offence in the sense of paragraph 215a of the Penal Code: ‘physical abuses against individuals living with the offender’. This amendment primarily addressed violence against women but it also potentially applied to other physical abuses or ill-treatment among family or household’s members.

In 2006, Act No 135/2006 changed various provisions in the field of protection against domestic violence. Although primarily addressing violence against women perpetrated by their partners, it nonetheless creates a broader regime of juridical protection that can be extended to children suffering abuses.

The new Penal Code, adopted in 2010, lists among criminal acts that can be prosecuted in the Czech Republic, ‘inhuman and cruel treatments’, ‘discriminations against specific groups’ and ‘persecutions’, even if they were perpetrated in a foreign country by individuals who do not have Czech Citizenship, or by stateless people. Therefore, it introduces a relatively broad application of the principles of universality and extraterritoriality.

Moreover, the new Penal Code stipulates that acts causing ‘serious harm to bodily integrity’ are punished by sentences of three up to 10 years of imprisonment, and five up to 12 years when these acts are perpetrated against victims under 14. Under paragraph 146, (simple) ‘harm to bodily integrity’ can be punished by sentences of six months up to three years, or one year up to five years when these acts are perpetrated against victims under 14. Besides, paragraph 198, which addresses abuses to persons placed under one’s responsibility (i.e. their own children), mentions sentences up to eight years when these abuses caused a severe harm to health or bodily integrity.

4.3. Child protection laws/provisions

No child protection provisions specifically address FGM in the Czech Republic.

Nonetheless, it should be noted that, as already mentioned, children’s protection provisions have undergone substantial changes since 1999, when Act No 359/1999, on the social and legal protection of children, was passed. This act applies to families in which children are thought to be in danger. Children can be removed from their families and placed under the responsibility of another family (upon decision of the competent court and proposal of the local administration). This act is applicable to any child having its permanent residence in the Czech Republic, but also to asylum applicants and persons under temporary protection. This act also establishes the Public Agency for the International Legal Protection of Children (Úřad pro mezinárodně-právní ochranu dětí), based in Brno, which aims to collect data and monitor protection measures, including for under-age asylum applicants, or illegal migrants.
In 2006, Act No 135/2006, meant to tackle domestic violence, introduced a measure of eviction of the offender for a minimum of 10 days, implemented by the police. But it also includes new general protection measures for people at risk of suffering violence from relatives or other people living with them. Those measures aim at ensuring psychological and medical support, provided by intervention centres, and access to a shelter for the victims of violence (paragraph 74a). They have been simplified by Act No 273/2008, on the police of the Czech Republic, which distinguishes between immediate protection measures implemented by the police, and those decided by jurisdictions.

4.4. Asylum law(s)/provisions

To date, we have found no record of any asylum application submitted on the grounds of an FGM threat (4). However, we also found that, although the data we could access on application for international protection strongly limit the perimeter of individuals at risks, they do not provide fully reliable data on this specific aspect (5).

After its separation from Slovakia, in 1993, Czech administrative courts applied a relatively restricted interpretation of the definition held in the Geneva Convention (Article 1, A2) as regards granting international protection. Yet, Act No 325/1999, on asylum, brought a clarification, introducing several regimes of protection (status of refugee, humanitarian protection, subsidiary protection). This act refers to a broad, domestic-specific, definition of the refugee status, according to which an applicant is entitled to be granted asylum when it is proved that ‘he was persecuted for his action in favour of civil rights and freedom (a) or that he fears, with reason, to be persecuted because of his race, sex, religion, nationality or ethnicity, belonging to a specific social group, or political opinion defended in the country from which he is a citizen or, in case he is a stateless person, in the country where he has permanent residence (b)’. This act also introduces subsidiary protection that can be granted for at least one year (renewable) to asylum applicants who do not meet the criteria fixed in the definition above. Any person is eligible to subsidiary protection ‘who fears, with reason, to be at risk of suffering serious prejudice if returned to his/her country of origin or, in case he/she is a stateless person, to his/her country of residence and who is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it’. The definition of prejudices includes inhuman or degrading treatments (Article 14a).

Act No 221/2003 on temporary protection addresses situations in which people collectively left their country or, in case they are stateless persons, their country of residence, to escape an immediate danger, a civil war or an armed conflict, and apply for asylum. They can be placed under temporary (provisional) protection. This act does not refer to any definition of groups or individuals entitled to international protection, but it creates a fourth — transitory — regime of international protection, under which potential applicants for asylum have restricted rights.

The case-law on international protection in the Czech Republic proves to be particularly restrictive. Besides, also as a result of the international cooperation developed within the Schengen Agreement and the Dublin Protocol, asylum seekers and migrants transiting via the Czech Republic are increasingly addressed through the categories of ‘detainment’ and border control (Darley, 2008), which place individuals in a semi-regime of detention that appears to be challenging for the potential development of prevention policies as regards FGM.

4.5. Professional secrecy provision(s)

The new Penal Code, which came into force in 2010, states that the non-denunciation of criminal offences, including ‘sexual abuses’, ‘inhuman or cruel treatments’ and ‘serious harm to bodily integrity’ can be punished by a sentence of up to three years of prison.

The Code of Ethics of the Czech Doctors’ Governing Body (Česká lekařka Komora, 2007) mentions that information sealed by medical secrecy can be disclosed upon a patient’s request or in case it is specified by the law or requested by Justice. In a recommendation issued by the same instance on the Bill on Health Services and their Functioning, it is also suggested to the legislator to extend the conditions for disclosing information to suspected cases of abuses and cruel treatments, especially to children.

Partly following this recommendation, Act No 372/2011, on healthcare services, creates numerous exceptions to professional secrecy to which are bound various categories of healthcare professionals, among which the duty to report criminal acts (paragraph 51). Nevertheless, most of these exceptions are designed for the juridical protection of practitioners.

4.6. Reflection on legal framework

As a country that has faced immigration from less developed country only very recently and with limited absolute figures, the Czech Republic largely ignores the problem of FGM and does not take into consideration situations that may occur, such as asylum applications on those grounds, or isolated cases among recent migrants.

Moreover, although issues related to gender have gained increasing relevance since the mid-1990s, this country does

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(4) This analysis has also been confirmed by Lucie Poláčková, one of the national experts we have contacted for the purpose of this study.

(5) As regards citizens from countries presenting significant to high FGM prevalence rates, in 2009 the most represented among asylum applicants originated from: Nigeria (41), the Democratic Republic of Congo (18) and Guinea (9). The total number of applicants from Africa was of 105 (8%). Besides, out of 75 asylum status granted in First Instance Jurisdictions in 2009, only five were granted to African applicants (all men, for political, religious and humanitarian reasons).
not implement a gender-sensitive policy agenda and the policy and legal frameworks adopted to tackle gender-based violence usually don’t focus on gender aspects, adopting a gender-blind, extensive definition of ‘domestic violence’.

At the same time, this trend could be an opportunity for the future development of preventive actions on FGM, as it provides an adequate policy framework in which protection measures for children can be implemented. This also relates to the current re-shaping of the children’s protection system, which sets up a comprehensive system of monitoring, reporting and protection that could provide an appropriate support for further policy developments.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

In order to be included in the database, an actor was defined as any organisation or individual actually performing activities related to FGM in the Czech Republic, as was specified in the ‘Guidelines for national data collection’.

Given that FGM is not an issue in the Czech Republic, we did not perform an academic database search. Instead, we mainly relied on personal contacts and the web links we could retrieve from browsing on the websites of relevant institutional actors.

The authors of publications incidentally dealing with FGM (press articles, book sections) who do not have a specific commitment on this issue were not included in the database.

5.2. Actors

In the absence of FGM cases in the country and due to the subsequent absence of policies or specific legal provisions, only three relevant actors were included in the database: two NGOs and an individual expert.

Asante Kenya is the most relevant actor on this issue. This foundation was created, in 2006, by Lejla Abassova, a Czech TV presenter and model of Sudanese origin, to carry out educational and development projects in Kenya. Asante launched a programme on FGM, in 2008, among the Masai communities of Narok, Kenya. Fund-raising in the Czech Republic was accompanied by awareness raising in the media, thanks to Lejla Abassova’s large audience. In 2011, Asante supported the documentary film ‘Latim, Obřezané’, reporting about FGM in Kenya, which drew the attention of Czech media on that issue.

As Asante Kenya did not answer our requests via e-mail and could not be reached by phone, data was only collected from browsing on the organisation’s website and the websites of other NGO or media partners. Among NGO partners, Femisphera gathers journalists and photographers aiming at documenting women’s living conditions in less-developed countries. In 2009, Femisphera carried out a project with Samburu women in northern Kenya, during which the documentary ‘Latim, Obřezané’, reporting on FGM in Kenya, was shot. The co-authors of this film, Lenka Klicperová and Olga Šilhová, are members of this NGO.

The individual expert is a gynaecologist who intervened in the media on the issue of FGM.

5.3. Reflection on actors on female genital mutilation

No specific trend is to be reported.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

An academic database search was performed, using the online thesaurus of the two major Universities of the Czech Republic: Charles University in Prague (http://ckis.cuni.cz) and Masaryk University in Brno (http://www.muni.cz/services/library/aleph). Key terms included, in Czech: ženská obřízka, mutilace, sexuální mrzačení žen a dívek.

Additionally, relevant tools and instruments were also identified through the web pages of the relevant actors.

6.2. Tools and instruments on FGM

We found no record of any specific mention of FGM before 2006. In 2006, a press conference was held on Human Rights Day, during which FGM was specifically mentioned by a gynaecologist and Lejla Abassova, a TV presenter of Sudanese origin, who helped drawing public attention on this issue and included FGM among the priorities of the foundation Asante Kenya she launched in the same year.

In 2007, a textbook for students on Cultural anthropology was published by Prof. J. Skupník, addressing the conflict of cultural norms that opposes western secularised cultures to the practice of FGM, grounded in specific cultural contexts and traditions. That same year, a fashion happening was organised in Prague by the foundation Asante Kenya, to draw attention on FGM in Kenya, against which Asante launched a programme in 2008.

In 2009, a project was carried out by Femisphera, in Kenya, during which a 52 minute long documentary relating FGM among Samburu tribes was shot. The film ‘Latim, Obřezané’ (The circumcised), had its premiere in September 2011. To date, this film is the first document designed for the larger public, which addresses the issue of FGM. Although it only considers this practice abroad, it contributes to drawing attention on the issue. It received relatively important media coverage, including interviews on public radio channels, premiers in Prague and in the province, notably within the framework of the celebrations on the International day against FGM in 2012.
6.3. Reflection on tools and instruments on female genital mutilation

To date, the major awareness-raising tool on FGM available in the Czech Republic, consists in the film ‘Latim — Obřezané’ directed by Femisphera members Lenka Klicperová and Olga Šilhová. However, this documentary adopts quite a normative and top-down, western-centred perspective and does not consider FGM as a potential issue for Europe but, instead, as a fundamentally alien practice, anchored in traditions.

7. FINAL CONSIDERATIONS

FGM remains largely unknown in the Czech Republic. Due to the relatively homogenous structure of its population, and given the countries of origin of its limited number of migrants and asylum seekers, this country clearly does not rank among those that stand in the frontline to deal with this issue. As such, FGM is not dealt with in the legislation and in public policies, and is not addressed by the major actors (both institutional and non-governmental) working with migrant populations.

Yet, over the recent years, FGM — as a persisting phenomenon abroad — has received some attention from the media, mostly due to the commitment of the popular TV presenter and model, Lejla Abassova, who helped drawing public attention to this issue. Her foundation, Asante Kenya, has thus become the (only) authorised source on FGM for the media and it has developed or given support to most of the awareness-raising tools dedicated to this issue so far.

Since 2010, the diffusion of a Czech documentary film ‘Latim — Obřezané’, directed by two relatively famous documentarians, has helped increasing public attention on FGM, without introducing it as a potential domestic issue.

References:


Country report: Denmark

1. IDENTIFICATION

Country: Denmark

Researcher: Lise Rolandsen Agustín

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

No prevalence studies were encountered for the Danish case. Searches were made in academic databases (Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Pubget, University library: aub.aau.dk, bibliotek.dk and Forskningsdatabasen.dk) as well as on the Internet in general (Google and Google scholar) with the key terms female genital mutilation (FGM), female genital surgery (FGS), female circumcision and the Danish terms kvindelig omskæring, omskæring af kvinder, omskæring + kvinde. This did not result in any prevalence information nor did the telephone and e-mail contacts made to experts and practitioners in the field.

A number of the policy texts included in the desk study mention that the extension of the problem is not known, that a national survey must be carried out in order to establish the extension of the problem and that the problem would, in theory, be most common among Somali immigrants. However, few cases are known in the municipalities with larger groups of Somali origin.

Faced with the lack of prevalence data, searches were made in the national statistics agency, Statistics Denmark, who collects official statistical materials in Denmark. The searches are free of charge (see Section 2.3 below).

As in the case of prevalence data, information on registration systems is scarce. It seems that no centralised registration system for cases of FGM exists in Denmark. This is confirmed by literature review carried out in relation to this study as well as information provided through policy texts (see below). According to a press consultant from the ministerial agency Danish Immigration, who was contacted by telephone, there is no national system for registration of FGM cases in Denmark. This information was confirmed by a press consultant from the national police.

2.2. Nature of prevalence studies/FGM registration systems

The only studies made on FGM in Denmark do not concern prevalence but focus either on ‘the consequences of circumcision for Somali women’s sexuality’ or legal implementation. The former is a cross-sectional study from 2004, carried out by health professionals Hanne Gylche, Héctor López and Ulla Virkkunen Jensen. Using questionnaires, it analysed the influence of circumcision on sexuality among 30 circumcised and non-circumcised women of African origin, showing that circumcision has some influence on sexuality. The latter study is a comparative desk study carried out by Els Leye, Jessika Deblonde, Sara Johnsdotter, Adwoa Kwateng-Kluitwe, Linda Well-Curiel and Marleen Temmerman in 2007. It is entitled ‘An analysis of the implementation of laws with regard to female genital mutilation in Europe’ and focuses on FGM legislation in 15 EU Member States. Results show that legal implementation is surrounded by difficulties. In other words, studies focus narrowly on a specific group or issue related to FGM or broadly on legal frameworks, but there are no studies concerning the prevalence of FGM in the Danish context.

As mentioned above, there is no national registration system for FGM cases in Denmark. The Danish Court Authority only registers court cases. Practitioners have the duty to inform the social services, who in turn decide whether or not to notify the police and/or the local health authorities, in cases of FGM or suspicion of FGM. However, neither the policies and literature reviewed in relation to this desk study, nor the experts or practitioners contacted, gave information of any registration measure in terms of FGM cases and prevalence data.

2.3. Findings from the prevalence studies/registration systems

The statistical data gathered from Statistics Denmark (2011) shows that 15,116 female immigrants and descendants with origin where FGM is performed are living in Denmark (10,025 immigrants, 5,091 descendants). The largest group (8,220 women in total) comes from Somalia. The data gives no information on the exact number of circumcised women living in Denmark, the length of stay in the country, or the date of birth of daughters (descendants).

Furthermore the data shows that 5,873 girls between 0 and 18 years old, at risk of FGM (with origin in countries where
FGM is performed) are living in Denmark. Again the largest group comes from Somalia (4 128). The data available shows no information on the length of stay nor the date and place of birth.

In the third quarter of 2011, there were 59 asylum-seeking women in Denmark with origin in countries where FGM is performed; 17 from Somalia, 12 from Nigeria. The data available gives no information on the age of the asylum-seeking women, the length of their stay in Denmark, the number of daughters (descendants) or the date of birth of daughters (descendants).

Since there is no national registration system, we rely on information about specific cases provided by practitioners and experts. After making an inquiry to colleagues at the department, the press consultant from Danish Immigration reports only remembering one case of asylum seeking on the grounds of FGM (persecution, see below) and concludes that there have been very few cases within the last 5 to 10 years.

Furthermore, national police informs us that they have knowledge of only a few cases of FGM. According to the Danish Court Authority only one case of FGM has been filed and taken to court in Denmark (see below).

Some of the policy texts and tools and instruments mention that clitoridotomy (or Sunna circumcision) is the form of FGM which is considered to be used in Denmark.

2.4. Reflection on prevalence studies

FGM is considered a minor problem in Denmark and there seems to be a lack of (continued) political will to act (see below). In general the problem is considered to be limited to the relatively small group of Somali immigrants and their descendants and efforts are primarily made to inform this group about the consequences of FGM. Consequently little attention and resources are directed towards prevalence studies and registration systems.

It is significant that no prevalence studies are carried out in the Danish context and that no national registration system exists. There seems to be little demand among stakeholders for such measures; the focus of demands is rather on information for target groups/groups at risk and health professionals. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk and health professionals. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk and health professionals. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk and health professionals. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk and health professionals. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk and health professionals. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk and health professionals. There is no aim articulated as regards registering cases but rather the focus is placed on information for target groups/groups at risk and health professionals.

One hindrance for centralised registration of FGM cases could be sensibility vis-à-vis the victims and their privacy. Several policy texts discuss the matter of the practitioners’ duty of secrecy and notification obligation as well as the potential tension between them. Passing on information regarding FGM cases to a number of different authorities is not considered to be unproblematic.

In conclusion there is a general lack of knowledge on the extension of the problem of FGM in the Danish context and very basic measures are needed in order to start getting an overview. Even though the general statistics are considered to be reliable, there are no comprehensive or representative studies or data on the prevalence of FGM in Denmark.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

The policy texts included in this study were found through a number of web-based searches. Most importantly in these searches were: http://retsinformation.dk (official database covering all legal texts), http://ft.dk (the web page of the Danish national parliament covering parliamentary debates and other policy texts) and http://statensnet.dk (the web library of the state containing publications from ministerial bodies and authorities). Furthermore regular Internet searches were carried out, with a special attention to ministerial websites (e.g. relevant information was found on the website of the National Board of Health, Denmark and the Ministry of Education).

Through these searches all relevant documents on FGM in Denmark were encountered. This was then double-checked with experts and practitioners to make sure that we had an exhaustive list of policy documents. Overall, this was confirmed by the information provided by a midwife and member of the Danish Association against FGM, who is considered one of the main experts on FGM in Denmark. She provided a thorough description of developments in the field and in this way verified the account presented here.

Ten policy texts are included in the Danish case study. These include texts from national authorities (parliament, ministries, and public authorities) and are primarily bills, national action plans and parliamentary questions and answers regarding FGM.

3.2. Policies on FGM

In Denmark we see two parallel developments. One is parliamentary debates and presentations of bills related to a legal perspective and potential prohibition of FGM. This trend is led by political parties and government actors. However, what triggers actions taken at the parliamentary level is often public debate and media attention to the issue. Another trend is the continuous development of national guidelines or action plans, carried out by different ministries and civil society actors. The latest and most updated national action plan has been completed on the basis of voluntary efforts. It contains a specific action plan regarding FGM and a timetable for carrying out the plan. The Minister for Health refers to the action plan and the plan is made official on the National Board of Health website, but no government agency participates in the execution of the plan.

Looking at the policy history, the issue of FGM was introduced on the political agenda in Denmark in the 1990s, in parallel with the immigration of Somali groups. The National Board of Health was the first ministerial
body to initiate action in the field. At first the Board made official announcements in the Journal of the Danish Medical Association (the main scientific journal within the health sector). Already in 1981 the Board wrote about FGM due to a question by an MEP regarding the performance of FGM in Danish hospitals. Referring to debates at the recent UN World Conference on Women celebrated in Copenhagen in 1980, the Board argues that circumcision is to be considered a mutilating operation and therefore it recommends for doctors not to perform such interventions.

In the beginning of the 1990s the issue of FGM was addressed in the national media due to the influx of Somali immigrants and in 1992 the National Board of Health was again asked to consider this practice. The Board issued an announcement, stating that FGM would be covered by the Penal Code, Section 245, 2, as ‘adding injury to body or health of another person’. Consent was not considered to influence the illegality of the practice. These interpretations were supported by the Ministry of Justice.

Also in 1992, the Danish Association of Female Doctors, which was one of the first organisations to act in the area, issued a proposal to the Minister for Health concerning a specific legal act on FGM. No bill was, however, presented in parliament at that time.

Policy action was not taken until 1996 when the oppositional Conservative Party as well as the right wing Progress Party and the Danish People’s Party presented a bill on prohibition of FGM. The bill was unsuccessful as a parliament majority opted for a targeted preventive effort centred on information and education rather than on a legal prohibition. At the time, the government was led by the Social Democrats. A subsequent review by the Ministry of Justice, in 1998, stated that the effects of the comprehensive awareness-raising activities undertaken by the Ministry of Health should first be assessed before potentially looking into any legal changes, especially concerning the principle of extraterritoriality.

Thus, from 1996 to 2000 the Ministry of Health, the National Board on Health in particular, engaged in a project which included an awareness-raising campaign. A working group was formed with representatives both from the ministries and the civil society. In relation to this the first national guidelines on FGM prevention were issued in 1999 by the National Board of Health. The guidelines targeted teachers and healthcare professionals, and they contained information about FGM, legislation and health professionals in the field. A film was also produced and local groups established.

Two years later, in 2001, an interministerial working group on violence against women and human trafficking issued a proposal for a national action plan within this broader field. The action plan briefly discusses FGM and emphasises that it is considered a minor problem in Denmark.

In 2002, a strong media debate ensued regarding the practice of FGM on Somali girls and women residing in Denmark and especially the ways in which Somali imams encouraged the performing of FGM in their local communities. A key point in this debate was the role of society at large and the position of professionals in particular. Following this debate, a national status report was issued by a governmental interdepartmental working group on FGM. It identifies obligations and options for professionals faced with FGM cases as well as the applicable legislation in the field and the need for new approaches.

Also in 2002, another bill proposal regarding FGM prohibition was presented in parliament. This time the authors included only parliamentarians from the Danish People’s Party. A new coalition government had been in place since 2001, formed by the Liberal Party and the Conservative Party, but with the Danish People’s Party as parliamentary support. The bill proposal, which included a prohibition of FGM and the application of the principle of extraterritoriality, was rejected in parliament once again.

After the attempts mentioned above, a bill on FGM was finally passed in May 2003. The proposal to amend the Penal Code and the Danish Aliens Act in order to include a prohibition of FGM was set forward by former Minister for Justice, Lene Espersen from the Conservative Party. The bill also made applicable the principle of extraterritoriality.

Also in 2003, another set of national guidelines were issued, this time by the Ministry of Children and Education. The purpose of the guidelines was similar to the previous ones, i.e. to inform health professionals, social workers and teachers on what to do when faced with cases of FGM or the risk of FGM. The guidelines were entitled ‘We all have a responsibility’.

In the second half of the 2000s the issue of FGM was again raised in the political debate in Denmark, through parliamentary questions and answers. In 2006, the parliamentary Committee on Health questioned the Minister for Interior Affairs and Health regarding legislation on circumcision. The question sprung from an article in the Danish tabloid newspaper, Ekstrabladet, which concerns a supposedly increasing trend among young Danish girls wanting to be circumcised for cosmetic reasons. Consequently the Committee on Health asked the minister whether legal changes were needed to prohibit young girls under the age of 18 to get circumcised for cosmetic reasons. The minister’s response is that the law already covers such cases in that it is a general law covering all cases of circumcision except if these are conducted for medical reasons.

Again, in 2009, a parliamentary question regarding FGM is posed to the responsible minister. This time it is the Political and Economic Committee of the Danish national parliament which, by request of an MP from the Danish People’s Party, addresses the Minister for Equality. The minister is asked to ensure that a national action plan on FGM is carried out in Denmark. In his response the minister refers to already existing legislation and possible measures. The general argument of the response is that FGM is considered to be a minor problem, according to the National Board of Health, and that no further action is necessary in the area, except for a national action plan carried out by a volunteer steering committee which was under way at the time.
The national action plan referred to by the minister was, in effect, published in 2009. It was elaborated by a volunteer steering committee consisting of a number of women’s organisations dealing with FGM. The action plan summarises national legal measures in the field. It also states that there is a low level of knowledge regarding FGM and that the law is not applied in practice. Therefore a national action plan is needed. The plan sets out strategies, target groups, responsible actors and a time schedule for the efforts to combat FGM in Denmark. It was discussed with the Minister for Health and presented in the parliamentary Committee on Health. However, no progress has subsequently been made; the Ministry of Health and the National Board of Health refer to the national action plan but no resources have been attributed in order to implement it.

3.3. Reflection on policies on female genital mutilation

The issue of FGM entered the political agenda in the 1990s and has been implicitly or explicitly related to Somali immigrants. Political action has, to a large extent, followed public debate and media coverage of specific issues. Pressure has been put on successive governments to prohibit FGM, especially by the Danish People’s Party who has seen the issue of FGM as an extension of their agenda focusing on strict immigration policies combined with the (instrumental) defence of gender equality and women’s rights.

The National Board of Health has played a prominent role in terms of the development of policy documents (national guidelines and action plans) but the Ministry of Justice and the Ministry of Children and Education have also been involved in the development of the policy field. Action has also been taken through interministerial activities, i.e. working groups have been established to work with the issue of FGM across ministerial areas. The latest development in terms of policy measures reflects the civil society action and pressure, as well as the political pressure and has been implicitly or explicitly related to Somali organisations dealing with FGM. The action plan summarises national legal measures in the field. It also states that there is a low level of knowledge regarding FGM and that the law is not applied in practice. Therefore a national action plan is needed. The plan sets out strategies, target groups, responsible actors and a time schedule for the efforts to combat FGM in Denmark. It was discussed with the Minister for Health and presented in the parliamentary Committee on Health. However, no progress has subsequently been made; the Ministry of Health and the National Board of Health refer to the national action plan but no resources have been attributed in order to implement it.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

For this section the online official database of legislation, http://retsinformation.dk, was used to compile information. For the section on asylum laws and provisions, in particular, the website http://borger.dk was also used, and the ministerial agency Danish Immigration was contacted. The latter resulted in useful information provided by their press consultant. Furthermore, a press consultant from the national police was contacted regarding information on systems for registration of FGM cases, reported or suspected cases registered with the police or other judicial authorities and number of FGM-related interventions.

4.2. Criminal law

In Denmark a specific criminal law concerning FGM, namely Section 245a of the Penal Code, applies. It has been in force since 2003. The law is applicable to any procedure that involves removing parts of the female external sex organs (clitoridectomy, excision, infibulations) whether or not this happens voluntarily or by force. Penalty is prison up to six years. ‘Attempt to’ and ‘participation in’ are covered by the general provisions of the Danish Criminal Code whereas ‘performance’ is inscribed in a specific law. The principle of extraterritoriality is also covered by the Penal Code (Section 7a, 3) if the offender is a Danish national or resident, and it is a case of double criminalisation or the victim is a Danish national or resident.

According to the law on doctors (Section 18), they are not allowed to perform circumcision.

One case has been taken to court, in 2008, two immigrant parents from Eritrea, holding Danish citizenship (the father is a political refugee who has lived in Denmark since 1991), were accused of having clitoridotomy performed on their four and six years old daughters during a trip to Sudan, in 2003, and were suspected of planning a similar procedure on their younger daughter. The girls were removed from their home by local social services. The case caught the attention of local social services when one of the daughters told a pedagogue about her plan. The pedagogue then notified the local authorities, and the police took the children into temporary custody with the social services when one of the daughters told a pedagogue that she was told to have them treated for worms. The police then notified the local authorities, and the police took the children into temporary custody with the social services when one of the daughters told a pedagogue that she was told to have them treated for worms. Eventually, in 2009, the court ruled and declared the father guilty whereas the mother was convicted with a two year sentence (of which six months were served) for having arranged the intervention. None of the parents were found guilty in planning for the third daughter to be circumcised. The mother had been imprisoned during the trial and was therefore released upon the final ruling.

4.3. Child protection laws/provisions

The Law on Social Services, Section 58, establishes the possibility of suspending parental authority and placement of the child outside the home without parental consent in
cases of FGM. Only once has this provision been used in practice, in relation to the court case described above (see Section 4.2).

Denmark has also ratified the UN Convention on the Rights of the Child (in 1991).

There is no centralised registration system for child protection interventions in relation to FGM.

The dilemma of placing a child outside her home once FGM has already been performed and how traumatic that experience would be, the disruptions it would cause on family relations, etc. are discussed in the literature.

4.4. Asylum law(s)/provisions

The Danish Aliens Act, Section 7, 2, stipulates the possibility of granting asylum if there is a reasonable risk of inhuman and degrading treatment (i.e. future persecution). The decision is made on the basis of an individual assessment for each application.

The law defines refugees as either ‘convention refugees’, ‘quota refugees’ or ‘refugees with protection status’. The latter is applicable in FGM cases. ‘Refugees with protection status’ are those who do not meet the requirements of the UN Refugee Convention but still need protection (by being at risk of death penalty, torture or degrading and inhuman treatment in their homeland, including risk of FGM).

According to a press consultant at the ministerial agency Danish Immigration, there are few FGM cases in relation to asylum: according to his inquiries, no asylum has been granted on the grounds of FGM and only once has asylum been requested on those grounds. This occurred in the case of a woman from Uganda who was detained by Danish police in 2008 and subsequently applied for asylum on the grounds of risk of forced FGM upon return to her country of origin. She argued that her father wanted to have her circumcised. However the woman had not been in contact with her father for years and furthermore she had stayed four months in Denmark before applying for asylum on the grounds of FGM risk. Therefore both The Danish Immigration Service and the Refugee Appeals Board denied asylum.

The press consultant from Danish Immigration also informs that women from countries where FGM is not prohibited will be less likely to be granted asylum because the practice is often performed on children and therefore women are either already circumcised or in no risk of being circumcised.

There is no national system for the registration of FGM cases in relation to asylum procedures.

4.5. Professional secrecy provision(s)

The Law on Social Services, Sections 153 and 154 (in force since 2007), states that any person with knowledge of plans to have children or young people circumcised have a duty to inform the social services. This applies both if the person becomes aware of, or has reasons to believe that such plans are being made. Enhanced obligation to notify authorities applies to persons who conduct public service or professions (health professionals, social workers, teachers, etc.) and have knowledge of facts which constitute evidence or reason to believe that a child or young person has been exposed to FGM or is likely to be exposed. There are no disciplinary sanctions in case of non-reporting.

There is no national system for registration of reports of (suspected) FGM cases.

4.6. Reflection on legal framework

Several attempts were made to make a specific criminal law on FGM during the mid 1990s and the beginning of the 2000s. A law was finally adopted in 2003, prohibiting FGM. The legal framework is nevertheless divided in the sense that general law applies to attempts to and participation in FGM whereas the part which was specified with an explicit law on FGM concerns direct performance of FGM. Furthermore when adopting the specific law, the principle of extraterritoriality was important as it was not covered by the general law. The legal change is to some extent related to the colour of the government. Whereas the Social-Democrat-led government of the 1990s opted for a preventive approach, the Liberal-Conservative government of the 2000s favoured an explicit focus on judicial protection.

The Law on Social Services makes it possible to remove a child from her home in FGM cases. This was applied in the one court case carried out in Denmark to date. The Danish Aliens Act includes the possibility of granting asylum on the grounds of FGM risk. Only once has this possibility been used (according to the ministerial agency Danish Immigration). The Law on Social Services also establishes the duty of non-professionals and the enhanced duty of professionals to inform of cases or suspicion of FGM. There are no sanctions nor any national registration system related to this.

All in all the legal framework can be said to be in place but it is hardly used (only one court case and one case of asylum application on the grounds of FGM) and therefore its efficiency should be further evaluated. Particularly noticeable and problematic is the lack of national registration systems in all areas covered by this study.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

Information on actors within the field of FGM in Denmark is readily available on the Internet and therefore only a few simple searches were necessary to identify the relevant ones and access information. The overall picture of relevant actors was confirmed by e-mail correspondence with experts from the Danish Association of Female Doctors and the Danish Association against FGM and literature reviews (i.e. policy texts for example mentioning a series of actors). Only in one case was it necessary to
seek further information regarding a specific organisation via telephone calls.

5.2. Actors

Thirteen actors were included in the Danish case study. These are considered to be the main actors in the field of FGM in Denmark. They include civil society organisations, governmental bodies and one research network.

Five civil society organisations were included among the main actors. These include one issue-specific organisation, dealing particularly with FGM, two women’s organisations, and two thematically more generic organisations which include FGM among a wide range of topics dealt with in organisational activities.

Attention towards FGM at the level of civil society was initiated through the Danish Association of Female Doctors which held the first meeting on FGM in Denmark in 1993, inspired by an international conference on the topic which one of the local members had attended in 1989.

The Danish Association against Female Genital Mutilation (established 2002) developed from the working group established by the National Board of Health in relation to its 1996–2000 awareness-raising activities on FGM. Once the project ended, some of the people from the working group joined forces with Zonta, a civil society organisation, and established the Danish Association against FGM. From 2003 to 2006 the association was able to hire a consultant thanks to the economic support of the Ministry of Integration and the Ministry of Health. The association aims to eliminate FGM in Denmark and in the rest of the world through information and education-related activities, such as campaigns, conferences, meetings with target groups (imams and Somali immigrants) and media relations (Somali television and radio). They are the authors of a number of the tools and instruments described in Section 6 (see below). The level of activity of this organisation has been uneven: during the period in which it received public funding (2003–06) it carried out a lot of preventive work. However, having to rely solely on volunteer work from 2006 onwards marked the level of activities and this might explain the lack of website updating (latest news in from June 2008), for example. Nevertheless, the organisation still exists.

An e-mail correspondence with a midwife and member of the Danish Association against FGM hinted at some tension in the sense that the association is suffering from a lack of resources and, at the same time, there is a feeling that the National Board of Health has lost its initial sense of initiative from the 1990s and should be more active and responsible in its efforts to combat FGM in Denmark. In recent years the Board has argued that FGM is not a substantial problem in Denmark. She argues back that the Board lacks data and knowledge on FGM (as well as registration systems) and that expertise, in practice, is gathered in a network of volunteers formed around the Danish Association against FGM. This means that women and girls who have been circumcised or are at risk of circumcision have few chances of getting professional help through the health system. There is a need of surveys to gain knowledge of the extension of the problem and of guidelines in order to help women who have been circumcised to reduce their health problems. Systematic research is also limited in the Danish context.

The Women’s Council of Denmark and the Somali Women’s Association in Denmark (established in 1993) focuses on women’s rights and gender equality and, in case of the latter, particularly so for Somali females and their integration and opportunities in Denmark. The Women’s Council was the mediator of material elaborated for the Danish Association against FGM, and the Somali Women’s Association in Denmark has organised debates, gatherings and conferences focusing on preventing FGM. Amnesty International Denmark and the Danish Family Planning Association both participate in activities related to the fight against FGM: the General-Secretary of the Danish Family Planning Association is a member of the Board of the Danish Association against FGM, and the association works to inform teachers about FGM, specifically aimed at reaching the target group of adult women and men of ethnic minority origin. Amnesty International Denmark has been working to combat violence against women in general and, in 2010, the organisation also initiated a three year project particularly aimed at fighting FGM. In 2003, before the specific law prohibiting FGM was adopted, Amnesty made suggestions to the Ministry of Justice on how to change the Penal Code in this regard.

Five governmental bodies, at local or ministerial level, are considered to be particularly prominent in the field of FGM. These are the Ministry of Children and Education, the Equality Committee of the Minister for Equality and the National Board of Health, under the Ministry of Health, as well as the Ethnic Consultant Team (the Day-and-Night Contact) and the Social Services of the Municipality of Copenhagen.

At ministerial level, several reports have been elaborated which have been considered the cornerstones of the (limited) efforts to combat FGM in Denmark. The National Board of Health was the first official body to act within the area of FGM. The 1999–2000 project of the National Board on Health (mentioned above) was the collaboration between authorities and civil society organisations. Over the years this link has become weaker. In 1999, the Board issued the national guidelines ‘Prevention of FGM’ and from 2003 to 2006 they attributed financial support to the Danish Association against FGM.

In 2003, the Ministry of Children and Education published the report ‘We all have a responsibility’, providing information and guidelines to health professionals, social workers and teachers on how to act when faced with FGM cases or risks.

A more recent report from the Ministry of Equality addresses FGM within the broader issue of ‘Gender equality among ethnic minorities in Denmark’ (2011). In particular, the report identifies the Danish Association against female genital mutilation as best practice in the area of family in
terms of its continued effort to enhance gender equality among ethnic minorities.

At the local level the ethnic consultant team (the Day-and-Night Contact); the social services of the municipality of Copenhagen and the municipality of Aarhus were identified as key actors. The Ethnic Consultant Team provides guidance to young people, social workers and other professionals on different matters related to ethnic minorities, including FGM. However, when contacting the service we were informed that they had only had few contacts and inquiries concerning FGM and estimated them to be less than 1% of the total number of contacts made. The social services of the municipality of Copenhagen, on the other hand, have been active in creating tools, such as the guidelines ‘Female circumcision — guidance for frontline workers’. The latter identifies situations of FGM and enhanced risk of FGM, what to do in cases of FGM or risk of FGM, and it recommends contacting the Ethnic Consultant Team for guidance. In the municipality of Aarhus a public debate, in 2003, led to the establishment of a working group and subsequently a report on prevention of female circumcision. The report suggests a number of broad efforts to be made in the field, such as surveys, dialogue with target groups as well as awareness raising. The report also refers to local work being carried out in another large municipality, namely Odense.

Finally, the FOKO Research Network unites researches in the Nordic countries from a variety of professional fields engaged in research on different aspects of FGM. In 2005, the third conference of the network took place in Copenhagen, hosted by the Danish Association against FGM. Proceedings from the conference were made available online.

5.3. Reflection on actors on female genital mutilation

Both at the ministerial level and in terms of civil society action the development of FGM activities can be said to be constant but limited. Political attention on the issue has been intense for short periods of time, and efforts are characterised by activities in a few ministries as well as cross-ministerial working groups.

There are not that many actors engaged in the fight against FGM in the Danish context. Whereas the National Board of Health was very active in the 1990s, its role has diminished over the years because the Board no longer gives priority to this area. The Danish Association against FGM has managed to gather most of the activists and experts in the field and accumulate knowledge at national level, but the association suffers from lack of resources and political will.

However, civil society actors have continued their efforts of putting pressure on policymakers and collaborating with authorities. A few professionals in the health field and ethnic minority activists have been important drivers in these efforts. The civil society is also characterised by one main organisation, i.e. the Danish Association against FGM. A lot of activities are coordinated through this organisation and it gathers a number of the key actors as well. Whereas there is a relatively high degree of coherence of activities in this direction, other efforts seem more disperse, like for example efforts at the local level where guidelines have been elaborated in the municipality of Copenhagen, apparently because the need arose and not because it was coordinated at national level.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Materials were found through regular Internet searches as well as through references in policy texts and on actor websites. Information on tools and instruments were also provided through personal contacts via e-mail and telephone to experts.

6.2. Tools and instruments on FGM

The target groups of the main tools and instruments can be divided into four groups: professionals in healthcare, social services and education (guidelines and manuals); ethnic minority groups, especially Somalis (information and prevention); general population (information); and researchers and experts on FGM (studies and journal articles).

Most of the tools and instruments are developed and published by civil society organisations and/or public authorities at ministerial and local levels.

Awareness-raising campaigns include a leaflet and postcard with information on FGM, entitled ‘No darling… You are not going to be circumcised’ (2012), issued by the Danish Association against FGM, as well as a leaflet on FGM (‘One female genital mutilation is one too many. Support the effort against female genital mutilation’) produced in Somali, English and Danish by the Danish Association against FGM. The first leaflet on circumcision, with general information on the issue and guidance in terms of what to do if you have been circumcised, was published in 1993 by the Danish Refugee Council (NGO).

Furthermore, a number of media productions have been made either as documentaries (‘The day I will never forget’ (2002), DK; and ‘The secret pain’ (2006)), or as educational films for Somalis as well as professionals (‘Let us talk’ (1998); and ‘The broken silence’ (2003). The latter two are in Somali/English with Danish subtitles. ‘Let us talk’ was financed by the National Board of Health, and ‘The broken silence’ was published with support from several ministries and civil society organisations.

Guidelines and manuals for professionals (social workers and healthcare workers) have been produced by the social services of the municipality of Copenhagen (‘Female circumcision — guidance for frontline workers’; and the World Health Organisation (‘Female genital mutilation — integrating the prevention and the management of the health complications into the curricula of nursing and midwifery’ (2001)). They give information regarding legal
framework, modes of action when confronted with FGM or risk of FGM, prevention, assessment and treatment.

In terms of research a few articles have been published since the late 1990s, especially in health study journals (such as *Acta Obstetricia and Gynecologica Scandinavica*). More recently a few studies have also been conducted. In general, research is scarce but spread throughout the years, i.e. slowly, research is accumulating. Some of these texts focus on the Danish, Nordic and European legal perspectives, others on FGM as a health issue in Denmark, the Nordic countries and Europe or on thematic issues such as circumcision and sexuality.

6.3. Reflection on tools and instruments on female genital mutilation

The first information material on FGM was published in the early 1990s but activities intensified in the late 1990s as regards research, ministries and civil society organisations. The main initiators at the time were the National Board of Health and the Danish Association against FGM. Increasingly, Somali organisations have also been active in the field. Furthermore, important efforts are made at the local level, in the large urban municipalities. Among the first to deal with the issue of FGM in a Danish context was lawyer Lene Ravn, who wrote one of the first research articles on the theme in 1999, focusing on the judicial perspective.

Overall, there is coherence between public policies and tools and instruments. In some cases collaborations across ministerial and civil society spheres are seen (especially in relation to the awareness-raising project 1996–2000 by the National Board of Health). However, civil society organisations feel that too little action is taken and not enough resources attributed to the area.

In terms of recommendations for possible developments of tools and instruments, consistent national guidelines for professionals across a variety of sectors seem pertinent. Furthermore surveys into the prevalence of FGM in Denmark as well as comprehensive research into the field are also needed. Research is in general scarce and few in-depth studies into the Danish case are provided.

7. FINAL CONSIDERATIONS

Knowledge on the extent of the problem of FGM in Denmark is very limited; no prevalence studies or surveys exist and no national registration system has been implemented. In general the problem is related to Somalis and authorities consider it to be a minor problem.

Since the immigration of Somali groups in the 1990s, policy measures on FGM have been carried out in Denmark. Political action has to some extent been triggered by media coverage of high-profile issues, followed by parliamentary debate. The content of the policies has been similar over time, referring typically to a broad framework defining the issue, a summary of laws, and guidelines for professionals when faced with FGM cases. National guidelines have been carried out, first at ministerial level and, more recently, by civil society actors faced with political inactivity and lack of priority of FGM issues on the political agenda. The political arena is to some extent characterised by passivity and no progress is being made in basic areas such as finding an adequate system for registering cases of FGM.

A specific law prohibiting FGM was adopted in 2003, including the principle of extraterritoriality. Prior to that, relevant ministries argued that the Penal Code covered FGM interventions. The legal shift also reflects a shift in focus from prevention (in the 1990s) to protection (in the 2000s and beyond). In the single FGM case taken to court in Denmark a mother of Eritrean origin was convicted for having had her daughters circumcised. During the legal process the daughters were removed from home. Everybody has a duty to inform of cases or suspicion of FGM; for professionals the duty is even more important. The Aliens Act states that FGM is grounds for asylum but so far none has been granted. The legal framework is comprehensive but there is a huge lack of use of the established laws.

Civil society is characterised by one particular organisation, i.e. the Danish Association against FGM, which has been able to create a network of experts (not least among health professionals), coordinate knowledge and publications, and serve as a common focal point for a number of organisations dealing with FGM. Increasingly, immigrant organisations have been active in the field, for instance the Somali Women's Association in Denmark has collaborated with the Danish Association against FGM. A lot of work is based on voluntary efforts and civil society organisations lack the necessary resources to remain very active in the field. In terms of authorities, the National Board of Health was the initiator of a number of awareness-raising activities in the 1990s. However, the Board lost interest in the issue because of the limited scope of the problem. At the local level, important activities are carried out, for instance in the form of guidelines for professionals. However, efforts are dispersed as they have not been coordinated in any way at the national level since the National Board of Health ceased to be active in the field.

The main target groups of the tools and instruments elaborated in the Danish context are professionals from the educational, social and health-related sectors, as well as ethnic minority groups, especially from Somalia. Measures are typically centred on dialogue with ethnic minority groups with the aim to change practice, awareness raising, and prevention. The tools and instruments are carried out and/or financed by civil society organisations and public authorities at ministerial and local levels. There are no major incoherence between the different policies and tools and instruments.

Overall there is a tension between the activists of the civil society sector and the political and ministerial arena where FGM has not been placed on the agenda in recent years. Thus the main efforts made in the area, in Denmark, are based on voluntary work, mainly by dedicated health professionals and immigrant groups, and organisations have a hard time finding funding to support their work. The official stance or narrative is that a huge awareness-raising
effort was made in the 1990s by the health authorities, it paid off, and now FGM is a minor problem in Denmark due to the decreased influx of Somali immigrants and the mentality change among those living in Denmark. It is highlighted that Somali fathers (especially) are now more aware of their responsibility in the family and as educators. Furthermore the National Board of Health argues that the guidelines available for professionals is sufficient and that no new national action plan is needed. The overall argument is that FGM has already been dealt with and no further actions are necessary since a coherent policy and legal framework are already in place.

Given this development, it is safe to say that there used to be a stronger agreement and collaboration previously, when the issue first hit the national agenda, especially between the civil society organisations and public authorities. Over the years this link has weakened and civil society organisations have had to put much more pressure for action as they disagree with the National Board of Health, for instance, on the prevalence of the problem and the need for new policy measures. In general, action to combat FGM has been constant over the years but also limited in the sense that only a few policy texts or activities are encountered from year to year. There are no major gaps, however, or long periods of time with no action at all. This is partly due to a continuous effort by civil society organisations to maintain a focus on FGM.

The main civil society actor in the field, i.e. the Danish Association against FGM, has several projects in the pipeline. Very recently the association published a leaflet and postcard concerning what to do in cases of FGM. The association is also working on new guidelines for professionals to replace the ones elaborated by the National Board on Health in 1999. And finally they are seeking funds for a project on young Somali men and their attitude towards FGM. Furthermore, in 2010, Amnesty International initiated a three-year project on FGM.

The volunteer committee behind the 2009 national action plan argues that there is a low level of knowledge on FGM in Denmark; ethnic role models are needed, as are procedures for prevention, examination and prosecution. The goals are to reduce the risk of FGM, make information, guidelines and healthcare services available to circumcised girls and women, as well as increase the political will and economic support of the area.

The Danish Association against FGM recommends the establishment of health contact points in each region. The aim would be to gather all knowledge and services at the regional level in one place. New professional guidelines are also needed, and the association calls on the National Board of Health to take responsibility in this area.

In conclusion, the main recommendations revolve around the establishment of basic measures, such as a centralised registration system, consistent national guidelines for professionals across a variety of sectors as well as coordination of the efforts to combat FGM. Comprehensive and in-depth research in the field is also needed as well as prevalence surveys of FGM in Denmark. Once these basic structures and data are in place, further measures can be discussed in a dialogue with target groups and NGOs.
1. IDENTIFICATION

Country: Estonia

Researcher: Kadri Aavik

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Prevalence data on FGM in Estonia was searched through the following means:

1. Search on websites of state agencies and NGOs/foundations who are responsible for asylum seekers/refugees and who deal with women’s/human rights and health issues:
   - Police and Border Guard Board — http://www.politsei.ee
   - Estonian Ministry of Social Affairs — http://www.sm.ee
   - Estonian Human Rights Centre (foundation) — http://www.humanrights.ee
   - Estonian Women’s Shelters Union (umbrella organisation) — http://www.naisteliin.ee

2. Inquiries via e-mail:
   - Police and Border Guard Board,
   - Estonian Ministry of Social Affairs,
   - Estonian Human Rights Centre,
   - Estonian Women’s Shelters Union.

There have been no officially known or reported cases of FGM in Estonia, according to the Ministry of Social Affairs, the Police and Border Guard Board and the Estonian Human Rights Centre (no reply was received from the Estonian Women’s Shelters Union). No statistics is collected on the prevalence of FGM in Estonia and there are no established rules or procedure as to which a national agency should be responsible for that. This is due to an almost complete lack of knowledge regarding the practice of FGM in Estonia and the very small immigrant population from countries where FGM is practised. There are no FGM registration systems in Estonia and no state body is assigned to collect information on FGM.

Only data on asylum seekers disaggregated by gender and citizenship was obtained from the Police and Border Guard Board, to estimate the number of girls/women at risk of FGM (see next section).

2.2. Nature of prevalence studies/FGM registration systems

As mentioned in the previous sections, there have been no reported cases of FGM among female asylum seekers and refugees coming from countries where FGM is practised. Official statistics on asylum seekers in Estonia have been available since 1997. Estonia has one of the lowest numbers of asylum seekers in the EU. According to the statistical data provided upon request by the Police and Border Guard Board, there have been only 272 asylum seekers in total between 1997 and 2011 (included). Most of them are men, with only 53 women and girls in total. Out of these 53, only six originate from countries where FGM is prevalent. One female asylum seeker originates from Cameroon, two from Nigeria and three from Somalia (including one minor). There are no data available on whether these female asylum seekers have undergone FGM. Also, it is unknown whether they underwent medical examinations upon arrival in Estonia. Furthermore, since asylum is granted only to about 12% of asylum seekers (1), it is unknown whether they are still currently in Estonia. Not only is the number of asylum seekers low, but only a few come from African and Asian countries.

Regarding the immigrant population in Estonia, I asked the Police and Border Guard Board for data on currently valid residency permits, disaggregated by citizenship and gender of the permit’s holder. However, I was only provided with a list of valid residency from 1 July 2011, by citizenship and not by gender. As from that date, only 84 citizens from countries where FGM is practised hold an Estonian residency permit. Since I was not provided gender-disaggregated data, it is impossible to determine how many among them are women. However, since most immigrants from African and Asian countries are men, the majority of those residency permit-holders are presumably male. There are no data regarding the FGM status of the female immigrants from countries where FGM is practised.

2.4. Reflection on prevalence studies

So far, no FGM prevalence data have been or are currently being collected in Estonia. As the number of women from countries where FGM is practised is very low in Estonia, as compared to most other EU Member States, this has not been a practical necessity so far. However, considering that, due to increased mobility (1), the number of immigrants and asylum seekers might increase in the coming years, including women and girls who have undergone or are at risk of FGM, it is recommended that relevant state agencies and officials, as well as NGOs (those dealing with asylum seekers/refugees, women’s health, human rights, child protection, women’s rights etc.) should be aware of the practice of FGM, in order to provide adequate assistance and support to those women. Therefore, it might be necessary to determine which national agencies would be responsible for collecting FGM data.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Policies were searched by visiting the websites of state agencies and NGOs/foundations responsible for asylum seekers/refugees, dealing with women’s/human rights and health issues, and combating violence against women.

1. Search on websites of state agencies and NGOs/foundations who are responsible for asylum seekers/refugees and who deal with women’s/human rights and health issues:
   - Police and Border Guard Board — http://www.politsei.ee
   - Estonian Ministry of Social Affairs — http://www.sm.ee
   - Estonian Ministry of Justice — http://www.just.ee
   - Estonian Human Rights Centre (foundation) — http://www.humanrights.ee
   - Estonian Women’s Shelters Union (umbrella organisation) — http://www.naisteliin.ee

2. Inquiries via e-mail regarding policies:
   - Police and Border Guard Board
   - Estonian Ministry of Social Affairs

3.2. Policies on FGM

There are no policies in Estonia that deal with FGM. However, I searched for other policies that deal with general violence against women, and criminal policies which might mention FGM among the forms of violence exerted on women. No policies were found which mention FGM. However, the document ‘Guidelines for the development of criminal policy until 2018’ (English version: http://www.riigiteataja.ee/officialOnlinePublication?language=en&id=51139/Guidelines-for-Development-of-Criminal-Policy-Until-2018.pdf) considers future possible risks of harmful traditional practices, stating that ‘criminal policy shall take potential future risks into account and be ready for the prevention of and responding to problems with racial, ethnical and religious background unknown or rare so far in Estonia, such as forced marriages, honour killings, becoming a destination country for trafficking in human beings.’ It is not specified how and by which measures those mentioned future risks will be dealt with. FGM is not specifically mentioned in these guidelines.

3.3. Reflection on policies on female genital mutilation

There are no policies on FGM in Estonia. Due to the absence of reported cases, the almost complete lack of knowledge regarding the practice of FGM, and a very small number of (female) immigrants and asylum seekers/refugees from countries where FGM is practised.

However, future policies should address the issue of harmful traditional practices, including FGM, as the number of immigrants and asylum seekers from countries where FGM is practised might increase in Estonia and therefore relevant authorities should be aware of the issue. It is advisable to elaborate more specifically targeted policies (criminal policy, policies on violence against women etc.) on how to deal with the prevention of, and response to, harmful traditional practices, or issues relating to racial, ethnic and religious background unknown or rare in Estonia, as cited in the ‘Guidelines for the development of criminal policy until 2018’.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Information on the legal framework was obtained mostly by searching the State Gazette (http://www.riigiteataja.ee), the official online publication of the Republic of Estonia, which contains up-to-date legislation of the Republic of Estonia, in full text versions and enables the search of the documents that are available in the State Gazette. As of 2010, the State Gazette is no longer published in the paper version. I visited the State Gazette website almost daily during the period of conducting the FGM desk research.

To search for the professional secrecy provisions, I also conducted Google searches in the Estonian language.

All documents collected on the legal framework, were obtained from the State Gazette, as direct sources. Occasionally I was not able to directly locate a relevant legal act, in which case Google search in the Estonian language with specific keywords helped me to locate the name of the legal act that contained the necessary information.

I mostly encountered two kinds of difficulties while searching for documents on the legal framework. First, it was sometimes difficult to determine which laws (and protection measures in these laws) would apply to FGM cases, as there are no specific laws dealing with FGM in Estonia and no legal acts that mention harmful traditional practices. Since there have been no FGM cases so far, I had
to assume which laws/provisions would be used if such cases occurred. Second, it was difficult to find, which legal acts contain professional secrecy provisions and in some cases, what would qualify as professional secrecy provision.

4.2. Criminal law

There is no criminal law on FGM in Estonia. However, the Penal Code (entered into force on 1 September 2002) can be applied to FGM cases. For example, Article 118 of the Penal Code: ‘Causing serious damage to health which results in e.g. the loss or cessation of functioning of an organ’, Article 121: ‘Causing damage to the health of another person, or beating, battery or other physical abuse which causes pain’, and Article 134: ‘Abduction (I) Taking or leaving a person, through violence or deceit, in a state where it is possible to persecute or humiliates him or her on grounds of race or gender or for other reasons, and where he or she lacks legal protection against such treatment and does not have the possibility to leave the state, is punishable by a pecuniary punishment or up to five years’ imprisonment’ could be used.

The Victim Support Act (entered into force on 1 February 2004) might be applied to victims of FGM who might be entitled to compensation or support: ‘A victim support service is a public service aimed at maintaining or enhancing the ability to cope of persons who have fallen victim to negligence, mistreatment or physical, mental or sexual abuse’.

There is no agency that registers (suspected) cases of FGM.

4.3. Child protection laws/provisions

There are no child protection laws/provisions that deal specifically with FGM. There have been no child protection interventions regarding FGM. There is no national/central agency or register of child protection interventions that deal with FGM.

In cases of FGM performed on children, two laws might be applied.

First, the Child Protection Act (8 June 1992) which states that it is prohibited to humiliate, frighten or punish a child in any way which abuses the child, causes bodily harm or otherwise endangers his or her mental or physical health. Adults who violate this principle might be punished under criminal procedure and the child who has suffered violent treatment will be provided with necessary assistance. Every person is required to immediately report if he/she knows a child who is in need of protection or assistance.

Second, under the Family Law (18 November 2009), parental rights might be restricted or suspended if parents endanger the well-being of the child. This includes endangering the mental, physical and emotional well-being of the child.

4.4. Asylum law(s)/provisions

There are no specific asylum provisions dealing with FGM. In cases of FGM, the Act on Granting Protection to Aliens (14 December 2005) might be used. According to this law, the following circumstances in the country of origin shall be considered to be persecution (based on which asylum might be granted): ‘physical and mental violence, including sexual abuse’ and ‘gender specific acts and acts directed against minors’.

Although FGM is not specifically mentioned in this law, the risk of FGM fits well under circumstances seen as ‘persecution and serious risk in the country of origin’ of the asylum seeker.

This law defines refugees as follows: ‘A refugee is an alien who, owing to a well-founded fear of being persecuted or for reasons of race, religion, nationality, political opinion or membership of a particular social group, is outside the country of nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country and with regard to whom no circumstance exists precluding recognition as a refugee’.

There is no national/central registration system for asylum cases related to FGM. According to the Police and Border Guard Board, no asylum seekers so far have cited FGM or threat of FGM as reason for seeking asylum in Estonia.

4.5. Professional secrecy provision(s)

There are no legal provisions with regard to professional secrecy concerning FGM. However, in the case of children, the Family Law can be applied, which obliges an official of a state agency or local government agency, policeman, healthcare professional, judge, prosecutor, notary, bailiff, teacher, or any other person who has information concerning an endangered child to notify the rural municipality government or city government or the court of residence of the child.

Judges and healthcare providers are bound by the duty of confidentiality (Courts Act and Law of Obligations Act respectively) and people/agencies processing personal data may not disclose personal information (Personal Data Protection Act).

However, as FGM falls under the definition of a crime, it must be reported, as failure to report crime is a criminal offence.

There is no national/central registration system for reports of (suspected) FGM cases by professionals.

4.6. Reflection on legal framework

There is no law on FGM in Estonia; however, other laws might be applied in FGM cases, such as the Penal Code, the Child Protection Act, Family Law, and the Act on Granting International Protection to Aliens.

Currently there is no real need for a specific law on FGM in Estonia, as other laws can be applied to FGM cases, should the need arise.

It is difficult to estimate whether asylum might be granted on the grounds of FGM, should any asylum seeker in Estonia request asylum on those grounds. However, due to the almost complete lack of awareness, in Estonia, on the
practice of FGM, officials deciding on asylum cases might underestimate the severity of the practice and the risks it poses to female asylum seekers who come from countries where it is practised. Thus, considering the possibility of increased numbers of immigrants and asylum seekers into Estonia, officials of relevant state institutions should be aware of harmful traditional practices, including FGM.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

In searching for information for this section, I first relied on the information obtained from the Ministry of Social Affairs, the Police and Border Guard and the Estonian Human Rights Centre listed in Section 2.1.

I also used my knowledge of and familiarity with non-governmental actors working on the topics of gender equality, women’s/human rights etc. as a result of working in the Estonian NGO sector on gender and women’s issues in the Estonian Women’s Studies and Resource Centre since 2007.

5.2. Actors

There are no actors in Estonia who are or have been involved in FGM work in Estonia.

5.3. Reflection on actors on female genital mutilation

There have been no reported cases of FGM in Estonia and public awareness of this practice is very low. Compared to most other EU Member States, the number of (female) asylum seekers and immigrants from countries where FGM is practised is extremely small. Thus, there has been and currently is no practical need for FGM work by Estonian actors.

However, if the number of female asylum seekers and immigrants from countries where FGM is practised should increase in Estonia, the need for FGM work might arise. Thus, actors involved in working with women’s/human rights, child protection, asylum seekers/refugees, health issues etc. should be aware of FGM.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

The tools and instruments were collected through search on the websites of the state agencies listed in Section 3.1. Also, search on Google Scholar and Google was conducted, using all variations of terms for FGM in the Estonian language.

I also contacted the Ministry of Social Affairs, the Police and Border Guard Board and the Estonian Human Rights Centre regarding the tools and instruments.

Except for the document ‘Guidelines for the development of criminal policy until 2018’, which was found on the website of the Ministry of Justice, all other documents were found using Google search.

6.2. Tools and instruments on FGM

There are no tools and instruments that deal with FGM in the Estonian context. Most of the tools and instruments are translations from original materials in the English language. In most of the tools and instruments collected, FGM is mentioned briefly, in connection with refugees and asylum seekers or as a human rights violation or gynaecological issue, depending on the target group of the publication. Four documents are targeted at midwives and/or gynaecologists, including two translated materials, which introduce the practice of FGM and a learning material and handbook that briefly mention FGM.

Tools and instruments on FGM are very few and most existing ones only briefly mention FGM. None of the tools and instruments refers to FGM in relation to Estonia; most of the documents are translations from respective materials in the English language. In the case of most of the materials, it is unknown whether and how they were distributed or introduced to target groups.

6.3. Reflection on tools and instruments on female genital mutilation

Due to the very small number of tools and instruments available on FGM in the Estonian language, it is difficult to observe any clear trend. However, none of the tools and instruments found dates back more than 10 years, while most of them are published in the second half of the 2000s.

The tools and instruments are not related to existing national policies, except the ‘Guidelines for the development of criminal policy until 2018’ (which does not specifically mention FGM). Four of the tools and instruments are targeted at gynaecologists and midwives, one for churches and one at the public sector and ministries, while the rest are for unspecified audiences.

7. FINAL CONSIDERATIONS

No FGM prevalence data have been or are currently collected in Estonia. As in Estonia the number of women coming from countries where FGM is practised is very small, compared to most other EU Member States, this has not been a practical necessity up to now. However, considering that the number of immigrants and asylum seekers might increase in the coming years, including women and girls who have undergone or are at risk of FGM, it is recommended that relevant state agencies and officials, as well as NGOs (those dealing with asylum seekers/refugees, women’s health, human rights, women’s rights etc.) in Estonia should be aware of the practice of FGM, in order to provide those women with adequate assistance and support. Therefore, it might be necessary to determine which national agencies should, if necessary, be responsible for collecting FGM data.
There are no policies on FGM in Estonia, due to the absence of reported cases, the almost complete lack of knowledge regarding the practice of FGM, and the very small number of (female) immigrants and asylum seekers/refugees from countries where FGM is practised. However, future policies should address the issue of harmful traditional practices, including FGM, as the number of immigrants and asylum seekers from countries where FGM is practised might increase in Estonia and therefore relevant authorities should be aware of this issue. It is advisable to elaborate ways of dealing with the prevention of, and response to, harmful traditional practices or issues related to racial, ethnic and religious background, unknown or rare in Estonia, and more specifically on relevant policies (criminal policy, policies on violence against women etc.).

There is no legislation on FGM in Estonia; however, other laws might be applied in FGM cases, such as the Penal Code, the Child Protection Act, Family Law, and the Act on Granting International Protection to Aliens. It is estimated that there is currently no need for a specific law on FGM in Estonia, provided that other laws can be applied to FGM cases, should there be any.

It is difficult to estimate whether asylum might be granted on the grounds of FGM, if any asylum seeker in Estonia did request asylum on those grounds. However, due to the almost complete lack of awareness in Estonia on the practice of FGM, officials deciding on asylum cases might underestimate the severity of the practice and the risk it poses to female asylum seekers in the countries of origin where it is practised. Thus, considering the possibility of increased numbers of immigrants and asylum seekers into Estonia, officials of relevant state institutions should be aware of harmful traditional practices, including FGM.

As the number of female immigrants or asylum seekers originating from countries where FGM is practised might grow in the future, an increased awareness on harmful traditional practices, including FGM, would be important for state agencies, officials and professionals, as well as NGOs working on women’s rights, human rights, health issues, child protection, criminal policy etc. In addition, health professionals, especially gynaecologists and midwives should be aware of FGM. Also, it would be important for officials managing asylum requests to be familiar with harmful traditional practices, including FGM, as possible grounds for granting asylum. There might be a need for policies and tools and instruments that take FGM into account.

### Note on the terms used for FGM in the Estonian language

The most common term used in the Estonian language for FGM is *naiste ümberlõikamine*, which is a direct translation of the term female circumcision. Also, the longer version of the term, *naiste suguelundite ümberlõikamine* (the circumcision of women’s genitals) is sometimes used. However, in some documents, direct or close translations of the English term FGM, which more accurately reflects the severity of the procedure, are used, such as *naiste suguelundite moonutamine*, *naiste suguelundite mutatsioon* (female genital deformation/mutilation) and *naiste suguelundite sandistamine* (the crippling/incapacitating of women’s genitals).

I recommend that the latter terms be used in the Estonian language, as opposed to the former, which does not adequately distinguish FGM from male circumcision and does not sufficiently reflect the severity of the practice.

There are no actors who are or have been involved in FGM work in Estonia, as there have been no reported cases of FGM in Estonia, and so public awareness of this practice is very low. Compared to most other EU Member States, the number of (female) asylum seekers and immigrants from countries where FGM is practised is extremely low. Thus, there has been, and currently is, no practical need for FGM work by Estonian actors. However, should the number of female asylum seekers and immigrants from countries where FGM is practised increase in Estonia, the need for FGM work might arise. Thus, actors involved in working with women’s/human rights, child protection, asylum seekers/refugees, health issues etc. should be aware of FGM.

Tools and instruments on FGM are very few and most existing ones only briefly mention FGM. None of the tools and instruments refer to FGM in relation to Estonia; most of the documents are translations from respective materials in the English language. In most cases, it is unknown whether and how they were distributed or introduced to target groups.

A search for academic papers on FGM in Estonia was conducted, but no documents were found. Only a few translations from English-language material exist, but these are mostly newspaper articles introducing the topic in the Estonian language.
Country report

Finland
Country report: Finland

1. IDENTIFICATION

Country: Finland
Researcher: Satu Lidman

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The research result concerning prevalence of FGM in Finland was obtained through academic database search, using the following databases: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Heinonline, Google Scholar as well as the Finnish ones, Linneanet and Theseus.

Key terms included the Finnish expressions tyttöjen/naisten ympärileikkaus/sukuelinten/sukupuolielinten silvonta/leikkaus, the Swedish terms kvinlig omskärelse/könsstympning and the English words female genital mutilation/cutting/excision/circumcision as well as FGM.

Additionally, several telephone calls to the best experts on FGM-related issues in Finland were made to confirm the information gained through database research and literature (for detailed contact information, please see the Excel database for Finland). For the results of these discussions, see Section 2.4.

2.2. Nature of prevalence studies/FGM registration systems

The studies concerning FGM in Finland have merely been qualitative and focused on the Somali population, but have not seen the prevalence question as their central task or even paid any attention to it. Furthermore, they are based on interviews with a limited number of Somali women and can therefore not describe the situation in the country as a whole.

However, at the moment the National Institute for Health and Welfare is finishing a research project concerning the health and welfare of immigrants. This is based on a very detailed questionnaire and interviews among immigrants, and will give at least some information of the prevalence issue when the results come out.

2.3. Findings from the prevalence studies/registration systems

There are no statistics of the prevalence of FGM available for Finland and no studies specifically and thoroughly investigating these issues. The only possibility to roughly estimate the prevalence of FGM in the whole country would be to count the number of females coming from the risk countries.

According to Statistics Finland, 25 650 persons immigrated to Finland from foreign countries during 2010. In the year 2000 there were 4 149 and in 2010 altogether 8 073 Somali-born people (men, women, children) living in Finland. The corresponding figures for persons born in Egypt are 407 and 796, for Guinea 9 and 53. A little less than 50 % of the total amount of these persons were female. The figures do not include the children born in Finland to these families. Additionally, the number of people from the Kurdish community is difficult to estimate, because they originate from different countries with different practices on FGM.

2.4. Reflection on prevalence studies

In the Finnish case there was no data available for the prevalence of FGM. This is because there is no registration of medical services, social services’ notifications, asylum seekers or any other actions due to FGM. However, it should be pointed out that the experts’ views on this challenge were uniform and expressed as follows:

A medical doctor said: ‘There is no specific research on prevalence of FGM in Finland, because FGM or the risk of it is not registered by any authorities. Some women come to the doctors when they need treatment for the health issues caused by FGM, but there are no statistics of these clients. Until now the research has been merely qualitative. However, when the results of the new project are published, there will be some data concerning prevalence. Regularly a few suspicions on attempted FGM come up, but none of these have led to further investigations. For this reason there have not been any legal cases either.’

An individual expert who is an activist in the field and a midwife said: ‘There is no conclusive evidence of the frequency of attempted or planed FGM in Finland. Equally, the number of women with FGM in Finland is not known.’
A person from the Finnish Immigration Service said: ‘There are no statistics on the reasons why people seek asylum, and therefore it is impossible to say how much or what kind of a role FGM plays in this.’

A person from the Finnish League for Human Rights said: ‘There is no existing data on prevalence of suspected, attempted or performed FGM in Finland. However, it is most likely that the vast majority of the immigrant women who arrived in Finland from Somalia in the early 1990s were circumcised. Certainly some girls have been sent to their country of origin to be circumcised since, but their number is not known.’

A person representing the Gender Equality Ombudsman said: ‘There is no data on prevalence of FGM in Finland.’

In conclusion, there is an undeniable need for a national registration system that would take FGM into account. This should include several authorities, and at least police, immigration services, hospitals and maternity clinics as well as schools and child welfare agencies.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

The research result concerning the policy framework was obtained through three source groups:
(a) academic database search, using the following databases: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Heinonline, Google Scholar as well as the Finnish ones, Linneanet and Theseus. Key terms included the Finnish expressions tyttöjen ympärileikkaus/sukuelinten/sukupuolielinten silvonta/leikkaus, the Swedish terms kvinlig omskärelse/könsstympning and the English words female genital mutilation/cutting/excision/circumcision as well as FGM;
(b) websites of the key actors concerning national policies: the Finnish parliament (http://www.eduskunta.fi), the national database for laws and regulations (http://www.finlex.fi), Ministry of Social Affairs and Health (http://stm.fi), National Institute for Health and Welfare (http://www.thl.fi), Ministry of the Interior (http://www.intermin.fi) as well as the Advisory Committee on Equality Matters (http://www.tane.fi);
(c) phone calls to experts. See Section 3.3.

In the end, the information obtained for the policy framework was based on the two latter source groups (b and c).

3.2. Policies on FGM

The data in POL sheet consists in parliamentary questions and governmental statements from the 1990s, one law proposal from 1992 and two recommendations, one from the Ministry of Social Affairs and Health given in 2008 and the other from the Advisory Committee on Equality Matters given in 2009.

Additionally, there are four action plans. The first was implemented by the Ministry of the Interior in 2008 and states the importance of preventive work but denies the need for changing the legislation.

The other three are implemented by the Ministry of Social Affairs and Health, one in 2007, another in 2010 and the third which is presently waiting to be published. Out of these three only the last one is specifically about FGM, the other two mention female circumcision within the framework of violence against women or as part of sexual health issues.

Before the 1990s the subject of FGM was not topical or given any attention in Finland. After the turn of the century several attempts for policy have been made. This is mostly due to the growth of the Somali population in Finland, to media attention and work by NGOs and governmental units, such as the Ministry of Social Affairs and Health.

3.3. Reflection on policies on female genital mutilation

When Somali immigrants started to arrive in the early 1990s, FGM became a subject for discussion, first concentrating on basic questions such as ‘what does female circumcision mean?’, ‘How should the authorities act in this matter?’ and ‘Does Finland need a special law for it?’.

The most active parties in the discussion were the Finnish parliament, some medical experts and some NGOs, such as the Finnish League for Human Rights, but especially the National Institute for Health and Welfare (called Stakes until 2009) and the Ministry of Social Affairs and Health. There were also attempts to update and change the law to specifically cover FGM-related issues, but these proposals were never accepted.

Lately, the basic line within the policy framework in Finland has been that there is no need to change the legislation, as the paragraph on aggravated assault can be applied. Since there have not been any legal cases, this discussion is only theoretical, which might explain the lack of incentive to take action.

However, action plans and recommendations very much emphasise the importance of non-stop preventive work at all level; schools, social and health care, immigration services, police and general awareness raising. FGM is seen as a serious violation of human rights and aggravated assault against physical female integrity.

During the phone conversations the experts made the following comments regarding the Finnish policy:

The representatives of the National Institute for Health and Welfare and the Ministry of Social Affairs and Health said that a new action plan specifically on FGM will be launched by the Ministry of Social Affairs and Health and academic expert Marja Tiilikainen.

An individual expert expressed his view that the successful preventive work, which started relatively early, could explain why Finland has not had any reported cases of attempted or performed FGM. However, there is still a great need for
4.2. Professional secrecy provision(s)

The professionals involved are as follows: social and healthcare services, education services, youth services, police, criminal sanction agency, fire and rescue services, social welfare and healthcare providers, education and training provider, parish or religious community personnel, reception centre workers, family home workers, and children’s morning and evening activity providers.

If these authorities suspect that someone is at risk of FGM, they are obliged to notify the child welfare. They have to take action, because FGM is considered a serious violation of the physical freedom of children. The relevant legal provision is the Child Welfare Act, Chapter 5, paragraph 25. Citizens have the right to report.

There is no national registration system for reports of suspected FGM cases by professionals.

4.6. Reflection on legal framework

The issues described in Sections 4.1 to 4.5 were discussed with a Detective Superintendent from the Helsinki police and with a lawyer at the Ombudsman for Children in Finland. They agreed with the picture depicted.

The Detective Superintendent also pointed out that the Finnish police are well aware of the future possibility of
FGM-related interventions. It is clear that these cases would be treated as crimes and most likely as aggravated assaults, and the police would have the duty to investigate. So far there have not been any notifications to the police from other authorities. Of course, the Detective Superintendent only represents the police of Helsinki, but he would know if there were investigations or trials in other parts of the country.

The lawyer could not say if an attempted FGM would be reason enough for custody, because there have not been any cases. She thought that if FGM was suspected, priority should be given to preventive measures, through education and the social services — taking someone into custody should be the last option. As there are no statistics concerning the reasons for custody in Finland, we cannot say if there have been any cases of FGM. The lawyer has not heard of any cases of custody based on attempted or performed FGM. However, the ombudsman is contacted every year by teachers and private persons who suspect FGM when an immigrant girl ‘disappears’ from school.

Additionally, a person working for the Ministry of Justice stated that there is no need for special law for FGM, because the paragraph on aggravated assault can be applied. This might not be the opinion of all the other actors, but so far the proposals for specific law on FGM have not passed through.

In conclusion, there has not been any criminal case or child welfare case based on FGM. The possible number of asylum seekers due to FGM is not known. However, there is a clear need for better registration within social and health care, immigration services and the police.

The theoretical issue of FGM was raised in the context of boys’ circumcision. There have been several investigations and trials concerning boys’ circumcision, made without medical reasons, which were brought to the knowledge of health or social services because of ensuing complications. As there is no reason to believe that girls’ circumcisions would cause fewer complications — quite the contrary — this might indicate that there have not been many female circumcisions done in Finland, if at all.

In Finland, asylum can be admitted due to past and future persecution: if there is a reason to suspect that the person has been or is at risk of being persecuted, which can mean physical injury, torture or other inhuman or degrading treatment in case of returning to the country of origin. However, Finland has recently sent back several individuals to countries with very unstable political circumstances and serious risk of inhuman treatment. In this perspective it seems quite possible that FGM would make no difference.

The original official English translations of the Finnish Criminal Code, Child Welfare Act and Aliens Act are included in the research as PDF-files.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

The research results concerning the different actors related to FGM issues in Finland were obtained through existing personal networks of human rights’ workers and NGOs, general website search with the help of keywords (tyttöjen, naisten ympärileikkaus, sukeliinten, sukupuolielinten silvonta, leikkaus) as well as phone calls and e-mails to the experts already identified.

The literature collected in the country library and in Section TI made it possible to see if the authors of the documents, and those who issued the documents, could be considered as actors. All individual researchers and organisations that had FGM in some way in their agenda were included as actors. However, Section 5.2 only mentions the most important individuals and projects fully concentrating on FGM.

5.2. Actors

The first actors appeared in the early 1990s. The most influential and comprehensive action has been the KokoNainen (The Whole Woman) project of the Finnish League for Human Rights, which started in 2002 and is still continuing. This also includes cooperation in finishing a national action plan together with the Ministry of Social Affairs and Health. The related website offering educational material on several human rights’ issues including FGM is called ihmisoikeudet.net.

In 2002, the Finnish Red Cross started a project called Haavo Taako targeting Somali women. The idea was to see how community methods can be used in community work to prevent FGM in immigrant communities in Finland and Denmark.

During a Daphne project, which ended in 2008/09, Nicehearts of Vantaa gathered a lot of ‘know-how’ and connections related to FGM issues.

Presently, there are approximately 10 NGOs in Finland actively working for the prevention of FGM. Their main activities consist of awareness-raising campaigns including the distribution of information leaflets for the general public and the authorities, the production of educational material for schools and professionals as well as cooperating with authorities in committees working for action plans, recommendations and other proposals.

At the University of Oulu there is a course on ‘harmful traditional practices’ including FGM-related issues, which has been running since 2007. Additionally, the universities of applied studies offering education on social and health care seem to have included FGM in their teaching, because there have been several master’s theses on FGM, especially during the 2000s.

The authorities involved are: the Ministry of Social Affairs and Health, the Ministry of Justice, the Finnish Immigration
Services, the National Institute for Health and Welfare, the Ombudsman for Minorities, the Ministry of the Interior, the Ombudsman for Children in Finland, the Ombudsman for Equality, the police, the Advisory Committee on Equality Matters, the Ministry of Employment and Economy and the Finnish parliament.

The major nationwide political influential authorities are the Ministry of Social Affairs and Health and the National Institute for Health and Welfare (called Stakes until 2009). Both publish manuals, recommendations and information on legislation. On their websites they offer links to FGM-related material. They have a wide cooperation with different NGOs and other authorities and good networks. Both are going to publish new research results in 2012.

The most influential NGOs are the Finnish League for Human Rights, Nicehearts of Vantaa, and Monika-Naiset litto. They offer educational material and educations and cooperate with key authorities.

5.3. Reflection on actors on female genital mutilation

The actors seem very well connected and aware of each other’s work and visions. In many instances, people have been working within the different organisation and on projects with each other over the years. However, there are also some disagreements. For the National Council of Women criminalisation of FGM is the goal, whereas the Finnish League for Human Rights considers this as problematic, as it results in labelling of certain immigrant groups.

Finland is a large country with a small population. The governmental and non-governmental organisations and actors are mainly situated in Helsinki and its surroundings. The cooperation between different NGOs and authorities seems to be quite fruitful. The major activities started at the beginning of the 21st century and are still continuing.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

The research result concerning the tools and instruments was obtained through academic database search, using the following databases: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Heinonline, Google Scholar as well as the Finnish ones, Linneanet and Theseus. Additionally, the websites of the key authorities and NGOs were searched for possible publications.

Key terms included the Finnish expressions tytöjen/naisten ympäilekkaus/sukuelinten/sukupuolielinten silvonta/eikkaus, the Swedish terms kvinnlig omskärelse/könsstypning and the English words female genital mutilation/cutting/excision/circumcision as well as FGM.

6.2. Tools and instruments on FGM

The first noticeable publication on FGM in Finland was published by the Ministry of Social Affairs and Health, in 1993. This was a handbook aimed at awareness-raising. Since then the ministry has published awareness-raising booklets and information on FGM regularly and offers them also on its website.

In 1994, the National Institute for Health and Welfare and one of the leading experts in the country published a qualitative survey on FGM based on 130 interviews of Somali women living in Finland. This was the first real survey on the subject. In 1996, another study with interviews of Somali women was produced by the Ministry of Social Affairs and Health. This was originally a Master’s thesis.

In 2004, the abovementioned expert published a study with the Finnish League for Human Rights, comparing the current situation with the situation in her earlier study from the 1990s. In 2007, Marja Tiihkalainen and the Finnish League for Human Rights published the recommendations of an expert group to the authorities. The recommendations were taken into account and have been a major factor leading Finland to where it is now regarding FGM-related issues.

In 2011, the NGO Africarewo published a detailed leaflet with updated basic information about the health risks and other aspects of FGM. It is widely disseminated electronically.

The National Institute for Health and Welfare is currently finishing its research project on the sexual health of immigrants, based on a detailed questionnaire. It will certainly give a lot of valuable information.

6.3. Reflection on tools and instruments on female genital mutilation

In Finland, the first awareness-raising campaigns started at the beginning of the 1990s. At the time there was little information about the basic facts of the tradition of female circumcision, and everything had to be carefully explained, not only to the general public, but also to the authorities.

During that decade the information spread and both authorities and the general public became more aware of FGM as a violation of human rights and as a crime according to the Finnish law. Presently, the need for more information, instructions, discussion and a national action plan is well recognised.

Lack of any prevalence data is the obvious gap in the tools and instrument. This problem is based on the fact that there are no registration and statistics related to suspected, attempted or performed FGM, as discussed in Section 2.

Most of the reports and surveys are based on interviews among the Somali women living in Finland, but they only represent a small section of the population at risk of FGM. Therefore, there is a great need for a bigger picture
that would cover the population at risk or already affected by FGM.

Additionally, there is an obvious, almost total lack of academic publications specifically on FGM-related issues. This means that there might have been women or families seeking asylum on the grounds of FGM, but their number is unknown and we don’t know if asylum was permitted or denied on those grounds. There are no statistics either on girls being taken into care as a result of attempted FGM. However, the few notifications concerning suspicions on FGM have never led to police investigations or legal prosecution.

The largest group of immigrants living in Finland from the FGM-risk countries are the Somali. When the first Somali immigrants arrived in Finland in the early 1990s, probably most of the women had already been circumcised. However, the attitude towards this harmful tradition has now changed among the Somali population in Finland, and increasingly families are turning against circumcision. They know that it is a criminal offence. The director of the Finnish Somali League, Abdirashid Awad Dirie, confirmed this. However, there are regular rumours of girls being sent abroad to be circumcised. Therefore, for the time-being, the question of prevalence has to be left open.

Within the policy framework we can see a trend. FGM was not a topical issue before the 1990s, but towards the 2000s the discussions and the attempts to find a proper way to encounter the challenge increased. There were attempts for a specific law covering FGM-related issues, but they failed. Since then, the basic line has been that there is no real need to change the legislation as there haven’t been any legal cases, besides the paragraph on aggravated assault can be applied in case of possible charges. However, the importance of comprehensive preventive work is recognised. After the turn of the century there has been several action plans taking FGM into account, but only as part of other issues, such as violence against women and sexual health issues. The first action plan specifically on FGM will be published by the Ministry of Social Affairs and Health in 2012.

Regarding the legal framework, there are no specific laws or regulations on FGM in Finland. Therefore, the different types of circumcision cannot be evaluated in this context. However, according to the Criminal Code, all types of FGM can be interpreted as assault or aggravated assault. Depending on the situation, the Child Welfare Act could also be applied and the child welfare authorities could utilise the child protection measures in case of attempted FGM. The authorities have a duty to report anyone at the risk of FGM. However, since there have not been any legal or custody cases based on attempted or performed FGM, this is only theoretical. There is no specific asylum provision dealing with FGM in Finland.

The first actors in FGM-related issues appeared at the same time as the immigration from Somalia in the early 1990s. There are now several NGOs in Finland which are actively working for the prevention of FGM as part of their agenda. The names that constantly came up were the Finnish League for Human Rights and a project called ‘KokoNainen’ (The Whole Woman), which has been running since 2002. The most influential authorities are the Ministry of Social Affairs and Health and the National Institute for Health and Welfare (called Stakes until 2009). Active preventive work has been going on since the 1990s, but it is only leading to a national action plan in 2012. The academic level of actors is thin and the preventive work has almost entirely been in the hands of NGOs and activists.

Similarly, the tools and instruments have been mainly created by key actors in the NGOs and Ministries. There are only very few academic publications concerning the Finnish situation on FGM. Nevertheless, since the first awareness-raising campaigns, in the early 1990s, Finland has now reached quite a good level of practical information — at least when it comes to their amount. There are manuals and handbooks for social and health care, other authorities and politicians, as well as schools and other youth education, with information regarding FGM. However, social and healthcare workers regularly complain about the lack of proper material and information. So, it seems there is a problem in the contents of the information, and therefore a need for more education on such matters as cultural sensitivity.

In conclusion, just as the national action plan on FGM is coming out in 2012, the lack of statistics on prevalence of FGM, on notifications concerning suspected FGM attempts and on FGM as grounds for asylum seeking, seems to be the most urgent challenge in the case of Finland. Most of the experts and actors claimed that this is because of the lack of funding. There are already people who know the field and what should be done, but they are lacking financial means. Additionally, a better coordination and information distribution between different organisations and bodies would be a crucial factor in building a wider national picture of FGM-related issues.

In Finland, FGM is seen as a serious violation of human rights and aggravated assault against physical female integrity. Almost all actors emphasise the importance of a continuous preventive work at all possible levels.
Country report

France
1. IDENTIFICATION

Country: France

Researcher: Maxime Forest

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Following the ‘Guidelines for national data collection’, we initially carried out an academic database search. The following databases were searched for prevalence studies in France (FR): Social Science Research Network, Sociological Abstracts, PubMed and Google Scholar. Key terms included, in French: excision, mutilations sexuelles féminines, mutilations génitales. Only a few valid entries could be retrieved through this research, as many academic institutions in France, especially in the fields of social sciences and humanities, do not have full access to international databases and research networks. As an example, we have been limited in our access to these databases, as our French institutions of affiliation, Sciences Po Paris (the leading institution in social science) and the University of Nice, do not have full access to all the databases listed in the ‘Guidelines for national data collection’, usually privileging national databases.

Therefore, we paid closer attention to the latter, such as Persée (http://www.persee.fr) and Cairn (http://www.cairn.info) which gather hundreds of scientific journals in full or limited (abstracts) access. We also completed our desk research for literature on FGM prevalence in France using JStor (http://www.jstor.org). This additional search yielded only a few additional references, mostly to the first prevalence survey on FGM carried out in 2007–09 by the Institut National d’Études Démographiques (INED). We thus explored the website of this institution (http://www.ined.fr).

Finally, we carried out a keywords search (using the same entries as mentioned above), through the following national websites:

http://www.insee.fr
Website of the Institut National des Etudes Statistiques (National Institute for Statistical Surveys)

http://www.gynsf.org
Website of an NGO (Gynécologie Sans Frontières), in the field of obstetrical and gynaecological medical relief, which deals extensively with FGM in France.

http://www.federationgams.org
Website of the main organisation (Groupe pour l’Abolition des Mutilations Sexuelles Féminines, GAMS) dealing with FGM in France.

We used a variety of channels to collect data on prevalence in France, including international and national databases searches, websites searches and e-mail and/or personal contacts with national experts. Due to the French specificities in collecting data on origins or ethnicity detailed in Section 2.3, we found very limited statistical information on the phenomenon.

2.2. Nature of prevalence studies/FGM registration systems

Until 2007, no prevalence study on FGM had been carried out in France, although this issue already emerged on the public agenda by the mid-1980s, when a first wave of FGM cases were brought to civil jurisdictions. Two decades later, only two rough estimations had been proposed, respectively in 1982 and 1989, indicating that 24 000, later 27 000 girls living on the French territory had been mutilated or were at risk to suffer FGM.

However, in 2005, researchers at the universities of Paris-1 Sorbonne and Nice made a first estimation of the number of girls having suffered FGM in France. This estimation was based on available data from the Etude de l’Histoire Familiale (*study of family trajectories), annexed to the 2004 update of the 1999 national census (380 000 respondents of both sexes). Only women over 18 whose both parents originate from a country at risk were taken into account for calculating a rough prevalence estimation with three hypothesis (low/medium/high) corresponding to the (non-) inclusion of three different study populations: women over 18 whose parents originate from a country at risk, who
arrived in France before 15 (A1), after 15 (A2), or were born in Europe (A3) (Andro; Lesclingand, 2007).

Between 2007 and 2009, the same researchers were commissioned by the National Institute for Demographical studies (INED), to carry out a well-funded, extensive survey on FGM: ‘Excision et Handicap’ (ExH). This study had both a quantitative and qualitative content, aiming at mapping and evaluating FGM consequences and needs in surgical repair. Data were collected in 74 public medical centres in the Paris region and four other regions with highest rates of populations at risk. Some 2 882 valid questionnaires have been collected (from 714 mutilated women over 18 and 2 168 non-mutilated women over 18 from countries at risk). Those questionnaires were collected during gynaecology consultations in day care centres and hospitals. Interviews lasted 60 minutes on average (Andro; Lesclingand et al., 2010).

This survey was the first extensive study ever conducted in France on FGM, although it does not provide prevalence data for the whole territory. In addition, our research led to identify two other studies including information on prevalence, collected on a much lower scale, both in geographical terms and absolute numbers.

In 2007, a doctoral thesis in general medicine was based upon both a quantitative and qualitative survey carried out in 2007 in different districts of Paris with a large sub-Saharan migrant population. The authors sent a questionnaire on prevention, screening, examination, diagnosis and abuse-reporting practices to 477 physicians. 152 answered, providing a valuable empirical material to evaluate the attitude of physicians facing cases of FGM, but also the frequency of FGM in districts with a large African population.

In 2009, a regional survey on violence against women was carried out in the Pays de la Loire region, including a work package on FGM. Over a period of one month (to be elected per maternity ward), previously trained obstetricians and midwives had to fill out, on a daily basis, a database indicating the number of births/number of parturients from countries at risk/number of mutilated parturients/typology of FGM. The study population was made of the parturients in 24 selected maternity wards of the Pays de la Loire region. This survey provided some useful data on prevalence in a region with a low, but recent, migrant population that was not previously considered in the mapping of FGM in France (1).

After a dramatic increase noticed in 2006 and 2007 by the OFFRA (Office Français de Protection des Réfugiés et des Apatrides), as regards asylum applications grounded on a risk of FGM (or FGM-related persecution for parents refusing to perform FGM on their children), the annual activity reports issued by this organisation, respectively in 2009 and 2010, extensively referred to FGM-related applications. These reports thus provide useful information on subsidiary protection granted on the premise of an FGM risk.

Until 2008, the registration of FGM cases was performed, following fully distinct procedures, by the police and/or by local public attorneys (procureurs de la république), as a preliminary step for prosecutions, and by the services of the Maternal and Infantile Protection (PMI) established at the level of departments. In addition, the Directions Régionales de l’Action Sociale et de la Santé (DRASS) could be referred to on FGM cases, especially where the justice and the police were not prepared to handle such situations. Moreover, issue-specific NGOs dealing with FGM, such as the GAMS and the CAMS (Commission pour l’Abolition des Mutilations Sexuelles) carried out monitoring activities of both suspected cases and cases brought before courts. Therefore, it was especially difficult for relevant actors to access information and to map the phenomenon, except when a policy actor as the Délégation Régionale aux Droits des Femmes et à l’Egalité (Regional Directorate for Women’s Rights and Gender Equality, DRDFE) succeeded in establishing long-term policy networks, as was the case in the Ile-de-France region, thus improving reporting and registration capacities on FGM cases.

Yet, in 2008, the ‘cellules départementale de recueil, de traitement et d’évaluation’ (Department-based units of data collection, treatment and evaluation, CPRI) were established under the authority of the president of each general council (local government). Since FGM have to be included in the mapping of FGM in districts with a large African population

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Yet, in 2008, the ‘cellules départementale de recueil, de traitement et d’évaluation’ (Department-based units of data collection, treatment and evaluation, CPRI) were established under the authority of the president of each general council (local government). Since FGM have to be included in the reporting activity, CPRI now plays an important role in registering FGM cases (2).

Besides, in 2011, an internal service notice was distributed to the Maternal and Infantile Protection Services, detailing the protocol to be followed in dealing with FGM cases, especially as regards reporting. It notably strengthens the contribution of the dense PMI network to a more systematic registration of FGM cases in France.

2.3. Findings from the prevalence studies/regISTRATION SYSTEMS

Due to severe constitutional and legal restrictions as regards the collection of personal data mentioning origins or ethnicity, which will be detailed in Section 2.4, available prevalence data are only fragmentary in France, making necessary some precautions as the general migratory context.

Indications about the migratory context in France

Publicly released data from the National Census provides some (fragmentary) information about migrants and foreign populations living in France. According to the National Institute for Statistical Surveys (INSEE), in 2009, France counted with a population of approximately 5 342 000 ‘immigrés’ (foreigners born in a foreign country, including people who have acquired French citizenship since) (3). Nationalities are specified only for certain groups, seemingly using an outdated typology (only countries from which originated major immigration flows over the past decades, such as Morocco, Algeria, Tunisia or Portugal, are disaggregated), whereas other African nationalities/citizenships are left unspecified under a same, global

1 Especially from Guinea.

2 Interview with President of GAMS.

3 http://www.insee.fr/fr/themes/tableau.asp?reg_id=0&ref_id=immigrespaysnaiss
category. For instance, data collected nationally in 2004 indicated that 570,000 migrants from sub-Saharan Africa lived in France. Besides, data collected in 2007, and updated in 2011, indicates that 213,767 girls under 18 were living in families of migrants from sub-Saharan Africa, of which 34,538 were born abroad (1). Data disaggregated per country of origin are not collected systematically — or at least, not systematically published, making it difficult to draw reliable comparisons over time. According to the INSEE, in 2005, major communities originating from countries with significant/high FGM prevalence rates were coming from the Democratic Republic of Congo, Senegal, Mali, Côte d’Ivoire, and Cameroon, ranging from 35,000 up to 50,000 members each (2). However, over the past two decades, sub-Saharan migration flows to France have more than duplicated. In 2011, the consulate of Senegal claims to have 70,000 registered citizens on the French territory (3), and we found record of estimations (including illegal or seasonal migrants) of up to 274,000 Senegalese in France for 2005 (4), to be compared to the 48,000 registered in official statistics for the same year.

**Indications on FGM prevalence**

According to the three hypotheses (low/medium/high) proposed by professors Armelle Andro and Marie Lesclingand, corresponding to the (non-)inclusion of three different study populations (women over 18 whom both parents originate from a country at risk, disaggregated among those who arrived in France before 15 (A1), after 15 (A2) or were born in Europe (A3)), the estimated figures of FGM in France were the following (2004):

- **Lower estimation:** 42,000 (A1)
- **Medium estimation:** 53,000 (A1+A2)
- **Higher estimation:** 61,000 (A1+A2+A3)

These figures were also used in the ‘Excision et Handicap’ (ExH) study. Besides, quantitative part of the ‘FGM and handicap’ project, and evaluation of the needs in surgical repair also contains a qualitative survey that does not provide prevalence data but refined statistics on medical, obstetrical and gynaecological complications, showing relatively low incidence, as well as concerning psychological health and sexual life, for which FGM proves to have a relatively high impact, as respectively 7 and 6 % of mutilated women acknowledge often/always painful intercourse, to be compared to respectively 4 and 2 % for control cases. This survey also brings indications as regards the age when FGM was performed, depending of the country of origin:

- **Age:** 0 to 4/5 to 9/over 10
- **Mali:** 82 %/15 %/3 %
- **Senegal:** 65 %/26 %/9 %
- **Guinea:** 35 %/47 %/18 %
- **Côte d’Ivoire:** 41 %/31 %/29 %

In ‘Regional survey on violence against women in the Pays de la Loire region’, no general prevalence data are provided. In this qualitative study, however, 14 FGM victims were reported in the selected maternity ward, from six countries (Guinea (7), Mali (2), Senegal (1), Egypt (1), Cameroon (1) and Mauritania (1)), in line with the increasing, newly established Guinean population of the Pays de la Loire region.

Similarly, ‘Preventive actions and medical screening of FGM and their potential medical complications in general practice’, without providing either comprehensive or fully reliable data, indicates that 63 % of surveyed female physicians and 37 % of their male colleagues already noticed FGM among their patients.

**2.4. Reflection on prevalence studies**

With regard to the relative abundance of the literature on FGM, to the richness of legislative and policy instruments detailed under the next sections of this report, to the number of actors dealing with FGM and to large populations from countries presenting high prevalence rates, the absence of reliable and comprehensive prevalence study is particularly striking in France.

However, far from illustrating the negligence of public and private actors for this issue, it has to be analysed in the light of strict constitutional restrictions for collecting data on the grounds of ethnicity or nationality, and a reluctance to publicly release information, when available.

France has always been reluctant to monitor the composition of its population in terms of cultural or national origins, and beliefs. As a consequence, no nationwide statistics or databases have been made fully available so far, even for research purposes. Nevertheless, in the past few years, the National Institute of Statistics (INSEE) indirectly questioned this status quo, carrying out various medium-scale studies which refer to origins either through the use of ‘objective’ criteria such as nationality or the place of birth, or through subjective categories as self-perception. A growing number of voices have argued in favour of the still much criticised ‘ethnic statistics’. For instance, in 2007 the Commission ‘Informatics and civil rights’ (CNIL) recommended the law to be changed in order to make a restricted use of ethnic statistics possible. The recommendation was accepted and included to Article 63 of the new act on immigration, integration and asylum submitted to vote. The bill went even far beyond the usual reference to origins and nationality, and made direct reference to racial or ethnic origins, allowing the collection of data for the purpose of ‘studies aiming at measuring the diversity of origins, discrimination and integration of individuals’. The treatment of such data should be expressly authorised by the CNIL, taking into account the high scientific value of the study and preserving the right for individuals to oppose the use of their own personal data.

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2. Etrangers par régions au 1er janvier 2005, INSEE.
information. Notwithstanding, collecting ‘sensitive’ data has remained prohibited in France, as result of a rather extensive interpretation of the law by the constitutional judge: referred to evaluate the constitutionality of this bill, the constitutional council rejected Article 63, considering that, if measuring diversity, discrimination and integration can draw upon objective data, it violates the first article of the constitution when considering ethnic origin or race (EC, 2008. Decision of 15 November 2008).

It is thus a matter of fact that in France, the methodological problem posed by the measure of diversity, that is, the difficulty to establish boundaries between ethnic or cultural groups, is reinforced by the legal prohibition affecting the collection of hard data. Additionally, when such data exist, their authors encounter difficulties in making it available to the public. For instance, the results of the latest and more extensive study ‘Territoires et Origines’ (Territories and origins, TEO), carried out in 2008, have still not been made available for the larger public. Similarly, the quantitative aspect of the ExH survey, carried out in 2007–09 has not yet been made fully accessible (1). This extreme precaution in releasing data on migrant population can also be explained by a political and electoral context in which everything regarding immigration is subject to strong political contention (on the politics of diversity in France, see: Sénac, 2012).

In this context, the collection of comprehensive and reliable data on FGM prevalence is made especially difficult, including for public-funded research and institutions. As a consequence, the majority of the policy documents, reports and preventive or awareness-raising (AR) instruments issued since 2004, do refer to the same rough estimation of 40 up to 60 000 potential mutilated girls/women living in France: an estimation that was inferred from gross migrant populations over 18, without a real statistical control. This paradoxical situation was recently addressed by the current Minister for Solidarities and Social Cohesion (also in charge of Gender Equality), Roselyne Bachelot, who insisted on the need to make data on violence against women more fully accessible (2). Thus, the next survey, to be launched in 2012, will also include girls under 15 (unlike the one carried out in 2000), notably in order to better account for FGM risks (3).

However, as will be shown below, France has nevertheless developed a relatively sophisticated policy framework to deal with FGM, despite the apparent lack of prevalence data.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

As for prevalence studies, first we attempted to retrieve policy documents on FGM using an academic database search. The following databases were searched for policies carried out in France on FGM: Social Science Research Network, Sociological Abstracts, Pub Med and Google Scholar. Key terms included, in French: excision, mutilations sexuelles féminines, mutilations génitales. This research yielded no relevant policy document.

Additionally, we carried out a keywords search, using the same entries as mentioned above, and broadening the scope of the research to related policies such as asylum rights and international protection, children’s protection, and domestic violence (in French: droit d’asile et protection internationale, protection de l’enfance, violences intra-familiales, violences domestiques). This additional research was done through the following national websites:

http://halde.defensedesdroits.fr/Missions-et-pouvoirs,11013.html
Haute Autorité de Lutte contre les Discrimination et pour l’Égalité (HALDE)/Défenseur des droits
(National equality bodies)

http://www.avecegalite.com/
Délégation Régionale aux Droits des Femmes et à l’Egalité (DRDFE)
(Regional equality body, Ile-de-France region)

http://www.travail-emploi-sante.gouv.fr/
Ministère du travail, de l’emploi et de la santé/Ministry of Work, Employment and Health

Ministère des solidarités et de la cohésion sociale/Ministry of solidarities and social cohesion

http://www.education.gouv.fr
Ministère de l’éducation nationale

Cellule départementale de recueil, de traitement et d’évaluation (CRIP)

Assemblée nationale

To make our survey as exhaustive as possible, we also tried to reach various experts, solicited to provide indications on policy developments as regards FGM and abovementioned related fields of public policy, but limiting the scope of our study to policy developments presenting an interest for present or future policies on FGM. Among those who answered our e-mail request or were joined by phone, the following experts helped us to complete our mapping, with relevant documents or information:

• the President of the Groupe pour l’Abolition des Mutilations Sexuelles (GAMS);
• the FGM policies coordinator and assistant at the Délégation Régionale aux Droits des Femmes et à l’Egalité (DRDFE) of the Ile-de-France region;
• the Head of Service, Direction Régionale à la Jeunesse, aux Sports et à la Cohésion Sociale (DRJSCS), Provence-Alpes-Côte d’Azur region;
• the parliamentary assistant of a member of parliament.

(*) Interview with President of GAMS.
(†) Interview with President of GAMS. To date, no information has been released about the methodology that will be implemented for the study, and no detail has been given about the study population or the aim of the survey.
3.2. Policies on FGM

Whereas FGM cases were already made public by the early 1980s, as African immigration began to change the face of migrant populations established in France, the first policy instruments were not developed until the mid-1990s, and most were issued after 2004. This delayed policy response can first be explained by the initial trend that consisted in criminalising FGM and attempts to regulate the phenomenon through case-law (as detailed in Section 4.1). Secondly, it can also be enlightened by a general feature of French public policies, which give priority to law-making over policy implementation instruments.

The relatively late blossoming of French policies on FGM thus partly explains that we only identified 13 relevant policy documents, listed in the database. Some additional explanatory factors will be suggested in Section 3.3.

As regards relevant policy documents listed in the database, they include:

- six reports issued by a consultative body (on migration issues), the National Assembly, the Office de Protection des Réfugiés et Apatrides and a working group at the Ministry of Health;
- three governmental notifications (circulaires ministérielles);
- three action plans (on FGM and violence against women);
- the General Codex of Medical Acts reimbursed by the Public Health Insurance.

The first governmental notification to be circulated on FGM, in 1994, had been issued by the Ministry of Social Affairs, Health and Urban Areas, enjoining every departments with an important migrant population, to list FGM among their priorities in the fields of social and health policies, and to organise awareness-raising actions from 1994 onwards. By that time, however, the first AR actions had already been organised by the regional services of the state in the Ile-de-France region. To a certain extent, this notification thus aimed at generalising the good practices experimented by that time in the Paris metropolitan area.

In 2003, two reports were consecutively handed to the Prime Minister, by the Haut Comité à l’Intégration (High Committee for Assimilation), listing some recommendations as regards the prevention of FGM, as part of the process of integration of migrants recently arrived in France.

In 2004, as Professor Foldès successfully implemented since 2001 a post-FGM surgical repair technique at the hospital of Saint-Germain-en-Laye, near Paris, surgical acts to repair sexual mutilations were added to the General Codex of Medical Acts reimbursed by the Public Health Insurance.

After Act No 2006-399 of 4 April 2006, strengthening the prevention and repression of violence perpetrated within a couple and against children, was passed, a series of preventive and educational measures were taken to tackle the issue of FGM, both at the regional and the national level, and the social, educational and health service of the state were mobilised for its implementation. Many of the documents issued after that date, as well as many events, explicitly referred to an ‘Action plan against FGM’. However, it has been confirmed to us that no such policy document was adopted (\(^{(*)}\)), this plan merely consisting in this set of policy actions. Nevertheless, due to the relative consistency of this policy, we opted to refer to this set of actions as a single ‘document’.

Two governmental notifications, issued in January and March 2007, illustrating the shape that was then given to the policies designed to address FGM in France have thus been issued by the Ministries of Health and Higher Education to upgrade the training of future practitioners (physicians, obstetricians, gynaecologists, midwives, nurses, paediatric nurses) with respect to FGM.

This issue was also mainstreamed in two broader policy plans on domestic violence. Unlike the first one adopted in 2005, the second global triennial action plan on domestic violence for 2008–10 thus listed FGM among its priorities. Following the first act ever adopted in France to specifically address domestic violence, an evaluation process was launched, which included an information report and exhaustive parliamentary hearings carried out with experts in a variety of fields, including FGM. Although this process has not resulted in including additional provisions on sexual mutilations in the new Act on Violence against Women passed in 2010, it urged public authorities to adopt new measures on FGM, included in the Interministry Plan to Fight Violence Against Women. FGM is addressed under a specific chapter on pages 48 to 56, with six specific actions to be taken:

- Ensure the diffusion of the outputs of the ‘Excision et handicap’ (ExH) study
- Inform newcomers from countries at risk
- Train professionals working with migrants
- Train consular and embassies’ officers
- Generalise multidisciplinary units taking care of surgical repair in regions
- Improve the protection of children with a status of refugee/subsidiary protection granted upon the motivation of a high FGM risk.

3.3. Reflection on policies on female genital mutilation

With respect to their relative comprehensive legal treatment (see Section 4) and the fact that first policy instruments on FGM were already adopted at the regional level by the mid-1990s, it is worth underlining the seemingly weak coordination of such instruments at the national (governmental) level. Yet, as will be briefly stressed below, this situation somewhat corresponds to a general pattern of policymaking in France and can be explained by some institutional path-dependent features.

Firstly, it should be emphasised, that French policymakers traditionally prioritise law-making on policy implementation and evaluation. Therefore, until recently, action plans were not implemented as frequently as in other policy contexts. Besides, when such plans were developed, they were only occasionally monitored and evaluated in the long run, as

\(^{(*)}\) Interview with President of GAMS.
evaluation tools are still missing. However, it can be noticed that over the last decade, action plans have been increasingly used as a key policy instrument, as part of a general modernisation of public policies. This is especially the case in the field of health and social policies. Nevertheless, the quality of policy instruments still strongly depends on the thoroughness of legal provisions in which these instruments are anchored, and of the (political) conditions in which those provisions have been adopted. For instance, the thoroughness of the evaluation process carried out in 2009, for the implementation of the act on domestic violence, is both unusual and exemplary, and strongly linked to the commitment of a few MPs with this particular issue (1).

Secondly, whereas the first ministry dealing with women’s rights was established in 1981, this field of policy has been characterised by a strong institutional discontinuity. In other terms, this ministry was later abolished and never re-established with similar competences since, being usually limited to a State-Secretary, or gender equality issues being placed under the supervision of other portfolios. Moreover, national gender equality machineries are weak in France, lacking both autonomy and funding. As an example, the Observatoire de la Parité, once placed under the responsibility of the Prime Minister, now under the Ministry of Health, has very limited prerogatives and authority. To a large extent, this explains that policies dealing with gender issues have usually limited coordination at the national level. It can also be added, that this path-dependent feature (institutional discontinuity), applies to every policy field. For this reason, the prerogatives and areas of action of each ministry do substantially change over time, not only from a legislative term to another, but also during a same mandate. This trend is reflected in the changing (and increasingly complex) designation of respective ministries, as it appears in the database.

Thirdly, it can also be acknowledged, that FGM is not a practice that uniformly affects French territory. Cases brought to criminal courts were all to be reported in jurisdictions of the Paris metropolitan area (Île-de-France region), which account for one sixth of the French whole population, with a focus on under-age population and children under six. In 1982, the coordination of PMI services was transferred from the state to the ‘Conseils généraux’ (local governments at the level of departments). Moreover, in France, there are 20 compulsory, free of charge, medical screenings up to the age of six. Those can be performed either by general practitioners or in PMI services, which is usually the case for low-income households and, specifically, for urban migrant populations. As the medical screening of girls’ genitalia is systematically carried out under the age of six, PMI services thus play a key role in reporting FGM cases. Therefore, the internal PMI service notice reported in the section on tools and instruments could also be considered as a relevant policy document, as it details the protocol to be followed by social and healthcare workers of the PMI with respect to FGM. Since it was not established to deal specifically with FGM, the PMI network cannot be considered as a dedicated policy instrument. Yet, it largely contributes to shape a dense and efficient institutional framework, in which FGM-related preventive or monitoring actions can be implemented (2) (see also Section 5 on actors).

It is in this complex institutional context, that some departmental and regional delegations for women’s rights and gender equality (DRDFE) have endorsed a forerunning policy activity, as in the department of Seine-St-Denis and the Île-de-France region, with respect to FGM. This policy development (3) has nonetheless been facing dramatic challenges in the past few years. Indeed, the general reform of public policies (known as the RGPP in France), implemented since 2007, has considerably reshaped policy networks dealing with FGM. Although these institutional changes have affected the implementation of recommendations on the reporting and monitoring of FGM in France (making this process longer and more complex), the RGPP has also drawn new opportunities for effective policy networks to emerge. This has notably been the case of the ‘cellules départementales de recueil, de traitement et d’évaluation’ (Department-based units of data collection, treatment and evaluation, CPRI), which facilitated the collection of reliable information on FGM, even in the regions with low migrant populations (4).

At this point, it must also be emphasised that FGM-related policies in France can rely upon an exceptionally dense welfare institutions’ network and a favourable health policies general framework. In particular, the Maternal and Infantile Protection Services (PMI), play a key role in the prevention and monitoring of FGM cases and groups at risk. The PMI was established in 1945 to carry out preventive actions for the whole population, with a focus on under-age population and children under six. In 1982, the coordination of PMI services was transferred from the state to the ‘Conseils généraux’ (local governments at the level of departments). Moreover, in France, there are 20 compulsory, free of charge, medical screenings up to the age of six. Those can be performed either by general practitioners or in PMI services, which is usually the case for low-income households and, specifically, for urban migrant populations. As the medical screening of girls’ genitalia is systematically carried out under the age of six, PMI services thus play a key role in reporting FGM cases. Therefore, the internal PMI service notice reported in the section on tools and instruments could also be considered as a relevant policy document, as it details the protocol to be followed by social and healthcare workers of the PMI with respect to FGM. Since it was not established to deal specifically with FGM, the PMI network cannot be considered as a dedicated policy instrument. Yet, it largely contributes to shape a dense and efficient institutional framework, in which FGM-related preventive or monitoring actions can be implemented (2) (see also Section 5 on actors).

Last but not least, it must be highlighted that policy coordination at the regional level, has shaped (and in some regions is still shaping) specific policy networks, which involve not only sectoral policies’ stakeholders, but also key non-governmental actors (as the GAMS and the CAMS), and experts (sociologists, demographers). Ultimately, specialists

(1) Information provided by the parliamentary assistant of an MP.

(2) On the policy framework of child protection at the departmental level, see: http://www.pascalpopelin.fr/docs/commissions-seances/schema_protection_enfance.pdf

(3) It is also to be linked to the fact that, unlike national politics, almost all regional policies are governed to the left, with a usually greater concern for integration and gender equality.

(4) Interview with President of GAMS.
in obstetrics have also been consulted to generalise multidisciplinary units taking care of surgical repair in all regions, as recommended in the ‘Interministerial plan to fight violence against women, 2011–13’.

As regards future policy developments, the new act on violence against women, passed in 2010 (6), notably aims at improving data collection on every types of violence. It also foresees the creation of an observatory of violence against women. However, to date, this institution has not been established. Once again, the Ile-de-France region plays a role of forerunner, as it plans to establish a similar institution soon.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The main source of information on legislation we used was the website of the Official Journal (http://legifrance.gouv.fr). We also referred to the websites of the respective ministries (including the Ministries of Health, Education and Solidarities and Social cohesion).

We also enriched our approach by consulting experts mentioned in Section 3 about past and future legislative developments. These contacts were especially fruitful to obtain relevant and detailed information on case-law since 1979, and to put subsequent legislative developments into perspective. In total, our research enabled to identify 22 relevant acts, codes and recommendations documenting the legal framework around the FGM issue in France.

4.2. Criminal law

The first FGM case denounced before a (civil) jurisdiction was brought to trial in 1979, after the death of a baby following her infibulation, and led to a sentence of one year of imprisonment for the woman who performed the mutilation. She was convicted of ‘unintended homicide’. This case initiated a process of criminalisation of FGM in France, i.e. of a regulation of this practice mostly in the field of law. It is worth mentioning that this first conviction, occurred at an early stage of the sub-Saharan immigration wave in France, reflecting a prompt reaction of the public authorities (in France; public prosecutors are placed under the direct supervision of the Ministry of Justice), in a context where first public denunciation of FGM in the press already occurred by 1974.

When the first case was brought before a court, the (old) Penal Code, adopted in 1810, under the first French Empire, included three penal offences, under which people having performed or assisted FGM could be prosecuted:

- Unintended bodily harm and homicide (Former Penal Code, Articles 327, 328, 329)
- Intended bodily harm (including homicide), Article 313, former Penal Code
- Failure to render assistance to a person in danger, Article 63, former Penal Code.

Therefore, no specific mention was made of (sexual) mutilations, and neither the age of the victim nor the status of the offender (parent or legal tutor) was taken into account. Nevertheless, despite the lack of specific provisions, between 1979 and 1994, at least 12 FGM cases were brought before courts, and convicted persons sentenced to six months, up to three years of prison (suspended or not).

After the pioneering judgment rendered in 1979, further cases were instructed in 1982 and 1984, before civil jurisdictions (Tribunaux de Grande Instance, chambres correctionnelles) involving authors of FGM, but also parents, sued and convicted for assistance. However, during the second trial held in 1984, a lawyer acting in the name of feminist NGOs and the Comité pour l’Abolition des Mutilations Sexuelles (CAMS), created in 1982, successfully argued that civil jurisdictions were not competent to judge on FGM cases, which should be brought before criminal courts (Cours d’assises), which are able to pronounce much more severe sentences, with different qualifications.

Consecutively, since 1986, FGM perpetrators have been judged before criminal courts, which tend to recognise permanent mutilations and the status of offenders (parents or legal tutors) as aggravating factors in their case-law. For 14 out of 16 cases judged between 1979 and 1994, intended bodily harm was retained as the main criminal offence. As a notable exception, in 1991, a single case brought to trial 15 parents, thus contributing to increase public attention on this issue.

Further legislative developments were triggered by 10 trials held between January 1993, and January 1994, leading to the condemnation of 13 parents and FGM authors to jail sentences (fully suspended or not) of up to five years (not suspended). The multiplication of criminal prosecutions was due to the willingness of public authorities to stop FGM, especially among the Malian community (most of convicted persons being from Mali), and to the systematic pursuits initiated by the lawyer mentioned above. The trend to be reported for this period is the increasing severity of sentences.

In 1994, the Penal Code had undergone a substantial revision and new criminal offences were introduced:

- Acts of torture and barbarity (Articles 221-2, 222-3 and 222-5), for which the maximum sentence is brought from 20 up to 30 years of imprisonment when those acts are the cause of a permanent mutilation or infirmity and/or performed or assisted FGM could be prosecuted.
- Intended bodily harm causing permanent mutilation. Ten years of imprisonment brought to 15 years when acts are perpetrated against children under 15 (Article 222-10).

Although it is not explicitly specified in the law, the French case-law for acts of torture and barbarity implements a principle of extraterritoriality that can thus be extended to FGM. At least 13 criminal court cases were judged, between 1994 and 2002, under the provisions held in the revised Penal Code. From 1998 onwards, condemnations often came with fines and in 1999, a trial brought before the

(6) This act was not included to the database, as it does not have any explicit implication as regards FGM.
court 28 parents and FGM perpetrators on 48 victims. All were sentenced to (suspended) imprisonment and to pay substantial damages (FRF 13 000 per victim).

This evolution of the case-law triggered new legislative developments. In 2002, Articles 222-9 and 222-10 of the Penal Code were revised, stating that violence causing a permanent infirmity or mutilation would be punished by a sentence of up to 10 years of imprisonment and a fine of up to EUR 150 000. Five criminal cases were brought before courts between 2002 and 2005 (latest available update), leading to heavy sentences, most of it coming with fines of up to EUR 15 000.

In 2006, further legislative developments came along with Act No 2006-399, of 4 April 2006, strengthening the prevention and repression of violence perpetrated within a couple and against children, which modifies Article 222-47 of the Penal Code so that sentences for criminal offences under Article 222-1 to 222-15, including acts of barbarity or intended bodily harm and violence causing permanent mutilations, can be aggravated by an expulsion from the French territory either permanent (acts of barbarity) or of up to 10 years (violence).

Moreover, Article 14 of this act explicitly introduces the principle of extraterritoriality for sexual mutilations, also lifting professional secrecy provisions (See Section 4.5). Protection measures reported in Section 4.3 are also annexed to this act. Finally, Act No 2006-399, strengthening the prevention and repression of violence perpetrated within a couple and against children, modifies Article 7 of the Penal Procedure Code: the time limit to sue perpetrators of breaches to sexual integrity (apart from rape) is brought to 20 years after victims have reached their majority (18 years).

In March 2007, another modification to the Penal Code added that when acts defined in Article 222-9 of the Penal Code are perpetrated on victims under 15, the maximum sentence is elevated to 15 years, and 20 years when these acts are perpetrated by the parents, the ascendants or any person exerting authority over victims under 15. This is, to date, the latest legal provision covering FGM in the general criminal law.

Although latest case-law updates are from 2005, we found little evidence of criminal prosecutions beyond 2004. Our rough estimation is of an average of less than one criminal case registered per year. The latest was brought to court in November 2011. In the meantime, however, case-law regarding FGM largely moved to the field of asylum rights (Section 4.4).

4.3. Child protection laws/provisions

Child protection provisions have remained untouched long after World War II, when General De Gaulle’s provisory government re-established a specific judiciary protection system for persons under 18. As regards social protection measures, those were briefly stated in Article No 375 of the Civil Code: the children’s judge can order the placement in public institutions, family shelter or under the responsibility of authorised associations, of children suffering psychological or physical abuses at home (§).

Whereas the protection of minors as regards their legal responsibility has undergone substantial alterations since the 2000s, specific protection measures for children came, in 2006, from another field of public action. Indeed, after the act on domestic violence was passed, perpetrators of violence against children have become subjected to the same measures as perpetrators of violence exerted within the couple and can therefore be evicted from their residence and prevented from any contact with their victims. Besides, this act also extended these protection measures to illegal under-age migrants, in order not only to prevent the expulsion from the territory of women suffering gender-based violence, but also (implicitly) to protect girls against a risk of FGM if sending them back to their country of origin.

Yet, the main change brought to child protection in France was Act No 2007-293, of 5 March 2007, reforming children’s protection provisions. After a long debate involving policymakers and experts, this act replaced the notion of children suffering psychological or physical abuses at home by the one, more inclusive, of ‘endangered children’, advocated by NGOs fighting against children’s abuses, including FGM.

Additionally, this act built protection measures upon a collaborative project also including parents, for whom it reinforces educational measures. Besides, this act strengthens the application of some protection measures to illegal under-age migrants and under-age migrants without family, notably in suspected cases of FGM. According to one respondent, this obligation is generally implemented, although NGOs constantly monitor its enforcement, in order to prevent infringements by public authorities (for instance, urging prefects to suspend expulsion measures in case of domestic violence, or suspicion of FGM risk).

Last but not least, this act modified the procedure to report situations of risks, now involving the Cellules Départementales de Recueil, de Traitement et d’Évaluation (Department-based units of data collection, treatment and evaluation, see Section 3).

4.4. Asylum law(s)/provisions

Asylum rights represent a field of increasing relevance as regards the action of public and private organisations against FGM in France. In total, we found seven relevant documents, of which five have been issued since 2001.

Until a new law was passed in 2003, the French Office for the Protection of Refugees and Stateless people (OFPRA) was regulated by Act No 1952-893 adopted to implement the Geneva Convention (1951). Therefore, a refugee was considered any person ‘owing to well-founded fear of

(§) It can also be added that De Gaulle’s provisory government also established the Maternal and Infantile Protection service (PMI) as part of the child protection framework. See sections 3, 5 and 6 of this report.
being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. The status could also be granted upon the HCR mandate.

Until 1991, we found no record of relevant case-law on the grounds of a risk of sexual mutilation. Yet, in 1991, the Commission de Recours des Réfugiés (Refugees’ appeals committee) issued a decision denying international protection on this ground, due to the absence of a real persecution risk for parents refusing to perform FGM on their daughters in their country. But at the same time, the judge implicitly recognised that FGM risk would constitute a valid argument for a girl (and by extension, her parents), to obtain protection as a member of a specific social group in the sense of the Geneva Convention.

Ten years later, the same instance finally validated this principle, granting asylum to the parents of an endangered girl.

In 2003, Act No 2003/11-76 on asylum rights was passed, introducing a new regime of international protection: subsidiary protection, granted to those who do not meet the criteria stated in Act No 1952-893 on the creation of a French Office for the Protection of Refugees and Stateless people (OFPRA), notably if they are threatened to be executed or at risk of suffering inhuman or degrading treatments.

In 2005, the ‘Code de l’entrée et du séjour des étrangers et du droit d’asile’ (CESEDA, Code of the entry and residence regulation, and asylum right) was enacted, which encompasses previous provisions on asylum rights and refugees’ protection, without altering the definition of inhuman treatments.

In 2006, after a governmental notification making it possible to regularise the parents of all children registered in public schools was cancelled due to a dramatic increase of asylum applications, many new applicants of African origin (especially among illegal migrants from Mali and Côte d’Ivoire) alleging a risk of FGM for their children to obtain subsidiary protection. This led the OFPRA to modify its doctrine and sending a mission to Mali, in order to obtain subsidiary protection on the grounds of a risk of FGM for their children to be returned to it. This status could also be granted upon the HCR mandate.

Moreover, the medical certificate confirming that no FGM was performed on the applicants’ children, upon which the subsidiary protection can be granted to parents, has to be renewed every year to renew this status. This doctrine modification is referred to as Doctrine Modification in the Granting of the Subsidiary Protection Status of the French Office for the Protection of Refugees and Stateless people (OFPRA) (July 2008).

After this doctrine modification was adopted, 179 positive decisions were made in 2009 by the OFPRA, granting international protection upon these grounds (21 % of subsidiary protection granted to female asylum seekers). This data is only for adult seekers. Besides, 266 medical certificates were produced for children, in 2009, to renew subsidiary protection on the grounds of FGM risk (18).

In March 2009, the Cour Nationale du Droit d’Asile (National Court of Asylum), established in 2007 to replace the Refugees’ Appeals Committee, issued a decision by which it re-established the principle of family unity, granting subsidiary protection to a woman whose children were born in France from a man legally established in the country, but who would be exposed to FGM if returning to Mali as a result of her separation from the father due to domestic violence problems. This decision takes into account the obligation of children’s protection against FGM established by the act of 2006 on domestic violence.

After this decision was made, the number of positive decisions made by the OFPRA slightly increased to 248 (but remained the same in proportion, corresponding to 20% of subsidiary protection granted to female asylum seekers). This data is only for adult seekers. Besides, 1 179 medical certificates were produced for children in 2010 to renew subsidiary protection on the grounds of FGM risk (19).

4.5. Professional secrecy provision(s)

Professional secrecy provisions have long remained under-legislated in France, professionals only being subjected to disclose medical or personal information upon courts’ request, or when requested by corporatist codes of ethics. Yet, primarily addressing sexual violence and violence against children, Act No 2004-1 of 2 January 2004 was passed to clearly establish, in the Penal Code, the conditions for disclosing information. This provision concerns medical and social workers and other professions usually bound to secrecy (not specified). Professionals are thus requested to report physical or psychological abuses perpetrated against children or persons unable to protect themselves due to their age or incapacity, as well as physical or psychological abuses noticed by a physician within the frame of his daily practice and supporting the strong presumption that physical, sexual or psychological violence is perpetrated against the patient. The formal agreement of the latter is requested for reporting abuses.


The same year, Article 44 of the Code of medical ethics, was annexed to the Code of Public Health stating that physical or psychological abuses should be reported to competent (medical, social or justice) authorities, although protection measures have to be taken with ‘caution and discernment’.

In 2006, the Act on Domestic Violence introduced the specific category of sexual mutilations under physical abuses mentioned in Act No 2004-1 of 2 January 2004.

Finally, in 2007, Act No 2007-297 was passed, modifying provisions detailed in Act No 2004-1 of 2 January 2004, and creating an exception to the obligation for a physician to obtain the formal agreement of his/her patient before reporting abuses, if the victim is an under-age child or a person unable to protect herself because of her age or incapacity.

The same act also introduces exceptions to the secrecy provisions for social workers held in Article 411-3 of the Code of Social Action and Family Policy, which cover the disclosure of information to competent police or justice authorities for the purpose of child protection.

4.6. Reflection on legal framework

Concerning provisions held in the general criminal law (Penal Code), at least three important aspects can be mentioned, which are relevant for FGM cases.

- Although the definition of criminal acts in the Penal Code adopted in 1810 did not include any definition of aggravated circumstances for mutilations or bodily harm caused by ascendants, legal tutors or other adults on under-age victims, first FGM cases were brought before civil jurisdiction as early as 1979. They were followed by numerous trials, occasionally involving up to 15 offenders and symbolic sentences were pronounced. This incipient process of FGM criminalisation started due to the willingness of public authorities to send a signal to newly established migrant communities, and to the action of fore-running NGOs and lawyers, who succeeded in bringing FGM cases before criminal courts.

- While it is not the French juridical tradition, it is clear that legislative developments in the field of criminal law were triggered by an innovative case-law on FGM, which formally considered sexual mutilations and the age of victims as aggravating circumstances, implemented an extensive concept of assistance to criminal acts, and introduced financial penalties. All these principles were later recognised by the law (from 1994 onwards).

- NGO (GAMS, CAMS) created in this context to report FGM before the justice and the larger public, as well as specialised lawyers, have played a key role in obtaining new legal provisions.

More generally, it can be emphasised that, although female sexual mutilations are not defined as a specific criminal offence, due to the reluctance of French legislators to recognise any sex-, religion- or ethnic-specific ground, they have been exhaustively covered by domestic legislation. This includes implementing a principle of extraterritoriality (depending on which criminal offence will be retained for prosecution), aggravating circumstances, specific financial penalties, and potential collateral sentences (loss of French nationality if recently acquired, eviction from the French territory).

Although child protection provisions introduced during the 2000s have not been triggered by FGM-related cases, but have resulted from new acts on domestic violence and from the willingness to update the definition of children to be protected, it can nonetheless be argued, that NGOs dealing with FGM once again played an important role. As an illustration of their contribution, we can mention:

- the fact that victims’ protection measures held in the act on domestic violence (2006), also concern illegal migrant children and asylum seekers;
- the extensive definition of ‘endangered children’;
- the obligation for new registration and monitoring structures to include FGM in their activities.

The legal framework for asylum rights has also undergone substantial changes since 2000. Those have been mostly triggered by the case-law of the Refugees’ Appeal Committee (later the National Court for Asylum), which fully recognised, in 2001, FGM threats as a valid ground for obtaining subsidiary protection. Yet, due to a dramatic increase of asylum applications from countries at risk (Mali, in particular), changes were introduced into the doctrine of the OFPRA to make the implementation of such provisions more restrictive. However, they were later removed in appeal by the National Court for Asylum. Therefore, it can be emphasised that in a context where asylum provisions are increasingly restrictively applied, FGM constitutes a sort of exception, thanks to the vigilance of issue-specific NGOs.

Finally, changes brought to professional secrecy over the past decade, can partly be attributed to growing concern for the protection of children against physical and sexual abuses, including FGM.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

To be included into the database, an actor was defined as any organisation or individual actually performing activities related to FGM in France, as was specified in the ‘Guidelines for national data collection’.

In order to identify relevant actors, we did not perform an academic database search, but, instead, we relied upon personal contacts and the web links we could retrieve browsing the websites of relevant institutional actors.

The authors of publications incidentally dealing with FGM (press articles, book sections) who do not have a specific commitment on this issue were not included in the database. Some are nonetheless included in the endnote library that was provided along with this study.

5.2. Actors

If we include public institutions or non-governmental organisations occasionally involved in the diffusion of
AR instruments, the reporting of isolated cases (as some police units), or the implementation of recommendations on professional training (as the faculties of medicine), the total number of actors dealing or having dealt with FGM in France is considerable and goes well beyond 100. However, the role of some actors is apparently weakly institutionalised and mostly relies upon long-established, well-functioning personal contacts. This is notably the case of the role of police units dedicated to the protection of children (0–16). In the Paris metropolitan area and other regional capitals, some of these units have developed a specific attention for FGM cases and regularly report to the justice, to social services and to non-governmental actors such as the CAMS and the GAMS (20), in order to secure immediate protection solutions for endangered children. To a lesser extent, police units who are in contact with migrants, such as units of the Police des Airs et des Frontières (Air control and borders police, PAF) are also likely to adopt grassroots, experience-based procedures with respect to FGM. Nevertheless, due to the non-institutionalised character of these activities, and to the secrecy provisions to which police proceedings are subjected, we could not document the role of these actors within the framework of this desk research.

Therefore, in order to make our database as reliable and updated as possible, and taking into account the tight schedule of this study, we only included institutions and organisations endorsing a leading role or, alternatively, a long-term commitment on this issue in France.

As a result of this more restrictive and operational definition, we included 32 actors to our database.

Those are mainly to be divided into three main subcategories:
- Issue-specific NGOs dealing mostly (or only) with FGM
- Other NGOs active in the advocacy of women’s or migrants’ rights, with a strong activity on FGM
- Public institutions or jurisdictions (at the local and regional levels) with a strong activity on FGM.

**Issue-specific NGOs dealing mostly (or only) with FGM**

The Commission pour l’Abolition des Mutilations Sexuelles (Committee for the abolition of female sexual mutilations, CAMS) was founded in 1982, as an issue-specific organisation dealing with FGM. Over the 1980s, 1990s and early 2000s, it not only provided juridical assistance to victims of FGM, but also sided with the state prosecutor in most of FGM cases brought to criminal courts. Activities on FGM include participation to most of the awareness-raising and prevention campaigns carried out at the national level, expertise for state and regional institutions, and participation to policymaking. Besides, the CAMS developed its own prevention tools in the form of a DVD (translation of a documentary film in English), a CD and a cartoon, available in different languages.

The Groupe pour l’Abolition des Mutilations Sexuelles (Group for the abolition of female sexual mutilations, GAMS) was also founded in 1982, in the aftermath of the first FGM cases brought before civil jurisdictions. It is now established in Paris and in seven other regional capitals. It aims at fighting against all harmful traditions, with FGM and forced marriage in the foreground, but also polygamy or repudiation. The GAMS occupies a nodal position in the French policy on FGM, as it has been regularly involved in policy orientation and policymaking, having a great impact on many of the advances made over the last decades in preventing sexual mutilations in France. The GAMS also established fruitful and long-term cooperation with most of the actors involved in these policies, from other national or regional networks to public policy stakeholders, health and social sectors’ practitioners and the police, OFII (Office Français de l’Immigration et de l’Intégration) or OFPRA officers. The activity of the GAMS draws upon a monitoring activity of suspected cases of FGM that complements the one performed by the department-based units of data collection, treatment and evaluation. The GAMS also plays a key role in the prevention of FGM towards groups at risk, and the training of health and social workers.

It can also be added that both the CAMS and the GAMS play a relevant role in reporting about the French case within the framework of international and European networks (as the European Women’s Lobby), or programmes funded by the European Commission (Daphne). It is currently one of the GAMS priorities to claim for a European protection order in favour of endangered children at risk of suffering FGM if travelling to another Member State where protection measures are less tightly operationalised, or to a country at risk. Similarly, these organisations advocate a simplification of the cooperation procedures between national police corporations, so far with limited results (21).

Tostan International was founded in 1991 by an American-born development volunteer, after a grassroots experience in Senegal, where the Tostan methodology, focusing on health issues and community projects carried out in the local language, was first implemented. The organisation is now present in several western African countries. In 2007, the French branch of Tostan was created, with a focus on the Senegalese population, both in Senegal and among the numerous diasporas living in France. Whereas most activities of Tostan International are carried out in Senegal, the Gambia, Mauritania, Guinea, Guinea-Bissau, Mali, Somalia, and Djibouti, consisting in a three years long tutorial programme, Tostan France also developed activities in France, targeting the Senegalese community. One of the main actions consisted in the making of a documentary film, L’Appel de Diégoune (Diegoune’s call), used as a support for training and awareness-raising sessions on FGM.

Established in 2009, SAFE aims at providing assistance to victims of FGM in Kenya, through local development projects and awareness-raising actions. SAFE also aims to carry out awareness-raising and information sessions in France targeted for local African communities in the Rhône-Alpes region.

**Other NGOs active in the advocacy of women’s or migrants’ rights, with a strong activity on FGM**

Actions et Droits des Femmes Exilées et Migrantes (Actions and Rights of Exile and Migrant Women, AFDEM): is a network of

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(20) Interview with President of GAMS.

(21) Interview with President of GAMS and website search.
interassociation initiatives in the field of women migrants assistance. It was created in 2008 to coordinate the efforts of two already established networks: the Groupe Asile Femmes (GRAF) (Women Asylum’s Group), and the action committee Droits des femmes, droit au séjour, contre la double violence (Women’s Rights, Asylum Right, Against Double Violence), respectively created in 2005 and 2003. Both member networks are active in providing juridical assistance to women claiming asylum on the grounds of their belonging to a persecuted social group. Along with trafficking, gender-based violence or persecutions and prostitution, FGM is one of the main grounds invoked by female asylum seekers to obtain a refugee status or subsidiary protection as members of a social group at risk (in the sense of the Geneva Convention). In particular, the AFDEM website provides updated information about the evolution of case-law in granting/denying asylum on the grounds of FGM.

Comité Médical des Exilés (Exiles’ Medical Committee): founded in 1979, the Comedex aims at providing medical, social and psychological assistance to all categories of exiles, including refugees, asylum seekers, stateless persons, illegal migrants, and unaccompanied minors. As the main medical organisation providing assistance to asylum seekers, refugees and illegal migrants, the Comedex plays an important role in reporting suspected cases or risk of FGM among targeted groups. In association with issue-specific organisations working on FGM, it has developed a monitoring activity in this field, which is reflected in its training tools and guidelines designed for health sector’s professionals.

Comité Inter-mouvements auprès des évacués (Intermovements Committee for Displaced Populations, Cimade): founded in 1939 as an ecumenical organisation to provide assistance to ‘inland refugees’ displaced from north-western France, this committee, now only known under its acronym, is the oldest French organisation in the field of assistance to refugees. It aims at providing judicial and social assistance to asylum seekers, stateless persons and refugees, and assist over 40 000 migrants each year, also intervening, upon governmental authorisation and request, in retention centres were illegal migrants are maintained. As the main organisation providing assistance to asylum seekers and refugees, including within retention centres, the Cimade has developed close cooperation with issue-specific organisations fighting against FGM, in order to improve case-reporting and warning authorities about situations of risk.

Equilibre et Populations (Fairness and populations): established in 1993 on the initiative of a group of journalists interested in development issues, it aims to provide a forum for involving populations from developing countries into the public debate. Equilibre et Population has been involved, as a communication partner, in many awareness-raising and preventive actions carried out on FGM issues.

Fédération des Associations de Solidarité avec les Travailleuse-s Immigré-e-s (Federation of the Migrant Workers’ Solidarity Associations): first established in the 1960s in Paris suburbs’ migrants’ shanty towns, the Migrant Workers’ Solidarity Associations (ASTI) had a strong leftist orientation. Currently, there are 60 ASTI in France, each having its own historical background and specificities in providing judicial and social assistance to migrant populations. The federation was later established, in the early 1990s, around issue-specific committees (Women, Asylum-Europe, North–South, and Youth). It claims to be feminist, internationalist and anti-capitalist. The women’s committee of the FASTI aims at fighting against multiple discriminations and violence faced by migrant women due to their status of inferiority and financial uncertainty. It pays specific attention to gender-based violence, personal autonomy, patriarchal structures attached to ethnicity, cultural traditions and religious beliefs. As such, it addresses FGM, especially as a ground invoked to obtain subsidiary protection or a refugee status from the OFPRA.

Femmes de la Terre (Women of the Earth): founded in 1992, its aims are to provide judicial and social assistance to women migrants, especially to those at risk of being persecuted or victims of gender-based violence, including prostitution and trafficking. Beyond judicial assistance to obtain a legal resident status, Femmes de la Terre also carries out training and awareness-raising actions targeting women. As it first addresses the needs of female migrants at risk of being persecuted or victims of gender-based violence, this NGO is directly involved in fighting against FGM in coordination with other issue-specific organisations. For instance, in 2010, it reports having assisted 40 women at risk of FGM for them or their daughters (53 in 2009). It also provides support to asylum seekers arguing a high FGM risk to obtain subsidiary protection, with a high success rate.

Gynécologie Sans Frontières (Gynaecology Without Borders): was founded in 1995, and aims at providing, as part of a global effort to promote women in society, a medical support to tackle situations of risk regarding gynaecological and obstetric pathologies, in countries or sectors with poor medical infrastructures. It implements a multidisciplinary approach, encompassing medical, but also psychological, social and gender aspects of women’s health. Gynécologie Sans Frontières now has a long record of activities related to FGM, as it notably helps training physicians and nurses intervening in foreign countries on gynaecological, obstetrical and women’s health issues. More recently, this NGO played an important role in promoting surgical repair after FGM, through a multidisciplinary approach that takes into account psychological and socio-cultural aspects. For this purpose, it developed one of the most complete tools (FGM, professional practices in maternity wards of Seine-St-Denis/Fighting female genital mutilations in the Loire-Atlantique region), in the form of a manual for practitioners. This organisation also regularly conducts training sessions which aims specifically address FGM or include it in a broader agenda.

Movemeent Français pour le Planning Familial (French Movement of Family Planning): established in 1956, the MFPP is a popular education movement providing information and life-long learning. It aims at creating the conditions for sexuality in respect of differences, personal autonomy, and responsibility. The MFPP places its action in the perspective of a society founded on the principles
of equality, diversity, secularity and gender equality. One of its main activities consists in providing assistance and information on reproductive health, including abortion and contraception. The MFPF is present throughout the territory. Due to its long-established presence throughout the territory and its vocation to provide assistance on issues related to reproductive health, the MFPF is one of the key actors of the French FGM prevention system. It is thus involved in most of the preventive and awareness-raising actions taken so far, although it mainly relies upon the GAMS or other issue-specific civil society organisations to provide contents or perform training action on this issue.

Réseau pour l’Autonomie des Femmes Immigrées et Réfugiées (Migrant and refugee women’s autonomy network, Rafjire): this civil society organisation established in 1998, aims at providing assistance to female migrants and refugees. It promotes gender equality, anti-racism, informing women of their rights as regard personal autonomy, asylum rights and legislation on asylum and violence against women. As part of its monitoring activity on the evolution of the implementation of asylum rights in France, Rafjire closely follows up decisions made by the OFPRA and the National Court of Asylum Rights (CNDA), providing its members with updated information regarding case-law on FGM as a ground for claiming a refugee status or subsidiary protection.

Réseau Education sans Frontières (Education without borders network, RESF): this network was launched in 2004, as the result of a joint initiative bringing together associations, trade unions and public personalities protesting against the deportation of migrant children already attending school in France. This network has no hierarchical structure or spokesperson but is present in every department and has a strong mobilisation capacity through social networks and newspapers. Its activity mainly consists in the monitoring of expulsion procedures including children, the organisation of awareness-raising or information campaigns and online petitions. As part of its mobilisation and monitoring activities, RESF regularly reports to its member associations and to the larger public (through the press and social networks) cases of evictions/deportation of illegal migrants from the territory, pointing out the risk of FGM. In 2009, this network launched a campaign on child protection and received a lot of public attention. RESF works in close cooperation with issue-specific organisations fighting against FGM. Since it is present in every department, it has contributed to draw public attention on FGM issues in the context of migration policies.

Public institutions or jurisdictions (at the local and regional level) with a strong activity on FGM

Due to the institutional path-dependent features detailed in Section 3, gender-related policies carried out in France are coordinated weekly at ministry level, where their continuity is challenged by regular changes in attributions and areas of intervention and the absence of any long-lasting and well-funded structure in charge of gender equality. This, however, does not mean that the ministries in charge of health, social services, education or social cohesion, have not occasionally played a significant role in institutionalising and promoting policy instruments (2). These have nonetheless been mostly shaped by working groups established in the parliament and in regional and local administrations, with the contribution of experts and NGOs.

Cour Nationale du Droit d’Asile (National Court of Asylum, CNDA): established in 2007, it replaces the Commission de Recours de Réfugiés (Refugees’ Appeals Committee), and has the final word as regards granting refugee status or subsidiary protection. In 2009, the CNDA released over 25,000 decisions. OFPRA decisions were cancelled in appeal by the court in 25% of cases. The Refugees’ Appeal Committee and, since 2007, the CNDA, have been the major source of case-law as regards FGM as a ground for granting a refugee status or subsidiary protection.

Cellule départementale de recueil, de traitement et d’évaluation (Department-based unit of data collection, treatment and evaluation, CPRI): established under the authority of the president of the General Council of each department, these units are in charge of collecting data and reporting about children’s protection. FGM is to be included in the reporting activity (3).

Commission Nationale Consultative aux Droits de l’Homme (French National Consultative Commission on Human Rights): the French National Consultative Commission on Human Rights is a national human rights institution, as defined by the United Nations’ generic terminology. NHRI have a hybrid status, given that they are created by states, while remaining fully independent from them. It is organised in working groups regularly issuing reports and recommendations on human-rights-related issues; to be followed or placed under consideration by state authorities. The French National Consultative Commission first established a working group on FGM in 2003, and published its first report and recommendations in 2004.

Délégations Régionales aux Droits des Femmes et à l’Egalité (Regional Directorate for Women’s Rights and Equality, DRDFE): these bodies, in charge of implementing the governmental policy as regards gender equality, have been established in the 26 French regions, with local delegates in each department. Whereas many of them carry out low-scale activities with limited funding, some DRDFEs have played a pioneering role in implementing innovative gender equality policies. This has been the case with the DRDFE of the Île-de-France region, and its delegation in the department of Seine-St-Denis. This region gathers about one sixth of the French population (11 millions) and about one third of migrant populations living in France, thus giving a key role to regional policy structure to develop, monitor and coordinate regional and national public policies on FGM.

(2) This role, however, was mostly limited to recommendations for generalising good practices with a limited control over their implementation, to the support to regularly held conferences and to the publishing of relevant T & I often shaped by commissioned experts from other institutions/organisations.

(3) According to one respondent, information on FGM is usually included in the reporting activity of the CPRIs, although with local variations, depending on the demographical importance of groups at risk and the more or less recent character of sub-Saharan immigration in the department.
The DRDFE Ile-de-France thus published the first booklets on the issue as early as the mid-1990s and has been one of the main institutional partners of issue-specific NGOs dealing with FGM in France. It also contributed to build long-lasting policy networks by organising regular conferences on the issue since 2002, which have become annual since 2006, coinciding with the International Day against FGM in February, and regularly updating monitoring reports and prevention documents. The pioneering action of the DRDFE of the Ile-de-France region as regards prevention, policy network building, information and support to training actions and NGOs, has triggered similar developments in a few other DRDFEs (in particular in the following regions: Pays de la Loire, Haute Normandie, Nord-Pas de Calais, Champagne- Ardenness, and, more recently, Provence-Alpes-Côte d’Azur, Rhônes-Alpes, Poitou-Charentes and Alsace.

Office Français de Protection des Réfugiés et des Apatrides (French Office for the Protection of Refugees and stateless people, OFPRA): the OFPRA is the state authority dealing with asylum applications. It takes decisions referring to the Code de l’entrée et du séjour des étrangers et du droit d’asile (Ceseda, Code of the entry and residence regulation, and asylum right), into force since March 2005. There are approximately 165,000 persons under the protection of the OFPRA (excepting subsidiary protections, 2010). The doctrine applied by the OFPRA in granting refugee status and subsidiary protection is of high importance for women and parents arguing that there is a risk of FGM and/or persecution related to their refusal of female sexual mutilation in their country of origin. As it intervenes in retention centres for illegal migrants and since its officers are in the front line to address new migrants’ populations’ needs, the OFPRA has been included in several training actions on FGM in 2001–05, and has been paying a growing attention to this issue in its annual activity reports since 2005.

Office Français de l’Immigration et de l’Intégration (French Migration and Assimilation Office, OFII): created in 1945, the OFII is in charge of coordinating, with French consulates abroad, the delivery of work and residence permits, and promoting the assimilation of legal migrants in France. For this purpose, it is in charge of compulsory citizenship training courses. It is also in charge, along with the OFPRA, of asylum seekers. As the main state organisation in charge of legal migrants, the OFII has been included in the monitoring of suspected FGM cases. For this purpose, at least one training session was organised by the GAMS for its senior officers.

Protection Maternelle et Infantile (Maternal and Child Protection, PMI): as already mentioned in Section 3 of this report, the PMI was established in 1945 to carry out preventive actions for the whole population, with a focus on under-age population and children under six years old. In 1982, the coordination of PMI services was transferred from the state to the Conseils Généraux (local government at the level of departments). PMI services are in the front line to carry out the 20 free, compulsory medical screenings scheduled for every child under six in France, especially for low-income households and specifically for urban migrant populations. As the medical screening of girls’ genitalia is systematically carried out under the age of six, PMI services thus play a key role in reporting FGM cases. As PMI services are present in every department, we did not mention each unit or departmental coordination structure (placed under the responsibility of the Conseil Général — local government) in our database. Instead, we mentioned only the PMI service of the Seine-St-Denis department, being a department with the highest migrant population rate in France and one of the most comprehensive PMI networks (there are currently 118 PMI day care centres in Seine-St-Denis that counts 1.5 million inhabitants (INSEE, 2009)). Besides, as has been mentioned above, this department has played a key role in developing a policy response to FGM.

5.3. Reflection on actors on female genital mutilation

If compared to the actors mobilised for the implementation of other public policies, the actors active in fighting FGM present some specific features.

First, it needs to be pointed out that these actors are actively cooperating, thus forming a rather comprehensive and tight policy network covering children’s protection, asylum rights, migrants’ assimilation policies, the police, local attorneys and, to a certain extent, training institutions such as some faculties of medicine and specialised schools for midwives and nurses.

The main actors assuming coordinating and monitoring roles are the DRDFEs, in particular in the regions with high immigration rates, and the NGOs specifically dealing with FGM, such as the GAMS and the CAMS. These actors can rely on the reporting activity of the Infantile and Maternal Protection Services, but also the cooperation established with key public and non-governmental actors in the field of migration and asylum policies, such as the OFPRA, the OFII, the Cimade or the Comede.

Over the past decade, these activities have increasingly involved other non-governmental actors that initially did not address FGM but are now playing an important role in reporting FGM in relation with their core activities, such as migrant women’s (and/or children’s) rights or planned parenthood.

Another evolution to be mentioned is the growing interest by the medical community for the FGM issue in France. From 2001 onwards, Professor Foldès successfully implemented a surgical repair technique, which has drawn considerable attention from the medical community, thus making sexual mutilations not only a matter of prevention, but also a therapeutic issue. This has definitely helped to increase the interest and awareness of healthcare professions for this issue, and to improve their training. This development has been supported by Gynécologie Sans Frontières, an NGO which developed thorough guidelines and protocols for practitioners, with the help of respected experts such as professors Henri Foldès or Philippe Henri-Jean. However, although the National Academy of Medicine issued recommendations on FGM in 2003, there is still a long way to go to make relevant information on FGM an integral part of the initial training of every health professional in France. This is reflected in the surveys carried out with the general practitioners we could access for this study, which indicate low training levels, especially among male GPs. Moreover,
several cases of alleged sexual abuses involving GPs over the past few years have made male physicians increasingly reluctant to systematically examine girls' genitals during periodical medical screenings. This situation is made even more complex in a context where religious or cultural beliefs are increasingly used by parents to prevent performing certain medical acts.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

For the purpose of this study, we have used a variety of channels to access relevant tools and instruments on FGM. First we carried out a keyword search on the websites of various institutions and non-governmental actors, in particular those listed below:

Ministère des solidarités et de la cohésion sociale/Ministry of solidarities and social cohesion

http://www.education.gouv.fr
Ministère de l’éducation nationale

Cellule départementale de recueil, de traitement et d’évaluation (CRIP)

http://www.gynsf.org
Website of an NGO in the field of obstetrical and gynaecological medical relief that deals extensively with FGM.

http://www.federationgams.org
Website of the main organisation dealing with FGM in France.

http://www.cams-fgm.net
Website of a long-established organisation dealing with FGM in France

http://www.planning-familial.org
Website of the Planned Parenthood Organisation

Website of the French Office for the Protection of Refugees and Stateless People

http://www.ofii.fr
Website of the French Office for Immigration and Assimilation

http://www.cimade.org
Website of the main relief organisation for refugees and asylum seekers

http://www.comede.org
Website of the main medical relief organisation for refugees and asylum seekers

http://rafire.free.fr
Website of the Migrant and Refugee Women’s Autonomy Network

This desk research has been completed by several e-mail and phone contacts with relevant experts, as those mentioned in Section 2.

6.2. Tools and instruments on FGM

In total, we listed 39 tools and instruments (T & I) in the database, including awareness-raising publications and events, manuals and guidelines, documentary films, toolkits for training sessions, cycles of conferences, etc.

Awareness-raising publications

Booklets:
One of the most distributed T & I categories is made of AR booklets designed in priority for parents and families among groups at risk, but also social and healthcare sectors’ workers and other professionals working with migrants and asylum seekers.

The first booklet was issued in 1992 by the DRDFE of the Ile-de-France region, at the initiative of experts of the two first established NGOs dealing with FGM. With the title Nous protégeons nos petites filles, this publication provided targeted groups with basic information on FGM (French and international legal frameworks, prevalence), a series of questions/answers challenging commonly shared assumptions on FGM, and resources (associations, hotlines).

According to its promoters, this document, aimed at the prevention of FGM through education, by presenting the legal grounds of FGM criminalisation in France emphasised that FGM was also being challenged in countries of origin. It also embraced a positive vision of populations at risk, making parents key actors in preventing FGM.

This approach was adopted to counteract the negative reactions which had been noticed among groups at risk with respect to the conviction of several parents during the first wave of criminal trials.

Widely distributed in the Ile-de-France region, this booklet was regularly reissued over the 1990s, and has been adapted in several other European languages. Moreover, the format of short (6 up to 16 pages) booklets was adopted as the main AR T & I in France. As a consequence, similar tools were later issued, first at the regional level and later at the national level, by the Ministry of Employment, Social Cohesion and Housing, issued in 2003 and 2006, and in 2009 and 2011.

Over time, all these documents issued by state services, adopted approximately the same shape and content, with minor variations and updates, such as the possibility of surgical repair.

In 2010, Gynécologie Sans Frontières designed a brief (four-page) booklet for the attention of medical practitioners including physicians, obstetricians, gynaecologists,
paediatricians, midwives, nurses and medical students, which was published and distributed by the Ministry of Health.

Therefore, approximately one quarter of the relevant T & I listed in the database take the form of brief, informative and widely distributed documents, thus lacking both methodology and interactive content.

Nevertheless, in February 2012, the DRDFE of the Île-de-France region renewed with its pioneering role with regard to FGM, issuing a 20-page-long document, designed for the attention of high school pupils of both sexes, parents of groups at risk, but also social and medical personnel working in the public educational system. This booklet addresses a new target group — teenagers — taking into account the decrease of FGM prevalence among younger children, and the fact that when FGM is still performed, interventions tend to be much later, on the occasion of travels to the country of origin. Secondly, this booklet adopts a different shape and content, including a multiple-choice questionnaire allowing target groups to test their knowledge about FGM. Information is also provided on the French legal framework, prevalence, cultural contexts where sexual mutilations still prevail, medical complications and surgical repairs. Knowledge-transfer is completed with recommendations on how to report FGM.

Other AR publications
This subcategory notably comprises Nos petites filles ne seront pas excisées, a 95-page-long illustrated book including a few testimonies from actors of the fight against FGM (NGO representatives, policy officers, Member of the European Parliament, etc.). This publication issued in 2006 by the GAMS mostly aims at promoting the actions taken over the past decades to prevent FGM. It also includes: Les aventures d’Aissatou, a cartoon with the same main character as the documentary film: Le pari de Bintou, issued in 2010 by the CAMS.

AR video documents
Le pari de Bintou, a 17-minute-long video, was the first documentary film used in support of AR actions on FGM. Referred to as ‘Bintou’s challenge’, it was issued by the CAMS in 1995. The same year, the GAMS produced a 26-minute-long video, captured in Senegal, in support of awareness-raising, preventive and training actions, along with Women seating under the knife’s edge, a manual for awareness-raising meetings and preventive actions against FGM.

In 2006, Noires douleurs (‘Black suffering’), a 52-minute documentary film picturing the personal experiences of four women of African origin, born in France or not, about FGM, was broadcasted on public TV channels and used in different AR actions.

More recently, in 2011, Tostan France, a newly active NGO on FGM, produced L’appel de Diéogoune (‘Diéogoune’s call’), a 35-minute-long video, captured in Senegal (Casamance region) by the NGOs Tostan International and Respect (Belgium). Previously used for supporting preventive and training actions in countries with high prevalence rates, this video has been made available to NGOs and public services working with African migrants in France, thanks to the support of the Regional Directorate for Women’s Rights and Gender Equality (DRDFE) of the Île-de-France region.

Guidelines, protocols and manuals
Another category of T & I is constituted by guidelines, protocols and manuals of different kinds, either designed to support training sessions or containing thorough instructions to deal with FGM in a variety of situations.

The subcategory of T & I designed to support training sessions, comprises Femmes assises sous le couteau, a manual for awareness-raising meetings and preventive actions against FGM issued in 1995 by the GAMS. This tool was designed to support the broadcast of the eponym documentary film. In 2011, a similar T & I, L’appel de Diéogoune, was produced by the DRDFE of the Île-de-France region in support of another documentary. This subcategory also includes Mutations sexuelles féminines: agir, prévenir, accompagner, réparer… pour en finir’, a CD-ROM issued in 2008 by Gynécologies Sans Frontières to support training actions held for healthcare professionals.

As for the subcategory of guidelines and protocol, it is made of an eight-page-long protocol to be used for awareness-raising sessions, as those held in 2010 in the Île-de-France, Champagne-Ardennes, Poitou, Haute-Normandie, Pays-de-la-Loire regions. This T & I was designed in 2010 by the GAMS, for the attention of regional and national social and health policies stakeholders, as well as social, education and healthcare workers working with migrant populations. This subcategory also includes guidelines on how to react in case of FGM, designed for the personnel of the Maternal and Infantile Protection Service of the Île-de-France region.

Besides, at least three manuals have been issued for different target groups. Migrants/étrangers en situation précaire: prise en charge médico-psycho-sociale is a manual for social and healthcare workers working in contact with migrants, asylum seekers and refugees, published in 2008 at the initiative of the Exiles’ Medical Committee. In this manual co-published by the National Institute for Prevention and Health Education, FGM is addressed on pages 275 to 279, alongside forced marriages. Information addresses the legislative framework, a typology of FGM and steps to be taken to report cases. Data about prevalence is also provided in the annex for main country cases.

Le praticien face aux mutilations sexuelles féminines (Medical practitioners facing female genital mutilation) is certainly the most thorough instrument designed for the attention of healthcare professionals. Primarily addressing medical practitioners including physicians, obstetricians, gynaecologists, paediatricians, midwives, nurses and medical students, this 102-page manual was issued in 2008 and 2010 by the Ministry of Health. Contents have been authored by a 23 members multidisciplinary team (including sociologists and psychiatrists) gathered by Gynécologie Sans Frontières. Part I provides data on prevalence, historical and cultural backgrounds of FGM, national and international legal frameworks, medical
complications, FGM typology and available surgical repair techniques. Part II addresses practical cases (diagnoses, medical screening, reporting to judicial authorities or social services), with specific guidelines and protocols. Sample reporting and medical certificates are annexed to the manual.

**Other training tools**

This category includes training sessions held for OFPRA officers and for medical students.

**Institutional tools and instruments**

In this category, we opted to list different sorts of T & I, such as the recommendations on FGM issued by the National Academy of Medicine, and the conferences on FGM regularly held since 2002 by the DRDPE, both in the Paris metropolitan area and in regions, which gather regional and national policy stakeholders. It also includes a study assessing the policy treatment of FGM in France, monitoring case-law related to criminal court cases and providing a few recommendations for policy coordination, issued in 2004, by the National Human Rights Consultative Committee.

Pluridisciplinary units refer to the multidisciplinary units established in about 12 major hospitals throughout the territory, to take charge of mutilated women opting for surgical repair.

6.3. **Reflection on tools and instruments on female genital mutilation**

It is worth underlining, that the first T & I on FGM was adopted in France by the early 1990s, when the process of criminalisation detailed in Section 4, had reached a first peak. Then, it became clear to a variety of actors, particularly to those (lawyers, NGO members, anthropologists, sociologists) gathered in the seminar on peoples’ rights and human rights held at Nanterre University in 1989–91, that the normative conflict raised by FGM between alien traditions and ‘universal’ values advocated in the French public space could not be solved only by criminalising this practice.

As a consequence of this (often contentious) dialogue, which triggered numerous publications during the 1990s (see, for instance: Verdier, 1990, 1991; Raulin, 1990; Bourdin, 1992) (**), AR tools have been designed for the attention of groups at risk, in order to prevent FGM, also with the participation of migrant communities.

The main medium used to raise awareness among concerned communities, as regards harmful practices and their criminalisation by the French legal framework, consisted in widely distributed, albeit brief and strictly informative booklets. This major development nonetheless triggered further innovations, such as the use of documentary films, cartoons, photo books and other documents in support of AR and training actions.

Additionally, the two first-established NGOs dealing with FGM — the CAMS and the GAMS — have developed training activities for a variety of audiences, which have been later reinforced by the activities carried out by Gynécologie Sans Frontières and Tostan France. However, it can be argued that training activities in France have found limited institutionalisation, being held rather incidentally, either upon request of public institutions such as the OFPRA, the OFII or the PMI, or upon the insistence of NGOs such as the GAMS or Gynécologie Sans Frontières. In particular, as underlined by one respondent, only a few faculties of medicine and specialised schools have introduced FGM into their core teaching curricula.

Whereas AR publications have been regularly re-issued, occasionally with minor updates, and widely distributed to concerned target groups, other T & I used in France usually lack continuity and appear to be weakly institutionalised. This major feature, however, as well as the relative lack of diversity of existing T & I, has to be put in perspective. Indeed, the major tools and instruments available for the prevention and the reporting of FGM cases in France could not be listed in our database, as they are anchored in the flesh and bones of French public policies, in the form of widespread and functioning health and social services specifically addressing migrant populations, long-established policy networks including NGOs dealing with FGM, or the strict medical monitoring of certain populations at risk, such as newly established migrants or asylum applicants.

7. **FINAL CONSIDERATIONS**

With a large population coming from sub-Saharan Africa, estimated between 500 000 and 700 000, which started to settle already by the mid-1970s, France has been in the front line as regards FGM prevalence in Europe. In a context heavily marked by the reluctance to recognise diversity of origins, and by an assimilationist model, it is remarkable, however, that the policy response to the challenge of FGM has never been grounded into a statistical knowledge of the phenomenon. For this reason, available estimations, ranging from 40 000 up to 60 000 girls having suffered sexual mutilations are neither fully reliable, nor updated, and they do not reflect the global trend to be reported by the beginning of the 2010s. This trend appears to show a sharp decrease in FGMs performed on the French territory among legally established populations, as reflected in the decreasing activity of criminal courts on FGM. New challenges emerged by the late 1990s and 2000s, however, such as the arrival of new migrant communities from other countries at risk (Democratic Republic of Congo, Guinea) who settled in regions where prevention systems were less tightly operationalised.

Whereas first FGM cases were reported to the public by the mid-1970s, the first cases were brought to civil courts already by the end of the 1970s, indicating a relatively quick response from the authorities. The process of criminalisation detailed in this report, was backed by the first established NGOs dealing with FGM and by the growing awareness of the larger public on this problem. As a result, France was the first western country to bring FGM perpetrators (or facilitators) before criminal jurisdictions, developing
a relatively abundant case-law that triggered new legislative and policy developments. This process of criminalisation reached a first peak in 1993–94, when a dozen of trials were organised in order to draw the attention of migrant communities on the legal cost of FGM. Another peak was reached in 2006, when new legal provisions came into force, strengthening the legal framework and leaving little space for FGM advocates on the French territory.

After the first peak was reached in this process of criminalisation, policy actors, including experts, NGOs, public institutions at the regional and the national level, and legislators, increasingly address FGM through prevention and social or health assistance. This policy development was largely driven by the most active NGOs, the CAMS and the GAMS and the DRDFE network, mostly in the Ile-de-France region, with the support or participation of larger actors and institutions such as the Ministries of Social Cohesion and Health, the Cimade or the Family Planning. This process was made possible by the institutionally dense and quite efficient French welfare state, which facilitates the sanitary control and social monitoring of populations, including groups at risk. On the legislative front, French policies on FGM have been supported by the major steps taken in legislating domestic violence and children’s protection. From the early 2000s onwards, FGM has also been thoroughly addressed in the field of asylum law. In 2009, the case-law of the National Court for Asylum (CNDA) (re)established a more extensive interpretation of situations in which subsidiary protection can be granted on the grounds of an alleged FGM risk.

Last but not least, France has played a pioneering role regarding the development of surgical repair techniques. Available since the late 1990s, they have been covered by the National Health Insurance System since 2004 and generalised throughout the territory, through the establishment of multidisciplinary teams in major regional public hospitals. Despite these developments, however, the contribution of medical professions — especially general practitioners — in preventing and reporting FGM has remained problematic, as the recommendations of the Academy of Medicine and the governmental notifications on the inclusion of FGM to the basic training of every future healthcare professional have not been uniformly implemented. Moreover, cases of sexual abuses from practitioners and the increasing use of religious or cultural beliefs by patients to prevent the performing of certain medical acts have recently complicated the role of healthcare professionals in France.

Yet, it can nonetheless be argued that, although France has shaped a rather comprehensive and exhaustive legal framework around the FGM issue, and benefits from the gains of a long-established welfare state in terms of prevention and monitoring, its policies have proved to be fragmentary and lacking continuity in their nationwide implementation. Moreover, due to the strict constitutional limitations imposed for collecting data on ethnicity and other personal circumstances, they still miss a thorough and reliable knowledge of the phenomenon, notwithstanding the recent inputs brought by the ExH (Excision et Handicap) survey carried out by the INED.

References


Analytical country report

France
Analytical country report

I. INTRODUCTION

This report aims at widening the knowledge and the understanding of the French approach to FGM developed in the desk study report. Its main objectives are to outline the milestones and the key developments in the policy response given to the issue with respect to the five ‘Ps’ defined in the general framework of this study: prevention, prosecution, protection, partnerships between relevant actors and provision of services. It also intends to make sense of prevalence data collected in France. Beyond the analysis of the main features of the approach implemented in the country, the objective of this report is also to assess its successes, the major challenges it has encountered as well as to identify the key domestic and external variables that have contributed to shape it.

For this purpose, it relies on six interviews carried out with relevant actors of the ‘politics’ of FGM in France. Three of them were suggested by the core team, taking into account two aspects which had been highlighted in the desk study report: the central position given to prosecution, at least during the first two decades of the fight against FGM in France; and the recent developments of implementing provisions regulating international protection, with respect to FGM as a valid ground for subsidiary protection. Two of the respondents were selected for interview because of their major contribution to FGM policies in France, both at the individual and at the collective level (through their respective organisations). Three other respondents were selected upon recommendation.

Whereas the first respondent had already been approached during the desk study, other respondents were contacted via official invitation letters indicating the framework, the objectives and the methodology of the study, as well as its commissioner. The interviewees received a customised questionnaire in their native language, mentioning the major issues to be tackled during the interviews. However, the questionnaires could be occasionally expanded or downsized, depending on the time lot available and the reactions of the respondents. We did not encounter any specific difficulty during the empirical stage of the study, as the contacted persons agreed to be interviewed and they made themselves available within the time frame of the study. Two respondents had nonetheless negative reactions with respect to the formulation of the letter of consent, which strongly clashes with currently admitted practices among social scientists in France. However, the interviews we carried out met the standards of length and content set for this study. In qualitative terms, our interactions with the respondent were usually fluid and they showed interest in the potential outlets of the study. Interviews lasted about one hour on average and were carried out under good conditions, at the offices of the interviewees. The interviews were performed over one month, between 7 June and 5 July.

Basic information on the respondents is provided in Section II ‘Information sources’. The historical and major policy developments with respect to FGM in France are thoroughly addressed in Section III ‘Historical context and policy developments’, separated into three subsections underlying the importance given to prosecution (III.1); the multi-level dimension of FGM policies (III.2); and the main intervening variables in the FGM agenda-setting process (III.3). Prevalence and data collection are addressed in Section IV, and the approach to FGM in France is detailed in Section V, under six distinct subsections, five of which explain the different ‘Ps’ addressed in this study. The successes and challenges of the approach implemented in France are analysed in Section VI, and lessons and policy recommendations are outlined in Section VII. The last section of this report (VII) attempts to identify potential good practices with respect to FGM, following the definitions provided by the EIGE.
II. INFORMATION SOURCES

Overview table of the interviews

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<td>7.6.2012</td>
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Brief description of each respondent

The Deputy Head of the Maternal and Infantile Protection Service (hereafter, PMI) in Paris. For the last 23 years, she has worked as a PMI doctor and chief of unit in the Seine-Saint-Denis department, which has the highest concentration of sub-Saharan population in France, and has played a pioneering role in tackling FGM in France. Thanks to her experience on this issue, she joined Paris PMI in 2011, where she coordinated the publication of a new internal notice on FGM, drawing upon a more comprehensive and transversal approach to the problem. The notice includes thorough guidelines for PMI professionals working not only in child protection but also in family planning and addressing reporting procedures, provision of services, surgical repair and partnerships with CSOs and other actors. It is the first document of that kind in France.

An administrator (member of the administrative supporting service of the MPs) at the French National Assembly. He acquired a wide knowledge on issues related to bodily integrity, gender-based violence (hereafter, GBV) and cultural diversity, within the framework of different ad hoc committees established for periods of six months by the French parliament. In 2009, he organised and documented the work of the committee established to assess existing policies and legislative provisions on gender-based violence, including FGM and forced marriage. It resulted in a comprehensive 700-page-long report which addressed FGM both transversally, and through specific measures. As an insider of parliamentary politics, this respondent has ample knowledge of policy paradigms which are referred to when addressing bodily integrity or GBV in general, and FGM in particular.

One of the historical actors of the fight against FGM in France. She became familiar with this issue at the end of the 1980s, within an academic framework, and coordinates the Groupe pour l’Abolition des Mutilations Sexuelles (GAMS) since 1991. Established in 1982, the GAMS is the main CSO active in the prevention of FGM. It has been associated to the major policy and legislative developments on this issue, and is at the heart of most partnerships and policy networks established around FGM. The GAMS also provides assistance to the different categories of actors directly involved in the protection against and prosecution of FGM (police officers, asylum officers, maternal and child protection’s professionals).

She can provide valuable insights on the overall policy treatment of FGM in France, both as activist and sociologist.

The Head of Unit of the Brigade de protection des mineurs (Children’s Protection Squad, hereafter: BPM) in Paris. She was interviewed alongside the Deputy Head of the same organisation. The BPM is the only structure of that kind in France. Unlike the brigades des mineurs (Children’s squads) which exist in other regions, it focuses only on cases in which children are the victims, thus entailing a notion of protection. There are two main fields of intervention for the BPM: intrafamily violence (including rape, acts of paedophilia, abuses, ill- or degrading treatments, including FGM/offences; and crimes perpetrated outside the family and trafficking. Due to its area and field of intervention, the BPM has been in the front line in dealing with FGM cases. It has built personal networking with major stakeholders intervening in the prevention and prosecution of FGM.

A member of France Terre d’Asile, one of the major CSOs intervening in the field of international protection, where she is responsible for asylum on gender-related grounds. In 2010–12, she participated in EU-funded projects on gender and international protection, through which she could build expertise, particularly on FGM as a ground invoked by refugees and asylum seekers. Her organisation has recently developed an increased awareness concerning gender-based violence, persecution and FGM, and it is adopting a pioneering position among non-governmental actors of asylum policies. Regularly consulted by the public administration in charge of migration and asylum policies, France Terre d’Asile occupies a nodal position in policy networks built around these issues. Besides, this respondent also recently published a comprehensive study on gender and international protection, which gives specific emphasis to FGM.

The Director of the CAMS (Commission pour l’Abolition des Mutilations Sexuelles), and one of the key personalities involved at the European level in the fight against FGM since its very beginning, at. As a lawyer initially specialised in civil jurisdiction, she has been present in most FGM cases brought before criminal courts, due to her literal and yet pioneering interpretation of the law. During the 1990s, she reactivated the CAMS as an instrument for the prosecution and criminalisation of FGM in France, bringing about 40 cases before the court. Deeply convinced that
no prevention action could effectively be implemented without formally criminalising FGM, she has nonetheless contributed to numerous preventive and awareness-raising actions in France and abroad and participated progressively reached consent among major stakeholders about FGM policies, as regards the combination of prosecution, protection, prevention, and partnerships.

III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

As will be further detailed in Section V, with respect to the five ‘Ps’ identified for the purpose of this study, France has to be characterised by the emphasis it initially placed on Prosecution. As underlined in the desk study report, this situation partly explains that, whereas FGM cases were made public already by the early 1980s, when African immigration began to change the face of migrant populations established in France, the first policy instruments were not developed until the mid-1990s, and most were issued after 2004. In fact, a penal response to FGM was developed well before it started receiving a comprehensive treatment in policy terms. In a country where case-law plays a much more limited role to trigger legislative developments than in common law countries, the criminalisation of FGM and its impact on subsequent policy development is an odd case that deserves specific developments. Besides, while prosecuting — and condemning — FGM before criminal courts largely shaped the conditions in which prevention and protection policies were later developed, it has not resulted in the adoption of specific provisions on FGM as those enacted in other EU-Member States in the absence of effective prosecution.

To make sense of these paradoxes, we will first draw upon the contribution of the main actor of the process which led to the criminalisation of FGM in France. We will also largely rely on the information provided by the coordinator of the Groupe pour l’Abolition des Mutilations Sexuelles (GAMS), one of the pioneering organisations in the protection of victims and the development of prevention instruments.

Back to the origins of FGM in France

By the late 1970s, France had long been an immigration country. Since the late 19th century, it had taken in millions of Italians, Poles or Spaniards. After the independence of its colonies in Africa, it accepted over 1.5 million displaced persons, closely followed by hundreds of thousands of ‘temporary’ migrants from the newly established countries, who were hired to work in agriculture and the industry. However, these African migrants were overwhelmingly male. In 1978, the right-wing government, as part of an effort to modernise society, adopted a new regulation on family entry and settlement, which resulted in the massive entry of female migrants. Tens of thousands of women originating from countries with high prevalence rates joined their husbands who were working for car manufacturers. The coordinator of the Groupe pour l’Abolition des Mutilations Sexuelles (GAMS) remembers: ‘From the 1980s, there was a massive flow of sub-Saharan migrants, among whom a few women, especially in Paris and the Seine St-Denis, but also all along the Seine Valley, where car manufacturers are located. This was followed by a massive flow of women, mostly Soninké and Toucouleur, who came from regions of Mali, Senegal and Mauritania, where FGM prevalence was extremely high [...]. These women, who were themselves mutilated, came to the Maternal and Infantile Protection Services with their daughters, who had either been subjected to FGM or were about to suffer FGM.’

Some voices then warned respected feminists about the fact that FGM was definitely being performed on the French territory, calling for an appropriate and swift response from the authorities. Additionally, first low-scale studies providing information on prevalence were carried out at the beginning of 1980, in particular a survey done in Parisian public hospitals and a police investigation monitoring complaints related to FGM carried out in a migrant district of the capital.

In response to the phenomenon, the Commission pour l’Abolition des Mutilations Sexuelles (CAMS) was founded by a woman of Senegalese origin in March 1982. Soon after the first case drawing public attention was brought before the court, the organisation split, due to different viewpoints on criminalisation and different strategic options long thought to be incompatible (prosecution/prevention and provision of services).

Nevertheless, between 1982 and the mid-1990s, most of the fight against FGM conducted before courts resulted in the criminal status and the prosecution of FGM.

III.1. FGM through the lens of the Penal Code: when prosecution anticipates on policy

First court cases emerging

This process has been long and complex. This was caused by fact that the phenomenon was underestimated for a long time, by the cautious positioning initially adopted by public attorneys and magistrates towards the penal nature of FGM, and by the interference of subjective statements or ideological positioning tightly linked with France’s colonial past. To date, no study has been published that could provide a fully reliable and exhaustive chronology of FGM court cases since the first was reported in 1979. Therefore, the contribution of the interviewee, who has been part of every procedures initiated since 1982, is key to understand further developments:

‘There is so much to tell [...]. Nowadays, we tend to analyse past events through today’s eyes, however, things did not happen like we think they did: a few decades ago, we discovered the practice of FGM (in France) little by little, as cases emerged. For instance, Mrs Roudy [first Women’s Right Minister ever appointed in France, in 1981] and I first became aware of FGM when little Abobo Traoré died, in July 1982. Mrs Roudy was shocked and she decided to act as a politician, bringing the issue in the public agenda [...]. Realising that this issue was drawing a tremendous attention from the media, the Paris General Attorney moved
FGM cases from the bottom to the top of his priorities and progressively, they were brought to the attention of Justice.’

By that time, the respondent knew that the first FGM case had been brought before a court as early as 1979 and had been qualified as ‘unintended homicide’. But it had not received any media coverage, and most of the cases came into light in the immediate aftermath of the Traoré case. These events were a turning point both for the respondent’s career and for the treatment of FGM in Europe, as she decided to push for a penal resolution to FGM cases in France. From the beginning it was her conviction that there was no point in voting for a specific law to criminalise FGM, as the (former) Penal Code already punished ill-treatments and bodily harm done to children. She defended this position within the frame of the working group set up in 1983 by Yvette Roudy, Women’s Rights Minister, also arguing that a specific act would stigmatisate migrant populations.

The respondent’s first priorities were to be able to sue in FGM cases, using the legal possibility offered to CSOs to act in justice under specific conditions, and to ensure that FGM cases would receive their appropriate judicial qualification as a crime and not as an offence, so that they could be judged before higher jurisdictions. The first of these priorities corresponds to the possibility in France for CSOs to sue. However, procedures have to be initiated by public attorneys (which represent the society), while if procedures are initiated by physical persons, CSOs cannot go to court. Finding a CSO that met all the criteria already triggered complications, especially as family associations refused to sue the parents of mutilated children. Nevertheless, the respondent obtained the support of the Women’s Rights League. This support had strong political and symbolical implications, as revealed in the following dialogue between one of the respondents and the lawyer of little Abobo Traoré’s parents, whose case came back before the court in 1984:

‘It was in Créteil, the case of little Abobo Traoré. […] It was the first of March 1984; I remember it perfectly […]. Her parents were defended by the President of the International Human Rights’ League. I was pleading in the name of the Women’s Rights League. He called me before the trial and he asked me: “Why do you put us in this mess for these stories of female circumcision? Do I, myself, complain about male circumcision?” “Listen”, I answered, “You represent the Men’s Rights League [Ligue Internationale des Droits de l’Homme: in French, man and human are used interchangeably] and I represent the Women’s Rights League: that’s pretty much the difference.”

The CAMS happened to be supportive of criminalising FGM and it soon offered the respondent to sue before courts on its behalf. A few years later, the respondent took full responsibility for the CAMS, which became tightly connected to the fight against FGM in the legal field.

Towards criminalisation
Initially, magistrates were extremely reluctant to address FGM as a criminal act, implicitly considering that since FGM healed, it did not cause permanent incapacity or illness: ‘There was a sort of consent between magistrates not to qualify FGM as a crime. This was my very first objective, from the beginning: I wanted the real qualification to be recognised. If facts were underestimated, I believe, this would lead to minimising the suffering of the victims and to denying a part of their humanity […]. According to Article 312 of the former Penal Code, light injuries caused by physical abuses were to be brought before police courts, bodily harm causing work interruptions were to be judged before civil courts. Yet, bodily harm causing the loss of an organ, and mutilations, could be punished by criminal sentences and they thus had to be sent before criminal courts.’

According to the respondent, the aim of going before a criminal court (Cour d’Assises) was to give FGM its true qualification and to draw greater public attention, thanks to the media coverage usually given to criminal trials in France. In the meantime, first FGM cases were brought before civil jurisdictions. Although there is no dual track in France (civil/penal) as might be the case in common law countries, civil courts are responsible for minor offences (délits) and thus pronounce milder sentences.

This is why the respondent argued about those courts’ incompetence to judge FGM cases. She stressed that she was proved right even in the first civil case in which she took part. Indeed, she argued that, although parents were judged for non-assistance to an endangered person, the true qualification should have been ‘crime’, since mutilation had preceded the situation of non-assistance which had been brought before the court. Against the attorney’s position, the judge considered that she was right and sent the case before a criminal court. The turning point was the notice sent by the judge of a criminal court, in which he considered that the removal of the clitoris had already been considered a mutilation, and therefore a crime, in a judgment he had himself pronounced a few months earlier in a case which did not belong to the usual definition of FGM, but nevertheless provided an accurate case-law for FGM. As a consequence, when another FGM case emerged in 1984, it was directly brought before a criminal court. Due to the fact that the judge in charge asked for an international request in order to identify the perpetrator in Mali, this case returned before a court only in 1988 (1). After the respondent successfully pleaded the incompetence of the courts, FGM cases were systematically brought before criminal jurisdictions.

Circumventing the law: new developments in FGM cases after 1990
This strategy thus revealed itself to be successful. Due to the public attention drawn on FGM court cases there was a decrease in reported FGM from the mid-1990s onwards. For the respondent a first battle had been won: ‘Sentences pronounced by the courts had been widely reported among migrant communities, thus having a preventive and dissuasive effect. We met mothers who told us: “for our eldest daughters, we had no idea and they were excised. The youngest won’t be.”

(1) The length of criminal procedures in France (up to 10 years), explain that FGM cases often overlap in time, and that same cases were successively brought before civil and criminal courts. This makes it extremely difficult to identify phases or cycles in the criminalisation process of FGM in France.
However, at about the same time, actors involved in the fight against FGM started to notice strategies to circumvent the law, such as sending young girls to their country of origin to undergo FGM there (See Section V ‘Successes and challenges’). These strategies requested a firm judicial response. As reminded by the respondent: ‘Article 113 of the former Penal Code mentioned that offences and crimes perpetrated abroad by/on French citizens could be prosecuted in France. Yet, in 1993 the so-called “Pasqua Law”, which made it difficult to know who was considered French or not, came into force. Prior to that, attorneys had been prosecuting parents or perpetrators of FGM, no matter if they had French citizenship or not. Their only consideration was whether the child was born in France or not. And if the parents’ lawyers complained, then they had to argue […]’. In 2006, we obtained the protection to be extended to children who had their permanent residency in France.’

This provision, contained in the 2006 act on domestic violence, did not specifically target FGM cases, but it increased the protection of children at risk and the possibility to prosecute perpetrators and facilitators.

### III.2. Policy development on FGM: from bottom-up to top-down policies?

#### Policy initiatives blossoming at the local and regional levels

The concern for this new phenomenon in France was also expressed at the governmental level: in 1981, the newly elected Socialist President, François Mitterrand, established a Ministry of Women’s Rights, with forefront feminist Yvette Roudy at its head. This was an important milestone also in the fight against FGM. A working group on FGM was established in 1983, and in 1985 the GAMS participated to the UN Women’s World Conference in Nairobi, on the request of the minister.

Nevertheless, the first governmental notification on FGM was not issued before 1994 by the Ministry of Social Affairs, Health and Urban Areas. It asked every department with an important migrant population to list FGM among its priorities in the fields of social and health policies, and to organise awareness-raising actions. To a certain extent, this notification was aimed at generalising the good practices experimented in the Paris metropolitan area from the beginning of the 1990s. As mentioned by a person who first worked as a doctor of the Maternal and Infantile Protection (hereafter, PMI) in the Seine-Saint-Denis department:

‘As soon as FGM cases were identified among communities from sub-Saharan Africa, professionals of the PMI have been sensitised by associations such as the GAMS, and through the cases to which they have themselves been confronted. In 1991, the chief doctor of the PMI in Paris issued an internal notice to help PMI doctors with consistently and uniformly dealing with FGM cases in terms of identification, reporting, and giving information to families. It was the first official document that requested PMI professionals to fully integrate awareness raising on FGM to their work. This has resulted in making families of African origin realise that they have valuable interlocutors at the PMI, who do not judge them but who inform and assist them, including through partnerships with CSOs like the GAMS.’

The PMI, which was created after WWII by the General de Gaulle, is a public service aiming at prevention. Among its main responsibilities, the PMI ensures the well-being and monitors the health of children through regular and compulsory medical screenings, up to the age of six. As it is free and of universal access, the PMI has been in the front line to deal with FGM. In 1982, its tasks were transferred to departments (local governments), which organise these missions depending on the needs of the local populations. This has given the PMI a pioneering role in a few departments, for example the Seine-Saint-Denis, which has the highest concentration of migrant population of sub-Saharan origin in France. In particular, under the initiative of Dr Emmanuelle Piet, a chief PMI doctor who is among the pioneers of the fight against FGM in France, this department has developed a transversal approach in which FGM is tackled as part of a continuum of gender-based violence (GBV).

According to another respondent, ‘Seine-Saint-Denis has become a pilot department, adopting a generalist approach, not specifically centred on FGM but drawing upon a broad and structural understanding of gender-based violence, including FGM, whatever the origin or the traditional practices of a community.’

#### First prevention campaign and policy networks

Whereas the Seine-Saint-Denis developed its own policy framework on FGM from the late 1980s onwards, in 1992, the Women’s Rights and Equality Directorate for the Ile-de-France region initiated a working group to prepare the first institutional awareness campaign on FGM through the high-scale diffusion of booklets and posters. This working group helped establish a fruitful and long-term cooperation between CSOs working on FGM for the benefit of complementary work and the efficient protection of victims and groups at risk.

For one of the respondents, ‘this working group institutionalised regular meetings and contacts between people who had already started to work together. It did reinforce the dynamics that had already emerged between the CAMS, the GAMS and the Maternal and Infantile Protection Services […]’.

The prevention and awareness-raising campaign launched in 1993 constituted a key milestone in the policy treatment of FGM, especially at the local/regional level. The booklet was regularly reedited and updated during the 1990s and 2000s in Ile-de-France and other regions, for instance in Haute Normandie, Champagne-Ardennes, Pays de la Loire or Nord-Pas-de-Calais. Regional Women’s Rights and Equality Directorates were also strongly encouraged by the ministries in charge of gender equality and ‘women issues’, to establish subcommittees on FGM within GBV committees in regions considered at risk.

As emphasised in the desk study report, FGM is not a practice that uniformly affects French territory. For instance, most cases brought to criminal courts were reported in
the jurisdictions of the Paris metropolitan area (Ile-de-France region), which accounts for one sixth of the French population, and one third of the total migrant population (a proportion that is much higher for communities coming from countries with high FGM prevalence rates). Rhône-Alpes (Lyon and Grenoble areas) and Provence-Alpes-Côte d’Azur (Marseille, Nice and Toulon areas) are, to a large extent, the other two potentially affected regions, followed by other urban areas from Nord-Pas-de-Calais, Midi-Pyrénées and Champagne-Ardenne. It is therefore not surprising that prevention policies on FGM were first implemented at the regional level. Besides, most of the instruments of the institutional dense and comprehensive welfare state (including social, health, education) are mostly implemented at the local (departmental) or regional level. Therefore, departments and regions are the relevant level where regional services of the state, regional institutions and local health and social services have to coordinate their action.

The forerunning actions, on FGM, by the local structures of the French welfare state are still in place nowadays. As an example, in 2011, the PMI service in Paris issued an internal notice that looks at all the PMI’s fields of intervention, including maternal protection and family planning. The notice also provides thorough guidelines to PMI professionals, framing intervention on FGM cases. They include the procedures for reporting FGM, and also detailed information on psychological, social and medical assistance that can be provided not only to girls, but also to adult women who underwent FGM. This more comprehensive framework reflects the fields of intervention of maternal and child protection, which goes far beyond the medical screenings of children under six.

**Tackling FGM at the national level**

Until the mid-2000s, FGM-related policy actions thus resulted from initiatives launched by state services at the departmental or regional level, with the support of other local public services such as the PMI and CSOs. Nevertheless, two policy areas, namely gender-based violence and children’s protection, have undergone substantial changes throughout the 2000s, providing a window of opportunity to strengthen policy instruments on FGM also at the national level.

After Act No 2006-399 of 4 April 2006 was passed, strengthening the prevention and repression of violence perpetrated within a couple and against children, a series of preventive and educational measures were taken to tackle FGM, both at regional and national level, and the state social, educational and health services were mobilised for its implementation. The issue was also mainstreamed into two broader policy plans on domestic violence. Unlike the first plan, adopted in 2005, the second global triennial action plan on domestic violence for 2008–10 listed FGM among its priorities.

Additionally, an ad hoc parliamentary committee was set up, in 2009, to assess the implementation of the 2006 Act on domestic violence and provide a broader policy and legislative framework for the fight against gender-based violence. Consent was reached among its members that the field of gender-based violence, including FGM and forced marriages, should be retained. For a person who has been involved in the preparatory work of this committee: ‘At the beginning of our work, the chairwoman, the rapporteur, the vice-chairs and the members of the committee had a frank and open discussion on the issues to be tackled. A number of problems were mentioned, including traditional harmful practices such as FGM and forced marriage. Only human trafficking and prostitution have been excluded from the field of the committee, but they were later tackled by specific committees (…). There was also consent to adopt an inclusive understanding of GBV and since FGMs were considered in the bill that legitimated this committee, they were placed under its scrutiny.’

Although this process has not resulted in including additional provisions on ‘Sexual mutilations’ in the new Act on violence against women passed in 2010, it addressed FGM under a specific chapter and made six issue-specific recommendations.

• Ensure the diffusion of the outputs of the ‘Excision et Handicap’ (ExH) study

• Inform newcomers from countries at risk

• Train professionals working with migrants

• Train consular and embassy officers

• Generalise multidisciplinary units taking care of surgical repair in regions

• Improve the protection of children with a status of refugee/subsidiary protection granted upon the motivation of a high FGM risk.

The main change brought to child protection in France since WWII, was Act No 2007-293 of 5 March 2007 , reforming children’s protection provisions. After a long debate involving policymakers and experts, this act replaced the ‘children suffering psychological or physical abuse at home’ notion, by the more inclusive one, of ‘endangered children’, advocated by NGOs fighting against child abuse, including FGM. This act also established the Cellules départementales de recueil et de traitement des informations préoccupantes (Department-based units of collection and treatment of information in relation with situations of risk, hereafter, CRIPs). Established under the authority of the president of the general council of each department, these units are in charge of collecting data and reporting about children’s protection, including about FGM cases.

Although CRIPs are established at the local level, they aim to provide a nationwide registration system, including on FGM cases, and have already been integrated into the daily practice of the main actors fighting genital mutilations, such as the police, the justice (through the attorneys), CSOs and the PMI. Although the role of the CRIPs will be analysed in more depth in Section V.3 of this report, it is worth mentioning that the objective to have an institutional, comprehensive and efficient system of reporting, registration and monitoring through the CRIPs has not yet been fully met.

According to one respondent, ‘CRIPs are useful, especially when there is no emergency. I have not heard of any general assessment or evaluation on their functioning. However, this has been scheduled in Paris, in order to form a clear picture of the reporting procedures on child abuse, GBV and FGM. I believe there is cooperation between the PML and the CRIPs on child abuse and ill-treatments, but we are still in a phase of reflection concerning GBV and FGM.’

For Céline Plumail (Deputy Head of the Children’s Protection Squad in Paris, BPM), ‘CRIPs function as a filter [of reported cases, some being transmitted to the attorney, while others are not] but there is still ample scope for improving the implementation of their tasks. The most important thing is that no information escapes from the circuit.’

Developments in other areas relevant to FGM

Although provisions regulating asylum and professional secrecy have not led to major policy developments in the form of specific instruments to deal with FGM (such as policy recommendations, actions plans or policy networks), important decisions have been taken in the relevant fields for the overall treatment of FGM in France. These decisions will be further detailed in Section V.3 of this report. Nonetheless, there are some major milestones concerning international protection and the regulation of professional secrecy:

Until a new law was passed in 2003, the Office Français pour les Réfugiés et Apatrides (French Office for the Protection of Refugees and Stateless People, hereafter OFPRA) was regulated by Act No 1952-893 adopted to implement the Geneva Convention (1951). In 1991, the Commission de Recours des Réfugiés (Refugees’ appeals committee) issued a first decision acknowledging FGM as a form of persecution (although the refugee status was denied due to poor credibility of the seeker). Yet, the first decision acknowledging a social group in relation to FGM was taken in 2001 (see: V.3 ‘Protection’).

However, the implementation of the Sissoko case-law was soon affected by the introduction of a new regime of international protection, by Act No 2003/11-76 on asylum rights. Subsidiary protection, granted for one year (renewable) to people at risk of suffering inhuman or degrading treatments, was consecutively systematically considered for applications on the grounds of FGM, thus weakening the degree of protection potentially granted (1). Moreover, in 2008–09, further precisions were brought by the OFPRA and the National Court for Asylum, restricting the definition of social group at risk of FGM (see: V.3).

Professional secrecy provisions have long remained under-legislated in France, with professionals only being subjected to disclose medical or personal information upon courts’ request, or when requested by corporatist codes of ethics. Yet, Act No 2004-1 of 2 January 2004 clearly established the conditions for medical and social workers for the disclosure of information. Professionals are thus requested to report physical or psychological abuse perpetrated against children or vulnerable persons, as well as evidence supporting the strong presumption that physical, sexual or psychological violence is perpetrated against a patient. The formal agreement of the latter is requested for reporting abuses. Besides, Article 44 of the Code of Medical Ethics states that physical or psychological abuses should be reported to competent authorities, although protection measures have to be taken with ‘caution and discernment’. In 2006, the Act on domestic violence introduced the specific category of sexual mutilations under physical abuses mentioned in the 2004 act, and since 2007, a victim’s agreement is no longer necessary for under-age patients or vulnerable persons. Beyond this evolution of the legislative framework, no policy development relevant to FGM has been made concerning professional secrecy.

III.3. Summary of the main intervening variables in the FGM agenda-setting process

In this subsection, we provide a summary of the main actors or variables (both domestic and external) which have contributed to put FGM on the policy agenda in France.

Key actors

- Issue-specific CSOs established in 1982 to shed light on female genital mutilations have played a key role in the process that led to put this issue on the agenda. Although both the CAMS and the GAMS were founded by women of sub-Saharan origin, these organisations were established separately, after the CAMS was split in the aftermath of the first FGM prosecution cases. As mentioned by the first respondent, ‘The GAMS, which was established after the scission, had prevention towards population at risk as its first objective. It was managed by women originating from sub-Saharan Africa and female doctors working for the Maternal and Infantile Protection Services, who considered that it was not possible to carry out preventive measures towards families at the same time as suing them, which was later the purpose of the CAMS.’

Although the objectives of the CAMS and the GAMS (i.e. criminalisation of FGM and prevention, information and provision of services to populations at risk) could retrospectively seem complementary, it was nevertheless necessary to rebuild the relationship between these two historical actors of the fight against FGM in France. This was made possible thanks to a generational shift at the head of the GAMS, as highlighted by the first respondent: ‘It was much easier for us, who were not among the founders of the GAMS, to restore this relationship, especially with [name of respondent] and the strategic option of criminalisation that she represented.’

Moreover, some African origin members of the GAMS helped the organisation to reconsider its positioning towards criminalisation, considering that a firm and clear discourse on the prohibition of FGM was necessary to trigger changes among migrant populations:

‘They had quite an outspoken and firm standpoint. They told us that we were too kind and naive and that some African women had convinced us it was possible to work on prevention and have efficient awareness-raising campaigns without the perspective of criminal sanctions — whilst it wasn’t.’

(1) Refugee status is granted for 10 years.
As a growing consent started to emerge acknowledging the role of criminalisation in the prevention of FGM, the CAMS and the GAMS increasingly collaborated towards raising the attention to FGM among professional communities such as GPs, obstetricians, social workers or the police.

- Maternal and Infantile Protection Services (PMLs), especially in the Paris metropolitan area (Île-de-France region) have also played a relevant role, as FGM cases were first reported by PML professionals. Besides, they elaborated pioneering internal protocols and guidelines with respect to FGM, and PML doctors were among the founding members of the GAMS.
- In interaction with PML services and CSOs, the Women's Rights and Equality Directorate of the Île-de-France region (DRDFE) also contributed to put FGM on the agenda, as it was very active in setting up the first long term policy network on this issue at the local/regional level in 1992. This policy network has been at the core of the main prevention and AR campaigns launched since and it is under the patronage of the DRDFE that many policy instruments and tools relevant for FGM have been shaped over the past two decades.
- Some political actors also contributed to develop the policy response to FGM. Yvette Roudy first gave legitimacy to the issue at the governmental level as early as 1982. After her women's rights ministry was dismantled, different ministries or state secretaries have been in charge of gender equality and 'women's policies', who, have seemingly always supported policy action on FGM. Among the most recent supporters of a comprehensive policy approach to this issue, the first respondent specifically mentioned Valérie Létard (State Secretary to Solidarity, 2007–09), Nicole Ameline (Minister for Parity and Solidarity, 2002–05) and Xavier Bertrand (Minister for Health, 2005–07). Advocates of women's rights at the parliament, in particular those involved in GBV, have also been active in promoting an inclusive understanding of gender-based violence, including FGM.

It is worth mentioning that in the process that led to considerably strengthen policies tackling GBV in France between 2004 and 2012, right-wing and left-wing MPs have both played a key role. An administrator at the National Assembly thus highlighted that despite its potentially contentious dimension for party politics, FGM did not trigger much ideological debate during the process of evaluation of GBV policies in 2009.

- Finally, key individual experts can also be mentioned. In addition to the CAMS and the GAMS which acted as prominent members of issue-specific CSOs, a few others have also had a relevant impact on policies addressing FGM. Although it is impossible to be exhaustive, Emmanuelle Piet, PMI chief doctor in the Seine-Saint-Denis department and Professor Foldès, who helped triggering the attention of health professionals on FGM due to his pioneering work on surgical reconstruction, also deserve to be mentioned.

Additionally, a number of other non-governmental and institutional actors have also played a significant role in putting FGM on the agenda and in the elaboration/implementation of policy instruments, awareness-raising and prevention tools, or training instruments. They are listed in the desk-study report and the database annexed to it.

**Domestic variables**

When addressing the main domestic variables which have influenced the judicial and policy treatment of FGM in France, it is relevant to underline that hard facts such as prevalence studies or research material on the phenomenon have played a very limited role in drawing the attention of the media and political actors on this issue. This is mainly due to the path-dependent features which have been extensively addressed in the desk study report and briefly summarised in Section IV ‘Prevalence and data collection’.

Instead, we would like to highlight the following variables, which are of different natures:

- The possibility, under certain conditions, for CSOs to sue before courts, has been emphasised as a fundamental element by two respondents, as it enabled feminist, later issue-specific organisations to address FGM in the name of society and public good, and to bring it high on the agenda. Retrospectively, and with respect to the role played by the CAMS in criminalising FGM, this legal provision appears extremely important.
- FGM cases were brought to the knowledge of the Justice and the public, soon after the Socialist Party won the presidential and parliamentary elections. It offered specific support to feminist activists and paved the way to more favourable conditions for migrants to create associations (before 1981, CSOs’ boards could not be made exclusively of foreign citizens). Although FGM was an extremely new issue in the public space, it was taken up by the French Minister for Women’s Rights both at the domestic and international level, as in Nairobi in 1985. Nevertheless, as mentioned in Section V, this window of opportunity also provided room for advocates of ‘cultural relativism’, who consider that French authorities, due to their colonialist past, are not qualified to regulate traditional practices among migrant communities. These arguments were especially manifest at the end of the 1980s, in the minutes of the seminar on Peoples’ Rights and Human Rights held at Nanterre University, which considered that the normative conflict raised by FGM between alien traditions and ‘universal’ values advocated in the French public space, could not be solved by criminalising this practice (see, for instance: Verdier, 1990, 1991).
- This aspect contradicts another relevant feature of the institutional context in which FGMs have been addressed: the broad concept of public order that prevails in France and which entails certain limits to the expression of cultural diversity or free choice, in the name of social cohesion and a set of principles concerning bodily integrity. As put by one of the respondents: ‘Another, related aspect is that in the French judicial and constitutional case-law or practice […], as for bioethics or any issue for which there is tension between self-determination and the respect of human dignity, we implement an approach that tends to reduce personal autonomy as well as the margins for the expression of those cultural practices which are considered to be harmful. This approach is rooted in principles such as
the non-patrimonialism of human body, human dignity and [...] the non-material public order, as defined by the state council: a set of fundamental common values and practices which constitutes the public order just as public security, salubrity and peace [...] I think that this is this approach which also applies to FGM, although it was not explicitly mentioned.’

- Another point of interest is that FGM was brought to the attention of the public, as France was undergoing its first process of decentralisation since the French Revolution. For instance, in 1982, the coordination of PMI services was transferred from the state to the Conseils Généraux (local governments at the level of departments). Since, most of the instruments of the institutionally dense and comprehensive welfare state (including social, health, education) are mostly implemented at the local (departmental) or regional level. As a consequence of this process, and due to the unequal repartition of populations at risk on the territory, FGM policies have been firstly developed at the local and regional level. This situation entailed specific features which will be addressed in Section V ‘Success and challenges’.

**External variables**

It is a relatively common feature highlighted by the literature on French public policies that limited references are made to the EU legal order and/or policy framework (Jacquot, Ledoux and Pallier, 2012). Especially in the case of social policies, this broad characteristic is often rooted in the conviction that French policies have been pioneering and therefore, largely anticipated on policy developments at the EU level. Another explanation is the relative EU-blindness of French policy actors, who tend to analyse policy developments as the product of purely domestic variables. As a result, whereas provisions on gender equality in the workplace, anti-discrimination or more recently, work-life conciliation, have been largely influenced — or even shaped — by provisions, recommendations or debates that were firstly developed at the EU level, little attention is paid to the Europeanism patterns of French policies.

Policy developments on FGM hardly escape this ‘domestic framing’ of policy issues. Therefore, interviewees made no reference to the EU as a source of inspiration or policy transfer as regards the legal and institutional treatment of FGM. If this can be related to the fact that the European Union had not yet developed specific provisions on gender-based violence and female genital mutilation, it can nonetheless be objected that the EU has a long record in the development of gender equality policies, including binding provisions but also soft policy instruments, ‘ways of doing things’ which provide policy-makers with valuable resources to tackle a number of issues related to gender equality. Besides, there is strong evidence in the literature, that Europeanism also impacted policy fields in which there are no EU binding norms, such as gender-based violence, through a variety of ‘soft’ channels and strategic usages of Europe (Woll, Jacquot 2010; Krizsan, Popa, 2012). In line with this argument, EU-funded long term (Daphne) or targeted (Gensen) programmes have contributed to shape the knowledge on FGM in France. Gensen (Enhancing gender sensitivity and a harmonised approach to gender issues in European asylum practices in order to better identify and serve the needs of vulnerable asylum seekers) thus triggered the attention for gender aspects, including FGM, of the French policy actors active in the field of international protection.

The fact remains, however, that references made to the European and the international level by our interviewees mostly emphasised the pioneering role of France in FGM prosecution or in recognising FGM as a ground for international protection, as put by one of the respondents: ‘This was quite a pioneering decision, since recommendations to include FGM under the criteria of the Geneva Convention were issued only in 2002 at the United Nations level, while UNHCR recommendations on gender and asylum, as far as I remember, were adopted in 2008.’

In the same vein, one of the respondents recalled that France helped put FGM on the international agenda during the cycle of UN international women’s conferences: ‘[Women’s Rights Minister Yvette Roudy] asked the GAMS to attend with her the UN Women’s World Conference in Nairobi in 1985. There were only two workshops on FGM then but there were about 50 in 1995 in Beijing […]’

Table 1 summarises the major milestones of the emergence of the FGM issue in France, and of its treatment in judicial and institutional terms.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>First FGM case brought before court.</td>
</tr>
<tr>
<td>1982</td>
<td>Foundation of the two first issue-specific CSOs (CAMS and GAMS).</td>
</tr>
<tr>
<td>1983</td>
<td>A working group on FGM is established under the supervision of the Minister for Women’s Rights.</td>
</tr>
<tr>
<td>1988</td>
<td>First FGM case brought before a criminal court.</td>
</tr>
<tr>
<td>1992</td>
<td>First policy network/partnership established at the local level.</td>
</tr>
<tr>
<td>1993</td>
<td>First institutional prevention and AR campaign at the regional level.</td>
</tr>
<tr>
<td>1999</td>
<td>28 parents and FGM perpetrators prosecuted in a single trial.</td>
</tr>
</tbody>
</table>
Legal constraints on data collection
As has already been extensively addressed in the desk study report and discussed during the expert meeting on prevalence that was held in Paris within the framework of this study, France does not provide a favourable environment for the collection of prevalence data on FGM. France has always been reluctant to monitor the profile of its population in terms of cultural or national origins and beliefs. As a result, no nationwide statistics or databases have been made fully available so far, even for research purposes. Collecting ‘sensitive’ data remains prohibited in France, as the Constitutional Council considers that, although measuring diversity, discrimination and integration can draw upon objective data, it violates the first article of the constitution when considering ethnic origin or race (EC, 2008. Decision of 15 November 2008). In this context, the collection of comprehensive and reliable data on FGM prevalence is made particularly difficult, including for public-funded research and institutions. As a result, the majority of the policy documents, reports and preventive or awareness-raising (AR) instruments issued since 2004, refer to the same rough estimate of 40 up to 60 000 potential mutilated girls/women living in France: an estimation that was inferred from gross migrant populations over 18, without a more refined statistical control (see below).

Until 2007, no prevalence study on FGM had been carried out in France, and only two rough estimates had been proposed, respectively in 1982 and 1989, indicating that 24 000, later 27 000 girls living on the French territory had been mutilated or were at the risk of undergoing FGM. However, in 2005, researchers at the universities of Paris-I Sorbonne and Nice made a first estimation on the number of girls suffering FGM in France. This estimation was based upon the data available from the Etude de l'Histoire Familiale (Study of family trajectories) study, annexed to the 2004 update of the 1999 national census (380 000 respondents of both sexes). Only women over 18 with both parents originating from a country at risk were taken into account for calculating rough prevalence estimation. Between 2007 and 2009, the same researchers were commissioned by the National Institute for Demographical Studies (INED), to carry out a well-funded, extensive survey on FGM: ‘Excision et Handicap’ (ExH). This study had both a quantitative and qualitative content, aiming at mapping and evaluating FGM consequences and the needs for surgical repair.

Indications on FGM prevalence
According to the three hypotheses (low/medium/high) proposed by the authors, corresponding to the (non-) inclusion of different study populations (women over 18 with both parents originating from a country at risk, disaggregated among those who arrived in France before 15 (A1), after 15 (A2) or were born in Europe (A3)), the estimated figures of FGM in France were the following (2004):

- Lower estimation: 42 000 (A1)
- Medium estimation: 53 000 (A1+A2)
- Higher estimation: 61 000 (A1+A2+A3).

These figures were also used in the ‘Excision et Handicap’ (ExH) study. This survey also brings indications as regards the age when FGM was performed, depending on the country of origin. These figures, reported in Table 2, are relevant to address the shift reported by interviewees as regards the age when FGM is performed on girls residing in France (see below). However, due to its methodology and to abovementioned legal constraints applying to data collection; this study does not fully meet the definition of prevalence study proposed within the framework of our research.

<table>
<thead>
<tr>
<th>Age</th>
<th>Country of origin</th>
<th>0 to 4</th>
<th>5 to 9</th>
<th>Over 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mali</td>
<td></td>
<td>82 %</td>
<td>15 %</td>
<td>3 %</td>
</tr>
<tr>
<td>Senegal</td>
<td></td>
<td>65 %</td>
<td>26 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Guinea</td>
<td></td>
<td>35 %</td>
<td>47 %</td>
<td>18 %</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td></td>
<td>41 %</td>
<td>31 %</td>
<td>29 %</td>
</tr>
</tbody>
</table>

With regard to the relative abundance of literature on FGM, to the richness of legislative and policy instruments, to the number of actors dealing with FGM and to large populations from countries presenting high prevalence rates, the absence of reliable and comprehensive prevalence study is particularly puzzling in France. This paradoxical situation was recently addressed by the current Minister for Solidarities and Social Cohesion (also in charge of gender equality), Roselyne Bachelot, who insisted on the need to make data on violence against women more reliable. Thus, the next survey to be launched in 2012–13, will also include girls under 15 (unlike the one carried out in 2000), in order to better account for FGM risks. The lack of prevalence surveys was also repeatedly mentioned in the interviews carried out for the purpose of this study.

However, the absence of comprehensive and fully exhaustive prevalence study in France was not particularly addressed during the assessment of GBV provisions and policies in 2009. The parliamentary committee established to carry out this task did not carry out any additional study on GBV or FGM, as it was not part of its mandate. Therefore, its members relied on the ‘Excision et Handicap’ study. Besides, as put by one respondent:

‘I do not remember any information concerning the lack of prevalence figures. In its report, the committee mentioned the three hypotheses elaborated by the study of the INED (p.68) […]. There was this very comprehensive study, which provided most of the quantitative and qualitative elements to assess FGM in France. And it is clear that within the framework of a committee with limited resources and a broad mandate on GBV, it was not possible to carry out our own study, mobilising several researchers. Therefore, we assumed that [the INED] study was reliable and comprehensive and that its results should not be challenged, especially as it was the only available on the market.’

Although it does not seem that committee members were concerned about the lack of accurate prevalence number on FGM in France, they made recommendations on the aspects to be tackled in future studies: ‘It was not suggested that a new, comprehensive study on FGM general prevalence rates should be carried out, but it was recommended that a protocol to determine the number of girls living in France who undergo mutilation each year should be established […]. This recommendation was related to the major difficulty identified by the committee concerning prevalence: beyond constitutional objections, which were left untouched in the report, MPs were interested in knowing whether girls were mutilated in France or abroad. This aspect is relevant for the orientation of public policies, and it is important to assess if there is an increase or a decrease of FGM performed in France.’

Interrogated about the persisting contrast between the relative sophistication of policy instruments — at least at the local level — and the lack of prevalence data and centralised instruments for data collection, one respondent considered that: ‘In our culture, there is no tradition of evaluation of health policies. The criminalisation process of FGM, nevertheless, enabled to identify reporting procedures and to establish protocols for actors who were confronted with this phenomenon. But there has been an evolution, from a reporting/prosecution issue, to an issue of prevention and public health, for which more subtle and comprehensive instruments are needed.’

The respondent thus assumed that ‘there is a need for figures, within the framework of a more comprehensive approach, concerning the number of cases reported, the size of population at risk…’ Nonetheless, she added, there is not enough distance to assess the impact of changes affecting migratory flows (in terms of migratory projects or origins) on the issue of FGM in France.

The lack of prevalence studies and hard data also makes it hard to assess the number of FGM-related asylum cases, as was highlighted by one of the respondents: ‘We have no figures about FGM-related applications submitted over time […]. As far as we know, there is no registration system at the OFPRA, although it seems that they expect to develop a new database.’ Although the OFPRA collected data on FGM-related granted protections in 2009 and 2010 (see desk study report), it was not systematised since.

V. APPROACH TO FGM

This section provides a picture of the approach to FGM in relation to the ‘five Ps’. The first subsection indicates the balance between the Ps and highlights the main distinctive features of the French approach to the issue. The next sections focus on the different Ps.

V.1. Overall

Definition of the ‘five Ps’ approach

A ‘five Ps’ approach was elaborated for the purpose of this study, namely: prevention, protection, prosecution, provision and partnership(s).

Prevention: involves measures to promote changes in the social and cultural patterns of behaviour of women and men of all ages, including awareness-raising initiatives, development of educational/teaching material, and training of professionals.

Protection: includes the reporting, under appropriate conditions, by any person or professional, of the occurrence of an FGM procedure or that this act is likely to be perpetrated. It also includes cooperative actions to protect victims who have undergone FGM and girls and women at risk of being subjected to this harmful practice, focusing on the safety of the victim and addressing specific needs of this target group. Here, two types of protection are specifically targeted within the scope of this study: child protection and asylum protection.

Concerning child protection, the focus of analysis is directed at measures (voluntary and compulsory) that take into account, as much as possible, the best interests of the child.

Regarding asylum protection, special attention is drawn at the recognition of gender-based violence as a form of
persecution and/or a degrading or inhuman treatment, as valid grounds for international protection.

Regarding prosecution: the Istanbul Convention (2) explicitly addresses the need to ensure criminalisation of FGM. In addition, this convention draws attention to other relevant aspects taken into account in this study, such as not accepting culture, custom, religion, tradition and honour as justifications for committing this crime; applying the law irrespectively of the nature of the relationship between the victim and the offender; establishing jurisdiction over any committed offence (e.g. the principle of extraterritoriality); establishing sanctions and aggravating circumstances.

For the purpose of this study, two other ‘Ps’ were taken into account: provision of a variety of services (e.g. healthcare, counselling, etc.) and partnership (coordinated and integrated approach followed by different actors at governmental level, but also by civil society organisations). Provision of services seems to be usually integrated within the framework of protection. However, considering the scope and purposes of this study, provision of services will be analysed separately from protection, focusing on services offered to victims living with FGM and girls and women at risk of being submitted to the FGM procedure (and their families), such as healthcare (e.g. reconstructive surgery, specialised techniques related to childbirth), counselling (e.g. legal and psychological), financial assistance, social services, education, training, specialist support services, telephone helplines, among others. Moreover, this ‘P’ also looks at the professionals who perform the activities related to these services (e.g. specialised training) and existing tools (e.g. guidelines, learning materials) to assist them in better addressing the needs of this target group.

Partnership: relates to the involvement of relevant actors at international and national level (e.g. governmental agencies, parliaments at national, regional and local level, civil society organisations) towards setting up concerted actions to combat FGM. A significant example of partnership in this topic is the development and implementation of (national and regional) action plans to address FGM by several stakeholders.

Balance of the respective Ps in the French approach

As an introduction to the developments in the next subsections, it is worth mentioning that in France, prosecution anticipated policy developments, particularly on prevention and protection. As will be argued, the French approach to FGM was thus largely shaped by its initial focus on criminalisation. Although criminalising FGM initially triggered resistance among certain categories of actors, its impact on the prevalence of mutilations performed in France was considered positive. This enabled to bridge the gap between the advocates of prevention based on community work, and those who argued that no prevention policy could be effectively implemented without prosecution. From this original normative conflict, there emerged a relative consensus around a global approach which meets the criteria of the Istanbul Convention, in the sense that culture, custom, religion, tradition or honour cannot be accepted as justifications, and that the law should be universally enforced, irrespectively of the origin of the offender/victim.

Prevention and protection have often been framed as the two layers of a same approach. This can be explained by the fact that the Maternal and Infantile Protection Services (or PMI) have been in the front line to deal with the first case of FGM in France. Therefore, their mission of prevention often coincided with a role of protection, as they not only had to report FGM that had already been performed, but also situations of risk. Similarly, the GAMS, established in 1982 to inform communities at risk and to develop preventive work with the support of public authorities, also developed its activity towards protection. Through tight partnerships with the PMI and the Brigade de Protection des Mineurs (BPM, Children’s protection squad) it has thus largely contributed in strengthening protection measures and their implementation. The fact is, though, that child protection draws upon a complex, vertical system of reporting which has long been left untouched, generating restrictive interpretation of professional secrecy and strong inertia which is scarcely compatible with the effective management of situations of risk.

As far as CSOs are concerned, provision of services has been limited by their structural financial insecurity. At the same time, these actors have had to broaden the scope of their interventions, due to the multiple solicitations of public actors in terms of training, expertise or legal counselling. As to public actors, they tend to put little emphasis on the provision of services in France. Mainly implementation-oriented or problem-solving, they are not much inclined to social innovation or engineering, which limits the scope of services they provide to their users or target groups. Nonetheless, because of its tendency to be relatively inclusive, not only addressing girls under six but also teenagers and young women, the French approach to FGM has developed a broader range of services, including information on FGM provided during family planning consultation or surgical repair. Besides, the increasing relevance given to FGM as a valid ground for international protection considerably broadens the scope of services to be delivered and to multiply the number of potential target groups. This challenge has not yet been fully taken up.

As far as the study to map the current situation and trends of FGM focus on prevention and protection, they are being progressively generalised in all regions with potentially significant prevalence rates. Weakly institutionalised, these partnerships nevertheless provide a framework for policy innovation, often anticipating on

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(2) The Council of Europe Convention on preventing and combating violence against women and domestic violence, also known as the Istanbul Convention, has not entered into force yet, but will be the first legally binding instrument in Europe to prevent and combat violence against women and domestic violence and the most far-reaching international treaty to tackle serious violations of human rights.
national policy developments concerning prevention and protection. At the same time, these grassroots partnerships have been established in the long absence of coordinating efforts at the central level to address the need for information-sharing among a variety of actors. Their existence at the local (departmental) level helped to identify pioneering entities, such as the Seine-Saint-Denis and good practices to be adopted elsewhere. This differential situation had quite unpredictable effects, as underlined by one of the respondents: ‘At some point, we realised that since everything was properly addressed in the Seine-Saint-Denis, people believed that everything was fine throughout the territory, which was not the case […]. This is something that became clear to me after we started to organise regional conferences on FGM by the mid-2000s.’

V.2. Prevention

Early developments in prevention

As already mentioned in Section III of this report, preventive work against FGM was first initiated by the Groupe pour l’Abolition des Mutilations Sexuelles (hereafter, GAMS), established with the help of PMI doctors in the Île-de-France region in 1982, with prevention and the mobilisation of communities at risk as its first objectives. This work initially consisted in awareness raising and capacity building among the sub-Saharan communities recently settled in France, and was mostly carried out by women of Malian and Senegalese origin who were among the first to draw the attention on FGM. At the time, the GAMS had no permanent (paid) staff, and although FGM had triggered the attention of the authorities, they provided little financial support to the CSOs carrying out preventive action on FGM.

This situation, which lasted throughout the 1980s, was largely due to the absence of a consensus among CSOs concerning the strategic option that should be adopted to fight FGM. Initially, the prosecution of FGM triggered fierce opposition in France. For instance, it was unacceptable to most of the founders of the GAMS — PMI doctors and African activists — that families should be stigmatised, and they were extremely cautious about any differential treatment that may cover racist prejudices. By contrast, the founder of the CAMS, also an African activist, was very much in favour of prosecution and considered that soft prevention instruments would not produce valid results.

These diverging perspectives were confronted within the framework of experts’ working groups established under the responsibility of ministries or state secretariats which took charge of FGM prevention during the 1980s and 1990s. Although one of the respondents’ arguments received increasing support, collaborative work on prevention nonetheless remained difficult. During that period, one of the respondents repeatedly participated in preventive events organised on the initiative of CSOs fighting FGM. These events, however, were not organised on a regular basis, with the exception of the annual conference on FGM which was organised at the level of the Paris metropolitan area. She nonetheless underlined the leading role of the GAMS in bridging the gap with communities at risk through field preventive work.

Whereas first FGM cases brought before civil, later criminal, jurisdiction definitely had a preventive impact, as underlined by two of the respondents, the GAMS, relayed by other CSOs working with migrant communities, carried out low-scale preventive action throughout the 1980s. However, before the GAMS could reach a critical mass in 1991 and hire permanent and professional staff, its activity could not rely upon sophisticated awareness-raising tools. As underlined by one of the respondents: ‘As soon as we could hire permanent staff, in 1991, we reinforced our activity towards migrants’ centres, Maternal and Infantile Protection Services, hospitals and also, more recently, schools and high schools as well as centres of socio-linguistic training [which provide training to migrants who wish to acquire French citizenship]. Yet, we could never have access to migrants’ shelters. Developing our activity towards school pupils entailed new challenges, as FGM cannot be addressed to children in the same way as to an adult audience. Therefore, we mostly opted to tackle FGM and forced marriage together, often using documentaries, cartoons and other instruments which have been developed over time.’

It is also due to a desire for professionalism, that the 39 tools and instruments listed in the database annexed to the desk study, which include awareness-raising publications and events, manuals and guidelines, documentaries, toolkits for training sessions, cycles of conferences, etc., have been produced from 1992 onwards. This is when the first policy network associating CSOs, PMI professionals, experts and policy actors was established by the Women’s Rights and Equality Directorate of the Île-de-France region. Its first outlet was the booklet Nous protégeons nos petites filles, the publication of which provided targeted groups with basic information on FGM (French and international legal frameworks, prevalence), a series of questions/answers challenging commonly shared assumptions on FGM, and resources (associations, hotlines).

According to its promoters, this document aimed at preventing FGM through education, presenting the legal grounds for criminalising FGM in France and emphasising that FGM was also being challenged in countries of origin. It also embraced a positive vision of populations at risk, making parents the key actors of FGM prevention. This approach was adopted in order to counteract the negative reactions which were noticeable among groups at risk as a result of the conviction of several parents during the first wave of criminal trials. Widely distributed in the Île-de-France region, the booklet was regularly reissued over the 1990s, and it has been translated in several other European languages. Similar booklets were later issued, first at the regional and later at the national level, by the Ministry of Employment, Social Cohesion and Housing throughout the 2000s.

Delegating prevention to CSOs

Public institutions at the national and regional level took up the high-scale publication of booklets, and backed the diffusion of more targeted booklets, such as the one designed by Gynécologie Sans Frontières for the attention of medical practitioners including physicians, obstetricians, gynaecologists, paediatricians, midwives,
nurses and medical students. Meanwhile, as a consensus was reached among major issue-specific CSOs dealing with FGM, preventive work gained both in relevance and sophistication. Associations thus broadened the range of instruments at their disposal, producing and using cartoons, documentaries and training tools for the purpose of awareness raising and prevention.

These developments went alongside a process by which state or regional/local authorities delegated preventive work to the CSOs, only providing financial support and a framework for collaborative work between major stakeholders. As put by one of the respondents: ‘This is not only true for FGM but for any kind of gender-based violence: prevention primarily relies on CSOs, particularly for FGM. They are largely financed by the state and they are de facto implementing public policies on behalf of the state.’ According to the same respondent, this situation was reflected in the work of the committee established in 2009 to assess GBV policies, which largely relied on the work of CSOs specifically tackling FGM to establish its diagnose: ‘As far as I remember, FGM has not been tackled historically by “mainstream” CSOs working on GBV, but by specific associations which build up their action in fighting against these practices, like the GAMS. It is mainly by drawing on their activity and on answers to our questions provided by public authorities, both at the national and the local level, that we have elaborated our recommendations on this issue.’

The respondent also highlighted the contribution of CSOs to the overall framing of gender-based violence adopted within the framework of the committee, with respect to the dominant framing present in the French policy context:

‘Unfortunately, at least from the point of view of the members of the committee, GBV is still narrowly framed in terms of marital violence, if not “battered women”, […] whereas those forms of violence can be included in a much broader category, such as intra-family violence. This is the framing adopted by the Ministry of Justice and the Police, who implement comprehensive indicators […] There is also another framing, in terms of violence against women. This is a framing used by “social” ministries and CSOs, who are conscious that there is a specific form of violence against women, rooted into structural domination mechanisms as patriarchy. This is a framing shaped by feminism but it is also pervasive among institutions in charge of social and family policies, and it was also dominant among the members of the committee.’

Broadening the scope of prevention
Preventive work carried out by CSOs with the support of public institutions reached a first peak by the mid-1990s, when the high scale diffusion of booklets started among communities at risk and professionals of social work, health and education. This coincided with the public impact of criminal trials held between 1988 and the late 1990s, which was pervasive among migrant communities. Later, by the beginning of the 21st century, it benefited from the introduction of new types of tools such as training instruments, documentary films available in the languages of the countries of origin, as well as from the emergence of new issue-specific actors, such as the local branch of Tostan International. Besides, other CSOs working in the fields of social assistance to migrant, asylum and reproductive health, increasingly addressed FGM as part of their daily practice.

As will be seen in Sections V.3 ‘Protection’ and VI ‘Success and challenges’, new concerns nonetheless emerged by the end of 2010, which made it necessary to broaden the scope of target groups reached by preventive action. Strategies adopted to circumvent the law and the monitoring carried out by PMI services for children under six, thus urged the actors of prevention to expand their activities towards new target groups such as girls over six, teenagers in age to be married in their countries of origin and young women consulting family planning organisations.

The risk thus persists for girls over six to undergo FGM during travels to their country of origin. As families have assimilated that, under six, FGM would very certainly be reported and they would be prosecuted, the age for performing FGM has been delayed and often coupled with forced marriage. One of the respondents thus mentioned how the PMI attempted to handle this new situation:

‘I have presented this new problem to the head of the service, who asked me to update our internal notice issued in the early 1990s. Whereas that notice only focused on child protection, the one we issued in 2011 takes into consideration all the fields of intervention of the PMI, including maternal protection and family planning’. Moreover, information on protection and prosecution measures have been updated, taking into account that “FGM can be performed elsewhere in Europe or in countries of origin, but that French law can also be enforced in these cases. The notice insists on the need to maintain awareness on FGM, particularly when girls are about to go to their country of origin on vacation. It also strengthens the monitoring of pregnancies, to better identify situations in which women have been mutilated prior to being forced into marriage, in order to provide them assistance (even after they have reached their majority) to initiate prosecution. Social and psychological support, as well as surgical repair, can then be offered to victims […]’

Recently, new prevention tools tackling these new challenges have been released. In February, 2012, the Women’s Rights and Equality Directorate of the Ile-de-France region published a booklet designed for the attention of high school pupils of both sexes; parents of groups at risk, but also social and medical personnel working in the public educational system. The booklet addresses a new target group – teenagers – taking into account the decrease of FGM prevalence among younger children, and the fact that when FGM is still performed, it tend to intervene much later. Secondly, the booklet adopts a different shape and content, including a multiple-choice questionnaire allowing target groups to test their knowledge about FGM. Information is also provided about the French legal framework, prevalence, cultural contexts where sexual mutilations still prevail, medical complications and surgical repairs. Knowledge-transfer is completed with some recommendations on how to report FGM.
**Funding allocated to preventive work**

Due to the fact that prevention campaigns have often been given support from state institutions at the local/regional level, we have found no relevant information concerning the allocated funding. Besides, AR campaigns through the diffusion of booklets issued during the 1990s and 2000s have been rather sporadic, and they were not included into broader strategies or action plans. For instance, the two first plans adopted to fight gender-based violence, respectively in 2005 and 2008, did not mention any specific budgets attached to actions on FGM, although the one launched in 2008 listed FGM among its priorities.

By contrast, the action plan to fight GBV adopted for 2011–13 gives precise budgets allocated to the targeted and transversal actions designed to tackle FGM, most of which can be related to prevention and information:

- **Diffusion of the results of the Excision et Handicap study:** EUR 20 000
- **Information of populations at risk recently settled in France:** EUR 15 000
- **Awareness-raising among professionals working with migrants:** EUR 25 000
- **Awareness-raising among consular officers:** EUR 80 000.

With respect to the targeted populations (200 000 for the information of newly settled migrants), those lump sums appear to be extremely limited.

We did not find any mention of private donation for the benefit of preventive action on FGM. With exception of personal contributions of their individual members, CSOs only marginally draw upon private financing in France.

**V.3. Protection**

As has been emphasised, both by the desk study and the interviews, a centralised, systematic, comprehensive and accessible data collection system is largely missing in France. In particular, beyond the lack of prevalence data, three missing elements have been identified through the interviews:

- Firstly, there is no fully centralised and exhaustive record of suspected FGM cases and girls at risk of suffering FGM. Whereas the Cellules départementales de recueil et de traitement des informations préoccupantes (CRIPs), established in 2007, have a broad mandate concerning the collection of all reporting procedures related to ill-treatments or abuses perpetrated on children, including FGM, the complexity of the reporting procedure (see V.3 ‘Protection’) negatively impacts their capacity to provide an accurate picture of FGM. Indeed, although all actors of prevention, including the PMI, the police, educational communities and hospitals, are asked to collect information and report it swiftly to the CRIPs, they don’t provide a comprehensive tool or statistics on FGM in return. This is not specific to this issue however, as French policy actors are increasingly requested to upload detailed information and figures on their performance, while the coordination structures, such as central services or ministries, only seldom process these data in the form of publicly accessible statistics. Therefore, it can be inferred from this situation, that the CRIPs constitute a relatively comprehensive and functioning network collecting detailed data on FGM cases throughout the territory, but they are not a reliable instrument of monitoring and information. It can be added that collecting reliable data does not entail effective protection for children at risk:

>The children’s protection system remains quite inefficient, despite its reform in 2007. Of course, the system (CRIPs) collects reliable figures on the number of intervention for endangered children, but it still misses many situations of immediate danger. Over the last month, four children have died due to “dysfunctions”; which is a little bit annoying (sarcastic)... The GAMS has the chance to get all its cases treated on the fast track but it might be very different for a “standard” social worker, whose cases can be parked for months on the slow track. France still has a lot to do to improve the system.’

- **Informal procedures to compensate the lack of effective protection measures**

It is a general feature of FGM-related policies in France that due to the emphasis traditionally laid on criminalisation, protection measures have been under-developed. Therefore, until the 2000s, there was no coordinated system to protect girls at risk identified by CSOs or public actors such as PMI services, hospitals, educational communities or law enforcement. This situation was also strongly connected to outdated children’s protection provisions and instruments inherited from the post-war period, and to the fact that until 2001, FGM had not been recognised as valid ground for asylum. As a consequence, relatively little was done at the institutional and legal level, to ensure the protection of the different risk groups.

Nevertheless, as the CAMS and the GAMS became increasingly respected by public authorities, sui generis and experience-driven initiatives were taken to increase protection of girls at risk. A major field of intervention of the GAMS has thus developed in quite a sui generis way, without being formally institutionalised: it concerns the monitoring of reporting procedures and the assistance to public services (police, PMI, public education institutions) in dealing with situations of immediate risk. As highlighted by one of the respondents: ‘Public recognition that came from the parliament, ministries and local authorities sharply reinforced our reputation, particularly concerning our capacity to provide technical and decision-making consultations […] This consecutively increased the number of solicitations in very concrete and variegated situations, reinforcing at the same time the credibility of CSOs, which were often considered unprofessional.’

This type of informal procedures, consisting of the joint assistance provided to girls at risk in order to ensure immediate protection measures, was developed at the request of the police — in particular from the Brigade de Protection des Mineurs, and of the PMI services. ‘The PMI has established a very active partnership with the GAMS
(PMI doctors were among its founding members). As our professionals inform families of the risks attached to FGM, of the law and of the services provided both in France and in countries of origin, they also inform them of the existence of the GAMS. This partnership goes further, however, since PMI professionals can also count on the GAMS to perform joint assistance to (potential) victims of FGM, especially when communication with parents has failed. For the sake of clarity, the progressive institutionalisation of protection procedures will be addressed chronologically, starting with asylum.

**International protection and FGM in France**

As mentioned in Section III, the main opportunity structure during which major changes took place in France with respect to international protection on the grounds of FGM, lasted from 2001 to 2008.

According to one respondent: ‘The social group issue only emerged in 2001 with the Sissoko case, when the asylum court granted refugee status to the parents of a girl at risk of FGM. Yet, the parent’s belonging to a social group was not formally established. The first decision mentioning social groups was issued in 2004. However, the major decision for our case-law is the 2001 one […] It is between 2001 and 2008 that the OFPRA implemented the Sissoko case-law, although international protection on the grounds of FGM was subject to the same procedure, carefully assessing the credibility of seekers […] It is also during that period that feminist CSOs put the issue of FGM and asylum on their agenda.’

Between 2001 and 2008, international protection was increasingly granted to parents of children at risk of FGM. Yet, from 2003, the introduction of subsidiary protection by Act No 2003/11-76 on asylum rights considerably changed the scale of the protection granted to successful applicants, as it is limited to one year, renewable under certain conditions.

‘We can see that there is a complete shift from asylum [to subsidiary protection]. Until the early 2000s, we used to work under the asylum regime. A case-law had developed, which made it possible not only for girls at risk but also their parents, to be granted a refugee status due to FGM. However, there was a turning point in 2008, when the authorities claimed to face a massive flood of asylum requests on the grounds of FGM […] The OFPRA made a decision not to protect children born in France, establishing a distinction between girls born in France or abroad. That’s pretty complicated, but girls born in France constitute the majority of the requests and in their case, only subsidiary protection can be granted. Subsidiary protection has a validity of one year, renewable on presentation of a proof of medical screening establishing that the child has not undergone FGM. On the other hand, the refugee status has a validity of 10 years.’

For the respondent, the conditions explaining this turning point were the following: ‘There were a lot of requests submitted to the OFPRA in 2008, mostly from Malian citizens. According to the OFPRA, most of these requests were not truly justified by the risk of FGM and children protection […] But there is another explanation, which is that prevalence rates remain high in Mali, making these applications legitimate. And it’s a matter of fact that no FGM was reported among the families who were granted subsidiary protection […] But still, this was the main justification.’

The OFPRA launched a mission in Mali and produced a report on FGM risks, which concluded that risk was still high in some regions, despite the efforts carried out by the government to eliminate FGM. This assessment had consequences in the way requests from Malian citizens on the grounds of FGM are processed: ‘We have very little information about the data collected by the OFPRA […] Yet, we must admit that there was some willingness from the OFPRA to collect reliable data about FGM in Mali, as proved when that country was removed from the list of safe countries established by the OFPRA, concerning women and girls. It cannot be argued that Mali is a safe country for female seekers, whereas it is the case for male applicants. The OFPRA recognises that risk. Besides, when making decisions on subsidiary protection due to FGM, the OFPRA tries to collect reliable information on the extent to which FGM is practised, in spite of there being a domestic legislation prohibiting FGM in the country of origin […] However, even if the OFPRA acknowledges that FGMs are performed in certain regions, it does not make finer-grained distinction between subregions or villages […] There is a genuine willingness to protect women, looking at the actual level of risk. But information is lacking and despite this willingness, they have moved backwards over the past few years.’

In the decision made in 2008, the OFPRA established different subcategories of applicants to international protection on the grounds of FGM: ‘This was done to prevent the massive flood of requests. The main distinction was made between girls born in France and those born abroad. For the first category, it was considered that international protection could not be granted, since there was a full judicial protection against FGM in the country of origin (France), so they put things upside down […] The decision was made by the National Court of Asylum in March 2009, after five appeals had been introduced due to the OFPRA’s decision to stop granting subsidiary protection to the parents of children born in France […] The court followed the OFPRA, by considering that the definition of the social group at risk does not include the parents of children who were born in France, because there is no risk of persecution in France […] while the parents of children who were born abroad can eventually be granted protection. Besides, girls at risk of FGM cannot be considered as members of the endangered social groups, due to the fact that they are too young to oppose this practice and suffer persecution.’

Due to that restrictive interpretation, girls at risk of FGM cannot be granted the status of refugee, only subsidiary protection, since sexual mutilations fall into the definition of inhuman and degrading treatments, but not under the French interpretation of the content of the Geneva Convention. As a consequence, according to one respondent, ‘France is among the EU countries which step into the breach opened by subsidiary protection in the early 2000s to grant international protection on forced
marriage and FGM, which are treated as "societal issues", something I find really inappropriate since it entails that there is no judicial qualification for these practices […] ."

She also mentions that there are background factors explaining why France is reluctant to acknowledge gender as a criterion that can define a social group at risk: 'I think, although perhaps I should not put it so clearly, that it is due to our colonial past with western Africa, where FGM prevalence rates are high, but also migration flows to France. Therefore, international protection on the grounds of FGM might concern a huge number of people, so there are some political undertones behind those decisions (on asylum) and the restrictive interpretation we make of the texts, if compared to the situation in other countries.'

**Strengthening children’s protection system**

While FGM has become a relevant area to asylum politics since 2001, triggering progress and contention, the children’s protection system has undergone substantial changes, from 2007 onwards, which have eventually led to the institutionalisation of a comprehensive, nationwide, but imperfect reporting and protection network.

The Cellules départementales de recueil et de traitement des informations préoccupantes (CRIPs) established by Act No 2007-293 of 5 March 2007 reforming children’s protection provisions thus implement an inclusive notion of ‘endangered children’ which includes girls at risk of FGM. The existence of a permanent instrument for data collection and cases reporting, which is present in almost every French department, entailed major changes in the practice of services directly dealing with FGM. Instead of informal protocols internally established to determine conditions under which situations of risk or actual FGM should be dealt with and reported to the attorneys, procedures were institutionalised placing CRIPs at the core of the protection system.

As soon as a situation of risk is identified by the police, a social, health or educational professional, some ‘warning information’ has to be sent to the local CRIP. In case of immediate danger, the situation can be reported directly to the attorney, with a copy for the CRIP. However, in most cases, the procedure is the following: warning information notice > CRIP > report to the public attorney. Depending on the structure initiating the reporting procedure, the latter can nevertheless vary, as internal steps have to be taken first, and they strongly depend on organisational structures (such as the degree of collegiality for decision-making). For instance, one of the respondents gave the following precisions concerning the PMI:

> “The reporting procedure is the following: “Both in infantilite protection and family planning, the PMI professionals must write their report under the supervision of the senior doctor […] If there is no emergency, it goes to the CRIP. Otherwise, it can be directly reported to the attorney. It first has to be discussed internally, in order to also take into account professional secrecy aspects […] Yet, the senior doctor has to be immediately available, whereas the PMI professional can inform the parents and remind them of the law before the senior doctor intervenes.”

The protocols and guidelines to make when reporting FGM are rather vague, as there is ample margin for interpretation, which can potentially damage the effectiveness of the procedure. This aspect has been particularly highlighted by police officers: ‘Although it is framed, there are no thorough guidelines that can be implemented step by step, thus leaving room for interpretation. This can slow down the process. Perhaps it would be a good idea to have more explicit and comprehensive guidelines, as in the case of incest […] . The most important thing would be to provide a time span during which the procedure should be completed. If a social worker in a school is told about a situation of risk on Friday, the doctor he refers to might receive the request only the following Monday and report it to the CRIP on Tuesday. This means a loss of four days, although we can catch up since the report can be forwarded to the attorney and to us in less than 24 hours.’

The police officers interviewed for this study also emphasised the differential appreciation of emergency, depending on the actors involved in the process, but also on subjective assessments or prejudices: ‘The swiftness of the process very much depends on the conditions in which the situation of risk is reported. This procedure is pretty much the same as for other abuses on children […] but the speed at which information is reported can vary and it occasionally takes too much time to launch the protection procedure. We often regret afterwards, that time was lost, especially when legal medical screenings were requested.’

Another respondent added: ‘In some schools, the actors are extremely proactive and swift in responding to situations of risk, especially when they believe an immediate protection measure is required, mostly to prevent children from be taken to their countries of origin. In other cases, however, there is a long internal contradictory procedure that can slow down the process. This phase of reflection can entail an appointment with the parents. In some cases, we received three-page-long reports from social workers, for instance, in which the different steps taken before the situation was reported were thoroughly described.’

For the interviewees, the potentially different treatment given to FGM-related cases can be explained by the following factors: ‘It very much depends on individual awareness and sensitivity towards the issue, as well as a willingness to establish the accuracy of alleged facts/risk, which is a responsibility that normally belongs to the police. Yet, some actors believe that they have to report any information they have.’

**The absence of institutionalised record systems**

It has become clear throughout the interviews that there are no instruments meeting the basic features of systematic and comprehensive record systems in France. In the field of children’s protection, quite paradoxically, establishing the CRIPs has not resulted in providing actors fighting FGM with reliable data on the number of cases attended. Although data are collected on the number of interventions, including on FGM, and whereas, according to certain actors, FGM-related interventions could be
is a need for figures' in order to implement a comprehensive action, particularly concerning protection. For police officers, the absence of centralised record systems, just as the differentiated understanding of the notions of risk and emergency, potentially affects the efficiency of the protection system: ‘The most important thing is that no information escapes from the circuit. For instance, as soon as they concern an under-aged child, registers compiling queries and complaints at police stations are transmitted to us […] We either consider that this information falls into our competence, or we forward it to the CRIP, which mobilises relevant services, so that nothing is lost or left without an adequate response […] Nevertheless, I am afraid that this is not always the case and that some relevant information is not transmitted to the CRIP’. Existing monitoring instruments, they add, can miss the point, as is the case with forced marriage, for which they are convinced that there are many more cases than those reported, especially among the Turkish community.

Training of professionals involved in protection

Regarding training the actors of asylum policies on gender and FGM, training sessions were organised every three month by experts of the GAMS for OFPRA officers between 2001 and 2005. According to one respondent, they were later stopped on decision of the administration. The same respondent also mentioned that in 2011 there was a pilot training scheme at the OFII (French Migration and Assimilation Office). Although there are specific needs — mostly training OFPRA officers and social workers to carry out personal interviews with women, including on intimate issues — the reasons for these institutions to carry out such training activities is unclear: is it to strengthen protection, or to report abuses of the legislation on asylum and international protection?

Regarding the PMI services, training efforts concerning GBV and FGM have been maintained over time. Once a year, the PMI’s newly appointed professionals are asked to follow a training course on these issues. Besides, implementing notice/guidelines issued in 2011 in Paris, requires added training, due to the multiple and transversal approach it adopts. To date, this has only resulted in one half-day training session in March 2011. As many changes have occurred in the hierarchy of the Paris PMI, this process has slowed down, and the need for practice-oriented, experience-driven training still exists.

The PMI also strongly encourages training sessions organised at the local level (in a PMI centre or in hospitals, for instance), with the support of CSOs. Pedagogical instruments (in the form of CDs, cartoons or booklets) are made available for the purpose of such training actions.

As regards the age of girls for whom FGM is reported, most of the cases still concern children under 12. However, it is necessary to better train teams dedicated to family planning so that situations concerning teenagers and adults can be more systematically taken into account. ‘We always need to draw on an anthropological approach, in order not to place ourselves in the position of judges. With regard to the older public, for instance women attending family planning consultations, we have to deal with professional secrecy issues, and we need to convince our professional workers not to abandon their first objective: attending and informing people.’

The OFPRA collected data on FGM-related granted protections in 2009 and 2010. This data is reported in the activity reports of the OFPRA.

It indicates that in 2009, 179 women were granted subsidiary protection on the grounds of FGM risk for their children (21 % of subsidiary protection granted to female asylum seekers). Besides, 266 medical certificates were produced for children in 2009 to renew subsidiary protection on the grounds of FGM risk. In 2010, those figures were respectively of 248 and 1 179.

However, these figures are only for adult seekers — as children cannot apply (alone) to subsidiary protection. Moreover, collecting and divulging this data has not been institutionalised over time, and there is no indication that the OFPRA has established a record system. For instance, disaggregated data per country regarding FGM as a ground for refugee status requests do not seem to be systematically reported, although it was stated in the 2010 Activity report, that requests on the grounds of FGM risk are especially significant for Mali, Senegal, Nigeria and Guinea.

This situation has triggered suspicion among the main actors of protection with regard to the overall capacity of the system to accurately reflect the situation of FGM in France. There is a need for figures to counter this impression of drift in the protection process. However, the OFPRA’s activity report usually mentions their work on the collection of data, but it is more often the case that the actors of protection are reluctant to disclose this type of information, since potential failures in the system may entail dramatic consequences, as highlighted by one of the respondents (see Section III ‘Historical context and policy developments’).
V.4. Prosecution

Prosecution, due to its forerunning role in France, it has been extensively addressed in Section III ‘Historical context and policy developments’. Therefore, this subsection mostly focuses on the challenges generated by the criminalisation of FGM, the current stage of prosecution in France, and the (non-)existence of records of investigations, procedures and court cases.

The challenges to prosecution

The French case highlights, in particular, the major challenges faced when prosecuting FGM, such as those mentioned by one respondent:

• 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;
• tensions between prosecution and prevention;
• presence or absence of provisions allowing CSOs to sue;
• absence of collaboration from the parents;
• lack of international cooperation (or lack of willingness to implement extraterritoriality);
• lack of willingness of social, health and educational workers to report FGM, depending on their perception of their mission and professional secrecy provisions.

The reasons why magistrates can prove reluctant to prosecute FGM do not only depend on the state of the legislation, but they are also deeply rooted in personal or cultural prejudices. Among those prejudices features the comparison between female and male circumcision, which denies FGM its mutilating aspect. This argument was then present in the dialogue between one respondent and the President of the Human Rights League and lawyer of the parents of a little girl who died after suffering FGM which is reported in Section III. It was also pervasive in one of the first trials when the judge ordered a forensic report which indicated that ‘The removal of an erogenous zone is likely to affect the woman’s future, according to our western perception’, without assuming its irreversible and mutilating aspects. Once FGM cases were more systematically brought before civil jurisdiction, the contention shifted towards the criminal nature of these acts. During the 1980s and 1990s, one respondent had to fully mobilise her expertise and to fight on different judicial fronts at once in order to make the criminalisation of FGM irreversible.

Another prejudice at play during this process, and which remains true nowadays both for reporting and prosecution, is the belief that families constitute a safe and protecting environment, whilst most child abuses are perpetrated within the family. This prejudice explains why family associations refused to sue in FGM cases and why the precautions taken not to stigmatise the family or to preserve its unity can occasionally jeopardise children’s safety and bodily integrity. This prejudice not only affects magistrates, but also social workers and health professionals, possibly undermining the reporting of situations of risk, as put by one respondent:

‘For instance, in the case of “shaken babies”, which is quite frequent but seldom reported, we face strong resistance from paediatricians and general practitioners, who are reluctant to stigmatise the family, at the expense of the interest of the child. We have met the same situation with FGM and forced marriage, for which the interest of the family is often privileged. It also has something to do with stigmatisation of the police, suspected to proceed without caution.’

‘Cultural relativism’ and post-colonial culpability also underpin the willingness of society as a whole to prosecute FGM. Common sense and arguments rooted in republican universalism have thus often been mobilised against this kind of prejudice, underlying that children’s bodily integrity should be preserved, no matter the cultural background, and that, taking up Dr Emmanuelle Piet’s words: ‘bodily harm hurts irrespectively of the origin of the victim.’ Although several of our interlocutors consider that France is in a better position than other European countries in tackling harmful traditional practices, due to its broader concept of ‘public order’ as pointed out by one respondent (see Section III), cultural relativism and the willingness not to adopt a post-colonial attitude have nonetheless often determined the position of individual actors with respect to prosecution.

Among the other challenges of prosecution and criminalisation, there is a tension with prevention policies, which employ a collaborative dimension also involving families as part of the solution to the problem. Advocates of a policy response placing the emphasis on prevention, can thus reveal to be firmly opposed to prosecution not only due to abovementioned prejudices, but also to the fact that in their view, stigmatising families through prosecution is incompatible with preventive work, information and the mobilisation of migrant communities. Besides the opportunity (or not) granted to CSOs to sue, which has already been pointed out, another background factor, relevant to prosecution, is the understanding of secrecy provisions among professional communities usually bound to secrecy. For police officers like one of the respondents, for instance, it is of utmost importance to convince these professionals to report: ‘we always remind social actors, of their duty to report FGM and situations of risk. This occasionally triggers resistance from certain categories.’

Another major challenge to prosecution, identified through the interviews, are the arguments often articulated by parents and reinforced by the lack of international cooperation in the matter.

When addressing an actual case of FGM, where mutilation has already been performed abroad, investigators of the BPM often have to deal with the same narrative: ‘They say: “I went to my village (in Africa), where I left my daughters under a relative’s supervision, as I needed to visit a relative in some other region of the country. When I came back, both had been mutilated.” So we have no perpetrators and no witness can be heard, since it would be necessary to ask for an international request that would be denied.’
In this case — which our interviewees have not seen these last few years — when parents return to France with both their children having suffered FGM and argue that it was done without their consent, prosecution is almost impossible, especially in the absence of testimonies, ‘except if we obtain an international request, which is not usually the case.’ Our respondents underlined that if the offence (FGM) is not legally punished in the country where it was performed, the international request will be denied. It can be objected, though, that FGM is prohibited in many countries, including those from which most of the populations at risk in France originate. Moreover, it remained unclear, whether or not the BPM had recently solicited an international request to prosecute FGM perpetrators or facilitators, as is made possible by French legislation. Indeed, the implementation of the principle of extraterritoriality was first codified in Act No 2006-399, of 4 April 2006, strengthening the prevention and repression of violence perpetrated within a couple and against children.

Yet, the interviewees argued that the BPM is more efficient when anticipating the risk:

‘The right approach is to summon parents before they return to their country, in order to remind them of the law concerning FGM and forced marriage. Once they feel under scrutiny, they usually walk the line and we do not remember any case of parents being warned who allowed FGM on their children afterwards.’ (Céline Plumail).

Available records of court cases and police interventions

Firstly, there is no institutionalised and accessible system collecting information on FGM-related procedures processed by law enforcement structures (police or gendarmerie). At this level, data collection and monitoring instruments seem to be rather sui generis and depend on the ‘know-how’ acquired within a specific unit, as is the case at the Brigade de Protection des Mineurs (BPM), which has the richest record on FGM. The interviewees thus confirmed that there is no specific code to register cases into national database. Nevertheless, a homemade, BPM-specific coding enables to keep trace of FGM cases.

Secondly, there is no institutionalised, functioning and accessible system centralising data on FGM-related procedures followed by attorneys and brought before criminal jurisdiction. Whereas the CAMS and its website are the main source of information on the number of cases brought before the court, there is no real monitoring instrument providing thorough information on their judicial resolution. In fact, one respondent appears to be the living memory of the fight for the criminalisation of FGM and she has the most comprehensive knowledge of each case, as she sued in 41 out of the 42 known FGM cases in France. Yet, information contained in the CAMS’ personal archives has never been processed through a database, and no sociological work has been carried out using this valuable source. Information provided online on cases is therefore fragmentary, not fully reliable as regards timelines and not exhaustive concerning pronounced sentences. Additional information provided during the interview pointed out the unreliability of existing sources on court case monitoring, and the fact that beyond this respondent, nobody has a full picture of the issue from the judicial point of view.

**Prosecution of professionals who do not report**

Since 2004 different provisions have been introduced into the legislation, mostly in relation to gender-based violence, to clarify the conditions for the disclosure of information usually falling under professional secrecy. Social workers and health professionals are thus requested to report physical or psychological abuses perpetrated against children and vulnerable persons, including sexual mutilations, without the consent of the victim.

According to the police officers we interviewed for this study, there is however a broader context of resistance towards reporting abuse from the medical sector in France. This context is partly shaped by their mistrust towards other actors, such as social workers or the police, intervening at the margins of their own practice. As a result, some health professionals have tended to express their willingness to assess the accuracy of alleged facts/risks, which is a responsibility that normally belongs to the police. Similarly, some are reluctant to share information on potential situations of risk with external actors. Additionally, although the interest and awareness of health professionals (mainly doctors) towards FGM increased as soon as obstetricians, surgeons and gynaecologists could suddenly address it as a ‘solvable’ medical problem, their initial training remains largely deficient as far as ethical issues in general, and FGM as a societal problem in particular are concerned. Nevertheless, we found no trace of prosecution of professionals who did not report FGM.

V.5. Provision of services

This section aims in particular at mapping services that exist in France for at-risk groups and for victims of FGM. It also explores whether these services are provided on a structural or an ad hoc basis, if they are countrywide or only available in specific target areas, and for which groups they are provided. Data is also completed by information on training courses attached to the implementation/delivery of these services. It must be nonetheless emphasised, that French actors, active in fighting FGM, do not usually refer to healthcare, legal counselling, psychosocial-cultural counselling, community work on behavioural and attitudinal changes, and helplines/hotlines as ‘services’, but as supporting, assistance or capacity-building activities. As a result, target groups are only occasionally meant to be the final users of these activities, and this may entail substantial differences in the way they are framed by suppliers.

**Services provided by the GAMS**

The main actor involved in providing assistance to groups at risk, victims or professionals dealing with FGM, is the GAMS. Its progressive recognition by public authorities and the expertise that derives from three decades of activity on this issue have shaped a growing demand in terms of psycho-social support, decision-making assistance, judicial counselling, training and capacity building.

Whereas the CAMS did not develop the provision of specific services due to its leading role in prosecuting FGM, services
provided by the GAMS have developed in a rather *sui generis* way, depending on the specific demands expressed by social workers, the PMI, educational communities, health profession organisations such as the Academy of Medicine, Gynécologie sans Frontière or the police. They have been tailored according to their needs and often built upon long-term partnerships (see Section VI ‘Partnerships’).

Initially, the GAMS mainly aimed to mobilise the communities at risk against FGM through information and prevention. However, due to its implantation among migrant communities of the Ile-de-France region, and later its regional branches in Champagne Ardennes and the Pays de la Loire regions, it has been increasingly asked to assist social, health and education workers in dealing with FGM. This provision of services includes counselling with regard to communication with families, judicial orientation, as well as joint case management with a variety of actors. This can also include finding solutions for the immediate protection of children at risk, and recommendations on cultural or socio-psychological aspects. Depending on the target groups and actors involved, new challenges have emerged, as well as new approaches, as pointed out by the first respondent: ‘Developing our activity towards school children has entailed new challenges, as FGM cannot be addressed in the same way as with an adult audience. Therefore, we have mostly opted to tackle FGM and forced marriage together, often using documentary films, cartoons and other instruments which have been developed over time.’

Besides, in 2001, the recognition of FGM as a ground for internal protection triggered a new demand in the sector of assistance to refugees that led to establishing new partnerships with the OFPRA and CSOs active in assistance to migrants. Yet, as underlined by one respondent, there is no specific, compulsory judicial attendant or caring measures offered to migrant women. This does not mean, however, that specific, well-trained actors are not providing more targeted services to migrant women concerning FGM, but this is not systematic. So it is case-specific, depending very much on the expertise of the actors on these issues, and in their willingness to draw upon the expertise of the GAMS. Besides, the growing number of adult women opting for surgical repair has triggered the need for psychological assistance prior and during the recovery process. Whereas thousands of women have already opted for reconstruction, this assistance is only provided through the multidisciplinary teams established in major public hospitals, by the GAMS, Gynécologie Sans Frontières and possibly by community-based organisations, although we found no trace of this.

The services provided by the GAMS also evolved as the profile of migrant population changed: ‘Currently, it is both interesting and quite rewarding to meet migrants who arrived on the French territory with a firmly anchored hostility to FGM, or even considering that protecting their daughters from FGM played a major role in their migration.’

**Training services**

Whereas most activities of Tostan International are carried out in Senegal, The Gambia, Mauritania, Guinea, Guinea-Bissau, Mali, Somalia, and Djibouti, consisting of a three-year-long tutorial programme, Tostan has also developed activities in France, targeting the Senegalese community, estimated at 300,000 members. A documentary film, *L’Appel de Diégoune* (*Diegoune’s call*) produced by this CSO, is used with a training manual as support for training and awareness-raising sessions by many actors fighting FGM in France.

Founded in 1995, Gynécologie Sans Frontières aims at providing, as part of a global effort to promote women in society, a medical support to tackle situations of risk regarding gynaecological and obstetric pathologies, in countries or sectors with poor medical infrastructures. It implements a multidisciplinary approach, encompassing medical, but also psychological, social and gender aspects of women’s health. Gynécologie Sans Frontières now has a long record of activities related to FGM, as it aims to train physicians and nurses intervening in foreign countries on gynaecological, obstetrical and women’s health issues. More recently, this NGO has played an important role in promoting surgical repair after FGM, through a multidisciplinary approach that takes into account psychological and socio-cultural aspects. For this purpose, it has developed one of the most complete tools available in France, in the form of a manual for practitioners. This organisation also regularly conducts training sessions which specifically address FGM or include it to a broader agenda.

Training is also at stake for health, social and education workers dealing with populations at risk. As it challenged the practice of PMI professionals, the implementation of the internal notices issued by the PMI in 1992 and 2011 has ‘always been implemented along with training and information activities.’ Alongside internal training, the PMI can also be solicited ‘by hospital services, who want to know if they are correctly implementing our guidelines’, as one respondent puts it. For the training sessions organised at the local level, usually with the intervention of CSOs such as the GAMS, pedagogical instruments (in the form of CDs, cartoons or booklets) are made available by the PMI.

However, the provision of services in relation to FGM remains rather limited in France. There are at least two reasons for this situation:

- firstly, issue-specific CSOs (GAMS and Tostan) implement an extensive mandate, by making operational public policies on FGM, on behalf of the state, with very limited financial and human resources;
- secondly, the provision of services is generally missing from French policies, which are weakly oriented towards implementation and innovation with regard to contents and formats. It is worth mentioning that since the Ministry of Women’s Rights has been re-established (May 2012), public authorities have shown interest in strengthening the protection of victims of gender-based violence through the provision of services (hotline).

**Services related to surgical repair**

In 2003, a conference on FGM was organised at the National Academy of Medicine, which the first respondent considers the most successful ever organised by this venerable institution, especially in terms of media coverage. The attention was in particular drawn to the work of Professor Pierre Foldès, on surgical reconstruction. Pierre Foldès, a feminist activist with a long experience...
of sub-Saharan Africa as an expert in international development and management of emergency situations, already experimented techniques of surgical repair by the early 2000s (1). Following the presentation of his work, and upon the recommendation of public authorities, surgical repair after FGM was included, in 2004, to the list of medical acts to be reimbursed by the Public Health Insurance System.

Since then, several surgeons have been trained in various public hospitals on the technique elaborated by Professor Foldès, and over 4,000 operations have been successfully performed, although the degrees of physical recovery may vary. Following the recommendations made by Professor Foldès’ team at the hospital of St-Germain-en-Laye, a global approach to surgical reconstruction has been developed, which encompasses physiological, but also psychological, social and cultural aspects in order to maximise the impact of the operation and to eliminate obstacles to full recovery. In accordance with this approach, and following the recommendation made in the report issued by the ad hoc parliamentary committee established in 2009 to assess GBV policies, multidisciplinary teams have been set up in major public hospitals throughout the territory. They provide psychosocial assistance, medical counselling and cultural intermediation to the women who opt for surgical repair. These services are now fully integrated into the information and prevention material issued by public institutions. Other actors involved in preventive work on FGM, including CSOs and PMI services, inform victims of the existence of such services, as mentioned by two respondents.

With the exception of the services related to surgical repair, it is clear that abovementioned services are weakly institutionalised, and have been developed and provided on an ad hoc basis, depending of the demands formulated by specific services such as the PMI, the OFPRA or public hospitals. Consequently, we found no information with regard to specific funding allocated to the provision of services on FGM in France.

V.6. Partnerships

The bottom-up development of grassroots, relatively functional partnerships between a variety of actors mobilised in fighting FGM, is a major feature of the policy response developed in France on this issue: firstly, because it triggered substantial policy developments also at the national level; and secondly, because French policies only occasionally rely on the development of policy networks and are usually marked by a top-down and centralised dimension.

This section briefly sketches the conditions of emergence and the main characteristics of these partnerships, their role in conceiving and implementing FGM policies, as well as the limits and challenges posed to their development.

Initiating and institutionalising partnerships through the DRDFEs and the CRIPs

In 1992, the Women’s Rights and Equality Directorate in the Ile-de-France region (DRDFE) initiated a working group to prepare the first institutional awareness campaign on FGM. This working group helped to establish a fruitful and long-term cooperation between CSOs working on FGM and building consensus among major actors and stakeholders on the approach to be adopted. Initially set up on an ad hoc basis, this partnership was later (from the early 2000s) institutionalised through the organisation of an annual conference on FGM prevention scheduled around the International Day against FGM, in February. Prior to these conferences, regular meetings were scheduled, to which participated representatives of the major CSOs, the PMI, health services, educational communities (rectorates), police officers of the Brigade de Protection des Mineurs, as well as individual experts, in order to outline the priorities/issues to be addressed during the conference.

In the Ile-de-France region, a functional policy network was built, in which originated major prevention and policy orientation tools, such as the booklets issued since the mid-1990s. Coordinated by a public agency, this network associates CSOs, state services and regional agencies. It provides a space for experience-sharing and innovation, taking into accounts FGM through prevention protection and to a lesser extent, through the provision of services. Nonetheless, as underlined by one respondent, ‘since CSOs specialised on FGM are not established throughout the territory, policy networks between state local representatives, criminal jurisdictions, the police and non-governmental actors, are not uniformly developed. In some places, public actors are not sufficiently aware of FGM while in others, there are no CSOs dealing with this issue. As a result, the committee (established to assess gender-based violence provisions and policies), strongly emphasised the need to strengthen these partnerships at the local or regional level, and to identify contact persons within criminal jurisdictions, the police, the Maternal and Infantile Protection, etc.’

In order to address territorial disparities, the Ministry of Social Cohesion strongly encouraged, from the mid-2000s onwards, its services in targeted regions to hold regular conferences on FGM and to establish similar partnerships as the one set in the Ile-de-France. A cycle of conferences has thus been held from 2006, with the participation of GAMS and Gynécologie Sans Frontières. These conferences have not only provided regional actors with data and information about FGM, but they have also helped gathering potential stakeholders and veto-players in the areas of health, social care and migrants’ protection, thus enabling the strengthening of regional policy networks. To date, conferences have been held in Pays de la Loire, Nord-Pas-de-Calais, Provence-Alpes-Côte d’Azur, Normandie and Rhône-Alpes regions, thus covering most of the populations of African origin in France.

Another impulse to develop partnerships throughout the territory was the institutionalisation, in 2007, of the Cellules départementales de recueil et de traitement des informations préoccupantes (CRIPs). Established under

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the responsibility of the presidents of the general council of each department, they count the monitoring of FGM-related interventions among their prerogatives, and necessitate communication among major stakeholders at the local level. However, as pointed out by the Deputy Head of the PMI in Paris, this has not led so far to establish functional and long-term partnerships, in the absence of an evaluation of the functioning of the CRIPs. Besides, as has already been stressed, while PMI centres, hospitals, schools and high schools are requested to upload information — specifically on FGM — to the CRIPs, the latter do not share data and do not provide an overall picture of FGM-related interventions. Whereas it is true that improving mutual information between the PMI and the CRIPs features among the priorities of the Maternal and Infantile Protection Services in Paris, we found no trace of nationwide efforts in that direction.

**Sharing information among services and actors: a contentious process**

The reform of the children’s protection system in 2007 not only established the CRIPs, it also addressed the need to share information among professionals of child’s protection, due to the increasingly complex and territorialised structure of that system. Indeed, a number of services and different categories of actors, who have to submit to differentiated regulations as regards professional secrecy and do not share the same concept of their role, participate in protection.

The notion of ‘shared secrecy’, which had already been recognised, in 1996, in an internal notice of the Direction Générale de l’Action Sociale (DGAS) establishing that it did not infringe on professional secrecy under certain conditions, was thus deemed important, to improve the effectiveness of children’s protection. Consecutively, this notion was extended to all the professionals involved in the protection of children by Act No 2007-293 of 5 March 2007 reforming children’s protection provisions. Since, the Code de l’action sociale et des familles (Code of Social Action and Family Policy) establishes that ‘professionals who implement children’s protection policies or contribute to their implementation, are authorised to share secret information in order to assess individual situations and to determine and implement protection and assistance measures to which under-age children and their parents can pretend. Nonetheless, this sharing of information is strictly limited to what is needed for the purpose of children’s protection. Parents or tutors as well as the child him/herself depending on his/her age, are to be informed previously, except if it is against the interest of the child’ (Article L 226-2-1).

In principle, a warning notice to be transmitted to the CRIP (and the attorney, if necessary) in case of immediate danger, does not fall into the regime of ‘shared secrecy’, as reporting such situations is a professional duty both for health professionals (Article R 4127-44 of the Code of the public health/Article 44 of the Code of medical deontology) and social workers (Article 411-3, Code of Social Action and Family Policy, Act No 2007-297 of 5 March 2007). Therefore, this notion aims at regulating the internal and external disclosure of personal information which helps to assess an individual situation in the longer term. Sharing information thus depends on the personal assessment of each professional and triggers specific difficulties due to the diversity of actors intervening in children’s protection.

Sharing information on potentially endangered children illustrates the tension between the respect of professional secrecy and the effectiveness of the protection system. As pointed out by our interviewees, it also implicates long established mistrust between different corporations (social workers, health professionals, law enforcement bodies). According to one respondent: ‘Preventing child abuse makes a transversal [mainstreaming] approach and inclusive partnerships necessary. This ideally draws upon mutual confidence and fluid information exchange. In this matter, we can — albeit still not efficiently — refer to the notion of “shared information” or “shared secrecy”. As far as I am concerned, I am convinced that we [the BPM] are included in this notion, but we need to persuade our interlocutors that they can share private information, such as medical records, with us in case of presumed abuses [...]. So far, there is no consent about the interpretation of legal texts establishing this notion. From my understanding, I consider that the children’s protection squad should be part of this notion, whereas a police station and its officers should not — unless in case of immediate danger.’

It seems that there is confusion and contention around the interpretation of this notion among the respective services, and other references can be found: ‘As for me, texts regulating medical secrecy and those establishing the CRIPs are to be referred to.’

In order to clarify the implementing of ‘shared secrecy’, the Agence d’Evaluation de la Qualité des Etablissements et Services Sociaux et Médicaux-Sociaux (ANESM) issued thorough recommendations in 2010. They not only remind the legislative background against which this notion is to be interpreted, but also provide a comprehensive list of the actors potentially associated with its implementation. Among police officers, only the members of the Brigade des Protection des Mineurs are explicitly mentioned (6).

The progressive institutionalisation of partnerships around FGM, has thus been shaped by three major developments in the fields of women’s rights policies and child protection: the good practices developed by the Delegates for Women’s Rights and Gender Equality; the creation of the CRIPs at the departmental level in 2007; and the implementation of the shared secrecy among professionals involved in children’s protection. In the meantime, however, actors more directly dealing with FGM have built informal, but often effective, personal partnerships.

**Building informal and personal networks around FGM**

This kind of partnership was notably highlighted by one of the respondents, who nonetheless emphasised the need to reactivate it constantly: ‘Our relationships with the police and the judicial sector need to be constantly renewed, due to the high professional mobility of our interlocutors. Since

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most of these actors do not receive any training on FGM, we have to re-establish contacts every two or three years. Nonetheless, it is worth mentioning that when these move to a new post, they keep in contact with us and they bring with them their expertise or awareness on FGM. So there is no loss of “know-how”, but it multiplies.’

Although they have not been fully institutionalised, partnerships with CSOs, local governments and public institutions tend to be established in the long term. This is also due to the fame of the GAMS. ‘Usually, when I say “GAMS”, everybody knows us and cooperation can develop swiftly. But this situation is not the same throughout the country. Whereas it is the case in Île-de-France, Nord-Pas-de-Calais or Champagne-Ardennes, it is not true in Rhône-Alpes, where we are recognised by public actors, but not by the dense local CSO network.’ The recognition from public authorities was also reflected in the contribution of the GAMS to the work of the parliamentary committee on GBV established over six months in 2009 to assess public policies in the matter. During this period, we have been the only CSO questioned on FGM. We have also worked a lot on the 2006 act on GBV with MPs and senators, to implement a transversal approach and build a consensus around an inclusive understanding of GBV, including FGM.’

Among the actors with whom long term cooperation was established by the GAMS, the respondent also mentioned the Maternal and Infantile Protection (PMI), as well as the Interservice to Migrants, which provides translation to migrants and asylum seekers. This is also the case of the large federation of the Family Planning. Partnership with the PMI was also addressed by one of the respondents, who emphasised that the PMI is at the core of multiple partnerships. In their action, PMI professionals ‘put the emphasis on CSOs as the GAMS, the CAMS or Tostan, and medical units performing surgical repair. They also refer to consultations provided by the Family Planning organisation to deliver certificates of ‘non-mutilation’ to families under subsidiary protection, and to the organisations providing psychological assistance. These are partnerships we often refer to in our daily practice, although they have to be regularly renewed or reactivated.’

In what concerns the grassroots feature of FGM-related policies in France and the exchange of (good) practices between local or regional actors, a respondent added:

‘We started to organise interdepartmental meetings on abortion. We expect it will soon focus also on FGM and GBV [...]. We also established a partnership with the Seine-Saint-Denis department, which assumed a pioneering role on this issue. So we are attempting to build up networks between our services at the departmental level […]. However, networking and information-sharing, which is crucial for FGM with respect to the number of actors involved, is quite new for our professionals.’

Challenges to partnerships around FGM

For one respondent, the ‘golden age’ of partnerships has passed, due to funding insecurity that places CSOs in difficult positions.

The fact that a Ministry of Women’s Rights was re-established with full prerogatives does not mean that it has its own, sufficient budget. Let’s hope that the minister will act as a catalyst to support mainstreaming action between respective ministries, in particular concerning the recognition of CSOs working against GBV. It would also be necessary to re-establish multiannual funding schemes and to reactivate GBV committees at the local level, which are of utmost importance to fight FGM.’

At the international level, one respondent expressed her concern about the dereliction of the Inter-African Committee, which entails a lack of reliable sources of information in countries with high prevalence rates. This lack, nonetheless, is partly compensated by the networks, such as Tostan, which have been developed by international organisations.

VI. SUCCESSES AND CHALLENGES

Our respondents proved to be quite reluctant to draw general conclusions about the strengths and potential weaknesses of French policies on FGM. This reluctance can be analysed as the result of a relatively fragmentary approach to the issue from respective actors. Whereas historical actors of the fight against FGM definitely have a global picture of policy developments since the early 1990s, they did not have the opportunity to formalise it in the form of general conclusions or recommendations. This is also due to the weak human and financial resources of their organisations, if compared to their broad mandate. Other actors are often active at the local/regional level or in a concrete field of intervention such as asylum, thus potentially missing the whole picture from which they could possibly draw more general statements. Therefore, the perceptions of successes and challenges summarised in this section, partly draw upon our own interpretation of the respondents’ views.

Perceptions about successes and challenges

Here are summaries of the main successful features of the French approach to FGM:

- Effective prosecution and criminalisation: although it initially triggered fierce resistance among CSOs dealing with harmful practices, prosecuting FGM — including before criminal jurisdiction — has increasingly become a matter of consent among major actors. In fact, prosecuting perpetrators and facilitators soon gave FGM their true qualification as a criminal offence and has drawn considerable public attention, including among communities at risk. Therefore, it became already clear by the mid-1990s that no migrant recently settled in France could ignore that FGM was prohibited in France. Consequently, prevention could focus on community work and rely on a public health approach. Working with families and migrant communities remained possible for CSOs as well as social and health professionals, but within the framework set by the (case-)law. Retrospectively, most of the actors interviewed for this study agree about the key role of this process of criminalisation for subsequent policy developments in France.
• Although Maternal and Infantile Protection Services were not established to fight FGM and that monitoring and reporting FGM cases only accounts for a very marginal part of their activity, PMI services nonetheless provide one of the major instruments dealing with FGM. In the front line to address this new phenomenon in the early 1980s, PMI services in the Ile-de-France region have been instrumental in drawing the attention of public authorities and in implementing prevention and protection. They also developed the first protocols and guidelines on FGM from the early 1990s onwards. Thanks to their missions, their targeted public and their dense network, PMI services often anticipated new trends in the practice of FGM, notably warning about the shift in the age when FGM is performed. Deeply entrenched in the basic features of French welfare state, PMI services largely contribute to the effective monitoring and reporting of FGM cases.

• Partnerships established among a variety of actors have also been pointed out as key for the effectiveness of policies. Many respondents and police officers of the BPM expressed their satisfaction about the networks they could establish or maintain between the PMI, the police, health professionals and some policy actors, both at the local and at the national level. Although most of these partnerships were established on an ad hoc basis, it seems that they could be maintained and developed over time, strengthening good practices among professionals dealing with FGM. As an illustration, several actors emphasised that these good practices ‘migrate’ with professionals, thus triggering a multiplying effect.

• Another subject of satisfaction, especially if compared with other EU Member States, is the relative political consensus around the approach to FGM. As put by one respondent, ‘As far as I am concerned and drawing upon my work for this committee, but also within the framework of the committees on the Islamic integral veil, or prostitution […]’, I would say that there are two main features characterising the French approach to diversity politics and bodily integrity: the first one is that a large part of the Left, which we could expect to be more prone to support cultural diversity, tends to give priority to the fight against GBV […] That is a specificity which is implemented, and the understanding of professional secrecy. These differences may entail differentiated levels of reactivity to situations of risk, with potential fatal consequences on children’s protection against FGM. As underlined by one of the respondents, ‘this system collects reliable figures on the number of intervention for endangered children, but it still misses many situations of immediate danger.’ In the absence of strict guidelines or protocols indicating specific deadlines to report and treat FGM-related cases, and without common instruments to assess the degree of emergency, actors involved in children’s protection often have to cope with differentiated levels of responsiveness in dealing with situations of risk.

• Since the early 2000s, professionals dealing with FGM have unanimously reported new strategies to circumvent the law and the thorough monitoring system established through the PMI. This strategy mostly takes the form of a shift in the place, age and social circumstances in which FGM is performed. Yet, the adaptive response necessitated by this evolution has been made difficult by a series of factors, such as the need to address new target groups (teenagers, school pupils including boys, young women attending family planning consultations) for which new competences and tools are required. Moreover, mobilising professionals to address situations involving teenagers or young adults triggers new sorts of resistances, as it poses different questions in terms of professional secrecy. As emphasised by one of the respondents: ‘Concerning girls before the age of six, I do think that we are well equipped to prevent FGM and report potential situations of risk. Beyond, we are much less prepared to adequately react and I am pretty sure that FGM on [teenagers] or FGM performed elsewhere in Europe will be increasingly reported. We still have not fully addressed this shift of the issue […]’. I also consider that we should work more actively towards the young, as many teenagers who are future French citizens are not comfortable with their dual-culture. They need help to understand that being French entails respecting a set of basic values.’

• Another puzzling element is the unequal development of the policy response to FGM throughout the territory. In fact, whereas some elements, such as the PMI or the CRIPs, are present in every departments, others are missing in some regions; as, for example, issue-specific CSOs, working groups on FGM and gender-based violence or police units comparable to the PMI (which only exists in Paris, while in other regions, this competence coexists with the repression of criminal offences perpetrated by under-age people), specifically dealing with endangered children. Although this can occasionally generate positive mimesis effects and policy transfers from a region to another, it...
has contributed to make French FGM policies less comprehensive and coordinated.

- Interviewees also pointed out that the training of professionals concerned with FGM remains largely unsystematic. The needs, in terms of training, are however deemed important for general practitioners, obstetricians and other health professionals, but also for social workers, police officers and members of educational communities. While some categories of actors (such as PMI professionals working in child protection) have long integrated the attention to potential FGM risks in their daily practice, others, including within other areas of the same organisations, still struggle with the notions of secrecy, intimacy or preserving family unity. Knowledge-transfer is often done at the individual level, thus limiting the generalisation of potential good practices. Additionally, no specific nor regular funding are allocated to training on FGM, and recommendations issued at the highest level are not systematically implemented, as pointed out by the first respondent: ‘With the support of the Minister for Health, we attempted to provide a basic training on this issue during standard medicine curricula. A governmental notice was issued for this purpose, but when we assessed its implementation, we discovered that only two faculties proposed a training module on FGM.’

VII. POLICY LESSONS AND RECOMMENDATIONS

Respondents were relatively reluctant to draw general statements or lessons drawn from their own experience, as highlighted by one respondent: ‘It is too complicated for me to make general recommendations. Perhaps I have not such a broad perspective on this issue […]. I am not an intellectual who makes analyses and draws conclusions. I am only telling you what I live, what I think and what I have done.’

However, several positive and negative features were underlined, from which can be derived policy lessons or recommendations.

**Tackling FGM as a problem affecting society as a whole**

A broad, but major lesson arose from the views expressed by the respondents: in order to develop and implement effective responses in terms of prevention and protection, FGM has to be framed as an issue which affects society as a whole, and not just communities or groups at risk. In one respondent’s words, this means ‘that we firstly need to consider that FGM falls under the general competence of the law, and that these people are not foreigners: no matter their citizenship, we are all part of the same humankind. Therefore, we cannot consider differently what causes harm to a little girl, depending on the origin of her parents […].’ Another point related to this aspect, is the need for a legislation enabling CSOs to act, in the name of civil society, before the court. They must be able to bring this issue to public attention, since magistrates tend to neglect those cases.’

Addressing FGM as a major social issue in terms of respect of bodily integrity, public health and children’s protection, also necessitates endorsing it as a priority, although it does not undermine social cohesion due to its marginal impact on the gross population. This is a matter of political will and sense of anticipation, as argued by one respondent, who draws a comparison with the Islamic scarf, which generated fierce debates in France over the 1990s: ‘When the scarf was first brought to public attention, we did not react properly and this resulted in corrupting the spirit of our society. This concerned only hundreds, perhaps thousands of girls. And look at the proportion it has reached now.’ The collective endorsement of FGM as a major issue to be treated by society, also implied a demystification of the traditional image of African cultural values in France, considered to be relatively peaceful and safe, in order to address the reality of African families. Challenging the image of family unit as a safe environment for children, was thus also at stake, especially with regard to the prosecution of parents. Pointing out their responsibility without stigmatising them, or their communities of origin, was therefore a key in the political treatment given to FGM in France.

Framing FGM as a challenge for French society, as did key individual actors and women of African origins who founded the CAMS and the GAMS, thus paved the way to prosecution and multi-level prevention and protection policies. It also made possible the mainstreaming of the FGM issue throughout different policy areas such as GBV policies, child protection, migration and asylum, and health. This multilayered and transversal approach is perhaps another lesson to be learnt from the French case.

**Implementing a multi-level and multilayered approach**

Additionally, addressing FGM as an issue that concerns society as a whole necessitated the mobilisation not only of law enforcement and magistrates, but also of the pillars of the French welfare state, through the Maternal and Infantile Protection Services, public hospitals, and educational communities. This approach was consistent with a mainstreaming perspective in which all relevant actors are mobilised, as has been privileged in tackling gender-based violence. For one respondent, ‘What makes our policy approach specific is its mainstreaming dimension, which is reflected in the 2010 Act. Our MPs’ idea was to provide a framing instrument with a set of measures which are common for the different issues, such as FGM, tackled under GBV: for instance, training actors or creating an observatory of violence against women […]. The committee wanted to include recommendations specific to FGM as regards prevention, prevalence measurement and prosecution, but its mandate mainly consisted in proposing a global framework to address GBV in terms of training courses of actors, communication and prevention which would also comprise FGM.’

Framing elements, however, have only recently been institutionalised and the approach to FGM was initially implemented at the local/regional level. As has been highlighted in the desk study report, the coordination of gender-based violence policies has been traditionally weak in France, a feature shared by children’s protection policies. Strengthening these two policy areas in terms of coordination, as happened from 2004 onwards, resulted in improving the coordination of FGM policy instruments. In the meantime, nevertheless, effective and functional policy
networks were established in the departments or regions with the highest prevalence rates, inaugurating a multi-level approach to FGM: community-based, local, regional and national.

This transversal and comprehensive dimension is also present through the implementation of a multilayered and multidisciplinary perspective: FGM is not only conceived in penal or epidemiological terms, but also as part of the continuum of gender-based violence or through the individual project which brings women to opt for surgical reconstruction. The fact that a Frenchman, Professor Pierre Foldès, was the first to experiment with surgical techniques has had an impact on the way FGM is framed in France. As it has so far concerned over 4 000 women, it has drawn the attention of a new audience on this issue, and has quickly been integrated by the actors of prevention and awareness-raising policies. Multilayered, the approach to FGM has also become multidisciplinary, as it mobilises sociologists, anthropologists, psychologists and health professionals. Multidisciplinary teams established in major public hospitals to attend women opting for surgery illustrates that FGM is framed in a complex way, even when it is addressed in its physiological aspects.

**Overcoming personal and social prejudices**

Last but not least, this approach also entailed overcoming personal and social prejudices that can prevent public actors and CSOs to firmly act against FGM. The respondents framed this specificity using comparisons to other European policy contexts and highlighting differences, as they often did in international venue where they advocated the virtues of the French approach.

The first respondent emphasised that prosecution — and overcoming resistances due to ‘cultural relativism’ are key to fight FGM, and that the consent reached in France on these two aspects has entailed substantial progress: ‘When all EU Member States have perfect legislation on FGM, we will have the situation of the UK: as long as there isn’t a trial with all the due media coverage and the “inconvenience” this might cause to the family members brought before the court, there won’t be any progress.’ The respondent also contrasted the situation of France with Belgium, where CSOs also have the right to sue but ‘do not receive any report of FGM’, considering that professional (medical) secrecy should be regulated at the EU level, in order to overcome judicial, cultural or personal prejudices that prevent actors to act firmly against FGM.

Another respondent points out another obstacle to reporting, which, in her opinion, is entrenched into personal concepts concerning intimacy and respect of traditional practices: ‘All over the world, I mean, in every country, there is a legislation punishing bodily harm, especially on under-age victims. Yet, in many cases, it is not applied to FGM. But listen, it is that simple: you must prosecute as soon as cases are reported. Otherwise, it means that you acknowledge a clandestine criminal activity. I have sometimes heard this argument, which I really like: “if you denounce — not reporting, but this dirty word of denouncing — you’re making FGM clandestine.” Come on: it is always clandestine! [...]’

She also provides an argument to unravel the differential treatment often given to FGM: ‘That’s how I always catch them before criminal courts: you know, there is always a boy in the family, and I ask: “is he circumcised?” “Of course”, the parents answer. “Oh! And where was the circumcision practised?” “At the hospital, of course!” This clearly means that no matter how long they have been in the country: they know that FGM is illegal [...] . I tell you: there is not a single woman disembarking from Africa who ignores that FGM is prohibited by Law.’

She has also underlined some cultural features entrenched in judicial systems that may prevent people who know about FGM to report suspected cases:

‘In the UK, there are currently people who protest against the fact that neither politicians nor the police adequately act against FGM. But for that, it is first necessary to report suspected cases, and neither GPs, nor midwives or social workers who know about such cases, report them [...] . Recently, I was told about a case, in which a 14-year-old girl had denounced the FGM she had suffered. She later withdrew her complaint, as she was receiving pressure from her family, with whom she was still living… and then: case closed. That’s really miles away from our French concept: we consider it is up to our society to protect under-age victims, who cannot sue, by the way. This is a completely distinct point of view.’

The UK is not just quoted as a counter-example, however. One respondent thus made reference to the abundant case-law on asylum: ‘In comparison with the UK, for instance, we are 20 years backwards as concerns the implementation of thorough guidelines on gender and asylum [...] . Yet, the OFPRA and the CNDA are now aware that there is a specificity of gender, but we are far from a systematic approach.’

The fact remains, though, that French actors tend to promote a universalist approach, in which the respect of personal integrity and children’s and gender rights, are privileged over the tolerance due to the expression of cultural diversity.

By contrast, the interviewees evoked two major concerns which limit — although to different extents — the effectiveness and thoroughness of the approach implemented in France.

**Improving data collection on prevalence**

Although it was not interpreted as a major challenge to be taken up by our interlocutors, the collection of figures on the prevalence of the phenomenon was nevertheless pointed out as something to be improved.

French policy actors usually pay little attention to hard data collection prior to/after the diagnosis of policy issues or problems. This general feature of public policies also applies to FGM policies. In this case, as has been mentioned in this report, severe legal constraints limit the possibility to collect data based on origin or ethnicity. The absence of reliable figures on prevalence (beyond extrapolations drawing upon African prevalence rates) is not framed as
a major obstacle to the implementation of effective public policies on FGM. Even if this was not mentioned by our respondents, we can infer that in the case of FGM, the little emphasis put on data collection by French actors is to be interpreted as the result of a broader taboo surrounding the measure of diversity in the population. This taboo makes any actor working in contact with cultural diversity extremely cautious with measuring it, as well as its positive or negative implications.

It remains, though, that the actors mobilised around the FGM issue now largely draw upon the extensive, both qualitative and quantitative study ‘Excision et Handicap’ carried out between 2007 and 2009. Rather than focusing on prevalence, this study addressed the impact of FGM on sexual, psychological and reproductive health, and assessed the needs in terms of surgical repair and psychosocial support. Additionally, three of our respondents did mention the lack of hard data as having potentially negative effects on the design and the implementation of FGM policies. Yet, these actors do not refer to the measure of global prevalence rates, but to fine-grained statistics concerning the number of cases reported, the size of population at risk or the number of applications to international protection submitted on the grounds of FGM.

**Strengthening the children’s protection system**

As mentioned in Section V.3 ‘Protection’, several of our respondents highlighted the structural weaknesses of the child protection system. Due to its territorial dimension and the fact that it involves a wide variety of actors, doubts can arise about its ability to identify and properly address every situation of risk. Moreover, its vertical dimension entails that data are uploaded with little information provided in return on the overall situation with respect to FGM.

As a consequence, recommendations were made with respect to the following aspects:

Swiftness and effectiveness in addressing situations of risk:
- establish general guidelines for all the actors involved in the reporting process;
- fix deadlines for internal consultation and reporting to the CRIP;
- limit interferences in establishing the accuracy of the facts;
- convocate families only when it is not against the interest of the child.

Coordination:
- establish a mechanism to exchange information between the CRIP and Maternal and Infantile Protection;
- hold regular joint coordination meetings;
- ‘download’ general data and statistics on children’s protection and particularly on FGM from the CRIPs to the PMI services.

**Broadening the scope of services**

As has been emphasised, ‘there is still much to be done in terms of psychological assistance or provision of services’. In fact, except in multidisciplinary units established to attend women opting for surgical repair, psychosocial assistance is not systematically offered to girls and women at risk, victims, families or professionals. This is the case for instance for asylum seekers or migrants, for whom relatively little services are available concerning FGM. This is to be related to the fact that in France, CSOs working on FGM are not centred on the provision of service, but on the implementation of some aspects of public policies which are delegated to them. This aspect is reinforced both by the dependence of these organisations on public funding, and their financial insecurity, which makes it difficult to broaden the scope of the services provided in the long term.

**Assessment with respect to the ‘five Ps’**

In the absence of specific legal provisions to criminalise FGM, France has been a forerunner in the prosecution of FGM. Following the arguments of one respondent, it has been considered that FGM should be treated through non-specific provisions, since harm to bodily integrity causing permanent mutilations, especially if perpetrated on children and by their parents or tutors, was already severely punished. Moreover, the rationale was that prosecution should not lead to the stigmatisation of a particular community. Instead, it was meant as a prevention instrument and the result of a strict application of the law, irrespectively of the origin. This approach has materialised in 42 trials, most of which were held before criminal jurisdictions.

In the field of prevention, France has developed regional and nationwide instruments from the early 1990s, under the impulse of pioneering regions or departments. Those first involved the PMI services, initially through the compulsory medical screening of children under the age of six. They were later reinforced by a broadening scope of tools and instruments, including booklets, conferences and training courses, which helped to eliminate the practice of FGM on the French territory and to prevent certain situations of risk. Prevention, however, very certainly lacks proper funding and coordination at the national level, in order to cover the whole territory and to trigger policy innovation.

As has been extensively mentioned, France has only recently reformed its child protection system, in particular to improve reporting and to address the effects of gender-based violence, including FGM. Although it has received major improvements since the mid-2000s, this system still has to cope with differentiated views on professional secrecy and the notion of risk. Improving the sharing of information among relevant actors involved in the assessment, reporting and resolution of the situations of risk, is therefore deemed important. In the specific field of asylum, where progress has been made to improve the protection of potential victims of FGM, avoiding a random treatment of gender-related requests would necessitate the instruments of a systematic assessment of individual situations. As pointed out by one respondent, another recommendation would be to train the main actors of asylum policies on gender issues, including gender-based violence (GBV) and FGM. Moreover, the ministry to which asylum issues are attached should give priority to protection over the control of migration flows.

Partnerships have proved to be efficient and should be generalised throughout the territory and involve CSOs,
In the interviews, during which our interlocutors could of good practices. This contrasted situation was reflected in the FGM issue and their often personal dimension may institutionalisation of policy networks established around framing instruments, provide a different, potentially in France, and the long absence of coordination and the relatively grassroot dimensions of FGM policies happening, can be extremely progressive. Nevertheless, Another consequence is that good practices are often term to another, but also during a same mandate. 

Traditionally, policymaking in France has not been experienced-based. Since WWII (at least), planning and top-down interventionism have been its main characteristics. It is only recently that the way diagnoses are established and needs are identified have been questioned, and that evaluation has entered the vocabulary of policymakers. This is notably the case for social and health policies. These path-dependent patterns entail that the identification of good or promising practices and their generalisation is still not widespread as a way to proceed cumulatively and to draw lessons from the experience.

One of the consequences of this peculiar feature is that in a number of policy areas French policies often lack continuity. This aspect has already been highlighted in the desk study report, emphasising the situation of gender equality policies, which lack both autonomy and funding. As an example, the Observatoire de la Parité, once placed under the responsibility of the Prime Minister, now the Ministry of Health, has very limited prerogatives and authority. This explains, to a large extent, that policies dealing with gender issues have usually limited coordination at the national level. This characteristic can be extended to social and health policies. For this reason, the prerogatives and areas of action of each ministry do substantially change over time, not only from a legislative term to another, but also during a same mandate.

Another consequence is that good practices are often not identified as such and that their generalisation, when happening, can be extremely progressive. Nevertheless, the relatively grassroot dimensions of FGM policies in France, and the long absence of coordination and framing instruments, provide a different, potentially more favourable context for the experimentation of innovative policy practices. At the same time, the weak institutionalisation of policy networks established around the FGM issue and their often personal dimension may hinder the collective identification and the generalisation of good practices. This contrasted situation was reflected in the interviews, during which our interlocutors could identify positive developments, rather than actual ‘good practices’.

**VIII. POTENTIAL GOOD PRACTICES**

*Path-dependent features of policymaking in France*

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**Institutionalising policy networks at the local/regional level**

The main policy practices to be positively assessed by our interlocutors were the policy networks established at the departmental and the regional level, on the initiative of the Women’s Rights and Gender Equality Delegates (DRDFE). First initiated in the Ile-de-France region, they have been progressively generalised to the regions potentially most concerned by FGM. These policy networks consist in creating working groups, regular meetings and an annual conference (held over a half-day in February), which gather regional policy stakeholders and actors (chiefs of PMI services, public hospitals, ‘rectorates’) and actors representing local PMI centres, the police, CSOs active on FGM and educational communities. The first — and most institutionalised — policy network of that kind was established in 1992 in the Ile-de-France region.

It coincided with the emergence of a growing consensus regarding a two-fold approach based on prosecution and prevention/protection. Since, it has not only facilitated cooperation among these actors, but also resulted in major innovations with respect to the treatment of FGM in France, in the forms of widely distributed and regularly updated booklets, of the publication of a regularly updated policy handbook (1), and the organisation of an annual conference which has become a major event for all the actors involved in fighting FGM. Moreover, this policy network has proved to be a useful instrument for the identification of new trends in the practice of FGM, such as the shift in the age of victims and the increase of reporting procedures initiated by educational communities. In 2012, the DRDFE has drawn upon the collective work of this network to publish a new booklet aiming at teenagers, professors and educational workers: *Filles et garçons. Parlons-en. Mutilations sexuelles féminines.*

Which respect to the major features and outputs of these policy networks, particularly in the Paris metropolitan area, it can be argued that this good practice meets the main criteria established for the purposes of this study.

Establishing this network in 1992 firstly resulted from the identification of real and urgent needs. Since the mid-1980s, jurisdictions and PMI services of the Ile-de-France region were faced with a growing number of FGM cases, which called for preventive action and policy coordination. This was also due to the high concentration of groups at risk in some departments as the Seine-Saint-Denis.

Secondly, this policy network has relied upon partnerships between a broad range of actors, including CSOs (partly community based as the GAMS), policy stakeholders, and individual experts. Depending on the needs and trends identified with respect to FGM, this network was later extended to educational communities and the police.

Thirdly, following the transversal approach implemented in a forerunning department (Seine-Saint-Denis), it has adopted a broad approach to FGM, as part of a continuum of gender-based violence. This perspective led to

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include not only judicial or health aspects, but also the psychological, cultural and social dimensions of FGM. From the mid-2000s, this approach coincided with the perspective adopted at the national level through the action plans on GBV.

Fourthly, this network has produced some monitoring and evaluation instruments, such as the handbook of FGM policies, and has encouraged its members to implement such instruments to assess their action on FGM. In particular, the annual conferences held by this network give the opportunity to present and discuss monitoring and evaluation instruments, such as the guidelines issued by the Paris PMI in 2011.

Fifthly, the fact that this policy network/partnership was established under the patronage of a state service (DRDFE) ensured its sustainability. Indeed, whereas gender equality policy machineries at the national level have gone through regular institutional changes which have undermined their capacity to produce sustainable policy results, DRDFEs have been left untouched since 1982, with limited, but relatively constant funding.

Sixthly, in terms of results, this policy network has produced and helped to generalise major prevention tools such as the booklets issued since 1993. Moreover, it has established long term cooperation between the actors dealing with it at different levels. Over time, these partnerships have become swift and fruitful, as shown by the cross-references made by our respondents to each other’s organisations.

Finally, due to its structure which articulates services organised at the local/regional level (PMI, DRDFEs, rectorates, etc.), this policy network could be initiated in other French regions, and its generalisation is in process. However, it can be objected that some of its pillars, such as issue-specific CSOs or the Brigade de protection des mineurs in Paris, are not present throughout the territory.

*Implementing a multilayered approach in prevention material*

Although not regarded as a good or promising practice by our respondents, another relevant practice could nonetheless be identified through the desk study and the interviews. It was consolidated over time, though the publication and high-scale distribution of prevention tools in the form of 6 up to 12 pages booklets issued by regional DRDFEs.

As mentioned above, the first, published under the title ‘Nous protégeons nos petites filles’ (Let’s protect our little girls), was issued in the Ile-de-France region. It consisted in an eight-page booklet providing targeted groups with basic information on FGM (French and international legal frameworks, prevalence, a series of questions/answers challenging commonly shared assumptions on FGM, and resources (associations, hotlines). According to its promoters, this document aimed at preventing FGM through education, presenting the legal grounds of FGM criminalisation in France and emphasising that FGM was being challenged in the countries of origin. It also embraced a positive vision of populations at risk, making parents the key actors in the prevention of FGM.

Since then, the booklet has been updated in order to include new actors and new services — such as surgical reconstruction — and has been customised and issued in the Haute Normandie and Loire Atlantique regions.

First designed by experts from the GAMS, the Family Planning and doctors from the PMI, this instrument materialises above-described policy networks and provides actors and communities at risk, with an easily accessible, readable and yet complete information and prevention tool. As such, it has also inspired other countries and has been adapted in Belgium, Germany and Luxembourg.

*Guidelines on how to react in case of FGM or in facing a situation of risk for a child or under-age girl*

This is definitely a promising practice to be highlighted, and it was thoroughly addressed during our interview with the Deputy Head of the PMI service in Paris. It takes the form of an internal notice issued in 2011, which looks at all the fields of intervention of the PMI, including maternal protection and family planning.

The notice also provides thorough guidelines to PMI professionals, framing intervention on FGM cases. They include the procedure to report FGM to the CRIP and the attorney, but also detailed information on psychological, social and medical assistance that can be provided not only to girls, but also to adult women who suffered FGM. This more comprehensive framework reflects the fields of intervention of the Maternal and Infantile Protection, which goes far beyond medical screenings of children under the age of six.

A typology of FGM was included in the guidelines, along with the recommendation to rely on trained professionals to make diagnoses. The guidelines remind professionals that FGM concerns populations beyond sub-Saharan Africa, as in Egypt, providing a map with updated prevalence rates. To prevent blind corners, it recommends adopting a generalist and systematic approach, not excessively focused on certain geographical areas.

Moreover, information on protection and prosecution measures have been updated, taking into account the recent evolutions noticed in the practice of FGM, concerning the age/place when/where it is performed. It also strengthens the monitoring of pregnancies, to better identify situations in which women have been mutilated prior to being forced into marriage, in order to provide assistance (even after they have reached their majority) in initiating prosecution. Social and psychological support, as well as surgical repair, can then be offered to victims.

These guidelines were presented during the annual conference on FGM held by the DRDFE, in February 2012. Due to their recent nature and in the absence of monitoring and evaluation instruments to assess their implementation, we decided not to label these guidelines as ‘good practice’. Yet, their teaching potential and their transferability to other regions or contexts, deserved to be mentioned.
IX. FINAL REMARKS

These final remarks only briefly summarise the main aspects which are thoroughly covered in the eight sections of this report.

Key features of French FGM policies

With respect to the FGM issue and the policy developments it triggered, France is to be characterised by the emphasis that has been firstly laid on prosecution. Soon after the massive flow of sub-Saharan (female) migrants which followed the simplification of family settlement regulation in 1978, first cases of FGM were reported by PMI doctors, as well as African and feminist activists. The newly established Women’s Rights Ministry (1981) soon addressed FGM by creating a working group and taking up the issue at international conferences. No specific policy instrument was established, at the time, and FGM was increasingly addressed before courts. One respondent, a lawyer, used the opportunity given by French law, for CSOs to sue under certain conditions. Since then, she has been present in 41 out of 42 FGM trials, first acting on behalf of the Women’s Rights League, later of the CAMS, which had been specifically established in 1982 to denounce female genital mutilation. From the late 1980s onwards, FGM cases were almost systematically brought before criminal jurisdiction, thus receiving considerable public attention. This abundant case-law, however, did not entail major changes in the legislation. These were mostly due to the changes recently introduced in the prosecution of child abuse and gender-based violence. Nonetheless, the effective prosecution of FGM left its mark on the overall framing of the issue as a problem affecting French society as a whole.

Consequently, FGM was not considered through the filter of cultural diversity and the expression of cultural values, but was soon interpreted through the sole lens of harmful practices. It was then considered that FGM fell under the general competency of the law, assuming that harm to bodily integrity causing a permanent mutilation had to be punished irrespectively of the origin of the perpetrators and the victim. In that sense, the juridical treatment of FGM, contributed to strengthen the approach implemented in France, which tends to consider that society is built upon a set of fundamental values that cannot be infringed upon, even if this implies setting limits to the expression of cultural diversity. A broad concept of the ‘immaterial public order’ has been elaborated, which encompasses the respect to human integrity and increasingly, gender equality. Although the process of criminalisation of FGM triggered resistance among certain categories of actors, a consensus progressively emerged to consider that prevention had to be rooted in the undisputed reign of the law, no matter the cost entailed for the families concerned or the risk of stigmatisation for practising communities.

Secondly, two historical actors in the fight against FGM, namely the CAMS and the GAMS, have played a complementary role, which has placed them in a key position to instigate policy developments and strengthen prevention and protection. Whereas the CAMS assumed a key role in criminalising FGM, the GAMS has developed a broad range of interventions, due to its growing legitimacy and professionalisation. From the early 1990s onwards, the GAMS has become an auxiliary to policy action, participating in the elaboration of the first prevention instruments and assisting state or local services to deal with FGM cases. This major contribution was facilitated by the institutionalisation of partnerships at the local/regional level, first in the Ile-de-France region, through which priorities and challenges concerning FGM could be identified. These grassroots, characteristic of French policy developments on FGM, are another key feature.

Indeed, these developments have long taken place mostly at the local/regional level, while coordination instruments and a national strategy have been missing. This can be partly explained by the fact that FGM does not uniformly affect the territory, due to the concentration of populations at risk in some regions, and by the decentralised nature of policy instruments in two relevant fields to FGM: child protection and, to a lesser extent, gender-based violence. Additionally, the coordination of gender equality and women’s rights policies has been historically weak in France, due to the lack of continuity, autonomy and funding of corresponding machineries. Yet, in a centralised country like France, the absence of coordination elements cannot be only attributed to path-dependent institutional features, and it is likely that FGM, if compared to other expressions of gender-based violence and other aspects of population control and migration policies, have received relatively little attention in policy terms. Underlying norms, such as ‘cultural relativism’ (although it is less pervasive than in other contexts) and the differential treatment of individuals, depending on their country of origin, are very certainly at stake, as well as the potential political cost attached to the fight against FGM. Besides, it cannot be discarded that FGM has been framed more in terms of principles than in epidemiological terms, given the overall magnitude of the phenomenon.

Although prevalence estimates range from 40 000 up to 60 000 mutilated women living in France, policymakers have been mostly concerned by FGM actually being performed on the French territory. This has tended to diminish over time, due to monitoring and reporting activities carried out by the PMI. Therefore, it could be considered that FGM did not undermine social cohesion, as long as it had been perpetrated before settling down in France. It appears through the interviews carried out for this study that such cases are now quite marginal. However, due to the systematic prosecution of reported cases, and to the dense control ensured through the PMI services and public hospitals, a shift has been noticed concerning the age to which FGM is performed and the conditions in which it is perpetrated, i.e. mostly in countries of origins, on the occasion of brief stays often associated with a traditional (forced) marriage. This situation emerged as FGM cases were increasingly reported by educational institutions or family planning consultations. While those had been largely put on standby at the end of the 1990s, as the number of cases was diminishing, policy networks on FGM were reactivated during the 2000s to deal with these new situations.
These new policy developments intervened in a favourable context, as provisions and policy instruments on child protection and gender-based violence were being updated and considerably reinforced. Consequently, new coordination instruments have been shaped at the national level, such as action plans on GBV, the CRIIPs or the notion of ‘shared secrecy’, in order to improve the effectiveness of policies. These have made the generalisation of some good practices possible, such as the local policy networks on FGM or the diffusion of prevention booklets drawing upon a broad approach to the issue. Besides, this aggiornamento of two relevant to FGM policy fields has generated more thorough guidelines and protocols on reporting and protection measures. In the meantime, FGM has also become a major issue in relation to international protection in France, as it issued pioneering decisions on the recognition of FGM as a valid ground for asylum and of a social group at risk, comprising the parents who oppose FGM on their children. Yet, after positive developments in the early 2000s, and due to an allegedly massive flow of requests related to FGM, a more restrictive interpretation of this case-law has been implemented since. Moreover, France counts among the EU Member States which step into the breach opened by subsidiary protection, thus diminishing the degree of protection granted.

Challenges and limitations

Nevertheless, whereas it is true that due to its colonial past, France has been placed in the front line to deal with FGM on the European soil, and while it can be argued that this country has been relatively swift, proactive and pioneering in tackling this issue, it remains that French policies on FGM have been confronted to major challenges and limitations.

Firstly, hard data and figures, which are thought to be a key for a correct framing and effective policy solutions, are missing in France. As has been extensively mentioned in this report, this is due to the severe constitutional constraints applying to the collection of data on ethnicity or origin. This absence was also reinforced by the lack of a policy evaluation culture, in which hard facts, impact monitoring and benchmarks play a central role. Whereas FGM has been extensively addressed in French academic and policy literature through the lenses of medicine, anthropology, psychology or cultural studies, little has been done to collect reliable figures on prevalence and other related issues such as the number of FGM perpetrated in France or the number of FGM-related interventions carried out by law enforcement bodies or child protection services. This lack of data, which has not been fully compensated by the publication, in 2009, of an extensive study funded by public institutions, is also to be framed within the overall absence of institutionalised and functional records. The records concerning court cases, police interventions, procedures launched by child protection services or FGM-related applications to international protection are missing. Although some records apparently exist, they have been elaborated on the initiative of individual actors, they have not yet been institutionalised and no common methodology has been adopted to facilitate the exchange of information.

The lack of data and recollection of FGM policies is in strong contrast with the existing dedicated CSOs and public services, like the PMI services, which have a long record of effective and innovative actions on FGM. This considerably undermines the overall sustainability, reliability and effectiveness of the monitoring and reporting systems, with potentially serious consequences on the implementation of protection measures. In a rather worrying manner, it also fuels the idea that in the French context, the FGM issue ‘sounds a bit old-fashioned’. Whereas in the daily practice of certain services, this issue has truly become peripheral and relatively anecdotic, it is however uncertain whether this is due to the effectiveness of policies, or to the blind corners which have been left, in the absence of fully reliable and easily accessible data.

References


1. IDENTIFICATION

Country: Germany

Researcher: Feleknas Uca, Leylan Uca

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The studies in Germany were obtained following the ‘Guidelines for national data collection’. The following academic databases have been used for research on prevalence studies in Germany (DE): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Heinonline and Google Scholar.

Furthermore we scanned the websites of ministries:


Then we gathered information through telephone contact and written e-mail requests from several respondents: one from the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth, one from the Federal Ministry for Economic Cooperation and Development and a person from the Department of Justice.

We also found data on the Internet pages of Terre des Femmes e.V., Unicef, Berufsverband der Frauenärzte e.V., and Plan International Deutschland e.V.

The Federal Office for Migration responded to our initial phone request with an e-mail. A respondent from the Round Table of Baden-Württemberg and the Ministry of Work and Social Affairs also spoke to us on the telephone.

The Bureau of Foreign Issues, the Department for Human Rights, as well as a respondent from Terre des Femmes, a person from the association Wadi and a person from ‘Runden Tisch NRW’ (Round Table Nordrhein-Westfalen) and ‘Aktion weißes Friedensband’ (Campaign White Ribbon for Peace) remained in contact with us via phone.

All these approaches were helpful to us and also helped us to gain access to other contacts, organisations and associations which transmitted information about relevant legislature and studies for our study about FGM.

2.2. Nature of prevalence studies/FGM registration systems

We have found four relevant studies that document prevalence data on FGM in Germany. The first study was published in 2005 by Terre des Femmes, the second was a 2005 survey from Unicef, Terres des Femmes and the Berufsverband der Frauenärzte e.V., the third was a statement by Terre des Femmes concerning the human rights of women held at the public hearing of the Committee on Family Affairs, Senior Citizens, Women and Youth on the subject: ‘Fighting female genital mutilation’, on 19 September 2007, and the fourth was from Plan International Deutschland e.V., in 2011.

2.3. Findings from the prevalence studies/registration system

The updated 2011 census shows that the total number of girls and women who come from FGM-practising countries and live in Germany amounts to at least 66 302. Against the background of the mutilation rate in their respective African countries, about 17 979 women above the age of 20 living in Germany can be considered to have undergone FGM. About 5 300 girls are in danger of FGM. In all, about 23 291 women and girls concerned by or in danger of FGM live in Germany.

This number can be seen as a lower bound, if we take into account the young women and girls from African countries living in Germany without identity papers and therefore not included in the statistics, or women and girls from FGM-practising countries who already have German citizenship, but who might be concerned or in danger of FGM. These numbers only take into account African countries and Yemen. Other states, such as Iraq and Indonesia, which also practise FGM, are not included in the statistics because of lacking mutilation rates.

The given data come from Amnesty International (only the Democratic Republic of the Congo), Unicef (only Yemen and Sudan) and the Population Reference Bureau (all other countries). The numbers were calculated on the basis of statistic data material relating to the average mutilation rate of the specific countries.
2.4. Reflection on prevalence studies

Germany started to estimate the number of girls and women with FGM or at risk of FGM in 2005. These underlying studies are not significant enough due to various reasons. On the one hand the studies have not been carried out nationwide and have not been updated at regular interval. On the other hand the concerned women and girls are not all included in the data so that the estimated number of unreported cases is high; i.e. women who submitted for political asylum are not included in the data.

The studies that already exist were not compiled under the authority of ministries, as anticipated, but have been extracted and devised by women’s associations. There are no lists or statistics conducted on women or girls with migration background that include FGM. It is difficult to achieve statistics which are a hundred per cent reliable, because the women concerned don’t, in the majority of cases, want to talk about FGM or bear witness.

The population on which the 2005 study on female genital mutilation was based were women who had been victim of, or women (girls) at risk of FGM. A second study ‘Cuts in Body and soul: A survey on the situation of circumcised girls and women in Germany’ (2005), based its research on findings from gynaecologists in Germany. Other documents include a statement from Terre des Femmes given at the public hearing of the Committee on Family Affairs, Senior Citizens, Women and Youth on the subject: ‘ Fighting female genital mutilation’ on 19 September 2007; on ‘Women with FGM: women and girls at risk of FGM’; and a study: ‘Listening to African voices: female genital mutilation/cutting among immigrants in Hamburg — Knowledge, attitudes and practice’ which based its research on women and men from sub-Saharan African countries residing in Hamburg.

The first study does not include empirical data collection. It refers to the existing specialised literature of the WHO, Unicef, the UN and others. To provide an overview of the situation it also refers to the German Penalty Code, the German Residence Act and others.

The second study is a survey from German gynaecologists on their experience in working with women who have undergone FGM.

In the third study the FGM prevalence figures were applied to all migrant women in Germany originating from countries where FGM is being practiced according to UN organisations and the WHO. To estimate the migrant female population in Germany, data from the Federal Office of Statistics have been included.

The fourth method of study is a reference review and a three-month field study targeting immigrants from sub-Saharan Africa residing in Hamburg. An interview on the basis of a questionnaire with 685 women and 1,082 men originating from 26 sub-Saharan countries was evaluated.

Limitations and/or success
1. The study on female genital mutilation is limited to existing data on FGM. There is no collection of new data.

2. The study ‘Cuts in body and soul. A survey on the situation of circumcised girls and women in Germany’ is limited to the work experience of gynaecologists in Germany with women who have undergone FGM; some parts of the study are also statements from experts and individual experience reports of women with FGM.

3. The statement of Terre des Femmes at the public hearing of the Committee on Family Affairs, Senior Citizens, Women and Youth on the subject: ‘ Fighting female genital mutilation’ mostly refers to migrants from African countries, but not from Arab countries like Yemen or the United Arab Emirates.

4. The study ‘Listening to African voices. Female genital mutilation/cutting among immigrants in Hamburg — Knowledge, attitudes and practice’ is restricted to the area of Hamburg and only considers migrants from sub-Saharan African countries.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

The documents and Internet links on policy in Germany were obtained following the ‘Guidelines for national data collection’. The databases in Germany (DE): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Heinonline and Google Scholar were searched. Furthermore, the ministries were contacted nationwide by phone or e-mail.

The websites of the following actors in Germany were scrutinised and included in the database/policy framework/tools and instruments:

3.2. Policies on FGM

In Germany, the policy development started in 1995 with a document from the German federal parliament about mutilation of women and girls in numerous countries worldwide.
This was followed by the German federal parliament dealing with genital modification in Germany, in 1996. A recommendation for a decision and a bulletin by the Commission for Family, Seniors, Women and Youth in 1998 have been affiliated to the federal parliament. Over the years, different references and educational documents have been produced and published via the federal parliament on their Internet page.

As a result of the Decision of the European Parliament of 24 March 2009 regarding the combat against FGM in the European Union, the European Parliament informed about the consolidated findings and requested all Member States to act against FGM. Germany responded with a legal bill, in 209, to change the penal code on the culpability of FGM.

In 2010, the Länder Baden-Württemberg, Bayern, Hessen, Niedersachsen, Rheinland-Pfalz and Saarland applied for the implementation of a statutory offence, beginning with the state of limitation of the majority age of the victim and the inclusion into the catalogue of deaths in foreign countries, an adaptation of the criminal proceeding arrangements with regard to eligibility of civil action as well as the appointment of a solicitor. Changes were made to Chapters 5, 78b and 227 as well as the inclusion of Chapter 226a, Penal Code, and changes to Chapters 395 and 397a, Criminal Proceeding Arrangements.

The Political Gender Action Plan 2009–12 was incorporated into the German federal government, which stipulates that female rights have to be consolidated.

3.3. Reflection on policies on female genital mutilation

In Germany, the drafts of the law changes regarding FGM requested by members of the parliament and other important protagonists, such as associations or organisations, are important for the political development. They should be done according to the demographic development of Germany and the changes in the population.

All the organisations and associations we talked to came to the conclusion that it is very important to change the German penal law concerning FGM.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The following data have been investigated on the Internet, via requests at Terre des Femmes and on the Internet page of the German federal parliament. The regulations came into force in 1982.


4.2. Criminal Law

General and specific criminal law/provisions:

German Penal Code, Chapter 17, Section 223; Conditions: German Penal Code Section/Applicability to Acts Abroad in Other Cases: (1) German criminal law shall apply to acts, which were committed abroad against a German, if the act is punishable at the place of its commission or the place of its commission is subject to no criminal law enforcement; (2) German criminal law shall apply to other acts, which were committed abroad if the act is punishable at the place of its commission or the place of its commission is subject to no criminal law enforcement and if the perpetrator: (1) was a German at the time of the act or became one after the act; or (2) was a foreigner at the time of the act, was found to be in Germany and, although the Extradition Act would permit extradition for such an act, is not extradited, because a request for extradition is not made, is rejected, or the extradition is not practicable. Chapter 17, Crimes Against Bodily Integrity, Section 223, Bodily Injury: (1) Whoever physically maltreats or harms the health of another person shall be punished with imprisonment for not more than five years or with a fine; (2) An attempt shall be punishable.

German Penal Code, Chapter 17, Crimes against Bodily Integrity, Section 224: (1) Whoever commits bodily harm: (…); (2) by means of a weapon or other dangerous tool; (…) (4) jointly with another participant; or (5) by means of treatment dangerous to life, shall be punished with imprisonment from six months to 10 years, in less serious cases with imprisonment from three months to five years. Chapter 17, Crimes Against Bodily Integrity, Section 226, Serious Bodily Injury: (1) If the bodily injury has, as a result, that the injured person: (1) loses his sight in one eye or in both eyes, his hearing, his speech or his procreative capacity (…); (3) is permanently disfigured in a substantial way or becomes inform, paralysed, mentally ill or disabled, then the punishment shall be imprisonment from one year to 10 years. And Law Draft/German Penal Code, printed matter 17/4759, Chapter 12, Crimes Against Personal Status, Marriage And the Family, Section 171, Violation of the Duty to Provide Care or Upbringing: Whoever grossly violates his duty to provide care or upbringing for a person under 16 years and thereby creates a danger for the ward, that his physical or psychic development could be seriously damaged, that he will lead a criminal life or engage in prostitution, shall be punished with imprisonment for not more than three years or a fine.

4.3. Child protection laws/provisions

The legal basis for the prosecution of FGM performed on children is the general German Penal Code (specifically Chapter 17, Crime against Bodily Integrity). This act is not specific for child protection and safety, but can be applied to children.

4.4. Asylum laws/provisions

From the Ministry of Migration and Refugees, in accordance with the Geneva Conventions Chapter 60, Section 1, No 3, Immigration Law (AufenthG) counts. According to that it has to be considered whether asylum can be granted.
The acceptance of political gender-related persecution requires that girls and women, or boys and men, in a given state form a specific group, which can be defined according to the standards of Article 10 of the Qualification guideline. In this regard the Federal Agency has to evaluate if the approval of the refugee status is to be given in case of danger of genital mutilation, honour killings, forced marriage, domestic violence or dowry murders.

4.5. Professional secrecy provision(s)

Chapter 3: Professions Regulation for German Doctors (Musterberufsordnung für die deutschen Ärzte), stipulates that doctors have the right, but not the duty, to report FGM. This means that it underlines the discretionary authority of the doctor, whether to denounce a case of FGM or not, thus protecting the victim, because the doctor is not under the absolute obligation to report a case.

4.6. Reflection on legal framework

Germany is only starting its review of laws and determinations concerning FGM, as a result of associations and organisations raising awareness on the issue of FGM through inquiries and petitions.

During the last few months the subject of FGM has been increasingly investigated in public, in Germany, resulting in giving the subject a growing attention also in politics.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

A list of the actors in Germany was obtained from: ‘Guidelines for national data collection’. The following database in Germany (DE) was searched: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Heinonline and Google Scholar were searched for relevant actors.

The actors found are against FGM. They try to have an influence at the national level so that the law can be changed to help the affected women and girls in various ways and towards the eradication of FGM.

5.2. Actors

The German Network for the Eradication of Female Genital Mutilation, the Children’s Fund of the United Nations and Amnesty International are only some of the actors found in the database. Nala inc. is not a formal foundation yet. We have found 37 actors, but are probably not the only ones. An actor is involved with improving the living conditions of African asylum-seeking women and children, the victims of war, displacement, tradition and patriarchy, and with the abolition of FGM. It provides educational information on the female genital cutting of girls and personal experience reports, it organises readings, panel discussions and participates in discussions.

Some organisations have joined forces. For example, 24 German organisations are involved: in combating FGM; sensitisation and education work on the ramifications of FGM; support local initiatives, private and governmental organisations that fight against FGM; measures for exchange and dialogue for women and men about FGM; and cooperation with religious and traditional authorities.

Members of the Women Physicians Academy, the Association of Scientific Medical Societies (AWMF) and the Federation of Operational Medical and Scientific Societies (FOMWF); the close connection between the Professional Association of Gynaecologists and the common occurrence in relation to those institutions increasingly ensure the success of joint efforts. This is a scientific society. It promotes research and science, thus ensuring the continuous development of diagnostic and therapeutic guidelines and recommendations.

5.3. Reflection on actors on female genital mutilation

There are many actors in the area of FGM in Germany. They support the fight against FGM of women and children.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Different sources were searched to find tools and instruments under Social Science Research Network, web of Science, Google and PubMed.

The results are included in the database under tools and instruments.

6.2. Tools and instruments on FGM

The subject of FGM is discussed in books, in studies, treatises, seminars, training aid, conferences, circulars, flyers, etc. and in different sectors in Germany. The material is aimed at the target group of affected women, as well as at persons who would like to be informed and people whose awareness should be raised concerning FGM.

6.3. Reflection on tools and instruments on FGM

Tools have been compiled since the late 1990s in Germany.

7. FINAL CONSIDERATION

From the designated sources it is becoming clear that Germany has made a good start to determine the extent of FGM and how many women are affected by FGM. Studies have been conducted since 1995, but they are regrettably very incomplete, due to the lack of acknowledged target subjects, to the fact that the studies are not repeated at regular intervals and that they are only conducted in sporadic towns. Nationwide, repeated studies based on the same basic material are lacking, and are thus not representative of Germany as a whole. This however, is indispensable to have significant, dependable studies and statistics.
FGM is now beginning to be recognised in the political setting. Unfortunately, after contacting delegates and ministries directly we found that neither in the Ministry of Health, nor in other ministries this topic is discussed continuously.

Legal requirements are pivotal in Germany. The conclusion of this data-collecting is that changes at that level have to be made. Law proposals to the federal government do exist, but nothing has been approved yet.

It is obvious that much more is gained at the social level through networks and the cooperation between institutions and organisations than at any other level. At the social level, a permanent current discussion about FGM can be found e.g. awareness raising, help for victims, allocation of materials, round-table discussions, etc.

The summary is due to the preceded investigations: work on FGM has to be developed, aided and improved much more in Germany than it is now. In view of this, we recommend the following ideas:

• Encouragement of research concerning the mental consequences of FGM, the needs of victims and strategies to overcome FGM
• Building up further helpdesks for concerned and victims
• Inclusion of female genital mutilation into the medical diagnostic key system and the accounting system of health insurances
• Inclusion of the topic violence against women and female health into migration courses, to inform female migrants about their rights and helpdesks
• Inclusion of the topic of FGM into apprenticeships and further education of health professionals, midwives, psychologists, social workers, educators, teachers, the police and justice
• Formulation of a national plan of action together with the people concerned and victims as well as representatives of the federal government, countries and communities
• Implementation of compulsory preventive medical examinations for all children in Germany, independently of gender and ancestry, so that not only cases of FGM but also cases of sexual abuse can be uncovered
• Implementation of the medical responsibility to call the Youth Welfare Office in case of mutilation of a minor as this means there is a concrete danger for younger sisters who need to be protected
• Inclusion of FGM as own statutory offence into the Penal Code, so that cases of FGM committed abroad can also be prosecuted. Prohibition of FGM should follow the WHO’s definition, which also includes reinfibulation (the restitching of a vagina after giving birth) as well as designer vaginas as elements of crime.
• Accepting genital mutilation as a gender-specific matter of persecution, even if mutilation is outlawed in the country of origin of the concerned women. In many cases the country does not attend to its duties of protecting its citizens, so that can be emanated from an official persecution of the concerned. This is why we are asking for an open-ended residence permit status for women who are threatened with FGM in their country of origin.

• Allocating money in the context of emerging cooperation for specific educational projects in the concerned countries.
I. INTRODUCTION

The in-depth study will investigate FGM approaches in Germany and current actors and their activities in pushing the agenda especially in the current FGM policies developed at all levels. Also the study will look at the existing FGM prevalence data in Germany and provide recommendations on how data can be best collected and implemented in Germany.

Six face-to-face interviews were conducted with different key informants who are actively working on the topic of FGM in Germany. The core team provided a list of informants to be interviewed in Germany. The respondents were contacted via e-mail first, which included an information letter describing the purpose and methodology of the study. The recruitment process posed some challenges:

• a reminder e-mail had to be sent and a telephone follow up was also necessary in relation to all the respondents who did not react to the invitation three days after the information letter was sent;
• the months of July and August are a ‘typical’ holiday season in Germany. Therefore, four of the contacted respondents were not available within the time frame proposed;
• an interview appointment was cancelled due to health reasons, a new appointment had to be arranged for a later date, this delayed the interview time frame;
• most of the respondents were located in different cities, which required travelling long distances.

The respondents who agreed to take part in the interview received a customised questionnaire 24 hours before the interview. Apart from one interview which was conducted in a ‘guest’ meeting hall, all the other interviews were conducted in a quiet room and all lasted over an hour. The interviews were conducted between 2 July and 3 August 2012.

Interview schedule and description of the respondents and their contributions to the work of FGM is provided on Section II ‘Information sources’. Section III ‘Historical context and policy development in Germany’ explains the driving forces for policy development on FGM and the key actors involved in pushing the policy in Germany. Sections IV ‘Prevalence and data collection’ and V ‘Approach to FGM’ provide insights according to the views of the respondents on the Ps framework defined for this study. Section VI discusses the successes and challenges of the German approach to FGM and Section VII ‘Lessons and policy recommendations’ summarises the key recommendations and suggestions based on the main lessons learned. Sections VIII ‘Potential good practices’ and IX ‘Final considerations and recommendations’ identify good practices with respect to the work of FGM.

II. INFORMATION SOURCES

(a) Overview table of the interviews

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<th>Observations</th>
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</tr>
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<td>2.8.2012</td>
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</tr>
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</table>
(b) Brief description of each respondent

The first respondent is Integra network’s (1) spokesperson. The network was initiated by GTZ (now GIZ) in 2000. In 2005 the network became more formal and assumed the name Integra which was launched by all the member organisations. To date, the network consists of over 25 members of different organisations and individuals. The focus of FGM-related work of the network includes awareness and education about the consequences of FGM, measures to change attitudes and behaviour regarding the practice, support for local initiatives and strengthening of private and governmental organisations working against FGM as well as lobbying for FGM in Germany and abroad. The respondent is responsible for the coordination of network meetings, sending notices and agendas, and formal representation and consultation with the patrons, ministries, etc. She is also a project officer for Misereor’s (2) African projects in Zambia and Madagascar. Misereor is the German Catholic Bishops’ Organisation for Development Cooperation. Misereor is a member of the Integra network which includes 25 other members who are involved in overcoming female genital mutilation worldwide. Misereor supported four projects in Africa (Tanzania, Ethiopia, Mali and Egypt) for combating FGM and initiatives that lobby for the elimination of FGM.

The next respondent is an ethnologist (focus on gender studies) and a specialist on female genital mutilation at Terre des Femmes in Berlin. In 2005 the respondent and her colleagues published an EU study (3) on female genital mutilation. The study provides background information and an overview of the current situation in African and European countries as well as current strategies in the fight against genital mutilation.

The next respondent is a law attorney who offers legal advice, particularly in the areas of information technology law as well as the end of life law (i.e. inheritance, living wills, burial rights, personal injury law/health, genetics, etc.), but also in other matters of civil and public law. Furthermore, since 2008, he has given free advice and represented girls and women who have undergone FGM or are at risk of being subjected to the practice (this is pro bono work). Since 2007, he has been a member of the Integra network in Germany. The respondent has also published several FGM-related articles/journals under Health Law and Law and Politics.

The next respondent has been involved for the past 25 years in the field of human rights, particularly concerning women and girls’ rights. As Head of the African Division of the Cologne club Agisra e.V. (4), she was active in advising African women and in 2001 she worked for the city of Frankfurt as a social and health consultant for African women. Agisra e.V. is an organisation against international sexual and racial exploitation, it is an information and counselling centre in Cologne that, since 1993, has been providing support and advice to migrant and refugee women facing problems in Germany because of the situation in their country of origin, their migration and their life situation. Since 2004, she has been the founder and Director of the Health Advice Centre for African Women of Maisha e.V., an organisation based in Frankfurt. She works with undocumented African migrants as well as migrants from Russia and other eastern European countries. She is also a Vice-Chair of the European Network of Migrant Women and has served as an expert in several consultative structures on integration and migration issues in Germany, including the German Integration Planning Committee.

The next respondent is a referent in the victim protection department at the Ministry of Work, Social Issues, Family and Integration in Hamburg. She is also a member of the Hamburg Round Table which aims at tackling the problem of FGM in Germany and provides support to girls and women who have undergone genital mutilation, and those at risk of undergoing the procedure. She has also been organising events in relation to her work and FGM, such as an event for presenting the study ‘Listening to African voices’ which was conducted by Plan International in Hamburg.

Another of the respondents is an anthropologist by profession, and has been working with GIZ since March 2011 as an advisor for the sector project ‘Ending female genital mutilation’ which since 2009, GIZ has been implementing the project on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ). The GIZ’s sectoral projects aim at achieving sustainable contribution in saving women and girls from the practice of FGM. Together with the representative from the Federal Ministry for

(1) Integra network is a German Network which was established in 2000 at the initiative of German technical cooperation (GTZ) to overcome female genital mutilation. Since 2005, the network operates under the name Integra which consists of over 25 members of organisations that are active in development cooperation. Integra’s objective is to combat female genital mutilation. The network is under the patronage of the President Joachim Gauck.

(2) Misereor is the German Catholic Bishops’ Organisation for Development Cooperation. For over 50 years Misereor has been committed to fighting poverty in Africa, Asia and Latin America. Misereor is a member of the Integra network which includes 25 other members who are involved in overcoming female genital mutilation worldwide. Misereor supported four projects in Africa (Tanzania, Ethiopia, Mali and Egypt) for fighting against FGM and initiatives that lobby for elimination of FGM. The projects are set at several levels: education awareness for the women and girls and their families, lobbying of governments and authorities, collaboration with religious leaders as well as alternative income for circumcisers.


(4) The acronym Agisra stands for ‘Arbeitsgemeinschaft gegen internationale sexuelle und rassistische Ausbeutung’ (Organisation against international sexual and racial exploitation). Agisra is an information and counselling centre in Cologne that, since 1993, has been providing support and advice to migrant and refugee women facing problems here because of the situation in their country of origin, their migration and their life situation. This includes, for example, women who were taken into Germany for forced prostitution, as wives or housemaids, women who are experiencing, or have experienced, violence in their families, and refugee women. Because of immigration laws, discrimination, racism and the ways traffickers are organised, it is necessary to give these women a special support (http://www.agisra.org/index.php?en_agisra).
Economic Cooperation and Development, she represented GIZ in the last Donors Working Group meeting, where GIZ has an advisory status.

III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

Approaches to FGM in Germany and its start

In Germany, concern for FGM started in 1990s and became a public discussion through autobiographical reports like *Desert Flower* (1998) by Waris Dirie, and activities in Africa which have influenced the development of activities in Germany initiated by different organisations, like Terre des Femmes (TDF). However, according to some of the respondents, there is no single approach to FGM in Germany: there are different approaches depending on the main actors, political parties and individuals.

Germany has been fighting against FGM for over 30 years, below is a chronological perspective from 1997 to 2009.

March 1977

The first article about genital mutilation on *Klitorisbeschneidung* (clitoridectomy) in Germany appeared in *EMMA* magazine; a popular feminist magazine and the first print medium that published a courageous, awaking article about female genital mutilation. The response was enormous. Until then, ethnologists and anthropologists had described this practice from a culture-relativism perspective. Since then *EMMA* has been continuously reporting about FGM issues in Germany.

1979

The first book on FGM was published in Germany under the title *Materialien zur Unterstützung von Aktionsgruppen gegen Klitorisbeschneidung* (materials to support action groups against clitoridectomy).

The same year, an article about FGM was published in the *Welt* (a German newspaper). After reading this article, Herta Haas (+ 1 1.5.2007) engaged herself on activities to eliminate FGM and became later one of the founders of TDF. It became clear to her that there was/is a need for supporting African human rights activists (women), and, for that reason, she decided to collect donations and generated cultural arguments that people are not allowed to confuse foreign cultures and religious practices.

1995

The World Conference on Women in Beijing outlaws female genital mutilation as a human rights violation.

1996

A Somali woman, Jawahir Cumar, created an organisation in Düsseldorf called ‘Stop mutilation’. She also built a mother–child hospital in Somalia and counselled FGM-affected women in her community.

April 1997

The Green party and Heinrich-Böll Foundation organised a public hearing with several organisations and African activists who were already involved in the topic of FGM. Organisations like TDF, Plan International, Task Force and Forward Germany were interviewed on the subject, specifically on awareness, requests concerning FGM, measures, laws and support for the affected women and girls.

1997

Christa Müller, wife of Oskar Lafontaine, created an organisation called (I)ntact in Saarbrücken.

April 1999

The ARD magazine ‘Report Mainz’ films an Egyptian physician who agrees to practise FGM for a charge of EUR 610 in the presence of a hidden camera. The investigation was closed due to lack of evidence.

October 2000

On the initiative of GTZ, network Integra was formed with 16 organisations who wanted to abolish the practice of FGM worldwide. In 2005, the network was under the patronage of the Federal President Horst Köhler.

Before then, there were many other organisations working on the topic of FGM through development cooperation like the GIZ. At the end of the 1990s and early 2000s, seven women from East Africa who are living in Germany created a small association and a help-group now called Maisha e.V. to support and help affected women and their families. In 2002, Maisha wrote a concept for a programme to help African migrants with their health issues, FGM being the main subject.

First January 2005

The new Immigration Act comes into force; women can apply for asylum in Germany due to the threat of being mutilated in their countries of origin.

November 2006

First Federal Medical Council’s recommendations for dealing with women and girls affected with female genital mutilation.

First February 2007

The German parliament starts a debate on the subject of genital mutilation; there is a clear consensus to the effect that the practice constitutes of serious human rights violations against women and girls which is not justifiable or tolerated.

27 September 2007

The Federal Ministry of Family Affairs presents its action plan on domestic violence; where female genital mutilation is also an issue.
January 2008

Rüdiger Nehberg and Annette Weber are activists and some of the founders of the organisation Target (\textsuperscript{1}); they were both awarded by the German Federal President Horst Köhler with a Federal Cross of Merit for their fight for integrity for African girls.

June 2008

The grand coalition of CDU (\textsuperscript{2})/CSU (\textsuperscript{3}) and the SPD (\textsuperscript{4}) submit a proposal ‘Effectively combating FGM’ in front of the Bundestag (\textsuperscript{5}). The contents of the request/proposal are to extend the limitation period for genital mutilation, and to promote research on the causes of FGM and possible counter-strategies.

14 May 2009

With the support of 91 parliamentarians from FDP (\textsuperscript{6}) (44), Alliance 90/the Green party (39), SPD (5) and CDU/CSU (2), a draft of law change for the offence of female genital mutilation (16/12910) from Sibylle Laurischl, Irmingard Schewe-Gerigk and Dr Konrad Schily is brought to the first reading in the parliament.

- FGM should no longer be regarded as a simple or dangerous issue; on the contrary, it should to be considered as a severe injury in the criminal code and with a penalty sentence of up to 10 years.
- Since FGM is often carried out at a very young age, the limitation period when a victim can press charges against the perpetrator is until the age of 28 years.
- If girls living in Germany are mutilated in their country of origin during vacations, the German authorities can prosecute the parent(s) in order to prevent the frequent practice of FGM during vacations.

27 May 2009

The proposal submitted on 14 May 2009 for an amendment to the offence of female genital mutilation is shot down by a vote of the grand coalition and taken off the agenda. Justification: they should bring their own proposals. In the federal sources this means that, the grand coalition singly plans the suspension of the limitation period without genital mutilation being a separate offence in the Penal Code.

Due to the experience of different organisations, help groups and the influence of the media, public awareness on the existence of FGM in Germany improved. Public awareness is important to inform people in Germany about FGM and to let them know that FGM is not only an African problem but also a problem that is slowly reaching Europe.

According to some of the respondents, the approach and attitude towards FGM in Germany has changed. One of the respondents reported that FGM was earlier referred to as a ‘private’ cultural custom of the practising communities; while nowadays it is considered as a severe violation of women’s rights. In 1990s this was not clearly understood by some organisations in Germany, but now FGM is clearly written down as a subject in national action plans and national/international conventions.

The respondent from Maisha e.V. reported that, since 1996, FGM was already an issue in the German media, and a lot has changed since then. Nowadays, there are more African organisations and communities involved and working on the topic of FGM in Germany.

Policy development in Germany

Policy development in Germany started in 1995. The beginning was set with a document of German federal parliament about mutilation of women and girls in numerous countries worldwide. A recommendation for a decision and a bulletin from the Commission for Family, Senior Citizens, Women and Youth, of 1998, have been affiliated in the federal parliament. Over the years, different references and educational documents have been acquired and published via the federal parliament page.

In 2010, the Länder of Baden-Württemberg, Bayern, Hessen, Niedersachsen, Rheinland-Pfalz and Saarland apply for the implementation of a statutory offence, beginning of the state of limitation at majority age of the victim and inclusion into the catalogue of depths in foreign countries, adoption of the criminal proceeding arrangements in question of eligibility of civil action as well as the appointment of a solicitor. There are changes to Chapters 5, 78b and 227, as well as ‘Inclusion’, Chapter 226a ‘Penal Code’, and changes to Chapters 395 and 397a ‘Criminal proceeding arrangements’.

Until today none of these motions have been ratified or put into force by the German parliament. There is only one exception: in 2009 the German parliament adopted a law that strengthens the rights of victims of violence. One of the changes of this law is the possibility for minor victims to press charges against the perpetrator until they reach the age of 28 years. This law can also be applied for minor victims of FGM.

A working group (of representatives from Federal ministries, the Federal state and NGOs) for the implementation of the

\textsuperscript{1} Target is a human rights organisation founded in 2000 by Rüdiger Nehberg. The main goal is in situ action against FGM. There were seven original founding members: five intermediaries and Annette Weber and Rüdiger Nehberg as activists.

\textsuperscript{2} Christlich Demokratische Union Deutschlands (Christian Democratic Union of Germany) is a Christian democratic and liberal-conservative political party in Germany.

\textsuperscript{3} Christlich-Soziale Union in Bayern (Christian Social Union of Bavaria) is a Christian Democratic and conservative political party in Germany. It operates only in the Land of Bavaria, while its larger sister party CDU, operates in the other 15 Länder of Germany.

\textsuperscript{4} Sozialdemokratische Partei Deutschlands (Social Democratic Party of Germany).

\textsuperscript{5} Bundestag is the national Parliament of the Federal Republic of Germany.

\textsuperscript{6} Freie Demokratische Partei (Free Democratic Party) is a classical liberal political party in Germany.
national action plan founded by the Federal Ministry for Economic Cooperation and Development in 2009 does not exist anymore. The ministry argues that it cannot implement a national action plan for Germany. There is no follow-up by any authority nor have resources been set aside to implement the proposed national action plan on FGM.

The driving forces for policy development on FGM

The driving forces for policy development in Germany have been the Network Integra, NGOs, activists and International conventions (e.g. convention for the rights of children and the Maputo protocol).

At International level

One of the driving forces is the cooperation of the German government together with NGOs in the work of FGM and the commitment of the German government; they launched cross-border projects and programmes on FGM in African countries. As the previous Minister for Economic Development and Cooperation (Heidemarie Wieczorek-Zeul) explains in an interview (2007) with the Global FGM consultation-development gateway foundation (DGF) that, there is evidence in the development cooperation that putting an end to FGM needs a systematic and holistic approach which addresses the cultural, religious, educational as well as the social and economic dimensions of FGM which is a grave human rights violation. The minister launched cross-border projects in eight African countries (Guinea, Kenya, Burkina Faso, Benin, Mauritania, Mali, Sierra Leon and Egypt) of high FGM prevalence which are all partners of the German development cooperation. In the same interview, the minister reported that, one of the important pillars of strategy is to support the advocacy work in schools, health centres, village assemblies and other community empowerment activities done by women’s associations and other NGOs against FGM. Another pillar is to integrate the advocacy work into ‘classical’ development cooperation aimed at fostering decentralisation, increasing agricultural productivity, combating desertification, improving health and education conditions and creating new income sources for family farmers and women’s associations.

At local level

Local administrations, like the Health Centre in Frankfurt, work together with NGOs and communities in their respective cities. According to one of the respondents, policy exists only at local level, thus commitments are only shown within cities e.g. branches of the Round Table which are available in some of the Länder in Germany and the key members of these Round Tables are mostly individuals who support the work of FGM and NGOs and are already active in the work of FGM. It is difficult to transfer this policy and the Round Table commitments to the whole country, due to unknown reasons.

At the moment, the Round Table exists in Hamburg, Berlin, Frankfurt, Düsseldorf (Nordrhein Westphalen), Baden Württemberg and Munich. As explained by one of the organisers of the Round Table in Hamburg, that the aim of these Round Tables is to improve prevention and intervention concerning FGM, a chain intervention where several professionals (like doctors, teachers) and migrant communities are involved, also to protect girls and women from FGM and support those who have undergone FGM. However, concrete methods and strategies on how to support and protect the affected women and girls at risk are yet to be discussed. The next meeting will be held on 15 August 2012 in Hamburg.

Since the technical cooperation is based on the protection and respect for human rights, the main driving force pushing the policy development in Germany is the human rights-based approach. Germany has a very strong civil society that is very active and always in contact with the responsible ministries. In her opinion, the topic of FGM is a priority in the agenda, BMZ being very active on the issue.

Key actors

Several actors were mentioned by the respondents as the key players in pushing the agenda in Germany. Some of the actors mentioned are working actively and precisely on FGM while others are working on the topic of human and women’s rights and on the protection of women and girls. The following key actors were identified:

The German network for combating female genital mutilation, Integra network: Integra network is one of the main actors that have been pushing and demanding a concrete national action plan. So far, Integra network has more than 25 members which include organisations and individual persons that engage into eradicating FGM in Germany and in African countries. Integra network managed to write a concrete national action plan in Germany.

Non-governmental organisations, for example women’s rights organisations like Terre des Femmes and Forward-Germany.

There are different Round Tables on FGM at the local and at the federal state level, for instance Baden-Württemberg, Berlin, Hamburg and Nordrhein-Westfalen.

Single activists, including one who started as a single activist and now has his own organisation called Target e.V. (‘). In 2007, one of the activists was awarded the ‘Burgerpreis’ (citizen’s award) of the city of Hamburg, his activities and work in Africa and Asia drew much attention in Hamburg. For his outstanding commitment to the worldwide campaign against female genital mutilation the activist was awarded the First Class Order of Merit of the Federal Republic of Germany by the German Federal President.

Target is a human rights organisation founded in 2000. The main goal is in situ action against FGM. Target sponsored a conference on FGM in Cairo, Egypt. Muslim scholars from many nations attended. At the conclusion of the conference on 24 November 2006, their final statement declared FGM to be contrary to Islam, an attack on women and a practice that should be criminalised.
The reasons cited on the Target web page for awarding these honours were as follows: ‘With the setting-up, in 2000, of the human rights organisation Target, the activist’s unswerving commitment to the struggle against female genital mutilation in many African and Asian countries came to the fore. Together with his partner he involved Target in tough negotiations and thanks to his huge personal involvement ensured that this subject was very quickly granted special status in a large number of Islamic states. Also great praise was given for the Al-Azhar conference held in Cairo in November 2006. The awarded and praised activist was thanked that FGM has had the “rug pulled from underneath”, he was thanked not only for this project but also the whole campaigns on FGM.’

IV. PREVALENCE AND DATA COLLECTION

Two relevant studies that document prevalence data on FGM in Germany have been identified by most of the respondents. The first example provided by one respondent was as follows:

‘There are very few hard facts and empirical studies in Germany; there are statistics in estimates e.g. from the study by Plan International (2010) “Listening to African voices” which was conducted in Hamburg. Also in 2005 there was a study from TDF, associations of gynaecologists and Unicef, which was a survey for gynaecologists in Germany on their knowledge of FGM and to find out if they had previously had FGM patients. The study was called “Schnitt ins Körper und Seele” (excision in body and soul).’

The methodology used in the study from Plan International consisted in a literary review and a three-month field research targeting immigrants from sub-Saharan Africa residing in Hamburg. An interview on the basis of a questionnaire with 685 women and 1,082 men originating from 26 sub-Saharan countries was evaluated.

Most of the respondents are opposed to FGM, 81% speak out clearly against any form of circumcision, 3% advocate for its continuation, 16% did not give any clear response.

The second study identified was a study by Unicef, TDF and the Association of Gynaecologists which was conducted among gynaecologists in Germany in 2005. The title of the study was “Schnitt in Körper und Seele” (excision in body and soul).

A questionnaire was sent to gynaecologists, where 495 of them participated in the survey which makes up 3.73% response rate. Gynaecologists were asked if they had any contact with FGM-affected patients, or if they had come across a circumcision pregnant woman and whether they had been asked by patients to perform reification or FGM. The most important question was whether the doctors needed more information on FGM.

From the result of the study, 43% of the doctors had treated circumcised patients. About 30% had cared for already circumcised women during childbirth. The survey showed that 76.3% of physicians, especially from the urban areas were involved. The study showed that, there is a great need for more information on FGM for the doctors, 87.4% of the gynaecologists needed more information and training on FGM.

The recommendations, which resulted from the evaluations, were:
- official guidelines for counselling and taking care of FGM-affected women should be provided;
- FGM should be part of the medical education (in medical schools);
- gynaecological and paediatric clinics should be multilingual.

Information materials for FGM were designed, TDF developed the brochure ‘Wir schützen unsere Töchter’ (We protect our daughters) which is available in six languages (German, English, French, Arabic, Kiswahili and Somali), to be distributed to the public and made available in clinics.

The result also showed that, there was a lack of counselling centres for the affected women.

Nevertheless, it is difficult to collect prevalence data on FGM in Germany because the only data available is the nationality of the migrants living in Germany but not the ethnic group where FGM is practised. She also considers that there is no specific data in Germany but that there is only presumption dependant on the data available in the country of origin:

‘For example, if you take 100 people from Burkina Faso and the prevalence of FGM in Burkina Faso is 45%, we assume that 45 women out of 100 have undergone FGM, but this is not really a hard database.’

Apart from the abovementioned studies, the desk study identified two more studies that documented prevalence data on FGM in Germany. One of the studies was conducted in 2005 by TDF; the population studied were women with FGM and women and girls at risk.

Another study was conducted in September 2007 by TDF; a statement of TDF concerning human rights of women at the public hearing of the Committee on Family Affairs, Senior Citizens, Women and Youth on the subject ‘Fighting female genital mutilation’.

To improve data collection in Germany, respondents gave a few recommendations on data implementation and improvement.

According to one respondent, since Germany has neither a central data collection system nor a registration of specific details of those affected or at risk, her recommendation is to conduct one-on-one interviews with migrants in order to estimate the prevalence rate and the number of girls and women who have already undergone FGM. She also adds that in order to have a better estimate, ethnicity should also be reported. She reiterates the importance of ensuring the privacy of those interviewed, and that no name should be recorded in
the central data. The data should be collected by trusted institutions such as the Immigration Office.

Another respondent wishes to have obligatory check-ups for young children (of up to nine years old) in all German Länder, this means that all boys and girls should take part in the check-ups and the paediatrician should make sure that all genitals are intact. Doing so could uncover FGM-related as well as sexual abuse.

Another recommendation is to have better statistics from the Federal Office of Statistics. TDF wishes to know the total number of bi-racial families living in Germany and also the number of families from the second and third generations. These statistics are not included in the available statistical database.

The Federal Office for Immigration and Asylum should record the number of women who seek asylum on the grounds of FGM and the number of women who have been granted asylum under these terms.

There is a problem in the health system. FGM is not officially regarded as a special health problem for women, thus no code is available for FGM problems in the International Code of Diseases, making it difficult for such problems to be identified by the medical insurance. One respondent says that, since there is no administrative data record in Germany, the only thing that can be implemented is an official FGM code/key which could help in billing reasons since insurances pays per code of disease. He also says this could improve the statistics on FGM in the country, as all the FGM-related problems would be coded and/or recorded.

According to a respondent from Maisha e.V., medical doctors and gynaecologists could be a good source of information if they were able to document all FGM-related problems related by their patients. Doctors could also help in figuring out what kind of help and services are needed for such patients.

According to another respondent, more studies could be carried out by NGOs. Based on the examples from the studies conducted in Hamburg by Plan International (2010) and TDF, Unicef and associations of gynaecologists (2005), similar studies should be conducted in other cities of Germany.

FGM should be included in apprenticeships and further education of health professionals, midwives, psychologists, social workers, educators, teachers, police and justice. There was also a suggestion that FGM should be included in the medical school teaching curriculum.

V. APPROACH TO FGM

This section of the report will provide a picture of the approach to FGM in relation to the six ‘Ps’ in Germany. The first subsection provides the broader picture and the focus on the ‘Ps’. The next sections zoom in on the different ‘Ps’.

V.1. Overall

The ‘six Ps approach’, established for the purpose of this study is prevention, protection, prosecution, provision of service, partnership and lastly prevalence.

Prevention was ranked as the most important ‘P’. The act of FGM should first be prevented before any other ‘P’ is brought to action. She continues that even though TDF sees prevention as one of the most important ‘P’, TDF can do little or nothing on the issue. This is due to unavailability of funds and to the nature of FGM-related work by TDF.

None of the interviewed respondents in Germany focused on protection. Protection was ranked as to be the most important ‘P’ in the work of FGM. (More information is described below under section V.3 ‘Protection’).

In this study, two respondents were interviewed whose FGM work focuses mostly/partly on provision of service to the FGM victims, those at risks, and professionals who work directly or indirectly with the victims and those at risk.

 Provision of service was ranked as the third ‘P’, the reason being that it is one of the most important parts of the work in tackling FGM in Germany. One respondent says that work on FGM in Germany is under the sectoral project, which is routed in the areas of networking and exchange of information: ‘There are no specific measures on FGM in Germany. As a personal opinion, I think there is much done under provision of services to women affected by FGM, for example by NGOs or centres like “Balance” in Berlin. The Health Office, in cooperation with Maisha e.V., offers counselling to African migrants in Frankfurt.’

Within the scope of this study, two types of partnership were discussed: international cooperation and national cooperation.

Another respondent ranked prevalence as the most important ‘P’ according to the work carried out by TDF, due to political lobbying work it is important to have exact figures on FGM. For many years, TDF has been carrying out statistics i.e. prevalence studies to estimate how many affected women and girls are living in Germany.

V.2. Prevention

Prevention work in Germany

As already mentioned above, NGOs in Germany started work on FGM in the 1990s. On the topic of prevention, three respondents working on prevention in Germany were interviewed. The organisations interviewed included Terre Des Femmes (one of the oldest NGOs, it has been working on the topic of FGM for over 30 years); and Maisha e.V. (since 1996, it has been working on the topic of FGM, and it started as a helping group supporting those affected and raising awareness to African migrants). A referent in the protection of victims, at the Ministry of Work, Social Issues, Family and Integration, was also interviewed.
Description of the intervention of these NGOs and public service:

**Terre Des Femmes**

The TDF association was founded in 1981. Two years later (1983) TDF took up the issue of FGM. In the same year TDF invited the Senegalese activist and author Awa Thiam to the general annual meeting in Frankfurt. By 1984, the issue of FGM was further integrated especially by the TDF’s women group from the city of Hannover who also gave lectures on the subject. Until 1990 TDF consisted in an executive committee and local groups working on a voluntary basis. A first full-time position as well as the main headquarter office were created in 1990. Since then, FGM has been regularly mentioned in the TDF journal under the Section ‘Human rights for women’.

In 1991, TDF called for donations for a project against traditional forms of violence in Nigeria.

In 1992, TDF’s co-founder Herta called upon a survey for gynaecologists in Germany on the subject of FGM, in the TDF journal under the Section ‘Human rights for women’.

At the beginning of 1995, TDF called for donation for the National Committee of the Inter-African Committee on traditional harmful practices in Benin. In February of the same year, TDF held the first FGM seminar in Kronberg/ Taunus. Comfort Ottah, a Nigerian midwife who lives in London, England, and a committee member of the organisation Forward-UK was invited as a guest speaker. Following the seminar, the TDF’s FGM Working Group was established. It consists of interested parties and experts from all over Germany, who meet once or twice a year; their goal is to advance the public and TDF’s lobbying work on FGM.

TDF delivers its objectives through: exhibitions, information stands, the film festival ‘Women’s Worlds’, lobbying, providing information and designing training materials for professionals, maintaining an archive of material on the subject of women’s rights campaigning. TDF also supports several independent projects initiated by women for women through media activities and fundraising. These projects range from offering refuge for women in danger, giving access to education to raising awareness on FGM.

TDF invests in promising projects including the first poster campaign in Germany (launched 25 November 1997). The first nationwide campaign ‘Stop female genital mutilation’ popularised TDF within the general population on the issues of violence against women’s and children’s rights.

TDF created a poster campaign, which had the sad face of an Egyptian girl who had undergone FGM, as a way of opening a public discussion about FGM in Germany to a broader audience who was not aware of the existence of FGM. Also, from November 2008 to 2010, TDF started a two year nationwide campaign (kein Schnit ins Leben) (no excision in life), which aimed to make the public aware of the situation of affected women and girls at risk, and to start a protection programme for girls at risk in Germany (above 4 000).

Since 2001, TDF has been organising an international film festival in Tübingen (one week every November) revolving around the ‘International Day for the Elimination of Violence against Women’. Dozens of documentaries and fiction works from over 20 countries on the theme of women’s rights in various cultures are screened in the presence of film directors and human rights experts. The programme also includes exhibitions, theatrical performances and panel discussions with directors on topics such as ‘Defending women’s rights through filmmaking’.

Regarding prevention, TDF works closely with communities and organisations who are already working in the community, like the network ‘African communities against FGM’ which was created by both TDF and Maisha. Moreover, TDF promotes public awareness on FGM through brochures, flyers, webpages and posters as well as also engaging in political lobbying work, such as giving press releases on FGM issues in Germany. For instance, TDF produced a brochure ‘Wir Schützen unser Töchter’ (We protect our daughters) in six different languages which was targeted at migrants and their families living in Germany. At regional and local level, TDF is represented in round tables.

However, TDF does not work exclusively on FGM, but in all areas concerned with women and human rights, such as violence against women, forced prostitution, etc. TDF is also involved in activities in the development cooperation. At the moment TDF is working with two partners in Burkina Faso and Sierra Leon where they are working on public awareness and collecting donations for the partners.

Although prevention is the most important approach, TDF does little or no FGM work on prevention issues.

**Maisha e.V.**

Maisha is a non-profit registered association for African migrants in Germany. Maisha was founded in 1996 with the aim to improve the living conditions of the target group (women) and to promote their integration into German society. At the onset, only African women were the target group, but nowadays men and boys are also included in Maisha work.

Maisha is also a helping group which was created by seven African women from East Africa. The group deals with issues such as children education, health education, financial planning and psychological problems. These women felt there was a need for more information on FGM

(10) Authors: Franziska Gruber, Terre des Femmes referent against female genital mutilation; Steffi Siegle studied for a Master’s degree on ‘Action humanitaire’ in France and did her Internship at Terre des Femmes in the Department against genital mutilation. (http://frauenrechte.de/online/images/downloads/zeitschriften/Frauensolidaritaet-107-fgm-Kampagne.pdf).
for the African communities living in Germany, as many of them did not understand the issue of FGM.

With its experience on migration, Maisha was appointed by the Minister for Public Health, in 2008, to be part of their working group. Maisha is the only African organisation which is part of the Public Health Working Group in the German government. Maisha gives recommendations to the government on migrant issues like health for undocumented migrants, guidelines for FGM and access to health for asylum seekers.

**Maisha:**
- has a project group on female genital mutilation (FGM);
- represents the interest of African women and families living in Germany;
- helps them with everyday problems (work, education, government, family, integration, crisis intervention, life planning, partnership, language acquisition);
- provides advice on health issues such as HIV prevention, pregnancy, childcare, nutrition and sports;
- participates in the political processes;
- advises on the African identity;
- teaches traditional values of African culture (roots) to the second generation;
- runs a traditional African woman savings club;
- works with schools, clubs, social workers, therapists, agencies, and police departments, as well as with other NGOs.

**Maisha’s FGM project**

Maisha was founded in the 1990s and from 1996 onwards FGM became one of its working fields. One of Maisha’s current projects is education on the practice of FGM in Germany; Maisha recognises the growing public awareness of the issue.

The main actors working on prevention work with Maisha are doctors, health mediators (both male and female from African descent), social workers, midwives, nurses and researchers. All these professionals have been trained by Maisha and some are part of the African network on FGM and Afya project which is sponsored by the Ministry of Integration, in Hessen.

Maisha provides a counselling service to African migrants at the health centre in Frankfurt. Together with a trained doctor, they help counselling and advising African migrants at the Health Advice Centre for African Women in Frankfurt on health issues and other FGM-related subjects.

In 2010, Maisha and TDF created the network ‘Netzwerk Afrikanischer Communities gegen FGM (NACAF)’ (Network of African communities against FGM), which is coordinated by Maisha e.V. The main aim of the network is to train as many mediators and counsellors as possible, in order to reach the communities at large, to enable a dialogue within the African communities as the African community in Germany is very diverse, and also to sensitise the community on FGM. Maisha and TDF started training courses for mediators and counsellors for FGM in African communities.

The training was funded by Filia (¹) a women foundation that funds nationwide networks of counsellors in Germany.

The first meeting was held on 21 and 22 May in Caldern/Lahn and the second meeting on 22 October in Frankfurt/Main. At the first meeting, there were 23 participants including men and women from different African origin who were already involved in counselling or wanted to get involved that area.

At the second meeting, 20 African men and women as well as different representatives from Maisha e.V. and TDF participated. The purpose of both meetings was to exchange information about past experiences and future improvements in the field of counselling in African communities, to exchange information on the subject, and for the participants who have been in contact with patients since the first meeting, to share any personal experience in dealing with patients.

In addition, recognising the importance of these training courses, Maisha, together with the mediators and counsellors, developed training manuals and materials.

‘For prevention work to achieve its objectives, the training of mediators is necessary for them to understand sensitive approach as well as engaging them in developing training tools.’

For general awareness Maisha’s prevention work is targeted at African communities where FGM is practised and where it is not practised.

According to one respondent, no budgets are allocated for prevention work, apart from the region of Hessen which has funded a programme in which Maisha provides health counselling to African migrants and offers health services at the Department of health in Frankfurt to those affected by FGM. Maisha receives a funding of EUR 26,000 per year from the region of Hessen; some of their contributions come from the members of the association. Maisha has about 500 members who each contribute about EUR 1,220 yearly, depending on individual income.

**Ministry of Labour and Social affairs**

In 2007, the topic of FGM became an explicit core theme in the Department for victim protection (before that FGM was never brought up).

We contacted a person who works for the Department for Victim Protection, which is part of the Ministry of Labour and Social Affairs. This department is responsible for:
- developing strategies and concepts concerning different violence topics such as forced marriages, human trafficking, domestic violence, FGM and violence against the elderly;
- supporting the networking and cooperation between different institutions and ministries;

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¹ Filia is a women foundation that has funded about 30 projects on violence against women between 2007 and 2010. Filia funded five projects in Germany in 2010, including the project from Maisha e.V. and Terre des Femmes, i.e. ‘Establishment of nationwide network of FGM counsellors in African communities’.
• the governance of some institutions and providing counselling for victims of violence.

According to this respondent, the aim of the prevention measures regarding FGM is:
• to make professionals capable of noticing and dealing with FGM, affected women and girls through training and further education;
• to include relevant migrant communities in future preventive measures.

According to her, the main activities concerning FGM developed by her department focus on networking, information and advanced education, and also on creating information leaflets for the youth welfare service providers. Moreover, the officers working on youth welfare service providers in Hamburg are trained on FGM. This department also participates in Hamburg’s Round Table, which is funded by Plan International. The main target group of the information and training are professionals (such as medical personnel), officers from the welfare service and migrants.

V.3. Protection

Regarding protection for girls already in Germany, two paragraphs in the Penal Code, paragraph 224 against bodily harm and paragraph 226 against grievous bodily harm, can be applied.

None of the interviews performed focused on protection work in Germany. However, some of the respondents gave their opinion on that topic.

Since 2012, there is a new law for child maltreatment: ‘Gesetz zur Kooperation und Information im Kinderschutz (KKG)’ (Law on cooperation and information on child protection). The law allows professionals (like doctors and teachers) to give information to the administration (such as the Youth Welfare Office) should they suspect a child is in danger.

The ‘Ps’ that come after FGM has been performed come too late to serve a purpose. The example was given of prosecution and provision of service, which as I understand can only be used after FGM has been performed. This means that one can only prosecute someone when a crime has already been committed, and the service which is mostly provided by NGOs in Germany is counselling, for the affected women.

There is consent, especially in her ministry, that protection and prevention have to be priorities before any other ‘P’, since the well-being of a child is very important in Germany. Concrete protection is necessary for children at risk and Germany has a duty to guarantee the physical health of child.

Protection is important, which is why there is sensitisation of professionals like medical personnel, nursery and primary school teachers as well as welfare officers. TDF informs these professionals on what to do should they come across a child at risk, and in the case of teachers, if they suspect that a child might be at risk.

V.4. Prosecution

The topic of FGM needs more open discussions to reach the policymakers and the politicians in Germany, since the system relies on open discussions. The main challenge in Germany is to get a victim to make a public statement in the media or in public, saying that she has been mutilated, so as to draw attention to FGM and put pressure on politicians and the general population.

According to one respondent, the challenge of getting a victim to give a public testimony could be overcome if teachers and nursery school caregivers were also engaged in monitoring and observing the behavioural patterns of the students at school. They need to get an insight of the changes of behaviour, as this might help the teachers to intervene and get some information from the children.

To date, in Germany, there have not been any central recording system for the number of investigations and there have not been any court cases.

However, on 23 August 2007 in Bremen, for the first time the police saved two girls from being mutilated, when they stopped a woman from The Gambia from taking her two daughters (one-year old and four-years old) to be mutilated in her home country against her husband’s will.

In case of any court cases, the practice of FGM in Germany can be prosecuted under general criminal law provisions dealing with bodily injury (more information is provided below).

The three bodily injuries are: (i) basic body injuries with a sentence of 6 months to 5 years; (ii) dangerous body injuries with a sentence of 6 months to 10 years; (iii) heavily/severely body injuries with a sentence of 3 years to 10 years. FGM does not fit under any of the three categories and there is still a debate in the German parliament on whether FGM should be categorised under heavily/severely body injuries.

Criminal law

In Germany, there is no specific law against FGM. It relies on paragraph 223 of the Criminal Code, against bodily harm and paragraph 224 against grievous bodily harm, regardless by whom it was performed.

German criminal law applies in principle only for acts committed within the country (Chapter 1, paragraph 3 of the Criminal Code) (*). Girls living in Germany have to be protected from the risk of being mutilated when travelling to their original countries during vacations. It

(*) Offences committed on the territory of the Federal Republic of Germany; German criminal law shall apply to acts committed on German territory (http://www.gesetze-im-internet.de/englisch_stgb/).
has also been reported in the study ‘Listening to African voices’ (2010) from Plan International (15) that most parents send their daughters to Africa or France to be mutilated.

It is, therefore, important to extend the protection to criminal offences committed abroad.

A study by TDF (2007) on FGM in the German Penal Code (Chapter 17, paragraph 223) ‘Applicability to acts abroad in other cases’: (i) German criminal law shall apply to acts, which were committed abroad against a German, if the act is punishable at the place of its commission or the place of its commission is subject to no criminal law enforcement; (ii) German criminal law shall apply to other acts, which were committed abroad if the act is punishable at the place of its commission or the place of its commission is subject to no criminal law enforcement and if the perpetrator (i) was a German at the time of the act or became one after the act; or (ii) was a foreigner at the time of the act, was found to be in Germany and, although the Extradition Act would permit extradition for such an act, is not extradited, because a request for extradition is not made, is rejected, or the extradition is not practicable.

Chapter 17, ‘Crimes against Bodily Integrity’, Section 223, ‘Bodily Injury’: (i) Whoever physically maltreats or harms the health of another person shall be punished with imprisonment for not more than five years or a fine (ii) an attempt shall be punishable.

There is a draft on proposed law by the Länder of Baden Württemberg and Hessen on Criminal Law Amendment Act — a criminal offence to female genital mutilation (StrÄndG …), where alternative law changes have been discussed. According to one respondent, there is a need to change the criminal law in Germany, in the case of a criminal procedure, so that the perpetuator gets a higher punishment. The law for child protection issues has to change not just for FGM matters.

Professionals who do not report cases or do not report girls at risk cannot be prosecuted under the German law. Since January 2012, there has been a law modification for child maltreatment in Germany, ‘Law on cooperation and information in the child protection’ (‘Gesetz zur Kooperation und Information im Kinderschutz (KKG)’). This law allows professionals like doctors, teachers, etc., to give information to the administrations such as the Youth Welfare Office if they suspect that a child is in danger.

V.5. Provision of services

Services provided by TDF

A nationwide telephone hotline for counselling girls at risk and affected women is provided. Affected women in need of medical advice or services call the hotline to contact doctors. TDF work together with doctors who are familiar and have had experience with FGM-affected women. This information is also provided on TDF’s main website where FGM victims or any person in need of information can send e-mails directly to a doctor.

TDF works closely with African associations to support those at risk of undergoing FGM procedure. Most African associations are in direct contact with the communities; this makes it easier to reach those at risk or affected women directly.

V.6. Partnership

This section briefly describes the FGM-related work of the Integra network, the technical cooperation and the main characteristics of their partnerships with different organisations and associations, their role in the concept and implementation of FGM policies, as well as the limits and challenges set for their development.

Integra network

The work on FGM in Germany started in the late 1980s and early 1990s. The main actors were a number of organisations including the German Society for International Cooperation (GTZ now GIZ) which then invited all actors that were globally active in efforts to end female genital mutilation (FGM) to join together in a network. The network started in 2000 with loose meetings once a year. In 2004–05 the network became more formal and assumed the name Integra which was launched by all the member organisations. In the last two or three years, the network has become an independent organisation, and has started doing more lobbying work such as:

- giving press statements on FGM once a year. This year the press statement was given on 6 February 2012;
- organising workshops for experience exchange where other organisations from different countries are invited to share their own experience on the work of FGM;
- a working group with the government and non-governmental organisations.

The GIZ only had an advisory status which allowed them to cooperate and take part in the network meetings, but since they did not have full membership to the network they were not entitled to do any lobbying work.

Some members of Integra network conduct FGM activities in the community through their respective organisations. Integra as a network does not conduct any FGM-related activities and there is no budget allocated for the network. Nevertheless, Integra network is planning a workshop in November to bring together all organisations that are active with FGM and learn from the best practices from other EU and African countries and introduce the best practices in Germany.

(15) The study was conducted to address how FGM is affecting migrant communities in Hamburg. Alice Behrendt, Listening to African Voices, Female Genital Mutilation/Cutting among Immigrants in Hamburg: Knowledge, Attitudes and Practice, 2010. http://www.planusa.org/docs/ListeningtoAfricanVoices.pdf
The Integra network is a loose network with no headquarters and no staff. Members of the network meet twice a year in different places in Germany. These meetings are hosted by one of the member organisations. For regulating the cooperation, the network follows ‘guidelines’ which have been agreed by all members. A spokesperson is elected for two years, who is in charge of organising meetings and formal representations of the network. The Integra network is under the patronage of the President of Germany, Mr Joachim Gauck, who officially supports the network.

One challenge in coordinating the network is the fact that the group is heterogeneous, and that some organisations work exclusively in Germany while others in Africa:

‘It is difficult to know whether the priorities and emphasis should be put in Germany or in Africa; so coming to a mutual understanding is a real challenge.’

German International cooperation (GIZ)

GIZ cooperates with the Ministry of Economic Cooperation and Development (BMZ). Cooperation means that GIZ provides advice to the BMZ on FGM and other related issues. GIZ acts on behalf of the Ministry of Economic Cooperation and Development and is an implementing agency working on behalf of the ministry in partner countries, in the context or framework of technical cooperation and implementation of results or agreements that have been made during political dialogues.

On behalf of BMZ, GIZ has been active in the Donors Working Group on FGM/C, in which major donors have joined together in an anti-FGM network. This active cooperation has brought influence to bear on the formulation of a common position by the donor community, and raised the profile of German development cooperation at international level (9). As a member of the donors working group, GIZ plays a role in giving input in approaches in good practices of FGM.

Aims of the Donors Working Group on FGM/C

The aims of the Donors Working Group on FGM/C are: exchange of information; harmonisation of approaches; and gathering of strength in the efforts to overcome FGM.

Implementing agencies and governmental institutions gather to discuss approaches, efforts and funds in the field of FGM, networking, finding a common approach (already achieved). Members in the working group are committed to the same criteria of quality for projects tackling FGM. The core members of the Donor Working Group are the UN agencies like Unicef, UNDP, UNFPA, the WHO, the German government and GIZ (in an advisor capacity). Other members are the Finnish government, the Italian government, etc. The working group was initiated in 2001; the secretary of the working group is at the Unicef’s headquarters in New York and takes care of the mailing list and the Google group. Group meetings change yearly, and each year a member is responsible for organising the annual meeting.

According to one respondent’s perception on this membership, it is important to have a foreign exchange to cooperate and coordinate efforts and exchange information. Since in Africa there are so many NGOs and UN agencies that are active in tackling the topic of FGM this partnership brings a lot of experience in exchanges and discussions on how to successfully tackle FGM. Being in a network is a lot of work, but in the area of FGM one should use every possibility to harmonise or coordinate information exchange on efforts that are currently undertaken in tackling FGM by either the implementing agencies or the governments.

The main challenge, as in any network, is to actively keep the network alive.

Challenges and successes of the partnership

Since the Integra network consists of members of NGOs and individuals involved on FGM work, the main challenge of the partnership with the network is that different network members work on different agendas in their own organisations. According to the spokesperson of the network, it is not easy to find a common understanding with regard to legislation in Germany. She adds that there are different opinions in the groups regarding the laws on FGM. There are groups that defend their own law on FGM and there are other groups who disagree with the law, claiming that the law will make life more difficult for the communities in Germany. At the same time, she says, the debate makes it more interesting because it means that there is a real exchange of ideas.

One success of the Integra network, as revealed by the spokesperson, is the setting-up of quality criteria for working programmes in Africa. The Integra network is now trying to set up the same quality criteria for the FGM work in Germany.

VI. SUCCESSES AND CHALLENGES

Here is a summary of the perceived key challenges and success reported by the respondents.

Reaching women and girls who have already been affected by FGM, or are at risk of FGM, is a big challenge because the topic of FGM is highly taboo and hidden and it is therefore difficult to find the right support for the affected women and children as they rarely talk about FGM.

The topic of FGM should be generalised, looking at the policies of all countries concerned, instead of being country specific. Women are only protected in Germany, which means that when they travel to their home countries, the policy against FGM might be different;

Another problem is the delay of procedures and decisions in Germany due to political reasons. There are no quick strategies to serve those at risk.

According to one respondent, rejection of asylum is a big problem especially if a woman has young girls, because when the asylum status is rejected the woman has to be sent back to her original country, meaning no protection for her young girls (if there are any) against FGM in her original country.

There are five ministries involved in FGM issues, the Ministry of Health, the Ministry of Internal Affairs responsible for immigration, the Ministry of Justice for legislation, the Ministry of Economic Cooperation and Development and the Ministry of Family Affairs, Senior Citizens, Women and Youth. One big challenge is that, no policy has been implemented, as the politicians are not prepared to accept the issue of FGM in Germany, and none of the ministries are ready to take responsibility and continue the working group of representatives of the German government, the federal Länder and NGOs, created in the last government (2009) and which aimed to combat FGM and develop concrete national action plans.

One of the common successes shared by most of the respondents is the change in the legislation, in 2009, with the statutory period of limitation for physical injury of minors in Germany. This was a political success as the affected women and girls now have the possibility to lodge a complaint until they are 28 years old.

Another key success in Germany is the fact that the Integra network has successfully made some concrete suggestions to the national action plan, enabling the network of NGOs to function actively.

Another success mentioned by one respondent is the implementation of the new KKG law in January 2012. According to him, this has been a success since it covers the whole topic of child protection and FGM can be integrated into this law.

It is obvious that more is gained at the social level, through networks and combination of institutions and organisations, than at any other level. At the social level, a permanent discussion about FGM can be found e.g. awareness-training, help for victims, allocation of materials, round-table discussions, etc. However, the majority of organisations working on FGM in Germany do not get any constant financial support from ministries or the government.

My own opinion is that, the respondents are working for awareness on FGM, which is already a big step, and one day this might lead to a bigger political action, even though at the moment, the state still lacks the political will to combat FGM in Germany. There was a mixture of conflicting opinions among the respondents about what the key success might be in Germany. Some of them reported that Germany has achieved a lot in the field of FGM since the topic was introduced in the country, while others think that Germany has a lot to do to accomplish at least half of the goals that other countries like the UK have already accomplished so far.

VII. POLICY LESSONS AND RECOMMENDATIONS

Cooperation between actors at national level

There is a need for better cooperation between actors at the national level, one good example being the working group’s failure to continue its work after the change of government in 2009. The respective ministries should take responsibility and pave the way in creating/continuing a platform where the government, the civil society and the NGOs could meet and discuss the steps that need to be taken to combat FGM.

TDF wishes that the politicians in charge would make it possible for the working group, which has been inactive for the last four years to exist again so that the national action plan and communities could be strongly represented.

More services of FGM work in Germany

According one respondent, there is a lack of institutions dealing with FGM issues or with the consultation of victims of FGM. According to another, a national hotline number will be established next year for women and staff who have been confronted with FGM. The hotline will be for all issues concerning violence against women; the hotline is run by the Ministry of Family and Social Affairs in Bonn.

More funds for FGM work

As already mentioned, there are few or no funds allocated to FGM-related work in Germany. More funds are needed for conducting empirical studies and for counselling affected women and girls at risk.

Some NGOs have difficulties in continuing with their work, especially within the community, due to lack of funds. More funds are needed in the context of emerging cooperation for specific educational and awareness projects and for the provision of services in different German cities.

Lessons learnt

It is clear that not all the respondents believe there are any lessons to be learnt by other countries from Germany.

According to one respondent, there is nothing to be learnt from Germany’s FGM experience. The respondent has seen great FGM projects and activities in other countries, like the UK.

Another respondent is not pleased with the current way things relating to FGM are moving in Germany. It was difficult for her to find any good examples from Germany which might be useful to other countries. However, the respondent says that, the Integra network has succeeded in addressing the policy and giving concrete suggestions...
on having a national action plan, but there is still a lot to be done in Germany on the work of FGM.

However, a third respondent explains that it is not easy to transfer the experience of Germany to other countries because of the different structures: ‘for example in France, where the communities live together while in Germany the communities are separated’.

Another respondent says that Germany is not an example to be followed when it comes to its policies regarding FGM. There are more pitfalls than positive lessons from which other countries can learn. One of the pitfalls mentioned is that FGM, in Germany, can never stand on its own, but it needs to be integrated into general child protection measures. We need to find a better incentive to make FGM-related work more efficient in the country.

Meanwhile, the respondent from the Integra network reports that round-table discussions on FGM could be considered as one of the potential good practices to be learnt from Germany by other countries.

### VIII. POTENTIAL GOOD PRACTICES

Some of the potential good practices reported by the respondents include:

- initiatives from individual organisations, for example the study from Plan International, ‘Listening to African voices’ which offers migrants in Hamburg a first step to success, explores possibilities for the protection of girls at risk and to provides more support to affected women;
- round tables’ great contribution, for example the Round Table against FGM in North Rhein Westphalia (NRW) which has devised a brochure called ‘Not with me’, available in various languages, and their multilingual counselling;
- the period of time in which children/victims can press charges, which has been extended to up to 28 years of age, and which can also be applied for FGM victims;
- events concerning FGM, such as the Plan International’s study in Hamburg, which was presented in front of many people including representatives from ministries and schools;
- the training of mediators and counsellors on FGM, which is one of the good practices in Germany. This could be implemented in other Länder in Germany, as at the moment the programme is only available in Frankfurt.

### IX. FINAL CONSIDERATIONS AND RECOMMENDATIONS

According to the information discussed and collected from the respondents, it is clear that more data collection strategies and prevalence studies are needed in Germany to determine the actual number of affected women and girls at risk of FGM. As mentioned in the discussions, the estimate studies conducted by TDF in 1995 and from Plan International in Hamburg in 2010 are both incomplete. Neither study is representative of Germany, since they were not repeated at regular intervals and did not give data for all migrants residing in Germany. Furthermore, the studies excluded bi-racial children as well as the second and third generation living in Germany.

More success has been achieved at the local and regional levels than at national level, through networks and the cooperation of NGOs and institutions with the community. However, as mentioned by many respondents, the lack of funds/support has hindered most of the work from NGOs on FGM within the community.

Some useful recommendations from the respondents and from the desk study are:

- to conduct one-on-one interviews with migrants in order to estimate the prevalence rate and the number of people who have already undergone FGM;
- to report the ethnicity of the migrants during any kind of FGM-related data collection to obtain better estimates;
- to ensure, for privacy reasons, that no name be recorded during FGM data collection;
- to include better statistics from the Federal Office of Statistics, the total number of bi-racial families living in Germany as well as the number of families from the second and the third generation in the data records;
- for the Federal Office for Immigration and Asylum to keep records of the number of women seeking asylum due to FGM as well as the number of women who have been granted asylum on those grounds, so as to keep better data collection;
- to allocate money in the context of emerging cooperation for specific educational projects in the countries concerned.
Country report

Greece
Country report: Greece

1. IDENTIFICATION

Country: Greece

Researcher: Maria Kyprianou

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The research for prevalence data was initiated through academic database search, following the 'Guidelines for national data collection'. The following databases were searched for prevalence data in Greece (GR): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, and Google Scholar.

Key terms included the Greek terms: κλειστές εμπειρίες, Αποκλειστικές Γυναικείες Οργάνωσες, ΑΓΟ.

Unfortunately, no documents were retrieved to include representative or reliable prevalence data. The only reference to a rather insignificant statistic was made in an academic article about FGM in Egypt, stating that FGM has its origins in Ancient Greece. Due to its insignificance this data was not included in the Excel file.

Apart from the above databases, the Ministry of Health was contacted through e-mail as well as non-governmental organisations, hereafter referred to as NGOs that deal with human rights issues in Greece.

The Ministry of Health did not respond to the request for information in time and has not responded since.

The Greek Unicef Commission was interested in the study and provided some general information for this purpose; nevertheless, no consistent studies were concluded at the time to include prevalence data of FGM cases in Greece.

An e-mail was equally sent to the Hellenic Statistical Authority (EL. STAT), in order to collect official statistical documents; however no such data were collected and no study was conducted on FGM by the Hellenic Statistical Authority. However, the Hellenic Statistical Authority provided the researcher with statistic information generally concerning sexually transmitted diseases and information on migration to Greece. The said information was not found relevant with the scope of this study; hence it was not included in the Excel file.

2.2. Nature of prevalence studies/FGM registration systems

As aforementioned, no documents including prevalence data on FGM in Greece were retrieved from the above desk research.

2.3. Findings from the prevalence studies/registration systems

It will be further substantiated in detail that there are generally no specific laws or government policies in place in Greece. Therefore, it would be a very challenging task to identify or quantify victims and protect possible future victims of FGM. Furthermore, data on immigration have not been representative or reliable since a large number of immigrants are illegal immigrants. Taking this into account, data collection on women who have undergone FGM and now residing in Greece, is made extremely difficult.

It is however important to note that in 2007 the first campaign against female genital mutilation, 'Stop FGM in Greece', was organised to raise awareness and to combat FGM in Greece (1). This campaign had a steering committee consisting of the Hellenic Sudanese Friendship League, the Institute of Child Health, the Greek Forum for Immigrants, the United African Woman Organisation, the organisation One Earth, Amnesty International — Greek Section — and the Adviser to the Mayor’s Office on Immigration. The Greece national plan of action to prevent and eliminate female genital mutilation (2), funded by the Daphne programme was drafted as a result of the campaign.

Although the Greece national plan of action to prevent and eliminate female genital mutilation does not seem to include an estimation or prevalence data on FGM in Greece, it is likely that the steering committee might have data that is not accessible or available through a desk study. It is very important to point out that most of the steering committee members were not able to reply to my request for information about the FGM project. The website where the abovementioned plan of action is published online was accessible; nevertheless registration was required in order to obtain the digital document from ISSUU.

(1) Stop FGM in Greece (programme coordinated by the Greek-Sudanese Friendship Association)

(2) The text of the action plan can be read at: http://issuu.com/drets/docs/greece_national_plan_of_action_to_prevent_and_elim
Due to the overall chaotic situation in Greece, NGOs seem to be the first to collapse and KEGME (\(^*\)), for instance, could not even be traced through their website. Due to the limited time frame of the desk study and due to all the reasons mentioned above, it was not possible to contact the members of the steering committee in order to collect information on FGM in Greece.

According to the abovementioned action plan, due to the lack of reliable prevalence data on how many girls and women living in Greece have been genitally mutilated, or how many girls may be in danger of being subjected to the procedure, a pilot research has been initiated to learn more about the scope of FGM in Greece with a view to investigate the extent of presence or absence of the practice of female genital mutilation among immigrant women residing in Greece. This pilot research was done in 2007 by our search team consisting of representatives from the following organisations and institutions: the Department of Social Policy at Panteion University, the Hellenic Sudanese Friendship League, One Earth, the Greek-Sudanese Friendship Association and the Training Centre INE/GSEE.

Although the pilot research is mentioned in the action plan, there is no reference or use of the results of the pilot research, hence it was difficult to find or use it. Two of the authors were however contacted by e-mail, yet no information was provided within the limited time frame of the study.

### 2.4. Reflection on prevalence studies

Greece only began research and data collection on FGM in 2007, under the ‘Stop FGM in Greece’ campaign. The ‘Stop FGM in Greece’ campaign was financed by the Daphne programme and the initiative was undertaken by the aforementioned steering committee.

There are currently no representative or reliable data on FGM in Greece.

There has been general action planning on domestic violence, equality between the genders and promotion of human rights. Nevertheless, FGM has not yet been recorded as a major problem in the country.

In conclusion, having received limited publicity, FGM and specifically prevalence data on FGM in Greece remain issues to be yet explored.

### 3. POLICY FRAMEWORK

#### 3.1. Methodological approach for collecting documents on policies

Three policy documents have been developed in Greece concerning FGM.

The start of the research on policy documents was done in academic databases, following the ‘Guidelines for national data collection’. The following databases were searched:

- Key terms included the Greek terms: κλειτοριδεκτομή, Ακρωτηριασμός Γυναικέων/Γεννητικών Οργάνων, ΑΓΓΟ.

Unfortunately, no policy documents were retrieved through the academic databases.

To further the search for policy documents, the Ministry of Health, the Ministry of Foreign Affairs, the Ministry of the Interior and the Asylum Service were contacted by e-mail.

None of the above government services replied to the request for information in time and have not responded since. The government services were also contacted by phone, however there was no response.

#### 3.2. Policies on FGM

The national programme for substantive gender equality 2010–13 was drafted by the Ministry of the Interior in 2010 with four strategic goals in mind:

1. protection of all women’s rights through the promotion of gender equality and the orientation of interventions towards groups of women facing multiple discrimination;
2. prevention and combating of all forms and types of violence against women;
3. support of women’s employment and their financial independence;
4. use of cultural creation in order to highlight the goal of gender equality. Traditional crafts and artistic creations will be used in order to connect cultures and discover diversities and similarities between women and men, while promoting equality of genders.

The national action plan for reproductive and sexual health 2008–12, was drafted by the Ministry of Health in 2009.

This action plan generally concerns matters of sexual and reproductive health. It illustrates that sexual and reproductive health issues concern more than one disease and also concern human rights. Matters concerning a woman’s mental and physical health are complex and they often need to be dealt with a holistic basis as they are usually connected to social and family traditions.

The main aims of this action plan are to improve the qualitative and quantitative indicators affecting the level of reproductive and sexual health by informing families of harmful practices and diseases, providing protection mechanisms, reducing domestic violence and sexual violence, etc.

Introduced through the national action plan for public health, this action plan aims generally to set a framework for all sexual diseases and reproductive issues. It refers specifically to FGM on pages 9 and 10. It sets the right to protection from FGM as one of the 12 sexual and reproductive rights in Greece.

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\(^*\) For more information please see: http://www.euromedalex.org/fr/node/5477
3.3. Reflection on policies on female genital mutilation

As demonstrated above, there is no official national action plan to prevent and eliminate FGM issued by government authorities.

The combination of the abovementioned action plans set out, in principle, a number of important actions and measures to deal with general forms of violence against women, such as informing families of harmful practices and diseases, providing protection mechanisms and reducing domestic violence and sexual violence.

In conclusion, it is important to reiterate the fact that the next main aim would be to find a way to involve government departments and politicians in the general fight against FGM.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Data for this section were retrieved from the following websites:
- UN Secretary-General’s database on Violence against Women (VAW), for information regarding the general legal framework in Greece concerning violations against women’s rights
- Website of the Greek police, http://www.policenet.gr
- Website of the National Archive of PhD Theses http://phdtheses.ekt.gr/eadd/handle/10442/18303

The coordinating team also informed the researcher about the following document, which was included in the desk study:

4.2. Criminal law

In Greece there is no specific criminal prohibition for FGM. There is, however, a general protection provision in the Penal Code: Articles 308, bodily harm; 309, dangerous bodily harm; 310, serious bodily harm; and 312, bodily harm inflicted on minors, provide that inflicting serious, grave or dangerous bodily harm to adults or minors is a crime under the said provisions of the Penal Code.

However, according to the Hellenic Statistical Authority (EL. STAT) and the Greek police, no cases have been reported.

Due to the fact that there is no special criminal provision for FGM, Greek Courts are not empowered to adjudicate and decide in cases where the offence of FGM was committed by non-citizens, or for FGM committed to non-Greek citizens; hence the extraterritoriality principle is not applicable.

It is, however, important to note that the reporting and investigation of female genital mutilation practices within the family are, in reality, difficult. The fact that there is no specific law provision in place to prohibit FGM creates an even greater hurdle to overcome, since usually victims and perpetrators belong to the same family and their relationship is characterised by a position of dependence.

4.3. Child protection laws/provisions

There are no specific law provisions protecting minors from FGM in Greece. Nevertheless, the general legislative framework appears to cover cases of FGM as a form of child human rights violation or child abuse.

Inflicting bodily harm to minors is a crime under provision 312 of the Penal Code. However, there is no specific reference to protection mechanisms or rehabilitation schemes for children facing bodily harm within the family, with special reference to FGM cases.

Another legal provision in Greece generally protecting children is Law 3625/2007 incorporating the optional protocol for the protection of the rights of the child. This law mainly focuses on child trafficking, child prostitution and selling children’s organs. It is important to note that this law provides for the prohibition of corporal violence and not for corporal punishment of the child, thus providing for a wider scope of protection.

In Greece, there are several child protection organisations such as ‘The Smile of the Child’ (1), an NGO supporting children with health issues and social or psychological problems and the NGO ‘Friends of the Child’ (2). These NGOs intervene to protect children and promote their interests; however they do not specifically deal with FGM cases.

4.4. Asylum law(s)/provisions

The relevant law dealing with asylum seekers is Asylum Law 3907/2011, which was last amended in 2011. Article 11 of the said law contains provisions on how to classify refugees according to their situation. It could be used to classify victims of FGM or persecuted women as refugees.

Article 18 refers to vulnerable persons and it could be used in cases of child victims of FGM. Articles 20 and 25 specifically refer to the protection of child asylum claimants.

There are no specific provisions dealing with FGM. Nevertheless the legal definition of refugee can be used in an asylum procedure to obtain the status of refugee in Greece by a woman or a child who have either undergone FGM, or are in fear of undergoing FGM if returned to their country of origin. Women who have undergone FGM may

(1) For more information in Greek please visit: http://www.hamogelo.gr/
(2) For more information in English please visit: http://www.mazigitopaidi.gr/main.php?f1=6&l2=17
be granted asylum on the basis of not being able to obtain medical treatment for complications arising from FGM if returned to their countries of origin. Article 3 of the ECHR would be breached by a country that sends victims of FGM back to their country of origin.

In Greece, the legal definition of a refugee is a translation of the 1951 Convention (1) definition in Greek: “the term “refugees” shall apply to persons who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, are outside their country of nationality and are unable, or, owing to such fear, are unwilling to avail themselves of the protection of that country; or who, not having a nationality and being outside the country of their former habitual residence as a result of such events, are unable or, owing to such fear, are unwilling to return to it.”

A woman could claim asylum on the basis of fearing persecution if returned to her country of origin, due to her belonging to a particular social group (2) which practices FGM. The practice of FGM itself could be interpreted as persecution, since FGM is defined as a cruel, inhuman and to some, a torturous act.

It is the opinion of some refugee law experts (3) that Article 3 of the European Convention on Human Rights, prohibition of torture, inhuman or degrading treatment, or punishment, would be breached by the Greek government, should a victim be returned to her country of origin. Another reason for following the non-refoulement principle (4) and not returning the FGM victim to her country of origin would be to grant her asylum status on a humanitarian basis. To further illustrate the above point, asylum is often granted to asylum seekers on humanitarian grounds which cover issues that are not covered by the 1951 Convention. Being a victim or potential victim of FGM could form one of the grounds to obtain the refugee status, for humanitarian reasons, or at least for the victim to obtain the humanitarian leave to stay in the safe third country.

4.5. Professional secrecy provision(s)

The are several legal provisions in Greece dealing with professional secrecy: the Greek Constitution, the European Convention for the Protection of Human Rights, incorporated in Greek Law under Law 53/1974, the Penal Code; Article 371, the Civil Code; Articles 57, 914, 932, Medical Deontology; Articles 22 and 23 of Law 1565/1939 and Law 2071/1992, as well as disciplinary rules and regulations of medical associations and hospitals.

The abovementioned legal provisions provide that medical practitioners have a duty to report cases of sexual or other suspected abuse. For reasons of public interest or the best interest of patients where the patient is a child, some confidential information can be disclosed.

It should be noted that criminal or civil sanctions could result in cases of non-reporting.

Information on the abuse of secrecy is usually collected by the Greek Medical Association if the perpetrator is a doctor. The police or the national child services will be notified if a doctor reports a suspected abuse.

4.6. Reflection on legal framework

As a general observation, I notice that specific legal provisions to deal with FGM in Greece are not in place.

Nevertheless, the general legislative framework seems to cover cases of FGM as a crime and as a form of child human rights violation or child abuse. The protection of minors and mostly unaccompanied minors is vital for a state that claims to protect and endorse human rights values. Therefore, if the need to protect child-victims of FGM emerges, which does not currently seem to be the case, Greece should legislate specifically for their protection.

As far as asylum cases are concerned, it is commonly the international refugee law trend to find the practice of FGM as a form of persecution. Greece asylum service personnel, who deal and decide at first instance on whether to grant or deny the refugee status to asylum seekers, should be educated about FGM.

As aforementioned in the policy framework section, once governmental departments and politicians get more involved with FGM, it is likely that legal provisions specifically dedicated to the prevention and elimination of FGM are bound to be enacted in Greece.

In conclusion, it is important to stress the fact that there are no specific law provisions in place to prohibit FGM which creates an even greater hurdle to overcome, since usually victims and perpetrators belong to the same family and their relation is characterised by a position of dependence.

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(2) ‘A particular social group’ is defined under provision 3D(1)(d)(i) of the Asylum Law L. 6(I)/2000, as a group comprising persons of similar background, habits or social status.

(3) Professor Satvinder Juss, King’s College London, Prof. Guy S., Goodwin Gill, Prof. James Hathaway.

(4) ‘The principle of non-refoulement is the cornerstone of asylum and of international refugee law. Following from the right to seek and to enjoy in other countries asylum from persecution, as set forth in Article 14 of the Universal Declaration of Human Rights, this principle reflects the commitment of the international community to ensure to all persons the enjoyment of human rights, including the rights to life, to freedom from torture or cruel, inhuman or degrading treatment or punishment, and to liberty and security of person. These and other rights are threatened when a refugee is returned to persecution or danger’. For more information please refer to UN High Commissioner for Refugees, ‘UNHCR Note on the principle of non-refoulement’, November 1997, available at: http://www.unhcr.org/refworld/docid/438c6d972.html
5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

According to the ‘Guidelines for national data collection’, an actor is any organisation or individual who has performed any work on FGM in Greece.

Relevant actors in Greece were found through a variety of search strategies:

The research for actors was initiated through academic database search, following the ‘Guidelines for national data collection’. The following databases were searched for prevalence data in Greece (GR): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar.

Key terms included the Greek terms: κλειτοριδεκτομή, Ακρωτηριασμός Γυναικείων Εννητικών Οργάνων, ΑΓΓΟ.

Relevant actors, such as FGM experts or institutions that appeared in the database search, were included in the database, as well as other organisations that were found through personal knowledge.

Authors of documents that were studied, as well as those who issued the documents, and those who commissioned the publication of the documents, were considered as actors and they were included in the database.

Nevertheless, it was not possible to find all the necessary information required in the Excel file for all the members of the steering committee of the Greece national plan of action to prevent and eliminate female genital mutilation: the Hellenic Sudanese Friendship League/Association, the Institute of Child Health, the Greek Forum for Immigrants, the United African Woman Organisation, organisation One Earth, Amnesty International — Greek section and the Adviser to the Mayor’s Office on Immigration.

A web-based search was then performed to include all the details that were requested to compile the actors’ sheet in the database.

The number of actors in Greece who have worked and are still working on FGM is limited and not easily verifiable through the actors’ websites. It is, however, important to note that due to the limited time frame of this desk study, it cannot be guaranteed that the relevant actors included in the Excel database are exhaustive.

5.2. Actors

Actors in Greece include two international organisations, four civil society organisations and one organisation founded by a ministerial decree, the Institute of Child Health.

Activities include research, the creation of informative strategies, prevention activities and developing policies at national level.

The Hellenic National Committee for Unicef has been one of the most important actors in the field of raising awareness on FGM. Unicef realises that the practice of FGM/C has persisted for over a thousand years but evidence shows that FGM/C can end in one generation. Community conversations and education programmes about human rights and fundamental values with adults, adolescents and religious leaders allow community members to discuss alternative ways of doing the best for their daughters without subjecting them to FGM. Unicef and partners support these initiatives and also assist governments in strengthening legislations outlawing the practice and policies enabling communities to make a coordinated and collective choice to abandon FGM/C.

Unicef deals with FGM by issuing toolkits and information material.

The Greek-Sudanese Friendship Association is an active member of the steering committee for the implementation of the Greece national plan of action for the prevention and elimination of female genital mutilation. Unfortunately it was not possible to find more information on the Greek-Sudanese Friendship Association through the desk study (10).

The Institute of Child Health is a research centre whose scope includes research, service provision and training in a wide area of fields covering children, families’ health and well-being. The institute operates within the wider public sector and is supervised and funded by the Ministry of Health and Welfare. The Department of Family Relations, the KaPa Centre, carries out studies concerning the interaction between the individual, the family and society. Since 1988, the department functions in parallel with the Centre for the Study and Protection of Child Abuse and Neglect. The KaPa Centre has as main focus the study of active and passive violence towards children and its prevention.

The institute’s primary areas of work are the study of family relations and family structures which are linked with violence and its manifestation. The institute’s research focuses on wider social structures, institutions and values, which formulate the setting in which violence is produced and maintained.

The Institute of Child Health is an active member of the steering committee for the implementation of the Greece national plan of action to prevent and eliminate female genital mutilation.

The Greek Forum of Migrants is a network of migration organisations and communities, founded in September 2002 and today numbering around 40 organisations. It is a form of an immigrants’ organisation, on the basis of a collective action plan, which was formulated through continuing consultations with the aim of strengthening the

(10) Much effort was dedicated in finding the Greek-Sudanese Friendship Association’s website; nevertheless, they could not be traced. They are listed as one of the partner organisations of the European Network against Racism (ENAR), in Greece, but there is no link or contact information (http://www.enar-eu.org/Page.asp?docid=15751&langue=EN). A possible translation of the name in Greek did not help either. The only community organisation found related to Sudan in Greece, through the desk study was the Greek Community of Sudan http://www.sees.gr/
representation and voice of immigrants, their organisations and communities in Greece, and the equitable inclusion and participation in the Greek society.

This organisation is also a member of the steering committee for the implementation of the Greece national plan of action to prevent and eliminate female genital mutilation.

The United African Women Organisation is an NGO aiming to create awareness on various issues concerning the African women and their children living in Greece, to support and fight for their rights especially for the second generation as a whole, to create mutual bonds of solidarity between Africans and the Greeks, to explore and incorporate the rich African woman heritage into the rich Greek heritage and to work hand in hand with various social, NGOs and other organisations that stand for justice, non-racial and friendly society for all.

The United African Women Organisation is an active member of the steering committee for the implementation of the Greece national plan of action to prevent and eliminate female genital mutilation.

One Earth NGO is also a member of the steering committee for the implementation of the Greece national plan of action to prevent and eliminate female genital mutilation. The principal aim of One Earth is to respond to extreme humanitarian needs, contribute to the eradication of global poverty and promote sustainable development.

To accomplish these aims, One Earth works hand in hand with local partners and communities to offer emergency support where this is needed most and empower the local population to build a better future for them and for their children.

They actively support networking and sharing information as a means of strengthening NGOs and civil society groups in their efforts to promote initiatives that give real scope to the disadvantaged of the world to exercise their right to education, to adequate food supply, to clean and safe water, proper shelter and health services.

Being a member of the steering committee for the implementation of the Greece national plan of action to prevent and eliminate female genital mutilation, Amnesty International’s vision is for every person to enjoy all the rights enshrined in the Universal Declaration of Human Rights and other international human rights standards.

5.3. Reflection on actors on female genital mutilation

The work on FGM in Greece is currently at an evolutionary stage. As demonstrated above, there are a number of actors dealing with FGM in Greece, but their work is neither limited to FGM, nor exclusively dedicated to it.

Fortunately, there seems to be a trend towards acknowledging the existence and the seriousness of the act of FGM in Europe and there is also some concern that this manifestation of traditional cruelty may in fact exist in Greece, within African communities. It seems, however, that most actors are within the area of Athens.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

The search for tools and instruments on FGM was performed according to the ‘Guidelines for national data collection.’ The following databases were searched for prevalence data in Greece (GR): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar.

Key terms included the Greek terms: κλειτοριδεκτομή, Ακρωτηριασμός, Γυναικείων Εννητικών Οργάνων, ΑΣΟ.

Relevant tools and instruments include, a Unicef handbook entitled Changing a harmful social convention: female genital mutilation/cutting and the Greece national plan of action to prevent and eliminate female genital mutilation.

6.2. Tools and instruments on FGM

The first tool presented in the excel file is the abovementioned Unicef handbook entitled Changing a harmful social convention: female genital mutilation/cutting. It is a publication of the United Nations Children’s Fund (Unicef), published by the Unicef Innocenti Research Centre in 2005.

The Unicef handbook examines the social dynamics of FGM/C. In communities where it is practised, FGM/C is an important part of girls’ and women’s cultural gender identity. The procedure imparts a sense of pride, of coming of age and a feeling of community membership. The social expectations surrounding FGM/C represent a major obstacle to families who might otherwise wish to abandon the practice. Taking this as its starting point, the handbook presents some of the most promising strategies to support communities to abandon FGM/C.

Legislators in Europe have tended to favour one of the three responses to FGM/C: the introduction ex novo of specific legislation criminalising FGM, the modification of existing legislation to make specific reference to this procedure, or the prohibition of FGM/C under existing criminal laws pertaining to physical injury and abuse of minors. According to the handbook, Greece is a country that has modified its existing legislation to criminalise FGM by using existing provisions, not expressly criminalising FGM, but on infliction of bodily harm. Additionally, several European countries include the principle of extraterritoriality in their legislation in recognition of the danger that legal prohibition may result in families sending women and girls back to their country of origin to undergo FGM/C. This document is used in Greece as an information tool.

The abovementioned Greece national plan of action to prevent and eliminate female genital mutilation is a national action plan, which was drafted in 2009 by a steering committee consisting of the Hellenic Sudanese Friendship
could be developed.

This plan aims to develop a national plan of action for preventing and eliminating female genital mutilation in 15 EU countries, by joining all actors at national level in these countries. The project is funded by the Daphne programme of the European Commission and coordinated by the European Network for the Prevention of FGM. Initially it states that female genital mutilation is a fundamental violation of human rights. In the absence of any perceived medical necessity, FGM subjects girls and women to health risks and has life-threatening consequences.

The Greek national plan of action was based mainly on the lack of medical care for girls and women who have been mutilated, the need to raise awareness of the practice, empowering communities and the need to develop a platform for informed public debate on FGM in Greece.

Within the first two years of the plan being operational, the Greek national steering committee worked very hard to address the issue of FGM, to raise awareness and to inform the involved stakeholders. In 2009, the committee stated that they had dealt with the issue of FGM in a way that has resulted in more NGOs and institutes being aware of the problem. The committee believes that even the affected communities are now more encouraged to talk about FGM. However, the committee is still struggling for the governmental department and politicians to be more involved, not just in words but also in actions.

The target groups include: religious leaders, community leaders, communities and relevant population groups, NGOs, healthcare professionals and other skilled people from countries that practice FGM, professionals (social workers, lawyers), politicians and parliamentarians.

Some of the most important actions to be implemented through this action plan include raising community awareness, and providing education and empowerment for community stakeholders, especially religious leaders, and community leaders, raising awareness and educating medical and health professionals, investigating the possibility of legal action to protect the second generation from FGM and the creation of an information line and consultancy service in Greece.

6.3. Reflection on tools and instruments on female genital mutilation

Tools have only recently been developed in Greece and they are limited in numbers. In fact, only two tools found through the desk study were relevant within the scope of this study. Through the research work of civil society organisations and international organisations in Greece, the development of coherent tools and instruments for FGM could be developed.

7. FINAL CONSIDERATIONS

As far as prevalence is concerned, it is important to note that Greece only started research and data collection on FGM in 2007, under the ‘Stop FGM in Greece’ Daphne programme, hence there are currently no representative or reliable data on FGM.

There has been a general action-planning on domestic violence, equality between the genders and promotion of human rights. Nevertheless, FGM has not yet been recorded as a major problem in the country.

Regarding the policy framework on FGM in Greece, although mainly at an NGO level, Greece has developed a national action plan to prevent and eliminate FGM since 2009. There is however no further reference about the progress and/or the implementation and/or the results of the plan.

It is important to reiterate the fact that the steering committee of the Greek plan of action is still struggling with the governmental department and politicians to be more involved not just in words but also in actions. Hence, the next main aim would be to find a way to involve government departments and politicians in the general struggle against FGM.

Concerning the legal framework, we generally observe that there are no specific law provisions protecting minors or adults from FGM in Greece.

Nevertheless, the general legislative framework seems to cover cases of FGM as a crime and as a form of child human rights violation or child abuse. The protection of minors and mostly unaccompanied minors is vital for a state that claims to protect and endorse human rights values. Therefore, if the need to protect child-victims of FGM emerges, which does not currently seem to be the case, Greece should legislate specifically for their protection.

As far as asylum cases are concerned, it is commonly the international refugee law trend, to find that the practice of FGM itself constitutes persecution. Greece Asylum Service personnel, who deal and decide at first instance to grant or to deny the refugee status to asylum seekers, should be educated about FGM.

As aforementioned in the policy framework section, once governmental departments and politicians get more involved with FGM, it is likely that legal provisions specifically dedicated in the prevention and elimination of FGM are bound to be enacted in Greece.

It is important to stress the fact that as there are no specific law provisions in place to prohibit FGM this creates an even greater hurdle to overcome, since usually victims and perpetrators belong to the same family and their relation is characterised by a position of dependence.

When it comes to actors, it should be noted that the work on FGM in Greece is currently at an evolutionary stage. As
demonstrated above, there are a number of actors dealing with FGM in Greece (mainly NGOs), but their work is neither limited to FGM, nor exclusively dedicated to it.

Fortunately, there seems to be a trend towards acknowledging the existence and the seriousness of the act of FGM in Europe and there is also some concern that this grotesque manifestation of traditional cruelty may in fact exist in Greece, within African communities. It seems however that most actors are within the area of Athens.

Tools have been only recently developed in Greece and they are limited in numbers. In fact, only one tool found through this desk study was relevant for the scope of this study.
Country report

Hungary
1. IDENTIFICATION

Country: Hungary
Researcher: Monika Pacziga

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

To find prevalence studies, first I searched the academic databases according to the ‘Guidelines for national data collection’. I searched the following databases for Hungary (HU): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar. I also searched the Hungarian terms besides the recommended English ones: csonkítás, női körülmetélés and infibuláció. The only document that these databases provided was an article in a medical paper published in September 2011, which gave an account of the history of various ritual self-mutilations. This was not relevant for the current research (Józsa, L. ‘Az emberi test mesterséges módosítása (deformálása). V. Az öncsonkítás, rituális csonkítás’ in Orvosi Hetilap, September 2011).

I then consulted NGOs, experts, women’s rights activists and gynaecologists. During this second search I found only one prevalence study on FGM in Hungary: ‘FGM prevalence in Hungary — an estimation’. I first learnt about this study from an expert in the field from the Hungarian Helsinki Committee and obtained the draft of the study from the Foundation for the Women of Hungary (MONA). The study was commissioned by MONA within the framework of the ‘End FGM European campaign’ (http://www.endfgm.eu/en/). MONA is a Hungarian partner organisation in the campaign. The study was one of the requirements of the campaign.

The study relied on the methodology of assessing the number of women living in Hungary from countries where FGM is practised and based on WHO data, extrapolating the number of women affected by FGM among them. To assess the number of women living in Hungary from countries where FGM is practised, it relied on various statistics.

- Number of residents in Hungary with residence permit as of 31 December 2008
- Number of those who obtained a refugee status between 2001 and 2010
- Number of those who obtained temporarily protected status (oltalmazott, befogadott (visszaküldés tilalma)) between 2006 and 2010
- Number of those residing in one of the reception centres operated by the Office of Immigration and Nationality or the guarded accommodation centres operated by the police in 2011.

The population studied, thus, was women and girls potentially living with FGM in Hungary as of 2011. Where the data was not disaggregated by gender, a 20 % estimate was used for women.

Limitations of this study

The study does not detail the information on which it bases its calculations, e.g. countries of origin, which countries were assessed as ‘FGM prevalent’ counties, or how it calculates the fluctuation of refugees and migrants (for instance, how do we know how many people who have been granted refugee status stay in the country). I was told that there would be a longer version of the study, which will hopefully give more information on this. The study admits that no data disaggregated by age could be obtained. Another limitation may be that the percentage used in the extrapolation may not reflect the actual proportion of migrant women
with FGM in Hungary, and non-registered migrants are not included in this estimation at all. A further limitation is that it does not take second and third generation into consideration, nor does it take into consideration those who become Hungarian citizens through marriage. At the same time, the study is groundbreaking as it is the first and only attempt to give an estimate on the number of women living with FGM in Hungary.

The other study that contains relevant information is a national report written by the Hungarian Helsinki Committee (HHC) within the framework of the project ‘Enhancing gender-sensitivity and a harmonised approach to gender issues in European asylum practices in order to better identify and serve the needs of vulnerable asylum seekers’. Its title is ‘Analysis of gender-related asylum claims in the Hungarian asylum procedure’ and it is going to be published (on the HHHC website) in 2012. I received a draft of the study. The study is relevant because among the case studies it analyses FGM-based asylum claims and because the study provides a table with the number of asylum claims, of granted refugees, protected and tolerated status and rejected claims in 2010, broken down by country of origin and gender. I have included the table in Section 2.3.

There is no FGM registration in Hungary. Data on the number of women living in Hungary whose country of origin is a country where FGM is practised can be obtained from the following sources:

- Directorate of Refugees at the Office of Immigration and Nationality (number of asylum claims, number of refugees, protected and tolerated status, number of rejected claims, broken down by gender and country of origin). The current data collection method started in 2000.
- Directorate of Immigrants at the Office of Immigration and Nationality (number of residents (with a resident permit) in Hungary broken down by country of origin).
- Potentially: the Hungarian Helsinki Committee. I was told HHC regularly receives statistics on asylum claims, refugees, and other protected statuses, e.g. the table provided further below is from their study, which I was told, they receive automatically.
- Potentially: UNHCR Budapest. I was told by a staff member at HHC that UNHCR regularly receives statistics on asylum claims, refugees, and other protected statuses; it is the same statistics that HHC receives.

Note: I tried to receive statistical information, such as the table in the HHC report for the years 1980 to 2012, but my request was turned down by the Office of Immigration and Nationality on the grounds that the amount of data was too big. I therefore asked for ‘as much as they have capacity for’, but they refused and no official explanation was given for their refusal. However, I received data (on 20 February 2012) from the Directorate of Immigrants regarding the number of women who lived in Hungary as of 31 December 2011 with the various types of permits (residence, settlement, or immigration permit, as relatives of Hungarian or EU citizens) from the countries listed in our methodology guideline (Annex 1) as countries where FGM is prevalent.

### 2.3. Findings from the prevalence studies/registration systems

According to Kőszeghy’s article there are approximately 100 to 200 women in Hungary currently living with FGM (the number is not supposed to have changed in the past few years). The study relies on data on:

- the number of female residents (those holding a residence permit) in Hungary from countries where FGM is performed (these are not necessarily second generation migrant women);
- the number of women refugee in Hungary from countries where FGM is performed.

The date study reports that the data are not disaggregated by age. Disaggregation by country of origin is available in the original data.

The table below is from the Hungarian Helsinki Committee’s national report: ‘Analysis of gender-related asylum claims in the Hungarian asylum procedure’. It gives us a glimpse of the number of women submitting asylum claims and receiving refugee or other protected status from affected countries in 2010.

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Asylum applications</th>
<th>Refugee status</th>
<th>Subsidiary protection</th>
<th>Temporary status</th>
<th>Rejection</th>
<th>Cases closed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
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<tr>
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</tbody>
</table>

Note: I tried to receive statistical information, such as the table in the HHC report for the years 1980 to 2012, but my request was turned down by the Office of Immigration and Nationality on the grounds that the amount of data was too big. I therefore asked for ‘as much as they have capacity for’, but they refused and no official explanation was given for their refusal. However, I received data (on 20 February 2012) from the Directorate of Immigrants regarding the number of women who lived in Hungary as of 31 December 2011 with the various types of permits (residence, settlement, or immigration permit, as relatives of Hungarian or EU citizens) from the countries listed in our methodology guideline (Annex 1) as countries where FGM is prevalent.

2.3. Findings from the prevalence studies/registration systems

According to Kőszeghy’s article there are approximately 100 to 200 women in Hungary currently living with FGM (the number is not supposed to have changed in the past few years). The study relies on data on:

- the number of female residents (those holding a residence permit) in Hungary from countries where FGM is performed (these are not necessarily second generation migrant women);
- the number of women refugee in Hungary from countries where FGM is performed.

The date study reports that the data are not disaggregated by age. Disaggregation by country of origin is available in the original data.

The table below is from the Hungarian Helsinki Committee’s national report: ‘Analysis of gender-related asylum claims in the Hungarian asylum procedure’. It gives us a glimpse of the number of women submitting asylum claims and receiving refugee or other protected status from affected countries in 2010.
The following table shows the data I received from the Directorate of Immigrants on the number of women from FGM-prevalent countries staying in Hungary as of 31 December 2011 with some kind of permits other than refugee or protected status (however, the numbers for women requesting those permits were higher, a total of 2 035 for the same countries).

<table>
<thead>
<tr>
<th>Citizenship</th>
<th>Total</th>
<th>Holding immigration permit</th>
<th>Holding settlement permit</th>
<th>Holding residence permit</th>
<th>Holding permanent residence card</th>
<th>Hungarian citizen’s spouse with third country citizenship</th>
<th>EEA (European Economic Area) citizen’s spouse with third country citizenship</th>
<th>National settlement permit</th>
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2.4. Reflection on prevalence studies

There is only one study on the prevalence of FGM in Hungary that gives an estimate of the number of women living with FGM in Hungary by trying to assess the number of women living in Hungary from countries where FGM is practised and extrapolating their number from this data. The data is and can only be an estimate, as it is based on official statistics on refugees, other protected statuses and
residents coming from countries where FGM is practised; however some of the recorded refugees might have left and non-registered migrants are not included in the statistics (although their number is probably not very high in Hungary). Furthermore, the WHO proportions used in the study may not reflect the actual proportions of women with FGM among the studied groups. Besides, second and third generation women are left out of the study. However, given the current data available, this is a good approach. It gives an approximate idea about the women potentially having FGM in Hungary.

The reason for the lack of prevalence studies on FGM in Hungary is the low number of women living in Hungary from countries where FGM is practised.

No agency is collecting information on FGM at the moment. The Office of Immigration and Nationality ought to be able to collect information such as the number of claims based on FGM, the number of claims given for women who have FGM (when this is known) and the number of claims given based on FGM.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

I consulted NGOs and experts in women’s rights from the Secretariat for Social Inclusion (Ministry of Justice) and the Department of Equal Opportunities (Ministry of National Resources). I also asked the Head of the Advisory Board of Gynaecologists (for the Minister of State for Health) about the policy. They all confirmed that there have been no policies on this issue so far. The head of the board said that FGM affects a very small number of women in Hungary (he has heard about one case of a gynaecologist treating a woman with FGM).

I also searched the academic databases suggested in the guidelines, but these produced no results. I searched the website of the Hungarian parliament, where all documents (proposals, debates) are freely available online from 1994. The search term csonkitás only yielded the following relevant result: Katalin Ertsey (LMP — Hungarian Green Party) refers to the 2010 EU strategy for equality between women and men, which discussed FGM in Africa. The other keywords (FGM, genital, körülmetétől) produced no result. I also searched the Hungarian national website, which includes all documents from all the ministries from 2010, but there was no result for the search phrases: csonkitás, genital, FGM, körülmetétől. From before 2010, I searched the website of the Ministry of Health (http://www.eum.hu/main.php) and the only relevant results for csonkitás were reports on FGM-related documents from abroad. The reports mentioning FGM are: (1) a translated action plan issued by the Queen Sofia Centre for the Study of Violence for the Women’s World Forum against Violence (2000), in Valencia; (2) a report (2006), on the health programme of the Austrian EU Presidency, which set the fight against ‘harmful traditional practices’ including FGM as a goal; and (3) a report on the 122nd board meeting of the World Health Organisation, which discussed FGM in Africa. The other keywords (FGM, genital, körülmetétől) produced no result. I also searched the Ministry of Public Administration and Justice’s website, from before 2010, and there was no result at all for the keywords csonkitás, genital, FGM, körülmetétől.

In the electronic database that I used for searching legal documents, I found one policy document with the keyword csonkitás: the government resolution on the national strategy to promote equality between women and men (2006). In that document female genital mutilation is mentioned as a form of ‘violence based on tradition,’ which, ‘according to some international experts, is one of the typical forms of violence against women’. However, although this document mentions FGM, it is not a policy specifically on that (and does not elaborate on FGM) and therefore I did not take the policy (strategy document) into consideration.

3.2. Policies on FGM

I have found no policies regarding FGM in Hungary. As the scope of the study was FGM in Hungary, I did not expand beyond it on topics such as violence against women, human rights, refugee rights, etc.

3.3. Reflection on policies on female genital mutilation

Those I asked (see Section 3.1) said that FGM affects a very small number of women in Hungary and this is the reason for not having any policy on this issue.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

I relied on an online legal database (software) for Hungarian laws and regulations used by lawyers, which includes current regulations and previous versions (with the possibility of comparison) and also a justification of the laws (OptiJUS Electronic Legal Database). It is also possible to search for certain words in the database. I searched for the following keywords: csonkitás, csonkitása, megskonkitás, megskonkitása, körülmetétés, FGM and genital. The relevant results for csonkitás were six court decisions on refugee appeals related to FGM; these will be developed in Section 4.4 of this report. For csonkitása I found one relevant result,
the government resolution on the national strategy to promote equality between women and men (2006). In this document FGM is mentioned as a form of ‘violence based on tradition,’ which, ‘according to some international experts, is part of the typical forms of violence against women.’ For megcsónkítás (I found no relevant result; while for megcsónkítása I found one further relevant document, a court decision on refugee appeal related to FGM (developed in Section 4.4). The other keywords (korületetlenség, FGM, genital) yielded no further results.

I also consulted lawyers of particular fields, who directed me to the relevant laws and extracts. I also read the Leyesabbe article (Responding to female genital mutilation in Europe — Striking the right balance between prosecution and prevention) for orientation and ‘Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence’ (Pap, E., Spronz, J., Wirth, J. (2010), ‘Hungarian national report,’ European Union). Seventeen individuals were contacted and consulted.

The most difficult section to collect all relevant information for was Section 4.5, as professional secrecy provisions for doctors are laid down in two laws other than the Health Act (they are not specified in the Health Act). Also, there are practically no strict secrecy requirements for social workers; they are only mentioned in their code of ethics and not in any law.

4.2. Criminal law

The Hungarian Penal Code (Act 4 of 1978) is being rewritten at the moment — a draft of the Penal Code was released for public debate on 9 February 2012 (1). In the following section I will present the law currently in force with an eye on the possible revisions according to the draft.

In Hungary, there is no specific law on FGM. According to experts and according to the ‘Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence’ (Pap, E., Spronz, J., Wirth, J. (2010), ‘Hungarian national report,’ European Union), FGM could be prosecuted under Article 170(4) of the Penal Code, which specifies punishment for bodily assault: ‘If the bodily assault causes permanent deterioration under Article 171(3), the penalty being

Original, upon the suggestion of a criminal lawyer, I included, but finally upon the argument of the representative of the Helsinki Committee I decided not to include, the following possible crimes which might be used against FGM: Article 285 on quackery and Article 171(3) on voluntary abuse of one’s profession causing permanent disability. Quackery applies to those who perform acts that are only allowed to be performed by a doctor. The penalty is a maximum of one year imprisonment, or a maximum of three if under the pretence of being a doctor. Gyulai’s argument against using quackery was that those who perform FGM do not perform activities that any doctor would perform as it has no medical value. In the draft new Penal Code this will be punished under Article 187 and the penalty is not changed.

The other crime I omitted was voluntary abuse of one’s profession causing permanent disability or severe health deterioration under Article 171(3), the penalty being a maximum of five years imprisonment. In the case of this crime, the perpetrator can also be forbidden to practise their profession for a definite or indefinite period of time. First I included this crime assuming doctors might perform FGM, however, after taking into consideration Gábor Gyulai’s arguments, I decided to omit it as it is unlikely that a licensed doctor would perform FGM in Hungary. The draft new Penal Code puts this crime under Article 165(3) setting a minimum of one year and a maximum of five years imprisonment. However, as this crime has actually been committed by doctors in the UK, it might be relevant in Hungary as well.

Extraterritoriality

If the crime is not perpetrated on the Hungarian territory (including Hungarian water vehicles and planes even if outside the borders), the Hungarian criminal law applies if the perpetrator is a Hungarian citizen. As Balázs Sahin-Tóth informed me, this includes refugees, those with subsidiary protection and tolerated status (általános befogadás), and those with a residence permit; they are all subject to the

(1) In the excel database on Hungary I only referred to the Penal Code currently in force and I did not mention the new Penal Code due to the short time between submission deadline and the availability of the draft law.
criminal law. If the perpetrator is not a Hungarian citizen (and the crime is committed outside the Hungarian territory), then it can be punished according to the Hungarian Penal Code if the crime is punishable in the country where the crime has been committed (exigency of double incrimination). The draft of the new Penal Code introduces a slight change in this regard relying on the passive personality principle: even if the crime is committed outside Hungarian territory, even if the perpetrator is not a Hungarian citizen and the crime is not punished where it was committed, the Hungarian Penal Code can be applied if the victim is a Hungarian citizen. However, there is a provision to this: the perpetrator has to be on Hungarian territory and the chief prosecutor has to decide if he or she initiates the procedure.

Expiration for prosecution

There have not been significant changes to this in the past years. However, in the draft new Penal Code expiration times are generally longer: the minimum expiration time has been increased to five years (from three years) otherwise as much as the maximum length of penalty for the particular crime (for certain crimes there is no expiration). Also, a new concept has been introduced in the draft: the expiration time for prosecution in case of human trafficking of or sexual violence against minors starts after a minor-victim has reached the age of 18 and it is for a minimum of five years.

There have been no criminal cases on FGM in Hungary. There is no registration of such cases. As Viktória László pointed out there is no category for this at the police. She has not heard of any such cases but it would not be seen in the national statistics because there is no category for FGM. She was hesitant as to what would be the right category of crime for FGM.

4.3. Child protection laws/provisions

In Hungary a separate Child Protection Act was voted for in 1997 (Act 31 of 1997). The law used international models, especially the British Child Protection Law. The law entered into force on 1 November 1997 and has been amended since. This law governs child protection in Hungary.

The Hungarian Child Protection Act (henceforth CPA) does not mention FGM. Guidelines on child abuse do not mention FGM. There is no central/national agency that deals with FGM cases in the child protection system (the experts consulted for this study were István Szikulai and Ién Farkas) and it was reported that there had been no such cases so far in Hungary. He added though, that detection is always an issue, which means that child protection workers and professionals connected to the system do not learn about particular instances of child endangerment. According to a child welfare worker who works in a service located in a Budapest district where the number of African immigrants is perhaps the highest, there have been no such cases in the Hungarian child protection system.

The Hungarian Child Protection Act states that ‘children have the right to grow up in their own family that ensures their physical, mental, emotional and moral development; healthy growing up and welfare’ (Article 6(1)). The law also stipulates that children have the right to ‘receive help to grow up in their own families, to develop their personality, to fend off situations endangering their development, to integrate society and become able to live independently’ (Article 6(2)). The law also says a child ‘has the right to human dignity, to be protected from… abuse, including physical, sexual and emotional violence. A child cannot be subjected to torture, physical punishment and other forms of cruel, inhumane and degrading punishment or treatment’ (Article 6(5)). Article 11(1) stipulates that the protection of children’s rights is a ‘duty by all natural and legal entities that nurture, educate, care for or arrange matters for the child.’ Article 12(4) states that parents must ‘respect their child’s dignity as laid down in Article 6(5).’

The Hungarian child protection system operates a notification system in order to effectively defend children’s rights. Article 17(1) lists the professionals who have a duty to notify either the child welfare service, or one of the authorities in case of child endangerment. The professionals included are doctors, health professionals, social workers, teachers, child psychologists (for a detailed list, see Section 4.5, Professional secrecy provisions). If the endangerment is not severe, they are obliged to notify the respective child welfare service; if the endangerment is severe, they are to notify one of the authorities (primarily the guardianship authority, which is either the guardianship office or the notary). Endangerment is defined as ‘a state resulting from either the child’s or another person’s behaviour, actions or lack thereof, or a situation, which obstructs or hinders the physical, mental, emotional or moral development of a child’ (Article 5(n)). The broad definition of the term endangerment and the difficulty to decide what counts as ‘severe endangerment’ has caused problems in application. Partly due to this, Section 2 was inserted in Article 72 to define severe endangerment as ‘an abuse or neglect that directly endangers the child’s life or causes significant and irreparable harm in the physical, mental, emotional or moral development of the child’ (in force since 1 January 2003). Plans to perform FGM on a child should count as endangerment, thus either the child welfare authorities or the guardianship authority should be notified. According
to the severity of a case, either counselling is provided to the child and the family (voluntary service) or the child is put under ‘protection’ if it is presumed that with help improvement is still possible in the family environment (mandatory). In case of severe endangerment (Article 72(2)), the child is immediately removed from the family for a certain period of time (one to two months according to the law) during which time the guardianship office decides on long-term solutions (the child can either return to their family or needs to be separated from their family and stay with foster parents or in a children’s home).

As FGM is not specifically referred to as a possible form of endangerment in law or in the guidelines on child abuse (I consulted two guidelines and asked expert István Szikulai on this) and due to the lack of information provided to professionals on FGM, child protection workers may be uncertain as to the assessment of endangerment and the criminality involved in case of FGM. Irén Farkas, child welfare worker, said that she had participated in a discussion on FGM in the mid-90s, at a time when there was a big increase in the number of African refugees, with the participation of social workers and representatives of African communities and the community representatives who argued that female genital mutilation was in fact ‘circumcision,’ very similar to male circumcision, hence if ‘female circumcision is forbidden, male circumcision should be forbidden as well’. This social worker said it would be very difficult to act properly in a situation where an immigrant family follows their tradition and would like to have FGM for their child, and the child agrees to it, as a child is entitled to ‘freedom of thought, conscience and religion’ according to the UN Convention on the Rights of the Child. She believes that through gaining the child’s confidence and convincing her that it is wrong, a social worker might achieve positive results in such a situation. Child protection expert István Szikulai, on the other hand, argued that such a case would require immediate intervention as it is an example of child endangerment and it is a criminal case.

4.4. Asylum law(s)/provisions

The Asylum Act (Act 80 of 2007) determines the conditions for receiving the refugee status. It follows the Geneva Convention. The definition of ‘refugee’ (Article 6(1)) was the direct translation of the definition of refugee in the Geneva Convention until recently but the law was amended and changed in 2011, and entered into force on 1 January 2012. Article 6(1) now refers to Article 14(3) of the (new) Convention, which says ‘Hungary — in case they lack nationality, being part of a particular social group, religious orientation or their gender.’

According to a lawyer from the Office of Immigration and Nationality, FGM asylum claims are granted, based on the possibility of future persecution, that is, future FGM or the consequences of type III FGM (which, she says, has future consequences). According to her, the Office examines the country of origin of the asylum seeker and even the region within the country to see which type of FGM is practised in the region where the asylum seeker is from: whether there is a practice of repeating FGM before marriage or if it is type III FGM, which has severe future health consequences. In these cases FGM claims may be granted. In other situations, when there is past FGM and there is no tradition of repeating FGM, and it is not type III, which is practised where the asylum seeker is from, individual circumstances may be taken into considerations (e.g. whether FGM has resulted in severe mental or physical consequences, due to which return to the country of origin would be harmful and the person should be protected). According to her, ‘our experience has been that the women who have undergone FGM claim that as well as having FGM they have also been raped, and since the danger of this is still present in the future, they are granted asylum on those grounds.’ According to her, two gender guidelines are used at the Immigration Office: one published by UNHCR (http://helsinki.hu/wp-content/uploads/UNHCR_Nemi_hovatarozas.pdf), the other being a Hungarian in-house publication. I did not receive permission to access a copy of the latter and it is not available on the Internet. The UNHCR document referred to above is included in the 2003 UNHCR publication listed among the tools in the excel database. She also pointed out Articles 66(2) and (3) of the government decree on the implementation of Act 80 of 2007, which stipulate that if the asylum seeker has suffered gender-based violence, the Office has to provide a translator and an officer of the same gender, at the request of the asylum seeker.

The Office of Immigration and Nationality (OIN) keeps record of asylum claims but there is no statistical category for FGM claims. Therefore there is no information as to how many asylum claims are based (at least partially) on FGM. An example of an OIN statistical table can be found in Section 1, Prevalence, which is data on the number of claims, granted refugee and other statuses disaggregated by gender and country of origin in 2010. My request for such data for the past 20 years was not granted by the OIN with the explanation that the Office does not have the capacity to collect such a huge amount of data. My second request

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(*) The ‘new’ — highly debated — constitution was accepted in 2011 and came into force on 1 January 2012.
The court ordered another procedure as according to its grounds:

- in the later decisions (as well as changes in the argument of the court); Between the date of the first decision in the database and the day when I received information from the OIN, there have been training courses for OIN staff on gender issues, such as Gábor Gyulai’s yearly seminar, since 2009, on current issues of refugee law and practice, including FGM (covering refugee and criminal law aspects, as well as general information, including case study and interactive exercise) for OIN staff and other participants, such as judges, lawyers, and NGOs staff (the information material on FGM used in the training courses should also be mentioned). The new Asylum Act, which specifically mentions gender-based violence as a form of persecution (with FGM named in the explanation), came into force on 1 January 2008.

**About the cases in the database**

In all seven cases the OIN rejected the refugee claim (otherwise they would not be before the courts) and in four cases it also rejected tolerated status (temporary protection for one year). The OIN’s arguments for rejection of the refugee status was mainly based on arguments as to the possibility of receiving protection in the country of origin and the internal flight option, on the inconsistencies of the claim, and hence questioning the credibility of the claim. The court accepted the appeals in three cases (out of the seven) and in these cases it criticised the OIN’s decision on the following grounds:

1. The court ordered another procedure as according to its view the information on the country of origin was not correct and the country does not provide protection against FGM. Even though the claimant already had FGM (there was no future danger), her five-year-old daughter is exposed to the danger of FGM, which the OIN did not examine at all, nor did it assess the option of internal relocation realistically for a single mother (date of OIN decision: June 2008).

2. The Court did not find the OIN’s opinion of non-credibility well founded. It also found the argument contradicted itself, and it ordered a repeat of the procedure. The OIN’s argument here was that, despite the fact that FGM is legal in the country and internal flight is not feasible for a single woman, in the particular case of the woman it did not find the fear well-founded, partly because her claim did not seem credible. They argued that it is not the general situation of the country, but the particular, individual persecution that needs to be proved (Date of OIN decision: November 2008).

3. The Court did not accept the country of origin’s information in light of other sources (Amnesty International) and did not accept the OIN’s claim about the non-credibility of the claimant. The Court changed the OIN’s decision and granted refugee status to the claimant. FGM was not the basis for the claim as the woman had it done at the age of 10 but it counted as a form of torture in the past (besides rape and piercing attack in genitalia by armed men) (Date of OIN decision: May 2009).

In two cases where the appeal was rejected, the court claimed that the country of origin provided protection against FGM, while in one case the court claimed that internal flight was an option and in two of these cases (date of decisions: 2006 at OIN, 2007 at court; 2008 at OIN and 2008 at court) they further argued that the claimant did not prove to be credible (in one case based on the fact that she changed the ground of her claim from fear of violence by a relative to FGM during procedure and didn’t give adequate explanation for this change; in the other case, based on inconsistencies in her claim). In one case the claim was made by a man who helped the flight of a woman threatened by FGM; in his case the OIN and the court both found that based on this action he would not be persecuted in his country of origin (where FGM is illegal).

According to the study by the Hungarian Helsinki Committee ‘Analysis of gender-related asylum claims in the Hungarian asylum procedure’ one of the biggest problems currently regarding the decisions on FGM cases by the OIN is the country of origin information (COI) used by the Immigration Office. This information is not publicly available and according to Gábor Gyulai the COI does not seem to be accurate or realistic as to the possibilities of internal flight alternative or available protection in the country of origin.

The OIN does not register the number of FGM-related asylum claims.

### 4.5. Professional secrecy provision(s)

Of the professions relevant for reporting FGM (doctors, health professionals, social workers, teachers) professional secrecy provisions are laid down in law for teachers, doctors and health professionals (medical secret), and for social workers and psychologists it is their ethical code that gives guidelines on secrecy.

The most clearly outlined secrecy provisions are for doctors and health professionals. Other than processing data for bodies specified in the Health Act and the Health Data Procedure Act, doctors and health professionals are required to disclose data on their patients if:

- the law requires it;
- it is necessary in order to protect other people's lives, bodily integrity, and health (Article 25(3) of Act 154 of 1997 (Health Act)).
In the case of doctors, there are two laws that require doctors to report: Article 17 of the Child Protection Act (Act 31 of 1997) (this applies to health professionals and other professionals as well) and Article 24(1) of the Health Data Procedure Act (Act 47 of 1997).

**Article 17 of the Child Protection Act (Act 31 of 1997)**

This requires all professionals working with a child to report:
1. to the child welfare service if the child is endangered;
2. to an authority and initiate procedure (primarily the guardianship authority but it can also be the police) if the child is abused, severely neglected or in case of any other severe endangering factor, and if the child's behaviour is severely endangering (dangerous to himself or to others).

Besides doctors, other professionals who are in touch with a child through child protection work are obliged to report, according to Article 17 of the CPA. Article 17(1) specifically mentions professionals who are under this obligation:

(a) doctors and other health professionals, especially those in touch with children, paediatricians, community child health and woman health workers (védődnő);
(b) family social workers;
(c) kindergarten and school personnel and educational/child care advice centres;
(d) the police;
(e) the Prosecutor's Office;
(f) the court;
(g) protection/supervision service for those who committed a crime (but are not incarcerated);
(h) bodies that help victims and reduce damage;
(i) refugee camps and temporary homes for refugees;
(j) NGOs, foundations, churches;
(k) labour authorities.

The law entered into force on 1 November 1997 with this provision (Article 17(1)), however it was modified as of 1 January 2003 in order to make it clearer which situations to report and to whom (endangerment to the child welfare service, severe endangerment to an authority). Reporting on child endangerment has been a sensitive issue in Hungary as it is difficult for professionals to assess the degree of child endangerment, partly because the term ‘endangerment’ is not defined clearly enough in legislation or other documents. Although there have been guidelines on how to notice and how to react to child abuse, which is one form of endangerment, considerations as to the privacy of the family and the general acceptance, until recently, of corporal punishment, results in the varied attitudes to reporting to authorities or the child welfare service. In the case of FGM, interpretations on the respect for cultural traditions might also come into play and as long as there is not enough information on FGM and guidelines on how to react on an FGM case, professionals will have diverse responses and will report or not report according to this.

Partly due to late reporting or failures to report in cases of child endangerment, in 2009 Section (4) of Article 17 was introduced, according to which if a professional fails to report in case of endangerment, the Guardianship Office initiates disciplinary action against them, and if there is suspicion of crime against a child, the Guardianship Office will initiate criminal procedures. In case of non-reporting by a child protection worker (or any other failure to fulfil their professional duty) one form of punishment can be a fine (also paid by the institution where they work) (Article 100/A of the CPA) or the obligation to attend a specific training course (Article 100/B of the CPA).

Besides doctors and health workers, Article 17 of the CPA thus requires social workers, teachers and psychologists working with children to report in case of child endangerment as well.

In the case of doctors, this requirement is repeated in Article 24(3) of the Health Data Procedure Act, which says that a doctor has to immediately notify the Child Welfare Service in their district if they treat an injured child and it can be assumed that the injury or illness is the result of negligence or abuse, or if the doctor learns about child abuse or negligence while treating the child. The guardianship authority is not mentioned in this case.

**Article 24 (1) of the Health Data Procedure Act (Act 47 of 1997)**

This article requires doctors to report to the police if they treat a person (not necessarily a child) who has an injury that takes more than eight days to heal (serious bodily injury) and it can be assumed that the cause was a crime. As FGM would be prosecuted under ‘bodily assault causing permanent disability’ (Article 170(4) of the Penal Code), that is, as one form of serious bodily injury (healing in more than eight days), doctors are required to report it if they deem that the cause was a crime. As FGM is not specifically mentioned in the Penal Code, and as there is little information about it in Hungary in general and also among professionals, it might happen that a doctor will not consider FGM injury a crime in the case of adults. However, theoretically, they are under the duty to report.


The Ethical Code for Psychologists stipulates that a psychologist must disclose data if the law requires it or if other people’s protection requires it (Article 5.4 of the Ethical Code for Psychologists). In the case of psychologists, Article 17 of the CPA applies, according to which psychologists have to report in case of child endangerment. No other law requires disclosure of data. The other provision in the ethical code is less concrete and refers to the protection of persons other than the client. Regarding parents or carers, the psychologist has the right to disclose information if non-disclosure would aggravate the mental health of their client. Psychologists may disclose information to the parent at any time but only if they deem that disclosure will not harm the child and is not against the child’s interest (Article 5.5 of the Ethical Code for Psychologists).

The Ethical Code for Social Workers stipulates that a social worker’s responsibility to secrecy might be modified in certain cases — such as for a crime or abuse — by their sense of social responsibility or other obligations, but this
must always be communicated to the client’ (Article 11 of the Ethical Code for Social Workers). Article 17 of the CPA also applies to social workers who work with children or families; which means that they are under the duty to report. There is no other legal obligation for reporting; however they are not bound by secrecy law: if their ‘social responsibility’ requires it, they are free to disclose information.

Article 40 and Annex 2 of the Public Education Law (Act 79 of 1993) confirms the reporting duty for teachers in case of child endangerment (Article 17 of the CPA). Other types of reporting duty (besides those related to educational procedures) are not specified for teachers.

In the case of non-reporting, in case of child endangerment, the Guardianship Office initiates disciplinary action against the professional at the professional’s employer, and if there is suspicion of crime against the child, the Guardianship Office initiates criminal procedures. In the case of child protection workers, a fine can also be levied, or mandatory training can be required. If doctors fail to report a ‘serious bodily injury’ which might be connected to crime, this can also draw disciplinary actions (the employer decides).

Other than the provisions detailed above, all professionals have detailed instructions as to to which bodies they need to release data automatically or at request.

There is no reporting centre for FGM.

In conclusion, reporting FGM, which in Hungarian law could be prosecuted as a ‘bodily assault causing permanent disability’ and also severe child endangerment (as it obstructs the physical development of children, and as it is abuse) has two forms of regulations: if FGM is (about to be) performed on a child; or if FGM has been performed on an adult. In case the victim is a child, all professionals working with children have a duty to report either to the Child Welfare Service or to an authority (to the Guardianship Authority or to the police) according to the Child Protection Act (Article 17). It all hinges on whether professionals identify the danger of FGM as severe endangerment or not. Currently FGM is not mentioned in guidelines on child abuse, which makes it more difficult for identifying it as severe endangerment (I consulted two guidelines and asked a child protection expert). If the victim is an adult, reporting is a duty only for the doctor, as doctors have the duty to report to the police if they encounter a bodily injury which heals in more than eight days and it can be assumed that the cause of the injury was a crime. Since FGM is not named in criminal law, it is again a question of whether doctors would interpret an injury from FGM as a crime.

4.6. Reflection on legal framework

In Hungary there is no specific law to punish FGM. There seems to be no trend to move in this direction. However, a completely new penal code is being written at the moment. The draft was released for public debate on 9 February 2012 and this might offer an opportunity for NGOs to lobby for a specific article on FGM. However, as the Advisory Board of Gynaecologists (attached to the Minister of State for Health) assumes that the number of women living with FGM is very low and thus considers FGM insignificant in Hungary (phone conversation with the head of the Advisory Board and e-mail correspondence), this idea might not be supported by the profession of gynaecologists. Regarding changes in the legislation on FGM, until now the only change has been in the asylum law and the application of that law.

Hungary signed the Geneva Convention in 1989, but until 1997, it used territorial restrictions and it only accepted European asylum seekers. From 1997, Hungary is accepting asylum seekers from non-European countries as well and this has increased the number of asylum seekers from outside Europe. The current Asylum Act was accepted in 2007 and the Justification of this act specifically mentions FGM as an example of gender-based violence. The Justification of the earlier Asylum Act did not list FGM, and the earlier Asylum Act did not specifically mention gender as a possible ground for refugee status. According to information from a legal officer at the Office of Immigration and Nationality, the Office uses guidelines on gender-based persecution, FGM among them. If any attention has been given to FGM in legislation, then it was in the asylum law. At the same time, according to NGO information, this awareness is not always reflected in individual decisions on cases involving FGM; although there might have been some improvement due to training courses in this regard (from 2009, by the Hungarian Helsinki Committee).

According to a representative of the Helsinki Committee, the main problem in the actual application of the law when determining refugee status is the information on the country of origin used by the Office of Immigration and Nationality, which is not made public and which, according to Gyulai, often does not reflect real circumstances regarding protection or options of internal flight options. Also, the OIN does not collect statistics on the number of FGM asylum claims in a given country.

According to the various sources I have consulted (NGOs working with refugees, gynaecologists, statistics on asylum seekers, and refugees from 2010), the number of female asylum seekers and refugees from African countries in general and specifically from countries where FGM is practised is very low. This is definitely one reason why FGM has not received much attention in Hungarian legislation. As Leye and Sabbe write about central and eastern European countries, ‘At present, other important issues are demanding the attention of policymakers. Violence against women, in particular domestic violence, is a massive problem’ (Leye-Sabbe 43).

Based on the various formal and informal conversations on FGM I have had with various professionals, it seems that professionals who might potentially encounter FGM cases do not have a clear idea as to its criminality. Even though professionals working with children have a duty to report to the Child Welfare Service in case of child endangerment, and to the authorities in case of severe child endangerment, and, furthermore, although doctors have a duty to report any serious injury (healing after eight days) if crime is assumable, until these professionals have a clear understanding of FGM and that it is a criminal offense, they may fail to report it. The crux of the matter is whether the
professionals who might encounter FGM or risk of FGM (for instance a family who is planning FGM for their young daughter) consider it as a crime or child endangerment, or rather as a cultural specificity not to be interfered with. As of now, since there is very little information about FGM among child protection and health professionals it is not certain that professionals would take FGM as a severe endangerment or as abuse. This might prevent or delay reporting to authorities. Another factor is detection and whether professionals are aware of particular cases of FGM. I believe that a clear reference to FGM in the Penal Code might help in this. Guidelines and training courses about FGM as a potentially severe endangerment would be particularly useful for child protection and social workers. Similarly, awareness raising among doctors would be useful so as to make them realise that FGM is to be punished and they have a duty to report it. I recently received information that within the framework of the ‘End FGM’ campaign, MONA (the Foundation for the Women of Hungary) is organising a seminar together with the Hungarian Helsinki Committee (and Menedék is also involved) on FGM for health professionals and social workers (including child protection workers). However, despite the invitation, no member of the Advisory Board of Gynaecologists (attached to the Minister of State for Health) will attend the seminar since after discussing the issue at a meeting they came to the conclusion that FGM ‘was not significant in Hungary’ (e-mail correspondence).

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

First I asked colleagues and friends if they knew of other relevant FGM-related actors to contact besides the ones I had already contacted (the Hungarian Helsinki Committee and Menedék — the Hungarian Association for Migrants). I contacted those which were recommended and they further recommended others. I also searched the websites of the actors who had been recommended to find other potential actors and also the NGO NANE website, a large NGO on women’s rights. Regarding ministries, I searched the government’s website (including all ministries), the Ministry of National Resources and the Ministry of Public Administration and Justice’s websites from before 2010, and the former Ministry of Health’s website.

5.2. Actors

NGOs are the main actors on FGM in Hungary. Besides NGOs, UNHCR has done a lot to disseminate a gender-sensitive approach in the Hungarian asylum system. There are also some individuals (in one case connected to an NGO) who have done research on FGM or on violence against women. Altogether I found five NGOs as actors, four of these have done more activities related to FGM.

1. The Foundation for the Women of Hungary (Magyarországi Női Alapítvány, MONA): MONA is the Hungarian partner of the ‘End FGM’ European campaign. It regularly organises awareness-raising events on FGM for the general public and it is an occasional partner of the Hungarian Helsinki Committee in giving training courses on FGM.

2. The Hungarian Helsinki Committee (Magyar Helsinki Bizottság): the HHC has organised training courses on FGM (Gábor Gyulai), represents refugees (among them women with FGM) at court (e.g. for appeal cases) and has done research on the asylum system (e.g. on the gender sensitivity of the Hungarian asylum system).

3. Menedék (Hungarian Association for Migrants, Migránsokat Segítő Egyesület): Menedék is providing social services for refugees; among them women with FGM (it has experience with women living with FGM).

4. The Cordélia Foundation for the Rehabilitation of Torture Victims (Cordélia Alapítvány — a Szerzett Erőszak Áldozataiért) — Cordélia provides psychological service for victims of torture (among them women with FGM, and it has experience with women living with FGM).

5. The NANE Women’s Rights Association (Nők a Nőkért Együtt az Erőszak Ellen Alapítvány) — NANE has a page on its website which gives information on FGM as one form of violence against women.

With regard to research on FGM, the Foundation for the Women of Hungary (MONA) is to be consulted. They have done a number of campaigns and lobbying in the framework of the ‘End FGM’ campaign. They organise training courses, discussions and research on gender issues. The Hungarian Helsinki Committee has worked on the asylum aspect of FGM: through litigation, training courses and research. Menedék — the Hungarian Association for Migrants and Cordélia Foundation have done social work, psychiatric and mental health work among refugees, during which work they have met women with FGM.

5.3. Reflection on actors on female genital mutilation

The issue was first taken up by the asylum sector, first and foremost by UNHCR. After UNHCR, it is the NGOs working with refugees that have had experience with the issue, partly because they have met FGM-affected women through their work (Menedék, Cordélia). The Hungarian Helsinki Committee, which is a human rights NGO for refugees and other marginalised groups, started doing training courses in this regard in 2009 (Gábor Gyulai). NANE, an NGO combating violence against women, put information on FGM as a form of violence against women, on its website (no information on when). Since the ‘End FGM’ European campaign was launched, MONA (the Foundation for the Women of Hungary) has been actively organising the Hungarian campaigns in the ‘End FGM’ framework as a partner organisation. Regarding NGO activities (there is basically only one in Hungary) the recent year seems to be more eventful (since the beginning of 2009).

It seems that the issue of FGM has been mainly taken up by NGOs. Information has been provided to the asylum system (immigration office, judges and lawyers), and according to the information I received, officers at the Office of Immigration and Nationality are competent in this regard — mainly as a result of the work done by UNHCR and NGOs. The Hungarian Helsinki Committee (Gábor Gyulai) gave training courses including sessions on FGM to OIN
staff and also to judges and lawyers. The HHC gave training courses focusing on, or including, sessions on FGM to social workers and medical staff who work with refugees (2009 and 2011). Apart from NGOs the other main actors are in the asylum sector (OIN officers, judges, and medical staff for refugees) where professionals have information on FGM from a human rights’ point of view.

Regarding state actors outside the asylum field, and more specifically ministries, there has been no action on FGM so far. Upon asking government officials and health professionals involved in the decision-making on why that is (see Section 3.1), I was told that the number of women living with FGM in Hungary is very low and thus the issue is not significant in Hungary.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

When contacting the experts and NGOs, individuals from the ministry, the health sector or the immigration office, I always asked for tools and instruments (guidelines, protocols, material on FGM). I also checked the following NGOs’ websites: NANE, MONA, and Menedék (the Hungarian Association for Migrants), the Hungarian Helsinki Committee, and the Cordelia Foundation. In the asylum field, there have been various tools and instruments produced, while outside the asylum field there have been various campaigns for the general public as well as lobby activities. Regarding training courses outside the asylum sector, there is an upcoming seminar, which also targets child protection workers and gynaecologists (I was informed about this via e-mail by MONA and Cordelia).

6.2. Tools and instruments on FGM

The majority of the tools and instruments were produced by the NGOs with only one being produced by UNHCR.


2. ‘Sign a rose petal’ campaign organised by MONA: awareness-raising campaign targeting the general public (November to December 2010) with a list of places where one could sign the paper rose petal saying ‘End FGM’.

3. Related to the event above (‘Sign a rose petal’ campaign, November to December 2010), MONA issued a two page description on FGM.

4. Related to the event above (‘Sign a rose petal’ campaign, November to December 2010) MONA published a flyer for the event.

5. Letter-writing to the Heads of the Hungarian Office for Immigration and Nationality to make the asylum system and the European Asylum Support Office gender-sensitive (according to the international campaign) — participating organisations: MONA and the Hungarian Helsinki Committee (HHC).

6. Training material compiled by Gábor Gyulai (HHC) on FGM (used in training courses where FGM is tackled, such as the yearly seminar on current refugee law and practice (from 2009) and also at the 2011 seminar mainly on FGM for social workers and health professionals working in the Békéscsaba detention centre). This material is not publicly available.

7. Public reading from a book called ‘Mutilated’ and a photo exhibition on violence against women. Discussion on violence against women after the reading. The event was organised by MONA on 10 December 2011.

8. Press release to call on European decision-makers to sign and ratify the Council of Europe Convention on preventing and combating violence against women and domestic violence — by MONA (3 February 2012).

9. Gensen Project to make asylum workers more sensitive to gender-based persecution and harmonise the European asylum procedures and make it more gender sensitive overall — the Hungarian Helsinki Committee (a country report is part of this) — October 2010 to March 2012.

10. One page information on FGM on NANE Women’s Rights Association’s website — no information as to when it was uploaded.

Targeted tools, such as training courses and guidelines for a particular field or profession, have made an impact. A social worker working with refugees I talked to and an OIN officer I e-mailed mentioned the guidelines produced by UNHCR, and the OIN officer also mentioned gender-sensitivity training courses as helpful tools.

Most of the tools were made by MONA in the framework of the ‘End FGM’ European campaign addressing the general public or decision-makers/state actors relate to the ‘Sign a rose petal’ campaign targeted at the general public. The December 2011 public reading event also targeted the general public. MONA (jointly with other organisations) also addressed decision-makers by letters or publicly calling on them. They also make those lobby events public by press releases.

6.3. Reflection on tools and instruments on female genital mutilation

Regarding available tools and instruments on FGM in Hungary, they are either awareness-raising material for the general public (campaigns, information flyers, webpages, discussions), lobby instruments targeted at decision-makers, or information material on FGM for professionals in the asylum sector. The fields that are missing are the child protection sector and the health sector (other than the health sector working specifically for refugees), although this is beginning to change as the training of 27 February 2012 targeted child protection workers and gynaecologists as well.

Actual hands-on material is rare even in the asylum sector; most are events, such a campaign or training courses (training ‘notes’ are included in the database). The trend is that NGOs have increased the number of activities in recent years (campaigns and training courses) beginning from 2009. The international and European campaigns and actions have definitely had a positive influence (e.g. ‘End
FGM' European campaign). There is no government-issued tool or instrument.

However, according to a social worker at Menedék, practical information (guidelines or protocols) as to how to approach FGM in practice, should a social worker, for instance, meet a family which might keep the tradition of FGM, is still missing. She said that she was trying to ‘translate’ the UNHCR’s guidelines ‘Sexual and gender-based violence against refugees, returnees and internally displaced persons — Guidelines for prevention and response’ into real-life situations. Practical guidelines for social workers, child protection workers, related professionals (teachers, child psychologists), and health professionals would be useful (even if online publication).

7. FINAL CONSIDERATIONS

FGM has not received much attention from the state in Hungary. There is no FGM policy, specific FGM criminal laws, or specific reference to FGM in guidelines for professionals in the child protection or health sector. The only area where FGM is specifically covered is the asylum sector: since 2007 the new Asylum Act contains reference to gender-based persecution and also to FGM in the justification (explanation) of the law. Internal and UNHCR guidelines used at the Office of Immigration and Nationality also give information on FGM and the legal aspect of it in the asylum procedure. The professional guidance of UNHCR and the work of the Hungarian Helsinki Committee were important for the asylum sector to familiarise themselves with FGM. However, besides the asylum sector, due to the lack of central attention to this question, professionals lack information as to the nature of FGM, its criminal evaluation and guidance of what to do should they encounter it during their work.

It is in NGOs that FGM has received the biggest attention in Hungary. This attention has increased in the past few years; Gyulai Gábor from the Hungarian Helsinki Committee has given annual training courses to professionals (OIN officers, judges, lawyers, UNHCR staff, NGO staff) since 2009, and in 2009 he gave training courses to social workers working for refugees, while in 2011 also to the staff (social workers, medical staff) in the Békéscsaba Detention Centre (the only detention centre where women are held). MONA (Foundation for the Women of Hungary) has been involved in the ‘End FGM’ campaign, has coordinated various awareness-raising activities and has lobbied state actors (through letters).

One reason for the lack of attention on FGM is the low number of immigrant women from countries where FGM is practised. This was confirmed by NGO staff, experts, and state actors. Besides, as mentioned in the Leye-Sabbe article, there are other more pressing considerations which state actors consider more important for spending resources on (Leye-Sabbe 43). However, the 100 to 200 women with FGM, whom the MONA study estimated to be currently living in Hungary, should also get attention. Given their low number, perhaps the state should design a targeted approach. Furthermore, as there is no mainstreamed information on FGM (in guidelines and protocols), detection remains difficult. However, the immigration situation may change and the number of immigrants from affected countries may increase in the future as well as the second generation of immigrants; for this, a mainstreamed approach would be preferable.
Country report

Ireland
1. IDENTIFICATION

Country: Ireland
Researcher: Siobán O’Brien Green

Please note for the purposes of brevity in this report any reference to the ‘national steering committee’ implies Ireland’s national steering committee for the national plan of action to address female genital mutilation. Any reference to the ‘plan of action’, ‘national plan of action’ or ‘NPA’ implies Ireland’s national plan of action to address female genital mutilation 2008–11.

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

There have only been two studies, in 2008 and 2010, that attempted to estimate the prevalence of FGM in Ireland and both studies have been undertaken by Sudha Patel commissioned by AkiDwA, a national network of African and migrant women living in Ireland. I commissioned the first study while working in AkiDwA in the summer of 2008 when Ms Patel was my student intern from Duke University. This was due to the complete absence of any data on FGM prevalence in Ireland which was impacting on the work of the AkiDwA Migrant Women’s Health Project. At first we examined maternity hospital patient charts to assess if we could use data from these charts to extract some nature of FGM prevalence data. At this point each maternity hospital in Ireland tended to use their own unique patient chart which made it impossible to collate data in the same format across Ireland. Therefore a statistical extrapolation method using data from the most recent Irish census was decided on. I commissioned the second FGM prevalence study from Ms Patel in summer 2010 again when I worked in AkiDwA. This was due to concerns that a decline in inward migration to Ireland could reduce the need for work, legislation and support regarding FGM in Ireland. A meeting was held with Ms Patel for the purposes of this research to discuss these studies. Future data collation for FGM prevalence is planned in 2012 using recent figures from the Irish Census 2011.

Information was sought on the new National Maternity Healthcare Record (NMHCR) and the ethnic identifier form used in looking at some maternity hospitals in Ireland from:

• Health Service Executive (HSE) National Planning Specialist: Social Inclusion

2.2. Nature of prevalence studies/FGM registration systems

There have only been two studies, in 2008 and 2010, that attempted to estimate the prevalence of FGM in Ireland and both studies have been undertaken by Sudha Patel for AkiDwA as part of the work of the Migrant Women’s Health Project. The initial AkiDwA study in 2008 was modelled on a similar study by the organisation Forward UK ‘A statistical study to estimate the prevalence of female genital mutilation in England and Wales, 2007’. This study was funded by the Department of Health and in collaboration with the London School of Hygiene and Tropical Medicine and the Department of Midwifery, City University, and it formed the basis for the first Irish prevalence research. The Irish prevalence research used a previously tested model to produce a credible measure of FGM within Ireland and estimated that 2,585 women living in Ireland had been subjected to FGM and 9,624 women who completed the 2006 Irish census were from FGM-practising countries. This research provided the first estimate of the prevalence of FGM within Ireland and a rationale for AkiDwA’s work on FGM. See Appendix 1 for country breakdown of the data.

To determine this estimate for the number of women living in Ireland with FGM, relevant population data from the 2006 national census was obtained from the Central Statistics Office (CSO). The collected data included the number of women residing in Ireland from FGM-practising countries between the ages of 15 and 44, broken down by age group 15 to 24 years and 25 to 44 years, and country of origin. The number of women from each country and in each age group was then integrated
with applicable global prevalence data from the World Health Organisation, demographic and health surveys (DHS) and multiple indicator cluster surveys (MICS) from the most recent years available. The result of these calculations presents an initial estimate for the number of women living in Ireland who have undergone FGM as of April 2006: 2,585 women. It is important to note that the estimates determined in this study provide preliminary statistics of the prevalence of FGM in Ireland and are subject to several limitations. Census data are likely to be an underestimate, as some individuals and groups may be hesitant to participate in the census. There is a lack of information on the ethnicity of women who migrate to Ireland; as FGM is more linked to ethnicity than to nationality, this might have biased the results. In addition, this study did not take into account the influence of migration on the practice of FGM. Another limitation is the lack of information on women living illegally in Ireland (undocumented migrants). Finally prevalence data in countries of origin might not be up to date and thus not reflect recent changes in the practice. The results from this prevalence study were published in the national action plan and Female genital mutilation: information for healthcare professionals working in Ireland and subsequent Women’s Health Council (WHC) publications. The data was also presented at an information day on FGM for healthcare professionals, organised by AkiDwA in October 2008, and at the launch of Female genital mutilation: information for healthcare professionals working in Ireland in January 2009.

Migration trends in 2010 showing a decline in inward migration to Ireland led to a concern by AkiDwA that FGM could be perceived as less of an issue for Ireland and as a result it undertook a second prevalence study in 2010. FGM prevalence figures from the most recent demographic and health surveys (DHSs) and multiple indicator cluster surveys (MICSs) and World Health Organisation FGM country prevalence studies were applied to all migrant women in Ireland originating from countries where FGM is being practised who participated in the 2006 Irish census and was added to data from the Office of the Refugee Applications Commissioner (ORAC) on women seeking asylum in Ireland from FGM-practising countries from April 2006 to August 2010. After integrating the new data, it was estimated that an additional 585 women with FGM were residing in Ireland since the 2006 census, leading to a new estimated total of 3,170 women with FGM in Ireland in August 2010, and a female migrant population aged between 15 to 44 originating from countries where FGM is practised of 11,577 women. This 2010 updated estimate of the number of women residing in Ireland who have undergone FGM was launched in a press release by the national steering committee to mark International Day of Zero Tolerance to FGM February 2011.

There are no FGM registration systems currently in Ireland.

### 2.3. Findings from the prevalence studies/registration systems

Data on female residents in Ireland from FGM-practising countries is limited and as a result it is very difficult to determine FGM prevalence in Ireland accurately. In addition the following data is not available to access in the public domain in Ireland:

- number of girls at risk of FGM from African countries or origin;
- number of non-registered female migrants from African countries or origin;
- number of asylum-seeking women on grounds of FGM from African countries or origin;
- number of refugee women from African countries or origin;
- number of women from African countries or origin who are treated by health professionals for any health issue related to FGM;
- number of FGM cases that are registered in any registration system by services: health service, social services, police, asylum agency, etc.;
- number of daughters from women of African origin and their age.

This lack of data is often a result of how data is collected and collated in Ireland. The Central Statistics Office (CSO) manages the census in Ireland and then collates the data on it. A census usually takes place every five years and the last census took place in April 2011. In terms of ethnicity and cultural background the sections to complete on the census form are: ethnicity, place of birth and nationality. As a result of these categories it is impossible to access detailed data in the public domain to the extent needed to fully examine FGM prevalence in Ireland. Cross tabulation and data mining of the census data would be needed for a more accurate set of statistics to estimate FGM prevalence. AkiDwA has managed to obtain specifically requested data sets from the CSO census and used it to extrapolate estimates of FGM prevalence in 2008 but some data was withheld by the CSO for reasons of confidentiality. A similar approach to using CSO census 2011 data is planned in 2012 by AkiDwA.

Data on non-registered female migrants in Ireland is very limited. The Migrant Rights Centre Ireland has collated some data on clients presenting to their services who are undocumented. Their data comes from the following country categories; Philippines, China, Ukraine, Pakistan, Moldova, Brazil, Bangladesh, Mauritius and South Africa and Other but these countries are not relevant for FGM data collection and there is no country and gender breakdown.

Data from the Reception and Integration Agency (RIA) which is charged with providing accommodation and ancillary services to asylum seekers under the direct provision system is released in a series of monthly reports which are based on number of applications received at office of the Refugee Applications Commissioner (ORAC). ORAC also releases monthly statistical reports. However, both RIA and ORAC data only show data for the top five countries of origin for applications for declaration as a refugee, data which changes on a regular basis and is reflected in their monthly reports. At the time of writing this report, data was available for the categories Afghanistan, China, Democratic Republic of the Congo, Nigeria, Pakistan, Zimbabwe and Other. Gender is not broken down on a country basis and the ‘Other’ category is the largest. AkiDwA did however manage to get much more
detailed statistical data for the second FGM prevalence study in Ireland from ORAC in 2010. There are some limitations with this data as a person’s status can change quickly and/or they can be deported, in addition the data collected is not collated in the same way year on year relating to top six countries of origin therefore it is difficult to make annual comparisons.

2.4. Reflection on prevalence studies

The method whereby prevalence from FGM risk countries in Africa are extrapolated to numbers of women from FGM countries from the Irish census and ORAC has a number of limitations which cause a serious bias in assessing reliable prevalence data on FGM in Ireland. Data on FGM prevalence in Ireland only began to emerge with the work of the Migrant Women’s Health Project in AkiDwA in 2008. Prior to this, the Women’s Health Council for their literature review on FGM had tried to apply a code to the hospital inpatient enquiry scheme data from 2005 for FGM treatment, repair and pregnancy. However this was not possible due to a lack of a systematic application of the code. Until recently all maternity hospitals in Ireland used their own booking and patient charts which meant that it was also not possible to collate data on FGM from maternity settings as the data collection tools differed between hospitals. The introduction of the National Maternity Healthcare Record (NMHCR) in all maternity settings in 2012 should alleviate this issue as FGM is now listed in the new NMHCR, under risk factors number 22. But the tools to gather country of origin/birth and ethnicity are not contained in the NMHCR. Improved data collection on ethnicity is part of HSE work as outlined in the national intercultural health strategy 2007–12. The HSE ethnic identifier is a short questionnaire that is designed to be used in healthcare settings to include the aspect of ethnicity in patient information gathered. The patient questions are based on the Irish census ethnicity questions. Use of the ethnic identifier text appears below; the patient picks one response from the following during an initial appointment booking or during initial consultation:

1. White;
   - Irish
   - Irish Traveller
   - Any other white background

2. Black or Black Irish;
   - African
   - Any other African background

3. Roma

4. Asian or Asian Irish;
   - Chinese
   - Any other Chinese background

5. Other, including mixed background
   - Write in description ______________________

These question response categories, in the potential absence of country of birth data, language spoken and religion, could lead to some limitations in terms of patient data collection. The HSE recommend that the ethnic identifier is used in conjunction with other relevant key questions. Potentially, only women presenting to maternity services in Ireland who have undergone FGM, will be captured in the data collection method using the NMHCR, possibly in combination with the ethnic identifier. Other women with FGM presenting to family doctors or reproductive and sexual health services may not be captured in any data collation formats. There are no current plans for national data collection using the NMHCR by the HSE. It is important to note that the HSE ethnic identifier may be updated soon and all staff who uses the ethnic identifier receives a half-day training programme on it. A leaflet explaining the ethnic identifier to patients was produced by the Rotunda Hospital in 2008. It is available in English and six additional languages.

Communication took place in 2010 between AkiDwA Migrant Women’s Health Project coordinator and the HSE Health Atlas Communication took place in 2010 between AkiDwA Migrant Women’s Health Project coordinator and the HSE Health Intelligence Geographical Information System (GIS) Women’s Health Project coordinator and the HSE Health Intelligence Geographical Information System (GIS) Women’s Health Project coordinator and the HSE Health Intelligence Geographical Information System (GIS) to map areas from the census at a county by county level, where larger numbers of women are residing from high FGM prevalence countries in Ireland. This was in order to target the development of relevant health services, community supports to reject and abandon FGM and to train health and social care professionals about FGM. But this approach has limitations in terms of data protection and privacy and the possible mobility of new migrants in Ireland. However GIS data should be explored for future FGM prevalence mapping potential.

The new NMHCR updated Irish prevalence study later this year by AkiDwA will be important additions to raising the profile and issue of FGM in Ireland but a more comprehensive national data collection tool is needed, in particular to identify girls at risk of FGM and baby girls born to women who have undergone FGM. Examples of good practice and robust data collection methods that result from this EIGE study will be particularly welcome in Ireland.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Information on policies related to FGM in Ireland was obtained by a variety of methods.

- We searched relevant websites (http://www.hse.ie) (http://www.garda.ie), Department of Children and Youth Affairs (http://www.dcy.ie), Reception and Integration Agency (http://www.ria.gov.ie) and AkiDwA.
- A phone meeting took place with the Children’s Rights Alliance in relation to FGM and current relevant Irish child protection resources such as the Children First national guidance for the protection and welfare of children, July 2011; Child protection and welfare practice handbook, Health Service Executive, 2011; and Our duty to care practical guide offering guidance on the promotion of child welfare and the development of safe practices in work with children, 2002. Subsequent e-mail contact also took place.
• A phone conversation and e-mail communication took place with the Department of Children and Youth Affairs on Children First national guidance for the protection and welfare of children July 2011, and on professional secrecy provision.
• A phone conversation with a member of the Garda (Irish police force) Domestic Violence and Sexual Assault Unit in relation to Garda Síochána domestic violence policy 2007.
• A lunch meeting with a respondent from the Health Service Executive (HSE) took place relating to aspects of this research, including the national intercultural health strategy 2007–12. Subsequent e-mails occurred.
• Ireland’s national plan of action to address female genital mutilation was accessed from the AkiDwA website and two site visits to AkiDwA to discuss aspects of this research including the national plan of action took place. Additional contact took place on a regular basis with AkiDwA staff members by e-mail and in person during this research.
• A phone conversation took place with RIA staff on the RIA Child protection policy for accommodation centres, 2005.
• Academic databases and University College Dublin (UCD) library database searches also took place.

However, in order to interview members of An Garda Síochána (national police) it is necessary to complete ‘Protocol for external researchers’ and ‘Data processing agreement’ forms which can take a number of weeks to be processed. As a result my interaction with relevant members of An Garda Síochána was very brief and served to clarify dates of policies, if the policies were being updated, and names and contact details of staff working in key Garda divisions. Cosc was also contacted in relation to the national strategy on domestic, sexual and gender-based violence 2010–14 but despite numerous e-mails and a phone call no response was received. Contact took place with HSE key staff in regard to HSE policy on domestic, sexual and gender-based violence.

3.2. Policies on FGM

The Irish policies in relation to FGM come from a range of government departments and agencies. They cover such areas as child protection, domestic and sexual violence, health service delivery and FGM in the national plan of action. The policy terrain in Ireland has changed recently with the newly formed Department of Children and Youth Affairs being established in June 2011 and the new Minister for Children and Youth Affairs Ms Frances Fitzgerald TD took up a full cabinet posting as opposed to a previous junior minister position. Prior to this the Department of Health (previously Department of Health and Children) would have been responsible for all child protection-related policies and documents. The National Office for the Prevention of Domestic, Sexual and Gender-based Violence, Cosc was established in June 2007 on the basis of recommendations in the national women’s strategy 2007–16. Despite containing recommendations on sexual and reproductive health, sexual and domestic violence, the national women’s strategy does not explicitly refer to FGM. The HSE has also become an active policy agent in terms of FGM in recent years through initial membership of the national steering committee in 2008 (it is not a current active member), by discussing the pregnancy and labour care needs of women who have undergone FGM in the national intercultural health strategy and by referencing the Ireland’s national plan of action to address female genital mutilation in HSE policy on domestic, sexual and gender-based violence 2010. This is to be welcomed and is a sign that Ireland’s national plan of action to address FGM and the work of the national steering committee is having an impact.

The Ireland POL sheet comprises of policies, strategies and guidelines addressing four areas:
• children,
• domestic, sexual and gender-based violence,
• intercultural health,
• FGM.

Children

These policies come from a range of statutory actors. In terms of policies relating to child protection only two of the five relevant policies, guidelines and handbook mention explicitly FGM; the Child protection and welfare practice handbook, Health Service Executive, 2011, and the Garda Síochána Policy on the investigation of sexual crime, crimes against children, Child Welfare, 2010. These are important inclusions and probably represent the work of the national steering committee and Children’s Rights Alliance in terms of lobbying for the recognition of FGM in relevant child protection policies.

The remaining three child protection policies and guidelines provide a framework that indicates how to respond to incidents of child abuse and the protection measures that should be in place. The Reception and Integration Agency (RIA) child protection policy for accommodation centres, 2005 is based on earlier editions of the Children First guidelines and provides information on policies and procedures in place for residential centres where families seeking asylum live while waiting for their applications to be processed. This policy would cover children living with their parents in accommodation centres and designated staff members would have received training on child protection and reporting mechanisms. Separated children seeking asylum are in the care of the HSE not RIA and as such are covered by HSE policies. FGM in the context of RIA accommodation does not appear to be an issue. It is concerning that FGM is not mentioned in this policy as many of the families that RIA accommodates may come from FGM-practising cultures or countries.

The Minister for Children and Youth Affairs is currently drafting legislation based on the Children First national guidance for the protection and welfare of children, July 2011 which would place the guidelines on a statutory legal basis. However the current 2011 guidance is considered national policy and the two statutory agencies with responsibility for child protection, the HSE and the Gardaí, are subject to it and have incorporated it into their staff policies. The HSE makes compliance with Children First a condition of contracting services with others agents or companies.
Domestic, sexual and gender-based violence

Three policies have been developed by statutory agencies; Cosc, the HSE and the Garda Síochána in relation to domestic, sexual and GBV. All three policies are recent dating from 2007 to 2010 and contain a brief reference to FGM. In the case of the HSE policy, the national plan of action is referred to. None of these policies contain explicit guidelines, strategies or actions in terms of FGM. However it is a very important sign of progress in Ireland and the increasing acceptance of FGM as a form of GBV relevant to women living in Ireland that it is mentioned in all three policy documents. This will allow civil society organisation (CSO) actors in Ireland campaigning on issues related to FGM to leverage contact, meetings and progress with the three statutory agencies and ensure that FGM is contained in future policy development and possible funding streams from them. Again the inclusion of FGM, however briefly, in these policies probably implies that national action plan and work of the national steering committee is having an important impact.

Intercultural health

The national intercultural health strategy 2007–12 was launched by the HSE in 2008 and it includes explicit reference to the possibility of FGM being practised in Ireland by migrants from some countries. It acknowledges the need for special care of women who have undergone FGM and who are pregnant or in labour and the need for staff support on training on FGM. The strategy also prioritises the roll out of an ethnic identifier to facilitate the development of evidence-based information on the maternity and associated needs of women from diverse cultures and ethnic groups. This will be useful for potential future data collection and possibly FGM prevalence collection. The national intercultural health strategy is a comprehensive and ambitious document and the challenges in the current economic climate with an increasing number of voluntary redundancies and retirement from the health sector and HSE and increasing budgetary pressure will be to achieve the vision and actions contained in the strategy.

FGM

Ireland’s national plan of action to address female genital mutilation 2008–11 (NPA) was launched 25 November 2008. The national steering committee that worked together to produce and launch the plan consisted of a mix of CSOs and statutory agencies from a broad range of sectors. The presence of the HSE, Women’s Health Council (WHC) and Irish Aid ensured the initial steering committee (none of these agencies are current active members of the committee) was in a crucial position to influence future statutory policies and make recommendations to government departments. However the NPA was never specifically adopted by a government department or agency and the ‘interdepartmental working group’ recommended in the NPA to monitor and evaluate the progress of the NPA never materialised. This meant that there was no specific funding to progress the whole of the NPA and neither a government department nor agency took responsibility to progress the NPA; this fell principally on the remaining steering committee members. The NPA was designed to conclude in November 2011 and although an internal evaluation of steering committee members has taken place, there are no reports on achievements or work to date in relation to the NPA, nor are there any evaluations in the public domain. But the impact of the NPA has been far reaching; and it is possible to conclude that the act of initiating a steering committee in early 2008, the resultant lobbying on the issue of FGM and the NPA launch have begun a new era in terms of FGM policy in Ireland. Prior to the NPA there was only one policy that included FGM (Garda domestic violence policy) and in 2012 there are now five more policies that include or reference FGM.

3.3. Reflection on policies on female genital mutilation

FGM has only been recognised as an issue for Ireland by the government since 2001 when the first prohibition of FGM Bill was tabled in the Dáil (Irish parliament) but later lapsed. In general, policy developments have followed a piecemeal fashion without a coherent framework stating who the stakeholders need to be and the policy structures required to comprehensively addressing FGM. This is despite the fact that the NPA clearly lists the stakeholders and actors operating in Ireland who have a role to play in terms of FGM and in some cases suggests actions relate to these actors. The lack of any mention of FGM in the national women’s strategy 2007–16 is telling. But since the concerted efforts of the national steering committee began in 2008 there has been a notable increase in the inclusion of FGM in a range of policies in Ireland. The relatively recent changes in Ireland from an emigrant nation to a country that attracts migrants, including women and children from FGM-practising communities, cultures and countries, is also possibly why Ireland has been slow to incorporate FGM into relevant policies and strategies. The lack of full engagement on the issue by the Department of Justice and Equality and its agencies could possibly relate to the fact that the department oversees the Irish Naturalisation and Immigration Service (INIS), the Garda National Immigration Bureau (GNIB) and the Office for the Promotion of Migrant Integration. These agencies may at any given time be dealing with asylum applications on the basis of having undergone FGM, fear of being subjected to FGM and fear of daughters being forced to undergo FGM if returned to country of origin. An adoption of clear gender guidelines by the Office of the Refugee Applications Commissioner (ORAC) in the forthcoming Immigration, Residence and Protection (IRP) Bill 2012 would alleviate this issue somewhat and allow for a possible greater engagement by the Department of Justice and Equality, its associated agencies and the minister on the area of FGM.

There are gaps in policy in Ireland, in particular in terms of protecting girls from FGM and a lack of policies aimed at the medical profession. With the pending introduction of legislation in Ireland specifically aimed at the criminalisation of FGM the possibility of incorporating FGM into a broader range of policies exists. It is hoped that there will be clear legal guidelines to guide and direct policies in Ireland once the current bill is signed in to law.
Policy development in Ireland relating to FGM will also be informed and influenced by three key pieces of legislation expected before the Irish parliament this year: IRP 2012, FGM Bill 2011, and the placing of current child protection guidelines onto a legal basis. There will need to be continued lobbying and advocacy work to maintain coherent pressure on relevant government departments to reflect FGM-related concerns in the text of these bills. But with the correct legislative framework in place it will be easier to develop and implement policies to combat and address FGM in Ireland. The national steering committee will have a key role moving forward to continue work that was not completed in the NPA 2008–11. It may draft a new NPA which can hopefully be progressed and funded by a government department or agency with an ‘interdepartmental working group’ that would include the active participation and input of the range of expertise from the CSO sector that currently makes up the national steering committee. It is also important that any reviews that occur of current policies (in particular the Garda domestic violence policy) continue to include FGM as a key issue and that training programmes for relevant professions also reflect the issue of cultural competency and FGM. The Department of Education and Skills will need to be included in any future NPA development and targeted to train teachers to recognise risk factors and warning signs for girls vulnerable to FGM. If there are reviews or revisions to any of the policies on the Ireland POL sheet due to new legislation or at a midpoint in a strategy this would be an opportune moment to highlight the issue of FGM and perhaps strengthen its content in the text. Historically, and currently, Irish Aid and overseas development programmes funded by the Department of Foreign Affairs and Trade, including very recent work on Ireland’s national action plan for implementation of United Nations Security Council Resolution 1325, 2011–14, have had a strong commitment to combating gender-based violence including FGM. It is now time that domestic Irish policies, strategies, and funding had a similar focus.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The principal documents, websites, reports and contacts used to research the FGM legal framework in Ireland included:
- Female genital mutilation/Cutting: A literature review by the Women’s Health Council.
- Ireland’s national plan of action to address female genital mutilation.
- The Irish Statute Book website (http://www.irishstatutebook.ie) was accessed for legal texts.
- E-mail communication and site visits to AkiDwA.
- E-mail and phone communication took place with Shauna Gillan, Legal Officer, Irish Refugee Council. Their website was also accessed.
- E-mail and phone communication took place with Aoife Gillespie, Barrister-at-Law, the Law Library.
- Orlagh O’Farrell (2010), Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission (Ireland), was consulted.
- E-mail and phone communication took place with the Children’s Rights Alliance.
- The Children’s Rights Alliance’s Report Card 2012, launched on 23 January 2012 was consulted.
- The UN Secretary-General’s database on Violence against Women (VAW) was accessed.
- Hagemann-White C., Kelly, L., Romkens, R. (coord.) (2010), Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission; van der Aa, S. and Romkens, R., Dutch national report.
- Leye, E. and Sabbe, A. (2009), Responding to FGM in Europe. Striking the right balance between prosecution and prevention.
- The Centre for Gender and Refugee Studies website (http://cgrs.uchastings.edu/law/gender_guidelines.php) was accessed to refer to gender guidelines in the asylum process.
- The Department of Children and Youth Affairs website was accessed (http://www.dcy.a.gov.ie/viewdoc.asp?DocID=120).
- Reforming laws on female genital mutilation in Ireland: Responding to gaps in protection’ by Mulally, Siobhan and NI Mhuirthile, Tanya.
- E-mail and phone contact with Child Welfare and Protection Policy Unit, Department of Children and Youth Affairs.
- E-mail and phone contact with the Ombudsman for Children’s Office and the ombudsman took place.
- The Department of Justice and Equality website was accessed.
- British and Irish Legal Information Institute website (http://www.bailii.org) and the Courts Service of Ireland website (http://www.courts.ie) were accessed to review relevant Irish High Court and Supreme Court cases relating to FGM.
- The president of the Irish Association of Social Workers was contacted and FGM as a child protection issue was discussed on the phone.
- The Refugee Appeals Tribunal was e-mailed and phoned.
- E-mail contact took place with the Office of the Refugee Applications Commissioner.
- Academic database and UCD library database searches also took place.

I attended the conference organised by AkiDwA and United Youth of Ireland to mark International Day of Zero Tolerance to FGM, which included a presentation of the Criminal Justice (FGM) Bill 2011. I also attended the Select Subcommitte on Health debate with the Minister for Health and Department of Health Officials on 9 February 2012 in the Irish parliament buildings on amendments to the proposed Criminal Justice (FGM) Bill 2011.

4.2. Criminal law

At the moment an act on FGM in Ireland would potentially be covered by the Non-Fatal Offences Against the Person Act, 1997. However there have been repeated calls to introduce FGM-specific legislation as the Non-Fatal
Offences against the Person Act, 1997 has a number of elements which fail to allow it to be effective in FGM cases including:

- a lack of extraterritoriality,
- a cultural relativist approach,
- consent issues.

FGM-specific legislation had been introduced in 2001 and 2009 in the Dáil chamber (lower parliament house) as private members’ bills by members of the opposition. In 2010 a private members’ bill was introduced in the Seanad (senate — upper house of parliament). This bill passed through all parts of the Senate with very strong cross party support but the then Minister for Health and Children decided to revise the bill and seek advice from the Director of Public Prosecutions and the Attorney General before it was presented to the Dáil for debate. The revised proposed Criminal Justice (female genital mutilation) Bill 2011, with proposed amendments from members of the steering committee, the Minister for Health and the Dáil Health Subcommittee was debated on 9 February 2012. The text of the bill has been radically amended and expanded from the original 2010 private members’ bill. This bill contains the following key elements:

- extraterritoriality but with the caveat of dual criminality;
- a definition of FGM based on the UK and Scottish FGM acts;
- there is no defence of cultural, customary or ritual reasons;
- a victim impact statement can be submitted in cases of prosecution;
- a girl under 18 can never consent to FGM.

The proposed bill is expected to have a strong deterrent effect for FGM-practising communities living in Ireland and will give a much clearer basis for doctors, midwives, social workers and other professionals to respond to requests for FGM including post-partum re-inflations from their patients/clients. The next stage is for the bill to be presented to the Dáil chamber and debated but it is hoped that the bill will be signed into law before the summer Dáil recess. The issue of dual criminality remains problematic but if Ireland ratifies the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Convention CETS No 210), which Cosc is currently examining with the aim of ratification, this issue would be resolved. The Minister for Health stated in the Select Subcommitte debate of 9 February 2012 that if ratified the convention would cover any issues of dual criminality, where a person can only be prosecuted if FGM is also an offence in the country where it is done Section 4(1)(c). He also stated that he is keen to extradite the FGM Bill as soon as possible.

There are no recorded court cases nor number of cases reported or investigated relating to FGM in Ireland. Any suspected cases would be reported to the Health Service Executive and the Garda Síochána (national police). New proposed legislation in 2012 ‘Children First’ and ‘Criminal Justice (withholding information on crimes against children and intellectually disabled persons) Bill 2011’ will also strengthen the legal situation in Ireland in terms of protecting girls from FGM.

4.3. Child protection laws/provisions

The child protection laws listed are principally in summary to allow for the removal of children by the Health Service Executive (HSE) in cases of child protection concerns, to prosecute those who abuse or mistreat children and to prosecute those who endanger children. There is no specific child protection legislation in Ireland currently and FGM is not cited in any of the previous acts. The government has recently released revised guidelines ‘Children First national guidance for the protection and welfare of children, July 2011’ from the Department of Children and Youth Affairs and supported by a practitioner handbook aimed primarily at social workers from the Health Service Executive: Child protection and welfare practice handbook, Health Service Executive, 2011. The handbook explicitly refers to FGM as a child protection concern. The Minister for Children and Youth Affairs and her Department are currently in the process of drafting legislation based on the 2011 guidance, which will put child protection on a statutory legal basis. The national steering committee and the Children’s Rights Alliance have been campaigning for this change over the past number of years. It is anticipated that a Children First bill will be introduced to the Dáil later in 2012.

There is no data available on the number of child protection interventions concerning FGM in Ireland or even if any interventions have ever taken place. Any suspected cases would be reported to the Health Service Executive and the Garda Síochána (national police) currently and in the future to the newly formed Child and Family Support Agency and the Garda Síochána. Discussions with the Irish Association of Social Workers did not indicate that there is any additional data on child protection interventions regarding FGM in Ireland.

The landscape in Ireland in terms of child protection has changed radically in the past year. A critical event came in March 2011 with the new government announcement that they would establish a Department of Children and Youth Affairs and create a dedicated Child and Family Support Agency, removing this function from the HSE. A minister at cabinet level was appointed and the Department of Children and Youth Affairs (DCYA) was established as and from 2 June 2011. The new government also removed the remit of children from the Department of Health and Children, which is now the Department of Health, to the new Minister for Children and Youth Affairs and her new department. The Minister for Children and Youth Affairs, Frances Fitzgerald, is a former social worker who has demonstrated considerable support in progressing FGM legislation while in opposition. The new Child and Family Support Agency is not yet fully functional but will have an important role for the protection from FGM of girls living in Ireland. The proposed criminal justice (withholding information on crimes against children and intellectually disabled persons) bill could also have a potential role to play in terms of child protection and FGM. The draft bill makes it an offence to withhold information relating to the commission of a serious offence against a person who is under the age of 18 or an intellectually disabled person. It should also be noted that the Minister for Justice, Equality and Defence, Alan Shatter, previously practised as a family
lawyer in Dublin and has experience in terms of child protection legal issues.

4.4. Asylum law(s)/provisions

There are no specific asylum provisions dealing with FGM in Ireland. The current Refugee Act 1996, as amended, is the relevant legislation dealing with asylum in Ireland. The interpretation within the act of ‘membership of a particular social group’ includes ‘membership of a trade union and also includes membership of a group of persons whose defining characteristic is their belonging to the female or the male sex or having a particular sexual orientation’, page 4 of the act. However it is unlikely that an application for refugee status would be granted in Ireland on the basis of past persecution except possibly under Section 5(2) of the European Communities (Eligibility for protection) Regulations 2006, signed into Irish law in 2006.

‘5. 2) The fact that a protection applicant has already been subject to persecution or serious harm, or to direct threats of such persecution or such harm, shall be regarded as a serious indication of the applicant’s well-founded fear of persecution or real risk of suffering serious harm, unless there are good reasons to consider that such persecution or serious harm will not be repeated, but compelling reasons arising out of previous persecution or serious harm alone may nevertheless warrant a determination that the applicant is eligible for protection.’

It is more probable that status would be granted under fear of future persecution.

The definition of a refugee is also outlined in the 1996 Act: 2. — In this Act “a refugee” means a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country; or who, not having a nationality and being outside the country of his or her former habitual residence, is unable or, owing to such fear, is unwilling to return to it, but does not include a person who —
(a) is receiving from organs or agencies of the United Nations (other than the High Commissioner) protection or assistance;
(b) is recognised by the competent authorities of the country in which he or she has taken residence as having the rights and obligations which are attached to the possession of the nationality of that country;
(c) there are serious grounds for considering that he or she —
(i) has committed a crime against peace, a war crime, or a crime against humanity, as defined in the international instruments drawn up to make provision in respect of such crimes;
(ii) has committed a serious non-political crime outside the state prior to his or her arrival in the state; or
(iii) has been guilty of acts contrary to the purposes and principles of the United Nations.’

There is no national/central registration system for asylum cases related to FGM. It is impossible to collate the number of asylum cases requested based on FGM and the number of asylum cases actually granted in Ireland without explicit data from the Office of the Refugee Applications Commissioner (ORAC) and Refugee Appeals Tribunal which they state is not available. Data on FGM and asylum is extremely limited in Ireland. The Refugee Appeals Tribunal is an independent body which decides asylum appeals against the negative recommendation of the Office of the Refugee Applications Commissioner to grant an applicant refugee status. Access to the Refugee Appeals Tribunal's decisions archive is only available to registered users of the archive and access is confined to appeal applicants’ legal representatives (i.e. member of the legal profession) so searching this database is beyond the capacity for this piece of EIGE research. All hearings by the Refugee Appeals Tribunal are private and confidential, no members of the public are admitted to the hearing and there are no public transcripts of cases. The Courts Services website and the BAILLI database are accessible to members of the public but FGM-related cases are only available in the High Court and Supreme Court, so the full details and documents of cases listed from the ORAC application stage to the Refugee Appeals Tribunal are not accessible. This does not allow for a full and comprehensive review of asylum law decisions and rulings for FGM and Ireland. The Office of the Refugee Applications Commissioner, the Central Statistics Office and the Office of the Director of Public Prosecutions annual reports and data collection do not list details on cases to such an extent that FGM-related cases can be extrapolated. The most comprehensive document available discussing this issue is ‘Reforming laws on female genital mutilation in Ireland: Responding to gaps in protection’ by Mullally, Siobhan and Ni Mhuiríthile, Tanya, 2010.

The national action plan outlines under the Irish Asylum Process heading Objective #1 ‘To enhance the capacity of the asylum process to accommodate gender related claims’ with three related actions in recognition of the shortcomings in this area in Ireland. It also states that there are no current publically available gender guidelines in use by ORAC. Many CSOs active in this area including the Irish Refugee Council are keen that the proposed Immigration, Residence and Protection (IRP) Bill 2012 expected later this year, will include a much stronger emphasis on gender related claims. The current Refugee Act, 1996 has been repeatedly amended and a revised IRP bill has been pending since 2010. AkiDwA is preparing draft domestic gender guidelines in asylum processes in relation to this new bill.

It is important to note that according to the Irish Refugee Council in January 2012: ‘The rate for acceptance of asylum applications has increased in 2011. However, Ireland still lags far behind its European neighbours, despite the fact that applicants come from similar countries of origin. This is due to a lack of legal advice and support for asylum seekers in making their initial application, the absence of a single protection procedure and inadequacies in the appeals system. In 2010, Ireland had an acceptance rate of 1.3 %, the lowest in Europe. As of November 2011, 57 people had been granted refugee status out of 1 738 applicants or 3.27 % at first instance. The European average in 2010 was 24.6%.’

This exceptionally low rate of acceptance of asylum applications in Ireland will undoubtedly have an impact on
the number of women and girls seeking asylum on the basis of having undergone FGM or fear of undergoing FGM and the number who are eventually granted asylum or leave to remain in Ireland.

4.5. Professional secrecy provision(s)

In Ireland there are no legal provisions with regard to professional secrecy concerning FGM. The current Children First national guidance for the protection and welfare of children, July 2011 outlines that professionals have a moral duty to inform the HSE Children and Family Services when a person has reasonable grounds for concern that a child may have been, is being or is at risk of being abused or neglected. The professionals envisaged are; ‘teachers, child care workers, health professionals and those working with adults with serious parenting difficulties. It is also an important responsibility for staff and people involved in sports clubs, community activities, youth clubs, religious/faith sector and other organisations catering for children.’

There are not any national/central registration systems for reports of (suspected) FGM cases by professionals but the HSE and the Garda Síochána would be the report collection points. This lack of legal provision makes it very difficult for relevant professions to draft their own guidelines and policies on FGM in Ireland. However the proposed criminal justice (withholding information on crimes against children and intellectually disabled persons) bill and the fact that the Minister for Children and Youth Affairs and her department are currently in the process of drafting legislation based on the 2011 guidance which will put child protection on a statutory legal basis will both be a very welcome legal addition to the area of professional secrecy provisions. This should allow for much greater clarity and future protective policies for relevant professionals and girls at risk of FGM in Ireland.

4.6. Reflection on legal framework

The recent trends in Ireland, in particular since the change of government in March 2011 have shown positive progress towards the drafting and enactment of new pieces of legislation that should have a much more enhanced protective mechanism for women and girls at risk of FGM who are living in Ireland. In particular the Criminal Justice (FGM) Bill 2011 and the movement towards statutory child protection provisions by the Minister for Children and Youth Affairs are to be welcomed. The work of the national steering committee and its members has no doubt advanced these legal initiatives. However, further lobbying will be required to ensure that both these legal measures fully protect girls and women from FGM and to ensure a joined-up response by all relevant professionals to future reported cases of FGM or of girls at risk. Rapid training of medical staff, social workers, Gardaí, teachers, etc. on FGM will be required when the Criminal Justice (FGM) Bill 2011 is finally signed into law.

In terms of information and data on asylum laws and provisions the proposed Immigration, Residence and Protection (IRP) Bill 2012 is being drafted so it’s not yet possible to assess its content but hopefully it will have a stronger emphasis on responding to gender-related asylum claims including FGM and recognise both past and future persecution. Finding information on ‘Reported or suspected cases registered with the police or other judicial authorities’ and ‘Number of asylum cases requested on the grounds of FGM’ and ‘Number of asylum cases granted on the grounds of FGM’ was not possible. This information could be considered sensitive by ORAC and the Department of Justice and Equality in light of a very high profile asylum case involving a woman and her daughters claiming asylum in Ireland on the basis that her daughters were at risk of FGM if they were returned to Nigeria. This case was covered in the Irish media over a number of years and it concluded with their eventual deportation in July 2011. Her case began in 2005 after a deportation order was issued and involved 20 appearances in the High Court and a number of appearances in the Supreme Court. The case finally went to the European Court of Human Rights where it was rejected. This complex case could have led to some hesitancy in making information on similar cases and rulings available in the public domain.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

Relevant actors in Ireland were collated through a variety of search strategies. The initial point of contact was the current Chair of the steering committee for Ireland’s national plan of action to address female genital mutilation, Alwiye Xuseyn, in AkiDwA, to assess who are current active and past members of the committee. Then contact with almost all these members took place.

In addition:
- the integration centre database of members of the network of more than 250 immigrant groups and organisations in Ireland was examined and e-mail and personal contact took place with Ali Dennehy;
- many of the organisations listed in the directory of services section of the IFPA Sexual health and asylum: handbook for people working with women seeking asylum in Ireland, 2010 were contacted;
- many of the ‘Other sources to collect information’ listed in the guidelines for national data collection document were contacted and their websites searched;
- as the Irish research progressed, a ‘snowball sampling effect’ of new contacts emerged from current researcher contacts, and these were then e-mailed and informed about the research;
- the One 2 One Solutions Evaluation Report of the AkiDwA Migrant Women’s Health Project, funded by the Office of the Minister for Integration through Pobal, February 2008 to January 2009;
- reports and media coverage on FGM awareness-raising events by United Youth of Ireland were also examined;
- websites for various professional bodies were searched for articles and policies on FGM;
- finally, relevant contacts from my work as the AkiDwA Migrant Women’s Health coordinator from 2008 to 2010 and chair of national steering committee 2010, member of the Cosc public-awareness steering committee 2010, from my role as Health Promotion and Education Officer, Crisis Pregnancy Agency from 2003 to 2007, and from my current volunteer work with United Youth of Ireland and
Sohragi were utilised. A few challenges arose in terms of FGM actors. Some of the key actors no longer exist in Ireland, for example the Women’s Health Council has been merged into the Department of Health in 2009. With the current economic climate in Ireland and an increasing number of redundancies in the CSO and state sector, many of the actors are under considerable workload pressures and therefore may have found it difficult to make time to fully engage with this research. Despite my best efforts there may possibly be some actors missing from the ACT sheet due to the limited time frame of the data collection for this desk study.

5.2. Actors

Specific draft legislation to prohibit FGM had been introduced in 2001 by Liz McManus T.D. a Labour member of parliament to the Dáil chamber. However the bill did not get passed by the government of the time. But this was the context in which the Irish Coalition against FGM was established by Comhlámh (the association of development workers) in 2002. Understanding female genital mutilation (also known as female genital circumcision: an information and educational booklet was written and published by Comhlámh in 2002. The coalition held a round-table discussion ‘FGM — Why is it relevant for Ireland?’, on 24 September 2004. The only documentation available from this meeting is a press release. The coalition consisted of AkiDwA, Comhlámh, the Irish Family Planning Association (IFPA) and Labour Women (a political party). The coalition recognised the work that needed to be done in Ireland on the issue of FGM and the needs for research and for legislation to specifically outlaw FGM in Ireland. In 2004 they transferred the secretariat for this work to the IFPA, possibly due to capacity issues and staff changes in Comhlámh.

In 2005, AkiDwA facilitated a series of groups in the Midlands in Ireland with migrant women on FGM. The four focus group discussions involved 15 women from seven different ethnic communities that practice FGM. Unfortunately there is no published report on these group discussions. A brief outline of the groups is found in the evaluation report of the Migrant Women’s Health Services Project. The key objective of the groups was to establish a baseline as to the knowledge and understanding of FGM among African women living in Ireland. Seven of the participants stated that they had undergone FGM and the remaining eight either had family members or friends who were victims of FGM. The discussion groups also highlighted that pressure from home within some practising communities could contribute to migrants continuing the practice of FGM on their daughters in Ireland.

In 2007, AkiDwA applied for funding, under the fund for non-government national and regional organisations to support the integration of legally resident immigrants to complete a one year action research project which would explore and document how Irish service providers could improve access to healthcare for women who have experienced FGM. This fund was provided by the Reception and Integration Agency of the Department of Justice, Equality and Law Reform through the Office of the Minister for Integration (this minister and office no longer exist) and was administered by Pobal (a not-for-profit company with charitable status that manages programmes on behalf of the Irish government and the EU). The target group for the fund was legally resident immigrants and their families but the funding excluded asylum seekers. AkiDwA Migrant Women’s Health Project Officer and a Financial Officer started in February 2008. When the Pobal funding concluded in February 2009, the HSE made a new funding stream available to progress work on the health objectives of the national plan of action by AkiDwA. This funding continued until late 2010.

The Project Officer post became the Project Coordinator and while in post until September 2010 the main achievements of the project were:

• establishment of the AkiDwA FGM Health Forum, an advisory group for the project;
• managing print, launch, media coverage, promotion and dissemination of the first handbook for healthcare professionals working in Ireland on FGM, developed with the Royal College of Surgeons in Ireland (RCSI). Its content was approved by the RCSI and the Irish College of General Practitioners and was launched by the Minister for Integration in January 2009;
• AkiDwA FGM Project selected by the United Nations Alliance of Civilisations for inclusion on its website as a featured integration project and international example of good practice;
• successful lobbying to have female genital mutilation (FGM) included in the new Irish National Maternity Healthcare Record (NMHCR) under risk factors;
• delivering training, presentations and lectures to healthcare professionals (including midwifery and social work students) on FGM in hospitals and universities across Ireland;
• initiating and managing first and second statistical data analysis on women living with FGM in Ireland;
• consultations on the issue of FGM with migrant women and healthcare professionals to facilitate improved healthcare service delivery and mobilise communities on the issue;
• presentation on FGM made by the Project Coordinator to the joint Oireachtas (upper and lower houses of parliament) Committee on Health and Children on FGM in January 2009 with the chair of the national steering committee and the CEO of AkiDwA;
• an FGM cost benefits article drafted with Dr Ilham Siddig which was presented to the HSE. It was submitted to the Minister and Department of Health and Children in August 2010. See Appendix 2;
• an evaluation report of the Migrant Women’s Health Services Project which was researched, written and delivered to project funders in January 2008.

In 2008, Euronet-FGM received funding under the European Commission funded Daphne project to assist 15 countries develop national action plans against FGM. In Ireland the IFPA was the Euronet-FGM partner who would develop an action plan to address the issue of FGM. The first objective was to invite statutory and CSOs to attend an initial meeting (which took place in April 2008) and then to form a national steering committee and work on the action plan. The AkiDwA Project...
Officer and other staff in AkiDwA also worked closely with the IFPA to develop the national action plan. The plan was launched on 25 November 2010 and gained excellent media coverage. Ireland’s plan of action steering committee is still active although there have been some changes to committee membership, probably due to capacity issues and staff changes in some CSO and statutory organisations.

The IFPA continued their work in the area of migrant sexual and reproductive health and FGM when they received funding from the European Refugee Fund, administered by the Office of the Minister for Integration and managed by Pobal to run the Majira programme which commenced and concluded in 2009. This project involved peer educator training for 31 asylum-seeking women and included training on the issues of gender-based violence (GBV) and FGM. The project produced the *Sexual health and asylum: handbook for people working with women seeking asylum in Ireland* publication in 2010.

In addition to an increased focus by CSOs through the IFPA Euronet-FGM work and the AkiDwA project the statutory sector in Ireland began to respond to the issue of FGM. Cosc: the National Office for the Prevention of Domestic, Sexual and Gender-based Violence was established in 2007, their national strategy on domestic, sexual and gender-based violence 2010–14 was launched in 2010. The HSE Intercultural health strategy launched February 2008. In June 2008, the Women’s Health Council (WHC) published *Female genital mutilation/cutting: A literature review* and commenced work on a major piece of research ‘Translating pain into action: A study of gender-based violence and minority ethnic women in Ireland’. This research and supporting documents were launched in February 2009. The AkiDwA Migrant Women’s Health Project Coordinator sat on the research advisory board for this project.

Amnesty International Ireland (AI) was an initial steering committee member, but it increased its work on FGM in Ireland and through the establishment of the End FGM European campaign in 2009. AI was a vocal supporter of the application of a woman and her daughters for asylum, leave to remain and subsidiary protection in Ireland on the basis of fear of future FGM on her daughters in Nigeria. This advocacy work was very active in 2008 and 2009. AI also undertook fund-raising initiatives on FGM in 2009 to support its work.

United Youth of Ireland (UYI) through social media, youth social events and Zero Tolerance Day events have become a key Irish actor since 2010 in terms of intercultural youth mobilisation on FGM. Their events usually have a mixture of presentations, music, fashion shows and time to socialise and bring together numbers of around 150 to 250 young people to speak out against FGM. Their membership is growing and the key activist in the UYI has been asked to present similar events in other EU countries. UYI have also harnessed social media to highlight and mobilise on the issue of FGM through Facebook and are active members of the national steering committee.

Considerable work on FGM abandonment has taken place by Irish overseas development CSOs and funding from Irish Aid has been made available in 2008 on FGM elimination work to the trust fund on female genital mutilation/cutting which is operated jointly by Unicef and UNFPA, EUR 500 000 was provided from Irish Aid to this fund. The gender-based violence consortium consists of human rights, humanitarian and development organisations, Irish Aid and the defence forces, all working together to address gender-based violence. Its overall aim is to promote the adoption of a coherent and coordinated response to gender-based violence (GBV) and it was established in 2004. Although FGM is an area of work relevant to the GBV consortium their focus is only on overseas work.

Despite funding challenges the AkiDwA Migrant Women’s Health Project Coordinator post has continued, presently the post is part-time. The main areas of work on FGM by AkiDwA currently are: supporting and facilitating FGM community forms in Cork and Galway, lobbying for the introduction of FGM-specific legislation, training of healthcare professionals and active membership of the End FGM European campaign.

A number of professional organisations for medical and social work professionals appear on the actors’ sheet. Although their inputs may have been limited so far in terms of publications, training programmes and policies, I expect with the introduction of the proposed FGM Bill they may increase. Continual professional development (CPD) or continuing medical education (CME) has emerged in recent years in Ireland as a key component to retaining a licence to practise in many professions as a result of new legal changes. Providing training programmes on FGM and on the new bill could be a route to reach a greater number of health and allied care professions on the issue of FGM and would fulfil organisational CME and CPD requirements.

The total number of NGOs/CSOs that are or have been active on FGM in Ireland on the Actors sheet is 18. In addition there are the following:

- seven government departments and agencies active (or that have been active) on FGM (Women’s Health Council, Irish Aid-Department of Foreign Affairs, Health Service Executive, Department of Health, Garda Racial and Intercultural Office, Cosc (National Office for the Prevention of Domestic, Sexual and Gender-based Violence), Office of the Refugee Applications Commissioner);
- four professional medical organisations;
- three individual experts;
- two international organisations;
- one statistics office.

5.3. Reflection on actors on female genital mutilation

There has been a definite trend of increased activism in Ireland on FGM, commencing with the work of Comhláthair in 2002, leading to the work of AkiDwA and the IFPA and culminating with the current work of the national steering committee and United Youth of Ireland (UYI). An increased statutory response and engagement with the issue of FGM followed the WHC publication in 2008. The formation of the national steering committee in 2008 with a broad range of members gave a new credible and united voice to the issue.
of FGM and much has been achieved in a more coherent manner since its inception following a strong template of goals, actions and aims contained in Ireland’s national plan of action. The AkiDwA and RCSI handbook publication led to international acclaim and finally Ireland seemed ready to address FGM amongst its own rapidly changing population. Youth engagement on FGM is a more recent addition to the range of activities and actors addressing FGM mainly through UYI events. A lack of coherent government policy on FGM and the relative newness of the issue in Ireland have meant that the work and progress has principally been led by CSO actors, apart from some notable work by the HSE. Some of the work on FGM is done by smaller CSOs working to support migrants in their communities but who do not have the capacity or funding to be actively involved in the steering committee or lobbying work.

Many of the challenges of consistent work on FGM in Ireland has been a pattern of staff leaving and work being put on hold due to a lack of sustained funding. Changes of government and Ministries and the economic downturn and recession in Ireland have also had a negative impact on progressing FGM-related legislation and concerns. Many key staff in government agencies and departments may avail of early voluntary redundancy schemes designed to address the economic downturn in Ireland. This may lead to a ‘brain drain’ around certain issues including GBV and FGM. Segments of the statutory sector also appear hesitant to discuss, engage, or publish information or statistics on FGM related to their work including: the Office of the Refugee Applications Commissioner and the Refugee Appeals Tribunal. There is also a new emerging challenge to ongoing work on FGM in Ireland, a decrease in immigration. The economic downturn and tougher immigration controls are seen as the driving factors behind the ninth successive annual fall in asylum applications in 2012 which could lead to a perception that the issue of FGM is no longer important in Ireland.

The establishment of Cosc: the National Office for the Prevention of Domestic, Sexual and Gender-based Violence in 2007 should have been a major boost for work on FGM but the office has been slow to engage on FGM-related work and issues. The initial aim, outlined in the national action plan was to have it monitored and evaluated by an interdepartmental working group and coordinated and progressed by an agency such as Cosc. Despite many efforts by the steering committee this has not taken place.

There may be an increased role for greater cooperation between health services especially maternity, sexual and reproductive health, and domestic and sexual violence services to address the needs of women who have undergone FGM and who are now living in Ireland. These actors could be motivated by the introduction of the proposed FGM Bill to include FGM in policies, patient/client care plans, referral systems, child protection policies, research, counselling services and the now mandatory continuing professional development/continuing medical education.

A forum or mechanism to share learning between the GBV Consortium and other Irish overseas development aid work on FGM and the national steering committee and other domestic actors on FGM could be mutually beneficial and relatively easy to set up within existing Dóchas (the Irish Association of Non-Governmental Development Organisations), Comhlámh, GBV consortium and steering committee frameworks. It could assist in Ireland having a unified position on FGM in both overseas development work and domestic work.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Relevant tools and instruments (TIs) for Ireland were included in the database using a variety of search strategies. An academic database search was performed, following the ‘Guidelines for national data collection’. The following databases were searched for ‘tools and instruments’ in Ireland: Social Science Research Network, Sociological Abstracts, HeinOnline, Web of Science, PubMed and Google Scholar. This however did not result in further TIs being found. In addition:

- Bibliographies of relevant research and publications were analysed for potential Irish TIs.
- Relevant websites were searched where possible, as many of the actors’ website do not have search facilities or do not have accurate and/or functional search facilities.
- All of the actors contacted were asked to highlight any TIs on FGM to the researcher.
- Relevant contacts from my work as the AkiDwA Migrant Women’s Health Coordinator from 2008 to 2010, member of the Cosc public-awareness steering committee 2010, and from my role as Health Promotion and Education Officer, Crisis Pregnancy Agency 2003–07 and from my current volunteer work with United Youth of Ireland and Sohragi were utilised to find suitable TIs.
- Ireland’s national research portal (http://www.rian.ie) was searched for theses related to FGM.
- Health Well an all-island (Ireland and Northern Ireland) health information website was searched for FGM TIs.
- Lenus, the Irish Health Repository website, was searched for FGM TIs.
- The current chair of the steering committee for Ireland’s national plan of action to address female genital mutilation, Alwiye Xuseyn, in AkiDwA was asked to identify any relevant TIs.

Challenges in sourcing TIs included academic database searches and library searches providing extremely limited results, non-functional search aspects of websites including the HSE and similar challenges to the actors’ sheet in terms of workload pressures and time frame for those contacted. Also some documents found have not yet been published, peer reviewed, or may not be in the public domain.

6.2. Tools and instruments on FGM

There exists virtually no academic research specifically on FGM in Ireland. There is a lack of quantitative and
qualitative data to inform and progress work on FGM in Ireland and apart from the WHC literature review many of the publications and research are addressing gender-based violence (GBV), maternity care or migrant health as a main topic and may only contain very small amounts of information pertaining to FGM. Since 2008, there has been a rapid increase in the TIs developed in Ireland on FGM. This is partly due to the aims and work of the AkiDwA Migrant Women’s Health Project, the development of Ireland’s national plan of action to address FGM and related steering committee work and a specific work programme on GBV issues by the Women’s Health Council (WHC). In general medical media (websites, magazines for GPs, nurses, etc.) have been very open to writing about FGM and how it relates to their subscribers and readers and have sent reporters to launches, training programmes and events on FGM. However this has not translated into Irish academic research and peer reviewed medical journal articles on FGM.

Most of the TIs are products of CSOs, medical magazine articles (whose subscribers are healthcare professionals in Ireland) or statutory health agencies. The compiled list of parliamentary questions relating to FGM was commissioned and obtained specifically for this research. Many of the TIs have been produced by AkiDwA (n=8 including two articles written by Siobán O’Brien Green while working in AkiDwA) and the WHC (n=4) as part of a work programme focusing on FGM and GBV. The excellent and comprehensive review of Reforming laws on female genital mutilation in Ireland: responding to gaps in protection 2010, is one of the very few Irish academic journal publications on FGM and is to be commended for being a thorough review of the legal issues surrounding FGM in Ireland.

The ‘Practice standards for midwives and recent rape/sexual assault: national guidelines on referral and clinical examination in Ireland’ are to be particularly appreciated as recent TIs. They provide information and guidelines for healthcare professionals working in Ireland that include and address FGM. One of the most recent TIs to emerge is the National Maternity Healthcare Record (NMHCR) which will have a crucial role when it is fully implemented in all maternity hospital settings for better data collection on FGM and possibly lead to hospital policies on FGM and patient care. The Institute of Obstetricians and Gynaecologists, Continuing Medical Education (CME) Study Day and Annual General Meeting (AGM), 24 September 2010, represents a new initiative of a professional organisation including FGM in their CME training.

6.3. Reflection on tools and instruments on female genital mutilation

The increased pace of development of TIs relating to FGM in Ireland since 2008 should be welcomed but there is an overall lack of coherence in their development and some sectors and actors that could benefit greatly from TIs on FGM such as social workers, family support workers and teachers or even women who have undergone FGM do not have any specific TIs available. This lack of coherence is probably a result of an absence of explicit legislation on FGM and child protection in Ireland and the relatively recent inward migration to Ireland from FGM-practising countries and communities. A patient information leaflet is required for maternity hospitals on FGM. One has been drafted by AkiDwA and submitted to the HSE but it is awaiting the FGM Bill 2011 to be passed prior to focus testing and printing. ‘Supports for staff in developing good practice in caring for women who have undergone FGM and FGM child protection quick reference guidelines’ aimed at social workers has also been drafted by AkiDwA and submitted to the HSE but again is awaiting content on the proposed FGM legislation. Updating the AkiDwA RCSI handbook on FGM will also be required when new prevalence research occurs and the FGM Bill 2011 is enacted. TIs on gender guidelines, country of origin information for migration officials and information on FGM asylum cases in Ireland are notably lacking. T & I development in Ireland has been piecemeal often reflecting funding available and work areas of interest of CSO staff as a result considerable gaps in Irish TIs have appeared.

7. FINAL CONSIDERATIONS

Prevalence

Initial statistical extrapolation studies by AkiDwA has ensured that the issue of FGM cannot be ignored by politicians and policymakers due to the substantial number of women estimated to have undergone FGM in their country of origin and who are now living in Ireland. But there remains significant work to be done to improve data collection systems in a range of settings including health, medical, social services and immigration services to get a complete and robust set of data on FGM prevalence in Ireland. The introduction of the National Maternity Healthcare Record (NMHCR) should assist with this work.

Policy framework

In Ireland there is no national sexual health strategy, which could be useful in terms of highlighting the issue of FGM to policymakers and healthcare practitioners. The current national women’s strategy 2007–16 does not mention FGM. But the increase in newer policies and strategies that refer to FGM, or explicitly have content on FGM is encouraging. The present concern is, given the economic situation in Ireland, if funds exist to fully implement these policies and strategies.

Legal framework

It is important to emphasise that there are no reported case of FGM occurring in Ireland in any of the TIs, POL or LEG documents and reports, and strategies examined. Anecdotal evidence suggests that girls are being taken out of Ireland to have FGM performed on them. The new specific criminal law developed in 2011 to address FGM is very welcome and will provide a much needed legal clarity on FGM in Ireland. The legal landscape in terms of child protection is also undergoing amendment and change in Ireland and these changes and proposed new laws should provide increased protection for girls at risk of FGM. The Asylum laws/provisions in Ireland require reform in terms of gender guidelines and recognition of future persecution.
Again proposed legislation, the Immigration, Residence and Protection (IRP) Bill 2012, may address some of these issues.

**Actors**

In Ireland the predominant actors on FGM are from the CSO sector and an increased role for statutory agents should be considered. This is with the exception of the Health Service Executive (HSE) who has produced policies, strategies, guidelines and TI s that include FGM and have provided funding to work on the issue of FGM to CSOs. Again concern exists as to if and when continued funding will be available considering the current economic climate in Ireland to maintain this important work on FGM. When the proposed new FGM Bill is enacted in 2012, the HSE and Gardai will have considerable work to do in terms of training and notifying staff. This work will probably be assisted by CSOs such as AkiDwA and United Youth of Ireland and the IFPA who are currently active in the field. The NPA clearly lists the stakeholders and actors operating in Ireland who have a role to play in terms of FGM and in some cases suggests actions relating to these actors.

**Tools and instruments**

Tools and instruments have developed in a rather ad hoc manner in relation to FGM in Ireland. Often the development has occurred in conjunction with CSO activity on FGM. Some of the TIs are as a result of a specific focus by the Women’s Health Council on GBV and FGM issues but this council no longer exists. A more coherent approach to T & I development will be required to meet the information needs of staff such as police, teachers, medical professionals, immigration officials and social workers when legislation pertinent to FGM is enacted in Ireland in 2012.

Two pending pieces of research relevant to this country report are not yet published and therefore cannot be included in the excel sheet or this report. Qualitative research on attitudes to fertility, sexual health, and motherhood among a sample of non-Irish national ethnic minority women in Ireland will be launched in 2012 by the HSE Crisis pregnancy programme and it includes interviews with young women from Nigeria and young Muslim women living in Ireland and the issue of FGM is raised in the interviews. A female genital mutilation survey by P. Bidwell and Dr Fanta Kaloma completed in November 2011 surveys midwives in two Dublin hospitals on their knowledge and awareness of FGM. This research could prove useful in developing and delivering training programmes on the NMHCR for midwives in Ireland.

**Note:** It is important to note that the opinions expressed in this report are those of the author and do not or may not reflect those of the actors, departments, agencies, CSOs and organisations discussed in and/or consulted for the report.
Ireland

Identification

Country: Ireland
Researcher: Siobhán O’Brien Green
Date: 6.8.2012
Revised April 2013

I. INTRODUCTION

This report aims to complement and develop the desk research conducted in January and February 2012 in relation to Ireland and work on female genital mutilation (FGM) through a series of semi-structured qualitative interviews with key informants. The key policy developments in Ireland regarding FGM will be discussed including the rapid recent policy progress, particularly in relation FGM criminal legislation. There has been considerable progress in Ireland since the desk study was completed with the passing of FGM-specific legislation in Ireland in April, and related Irish child protection measures have also advanced. The research framework of the ‘Six Ps Approach’ will contextualise the interview feedback into six distinct categories of: prevention, prosecution, protection, provision of services, partnerships between relevant actors, and prevalence estimates. Five of the interviewees or agencies had been identified by the core team and the sixth interview has sought to examine the recent Irish FGM legislation (key informant to be identified by the researcher). All interview subjects received formal invitations to participate in the research and all documentation used for the interviews were branded with Yellow Window and ICRH logos and contact details.

Scheduling interviews was problematic and exceptionally difficult for one proposed interview subject, An Garda Síochána (Irish police force) as they required multiple forms completed and documents in advance of granting an interview, regardless of the willingness of relevant police staff to participate in the research. Despite contacting research subjects on the 25 June, some proposed interviewees had holidays scheduled and many were on leave for part or all of the time frame designated to conduct interviews. One key interviewee had to reschedule her interview due to a death in the family. This meant that the tight time frame in which to conduct the interviews became even more challenging. Finding a place to interview subjects was also problematic, due to the fact that some did not have offices that were available or quiet. All key informants were under time and work pressures; this meant that finding sufficient time to reflect on the ‘Six Ps Approach’ and their questionnaires and making time for the interview was a challenge for them, despite their commitment to the issue of FGM.

Continual efforts to access an interview with An Garda Síochána occurred but the official protocols required and time frame defined for the in-depth study meant that this was not possible. The researcher completed and submitted all required and requested documentation, made numerous phone calls, sent multiple emails and finally accessed a Garda interviewee in the Garda Racial, Intercultural and Diversity Office (GRIDO) in early October 2012. Nevertheless, the information that was intended to be collected through this key informant was partly fulfilled by efforts of the researcher to include supporting information in relation to relevant Garda policies, using data sources from the Garda website and publications. An alternate informant was found to complete the six required interviews for the study. Additional information sources were used for the study but some offices and staff were closed due to holidays and the researcher was not able to access all the potential information sources she wished to. One other potential informant, Meghan Doherty, formerly of the Irish Family Planning Association (IFPA), who drafted Ireland’s national plan of action to address female genital mutilation 2008–11 was not available to interview as she has left Ireland to work in Canada. Data and information from the Garda (police) interview was incorporated into reports submitted to EIGE at later stages in this research process.
A description of each interviewee follows, and the depth of their knowledge and their relevant expertise on FGM is highlighted. Five of the respondents were active members of the national steering committee (NSC) for Ireland’s national plan of action to address female genital mutilation 2008–11 (NAP). Their expertise in relation to gender-based violence, women’s health, migration and integration issues and criminal legislation is also outlined where relevant.

The first respondent is the CEO of AkiDwA — The African and Migrant Women’s Network Ireland and is the founder of AkiDwA the African and Migrant Women’s Network Ireland and currently the National Director. Her background is in social work and community development, she is an activist and advocate of human rights, justice and gender equality. She serves on the board of the equality authority, observatory committee and national steering committee on violence against women. She is a board member of the Black European Women Council based in Vienna and is a member and coordinator of the European Network of Migrant Women, based in Brussels and administered by the European Women’s Lobby.

Through work by AkiDwA, she has been one of the key actors in Ireland working on FGM. AkiDwA was one of the original members of the national steering committee (NSC) for Ireland’s national plan of action to address FGM 2008–11 (NAP). She has spoken about FGM as a form of gender-based violence at numerous conferences and launches both in Ireland and internationally. AkiDwA has lobbied for the introduction of FGM-specific legislation in Ireland and have been at the forefront of Irish work to address, respond to and prevent FGM in Ireland and to support women who have undergone FGM who are now living in Ireland. AkiDwA are also an active member of the End FGM European campaign run by Amnesty International Ireland.

The second respondent is a social studies student, the founder of United Youth of Ireland (UYI) and a strong voice for the End FGM European campaign. She has been living in Ireland for the last 6 years and is an active member of Ireland’s Somali community. During this time she has worked on many different projects with many voluntary organisations including: Cairde, the Africa Centre, Spirasi,

II. INFORMATION SOURCES

<table>
<thead>
<tr>
<th>Date of the interview (dd.mm.yyyy)</th>
<th>Duration of interview (in minutes)</th>
<th>Observations</th>
</tr>
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<td>55</td>
<td></td>
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<tr>
<td>9.7.2012</td>
<td>79</td>
<td>Additional second interview took place</td>
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<td>10.7.2012</td>
<td>13</td>
<td></td>
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<td>20.7.2012</td>
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</tr>
<tr>
<td>27.7.2012</td>
<td>52</td>
<td>Former Women’s Health Council staff member</td>
</tr>
<tr>
<td>31.7.2012</td>
<td>48</td>
<td>Interview was rescheduled</td>
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<tr>
<td>2.10.2012</td>
<td>67</td>
<td>Garda Racial, Intercultural and Diversity Office</td>
</tr>
</tbody>
</table>

The third respondent is a Professor of Criminal Law at Trinity College Dublin, a senior lecturer and Fellow of Trinity College, a practising barrister and has been an elected member of the Irish Senate since 2007.

In 2010, she introduced a private members’ bill to the Seanad entitled Female Genital Mutilation Bill 2010. At this point the senator was a member of the opposition, but she followed two of her Labour Party female colleagues in trying to get FGM-specific legislation introduced to Ireland by a member of an opposition political party. The 2010 bill was taken by the then Minister for Health and Children to be developed and sent to the Attorney General and was reintroduced into the parliament by the new Minister for Health James Reilly in late 2011. By this time there had been a general election and Labour and Fine Gael were in coalition government and had an explicit reference to enact legislation on FGM in their programme for government. This respondent is now (since February 2011) in government. At all stages of the bill being debated in the Seanad, she was extremely vocal and supportive. When the bill was finally passed and became an Act, the Minister for Health, James Reilly TD, appreciated her exceptional work on this law. The respondent has spoken at events organised by the national steering committee prior to the passing in the
parliament of FGM legislation and has a strong record of work in the areas of equality, social policy issues, women's rights, criminal justice and human rights.

The fourth respondent is the Children's Rights Alliance (CRA) Policy Officer, a position she has held since 2008. She has a Master's in Globalisation from Dublin City University (DCU) where she focused on international human rights law, and her dissertation focussed on separated children seeking asylum who go missing in Ireland. Prior to working in the CRA she worked in the Irish Society for the Prevention of Cruelty to Children for six years and she has a strong background in child protection issues and rights of children.

The CRA Alliance has been an ongoing and active member of the national steering committee (NSC) since 2008. The respondent became the CRA representative on the NSC from late 2008, her colleague was the initial CRA NSC representative. The CRA participated in the development of steering committee policy papers, submissions, letters and press releases throughout the campaign. The CRA were particularly important in terms of communications and media tools, publishing updates on Twitter and Facebook, as well as a number of newsletter articles to highlight the issue of FGM in Ireland and including FGM in their annual Report Card series in 2011 and 2012. The fact that the CRA is a representative body of over 90 member organisations, focusing on rights and welfare of children in Ireland, gave their input to the NSC and the NAP a distinct gravitas and impact.

The next respondent currently works as an Assistant Principal Officer in the Social Inclusion Unit of the Department of Health and deals primarily with issues related to reproductive health. Prior to joining the department in 2009, she was the Policy Officer of the Women's Health Council (WHC). She joined the council in 2004 to develop its position on women's health issues and gender-sensitive policy formulation and service provision as well as conducting research in a number of areas related to gender and women's health. She had previously worked as a research consultant and as a project manager for the Rape Crisis Network Ireland.

She worked specifically on the 2008 WHC Female genital mutilation/cutting: A literature review and on the major WHC research project 'Translating pain into action: A study of gender-based violence and minority ethnic women in Ireland', 2009. Both of which were key research on FGM and GBV in Ireland from a statutory agency. The WHC 2008 literature review on FGM noticeably outlined the shortcomings of the existing Irish legislation in terms of prosecuting FGM cases. The respondent sat on the national steering committee (NSC) for Ireland's national plan of action to address FGM (NAP), representing the WHC until 2009. In 2009 as part of a larger reform process the WHC was subsumed into the Social Inclusion Unit in the Department of Health. This unit was instrumental in drafting the recent Criminal Justice (Female Genital Mutilation) Act 2012.

She was a member of the AkiDwA FGM Health Forum an expert advisory group for the Migrant Women's Health Project. She presented at a series of seminars for healthcare professionals in 2008 on FGM organised by AkiDwA with Dr Comfort Momoh from London, UK in the Coombe Women and Infants University Hospital, the Islamic Cultural Centre of Ireland and the Irish Aid Information Centre all in Dublin.

The final respondent qualified as an occupational therapist at the University of Cape Town and worked in various settings in South Africa before moving to the Western Cape Department of Health as Assistant Director for Rehabilitation. In 2001, she moved to Ireland and was employed in the former Eastern Regional Health Authority as a Service Planner for Disability and for Social Inclusion. With the establishment of the Health Service Executive (HSE) in Ireland in 2005, she took on the role of National Specialist Planner for Social Inclusion. In this role, she led on development of the HSE national intercultural health strategy and has responsibility for coordinating its implementation. She presently heads the National Social Inclusion Unit of the HSE, which has a strategic remit including addiction, homelessness, intercultural health (including asylum seekers and refugees), traveller health, lesbian gay bisexual and transgendered health, and community development. The ethnic identifier is another area of her current work within the HSE.

The respondent was a member of the national steering committee for Ireland's national plan of action to address FGM from its inception. She was instrumental in funding work on FGM through the AkiDwA Migrant Women's Health Project. She sat on the steering committee for the Women's Healthy Council 2009 research 'Translating pain into action: A study of gender-based violence and minority ethnic women in Ireland'. She was also on the advisory group for the recent HSE Crisis pregnancy programme 2012 research 'Attitudes to fertility, sexual health and motherhood amongst a sample of non-Irish national minority ethnic women living in Ireland'. She is currently pursuing a PhD in the Royal College of Surgeons in Ireland on the Connecting Health Research in Africa and Ireland Consortium programme.

Additional contacts and complementary sources of information

Addition sources of information were supplied to me by some of the interviewees such as internal reports and briefing notes.

Websites of organisations or of the interview subjects were reviewed for pertinent information including: AkiDwA, United Youth of Ireland/Ifrah Foundation, Children's Rights Alliance, Health Service Executive, Department of Health, An Garda Síochána. Additional information was utilised from the Central Statistics Office website.

Follow up after some interviews occurred by phone, in person and by e-mail in order to clarify and expand on information or to seek copies of resources or documents that were referred to in the interview. These resources were
used in the report for additional data or to complement the interview data. See references for more details.

Some relevant publications and announcements occurred before and during the report-writing phase of this study including: HSE Crisis pregnancy programme ‘Attitudes to fertility, sexual health and motherhood amongst a sample of non-Irish national minority ethnic women living in Ireland’ (May 2012), and the Fifth Report of the Special Rapporteur on ‘Child protection: a report submitted to the Oireachtas’ by Geoffrey Shannon, 2011.

E-mail and phone contact occurred with some key informants from the desk study phase of the research to elaborate and expand on issues remerging in the in-depth study phase. Contact took place with: Children and Family Services, HSE; Quality and Patient Safety Directorate, HSE; Research Unit, Department of Children and Youth Affairs; and Cosc, the National Office for the Prevention of Domestic, Sexual and Gender-based Violence.

III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

The initial work on FGM in Ireland began with work by a CSO in the development aid sector, namely Comhlámh, a network association of returned Irish development aid workers. This could be interpreted as a good metaphor for the realisation that FGM was no longer something that occurred outside of Ireland, far away where development and missionary work took place. As the population in Ireland was changing, so were the issues Ireland needed to begin to address. This historical development of FGM policy work must be seen in the context of Ireland never having been a colonial nation, it was in fact colonised, and traditionally it had been an island of emigration. This began to change in 1997 when immigrants to Ireland outnumbered emigrants and it also coincided with a gradual natural population growth since 1961. The immigration trend into Ireland continued unabated until 2008, when the trend began to reverse principally due to economic factors. A surge in asylum seekers presenting in Ireland was also simultaneously noted, especially between 1997 and 2003, this trend has declined since then. FGM work accelerated in Ireland to correspond with inward migration from many countries, including FGM-practising countries, tribes and communities. The relatively recent nature of integration, multicultural and intercultural work in Ireland, especially in relation to health, gender-based violence and harmful traditional practices, was noted by all interviewees.

The initial Comhlámh work on FGM involved three key aspects, these being the formation of the Irish Coalition against FGM in 2002, the publication of a booklet entitled Understanding female genital mutilation and accessing funding to facilitate four focus group discussions on FGM with women from practising communities now living in Ireland through the IFPA and funded by Euronet in 2005. A member of the coalition, elaborated on the objective of the groups in her interview: (1) to establish what the baseline level of understanding is of female genital mutilation among African women living in Athlone, and (2) to provide a space for the target group to discuss the issue of FGM in a safe environment. This early work was the only (unpublished) research with women who had undergone FGM in Ireland at the time and it provided the impetus and foundation for future AkiDwA work in the area. The coalition had attracted membership and support from Labour Women, the women’s wing of the Labour political Party. This was to prove particularly important in relation to FGM legislation in Ireland as all three draft FGM Bills were introduced into the Irish parliament by opposition Labour Party politicians. The work by Comhlámh was not sustained in relation to FGM, possibly due to staff change, shifts in strategic direction for the network and funding issues.

Between 2006 and 2008 three significant steps occurred in relation to FGM in Ireland all of which became key policy drivers. They featured in many of the interview responses. The statutory body the Women’s Health Council (WHC) began to research FGM, the IFPA received Daphne funding from the European Commission via EuroNet–FGM to produce a national action plan on FGM for Ireland and AkiDwA received funding from the European Commission under the European Integration Fund and the Office for the Minister for Integration (under auspices of the Department of Justice), via Pobal (a not-for-profit organisation with charitable status that manages various funding programmes on behalf of the Irish government and the EU) to undertake a one year action research project focussing on improving access to healthcare for women who have undergone FGM.

The work of the WHC on FGM began in an organic way. In 2006 the Board of the WHC identified the health of ethnic minority women as a key area of work for the council as part of their strategic plan for 2007 to 2009. Ireland had experienced an influx of migrant women since the late 1990s and start of 2000; these women had become a significant subset of the Irish female population. The systems in Ireland were not necessarily ready or equipped to deal with these new patients and the WHC were aware of this. One respondent said:

‘We felt that the health of ethnic minority women was an important area we needed to look at that we hadn’t looked at adequately before,...at the same time in the same strategic review it was decide that the problem of gender-based violence would be addressed and there were a number of research and policy initiatives that would look at that strand.’

The WHC were also instructed by their board and through their strategic plan to work on gender-based violence (GBV) and had published a report entitled Violence against Women and Health in 2007. This intersection of the health of minority ethnic women and GBV led to work on FGM by the WHC, as it reflected both areas of interest. The WHC saw FGM as an internationally recognised form of GBV and knew that FGM has extremely significant health repercussions. They also had links with NGOs working in the area of women’s health and there was some anecdotal evidence that FGM was an area that needed examination in Ireland. This prompted
the development of their literature review on FGM. As one interviewee put it:

‘We weren’t a service provider so really we felt our role, as much as we could do at the time, was to look what was there to look at the literature that was available internationally, to try and provide an introduction as much as we could from our perspective as policy advisors and researchers to what FGM is, to what were the recognised models of best practice internationally. [...] and try and put forward recommendations, to the Department of Health especially, but also to other statutory players as to what could be done in Ireland to try and address the issue.’

This work by the WHC culminated in the publication and launch of the WHC Female genital mutilation/ cutting: A literature review document in June 2008. This review gave clear recommendations for work in Ireland in relation to FGM, under four headings: health sector, prevention, legal, and research and information. Notably it recommended specific FGM legislation to be enacted in Ireland containing the principle of extraterritoriality. This was a major step forward in moving the issue of FGM from the NGO and overseas development aid sectors into the statutory sector, the literature review came from a state body and made recommendations directly to the Minister for Health and Children. The review became a tool to leverage action and progress in the area of FGM for NGOs moving forward.

‘I think that, from my perspective, the work of the Women’s Health Council played a part, if you want to put it that way, to move it [FGM] from the NGO arena to the statutory section.’

The WHC followed on from their FGM review with the first national study of GBV and ethnic minority women in Ireland which was initiated by the WHC in 2008 and was a very significant piece of work. ‘Translating pain into action: A study of gender-based violence and minority ethnic women in Ireland’ contained qualitative and quantitative data, and included interviews with women on their experience of GBV. One of the research qualitative interviews related to FGM. It was launched in March 2009 and along with a research summary, principles of best practice for service delivery and a resource document for service providers.

From early 2008 the IFPA, one of the original Irish Coalition against FGM members, began work on drafting a national action plan (NAP) on FGM for Ireland. This was part of a Daphne funded project managed by EuroNet-FGM and comprised of 15 EU countries developing action plans and work on FGM in each country. In April 2008 the first meeting of the national steering committee for Ireland’s NAP took place. The IFPA had invited a very broad range of statutory and non-statutory actors to participate and momentum for work developed from this committee. The steering committee initially comprised of:

• AkiDwA
• Amnesty International (Irish section)
• Barnardos
• Cairde
• Children’s Rights Alliance
• Christian Aid
• Comhlámh
• Health Service Executive (both Children and Families and Social Inclusion Units were at early meetings — Statutory)
• Integrating Ireland
• Integration of African Children in Ireland
• Irish Aid (Statutory)
• Irish Family Planning Association
• National Women’s Council of Ireland
• Refugee Information Service
• Somali Community in Ireland
• Somali Community Youth Group
• Unicef
• Women’s Health Council (Statutory).

Ireland’s national plan of action to address FGM 2008–11 was launched on 25 November 2008 by Senator Fiona O’Malley and the Lord Mayor of Dublin, Cllr Eibhlin Byrne in the Irish Aid Visitor Centre. The launch was well attended and garnered a lot of media attention, including television news coverage. It contained three main goals, five strategy headings (legal, asylum, health, community and development aid) under which objectives and actions followed. The actions contained in the NAP had a broad reach across many sectors and this was useful for engaging beyond the health sector according to one respondent. The Irish NAP built on the recommendations in the WHC literature review (stated in the NAP introduction) and both resources were conscious of replicating good practices relating to FGM prevention from outside of Ireland.

The combination of organisations involved in the NSC was commented on by all the interviewees. In particular the partnership approach was thought to be helpful in progressing policy development on FGM in Ireland and especially in terms of the recent FGM criminal legislation. The NAP and NSC were both imperative in progressing policy development on FGM in Ireland and especially in terms of the recent FGM criminal legislation. The combination of organisations involved in the NSC was commented on by all the interviewees. In particular the partnership approach was thought to be helpful in progressing policy development on FGM in Ireland and especially in terms of the recent FGM criminal legislation. The NAP and NSC were both imperative in progressing policy development on FGM in Ireland and especially in terms of the recent FGM criminal legislation. The combination of organisations involved in the NSC was commented on by all the interviewees. In particular the partnership approach was thought to be helpful in progressing policy development on FGM in Ireland and especially in terms of the recent FGM criminal legislation. The NAP and NSC were both imperative in progressing policy development on FGM in Ireland and especially in terms of the recent FGM criminal legislation. The combination of organisations involved in the NSC was commented on by all the interviewees. In particular the partnership approach was thought to be helpful in progressing policy development on FGM in Ireland and especially in terms of the recent FGM criminal legislation.
2007–12 (NICHs) played a role in policy development as it referenced FGM and described some of the risks associated with FGM. The NIHs was launched in February 2008 by the Minister for Health and Children, Mary Harney TD. The NICHs development had involved wide consultation and call for submissions to the strategy. FGM had been raised in the submissions to the HSE by the Women’s Health Council and the Irish Family Planning Association. AkiDwA also took part in the NICHs consultation workshops.

‘Those kind of dovetailed (NIHS and NAP) very nicely with each other, so it gave us the impetus as well within the health service to progress actions around addressing FGM … those were the two kind of complementary plans.’

The NIHs and the NAP coincided with a need to respond to the immigration that was occurring in Ireland. The NIHs was a timely key document in Ireland in raising awareness around the unique needs of health service users from diverse cultural and ethnic backgrounds and its recommendations framed an approach for the statutory health service and structures to address issues, such as FGM, in an integrated way. It also coincided with a generalised realisation in the need for integration and the unique health and support needs that people have from different cultures and backgrounds. Both documents were complementary to each other which supported the National Social Inclusion Office of the HSE taking part in work on FGM and eventually funding work by AkiDwA. The NICHs was also the driver for the development of the ethnic identifier tool and additional intercultural health resources by the HSE.

In parallel to the NICHs development and prior to the formation of the NSC, the Children’s Rights Alliance (CRA) had begun work that acknowledged the issue of FGM for children in Ireland. The CRA had been working on FGM since 2006, when they submitted a Shadow Report to the United Nations Committee on the Rights of the Child, calling for the introduction of legislation on FGM in Ireland. In 2006 the CRA also undertook a review of the Children First National Guidelines for the protection and welfare of children and made a submission to the Office of Minister for Children. The CRA suggested that the guidelines needed to take into account issues for children from immigrant communities, including FGM. The CRA framed FGM as both a children’s rights issue and a child protection issue within their work.

‘We see FGM for children as a very key child protection issue, we believe that children are at risk in Ireland, absolutely, and we believe the necessary professionals need to have the expertise to recognise and deal with FGM.’

As the CRA were one of the initial NSC members it meant that they were fluent in the issues around FGM and child protection when they joined the NSC. They had developed submissions and knowledge of FGM and had a national network of over 90 member organisations which gave resonance and influence to their work on the NSC.

The AkiDwA Migrant Women’s Health Services Project began in early 2008 when a full-time project coordinator and a part-time financial administrator were employed. When the Pobal funding concluded in February 2009, the National Social Inclusion Office of the HSE made a new funding stream available to progress work on the health objectives of the national plan of action by AkiDwA. This funding continued until late 2010. Since then the post has been part-time and is funded by philanthropic sources. The AkiDwA Project coordinator was very involved in the development of the NAP for Ireland and sat on the NSC. This post and subsequent work by the post holder advanced work on FGM and raised awareness of FGM both to healthcare professionals (through training and resources) and to the general Irish population (through media coverage and events). Training healthcare professionals in relation to FGM, developing with the Royal College of Surgeons in Ireland (RCSI) the first handbook for healthcare professionals working in Ireland, initiating and managing the first and second statistical data analysis on FGM prevalence in Ireland were key outputs of the project mentioned in interviews.

Additional Irish policies and strategies were stated as assisting with policy development in Ireland on FGM; the national action plan for social inclusion 2007–16, the HSE policy on domestic, sexual and gender-based violence and the Cosc national strategy on domestic, sexual and gender-based violence 2010–14.

The recent Criminal Justice (Female Genital Mutilation) Act 2012 has been an important step forward in FGM policy in Ireland. It represents the culmination of sustained and collaborative lobbying from the NSC and has been welcomed by the NSC members and by politicians. It is expected to be enacted in the coming weeks and will harmonise legislation between Northern Ireland and the Republic of Ireland regarding FGM and provide legal clarity on the criminality of FGM in Ireland and related penalties. It contains the principle of extraterritoriality.

**Key actors**

The key actors that were mentioned by all interviewees mainly relate to the members of the NSC. In particular AkiDwA was highlighted by all the interview subjects as a major force in driving policy development on FGM in Ireland. Other actors listed include: the Department of Health, UYI, IFPA, Amnesty International, the National Women’s Council of Ireland, the WHC, Unicef and the CRA. One respondent also mentioned the UNHCR as a key actor who, although not members of the NSC, were very helpful in progressing the NAP and who have spoken at UYI FGM events. Another described why AkiDwA was so integral to the Irish work on FGM:

‘We were the driving force, we had to push everything. We also wanted to do it because we were from the practising communities. […] We were speaking from our own experiences and our own understanding.’
Two additional actors that helped to frame and initially develop intercultural work in Ireland were listed: the Office for the Minister of State for Integration and the NCCRI. The Minister for Integration was integral to general work on the area of integration and health, and his office funded the AkiDwA FGM project in 2008. This office and minister was located under the Department of Justice and was established in 2007. This ministerial position is no longer in existence since the last Irish general election in February 2011. The National Consultative Committee on Racism and Interculturalism (NCCRI) were also very active at the time of developing the NAP and their work and resources laid the framework for actions and work to address interculturalism and integration in Ireland. The NCCRI was established in 1998 as an independent expert body focusing on racism and interculturalism. The NCCRI was dissolved in December 2008 due to government budget cutbacks.

In particular, the role of the former Minister for Health, the Minister of State at the Department of Foreign Affairs and Trade with responsibility for trade and development and the former Lord Mayor of Dublin were mentioned by one of the respondents. One interviewee described how support for work on FGM, and in particular the recent legislation, was across all political parties in Ireland:

‘There has been quite a lot of driving forces from in and outside of government [..] myself initially as an opposition legislator you know I found huge support across the political spectrum within the Seanad and then within the Dáil for this.’

Research and data to support policy development

The statistical extrapolations by AkiDwA in 2008 and 2010 to estimate FGM prevalence in Ireland were discussed in all the interviews. AkiDwA’s extrapolation of data from 2006 census figures estimating over 2 585 women affected in Ireland was considered key data for policymaking. One respondent described how the figures and data on FGM provided to legislators by AkiDwA in terms of the number of women who have undergone FGM in Ireland and numbers at risk were very useful and helpful in developing the Irish legislation.

‘I think that people might not have realised how widely spread the practice is so I think to have that (AkiDwA FGM prevalence estimate), that was a key piece of information.’

Anecdotal evidence was also mentioned by interviewees and in the absence of facts it is and was utilised. The WHC FGM literature review was referred to also in interviews. A lack of child-specific FGM data is problematic in Ireland. There is no data on girls at risk of FGM in Ireland, which is a big concern for the CRA. The AkiDwA prevalence data for women has been useful for progressing policy, but it does not include data on girls. This lack of data on FGM in Ireland was noted.

‘There is a big data gap there [..] that isn’t available to feed into policy development.’

Both informal and formal information networks were utilised in terms of feeding data and information into the policymaking process and relationships were built up between policymakers (including politicians) and NGOs during this process. This process of working helps to feed information into policymakers.

‘AkiDwA is working on all levels so our approach is very different. We engage very well with our women on the ground [..] that is the beauty of working at all levels. From there then we draft the submission papers and our policy papers which are informed by the women on the ground.’

EU influence on national approaches to FGM

European funding and related FGM work was only mentioned by one interviewee. She discussed the importance of the European Commission Daphne funding to progress the NAP. She also referred to work at an EU level by AkiDwA on the End FGM European campaign (run by Amnesty International Ireland) from which AkiDwA has received some funding for FGM work and the European Women’s Lobby. The funding for the AkiDwA Migrant Women’s Health Services Project in 2008 was from the European Integration Fund (EIF) but sourced through the Office for the Minister for Integration and administered by Pobal in Ireland.

Although the EU influence was not specially probed for in the interviews and therefore does not feature in the interview summaries it was important in progress FGM work in Ireland in two ways. European instruments and resolutions from the Council of Europe were included in the NAP and the 2010 International Day of Zero Tolerance to Female Genital Mutilation: briefing paper on FGM by the NSC. Both informal and formal information networks were seen as tools to leverage progress on FGM in Ireland by the NSC. Secondly, the WHC 2008 literature review examined work in Sweden, France and the UK in terms of FGM prevention. Utilising examples of work and legalisation on FGM in other European jurisdictions has been important in demonstrating to policymakers good practice in terms of work on FGM and subsequent gaps in Ireland. In particular, comparison between FGM legislation in Ireland’s neighbour, the United Kingdom, and the complete lack of Irish legislation due to cross-border issues in Northern Ireland were spelt out in the 2010 Briefing Paper on FGM by the NSC. Both FGM prevalence data and samples of legislation from other jurisdictions are helpful in progressing parliamentary work on FGM.

‘We were fortunate to learn from other countries because we were behind the curve in terms of legislation.’
IV. PREVALENCE AND DATA COLLECTION

Current data

There have only been two studies, in 2008 and 2010, that attempted to estimate the prevalence of FGM in Ireland and both studies have been undertaken by Sudha Patel for AkiDwA as part of the work of the Migrant Women's Health Project. The initial AkiDwA study in 2008 was modelled on a similar study by the organisation Forward UK 'A statistical study to estimate the prevalence of female genital mutilation in England and Wales, 2007'. This study was funded by the Department of Health and in collaboration with the London School of Hygiene and Tropical Medicine and the Department of Midwifery, City University and it formed the template for the first Irish prevalence research. The Irish prevalence research used this previously tested model to produce a measure of FGM within Ireland and estimated that 2 585 women living in Ireland had been subjected to FGM and 9 624 women who completed the 2006 Irish census were originated from FGM-practising countries. The data contained in both AkiDwA statistical extrapolations is based on the female migrant population originating from countries where FGM is practised aged 15 to 44 who completed the 2006 census form. These estimates were published in the 2008 NAP, AkiDwA and RCSI document 'Female genital mutilation: information for healthcare professionals working in Ireland', the 2009 WHC document 'Translating pain into action: A study of gender-based violence and minority ethnic women in Ireland' and the 2009 WHC document 'Gender-based violence: a resource document for services and organisations working with and for minority ethnic women'. All the interviewees referred to this Irish FGM data.

'It was our responsibility as an organisation to get the data. It could help us to get a law; it could help us with protection, it could also help us in asking for services [...] medical services [...] psychological supports.'

Migration trends in 2010, showing a decline in inward migration to Ireland, led to a concern by AkiDwA that FGM could be perceived as less of an issue for Ireland and as a result undertook a second prevalence study in 2010. FGM prevalence figures from the most recent demographic and health surveys (DHSs) and multiple indicator cluster surveys (MICSs) and World Health Organisation FGM country prevalence studies were applied to all migrant women in Ireland originating from countries where FGM is being practised who participated in the 2006 Irish census and was added to data from the Office of the Refugee Applications Commissioner (ORAC) on women seeking asylum in Ireland from FGM-practising countries from April 2006 to August 2010. After integrating the new data, it was estimated that an additional 585 women with FGM were residing in Ireland since the 2006 census, leading to a new estimated total of 3 170 women with FGM in Ireland in August 2010, and a female migrant population aged 15 to 44 originating from countries where FGM is practised of 11 577 women. This updated FGM prevalence estimate was utilised in training sessions, presentations and press releases by AkiDwA and the NSC. Both AkiDwA estimates were referenced in parliamentary debates to support the introduction of the recent Irish FGM criminal legislation.

The data assisted with the lobbying for a law to criminalise FGM in Ireland and it should assist in getting FGM-related services for women. However, the figures are probably an underestimation, as immigration is continuing to Ireland and undocumented women may not participate in the census and, so are not, therefore, counted in the official figures. AkiDwA is waiting for the 2011 census figures in order to do a third data extrapolation using the same methodology and it is believed that the next set of figures will be even higher. She hopes that this data will be available in August or September 2012. There are limits to the data used although it was helpful in terms of progressing work on the FGM legislation and the only dilemma is that it could be an underestimation.

'It was helpful to help us to come with the very first data in the whole country which actually supported our work [...] and the need to have a law [...] forbidding the practice of female genital mutilation.'

Concerns regarding this data estimate were also articulated by other key informants. There remains a lack of child-specific FGM data in Ireland and there is no data on girls at risk of FGM in Ireland which is a worry for the CRA. There are children who have undergone FGM and are now living in Ireland but there is no hard data to prove this. One respondent suggested that the AkiDwA FGM figures were an underestimation and that the Department of Justice and Equality needs to release figures of numbers of women seeking asylum both on the basis of having undergone FGM and fleeing FGM. There are more than 3 000 women living in Ireland who have undergone FGM and that data on immigration is important and not yet being utilised in Ireland. A special focus was needed on the Nigerian, Sudanese, Egyptian, Kenyan, Somali and Ethiopian communities living in Ireland in terms of gathering enhanced FGM prevalence data.

One respondent described how FGM is a difficult issue, which is not easy to discuss and talk about, so research and hard data was important to progress work. As some data was not available in Ireland international research and data was referred to where needed, local anecdotal evidence from NGOs working with women affected by FGM in Ireland was used in policymaking as well.

Recent innovations: the ethnic identifier (EI) and the National Maternity Healthcare Record (NMHCR)

Two respondents referred to the ethnic identifier tool in their interviews. One of them has been heavily involved in its development; she described the EI, its use and elaborated as to how it can be used to collate data relevant to FGM. The EI is a pillar of the NICHS and it is based on the concept that ethnic background is important to know, as opposed to only nationality, in terms of being aware and being able to address the diverse health needs of different population groups. The EI is based on the Irish census ethnicity question from 2006 and 2011 censuses. It is being used in certain health services but it is still in its ‘infancy’, as there has not been enough data collected through the EI yet to be able to draw definite conclusions on its use.
The need for the EI emerged as part of the consultation on the NICHS by the HSE through submissions from different bodies, such as the Institute of Public Health, outlined the importance of having an EI tool in Ireland. Development of the EI was spearheaded by the Travellers (an Irish nomadic ethnic minority population) and the NCCRI. There were pilot projects using the EI tool, but there is no formal report on its use to date. The process for developing the EI was: emerging as an issue in a call for consultation on the NICHS, consultations on the concept of an EI, developing the EI based on models from other countries, and piloting the EI in two sites (one maternity hospital and one general hospital with a children’s department). The implementation of the EI is part of ethnic equality monitoring by the HSE.

‘So anecdotally we know the pilots [of the EI] were successful but there is no actual concrete written report around it, which is a great pity, as it would have given us the kind of motivation and the kind of force to move things on.’

The maternity hospital involved in the EI pilot, the Rotunda Hospital, has been very positive about the EI and has continued to use it. The Rotunda Hospital is currently developing a new patient information system and is planning to include the EI within the new system to encompass patients in all departments of the hospital. Similar EI data collection tools in Scotland, the UK and New Zealand were examined in developing the Irish EI, but a shorter more practical tool was required in Ireland.

‘Our one is much more limited. But it will be a good way of starting to build up evidence and it allows for drop down menus down the line.’

This enables categories to be added to the EI in the future if required. This has already happened as ‘Roma’ has been added to the EI since it was first used in the pilot phase. The initial pilots began in 2005 and from 2009 the Rotunda Hospital has been using the EI. Temple Street Children’s University Hospital began using it after the launch of the NICHS, but to a lesser extent. Challenges to using the EI are mainly from staff in hospitals and medical settings who may feel initially that asking patients questions on ethnicity would be construed as probing on a sensitive issue.

‘The main challenges are service provider resistance more than anything, convincing service providers that nationality is not the same as ethnic background and also convincing them that it is not a stigmatising question that they don’t need to be uncomfortable around asking it.’

To counteract this hesitancy, training specifically on the value and use of the EI has been developed and delivered. The feedback from the training in the Rotunda Hospital is that healthcare providers are much more confident following on from this training, both in using the EI and in asking for ethnicity information from patients. Moving forward in terms of rolling out the EI across the Irish health services, any seed funding for projects from the Social Inclusion Unit builds in using the EI as a project criteria. This means that more services will be using the EI with time. There is a need to demonstrate why this data and information is being collected, and to apply what has been learnt from it.

The HSE has listed EI progress as a key performance indicator within their national service plan so that they will be able to advance and build on work to date and to insist on EI data collection more firmly than in the past. In relation to provision of services, the EI has been useful in identifying cases of Sickle Cell Anaemia, and this could be a motivation for applying the EI in terms of training medical staff in recognising and identifying health issues related to ethnicity, such as FGM. This would have larger implications in terms of services and supports such as peer counselling provision, based on the ethnic backgrounds presenting to particular services. Translation services would also be targeted to areas of need in a rapid and cost effective manner. One interviewee also referred to the National Maternity Healthcare Record (NMHCR) containing FGM as a risk factor and she feels that this, along with the EI, will assist in the gathering of data related to FGM. She feels that the EI and NMHCR will both have uses in relation to FGM, in terms of creating new prevalence estimates, but only if the data is properly collected.

‘So I think that all that coming together [EI and NMHCR] will certainly help in the medium term at least in building up evidence.’

The introduction of the National Maternity Healthcare Record (NMHCR) began in all Irish maternity settings in January 2012 and roll out should be completed by September 2012. The NMHCR will be used for all women booking for maternity care and includes, for the first time at a national level, FGM as a risk factor for obstetric care. Any woman giving birth in a maternity hospital will be screened and admitted using this record.

FGM is listed as a risk factor on the record, where patients will be asked about it in a similar manner as other maternal health risk factors such as heart disease, back problems, gynaecological complications, etc. However, this will require training for healthcare professionals in terms of asking patients about FGM in a sensitive way. Challenges to data collection using the NMHCR could be women not disclosing having undergone FGM, women not recognising the terms used by healthcare professionals to describe FGM, healthcare professionals not having the language, words and terms to correctly ask women and probe on FGM and training for staff especially nurses and midwives, using the NMHCR on FGM and recognising it.

‘Women do not say ’I have been genitally mutilated’ so it is about finding the right way to ask the question.’

The NMHCR will hopefully provide additional information in relation to FGM which will be useful for the HSE and the Department of Health, such as are the correct clinical guidelines in relation to FGM being followed in hospitals. In addition the referral and support procedures for women who have undergone FGM and who give birth in Irish hospitals will be collated. As every maternity
hospital has social workers to refer patients to, this could include counselling and informing the new parents on the consequences of FGM, on the new Irish FGM legislation and on the supports available to them. In terms of FGM data collection tools, the NMHCR will be critical, and could be used to extract data in terms of FGM and delivery and post-delivery procedures, and practices in Irish maternity hospitals. It is planned that the NMHCR will be online eventually and this will help with data extraction and analysis.

Other potential tools

Interview respondents suggested some possible future routes to data collection in Ireland regarding FGM. The ethnicity question on the Irish census may also assist with data collection relevant to FGM. As the FGM legislation is so recent there are no data collection tools within police and court systems to collate relevant data. It was predicted that recording of any FGM investigations and complaints will be contained in the Garda Síochána annual reports, which are collated by the Crime Section of the Central Statistics Office. Future data and reports from the Courts Services should detail any judicial proceedings or court cases on FGM.

In relation to data on girls at risk of FGM, the soon-to-be-established Child and Family Support Agency might play a role in future data collection and information structures around FGM. The Department of Children and Youth Affairs also have a research unit which gathers data on children. One respondent suggested FGM data could possibly be collated by this unit.

‘When you know what the problem is then I think you can deal far better with it in terms of the services that you provide and the supports that you could provide.’

Overall with new children’s agencies, the EI embedded in the Irish census, the continued use of the EI in the health sector and the new NMHCR, respondents felt that data collection in Ireland is improving.

‘Hopefully, in time it will become easier to build on our information or data gathering.’

Suggestions and recommendations for data collection

Public Health Nurse (PHN) records could also be a useful future tool for data collection; this is due to the key interaction that PHNs have with families and young children/babies often in a community setting or in the family home. Children’s health check-ups in schools could be another possible route to identifying the issue of FGM, girls at risk and gathering data.

One interviewee elaborated in some detail the limitations of current FGM prevalence estimates, as they do not take into account second generation girls at risk of FGM. She described how essential it is to know how many girls in Ireland come from FGM-practising backgrounds (both those born in Ireland and those born elsewhere, but who are now being raised in Ireland). In particular there is no data on girls from African or FGM-practising countries of origin who are at school here in Ireland. This data should be available from Irish school records. One respondent described how data on second generation migrants is also needed in relation to Ireland as these girls could be at risk of FGM. She also discussed daughters from ‘mixed marriages’, where either the mother or father originates from an FGM-practising country and the other parent is Irish or European, as they could be at risk of FGM. There is no data or statistics available on these Irish citizen children from ‘mixed marriages’.

‘It is important that we should have information on how many young African girls born in Ireland or even raised in Ireland are at school, then we would know. It is important when you are raising the issue that you are not estimating in your head.’

In terms of improved datasets, data from the Department of Justice required in relation to numbers of women seeking asylum in Ireland regarding FGM should be used. This information is currently not available in the public domain in Ireland.

Suggestions from the researcher

The initial data extrapolation on FGM prevalence in Ireland was an important tool to justify the need for legislation and ongoing work in the area. There are limitations to the model used by AkiDwA including:

- census data which are likely to be an underestimate, as some individuals and groups may be hesitant to participate in the census;
- the lack of information on the ethnicity of women who migrate to Ireland. As FGM is more linked to ethnicity than to nationality, this might have biased the results;
- the fact that this study did not take into account the influence of migration on the practice of FGM;
- the lack of information on women living illegally in Ireland (undocumented migrants);
- the fact that prevalence data in countries of origin might not be up-to-date and thus might not reflect recent changes in the practice. However it does provide a baseline, starting point for assessing FGM prevalence at a national level in Ireland.

Additional data sets could be used to augment, refine, adjust and verify the baseline estimates. These data sets could be drawn from some of the following sources in Ireland:

- data from maternal death enquiries through the Maternal Death Enquiry, Ireland reports;
- data from sexual transmitted infection (STI) screening services, through STI clinics, family planning services and GP practices. This data is collected for all notifiable infections by the Health Protection Surveillance Centre, Ireland. STI screening is free and confidential in hospital locations nationwide in Ireland;
- data from the new National Maternity Healthcare Record;
- data from sexual assault treatment units (SATUs). There are six SATUs in Ireland and the document ‘Recent rape/sexual assault: national guidelines on referral and clinical examination in Ireland, 2010’ includes a section on FGM;
- data from Cervical Check, the national cervical screening programme provides free smear tests to women aged
V. APPROACH TO FGM

The first section describes the overall approach to FGM in the Irish context in relation to the six ‘Ps’, according to the interview subjects. The next section focuses in detail on responses to each P category.

V.1. Overall

There was a somewhat mixed response to the ‘Ps’ approach from the interview subjects. Some found it a clear framework, on context for the study, and a useful tool to assess work in the area of Ireland on FGM.

Due to very recent events in Ireland in relation to the Criminal Justice (Female Genital Mutilation) Act 2012, which was signed into law in April 2012, some felt it was such a new area it was difficult to rank it. One respondent stated overall it was early to rank the six ‘Ps’ in Ireland:

‘I would have trouble ranking them. I think they are all important in any policy on FGM in Ireland or in any other country, I think they are a good model… in Ireland the issue of prosecution is so new because the legislation has only just been passed so it is really a bit premature to look at rankings.’

Other interviewees required post-interview follow up to establish a clear order in their ranking of the ‘Ps’. Interestingly, despite the development of prevalence estimates for Ireland on FGM since 2008, the subjects ranked this P in varying positions (2, 3, 4, 5, 6) so it is hard to draw conclusions on this P. All the subjects stated that the existing data was useful but that more data and research was required. Gaps on data a girls at risk of FGM in Ireland were particularly highlighted.

Partnership was ranked in a first position by four of the five interviewees who ranked the ‘Ps’ and all referred to the collaborative work of the NSC and the development of the NAP. This also probably reflects the fact that five of the six interviewees had worked together on the NSC. The cross political party support for the FGM legislation was also described. In relation to prosecution there was a variety in the approach to ranking it. It was ranked from 1, 3, 4, 5 by the interviewees, despite all the interview subjects having worked towards the introduction of the new legislation their perception of its ranking varied. Challenges in relation to funding for work, the sensitivity of the topic of FGM and the new nature of immigration in Ireland as impacts on the six P areas emerged in the interviews:

However despite the newness of the topic in Ireland, work has had rapid progress in the past years and this was noted.

‘We are seeing I think a whole really dynamic move forward in policy on FGM across all six ‘Ps’ in recent years.’

V.2. Prevention

Prevention of FGM is a relatively under-developed area in Ireland. As much of the focus of work has been to enact legislation on FGM, prevention has taken a lesser role. But the FGM Act 2012 was felt by interviewees to have a preventative impact as it is a deterrent. There are strong penalties in terms of fines and prison sentences contained in the act and as such it will support FGM prevention measures.

‘Now the law proves nobody can do it (FGM), if they do it then they can go to prison […] the criminalising is very important because it will help us and the community to be aware and know there is a law there.’

However, the potential shortcomings of relying on legislation solely as a preventative measure are clear as well:

‘Even if we have the law […] and we don’t reach out to the communities then we won’t be able to protect the children. The community is very important in terms of prevention […] Our target is the communities.’
There are no formal mechanisms for FGM prevention work in Ireland and it is generally carried out in the NGO sector. There are two main actors working on FGM prevention initiatives in Ireland, namely AkiDwA and United Youth of Ireland (UYI). An increased role for the government in prevention was highlighted and the necessity of a strong, united, overall umbrella organisation that would campaign on FGM prevention in Ireland. This would avoid fragmented, ineffective pieces of work. Mutual support for all organisations working on FGM is needed as they are all working for the same thing: eliminating FGM.

The efforts required to effectively prevent FGM were outlined in the context of strong cultural traditions and in the context of migration:

‘FGM is a cultural practice […] people they want it to be practised and they want to keep their culture wherever they go […] It is a lot of work because people […] believe this [FGM] is our culture and we have to practise it.’

AkiDwA has been working with FGM-practising communities in particular through their two community forums (more information has been repeatedly requested by AkiDwA on the forums but has not been forthcoming). There are two forums nationwide, one in Cork and one in Galway, to look at FGM prevention. In Galway a meeting took place with the forum in June 2012 to discuss the recent FGM law and to train the forum members on how to talk about the issue of FGM and the new law within their communities as awareness raising on the new law is very important for AkiDwA.

The target groups for FGM prevention work have been women from FGM-practising communities, including teenagers, relevant professionals and society as a whole (mainly targeted through press releases, media coverage, radio interviews, etc.). Relevant current and future prevention initiatives in Ireland include the following:

- AkiDwA are developing a leaflet on FGM for practising communities that will outline the new law. This is being supported by the National Social Inclusion Office of the HSE.
- AkiDwA provide training programmes for health professionals on FGM (this will be discussed in more detail under the subsection ‘Provision of services’).
- Social media as an FGM prevention and awareness-raising tool is beginning to be harnessed. UYI, in particular, use Facebook, Twitter and YouTube to promote events and work.
- The FGM awareness-raising fashion show concept brings communities together on the difficult and challenging topic of FGM in a prevention context.

Inviting other organisations to speak at UYI events is a strategic approach by UYI. UYI ask for speakers who lead organisations involved in human rights work such as UNHCR, Amnesty International Ireland, Unicef, Children’s Rights Alliance and AkiDwA. UYI ask the directors of these organisations to share their experiences of working on FGM and to emphasise the importance of protecting girls. UYI also invite politicians, ambassadors, Lord Mayors, among others to their events. This leads to good working relationships between UYI and other organisations and also allows for a relationship between prevention work and policymakers to be built.

This strategic invitation approach has worked well for UYI and Ifrah outlined a recent success at a Cork photo exhibition launch for International Day of Zero Tolerance to FGM 2012. At the launch a woman shared her personal experience of having undergone FGM. One of the local politicians who attended was Jerry Buttimer TD, who also is the Chair of the Joint Committee on Health and Children in the Irish parliament. He was so moved at the UYI Cork event that he gave a personal commitment that his government will do something in relation to the FGM law. He crucially chaired the debate on amendments to the FGM Bill at joint committee stage just before it became an Act. One interviewee described how inviting such a broad range of people to attend and participate in UYI events was crucial to successful lobbying. There is great support from the range of people and politicians Ifrah has links with, who attend UYI events and who were lobbied on the FGM Bill. But young people remain the key element attending and participating in the UYI events.

‘We invite everybody who can benefit from us and who we can benefit, who really want to know about FGM … young people are the feature because they would be at risk to be taken home [to have FGM performed on them].’

Finally, work with practising communities on FGM prevention remains a major concern. Budgets for this work are extremely limited and prevention work on FGM cannot continue without ongoing government funding.

‘Resources are our key major, major problem. If we have resources we will be able to work more and progress work on FGM.’

AkiDwA receives some funding from the HSE and through philanthropic sources. On the other hand, UYI rely on volunteers and donations to run their events and fashion shows, but this limits the work and is frustrating for the actors.

V.3. Protection

Protection in Ireland in relation to FGM principally relates to child protection measures. While there some exemptions contained within the new FGM Act its broad aim is to cover both women and children. The area of asylum protection is very vague in relation to FGM as no data, records or statistics are available in Ireland on women and girls seeking or who have been granted asylum based on FGM. AkiDwA is trying to address this gap by doing a research study with FLAC (Free Legal Advice Centres) and PILA (Public Interest Law Alliance) on gender-based violence claims for asylum in Ireland. This study will look at data in terms of number of asylum claims in Ireland and will aim to collate FGM claims, and will hopefully build up some data on the situation in Ireland.

The new Irish FGM law has coincided with many developments in relation to child protection in Ireland. There is now legal clarity for the first time for those working in the area of protection on the criminal nature
of FGM contained within the FGM Act 2012. This should enable and empower the child protection dimension to a greater extent compared to when there was no FGM-specific legislation in Ireland. Focussing on protecting the girl was actually a key path to getting the new Irish FGM law in place. The recent developments in terms of child protection in Ireland include the appointment of the new Minister for Children and the setting up of her Department for Children and Youth Affairs in 2011. The Irish child protection guidelines have been updated and amended in 2011 (they are now called guidance) and will be put on a statutory basis soon. The protection measures and protocols for children at risk are contained within the Children First guidance. This is very positive as when the guidance is put on a statutory basis in the near future, any of the key actors who suspect or identify FGM will have a legal duty and requirement to act. There will be a much stronger onus on these professionals to protect children and girls at risk of FGM when Children First is on a legal basis. The HSE and Gardaí are currently mandated to adhere to the Children First guidance, but it will have a broader remit for more professionals once it is on a statutory footing. However, that is the theory and policy and, in terms of practice, it can be different and have gaps.

‘Where we would have a concern would be: are the necessary practitioners being up skilled in this? Are the necessary training programmes in Children First happening […] is that focussed enough on FGM? Does it include FGM specifically as an issue? So the policy is quite good on that, but is the practice?’

A handbook was released by the Health Service Executive (HSE) in conjunction with the Children First guidance in 2011 called *Child protection and welfare practice handbook*. The aim of the handbook is to describe to practitioners how to use Children First guidance in their work. Within the handbook there is a section on FGM, which is a very positive step forward in terms of policy development. Mandatory reporting has also been revised in Ireland, and while writing this report, the Criminal Justice (withholding information on crimes against children and intellectually disabled persons) Bill was passed by the Irish parliament. One interviewee felt this will have important repercussions for actors in the area of child protection in Ireland are: social workers employed by the HSE, members of An Garda Síochána (police), teachers, public health nurses, the ombudsman for children, the special rapporteur on child protection and lobby groups such as Barnardos, CRA, Unicef who campaign for enhanced child protection measures and supports. Within the HSE, child protection overlaps with many areas of work, including the Social Inclusion Unit. One of the respondents is keen to liaise with colleagues in the child protection sector on the issue of FGM. The area of child protection is changing and developing a lot at the moment and the Social Inclusion Unit will have a Children First committee. Another respondent said she would locate and advance work on FGM and child protection within this committee. The committees are being set up at the moment.

In terms of training on FGM for professionals in Ireland on protection:

- there is a training programme run by the HSE on the Children First guidance. However it does not cover FGM specifically;
- there is no specific training on FGM for members of An Garda Síochána;
- AnkiDwA has delivered training programmes to social work and social care students in colleges and universities;
- school teachers in Ireland may not have received any specific FGM training. An FGM-specific protocol and handbook for teachers could be useful as currently there do not appear to be any.

One interviewee said she was not aware of any recording systems related to either: (a) asylum requests/granted based on FGM; or (b) child protection interventions for girls at risk of FGM in Ireland. There are no publically available recording systems for asylum requests received and granted in Ireland. As the FGM law has not yet been enacted there are no available record systems of child protection investigations with regard to FGM. The child abuse records in Ireland are collated by the HSE and the Gardaí and compiled by the Central Statistics Office but are not readily available to the public. Sexual offences and attempts/threats to murder, assaults, harassments and related offence (recorded and detected, 2006, 2009 and 2010) include child-related offences and are published in the Central Statistics Office, Garda Recorded Crime Statistics 2006–10, but do not include FGM as an offence. The Fifth Report of the Special Rapporteur on Child Protection, July 2011 presents some statistics on child victims in Ireland, mainly from media sources. It can be assumed that, especially from the Special Rapporteur Report, child abuse records and statistics are distinctly lacking in Ireland.

Work in the area of protection is financed by the Irish government and administered through different departments. In relation to policing by An Garda Síochána by the Department of Justice and Equality, for social workers by the HSE funded by the Department of Health although these structures are in the process of changing and will be managed by the Child and Family Support Agency through the Department of Children and Youth Affairs soon.

The protective nature of the new FGM Act 2012 for actors against FGM was noted and it was felt that it was important to have a law. One respondent says she feels safer now the law has been passed.

‘It helps, I think it is really great and is good news for me that we have it. Because now I believe in myself, I am safer, as a person, because I am a campaigner. Because I was accused of not being able to do anything, I was blackmailed, threatened to be killed, a lot of things happened to me […] It helps me and I believe it helps also others.’
Work in relation to asylum protection measures needs enhancement. The asylum process needs to respect women more and to trust them, if they are claiming asylum on the basis of FGM, both if a woman has had FGM or she is escaping it. Protecting girls that are born in Ireland and raised here will be a future challenge according to Ifrah. It is now the responsibility of the Irish government to stop young Irish citizen girls to be taken to other countries to have FGM performed.

V.4. Prosecution

Most of the respondents discussed the background to the development, content and possible future policing of the new Criminal Justice (Female Genital Mutilation) Act 2012 in relation to FGM prosecution. The development of the legislation involved a huge lobbying effort from the NSC that was complemented by research by the WHC and cross party political support. One of the respondents discussed the legal background to the new Act and emphasised that there had been extensive legal analysis explaining the shortcomings of the assault law in Ireland in relation to FGM. The analysis focused in particular in terms of consent, to an act such as FGM, by parents of a child. The senator referred to the case of a baby boy who died in Waterford, Ireland in 2005 after he was circumcised for non-medical reasons and how the subsequent prosecution failed to convict anyone under the Irish assault law. The parallels with this baby’s legal case for any future prosecution for FGM cases in Ireland were clear to the senator and to other legislators and, as a result, they felt specific FGM criminal legislation was required. The extraterritoriality jurisdiction aspect of the FGM Act is a new and important aspect of the legislation the senator stated. It enables prosecution where someone is known to be bringing, or has brought a child abroad, in order to perform FGM.

Another respondent also outlined the rationale for having a specific criminal law on FGM in Ireland as being based on the lack of clarity in existing legislation on FGM. It was not clear to the general population that FGM was against the law and there was no provision for extraterritorial application of existing Irish law. Although other countries have managed to use non-specific FGM legislation very well in relation to FGM this was not the case in Ireland where there was less legal clarity as the Non-fatal Offences against the Person Act 1997 had never been tested in the courts regarding FGM and lacked the extraterritorial dimension. The new Criminal Justice (Female Genital Mutilation) Act 2012 will give a much greater level of legal clarity that FGM is a specific crime in Ireland and this will assist healthcare professionals, social workers and teachers in their jobs.

'I hope it will be really useful, it will just bring a legal clarity to the fact that there is a law now that very clearly states that this is a crime, and very clearly lays out the penalties for that specific crime rather than being part of a much bigger and broader law.'

Now for the first time in Ireland there are also clear penalties for the crime of FGM. There are limitations within the act in terms of extraterritoriality, as FGM can only be a considered a crime if it happens in a country which has also has criminalised it. However, to counterbalance this possible legislative limitation, the drafters of the act included an innovative clause in Section 3 of the act, which criminalises the actual removal of a girl from Ireland for the purposes of FGM. Uniquely, the removal of a girl with the intent of her undergoing FGM abroad is now actually a crime. Therefore, the limitations of Ireland’s international law commitments have been circumvented with a new legal clause in order to provide protection for girls living in Ireland from FGM.

The origins of the bill are very unusual in Ireland. It started as a private members’ bill and the then Irish Minister for Health, who was a woman, Mary Harney T.D., agreed to take the bill and develop it into legislation within her department. The senator noted that there was as real consensus built up through all the lobbying work by NGOs on the bill. When the bill was going through the drafting stage in the Department of Health there were two very important inputs: there was wide consultation with NGOs and professionals on the bill by the civil servants in the Department of Health which helped to tweak the legislation. The civil servants in the Department of Health went far beyond the call of duty according to the senator while drafting and working on the bill. It received support across the politician spectrum in the parliament and senate.

‘I thought that was a good practice, the legislature reaching beyond party political interest and a consensus emerging among politicians.’

From an NGO perspective, the Irish FGM law is very new, it will need to be reinforced with supports and services and will have to be monitored to ensure it is working. It is believed that groups from the NSC and NGOs will help in monitoring the law and to ensure it is working well. She expects within the next two years they will monitor it closely to see if there are any cases or prosecutions related to FGM.

‘At least we have the law, which is the first step.’

One interviewee expressed disappointment that not much has occurred since the act was passed in April 2012. She feels more must be done to promote the new law and make people aware of it. The Gardai and the government, in particular the Department of Justice, need to work together and distribute leaflets, posters and information on the new FGM law. Leadership on the issue is needed from the Department of Justice to give a strong mandate to the Irish police force to address FGM and to work on it.

‘If there is no communication between the government and the campaigners and the police there will be nothing happening.’

The support for the FGM legislation has been vocal and overwhelming positive. One respondent discussed how it received cross political party support in the Irish parliament, there was no opposition to the Act and politicians wanted to work together to ensure that the act was the best possible piece of legislation and that is
was as robust as possible in legal terms. Campaigners for the Act have strongly welcomed it and members of the public have also expressed their support by contacting the Department of Health in relation to the Act. It was felt that there were no legal obstacles to implementing the new FGM Act in Ireland, but as with other offences that are intra-familial there are always difficulties with getting evidence and having people come forward to report cases. Therefore, challenges to prosecution will include the difficulty of gathering evidence and getting witnesses to come forward.

As the law is so recent there are no available records of court cases, investigations, convictions or available records of police interventions. To date, there are no official reports of FGM taking place in Ireland from either health service providers or the Gardaí. The reporting mechanisms for cases of performed FGM would be similar to any other criminal offence. Although there are currently no formal protocols for Gardaí in relation to FGM, the reporting mechanisms for cases of FGM (both performed and suspicion of) would consist of any person presenting at any Garda station and reporting, or by contacting HSE Child Protection Social Work Services. The Children First national guidance for the protection and welfare of children, July 2011 and the Child protection and welfare practice handbook, HSE, 2011 would provide notification and reporting forms, procedures and checklists in relation to child protection incidents, including FGM. But there are no specific protocols, procedures or forms in place for FGM cases yet.

The Garda Racial and Intercultural and Diversity (GRID) Office would be an initial point of reference for all Gardaí encountering cases suspected or performed of FGM in Ireland. One of the GRID Office staff has attended specific training on honour based violence and is familiar with the issue of FGM.

Prosecution of professionals who do not report or mandatory reporting has just been legislated for in Ireland. Whilst writing this report, the Criminal Justice (withholding information on crimes against children and intellectually disabled persons) Bill was passed by the Irish parliament in July 2012. It covers the area of FGM and provides an enhanced legal framework for the mandatory reporting of FGM.

V.5. Provision of services

Interview respondents emphasised that FGM is a new issue for service providers in Ireland and, in particular, for health services. The pressures facing all health services in relation to operating in an environment of cutbacks and recession were also articulated. One respondent felt that while the health system in Ireland can be very good and professional supports are available, there are issues in terms of access and waiting lists. The respondent also commented that FGM is a sensitive thing and women may not be able or empowered to come forward and seek help from service providers related to having undergone FGM. One respondent stated that provision of services is a very important P and that services should be developed in parallel with the legislative framework.

Another respondent discussed how work in the area of service provision has been very slow and it has not been a priority area in Ireland, despite AkiDwA consciously working on it since 2008. Currently there are no specific, dedicated services or clinics for women who have gone through FGM. There are healthcare services for FGM across Ireland and are located in general health services, particularly in maternity hospitals. However, the service provider approach can vary depending on different elements around the nature of provision.

‘The healthcare services are there, but certainly need enhancement and support.’

AkiDwA would like a named doctor to refer women to a ‘one stop shop’ type clinic as in the UK. AkiDwA have been lobbying for a targeted ‘one stop shop’ for healthcare for women who have undergone FGM, possibly located in a Dublin or Cork maternity hospital for some time. It was discussed when a targeted health service might be needed. The principle in Ireland around health services is that everyone is entitled to the same services in an equitable manner. Targeted services are not developed unless there is a specific reason requiring them. If there are targeted services there needs to be a clear vision as to why they are there and how long they should exist and if and when they will be mainstreamed in time.

‘I suppose it is the same with the healthcare services around FGM as well, maybe one could start off with something targeted but with a view to ultimately making the whole healthcare service so competent that one would not need the targeted services.’

The health services in relation to FGM are on an ad hoc basis and although Irish health services are countrywide there would be a greater concentration of specific services within urban areas and main maternity hospitals. Rural areas may not be as well catered for in terms of service provision. One respondent was not aware of any FGM-specific services; if they exist, they would be in a broader sense provided (perhaps through violence against women services).

The ad hoc nature of provision is problematic for separated children seeking asylum in Ireland. The housing of these children has recently changed from a hostel based system (mainly in the greater Dublin region) to a foster care one, in homes across Ireland. While this is a good model of childcare, there are practice issues in terms of professional expertise in local areas. There was considerable expertise built up around the hostels in Dublin but, in more rural areas where the children are now being fostered, there may be a lack of relevant local services or local expertise and local professionals, of which many never have had experience in caring for girls who have undergone FGM.

A positive note is that many healthcare professionals working in Ireland are migrants: there are doctors and midwives working here that are originally from FGM-practising countries. Thus, there may be some expertise already and knowledge on FGM in hospitals in Ireland.
One respondent suggested that hospitals need to know the background of their patients and that they should ask women originating from FGM-practising countries about FGM earlier in their pregnancies than they are currently doing. She felt this could avoid unnecessary Caesarean sections. The roll out of the NMHCR should therefore assist this process.

Although there is demand for specific FGM counselling services by women contacting AkiDwA, only general counselling is currently available in Ireland. One interviewee has talked to AkiDwA and colleagues about the HSE counselling services and the need to incorporate FGM as a consideration for training counselling staff on aspects of FGM. FGM is on the agenda for work in terms of HSE counselling services. Provision of services is on an ad hoc basis in Ireland, mainly depending on the initial expertise of the healthcare professional a woman encounters. AkiDwA also noted that the lack of a single focal point for care for women with FGM is problematic.

Training and information for healthcare professionals in relation to FGM has been led by the work of the AkiDwA Migrant Women’s Health Coordinator and project in Ireland. The publication and CD-ROM ‘FGM: Information for healthcare professionals working in Ireland’ developed by AkiDwA and the Royal College of Surgeons in Ireland are important tools for educating relevant professionals on FGM. AkiDwA has given many training sessions on FGM to healthcare professionals (HCP), midwives, in hospitals and to student midwives, and has brought experts to Ireland to share their experiences and to train healthcare professionals on issues of FGM. AkiDwA has trained over 3,000 healthcare professionals in relation to FGM. AkiDwA would like FGM to be in the curricula in relevant university courses and programmes. Once FGM is embedded in the curricula for appropriate courses it can be taught on an ongoing basis and will not rely on staff from AkiDwA to deliver FGM-specific training.

Funding for all health services would come from the HSE, however healthcare in Ireland is a mix of public and private funding and many patients pay up front for their medical costs and care. This can be a disincentive to accessing medical care in Ireland.

V.6. Partnership

Partnership was a very positive area for all the interviewees in relation to work on FGM. It was seen as the crucial element and working modality in making rapid progress on FGM in the preceding years. The NSC was the key component of the Irish partnership approach. The main actors involved in partnership were the members of the NSC, in particular the IFPA who initiated the NSC work and was an earlier Coalition Against FGM founding member and AkiDwA. The IFPA coordinated the NSC in 2008 and since then AkiDwA has been the main coordinator and driving force. There appeared to be little or no inclusion and exclusion criteria to be involved in the NSC partnership; a commitment to work together on the issue of FGM was the main criteria. There have been radical reforms regarding child protection agents in the Irish statutory sector since the formation to the NSC, in terms of the new government Department of Children and Youth Affairs and the new Children and Family Support Agency which will sit under the department. This department and agency were not in existence when the NSC was formed and therefore could not have been invited to sit on the initial NSC.

The role of partnership at policy development, policy implementation, and monitoring levels appears to be mainly related to driving the recent FGM Act 2012. Partnership is very well developed in Ireland and it really started to progress in 2008 with the NAP steering committee. The NSC included NGOs, governmental bodies and women coming from practising communities. This collaborative multi-agency partnership approach is very important and it has helped get the new law in place. The inputs and dialogue with the NSC was also helpful to those drafting the FGM Bill.

One of the respondents articulated that partnership was critical in working on such a sensitive topic as FGM. Using the knowledge and expertise of NGOs on the topic made sense on many levels.

‘It would seem much more appropriate and of much more value to use the expertise of people who have that knowledge and awareness and ability to communicate with the communities who are most affected, so for me partnership is a hugely valuable tool in any work around FGM.’

Resources for this partnership work were first made available through the Daphne Euro-Net FGM funding, and later for AkiDwA from the National Social Inclusion Office of the HSE. Partnership is well developed in Ireland, and it now needs to be supported and sustained. This is a difficulty in terms of resources to carry on the work in Ireland in the present financial climate.

‘It is certainly something to our advantage that we have built the relationships and we have been able to support up until now any work around the area, it is just the challenge is sustaining it.’

Success factors to the partnership would seem to relate to broad range of actors involved especially the statutory and CSO mix. It was stated that building relationships with potential allies such as policymakers and politicians and providing them with straight-forward information is also a good practice. This information provision directly to policymakers and ministers has helped them to be informed and has improved the legislative work. She also outlined the importance of engaging people from practising communities, and how bringing them around the table is necessary. The range of outputs including the NAP, multiple events, briefing papers, press coverage and lobbying as a united group for FGM legislation were noted by interviewees. There is now less statutory input to the NSC which is missed and it has more of an NGO emphasis. One respondent felt it would be more positive if a broader range of members were on the NSC again.

Challenges moving forward will include staff availability,
many of the initial NSC members are not currently active. Competition for resources within the partnership, although not articulated by interview subjects, could also be problematic as funding becomes more constrained in Ireland.

The role of partnership in policymaking and implementation in Ireland has been very positive. The Irish NAP concluded in 2011, so it now needs to be reviewed and areas of outstanding work identified. Success. One respondent suggested it could be updated and re-focused on new key, and with achievable targets. She also commented that the NAP has not been taken on and ‘adopted’ by any Irish government department or agency which was a key aim of the NSC. This lack of a statutory home for the NAP has been a disappointment for the NSC and a possible obstacle to further work. One area that has been very successful and could have been seen as a potential stumbling block is the multi-departmental engagement the NSC has had. The range of departments and ministers contacted by the NSC regarding FGM was very broad and this was primarily because the NSC was not sure whose remit FGM fell under. But this lobbying eventually allowed the NSC to have a lot of interaction with multiple actors, ministers and government departments.

VI. SUCCESSES AND CHALLENGES

All the interviewees were keen to share what they perceived as the successes and challenges in relation to work on FGM in Ireland. Partnership as a success and the ongoing challenge of financial constraints due to the economic crisis in Ireland were repeatedly mentioned.

Successes

All the interviewees saw partnership as a key success factor in relation to the work on FGM in Ireland. One interviewee articulated the successes as: the partnership approach, working together and the good will between many different agencies. The NSC involved different organisations who agreed to work together, and this allowed FGM to be seen as a concern for agencies and organisations and not simply a migrant women’s issue. This partnership approach has been beneficial for the CRA as they have built new links through the NSC and developed new working relationships with CRA members beyond the NSC.

‘There is a knock on positive thing beyond the FGM issue which we have forged links in new areas with new partners.’

The success factors are, from a children’s point of view, the fact that Children First guidance will be on a statutory footing soon, the new Child and Family Support Agency and the commitment to FGM legislation in the programme for government.

One respondent felt that the FGM awareness-raising fashion show concept is a successful tool that she uses to bring communities together on the difficult and challenging topic of FGM. It has been delivered as a model for the work on FGM in other European countries.

The work of grassroots organisations such as AkiDwA and United Youth of Ireland who are actively and successfully engaging with practising communities on FGM was defined as a success. Another respondent referred to ‘champions’ or vocal, campaigning individuals on FGM in Ireland, both political and individual, as being very successful.

The passing of the recent Criminal Justice (Female Genital Mutilation) Act 2012 was also seen as a success by all interviewees and a culmination of their work and lobbying.

‘I was delighted we got through it [the 2012 FGM Act] […] I’m sorry we didn’t get the legislation in quicker, there was a fall of government in the meantime and a collapse of the economy so I suppose other factors intervened!’

Challenges

All of the interviewees stated that FGM is a new area of work in Ireland: it corresponds to recent inward migration into Ireland and the country is only coming to terms with issues such as cultural diversity, multiculturalism and changing populations. Accessing funding and a lack of resources to continue what is perceived as good work and excellent partnerships in relation to FGM are a huge challenge now in Ireland. The key challenge in relation to policy implementation is the lack of resources. The main challenges are: training, financial restrictions, lack of data and lack of awareness. UYI are also experiencing limitations in their work due to a lack of funding. One of the respondents discussed the challenges in relation to FGM as being related to the overall Irish economic climate.

Challenges remain in the area of FGM and asylum, and bringing men on board to work on the issue of FGM. Involving men in FGM eradication is very important as they may refuse to marry a woman who has not undergone FGM:

‘We do need to put men into the picture, if we are really going to talk about combating female genital mutilation completely and eradicating we would have to think of a holistic approach that would work and including men in this process is very, very important.’

Funding for the work on FGM remains the major challenge for all the interviewees.

One interviewee discussed the problem of policing the new FGM law as a particular challenge. A potential barrier is the asylum appeal case of a Nigerian woman and other immigration/asylum cases, where Gardai may feel the applicants were not honest in their asylum claim regarding FGM. This case was reported on in the Irish media over a number of years and the woman was eventually deported in 2011. This may have led to a culture of disbelief and distrust in some members of the Irish police force about FGM. The interviewee has tried to
combat this by using women from many countries (Kenya, Liberia, Nigeria, Somalia, etc.) to talk about their own experiences of FGM at UYI events. She includes women who have Irish citizenship and who have daughters here in Ireland to speak out on FGM, as they are not applying for refugee status in Ireland but are still affected by FGM. She described this complex situation as a challenge to the work on FGM, as Gardaí in Ireland need information and training on FGM but may have inherent biases in relation to the issue.

‘Whatever happened in the past is one person […] we have to make them (police) understand that there are young citizens who are born and raised in Ireland and who are at risk to be taken home and they have to know the rules that will help those girls. There is more work to be done between the Guards [police] and also social workers.’

**Researcher’s analysis**

Locating work on FGM within a context of developing an NAP and allowing this development to be led by a multi-agency and multidisciplinary working group such as the NSC was very successful in Ireland. A commitment to this partnership method of working, led initially by the IFPA and later by AkiDwA, was a crucial success factor to work on FGM in Ireland. This made FGM an issue for many organisations and not simply be seen as gynaecological or a minority issue. The recent FGM Act 2012 and progress in relation to child protection guidelines and frameworks are concrete examples of the successful outcomes of the NSC partnership approach.

However, retaining this approach will be a challenge moving forward as the NGO sector becomes increasingly competitive regarding funding and many of the initial NSC members are no longer in existence as a result of funding shifts or mergers (Integrating Ireland, the WHC and Refugee Information Service are examples of this). Strong, altruistic leadership within the NSC will be required to navigate these challenges. Additionally organisational staff changes, redeployments and redundancies and across all sectors in Ireland are occurring mainly related to financial and budgetary cutbacks; there is a very real challenge that expertise, institution knowledge and good working relationships in relation to FGM will be yet another casualty of the recession in Ireland. The joint responsibilities of policing the FGM Act and reviewing immigration applications falling under the remit of the Department of Justice and Equality and the Garda Siochána has some inherent tensions which could be challenging to successfully resolve.

**VII. POLICY LESSONS AND RECOMMENDATIONS**

**Lessons learned and what works**

All interviewees had ideas to share on what works in terms of FGM policy development in Ireland. They were varied and consisted of a broad range of suggestions, of which partnership was constantly referred to.

The importance of getting legal advice where and when needed was highlighted. As the NSC were not legal experts, but were lobbying for legislation on FGM, they sought pro-bono legal advice on the draft FGM Bill in order to better inform their work. In terms of what works from a children’s perspective, it is imperative to get FGM recognised as a child protection issue. Then it is necessary to provide training and support to relevant professionals, to provide support to girls and families at risk of FGM and support to those who have undergone FGM. There were key committed individuals involved in the FGM work in Ireland, so identifying these FGM champions and forging relationships with them was very positive and highly recommended.

Very concise recommendations on what works in Ireland were made: ensuring cooperation between NGOs who are working within communities at risk, building a consensus among politicians on the issue and having data available for legislators and policymakers. Both FGM prevalence data and samples of legislation from other jurisdictions are helpful.

One interviewee referred to involving young people as a key factor in successful work on FGM. She felt that mobilising young people is critical to work on FGM and that the fashion show model is good way to bring them to events. The entertainment aspect of the fashion show engages young people to attend and to learn more about FGM, but it is also fun.

‘People used to say to us: how can you mix fashion show with a human rights issue which is a very sensitive issue? Then I say because as I train young people I see the young people’s interest, I see what young people will listen […]’

The interviewee stated young people can work in a very professional way and can be stimulated to learn more about FGM and to share this information after UYI events.

‘It is important that the youth are involved and youth are the people that are actually making all the noise and telling people this is against human rights, we have to do something about it.’

There are three main recommendations related to policy work on FGM in Ireland. It was important to have prevalence data in terms of policy implementation because facts are needed to lobby and progress work. Including the voices and experiences of women who have undergone FGM in the dialogue and work, as they bring the personal and emotion impact of what they have gone through to policymakers and the campaign. However this needs to be done with supports in place for them, so that being vocal on the issue of FGM and their personal experiences does not affect them in a negative way. Finally involving a very wide range of actors is vital in order to build alliances, develop networks and progress lobbying.

**VIII. ACTION RECOMMENDATIONS**

**FGM champions**

Identifying and engaging FGM champions is very important. These are key committed individuals involved in the FGM work in Ireland, so identifying these FGM champions and forging relationships with them was very positive and highly recommended.

**Investigating and sharing personal experiences**

Including the voices and experiences of women who have undergone FGM in the dialogue and work, as they bring the personal and emotion impact of what they have gone through to policymakers and the campaign. However this needs to be done with supports in place for them, so that being vocal on the issue of FGM and their personal experiences does not affect them in a negative way. Finally involving a very wide range of actors is vital in order to build alliances, develop networks and progress lobbying.
One respondent recommended very strategic approaches to successful working methodologies in relation to FGM in Ireland. She recommended working closely with the Department of Health as health structures are changing at the moment in Ireland. Building on what is happening in the wider health arena is also key, as social inclusion is a relatively small care group she has learned to link into broader health work and strategy development, such as the new national sexual health strategy. The respondent is on some of the subgroups preparing this new strategy, so she will be able to reference FGM within it.

‘It is kind of being strategic about things as much as possible, so we are in there even if we are not a key driver, but it’s whatever we can do is documented and taken into consideration.’

In summary, one respondent felt that good work had been done on FGM in Ireland to date, especially in relation to the new legislation.

‘In the Irish context we can lead the way as a European country with a good piece of legislation in place […] we have some very vocal champions around it as well.’

**What does not work?**

There was very little reaction and response to the question of what doesn’t work so well and both respondents referred to more general ways of working on FGM and not specific Irish examples. One interviewee spoke about the use of short films for raising awareness of FGM. She felt that many short films and videos on FGM are hard to watch, and can make women who have undergone FGM very upset. In particular she spoke about a recent video piece by Makode Linde in Sweden on FGM that she described as ‘horrible to see’ and abusive. She feels that it is important that any films on FGM must be simple, increase understanding on FGM and sensitive to women who have experienced FGM. Another interviewee articulated a similar response to working on FGM. AkiDwA is keen to frame FGM in a health, gender and human rights’ point of view to avoid the ‘awful and scary’ responses it tends to provoke and in order to engage people on the issue and not put them off. They are sharing expertise and experiences with Forward UK in terms of how to work well with practising communities on FGM and to avoid this kind of reaction to the topic.

**Priority areas to improve and strengthen the work on FGM in Ireland**

Moving forward and particularly in relation to the new FGM Act 2012, interviewees had many suggestions for areas of work to develop and build on.

One respondent identified that work in Ireland needs to focus on service provision and identify accurately those who have undergone FGM and those who are at risk of FGM. Prevention and education regarding FGM through working with affected communities is also needed. Another respondent suggested increasing the level of awareness work on FGM with communities, NGOs and the government through information materials, training and social media. This would be done with government support and would focus on the new FGM law and the repercussions of breaking the law. She also suggested developing a specific website and using a Facebook page to raise awareness. This work should be done in conjunction with other EU countries and the USA to harness global contacts and expertise. Ifrah felt that there are two other priority areas of work for Ireland: training for the Department of Justice staff who interview asylum seekers on FGM; and airport police and immigration staff (members of An Garda Síochána) based in Irish airports should be trained on the risks of FGM being performed on girls being brought out of Ireland by their families. Information on FGM and the recent Irish criminal law should be in airports in formats such as posters.

The main priorities for future work in Ireland on FGM are: a commitment from the government along with resources to fully implement and adopt the NAP. This would be both helpful and meaningful for NGOs and NSC members. Monitoring the new FGM law needs to occur and supports on the law are required for professionals such as the police, healthcare professionals, teachers and other professionals in schools. This would also include raising awareness at a community level on FGM. Having one focal point for support and medical care of women is needed. Having somewhere that women with FGM know they can go to for medical care and support is lacking in Ireland. Ultimately high level support and sufficient resources is fundamental to progressing work on FGM in Ireland. She emphasised it is important the EU countries link and work together to ensure FGM is not happening within the EU. She highlighted that country of origin and country of destination are part of a continuum for migrants and work must be done in countries of origin to eliminate FGM as well. Pressure from home countries is a huge part of the issue: education and work must be done to eradicate FGM globally.

‘It is important that we have the linkages between destination countries and countries of origin and unless we do that we are not going to eradicate female genital mutilation. We need to work it together. We need to do it and do it well because women continue to be mutilated.’

Publicising the new legislation, continuing to train medical professionals and disseminating information was highlighted. It was stressed by one of the respondents that it was important to train all healthcare professionals, not only obstetricians and gynaecologists, but also general practitioners (family doctors) who are likely to be a first point of contact in the health services for women with FGM and allied health and social professionals such as Community Welfare Officers.

Moving forward to improve and strengthen work in Ireland on FGM, it is about building evidence, influencing people and being strategic in work particularly due to the current lack of funding in Ireland and the small Social Inclusion Unit team.
In conclusion, all of the respondents were articulate about identifying work priorities on FGM moving forward in Ireland, many of them related to prosecution, prevention and provision of services regarding the new FGM Act 2012. Awareness-raising aimed at FGM-practising communities and training key professionals regarding the Act is important and was highlighted by five of the interviewees. Data collection and research relating to Prevention was also mentioned and utilising new data collection tools such as the EI and the NMHCR in a correct and competent manner should progress this area. Enhancing the Protection area was not discussed in detail but would relate to more training and information for teachers and airport police staff. Two interview subjects emphasised the importance of embedding FGM in a variety of strategies and work plans as a way to strengthen work on FGM in an environment of increasing financial constraints. The Partnership mode of working had been discussed in detail by all the interviewees in relation to what works regarding FGM policy development, and was not addressed in relation to future priority areas.

VIII. POTENTIAL GOOD PRACTICES

All interviewees were happy to share what they perceived as good practices originating in Ireland on FGM. Partnership was repeatedly mentioned in all the interviews. One interviewee referred to a number of good practices she observed in relation to FGM work in Ireland: the coalition of NGOs and government organisations working on FGM, and the coming together of government and opposition parliamentarians on this issue. There was a general consensus that FGM legislation was needed in Ireland and politicians worked together on it. Strong support from the medical community, especially the Institute of Obstetricians and Gynaecologists, gave a rationale from the medical community on the need for FGM legislation in Ireland.

‘We have got to look at different ways of working… how do we link in and progress things […] so it is about maximising our resources to best advantage.’

In relation to data sets and records on FGM implementation of the EI will be a huge advance and will enable data to be gathered and trends to be monitored. Moving towards evidence based planning using the EI will be helpful as it is not possible at the moment. Finally, there will be a review of the NICHS 2007–12, which could assist with strengthen work on FGM in Ireland despite some resistance to the idea.

‘We are very conscious as the years have passed times have changed dramatically and there is a notion that there is no need for another intercultural strategy.’

Another respondent elaborated on the FGM awareness-raising fashion show model she has developed as a good practice. She has shared the model with other European countries.

‘I really want that FGM fashion show to go global, to raise awareness. It brings more women together, also it shows that women are beautiful, and that there is nothing to be ashamed of.’

She feels that she is part of a global FGM campaign that brings women together with young people to understand more about FGM. It is not about attacking a culture in any way. Ifrah recommends the FGM fashion show model as a non-threatening route to bring families, young people, women and practising communities together on the issue of FGM in a social setting.

‘We are showing multicultural clothes, we are telling them this is us, we are beautiful, this is our culture, but FGM is an issue.’

Another respondent discussed good practices in relation to FGM in relation to information dissemination, useful resources and tools and the partnership mode of working. Good practices that she gathers from both informal and formal routes are passed on to her regional HSE social inclusion specialist colleagues, across Ireland and they disseminate them as appropriate to their local colleagues. She also referred to the AkiDwA and RCSI resource on FGM (‘Female genital mutilation: information for healthcare professionals working in Ireland’, 2008) and the NAP as examples of good practice. The earlier research by the Women’s Health Council on FGM in 2008 provided a foundation for good practice in Ireland.

‘I would be very conscious of the good practice and I suppose within Ireland as well there is that healthcare resource for professionals which I think is a very good example, the national action plan itself is a good example as well, it just goes back to the capacity to progress the recommendations in whatever has been done.’

The interviewee felt that routing HSE National Social Inclusion Office funding on FGM through supporting the post of the Migrant Women’s Health Project coordinator in AkiDwA, as an organisation that has credibility with communities on the issue of FGM, which may as a result have potentially more impact than a statutory organisation working on this issue, was a successful good practice. This proves the importance of partnership, especially in relation to sensitive areas such as FGM. The work that emanated from this funding on training healthcare professionals was also a good practice.

‘It was very much around the whole partnership aspect, within the health service I think in social inclusion we are
quite unique in the way we work with different NGOs and recognise their expertise.'

She also mentioned a number of HSE Social Inclusion Unit initiatives as good practices in relation to partnership including the ‘HSE health services intercultural guide: responding to the needs of diverse religious communities and cultures in healthcare settings’. This is a resource for HSE staff in being culturally competent in their work and a good practice tool. The Social Inclusion Unit also produces regular newsletters which are circulated to all actors involved in the development of the NICHS, and they are then requested to circulate the newsletter to their own stakeholders. One newsletter was focussed on FGM work in Ireland. This is an effective good practice in terms of information dissemination.


In conclusion the good practices referred to by the interview subjects can be grouped into three main practices.

- Partnership: in the broadest possible sense, moving beyond NSC working relationships to include all relevant actors in multiple sectors and settings.
- Resources: including the AkiDwa and RCSI resource ‘Female genital mutilation: information for healthcare professionals working in Ireland’, 2008 and the NAP and the development process that took place for both these resources.
- Youth mobilisation for FGM prevention: the FGM awareness-raising fashion show model developed by UYI of Ireland is perhaps the most innovative modus operandi for mobilising youth and communities around FGM. It has already been replicated in many European countries including Denmark, Poland, Sweden, etc.

The AkiDwa Community FGM Forums were mentioned in the Ireland country report that resulted from the desk research phase of this study and in the AkiDwa interview for this analytical report. However, no information has been forthcoming on the community forums from AkiDwa and there is no information on them in the public domain, so it is not possible to conclude if they constitute either a good or promising practice.

In relation to partnership as a good practice, its foundations began with the Irish Coalition against FGM and had accelerated development with the formation of the NSC in 2008, which, although somewhat diminished in terms of active members, is still in existence. Despite very tangible outputs and outcomes there has been no evaluation or monitoring process for this partnership outside of its own publications. A lack of reports, and especially an end of NAP report in late 2011, makes it very difficult to assess the scale of potential or indeed even the sustainability of partnership work in Ireland on FGM. However, as it featured so heavily in all the interviews is should be included as a promising practice for Ireland.

Three interviewees mentioned the AkiDwa and RCSI resource ‘Female genital mutilation: information for healthcare professionals working in Ireland’ (2008) as a good practice both in terms of its development process and the final resource. It built on the partnership model of the NSC by using the AkiDwa FGM Health Forum and the staff and students of the RCSI MSc programme in women’s health. The HSE National Social Inclusion Office is planning to fund a reprint of the resource containing updated information on the new FGM Act 2012 and updated AkiDwa prevalence statistics within the planned second edition. It has been selected by United Nations Alliance of Civilisations for inclusion on its website as a featured integration project and international example of good practice and has been disseminated internationally but it has not been assessed in terms of effectiveness and impact yet. It was produced in a very cost-efficient manner but would probably constitute a promising practice more than a good practice until more data on it is collated and mainstreaming potentials are realised.

Possibly the most innovative initiative to emerge in Ireland in relation to FGM is the FGM awareness-raising fashion show model. The interview for this study allowed one of the respondents to discuss the themes of aesthetics, self-esteem, self-image, and self-confidence as being closely interlinked in Ifrah’s approach to work on FGM through the fashion shows.

‘It wasn’t all about fashion: it is all about women’s confidence. It is all about bringing their confidence together and making them aware that they are beautiful.’

‘It is all about women, it is all about their beauty, it is all about their confidence and self-esteem.’

As it has already been replicated in other European countries and there is continued demand for Ifrah to bring this model of engaging and motivating young people around FGM it constitutes the strongest promising practice in this study.

IX. FINAL CONSIDERATIONS AND RECOMMENDATIONS

Work on FGM has been recent and rapid in Ireland, principally in response to inward migration in Ireland since 1997 and driven by an exceptionally active multi-sector/agency NSC for Ireland’s NAP since 2008. The landscape for child protection in Ireland has also changed radically since 2006. Successful lobbying by the NSC and other relevant actors, such as the CRA, has managed to embed FGM into relevant child protection resources and frameworks, for instance the Child protection and welfare practice handbook, Health Service Executive, 2011 and the Garda Síochána Policy on the investigation of sexual crime, crimes against children, Child Welfare, 2010. The Fifth Report of the Special Rapporteur on Child Protection, July 2012 makes explicit reference to FGM which is very promising. The strategic route of embedding FGM into strategies and policies, for example in the upcoming national sexual health strategy, is a method of leveraging future work, commitments and possibly funding in the area. It will need to be continued
to ensure FGM does not fall off the agenda in a climate of cutbacks, staff redundancies and agency closures.

A shortcoming in the outcomes of Ireland’s NAP, noted by several of the interviewees, was the lack of a ‘home’ for the plan within a government agency or department. This failing is possibly due to the economic cutbacks in the statutory sector at this time, or an unwillingness to engage with an issue that is somewhat contentious within the Department of Justice and Equality due to its dual mandates of policing and immigration processing and control. This analytical study is missing input from the justice sector and despite repeated attempts an interview with a member of the Garda Síochána could not be arranged within the research time frame.

Finally while the major achievement of FGM-specific criminal legislation has been a huge step forward in Ireland, primarily due to the efforts of the NSC, work remains to be done in relation to FGM. Continuing this work will be challenging in the current economic climate but NSC members are optimistic.

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Country report

Italy
Country report: Italy

1. IDENTIFICATION

Country: Italy
Researcher: Maria Sangiuliano

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Prevalence data were searched for by using both academic databases and a web search across national institutional relevant bodies as suggested in the guidelines. More specifically, the academic databases which were searched were: Web of Science, EBSCO, ScienceDirect (Elsevier); Scopus; Francis (humanities and social sciences); journal citation reports (JSTOR); Springerlink. In addition to those suggested in the ‘Guidelines for researchers’, some Italian databases were consulted: Banca dati Centro Studi Emigrazione Roma; Bibliografia della Sociologia Italiana on line (BSI); Catalogo unico del Centro nazionale di documentazione e analisi per l’infanzia e l’adolescenza; Leggi d’Italia. None of these directories provided any relevant documents/sources of information as far as prevalence studies are concerned.

A web search was also performed, browsing several websites such as those of the ISTAT (national institute for statistics) (no documents retrieved), Ministry of Health (one relevant document retrieved), ISS (Istituto Superiore Sanità, the national institute for health, no documents retrieved), Ministry of Equal Opportunities (one relevant document retrieved), Ministry of Employment and Social Affairs, and Google/Google Scholar. From the more general Google search, and some actors’ websites, some studies were retrieved which included regional research on FGM and contained some limited figures on prevalence, and were therefore added to the country database on Italy.

The websites of the national associations of gynaecologists (AOGOI) and obstetricians (FNCO) were also accessed, leading to some documents being analysed which contained only policy development information already reported by other sources.

In both cases, the following keywords for research were used: mutilazioni genitali femminili (incidenza delle), infibulazione, circoncisione, escissione.

The latest issue of the national Statistical dossier on immigration by Caritas/Migrantes was also looked for and accessed in a local library (Caritas/Migrantes, 2011) in order to have the most recent statistics on migrant women from countries with an FGM tradition from what is known to be a reliable statistical source on migration issues.

As far as quantitative and qualitative evaluation of the phenomenon of female genital mutilation in Italy is concerned, a specific attempt was made to verify whether the PowerPoint presentation which it is possible to download from the website of the Ministry of Equal Opportunities was the only source of prevalence information held by the ministry and/or if a full report of the same research was available. An e-mail was written to the secretariat of the National Commission for the Prevention and Combating of FGM to verify this issue, and the answer from the technical secretariat of the commission stressed that the PowerPoint file itself was the final product of the research which the Ministry of Equal Opportunities commissioned from Istituto Piepoli SpA.

2.2. Nature of prevalence studies/FGM registration systems

Four studies were catalogued under the ‘Prevalence’ category of the country database.

The guidelines by the Ministry of Health were published in 2008, as an initiative undertaken by the National Commission for the Prevention and Combating of FGM, and contain a section on prevalence data. At the first stage, calculations are made by projecting DHS/Unicef prevalence indices in African countries to the population of migrant women from the same countries that were legally resident in Italy in the year 2006. Then, considering that migration impacts upon behaviour and usually leads to gradual integration and thus abandonment of the practice, the previous estimate is further reduced, thus leading to an overall estimate on prevalence, although without clarifying according to specific rate/index. Disaggregation by countries and group ages is provided only for the first stage of the analysis.

These may be considered as ‘partial and limited’ figures according to the authors of the guidelines themselves, who defined them as being ‘not really scientific’.

Some regional figures are contained in other studies, even if their main focus is not on prevalence but on the perception of FGM among healthcare professionals and other actors.
For example, *Le mutilazione genitali femminili nel Lazio — Esperienze e conoscenze di operatori, donne e comunità immigrate* reports ISTAT figures on migrant women per country of origin and province of residency, along with data from the Ministry of Education about students enrolled in all types of public schools (from kindergartens to upper secondary schools) coming from the same countries and disaggregated by provinces and Rome’s municipalities in order to identify areas where potential victims may be concentrated. Eight areas were identified, from which 420 healthcare and 702 socio-cultural professionals and cultural mediators were selected to answer a questionnaire on their knowledge of FGM and Law No 7/2006, 30 % of whom had directly experienced and/or treated cases. Thirty-three opinion leaders from migrants’ NGOs and cultural mediators answered a semi-structured interview on the prevalence of FGM among migrant communities in the Lazio region.

The study *Mutilazioni dei genitali femminili e diritti umani nelle comunità migranti. Rapporto di ricerca nelle regioni Veneto e Friuli Venezia Giulia* reports statistics from ISTAT on legal migrants residing in the regions and qualitative feedback on FGM among migrants’ communities from Africa gathered through interviews and focus groups with key informants and opinion leaders, both Italians and Africans.

In 2009 the Ministry of Equal Opportunities presented the results of a study on the prevalence of FGM commissioned from Istituto Piepoli SpA, a private company specialising in market analysis. Two methodological approaches were used: a quantitative one, through desk research on available data and some interviews with informed actors in order to come to a realistic estimate; and another, defined as a ‘motivational’ approach, with in-depth interviews carried out by psychologists in order to grasp qualitative information that key informants may share (medical doctors, cultural mediators, women’s NGO activists). Prevalence is calculated by applying WHO/DHS prevalence indices for African countries defined as having an ‘FGM tradition’ to the numbers of legal migrant women in Italy from the same countries. It is stated that these figures should be increased by 20 % as the proportion of illegal migrants in Italy is one in five. Another 30 % is subtracted after this calculation as it emerged from qualitative interviews that the prevalence of FGM in the countries of origin does not correspond to what is happening during migration. Nevertheless, the relationships between the quantitative and qualitative parts of the study are not clarified, and therefore the 30 % further reduction over the overall prevalence data cannot be scientifically argued; disaggregation per country is also missing at this level.

As far as FGM registration systems are concerned, research showed that there is no dedicated organisation/body which collects this information in Italy. Information from the Ministry of Equal Opportunities (which according to Law No 7/2006 is the main coordinating body on the issue) stating that ‘Quantitative and qualitative evaluation of the phenomenon of female genital mutilation in Italy’ was the only available source of data on FGM prevalence, itself based on ISTAT figures on official migration, seems to show that there are no other coordinated ways of gathering and storing information on FGM.

- The health system is regionalised and no national registration measures have been put in place; the guidelines for health professionals issued by the Ministry of Health do not include any specific recommendations on how to register or document FGM cases; regional guidelines for health professionals that have been retrieved do not include any specific procedures to be followed regarding the registration of cases.
- The judiciary system does not appear to be equipped with any coordinated mechanism for registering FGM cases/complaints. As nothing of this sort was mentioned in any of the texts and websites which have been analysed, a specific question on registration systems was posed to experts who answered e-mailed requests for collaboration. All of them answered that no such system is in place in Italy.
- As far as the registration of motivations for seeking asylum is concerned, decisions on recognising refugee status and/or subsidiary protection for people who present requests for it are decentralised and seven territorial commissions hold responsibility for evaluating them (Gorizia, Milan, Rome, Foggia, Syracuse, Crotone and Trapani). Both the Ministry of the Interior and the Italian Council for Refugees (CIR) NGO were sent e-mails in order to obtain more specific information, but no answer was received.

### 2.3. Findings from the prevalence studies/registration systems

According to Ministry of Health guidelines, 188 047 women from countries with an FGM tradition (35 countries) were legally resident in Italy at the end of 2006. Of them, 125 421 (66.7 %) were aged 19–40, 54 738 (29.1 %) were over 40 years old, 7 070 (3.8 %) were aged 14–18 and 818 were aged less than 13 (0.4 %). Applying national prevalence indices to this initial population, the Italian prevalence can be related to 93 809 women, with the following disaggregation per country: Benin 222; Burkina Faso 4 197; Cameroon 592; Central African Republic 26; Chad 38; Congo 162; Côte d’Ivoire 4 391; Egypt 44 497; United Arab Emirates 0; Eritrea 6 126; Ethiopia 4 001; Gambia 335; Ghana 2 760; Djibouti 28; Guinea 1 377; Guinea-Bissau 0; Equatorial Guinea 352; Liberia 567; Mali 423; Mauritania 415; Niger 33; Nigeria 4 517; Oman 0; Papua New Guinea 0; Democratic Republic of the Congo 48; Senegal 12997; Sierra Leone 512; Somalia 3 515; Sudan 1 700; Tanzania 115; Togo 305; Uganda 18; Yemen 24; Zambia 0; Zimbabwe 0.

Taking into account a trend to abandon FGM during migration, small children (less than 13) at risk would be reduced to 409, girls aged 14–18 to 3 535 and women aged 19–40 to 62 710, while 26 098 women over 40 would be likely to have undergone FGM.

According to ‘Quantitative and qualitative evaluation of the phenomenon of female genital mutilation in Italy’, the number of migrant women coming from African countries defined as having an ‘FGM tradition’ (WHO/DHS prevalence
data 2005, 26 countries, does not include Niger and Yemen) is calculated to be approximately 110 000. There are approximately 4 600 women aged less than 17 who are therefore potential current or future FGM victims. An average prevalence index is calculated as 46 % of the total female population from such countries, further reduced to include illegal migration and the impact of migration itself as a factor leading to abandon these practices. 30 % of the total female population is considered to be ‘realistic’ and therefore it is calculated that approximately 35 000 African migrant women in Italy have been victims of FGM, most likely in their country of origin. For young girls aged less than 17 a prevalence of 30 % less compared to adult women shall be considered. There are approximately 4 600 girls aged less than 17 with African origins and approximately 22 % of this number are potential victims. There are therefore calculated to be approximately 1 000 young potential victims aged less than 17.

More up-to-date statistics about the overall population of legally resident women from African countries where FGM is prevalent (29 countries) are provided by Caritas/Migrantes (2001) in a book included in the country library.

Findings from the qualitative studies included in some of the abovementioned regional surveys with interviews with, among others, healthcare professionals provide a picture of an underground phenomenon, with a very limited number of cases reported by healthcare staff and a certain number of suspected cases. From the reports it seems the number of reported cases was bigger in the 1980s/1990s, when migration and asylum-seeking from countries such as Somalia had a greater impact than today. In those days the most harmful forms of FGM, such as infibulations, were treated by healthcare staff. In regions such as Veneto, with a considerable number of migrants from Nigeria, it seems that clitoridectomy is now the most common form of FGM the healthcare professionals have directly experienced, although it is often difficult to detect.

2.4. Reflection on prevalence studies

The Ministry of Health was the first national institution to try and make some estimates on the prevalence of FGM in Italy, within the broader framework of preparing guidelines for healthcare professionals. By the admission of its authors, the report contained only partial and limited figures, and could not provide any reliable or scientific data.

The only study specifically commissioned with the goal of collecting and analysing data on the prevalence FGM in Italy was ‘Quantitative and qualitative evaluation of the phenomenon of female genital mutilation in Italy’, published in 2009 and based on a different study population than the previous one. After that publication no further national research was carried out. Again this study appears to have several gaps, among which: it is based on WHO/DHS prevalence indices from 2005; it calculates prevalence without applying a specific country’s prevalence index to the female migrant population from that particular country; it states that the average prevalence index of 46 % of the total female population should be reduced to the 30 % due to the impact of migration on abandoning the practices, arguing that this is evidenced from the qualitative part of the study, but this is not explained when presenting the qualitative outcomes of the survey. The same goes for the attempt to calculate a specific prevalence index for girls aged less than 17.

It is not clear if the impact of illegal migration is included in the estimates. As an overall feature of the study, results are not presented in a methodologically transparent way (only a PowerPoint presentation is available).

Regional surveys are also quite limited in their scope. When they try to assess how many FGM cases have been encountered by health professionals, they are not based on statistical samples or even meaningful numbers of interviewees, nevertheless they can be useful to give an idea of the extent to which healthcare professionals have come into contact with FGM cases in their routine work.

It is clear that several factors can be considered as hindering sound and reliable research on this issue, including the lack of any coordinated way to register FGM cases at any level, the issue itself not being easily tackled openly with migrant communities and therefore not being easily investigated. Nevertheless, it would be recommendable that national surveys could be commissioned over time, in order to identify trends and disaggregation at various levels. The involvement of national institutions such as the ISTAT (National Institute for Statistics), the INMP (National Institute for Health, Migration and Poverty) and the ISS (High Institute for Health) could be recommendable for future prevalence studies carried out at the national level.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Policy documents were searched both by using academic databases and through a web search across national institutional bodies relevant for being involved in studying FGM and policymaking, as suggested in the guidelines. More specifically, academic databases which were searched were: Web of Science, EBSCO, ScienceDirect (Elsevier); Scopus, Francis (humanities and social sciences); journal citation reports (JSTOR); Springerlink.

As far as Italian academic databases are concerned, the following ones were consulted: Banca dati Centro Studi Emigrazione Roma; Bibliografia della Sociologia Italiana on line (BSI); Catalogo unico del Centro nazionale di documentazione e analisi per l'infanzia e l'adolescenza; Leggi d'Italia. From this search a number of documents were retrieved that can be considered as the main sources for researching FGM policies and that were included in the country library mentioned in the ‘Observations’ column within the POL Excel sheet.

The following keywords for research were used: mutilazioni genitali femminili, infibulazione, circoncisione, escissione,
Several of the academic papers/studies catalogued in the country library contained references to two specific policy documents (‘Circumcision: bioethical profiles’ and the opinion of the Regional Bioethics Committee formulated on 9 March 2004 regarding ‘FGM: ethical conduct and juridical legitimacy of physicians’ participation in an alternative ritual’, which were found by searching Google with the document title or searching the website of the National Bioethics Committee. In most cases academic papers/books refer to Law No 7 of 9 January 2006 (dispositions regarding the prevention and prohibition of female genital mutilation practices), or to bills proposed from the year 2000 onwards and to parliamentary debates for the approval of Law No 7/2006, partially contained in Parliamentary Act 4204-B (second reading in the chamber of deputies) ‘Dispositions regarding prevention and prohibition of FGM practices’ and traceable in several other parliamentary acts (motions, inquiries) also included in the POL sheets. The Ministry of Equal Opportunities’ website was the source from which the decree for the establishment of the National Commission for the Prevention and Combating of FGM was retrieved, while the decree for the establishment of the National Commission for the Prevention and Combating of FGM was accessed through the Caritas Roma website (http://www.caritasroma.it).

A web search was also performed browsing several institutional websites such as those of the Ministry of Health, the INMP, the Ministry of Equal Opportunities (one relevant document retrieved and other four web pages analysed), the Ministry of Employment and Social Affairs (no documents retrieved), the Ministry of Justice (no relevant documents retrieved), the Ministry of the Interior (no documents retrieved) and the Ministry of Education (no useful documents retrieved).

The historical archives of the national parliament/chamber of deputies were also browsed and all 17 items that were retrieved were included in the POL database.

The websites of FGM actors were also quite useful in gathering information on policy initiatives, both at the national and regional levels. Especially but not exclusively, this included the websites of AIDOS and MGF Toscana.

In all cases, the following keywords for research were used: modifizazioni genitali femminili, combined with words such as politiche, iniziative, piano d’azione, dibattito.

In the case of governmental bodies, actors were contacted by e-mail to request documentation on policies and/or policy evaluation, specifically with regard to the implementation of Law No 7/2006. The secretariat of the National Commission for the Prevention and Combating of FGM at the Ministry of Equal Opportunities answered and stated that the commission itself is in the process of being renewed. Before concluding its mandate it had just drafted a new national action plan which cannot be shared at the moment. Requests to provide all available documentation from 1980 onwards received the answer that all available documents were already uploaded on the official web pages.

The e-mail sent to the Ministry of the Interior, which is in charge of managing the freephone number for reporting FGM, got no answer, nor did online form submitted on the national police website to ask for the same information.

Instead of writing to a Ministry of Health press office e-mail address, I chose to directly contact the INMP — the ministerial research institute which has been implementing research and training projects on FGM. After a phone call, the first feedback came by e-mail from an informant, a director of relations with national and international bodies, along with a request to provide some more details about this study (which was done by sharing the factsheets), followed by a promise in writing to send me the requested documentation.

NGOs were mainly contacted by e-mail to get information and documentation (see details in actors’ paragraph) about their projects and tools on FGM, but they were also asked to share any available information on prevalence and policies. Documents shared by Almatera, as well as documentation on the websites of Nosotras and AIDOS, were useful for research policies.

As far as individual/academic experts are concerned, three kindly sent me their papers (included in the country library), which were very helpful in tracking policy developments in Italy.

3.2. Policies on FGM

The end of the 1990s was a crucial moment in migration history at the national level, with increasing numbers of migrants coming to live and work in Italy and the country turning into a multicultural society. This is the period when FGM started to be a problematic issue, as shown by initiatives such as regional health structures in Emilia Romagna (IDIL — Instruments to Develop the Integrity of Lasses; female genital mutilation (FGM) in the immigrant population — results of the regional survey) asking the National Bioethics Committee in 1997 about the legitimacy of practising male and female circumcision in public hospitals. The commission issued a recommendation which distinguished the two practices, declaring girls circumcision TO BE unacceptable as it is aimed at controlling women’s sexuality.

During the same PERIOD some healthcare institutions started to build specific expertise on how to support pregnant women with FGM during delivery, or to propose defibulation as a treatment. Careggi hospital (Florence), Forli hospital (Cesena), San Camillo Forlanini hospital (Rome) and San Gallicano hospital (Rome) all gained a reputation for the procedure.

FGM definitely entered the public debate during the XIII Legislature. In 1999 a newly established national parliamentary commission for childhood approved a resolution on FGM, committing the government to promoting a survey on the phenomenon in Italy (http://www.
In September 1999, the Ministry of Equal Opportunities established by decree a commission to define a national project to combat and prevent FGM, which was dismissed afterwards.

One year later, in 2000, the women’s NGO AIDOS was running the initiative ‘Information campaign in Italy against FGM,’ targeted at journalists, policymakers, NGOs, activists for human rights, together with No Peace Without Justice, in connection with its extensive awareness-raising and lobbying work done in international development cooperation programmes in Africa.

A clear mark of FGM’s entry into the parliamentary agenda is represented by the two bills presented to the chamber of deputies in the years 1999 and 2000, both of them proposing to define FGM in terms of specific crimes and the second one proposing deportation for migrants who are incriminated and some policy measures for prevention.

At the same time, the participation of several women’s NGOs (Almatera, Nosotras, Naga), together with the University of Turin, in the IDIL Daphne project contributed to enhancing knowledge and competences on the issue by women’s groups from civil society.

In general, from 2000 to 2004, EU projects or other forms of cooperation with international organisations contributed to increasing awareness of the current state of the debate and transnational policies on the issue.

What really fostered the debate and made FGM a hot issue in the national political debate was the proposal in 2004 by two gynaecologists from the Careggi hospital in Florence of an alternative ritual to FGM consisting of a light ‘sunna’ to be practised in public hospitals. According to Pasquinelli (2007), such an idea was supported by 3 000 Somali women and was an outcome of a dialogue process with Somali communities. It was initially rejected by the council of the Tuscany region and afterwards considered as legitimate by the Regional Bioethics Committee. Migrant women’s NGOs such as Nosotras in Florence fiercely reacted against this possibility, being supported by other national NGOs like AIDOS (Rome) and Almatera (Turin). The media gave a lot of emphasis to the case, presenting it as a scandal, and a very hot pre-electoral climate did not contribute to an objective debate. Nevertheless, it stimulated legislation on the issue, and the final bill presented by senator Consolo merged together the other pre-existing proposals in what was finally approved as Law No 7/2006. The law both introduced FGM as a specific crime by way of integration into the Penal Code, and set up a series of preventive, awareness-raising and training initiatives. The structure of the law gives emphasis to prevention and information activities (it was changed after the parliamentary debate in order to avoid the risk that migrant communities from Africa could perceive it as an attack criminalising their cultures). In Article 3, EUR 2 million is allocated for information and awareness-raising campaigns, both in Italy and in African countries, to be organised with migrants’ NGOs and healthcare institutions; training courses for infibulated pregnant women; training courses for teachers; and monitoring of FGM cases within healthcare centres and hospitals. Article 4 is dedicated to the training of healthcare professionals and allocates EUR 2.5 million per year. Under Article 5 a freephone number is established (to be managed by the Ministry of the Interior) with the aim of collecting reports about (suspected) violations of Article 583 bis of the Penal Code and providing information about support and healthcare institutions — for this purpose a budget of EUR 500 000 per year is allocated. Articles 6 and 8 respectively contain the integrations to the Penal Code (Articles 583 bis and 583 ter) and the amendment of Legislative Decree 231 of 8 June 2001 on sanctions applied to establishments where FGM may take place. Article 7 regards the integration of awareness-raising initiatives on FGM in international cooperation programmes run by the Ministry of Foreign Affairs.

The Ministry of Equal Opportunities was appointed as the coordinating structure to work with the Ministry of the Interior, Ministry of Health, Ministry of Social Policies and Ministry of Foreign Affairs, and a National Commission for the Prevention and Combating of FGM was established.

In 2007 a call for proposals was issued to finance research, training and awareness-raising projects, and 20 projects were funded, most of them being integrated initiatives targeted mainly at healthcare (or socio-cultural/educational) professionals and migrant people. Among them, the pilot project by the INMP (National Institute for Health, Migration and Poverty) funded by Law No 7/2006 invested a lot in training cultural mediators on FGM-related issues and establishing a roster of cultural mediators with expertise on FGM to be used by hospitals and other healthcare institutions in the Lazio region when needed.

In 2008 the Ministry of Health published guidelines for healthcare professionals.

The Ministry of Equal Opportunities has been active in organising annual conferences and awareness-raising initiatives, mostly concentrated around the International Day Against FGM on 6 February. In recent years many regions have integrated initiatives to prevent FGM into their biannual plans for healthcare policies, including them in health policies for migrants’ initiatives. No information is available on national policy implementation and no evaluation of the effectiveness of projects and measures which have been put in place is available.

Very recently, AIDOS publicly addressed the new government by criticising the paucity of information available on FGM policies and on the use of allocated resources, and the fact that throughout the years Law No 7/2006 had not been refinanced (http://www.yallaitalia.it/2012/02/non-basta-la-legge-per-fermare-le-mutilazioni-genitali-femminili/).

In 2009, following the deaths of two Nigerian boys due to circumcision carried out at home, an agreement protocol was signed by the Ministry of Health and the National Federation of Paediatricians to monitor FGM and male circumcisions through birth centres and paediatric...
healthcare institutions. (Source: http://www.minori.it, the portal of the National Documentation and Analysis Centre for Childhood and Adolescence). A leaflet was distributed inviting parents to practise male circumcision within national healthcare centres and to inform them that FGM is a criminal offence prohibited by Law. No information was found about the implementation of such an agreement protocol.

In February 2012, when presenting political priorities on equal opportunities, the Minister for Social Policies, Employment and Equal Opportunities, Professor Elsa Fornero, included FGM among the nine relevant problems that will be tackled (http://www.pariopportunita.gov.it).

3.3. Reflection on policies on female genital mutilation

The Italian policy debate seems to be dominated by a series of weak points attributed to Law No 7/2006, as from the very beginning the definitions of the criminal offence were criticised by many experts and actors for not allowing clear identification of FGM practices, especially for those defined as causing ‘personal harm’ distinguished by ‘mutilation’. The need to involve migrant communities, and particularly women, has been stressed since the approval of Law No 7/2006 to balance any effects of the criminalisation of African migrant people and to prevent the risk of FGM going even more underground. The issue continues to be raised of the law being a sort of symbolic act that is motivated by a cultural viewpoint instead of really being intended to solve a problem, with some experts also highlighting the colonialist traits of this policy tool, in the broader context of other ‘culturally motivated crimes’ which received a different juridical treatment (Giordano and De Masellis, 2011; Miazzi, 2010).

Unfortunately, as no overall evaluation of all awareness-raising and training initiatives was carried out and/or made public, it is difficult to assess to what extent the goal has been achieved, and some experts openly declared their scepticism about this (Grassivaro Gallo, 2010). More direct work with communities and the involvement of women could be useful, along with initiatives targeted at second generation migrants and teenagers. The role of cultural mediators could also be enhanced as the interesting initiative by INMP proved.

It has been also stressed that one of the main gaps in Law No 6/2006 was the lack of measures to support women who had undergone FGM, in terms of medical and/or psychological support (Brunelli, 2007). Although the guidelines from the Ministry of Health recommend highly that health structures should be prepared to support women in giving birth naturally and to deinfibulate them, it is not clear to what extent these competences and treatments are really available in all or the majority of public hospitals/family planning clinics, apart from those centres which have become specialised over the years. Future policies could take advantage of the exhaustive monitoring of the services provided.

Apparent there is a lack of homogeneous, coordinated procedures concerning the training of the medical staff, medical treatments and support offered to victims/women at risk, and concerning registration procedures. Coordination of policy initiatives by the Ministry of Equal Opportunities did not seem to go together with an equally active engagement by other ministries directly involved in implementing healthcare, social and educational policies.

The overall impression is that a further step in policy development could definitely involve the sound monitoring of the results achieved so far, covering geographical gaps, the implementation of training courses and awareness-raising initiatives, as funded projects have persisted in some areas of the country more than others.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Documents on the legal framework were mainly accessed through an academic database search from which a number of papers/books were identified. Only in a few cases it was possible to download the full texts from the databases themselves; in other cases full texts were found by searching Google/Google Scholar/Google Books with the title/author information already gained from the academic search engines. Academic publications represented sources of information to directly access legal documents from institutional websites (Ministry of Equal Opportunities/Ministry of the Interior) and other web publications (Altalex — quotidiano di informazione giuridica).

Academic papers retrieved from the database search with access to the full text relevant for the legal framework were Basile (2007), Brunelli (2007 and 2011), Giordano and De Masellis (2011), Lancia et al. (2006), Miazzi (2010) and Pasquinelli (2007).

With further e-mails sent out, two respondents were also explicitly asked about the existence of any FGM information collection points, at the level of the judiciary system, social policies or healthcare, and they both answered that as far as they know there isn’t anything similar to the example presented (the perinatal registration system put in place in the Netherlands). The same answer came from a third respondent, along with an informal notice regarding one case of recognition of refugee status for FGM-related reasons, to be verified, during a comprehensive conversation on the phone.

Both the abovementioned academic articles were used for the collection of information on court cases, along with a summary of court cases up to 2009 provided by Ass.ne Almaterra, in a Word document, as an answer to my e-mail.

E-mails were also sent to the Ministry of the Interior, the Ministry of Justice, and the NGO Consiglio Italiano Rifugiati (CIR) in order to have information on the legal framework, court cases and sentences, but no answers were received.
4.2. Criminal law

By way of the provisions of Law No 7/2006 two articles on FGM were integrated into the Penal Code: Articles 583 bis (female genital mutilation practices) and 583 ter (ancillary penalties). The first article punishes with a term of imprisonment of 4 to 12 years of any person who, without any therapeutic need, causes mutilation to female genitals (‘clitoridectomy, excision, infibulation and whatever other practice causing similar effects’). The second paragraph punishes with a term of imprisonment from 3 to 7 years any person who, without any therapeutic need, causes ‘harm’ other than that listed in the previous paragraph to female genitals and causing physical or psychological illness. Punishment may be reduced to two thirds in case of minor harm. The third paragraph provides for an increase in the related term of imprisonment of one third when FGM is practised on children/underage persons or for profit. According to Article 583 ter, a judgment against a professional working in the healthcare sector leads to disqualification from the profession for 3 to 10 years, and the consequent communication of this measure to the National Medical Association. The administrative responsibility of the institution where the banned practice has taken place is also recognised.

According to Article 583 bis(iv), the extraterritoriality principle is recognised and sanctions are applicable even when FGM is practised abroad either by an Italian citizen or by a foreign citizen living in Italy, causing harm, or by an Italian citizen or a foreign citizen living in Italy (interpretative problems may arise here, according to Giordano and de Masellis, 2011).

Only one sentence was issued after the approval of Law No 7/2006 and the introduction of a specific form of criminal offence: judgment No 279, Tribunale di Verona, est. Ferrara, condemned a Nigerian woman for having violated Article 583 bis (paragraph 2, on genital modifications). The case actually concerned a sort of ‘symbolic’ light cut which was almost impossible to detect in the forensic visits; this lead some experts either to denounce the colonial traits of sentences or to affirm that the sentence clarified once and for all the motivation leading FGM to be considered a crime: judgment No 279, Tribunale di Verona, est. Ferrara, condemned a Nigerian woman for having violated Article 583 bis(iv), the extraterritoriality principle is recognised and sanctions are applicable even when FGM is practised abroad either by an Italian citizen or by a foreign citizen living in Italy, causing harm, or by an Italian citizen or a foreign citizen living in Italy (interpretative problems may arise here, according to Giordano and de Masellis, 2011).

Before the FGM criminal offence was introduced in 2006, such practices were punishable anyway according to Articles 582 and 583 of the Penal Code on personal harm, with less severe penalties: 3 to 7 years’ imprisonment if it were to cause illness putting the victim’s life at risk or producing a permanent weakening of a sense or an organ; or it could have been judged as ‘very serious’ and 6 to 12 years’ imprisonment if it were to cause loss of the use of an organ and reproductive capacity.

Article 5 of the Civil Code (prohibiting any actions on one’s own body when causing permanent damage to physical integrity) and Article 32 of the Penal Code (prohibition against forcing anybody to undergo a certain treatment) also contributed to identifying FGM as a criminal offence.

Judgments before 2007 — The judgment of 25 November 1999 of the court of Milan was symbolic: an Egyptian citizen who brought his daughter to Egypt to be infibulated without informing his Italian wife. He was condemned to 2 years’ imprisonment for having caused serious personal bodily harm, punishment suspended due to the granting of extenuation and a plea bargain.

Other reported cases — A husband and a wife presented a statement to the public prosecutor’s office in Milan against the head of an Islamic centre and two medical doctors (from Algeria and Ethiopia) that practised infibulation on a 6-month-old baby girl. Another, more complex case was that of a Nigerian girl who was subjected to FGM in a Nigerian hospital and who when in Italy started to have serious genital problems. Her parents brought her to the hospital in Turin. The juvenile court intervened and temporarily separated the girl from her parents to investigate the family together with a cultural mediator. The information collected was reassuring about a positive family and parental relationship; as the parents had taken good care of the girl from Nigeria to the hospital in Turin and their behaviour was explained by Edo customary law (not punished by Nigerian local courts), according to which a girl who has not undergone FGM will not find a husband. A complaint was lodged against the parents but the case was dismissed as the practice took place abroad (Article 10 of the Penal Code).

4.3. Child protection laws/provisions

Article 330 of the Civil Code, ‘decadenza della patria potestà’ (loss of parental authority), applies as a protection measure removal of the child from the parents’ house or banning of the parent or cohabiting partner whose behaviour is threatening the child’s well-being.

Article 333 of the Civil Code, ‘condotta del genitore pregiudizievole ai figli’ (parent’s behaviour which is prejudicial to children) applies as a protection measure the removal of the child from the parents’ house or banning of the parent or cohabiting partner whose behaviour is threatening the child’s well-being.

In the 1997 case of a Nigerian girl reported above the court was criticised for having separated the girl from her family, putting her at risk of further trauma. According to Brunelli (2011) this case actually questions the relevancy of the application of Articles 330 (loss of parental authority) and 333 of the Civil Code (preventive interventions in case of prejudicial parental behaviour).

No central agency is attributed the task of registering FGM cases regarding minors.

4.4. Asylum law(s)/provisions

Article 19 of Legislative Decree 268/1998 ‘Testo unico delle disposizioni concernenti la disciplina dell’immigrazione e norme sulla condizione dello straniero’ (Unified text on dispositions concerning the discipline of immigration and regulations on the conditions of foreigners) provides as a measure the prohibition of deportation to a state where
the migrant could be persecuted for reasons related to his/her race, gender, language, personal or social conditions, or could risk being moved to another state where he/she would not be protected from persecution. Paragraph 2(a) prohibits the deportation of children and youngsters aged less than 18 years.

According to Legislative Decree No 251 of 19 November 2007 (legislative decree for the implementation of Directive 2004/83/EC on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted), acts of prosecution deemed relevant for provision of the status of refugee can concern ‘physical or psychological violence, or acts specifically directed against one gender or against children’ (Article 7(2)(e)). Recognition of refugee status entitles persons to a 5-year residency permit that can be extended to their children, and the possibility of asking for family reunification with some facilitation. It may concern parents who would risk persecution or threats if they were to refuse to practise FGM on their daughters. The law includes both past and future persecution. Article 3(4) states that the fact that someone has already been victim of persecution or serious harm constitutes a serious indicator of the substance and validity of the fear of becoming a victim of persecution or harm in the future.

Decisions on recognising the refugee status and/or subsidiary protection of people who present requests for it are decentralised, and seven territorial commissions hold responsibility for its evaluation (Gorizia, Milan, Rome, Foggia, Syracuse, Crotone and Trapani). One respondent stated that she was informed that around the year 2007 one woman from Togo was entitled to refugee status for reasons related to FGM in Trieste.

As demonstrated by the parliamentary debates tracked in POL, attempts were made to include specific provisions on asylum seeking in Law No 7/2006, abandoned mainly as a consequence of the ongoing electoral campaign (Brunelli, 2007).

5. Professional secrecy provisions

Reporting on FGM is a duty according to the Italian legislative framework. According to Article 361 of the Penal Code (*failure of a public officer to report a crime), any public officer has the duty to report any criminal offences he/she was informed about while in the course of his/her duties or because of his/her profession. Administrative sanctions are applied. A ‘public officer’ is anyone who is in charge of legislative, jurisdictional or administrative duties where the will of the state is formed or manifested; he/she shall have the power to authorise, to certify, to deliberate (e.g. policemen/women, judges, firemen, military personnel, medical doctors leading healthcare institutions, notaries public, mayors, school teachers, etc.). Article 362 of the Penal Code (*failure of personnel in charge of public offices to report a crime) affirms the duty to report under the same conditions as above of any person, without being a public officer with related powers, that is in charge of delivering a public service in public bodies/institutions.

Article 365 on failure to provide a medical report sanctions those medical doctors who do not provide medical reports having become aware of a crime (among those against which it is possible to proceed ex officio) in the course of their professional duties. This disposition is not valid when the report would expose the patient to a penal procedure.

4.6. Reflection on legal framework

Approximately 6 years after the first bills on FGM were presented to the parliament, the introduction of FGM as a specific criminal offence in 2006 clarified that the main goal of the legislator was to launch an explicit message on the illegality of criminal practices which were punishable according to already-existing articles of the national Penal Code on personal harm. By way of integrating already-existing articles of the Penal Code, punishments were increased for offenders and an overall framework was provided guaranteeing the extraterritoriality principle (although not clearly interpretable according to some experts); establishments at which FGM is carried out were also made liable. The distinction between ‘genital mutilation’ and ‘genital modification’ other than clitoridectomy, excision and infibulation was an outcome of the debate on the proposal of a legalised alternative symbolic ‘sunna’ which preceded the law’s approval, as the need to definitely ban it was very strong at that time. At present, the only sentence which was issued after the law’s approval was finally related to a sort of symbolic ‘sunna’, which it was difficult to forensically detect on the victim’s clitoris. As already reported, limitations and contradictions have been highlighted by experts regarding ambiguities on the extraterritoriality principle, lack of monitoring/registration systems, lack of provisions on asylum, different treatments of female/male light genital modifications and the relevancy of applying Articles 330 and 333 of the Civil Code. Nevertheless, others expressed their full appreciation of a law which is considered as a benchmark at the international level (Cassano and Patruno, 2007).

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

Information on actors was gained initially from academic articles/books accessed as described in other sections of this report and by performing a web search on Google using the same research terms as already specified.

In general, due to the high number of actors in Italy, priority was given to institutions/NGOs over individual experts.

The Ministry of Equal Opportunities has published the list of approved projects within Law No 6/2006 on its own web pages dedicated to FGM. This list was another source for identifying the main actors; all of them have been included in the database.

As far as academic actors are concerned, due to the large amount of academic papers and books which have been identified and the short time available for this desk research,
selection was carried out including in the database only those which seemed to have developed the most consolidated research activities on FGM with an orientation to policies (more than for example medical–clinical studies).

Nevertheless, healthcare institutions reported to be excellence centres for the treatment of FGM have also been included.

5.2. Actors

Thirty-four actors have been included in the country database. As reported in previous paragraphs, many actors have been working on FGM since the end of the 1990s. Among the first we find hospitals like Careggi hospital in Florence, the hospital in Forlì/Cevas and San Gallicano hospital in Rome, whose experience was recently absorbed and consolidated by INMP–NIHMP.

These establishments have been confronted with the need to support pregnant women with FGM, to treat the gynaecological and urological consequences of FGM and to practise desinibulation. Healthcare professionals have been at the forefront of the fight against FGM, as the literature published in medical journals shows.

NGOs such as AIDOS, NPWI and Nosotras are also among the actors that played a key role in lobbying for the approval of Law No 6/2007. AIDOS has capitalised on its activities in international development cooperation in Africa since the 1980s and all these organisations benefited from transnational cooperation from 2000–03. Partnerships with supranational institutions, as in the case of the hospital in Forlì/Region Emilia Romagna collaborating with the WHO or Daphne programmes, allowed a triggering of the debate and an enhancement of national expertise on the issue. Another actor with a long-term experience is the Working Group on FGM at the University of Padua, whose studies since the beginning of the 1990s have been mainly conducted with an anthropological approach, including through field research in African countries.

An anthropologic perspective seems to feature in the Italian debate on FGM, with some emphasis on postcolonial issues. For example, it is probably not by chance that the Padua working group has focused a lot on women’s experiences of overcoming FGM in Africa by way of practising alternative symbolic genital modification, and that the same issue has gained such strong relevance in the policy debate. When the debate on the proposal of the ritual ‘sunna’ in public healthcare centres as proposed by Careggi hospital in Florence became a hot topic in the media, women’s NGOs such as Nosotras and AIDOS firmly stood up against this possibility. The Regional Bioethics Committee from Tuscany and the National Bioethics Committee were also influential in this respect, the latter with its banning of such a possibility.

Several legal studies scholars and researchers also discussed FGM and the Italian legislation, often with a critical perspective, as is evident from the country library. A National Commission for the Prevention and Combating of FGM was established in 1999 by the Ministry of Health and afterwards re-established following the approval of Law No 6/2007 by the Ministry of Equal Opportunities, leading to the process of providing guidelines for healthcare professionals and the abovementioned national call for proposals for awareness-raising and training projects issued in 2007. The commission itself and the Ministry of Equal Opportunities are nowadays the primary institutional actors, organising the annual events for the International Day Against FGM in February and directly financing regions for initiatives on FGM. A series of other NGOs have started to work on FGM as a consequence of this initiative and the available resources, some of them already active on migration and intercultural integration issues (ISMU, Tolbà, Anelli Mancanti), while others are migrant women’s NGOs or cooperatives (No.Di; Kantara; Almaterra).

Local and regional authorities are also relevant actors: regions are the administrative bodies in charge of managing healthcare institutions and they implement biannual or triennial action plans on healthcare and migrants’ healthcare; in several cases they have recently integrated FGM into their programmes. The Tuscany region set up its own working group on FGM in 2004, which was refinanced by Law No 6/2007 in 2008 together with a awareness-raising/training initiative and the establishment of the web portal MGF Toscana. The Veneto region got funds from the region to implement training courses for healthcare professionals in 2008–09. The Basilicata region, along with the Tolbà association, also funded research and training initiatives, although it is not clear if national or regional resources were used. Some municipal governments have also been active in projects on FGM, such as Rome in a Daphne project in 2003–04, or Pescara in one of the initiatives funded by Law No 6/2007 in 2008.

5.3. Reflection on actors on female genital mutilation

An increase in the number of actors can be noticed due to the implementation of policies at the national level and the availability of resources after the approval of Law No 6/2007; a greater variety of actors are active on the issue, with different perspectives, while at the end of 1990s only some healthcare institutions, some major (women’s) NGOs and the University of Padova were taking the initiative.

Actors have been recently working coherently with the goal of preventing FGM and providing information on the law itself and prohibition of genital mutilation. Nevertheless, several critical voices have been raised by both NGOs and academics on the implementation of the legislative framework and FGM policies. This can be seen both in papers/books stored in the country library and in some of the tools and instruments.

As far as regional governments are concerned, not all of them have been found to be involved as actors against FGM, and it is likely that awareness-raising initiatives did not reach the whole national territory homogeneously. Further research should be carried out to produce a complete map of all regional governments, as the role of regions is crucial in that they are responsible for healthcare policies and services, and therefore their involvement impacts upon the training and awareness raising of healthcare staff, and
the type of healthcare support/treatment that is offered to FGM victims.

Child protection agencies did not seem to have an active role in the fight against FGM and the related policy debate. The national police force is directly in charge of managing the freephone number on FGM, but unfortunately it was impossible to find specific information on the outcomes and impacts of this service.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Tools were mostly retrieved by searching the websites of relevant actors and governmental institutions involved in policy implementation on the issue. All web sources for tools and instruments have been included in the country database.

When selecting tools and instruments I deliberately chose to focus on non-academic products as my understanding was that academic papers/books would have to be considered only for the country library in the endnote, even if it was not always easy to distinguish the two typologies.

A book and a video were received by Istiss, and this was the only hard copy tool which was sent to me. The INMP and the ISMU also promised to send me their documentation but as of today nothing has been received.

6.2. Tools and instruments on FGM

Available tools are quite varied and cover guidelines/recommendations for healthcare professionals to project reports, research reports and, most of all, informative booklets and awareness-raising documentation. Many training courses have been carried out in Italy and some videos have been produced, in some cases in the docufiction style, targeted at migrant communities/women. Some multilingual materials have also been made available to inform migrants and make them aware, in their mother tongue, about how harmful FGM is for women, and most of all to inform them about Law No 6/2007.

In general, it is possible to say that the main typologies of tools are related to training activities/seminars, and that many surveys are available on the perceptions of professionals about FGM, their knowledge of the legislative framework and/or their training needs. Several guidelines or manuals have been delivered. Much has been done in Italy to address the training needs of healthcare professionals and the broader target of socio-cultural professionals, including social workers, cultural mediators and teachers, and this is reflected in the existing tools.

6.3. Reflection on tools and instruments on female genital mutilation

At the end of the 1990s the main focus was on guidelines for healthcare professionals and awareness-raising campaigns for stakeholders and the media; tools were commissioned either by NGOs or regional authorities/public healthcare institutions. Following the approval of Law No 6/2007, major efforts have been made to target migrant communities as well, as this was a specific policy orientation included in the Law itself and an outcome of the overall debate preceding its approval. NGOs became more directly involved in delivering tools and instruments, with the Ministry of Equal Opportunities as a funding institution.

The impression is that it could be interesting to increase future efforts in order to have more specialised training/information and related tools to meet the specific needs of different professionals, particularly by distinguishing healthcare personnel from the others, concentrating more on social workers and teachers, who usually are at the forefront of reporting suspected abuses on children, and cultural mediators.

7. FINAL CONSIDERATIONS

In 2009 there were approximately 110 000 women from countries at risk of FGM, of whom 4 600 were girls aged less than 17 that could be potential actual or future FGM victims, reduced to 1 000 after further estimates on the impact of migration. There is a lack of disaggregated data per country of origin and age, and a lack of scientific research on the issue and of studies on the trends over time. Limitations in the availability of prevalence studies are connected in one way to the absence of a coordinated registration system at any level. This could probably be solved by involving national institutions such as the ISTAT, INMP and/or ISS in future prevalence studies to be carried out at the national level.

Studies carried out in 1993 among gynaecologists and obstetricians in certain regional areas documented that 50% of professionals interviewed had at least one experience with FGM patients (Grassivaro Gallo et al., 2010), while other studies reported lower figures of approximately 27% (Gori et al., 2002).

FGM became a policy issue at the end of the 1990s with the rise in the amount of immigration to Italy and when regions such as Emilia Romagna and Tuscany and their healthcare institutions/hospitals were confronted with cases of women with FGM and started to develop expertise and the first guidelines on the issue. The working group on FGM at the University of Padua was intensively researching on FGM in Africa and in Italy and organised conferences which contributed to increased awareness of the problem. At the same time, some international projects were run by NGOs and other actors, particularly within the Daphne programme, and women’s NGOs like AİDOS were running campaigns on FGM in connection with their international development cooperation projects in Africa. The first bills on FGM were proposed to the parliament to establish a specific form of criminal offence related to FGM, and in 1999 a National Commission for the Prevention and Combating of FGM was set up by the Ministry of Health, later on disbanded. During these same years, the first two trials for practising FGM took place in Milan and Turin. In 2004 a proposal by the Careggi hospital in Florence on
practising an alternative symbolic sunna in public hospitals as a way to contrast more violent forms of FGM provoked a firm reaction among women's NGOs (AIDOS and Nosotras, among others) that opposed such a possibility, and led to a hot debate in the media and in parliament, where several bills were merged into the so called Consolo bill (from the name of the Senator who presented it). In a climate of electoral campaigning and with a cross-party alliance, Law No 6/2007 on the prevention and combating of FGM was passed. The crime of FGM was established by integrating Articles 583 bis and 583 ter into the Penal Code, punishing both female genital mutilation (excision, clitoridectomy, infibulation) and any other forms of genital modification practised without any therapeutic need. Administrative sanctions for any health establishments involved were also introduced, as well as disqualification for medical staff found to having practised FGM. The law also established a policy framework aimed at preventing FGM by informing and involving migrant communities and women, and by the training and awareness-raising of healthcare professionals, educators and social workers. Resources were made available for these purposes. A freephone number for FGM was established, and in 2007 a call for proposals was issued and action research projects were approved and financed, including awareness-raising campaigns carried out up to the end of 2009. In 2007 the National Commission for the Prevention and Combating of FGM was reappointed and contributed to the national guidelines for healthcare staff published by the Ministry of Health. The law was not refinanced over the years (although there are traces of financed actions towards some regions, like Tuscany and Veneto), and there are no reports available to the public that evaluate its implementation and the effectiveness of the actions which have been rolled out. In 2010 the very first sentence for the crime of genital modification was issued by the Court of Verona after the approval of Law No 6/2007. The recently expired commission drafted an action plan for the upcoming years which will have to be approved by the new government. The Commission is going to be reappointed and the Ministry of Equal Opportunities recently committed to including FGM among the priority policies to be addressed in the next years.
Analytical country report

Italy
Analytical country report

The central goal of the report is to analyse the Italian work on FGM, highlighting the current Italian policy developments on and implementation of FGM, and underlining its success and challenges in reference to six major areas, known as ‘Ps’: ‘prevention’, such as measures to promote changes in the social and cultural patterns of behaviour of women and men of all ages; ‘protection’, such as measures implemented to protect victims who have undergone FGM, and girls and women at risk; ‘prosecution’, such as criminalisation of FGM and measures related to ensuring investigations and judicial proceedings to prevent and punish FGM; ‘provision of services’, focusing on services offered to victims living with FGM, and girls and women at risk of FGM; ‘partnership’, relating to the involvement of relevant actors at international and national level; ‘prevalence of estimates’ and quantitative and qualitative data collection concerning FGM research and administrative records/data sets that allow understanding of the approximate reality of the phenomenon.

A qualitative in-depth study was conducted by performing six face-to-face interviews with key actors who played different roles in policy development and implementation. Interviews were conducted through semi-structured questionnaires including mandatory themes and specific questions related to the competences and role of the interviewees in reference to the Ps. Mandatory themes include: a country’s historical context, against which the current situation in terms of approach to FGM has to be seen; general evaluation of Italian policy in reference to the ‘six Ps’; policy development, policy implementation, challenges and successes of the Italian approach; and key recommendations and successes to improve work on FGM in Italy.

The following table outlines the specific themes explored by each interviewee.

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Respondent from AIDOS</td>
<td>Prevention; provision of services; partnership</td>
</tr>
<tr>
<td>Respondent from the Office for International Affairs and Social Interventions of the Ministry of Equal Opportunities at the Presidency of the Council of Ministers</td>
<td>Prevention</td>
</tr>
<tr>
<td>A judge at the Court of Verona</td>
<td>Prosecution</td>
</tr>
<tr>
<td>Respondent from the Centre for the Prevention and Care of Complications of Female Genital Mutilation, Careggi hospital, Florence</td>
<td>Provision of services</td>
</tr>
<tr>
<td>Respondent from the National Commission for the Prevention and Combating of FGM</td>
<td>Partnership</td>
</tr>
</tbody>
</table>

No difficulties were encountered during the interviews. Interviews were summarised and partially transcribed in order to carefully report the interviewees’ most important statements.
II. INFORMATION SOURCES

Overview table of the interviews

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<tr>
<th>Date of interview</th>
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<th>Observations</th>
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</thead>
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<tr>
<td>23.7.2012</td>
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</table>

Brief description of each respondent

**First interview**
Development economist. In 1981 she started AIDOS, a leading civil society organisation on FGM in developing countries and in Italy. AIDOS works in the field of development cooperation, implementing projects and activities related to sexual and reproductive rights and health, capacity-building, economic empowerment, advocacy and education for girls and teenagers. The association is recognised for its solid expertise and actions against FGM. The association actively followed and contributed to the Italian debate on FGM, contributed to the development of the first draft of Law No 7/2006 and carried out a project financed by Law No 7/2006.

**Second interview**
Medical anthropologist, member of the National Commission for the Prevention and Combating of FGM and expert/consultant of the Italian National Office Against Discrimination (UNAR). His experience on FGM dates back to the beginning of 2000 when he carried out a training project with a leading dermatologist, working on FGM in Italy.

**Third interview**
Assistant professor at the University of Cassino, former researcher at National Institute for Health, Migration and Poverty (henceforth INMP). She was the coordinator of two projects funded by the Law No 7/2006. These projects trained healthcare professionals and cultural mediators on FGM so that their expertise could be used in hospitals and other healthcare institutions.

**Fourth interview**
Director of the Office for International Affairs and Social Interventions of the Ministry of Equal Opportunities at the Presidency of the Council of Ministers, also in charge of the anti-FGM policy area. The director has been in charge of coordinating activities linked to the enactment of Law No 7/2006. He followed the establishment and work of the National Commission for the Prevention and Combating of FGM and the coordination of the call for project proposals funded by Law No 7/2006.

**Fifth interview**
Judge working at the Court of Verona. He issued the first sentence in an FGM case, applying the sanctions included in Law No 7/2006.

**Sixth interview**
Gynaecologist, director and founder of the Centre for the Prevention and Care of Complications of Female Genital Mutilation (Careggi hospital, Florence), member of the two commissions instituted at the Ministry of Health and the Ministry of Equal Opportunities by Law No 7/2006. His proposal of a harmless alternative practice to FGM to be practised in his centre led to a vibrant debate that still has echoes in the current approach on FGM in Italy.

**Additional contacts and complementary sources of information**
Two additional persons were at the Ministry of Equal Opportunities. They were asked to join the interview due to their experience in policy development and the implementation of Law No 7/2006, and the establishment of the National Commission for the Prevention andCombating of FGM.

The President of the Federation of Somali Associations in Italy joined one of the interviews for the last 10 minutes. He was asked to give information concerning the issue of FGM and the right of asylum in Italy.

III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

The Italian debate on FGM started in the late 1970s in the universities, especially in anthropology workshops, and within women’s associations. The first Italian article on FGM was written by the first interviewee and published in 1978 in the magazine Effe, the first Italian feminist magazine. Interestingly, in Italy, the debate on FGM started before
the arrival of immigrant women originating from FGM-practising countries.

The early presence of African communities in Italy dates back to the 1960s, but it was only in the 1980s that immigration began to significantly increase. Even then, FGM was not considered a prevalent issue to tackle. The internal debate developed by Italian women’s associations, the echoes of the international debate and the first narratives of African women that had undergone FGM living in Italy introduced some basic knowledge on the practice.

FGM started to become part of the Italian public debate in the 1990s. In 1997 the National Bioethics Committee responded to the health structures of the region Emilia Romagna about the legitimacy of practising male and female circumcision in public hospitals. The commission issued a recommendation which distinguished the two practices, declaring girls’ circumcision as unacceptable as it is aimed at controlling women’s sexuality. Also, Careggi hospital in Florence, Forli hospital, San Camillo Forlanini hospital and San Gallicano hospital started developing specific expertise on defibulation.

In 1999 the Minister for Health, Livia Turco, supported the first Italian survey on FGM and, a year later, AIDOS and No Peace Without Justice (henceforth NPWJ) implemented the first Italian awareness campaign on FGM. The campaign targeted journalists, policymakers, CSOs and human rights activists.

As described in the report of the desk research performed within this study, in 1999 and 2000 two laws were proposed to the parliament. Both addressed FGM in terms of specific crimes punishable with deportation for migrants who are incriminated and some policy measures for prevention.

From 2000 to 2004 EU projects implemented the first training courses and awareness campaigns on FGM. Two DAPHNE FGM-prevention projects were put into action. A project named ‘Stop female genital mutilation’, starting in 2003 and ending in 2004, was carried out in partnership between Italy, Sweden and Spain. The lead Italian institutions were the municipality of Rome and the Department of Social Security Policies, the International Institute of Medical, Anthropological and Social Sciences (Iismas), the Department of Medicine of Migration — San Gallicano Institute, Rome, and the Italian Committee for Solidarity between People (CISP). The project coordinator was Aldo Morrone, a dermatologist, who at that time was the head of the Department of Medicine of Migration at the San Gallicano Institute in Rome.

Another project, named IDIL, starting in 2001 and ending in 2003, was implemented by the Centro Piemontese di Studi Africani (Piedmont Centre for African Studies, University of Turin) and the Centro d’Iniziativa del Piemonte, in partnership with local CSOs including Almaterra, Nosotras and Naga.

In 2006, Law No 7/2006 was passed by the Italian parliament, and it appears in the cultural and juridical contexts of strong condemnation of FGM, which was inspired by debates regarding the proposal by one respondent of a ‘harmless and symbolic’ alternative to FGM to be practised at Careggi hospital, Florence. The public debate was led by those advocating the right to practise FGM in a protected medical environment and those recognising in all types of FGM a violation of human rights and violence against women and children.

Neither the national and regional bioethics committees nor the Italian Ministry of Health supported the proposal, declaring that any act which harms women’s dignity and physical or moral integrity (even in a symbolic way) was illegal (for its incompatibility with the Italian constitution and moral values), in the name of universal human rights.

According to the respondent, his proposal of a harmless and symbolic alternative to FGM was the main reason for Italian legislators to enact the law. He underlined that in Italy very few people were aware of the practice. His proposal stimulated an animated public debate that facilitated the circulation of information on FGM and pushed the legislators to develop a national law.

‘The Italian law was enacted due to the debate started by my proposal. I know the journey of the law. I met the legislators several times. It all started when I proposed the symbolic alternative to FGM. Italian public opinion splits into two positions. One the one hand there were people supporting my proposal, on the other hand there were people who strongly attacked me, especially feminist groups and CSOs.’

The respondent acknowledged the decision of the bioethics committees and followed the received indication. However, during the interview, he said that he was still convinced that his proposal is more helpful to women than the ideological debates led by feminists and CSOs. He clearly stated that his main concern was and is the women. His experience of witnessing their pain brought him to set out a proposal which aims at saving the rite and its meaning for the community and the family, and saving the integrity of a woman’s body.

‘I never changed my mind. My aim was — and still is — to eliminate FGM. The alternative rite was not meant for women already subjected to FGM. The proposal was born here, in this very place, in response to women who were asking me to practise FGM on their little girls. I saw there was no way to convince them to abandon the idea. To their request, my response would have been an alternative practice to let come out of the clitoris only few drops of blood. Nothing else. No cutting, no closing. The body keeps its integrity. There would be the rite, the party, the family and the presents for the girls. I spoke with colleagues, paediatricians and obstetricians about this. It did not come out of the blue.’

‘Safeguarding the symbolic value of a ritual whose scope is the control of female sexuality by males would mean legitimising the cultural belief system behind it, making it more difficult to eradicate female genital mutilation. We opposed this ritual requiring the manipulation of the genital area, both because it compromises the integrity of the body, and because it would be completely useless, since the puncture would of course leave no visible sign.’
The respondent’s proposal had the merit of revealing the diverse aspects of the approach that implemented the law and that still play a major role in the application of its measures of prevention and punishment. One of the CSOs that spoke up against his proposal was AIDOS. In this regard, another respondent restated the reason why the proposal could not be accepted.

Opposite positions among the interviewees also revealed different opinions concerning the interviewee’s proposal. While some respondents clearly conveyed their disagreement, one expressed her support for the proposal.

‘I believe this proposal modifies the practice and keeps alive the rite and its necessity. He was attacked because its proposal was innovative. Every time there is an innovative proposal there is resistance.’

The interviewee’s response to the people who attacked him focused on the necessity to protect women from the consequences of the practice.

‘One thing is to do politics, the other thing is to meet these women every day, talk with them and see what they are going through because of FGM. There is a difference between ideas and health. All these feminist groups animated such a harsh debate with their slogan “my vagina is mine!” I talk from a medical point of view not from a political point of view. Many people misunderstood my proposal. They said I was proposing a soft infibulation. I proposed to use anaesthetic ointment and then spill only a few drops of blood from the clitoris area. This would accommodate women and families who refuse to give up the rite and the celebration of the girls. For them, it is like a Catholic first communion. I see that many young African women decide on an alternative rite. I know this is happening in Africa. I even saw that other doctors in the US proposed the same alternative. But when I did it, it was badly received.’

Nevertheless, different political parties came to a substantial agreement on the law. The support had diverse standpoints such as criminalisation and prosecution on the one hand, and prevention on the other hand.

The first draft of the law was strongly focused on prosecution. The development of the approach on prevention is the result of an intense parliamentary debate followed by consultations with experts and CSOs. According to one of the respondents:

‘The actors who proposed the law were initially focusing only on punishment, then they slowly smoothed their approach. This was due to long consultations with experts from various disciplines, and CSOs. The debate contributed to the definition of the final text and to the enactment of Law No 7/2006, which is more focused on prevention.’

Even the initial approach of the awareness campaigns was shaped by a severe and unconditioned condemnation. One interviewee said:

‘The first draft of the leaflet of the first general awareness campaign said: “A meaningless and savage practice”. This was before the enactment of the law. When I was consulted, I told the people in charge that their approach was very wrong. I told them that a practice is never meaningless. A practice that aims at modifying the human body has deep meaning. Besides, calling somebody savage does not help any dialogue. I suggested consulting African immigrant women to rewrite the flyer. The women modified its language and content, ending up by focusing on the medical consequences of the practice.’

The two ministers who first signed the law were the Minister for Justice and the Minister for Equal Opportunities. The law was developed according to the political guidelines of the ministers. The Ministry of Equal Opportunities shaped the content of the first part of the law focused on prevention, protection of the victims and provision of services, whereas the Ministry of Justice shaped the punishment measures and the approach on prosecution.

As acknowledged by the interviewees, the Italian approach was deeply improved with the activities promoted by Law No 7/2006 and by the projects funded by Daphne. The projects had the merit of building knowledge and medical expertise on FGM. Law No 7/2006 significantly contributed to the inclusion of FGM in the Italian social, political and legislative agenda. One of the strong points of the law is that it does not limit the preventive action just to the ‘deterrent factor’, but provides finances to develop and implement prevention, information, research and training activities.

The law was complemented by a budget of EUR 5 000 000 allocated as follows: EUR 2 000 000 allocated for information and awareness-raising campaigns both in Italy and in African countries; EUR 2 500 000 for the training of healthcare professionals; and EUR 500 000 allocated for the implementation of the call centre. The law also had annual financing of EUR 200 000. The law also instituted a special commission with the aim of coordinating national activities and a call centre/helpline to protect girls at risk, instituted and managed by the anticrime unit of the Ministry of the Interior.

The law instituted two commissions. The commission instituted at the Ministry of Equal Opportunities, named the Commission for the Prevention and Combating of FGM, has the role of coordinating national action plans and prevention activities. It also coordinates the allocation of the national budget instituted by the law. The commission coordinated the first national call for project proposals and developed guidelines for their implementation. One interviewee underlined that the Commission acknowledged the key role community leaders and cultural mediators played in the implementation of the prevention activities. Moreover, the ideological standpoint of the commission was shaped by the recognition of equality between cultures and by the aim of promoting the respect of cultural differences and
traditions. Nevertheless, the commission recognised FGM as a violation of the rights of children and as an unjustified injury to women’s bodies. All efforts were made to guarantee harmony between the Commission’s approach and the activities carried out after the enactment of the law.

The commission is formed of six or seven experts with multidisciplinary competences. The various experts contributed to the analysis of the medical, political and social aspects of FGM in Italy and to the enactment of the preventive activities promoted by the law. The first commission was appointed in 2007, the second in 2010 and the third will be appointed by the end of August 2012.

The composition of the commission was often influenced by different political approaches, concerning in particular the role of CSOs and African representatives. One of the respondents described the three commissions appointed by the different governments in this way:

‘The first commission was oriented towards the CSOs. There was good representation and participation of associations. The second was more politically oriented and was mainly composed of political representatives. However, we saw that the commission always granted an open debate and the possibility for every participant to have its say at the discussion table’.

The commission led by Minister Carfagna was criticised by CSOs who protested the absence of African representatives and associations. To respond to the critiques, the minister invited some associations to a day aiming at collecting their proposals for future actions.

According to two respondents the next commission will include CSOs and African experts. However, the final approval of the nominated members will depend on the decision of the Minister for Equal Opportunities.

The commission instituted at the Department of Health distributed the first guidelines for healthcare services aiming at promoting preventive activities, and the care and rehabilitation of women and girls subjected to FGM. The guidelines are an educational tool that characterises FGM not solely as a health issue. They also provided instruments to deal with cultural diversity and to improve doctor–patient relations, especially when the latter is a foreign citizen. The guidelines recommended the following:

(a) Provide all the necessary knowledge to professionals and practitioners.

(b) Recognise the types of FGM and possible complications.

(c) Use appropriate language and confront relational problems between doctors and patients.

(d) Be aware of the existence of networks of experts and services dedicated to women with FGM.

(e) Identify a limited number of dedicated facilities to provide appropriate levels of clinical competence while ensuring a multidisciplinary approach and adequate surgical preparation.

(f) Develop regional training courses and adequate plans for the implementation of specific structures.

The first call for project proposals promoted by Law No 7/2006 was issued in 2007. Twenty-one projects were funded, addressing the macro areas ‘training’, ‘action-oriented research’ and ‘awareness campaigns’. For each macro area there were seven funded projects. Official proponents and representatives of the projects were 13 associations, five research institutes, one local institution and one hospital. Other actors, like universities and hospitals, were included as partners of the projects. All projects were carried out in partnerships, joining various actors whose actions covered one or two of the macro areas.

The following table summarises the major milestones of the emergence of FGM issue in Italy.
Finally, according to the interviewees, the main actors who promoted the enactment of the law were national policymakers, but the ones who contributed deeply to shaping it were CSOs like AIDOS and Nosotras, and key individual experts. International instruments and legislation enacted by the UN and the EU, and national legislation, including the Italian constitution and criminal and child protection law, represented the legal framework. According to the interviewees, the Italian law is the result of the work of national actors and international forces. Some of them put the emphasis on the influence of the international laws, especially the role of the EU, the UN, the Maputo protocol and the Beijing conference. Others recognised the main role of CSOs like AIDOS and Nosotras. One interviewee said:

‘Before being a national priority, FGM is an international priority. The 2006 law is mostly a response to the international requests for action against FGM. It was a top-down stimulus coming from the UN and going to the states and the local governments. What Italy is doing is mainly a response to those international inputs.’

CSOs like AIDOS, together with African women, contributed significantly to the debate aiming at reviewing the first draft of the law promoted by a team of lawyers and experts headed by Senator Giuseppe Consolo. In this regard, AIDOS highlighted the fact that the first draft was really unacceptable. They collaborated significantly with African women in the discussion phase of the law.

‘We have been working on FGM since 1985, but now we are not the only ones. African women are also very active. They actively participated in the Italian debate on the 2006 law. We always went together with African women to discuss the draft of the law in the parliament. We never went alone.’

Concerning the role of CSOs one interviewee disagreed with other interviewees. She said:

‘African women with FGM, together with the impact of the international debate, are the main actors and forces that solicited a legislative intervention. I do not think Italian CSOs played a big role.’

To sum up, according to the information provided by the interviewees, the main actors who pushed for policy development on FGM are as follows.

- Policymakers, such as the deputies who submitted the drafts of the law, the final version of which merged together the other pre-existing proposals, from the Ministries of Equal Opportunities, Health and Justice.
- AIDOS and NPWJ worked towards sensitising policymakers and activists through their first national awareness campaign. Furthermore, CSOs like AIDOS, Nosotras and Almaterra took part of the public debate that preceded the law. They emphasised the limits of an approach based exclusively on prosecution and highlighted the contradictions and gender discrimination behind the proposals to legitimise the practice of light forms of FGM.

The interviewees also acknowledged the influence of an international call for action and law against FGM and violence towards women, especially from the EU, the UN, the Maputo protocols and the Beijing conference. They also emphasised the role of the healthcare services, especially Careggi hospital, Florence, and Forli hospital, that stimulated...
the debate, interrogating the institutions on the legitimacy of practising FGM in healthcare institutions.

IV. PREVALENCE AND DATA COLLECTION

Italy has been, since relatively recently, an immigration country, with a limited immigrant population from African countries where FGM is endemic. East African immigrants represent 4.7% of the total number of African immigrants living in Italy. The majority of African immigrants come from north and west Africa (ISTAT 2011). ISTAT data on African immigrants in Italy does not take into account the number of undocumented immigrants and the number of Africans with Italian citizenship, which can be the case of the first African immigrants coming to Italy or African-Italians.

In Italy there is no dedicated organisation collecting data on the prevalence of FGM.

According to the interviewees, the available data on the prevalence of the practice in Italy are very approximate, vague and contradictory.

The very first survey conducted in healthcare services dates from 1993 and was carried out by the Department of General Psychology of the University of Padua on a sample of 318 obstetricians and gynaecologists working in hospitals, universities and private clinics in different regions. According to the result of the study, 147 practitioners admitted having treated women or girls who have been circumcised or infibulated. Almost all had examined up to 10 circumcised women. Seven of them had examined up to 100. Of these seven practitioners, five were working in Milan in specialised establishments dedicated to immigrated women, and two of them were working in the hospitals of Florence and Padua.

Diverse data are reported by AIDOS:

‘In 1999, we requested from the Ministry of the Interior statistical data on migration in Italy. We confronted them with the prevalence of the practice in Africa and made a possible estimate on the situation in Italy, making a clear distinction between the number of women that are already victims of FGM and the girls at risk. We found out that 500 girls were at risk. Our findings were very different from other research, which presented an estimate of 35 000 female victims of FGM. We do not agree with this data. It is misleading information.’

The regions of Lazio, Tuscany and Abruzzo conducted studies on the perception of FGM among healthcare professionals and cultural mediators. For instance, the study carried out by the Lazio region in 2008 reported the result of a survey conducted through questionnaires sent to cultural mediators on their knowledge of FGM and Law No 7/2006. Some 30% of them had directly experienced and/or treated cases. Similar research was conducted by the Abruzzo and Tuscany regions.

In 2008 the guidelines distributed by the commission instituted at the Ministry of Health contained a section on prevalence data. To begin with, calculations were made by projecting DHS/Unicef prevalence indices in African countries to the population of migrant women from the same countries that were legally resident in Italy in the year 2006. Considering that migration impacts on behaviour, and usually leads to gradual integration and thus abandonment of the practice, the previous estimate was further reduced, thus leading to an overall estimate on prevalence, although without clarifying according to what specific rate/index. Disaggregation by country and age group is provided only for the first level of the analysis. This led to an estimate of 400 girls at risk.

One of the challenges faced by the commission was the limited epidemiological information and the availability of data (mostly qualitative) based on estimates and subject to revision. According to one interviewee, who was part of the commission, one of the main problems in obtaining reliable data is the high number of women who, because of their condition as undocumented migrants, do not appear in the official statistics.

In 2009 the Ministry of Equal Opportunities presented the results of a study on the prevalence of FGM commissioned by Istituto Piepoli SpA, a private company specialising in market analysis. Prevalence was calculated by applying WHO/DHS prevalence indices for FGM-practising countries to the numbers of legal migrant women in Italy from the same countries. These figures were further increased by 20% as the proportion of illegal migrants in Italy is one out of five. Another 30% was subtracted to adjust the number to the behavioural changes occurring through migration. The changes were calculated according to the findings of qualitative interviews. Piepoli’s study calculated that there are approximately 110 000 migrant women from FGM-practising countries. There are approximately 4 600 women aged less than 17, and therefore potential FGM victims. An average prevalence index is calculated as of 46% of the total female population from such countries, further reduced to include illegal migration and the impact of migration itself as a factor leading to the abandonment of these practices. 30% of the total female population is considered to be ‘realistic’, and therefore it is calculated that approximately 35 000 African migrant women in Italy have been victims of FGM. There are therefore calculated to be approximately 1 000 young potential victims aged less than 17.

According to the interviewees, the problem of data collection is due to two major elements: the secrecy of FGM and the lack of a strong will to implement concrete data collection strategies involving healthcare services. In this regard, one interviewee pointed out the excessive rigidity of the national healthcare system, which rarely accepts changes to the consolidated practice of collecting data through the patient’s medical chart.

‘With Dr Morrone we proposed to test the collection of data in two or three big hospitals for 1 year and then to replicate it in other hospitals if the results were satisfactory. But our proposal was not accepted.’
Despite the pessimistic attitude of the interviewees concerning the possibility of collecting data on FGM in Italy, several proposals were made. Interestingly, they all addressed the key role of the healthcare institutions.

One interviewee considers that the available data does not show the real incidence of the practice. According to him, the numbers are even lower than the estimates. Together with his collaborators he presented the proposal of including FGM data collection in other initiative on violence against women to be implemented in healthcare services.

‘Currently we are working on a project on violence against women. We would like to open a pink room in the emergency services to help female victims of violence. In these rooms healthcare workers could also monitor the presence of women with FGM. Healthcare workers would be trained to collect data and hard facts.’

‘Identifying the victims of FGM and the girls at risk through the case sheet and training social and healthcare workers to collect information on the presence of FGM’. She also emphasised the need of a common European system of data collection: ‘It is important to have data but we need a European common systematic method to collect the data.’

To sum up, the available data collected — through estimates calculated according to variables of age, migration condition and country of origin — indicate the presence of girls at risk and female victims of FGM. Concerning the girls at risk the estimates calculated by diverse actors are as follows:
- 400, according to the commission of the Ministry of Health
- 500, according to AIDOS
- 1,000, according to a study by Piepoli.

V. APPROACH TO FGM

V.1. Overall

This section will examine the work on FGM, taking into account the analytical approach developed for this study which focuses on the ‘six Ps’, namely prevention, prosecution, provision of services, protection, partnership and prevalence of estimates. The analysis will consider which Ps are most developed or emphasised, how the focus has evolved and how respondents explain the policy focus. The interviewees were asked to rate each Ps according to its impact and success in the work on FGM. The highest value was one (first classified) and the lowest was six (last classified). The results of their classifications are outlined in the following table.

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Prevention</th>
<th>Partnership</th>
<th>Provision of services</th>
<th>Protection</th>
<th>Prevalence estimate</th>
<th>Prosecution</th>
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*The judge at the Court of Verona humbly said that he did not know enough on the work on FGM in Italy to rate the Ps. He only rated prevention.

According to the interviewees, prevention is the area that has been most developed in the work on FGM. Their response acknowledged the successful implementation of several prevention projects funded by Daphne projects and Law No 7/2006. The interviewees also emphasised prevention as the main goal of the Italian law. One interviewee emphasised the fact that the law developed a very comprehensive policy of prevention that includes training, action-oriented research and awareness campaigns. Another made similar comments outlining the many successful prevention activities carried out since 2000. The two interviewees, who were personally involved in the implementation of two projects, expressed their satisfaction concerning the accent put on this area by the Ministry of Equal Opportunities. The budget allocated by Law No 7/2006 contributed significantly to empowering the prevention strategy.

According to the interviewees, work on FGM in Italy was greatly improved by the implementation of several projects involving actors with different knowledge and expertise. Since 2000, partnership projects focusing on awareness campaigns and training projects saw the collaboration of universities, healthcare services, CSOs, local institutions and international partners. The interviewees acknowledged the promotion of partnerships which developed a multidimensional approach on FGM. Only one interviewee outlined the challenge of the current state of partnerships among CSOs. According to her, the scarcity of resources is negatively affecting the possibility of collaborating and acting in synergy.

This area was rated second by two respondents. Their rating refers especially to education and training provided to social and healthcare services. According to them, training
courses, guidelines and learning materials have been provided to professionals involved in the services devoted to girls and women subjected to FGM. The respondents who rated this area five and four outlined the scarcity of specialised health services provided to women with FGM. Only three specialised centres are currently operating in Italy. The interviewee who is in charge of one of the health centres dedicated to women with FGM acknowledged the impact of the work of his centre and the capacity-building implemented through the expertise he has been able to transfer to colleagues of other hospitals.

According to the interviewees, protection was moderately developed. Protection for women accessing social and healthcare services is positive. Other interviewees addressed the question of the controversy of the application of protection measures included in the national law. They all expressed their disagreement concerning the activation of the helpline. When asked about the Ps rating, none of the interviewees mentioned the issue of the right of asylum for women with FGM.

According to the interviewees, prevalence estimates were not successfully developed. Currently, there are no reliable data on the prevalence of the practice in Italy. The interviewees expressed the need to have hard facts on FGM. Disagreements on the available estimates and difficulties in developing a strategy to improve data collection characterised the main features mentioned by the interviewees regarding this point. The results of the research conducted in Italy are a good starting point to develop a new strategy for data collection.

According to the informants, prosecution should not be negatively evaluated. One interviewee underlined that the second part of the law, focusing on prosecution, is not the prominent part and should not be considered as such. However, he acknowledged the effort of the legislator to develop this area by recognising FGM as a crime and by including specific punishments for it. The other interviewees interpret the existence of only one court case as an indication of the low impact obtained in terms of prosecution of FGM-connected crimes.

V.2. Prevention

This section will look at how prevention has been promoted and implemented, especially since Law No 7/2006 was enacted. It will also look at the major actors involved in the projects. Particular attention will be paid to the projects coordinated by the respondent from AIDOS and another from the INMP. The two projects were funded by Law No 7/2006. The experience of the two interviewees also contributes to an analysis of how prevention has been implemented and challenged in the work on FGM.

However, it is worth noting that the first prevention and awareness campaigns date from 2000 and 2001. AIDOS and NPWJ developed their national awareness campaign in 2000, and two 2-year Daphne projects were implemented in 2001 and 2003. The projects were coordinated by the University of Turin and the San Gallicano health institute in Rome. Both projects enjoyed the collaboration of a wide range of partners, including local institutions, universities, research centres, CSOs and representatives of African immigrant communities in Italy.

The aims of the project developed by the San Gallicano hospital in Rome, named ‘Stop female genital mutilation’, were:
(a) to provide information and analysis of the practice, its reasons and consequences for the victims;
(b) to analyse the practice in significant urban areas;
(c) to devise intercultural methods and practices for prevention and support to the victims, based on positive experiences in Europe and in the developing countries where the FGM is practised;
(d) to prepare intercultural educational modules and communication patterns for teachers, doctors, social services staff and key persons of the communities involved in such practices.

The beneficiaries of the project were health staff in public and private family advisory centres, social assistants, cultural mediators and key actors of the communities that have immigrated from areas where FGM is practised, and primary school teachers.

The goal of the project realised by the University of Turin, named IDIL, were:
(a) to train the trainers on FGM;
(b) to train health/education staff, social workers, cultural mediators, facilitators;
(c) to produce an informative kit and brochure for communities coming from FGM-practising countries;
(d) to produce booklets for health and social services professionals;
(e) to implement an awareness campaign.

The beneficiaries of the project were cultural mediators, African communities coming from FGM-practising countries, and social and healthcare workers.

The first prevention projects included mostly training courses and awareness campaigns. Training courses targeted social and healthcare workers and cultural mediators. The most recent projects within the prevention framework were funded by Law No 7/2006. According to two interviewees the prevention activities were adequately supported by the budget of the law.

‘I think we have a good law, especially for the first part concerning provision of preventive measures. The other good point is allocation of financial resources for the implementation of the prevention activities.’

Under this framework, prevention work consisted mostly of action-oriented research (also known as research for social change), training programmes and awareness-raising campaigns. Activities were mainly carried out within the social and healthcare sectors. African communities residing in Italy were also involved through the presence of cultural mediators and community leaders. Therefore, prevention work targeted professionals from these sectors and, to a lesser extent, African communities. The main actors working on prevention have been CSOs working together
with local institutions. Two of the interviewees were among the actors involved in the funded projects, as described below.

The projects developed by AIDOS and INMP will be described and their training courses, education programmes, and awareness-raising campaigns will be analysed.

**Training and action-oriented research**

AIDOS’s project
AIDOS works in the field of development cooperation, implementing projects and activities related to sexual and reproductive rights and health, capacity-building, economic empowerment, advocacy, and education for girls and teenagers. The association is recognised for its solid expertise and actions against FGM.

In 2007, AIDOS drew up and proposed a research and training pilot project to be implemented in two Italian regions, namely Veneto and Friuli Venezia Giulia. The 18-month project was therefore carried out in collaboration with the ADUSU (Association for Human Rights and Human Development) and Culture Aperte, an association focusing on social and cultural services dedicated to immigrants. AIDOS conducted explorative research in these two regions on the attitudes towards FGM of African communities, associations, social and healthcare workers, and police officers.

The research included interviews and focus groups with female and male African community leaders, representatives of local institutions and healthcare workers. Drawing from the results of the research, AIDOS developed a training programme and a special training manual for social and healthcare workers, and cultural mediators. The project also developed a comprehensive communication strategy for the training modules and for the awareness-raising campaigns.

The training manual was complemented by the popular movie ‘Moolaadé’, which narrates the story of a group of young African Muslim girls who have refused to undergo FGM in an African village, and a fiction-based documentary.

AIDOS adopted the movie Moolaadé for training and awareness campaigns in Italy. They provided an articulated Italian introduction to the movie and contributed to its distribution in public libraries and bookshops all over the country.

The fiction-based documentary is one of the deliverables of the project and it is the final product of eight meetings carried out with African women. It aimed at discussing issues pertinent to FGM such as gender, family, religion, the body and matters concerning their experience as women, immigrants, mothers, and wives.

One of the main challenges in implementing such training projects is time constraints. FGM is such a complex reality that it normally requires a considerable amount of time to be properly explained and understood, however the time schedule often imposed by the social and healthcare institutions represents a limitation.

‘It is very difficult to change the mind and the heart of people about FGM in 2 days of training. Our training programmes take 5 days. It has been very challenging to convey the importance of such training to the regions that asked us for training on FGM. But we know what we are doing. We have a consolidated experience of training in Africa. We have manuals and training materials as a result of 20 years of training programmes.’

The other challenges identified concern standards of professionalism, experience, and knowledge. AIDOS strongly supports the need for trainers and organisers to have a consolidated competence and knowledge on African culture and communities, both in Africa and in Italy. Direct field experience is one of the fundamental elements for effective action.

‘It is fundamental to know Africa before training on African practices. Africa is a complex continent. Also, the behavioural norms and cultures behind FGM are diverse. We strongly believe that experience in Africa is pivotal to effective training in Italy. We believe that improvising experience on FGM is very dangerous. If you know Africa, its diversity and complexity, you know how to work and communicate.’

AIDOS is indeed a CSO with long experience regarding FGM in Africa. Such experience helped them to develop their own training approach, which starts from the knowledge and feelings of the group being trained. Their field experience and their transcultural and gender approach are the main features of their training programmes.

‘We work with women and men. We show how Italian women were in 1968. We always say that FGM is a matter of gender relations with serious consequences for human rights and the health of women. It is important for us to look at gender relations and their changes in different times and spaces.’

The INMP’s project
The National Institute for Health, Migration and Poverty (INMP) is a public structure, under Ministry of Health control, which provides social and healthcare services to all citizens, Italians and foreigners.

The staff is composed of professionals in different disciplines and from several countries. Integrated work between doctors, nurses, psychologists, anthropologists and cultural mediators, allows a holistic and multicultural approach to people. The mission is to perform scientific research on subjects concerning health, human mobile population and travel medicine, to facilitate access to health services for disadvantaged groups of population, and to counter existing and emerging poverty-related diseases.

In 2007, the INMP developed two projects that were conducted in partnership with La Sapienza — University of Rome, Careggi hospital of Florence and two local Italian associations. The projects were coordinated by
Aldo Morrone. The first project was 12 months long and was implemented in nine cities in five Regions (Tuscany, Lazio, Piedmont, Puglia and Sicily). Puglia and Sicily were selected because they are two of the main arrival areas for undocumented migrants. The project included explorative research, a training project and direct interventions in the selected areas.

The first step was explorative research to analyse the degree of reception of Law No 7/2006 and the related guidelines for healthcare workers issued by the Ministry of Health.

Some 2,500 questionnaires were sent to investigate healthcare workers’ perceptions of FGM and their attitude towards cultural diversity. The process was conducted in partnership with an Italian consortium of social workers named Parsec. The questionnaires were addressed to paediatricians, doctors, nurses, obstetricians and cultural mediators.

Concerning the approach to training, one interviewee emphasised their non-judgemental attitude to the subject. She stressed their commitment to developing an open dialogue with the social and healthcare workers in order to encourage them to express their deep feelings and internal conflicts.

‘Our approach was not judgmental. Our idea was to focus on transforming discriminating attitudes through knowledge. It was important for us to find cultural models and social beliefs behind discriminating attitudes. In one of our training meetings a healthcare worker openly stated that he was racist and that his attitude was strongly influenced by the discovering of the practice of FGM. He said he could not accept any culture that cut women. His coming out was useful to open a discussion on the deep feelings of healthcare workers towards the practice and the people who practise it. It is important to reach this kind of people. They are the ones who need training. However, the big challenge remains reaching those who do not even come to training courses. The participants decided to come because they were interested. Most of them were nurses.’

The second project was conducted in the region of Lazio and focused on training. The participants were social and healthcare workers. There were no cultural mediators due to their very limited presence in the region of Lazio. In this regard, the respondent also expressed her concern about the fact that there is inadequate involvement of cultural mediators in the healthcare services and that very often healthcare workers count on the collaboration of improvised translators (like hospital porters) to communicate with immigrant patients. Concerning the training programme implemented in the healthcare service of Latina province, Lazio, training courses were free and open to all healthcare workers. They reached almost 400 people and 25–30 participants, who were mostly healthcare workers and cultural mediators. Training courses had a duration of 32 hours. Training courses were focused on socio-anthropological, medical and gynaecological lectures. Training also included notions on legal medicine and on the medical investigation protocols of FGM. Part of the training courses also included case studies and role-playing.

In this sense, training sessions were also meant to create a collaborative and synergic relationship between healthcare workers and cultural mediators. Training programmes also acted as contexts to explore new synergies of collaboration.

‘Training courses were the context for encounters where people could experiment with a spirit of collaboration and partnership. Also, training courses were unique opportunities to talk about other important topics on reproductive and sexual health.’

However, concerning the involvement of African communities and leaders, the respondent noted that their response to training courses was not very enthusiastic. In particular, the involvement of African men in training sessions was not very successful. Only a few men participated. She summarised the conversation she had with a community leader concerning his participation in a training session on FGM as follows:

‘Why should I come to your training activities, spend my time and make available my experience free of charge? Besides, why should I come and unconditionally share with you your objective of producing a change that you are convinced is good for us?’

Similar information was provided by another respondent. He recalled his past experience of collaboration with Morrone for the Daphne project and the successful involvement of African women.

‘We trained a small army of African women with previous experience as cultural mediators in healthcare services. They were already conversant with the Italian healthcare system. The training project was funded by a “Daphne”. The same women, after the training, created their own associations and kept working autonomously on the issue of FGM. We created little groups and movements of African women that are now autonomous and also independent and are still working on FGM.’

He added:

‘I personally support a culturally orientated approach. I strongly advocated for the involvement of the communities in the training projects. We need to train and orientate the African communities. We need to implement training programmes for them and with them. They worked very well in the awareness campaigns but few of them were involved in the training courses. Yes, I saw some cultural mediators in the training programmes but it is not enough. Also, African women and associations can work extremely well with a small budget. With EUR 200,000–300,000 they can work within the communities, going to weddings and other ceremonies. We need to reinforce this part.’

He also added that another aspect that needs to be strengthened is male involvement.
‘From the Cairo conference onwards, we tried to support male involvement but it seems this is not happening. Associations and institutions must not underestimate this aspect. This is a limit because any change occurring in any culture has to do with men as well. For example, we have few men among the cultural mediators working on FGM.’

Concerning the training techniques, according to one interviewee it is important to utilise teaching methods based on open discussions.

‘I believe it is important to promote discussions even going through conflicts and tensions. I do not think that classic lectures are a good way to provide an effective training programme. In the training programmes I gave on FGM, cultural mediators coming from FGM non-practising countries furiously attacked the cultural mediators trying to mediate on the practice. The discussions were very constructive because they revealed the various feelings and contradictions behind the practice. This is important. As training methods I would suggest utilising focus groups or tea and coffee ceremonies as well. We used them many times. Also, the cultural mediators we trained went to weddings and families to talk about reproductive health, child health and so on, including the issue of FGM. The methods and content of communication are important.’

Awareness-raising campaigns and communication
One interviewee stressed the importance of strengthening the content and methods of the communication campaigns on FGM.

‘We implemented several good projects on FGM and on other issues focusing on specific methods and languages of communication. We have a very interesting and huge archive concerning our projects where you can see brochures and pamphlets translated into several languages. You can also see how we approached the problem using stories and narratives understandable by the communities.’

AIDOS’ project funded by Law No 7/2006 also implemented a grassroots awareness campaign involving African immigrant communities and focusing on the enactment of the law and its legal implications. The main instruments of such a campaign were the public screening of the fiction-based documentary, followed by debates, the distribution of information leaflets on FGM translated into various languages, and media coverage by local television and newspapers. A number of cultural mediators and community leaders who initially benefited from the training sessions were also able to autonomously carry on with awareness-raising initiatives for their communities of reference.

A similar reflection was made by another interviewee. He also emphasised the need to be extremely careful about the communication aspects of FGM.

‘I strongly support the implementation of bottom-up campaigns. It is very important to think about the reactions of the general public to crude images and ambiguous messages. I was against TV spots and other high-impact campaigns but my opinion was not taken into consideration. However, I have to say that at the end the language that was adopted was very soft, maybe too soft. At the end it was even difficult to grasp the message. The problem was that we spent the money targeting the wrong subjects. We were not supposed to work on the general public but on the communities.’

However, there is a need to educate and inform Italian society as well, i.e. help people to understand and look at FGM with the right sensibility.

‘We should implement general public awareness and this seems to be very complicated. I believe Italian society was not ready to deal with FGM. We are aware of the risk of information campaigns. In many cases they reinforce the stigma and stereotypes attached to migrants with the result of fomenting intolerance and racism. We should find a way to talk about FGM while contemporarily promoting integration and fighting discrimination.’

Training programmes in schools
Concerning the target of the training programmes, AIDOS is very cautious about implementing such programmes in schools. The wrong information and the wrong approach, especially if students are involved, can have very negative consequences for any females of African origin. That is the reason why AIDOS believes that the main target of training programmes should be social and healthcare workers, cultural mediators and the leaders of the African communities. One of the respondents also shared a similar reflection, stressing the fact that the result of awareness campaigns and training programmes targeting teachers and schools in general can turn into excessive attention on girls at risk and their families, creating more damage than positive impact.

To sum up
Prevention has been implemented through several training projects, action-oriented research and awareness campaigns. The main actors contributing to prevention were research institutes, CSOs, hospitals and, to a lesser extent, African leaders coming from FGM-practising countries.

The main beneficiaries of the training have been social and healthcare workers, cultural mediators and the time constraints.

Budgets to prevention work
The first call for project proposals, issued in 2007, allocated a first tranche of the budget, calculated in the amount of EUR 1 500 000. INMP and AIDOS were financed with EUR 250 000 each.

The challenge of the first call was that the projects focused only on seven regions out of 22. The projects did stimulate local interventions, but they did not turn into a coordinated national action plan. Taking into account this limit, the
department decided to grant the request of the regions to locally address the issue of FGM by managing the funding of the national budget at the regional level. Besides, the decision was also due to the modification of Chapter V of the Italian constitution, under which the regions become the main actors for the management of healthcare services (1). Since 2006, only one call for project proposals has been implemented. The next call, which is supposed to be announced by the end of 2012, will therefore be managed at the regional level.

The budget will be allocated to the regions according to the prevalence of immigrants coming from FGM-practising countries. This was not recognised as a good decision by the interviewees. Several interventions had already been carried out at the regional level and this, considering the deep differences running between the northern and the southern regions, created a kind of jeopardised national action showing that northern regions were more active and receptive to the law than southern regions.

The regions that will benefit more from the budget allocation will be those with the highest number of regular migrants, such as the northern regions and Lazio, which have already developed several activities funded by the first call for project proposals. Southern regions will be affected since they do not have high numbers of permanent migrants. They have a high number of temporary and undocumented migrants and asylum seekers. Sicily and Puglia, for instance, have the biggest centres for asylum seekers and immigrant identification centres. Two respondents expressed their disagreement concerning the regionalisation of the budget.

‘The first national call for project proposals funded 21 projects. The budget of the second call will be managed by the regions because they claimed that the realisation of projects on FGM is a regional matter. Funding will be distributed at local level according to the presence of migrants coming from FGM-practising countries. We do not support this decision, but the regions did not want to step back on this issue.’

V.3. Protection

This research interprets protection as the reporting, under appropriate conditions, by any person or professional of the occurrence of an FGM procedure.

Concerning child protection, the issue of the measure of protection implemented in the cases of girls at risk is extremely controversial. Italian law has specific child protection provisions that were applied in the past in two cases of attempted FGM. These provisions are Articles 330 and 333 of the Civil Code. Article 330, ‘decadenza della patria potestà’ (loss of parental authority), applies as a protection measure the separation of the child from the parents’ house or the banning of the parent or cohabiting partner whose behaviour is threatening the child’s well-being. Article 333 of the Civil Code, ‘condotta del genitore pregiudizievole ai figli’ (parent’s behaviour which is prejudicial to children) applies as a protection measure the removal of the child from the parents’ house or the banning of the parent or cohabiting partner whose behaviour is threatening the child’s well-being.

A very recent case raised several critiques concerning the application of these protective measures. On June 2012, the juvenile court of Albenga suspended the parental authority of the parents of an 11-year-old Egyptian girl. The girl told her friends that she would be leaving for Egypt to be subjected to infibulation. The girl and her family were stopped by local police and social workers shortly before boarding the train to the port of Genoa. The police stopped the Egyptian family when they arrived at the station. The father and mother initially refused to deliver the children to the police and returned home, where police convinced them to desist. The mother of the girl was hit by a respiratory crisis, and relatives and family friends turned up en masse to block the road, in an attempt to stop the police. Eventually the three children were taken into custody by social workers. The parents have requested the services of a lawyer to appeal against the decision. The investigation was triggered by the juvenile courts following a report by some parents whose children had revealed their friends’ journey to her homeland to be infibulated.

Concerning the application of such protective measures, the respondents emphasised the negative consequences for both the girl and her two little brothers, and the family.

One respondent commented on the case of the little Egyptian girl and considered it to be an example of the wrong perception of the law by the stakeholders. According to him, the police officers, the social workers and the judge saw in the intention of the parents an act of violence against the girl and treated the case like any other case of violence against children. They did not consider the peculiarity of the situation. In this regard, he added that the department is willing to implement special training for police officers and judicial authorities.

‘Regarding the last case of FGM and the decision to separate the little girl from her parents, we know that this is not a good decision for the girl. This is a second instance of violence. The law does not prescribe this. It is the approach of police officers, judges and stakeholders that is causing this hyper-reaction. The law is very clear. It is its application that has some problems, due to the ignorance of the stakeholders. We hope to change this attitude by informing and training them. We, as a department, are considering keeping some resources of the national budget to tackle this attitude. We would like to carry out a special training programme on the legal implications of the law, involving especially the people in charge of its application.’

(1) On 16 November 2005 the Italian senate enacted a law reforming the system of devolution of the state’s powers to regions. The reform allocated powers to the central state and the regions in a new way. Regions have been granted concurrent legislative powers (podestà legislativa concorrente) with the central state on subjects such as health protection, supplementary and ‘integrative’ pension schemes, international and EU relations at regional level, protection and safety of labour, education, and scientific and technological research.
One interviewee also commented the decision of the court, emphasising the meaning of FGM in light of the relationship between the girl and her parents.

‘Suspending parental authority and separating the little girl from her family is not the appropriate measure of protection. Parents love their daughters and, strangely enough, FGM is also part of the love they have for them.’

The judge at the court of Verona expressed a different opinion. He did not apply such measures in the case he handled because his sentence was issued 4 years after the case was discovered. The Nigerian woman was arrested but he could not remember for how long. He reflected on the circumstances demanding urgent protective measures for girls at risk and came to the conclusion that the suspension of parental authority is still the best measure to guarantee the best interest and the well-being of the girls.

‘The suspension of parental authority is an option and to me it is a good measure to protect the girls. The priority is the interest of the girl. However, I do not deny that it is extremely complicated. In the last case, which happened in Albenga, I believe there was no other choice. The girl needed to be protected. These are very deep conflicts but I understand the decision of the judge.’

The application of such protective measures is one of the actions proposed by the Council of Europe in the Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, signed in Lanzarote on October 25, 2007. On 23 March 2009 the Italian government proposed a bill before the house of representatives on the ratification of the convention. During the debate between the Committee for Justice and the Committee for Foreign Affairs in the house of representatives and in the senate, an amendment was introduced proposing the withdrawal of parental authority and permanent disqualification from administering support, protection or care for minors for the offence of female genital mutilation.

‘We are protesting against the Lanzarote law, including a regulation that adds further punishments such as the removal of parental authority. We do not agree on this point. Unfortunately we found out that the same regulation was included and approved in the Italian security decree. I believe that this has much to do with the fact that in 2010, the UN commission produced a comprehensive strategy on violence against women, which includes FGM, as part of its strategy for equality between women and men. Because the UN included FGM in violence against women there was this punitive approach including the removal of parental authority. It is an incorrect reception of international laws.’

One of the interviewees also expressed his concern about the consequences of the ratification and execution of the same convention. According to him, the consequences of the measures proposed by the convention could be extremely painful for the girl and her family. He said:

‘If the prosecution is supported and reinforced this will have shocking consequences for the girls at risk. We did not want to propose strong measures and endorse a demagogical discourse on human rights. We could have proposed the most severe measures to fight FGM and make several political parties and half of the parliament very happy... but who would pay the consequences of this? The girl.’

Concerning asylum protection, Italy has not recognised FGM as gender-based violence and as a form of persecution entitled women to the right of asylum. As already discussed, at the time of the publication of the final text of the law, the article allowing refugee status to women who escape from their country to save themselves or their daughters from genital mutilation was suppressed. Some senators from opposition parties attempted to introduce an article regarding this issue and proposed the following article (Article 4 bis): ‘Refugee status is granted to women who want to save themselves and their minor daughters from the risk of genital mutilation as their country of origin or of provenance allows these practices.’ This amendment, like similar ones presented by other parliamentary groups, was rejected.

In this regard, the president of the Somali association in Italy said:

‘This is a very controversial issue. I discussed this issue with the Italian Commission for Refugees in Rome several times. The main point is that women arriving from Somalia would hardly talk about this issue. There will be strong discrimination of treatment between women who, knowing the law, will apply to the commission and women who will not see their right recognised only because they do not know the law and do not say anything about their condition or the condition of their daughters.’

However, concerning women refugees and their daughters, the Commission for the Prevention and Combating of FGM will be encouraged to support prevention projects targeting centres for asylum seekers. The next Commission for the Prevention and Combating of FGM will evaluate the possibility of working in centres for asylum seekers and immigrant identification centres. He pointed out that there are no previous experiences of training and awareness campaigns in these contexts.

‘The centres are very important contexts in which to work. Women and men stay there for months. It is important to approach them in that particular moment of their life. They have the opportunity to reflect on their lives and their choices. Besides, the data on the countries of origin of arriving migrants show that the majority of them come from FGM-practising countries.’

However, the possibility of working in these centres might be affected by the new system of budget allocation. The regionalisation of the funding is bound to provide a limited budget to regions with a high number of undocumented migrants and asylum seekers. Sicily and
Puglia, for instance, have the biggest centres for asylum seekers and immigrant identification centres.

AIDOS has already implemented several training programmes for social workers of the Italian Centre for Refugees (CIR).

'We trained the CIR’s social workers several times. Cristiana Scoppa did it for free, spending hours with them. We also wrote a report for them concerning a case of a young asylum seeker who was in the front line of the struggle again FGM in Burkina Faso.'

One of the interviewees is collaborating with the technical working group of the centre for refugees. Just recently 30 young women from Somalia arrived. They were all infibulated. The centres are only dealing with the medical aspect of the issue but this interviewee expressed her intention also to propose preventive measures targeting the African population temporary residing in the centres.

The necessity of conducting training sessions for professionals, police officers and prominent stakeholders involved in the application of the protective measures was expressed by respondents.

One of them confirmed that such a recommendation would be formally brought to the attention of the Commission for the Prevention and Combating of FGM. In this regard, the Commission should, in turn, be able to promote the inclusion of training and information projects in the coming call for proposals funded through Law No 7/2006.

V.4. Prosecution

By way of the provisions of Law No 7/2006 two articles on FGM were integrated into the Penal Code: Articles 583 bis (female genital mutilation practices) and 583 ter (ancillary penalties). The first article punishes with a term of imprisonment of 4 to 12 years of any person who, without any therapeutic need, causes mutilation to female genitals. The second paragraph punishes with a term of imprisonment from 3 to 7 years any person who, without any therapeutic need, causes ‘harm’ other than that listed in the previous paragraph to female genitals and causing physical or psychological illness. Punishment may be reduced to two thirds in case of minor harm. The third paragraph provides for an increase in the related term of imprisonment of one third when FGM is practised on children/underage persons or for profit. According to Article 583 ter, a judgment against a professional working in the healthcare sector leads to disqualification from the profession for 3 to 10 years, and the consequent communication of this measure to the National Medical Association. The administrative responsibility of the institution where the banned practice has taken place is also recognised. According to Article 583 bis(iv), the extraterritoriality principle is recognised and sanctions are applicable even when FGM is practised abroad either by an Italian citizen or by a foreign citizen living in Italy, causing harm, or by an Italian citizen or to a foreign citizen living in Italy.

Before the classification of FGM as a criminal offence (2006), similar practices were punishable as personal harm according to Articles 582 and 583 of the Penal Code, with less severe penalties, i.e. from 3 to 7 years’ imprisonment if it leads to illness, puts the victim’s life at risk or produces a permanent weakening of a sense or an organ, or else can be judged to be ‘very serious’; or 6 to 12 years’ imprisonment if it causes loss of the use of an organ and reproductive capacity. Article 5 of the Civil Code (prohibiting any actions on one’s own body that could lead to a permanent damage to one’s physical integrity) and Article 32 of the Penal Code (prohibition against forcing anybody to undergo a certain operation) had also contributed to identifying FGM as a criminal offence.

The law was initially proposed as a mere means of prosecution. It was a long debate and consultation with experts and CSOs which aimed at striking a balance between the prosecution approach and a comprehensive vision on the role of and need for prevention. Interviewees seemed to be quite reluctant to address the issue of prosecution and recognising FGM as an act of violence against women. The Istanbul Convention, for instance, calls upon states not to accept culture, custom, religion, tradition and honour as justifications for committing this crime.

One interviewee stressed the importance for stakeholders to look at FGM not as mere violence and abuse of the child. He outlined the necessity of dealing with FGM with a multidimensional approach. He said:

‘There is a tendency to look at FGM as mere violence and abuse of the child. We strongly believe that parents do not act with the aim of hurting their daughters. We know that even love is one of the reasons behind their decision to practise FGM on their daughters. We know that FGM is a complex phenomenon that needs to be analysed with a multidimensional approach. However, because of lack of knowledge and sensibility, there is a tendency to focus on punitive measures without considering the complexity of FGM. We, as the Italian government, do not endorse this approach and I would like this to be extremely clear! FGM is not just sheer violence.’

In Italy reported cases of FGM are scarce. So far only three cases have been reported, in 1997, 1998 and 2010. In 1998, the case involved a couple who presented a statement to the public prosecutor in Milan against the head of an Islamic centre and two medical doctors (from Algeria and Ethiopia) who practised infibulation on a 6-month-old baby girl.

In 1997, another case involved a Nigerian girl who had been previously subjected to FGM in a hospital while in her home country. After returning to Italy, she started to have serious genital problems and had to be accompanied by her parents to the hospital in Turin. In these circumstances the juvenile court then intervened and temporarily separated the girl from her parents with a view to investigating the family with the support of a cultural mediator. The information gathered on the matter by the court was reassuring and portrayed a positive family and parental relationship: the parents had already demonstrated their
ability to take good care of their daughter both by sending
her to a hospital in Nigeria and, successively, taking her
to the hospital in Turin. Besides, their conduct would also
have been justifiable by Edo customary law (deemed not
punishable by Nigerian local courts by then), according
to which a girl who has not undergone FGM cannot be
considered a suitable spouse. Notwithstanding the fact
that a complaint was lodged against the girl’s parents, the
case had, at the time, to be dismissed since the practice had
taken place abroad (Article 10 of the Penal Code).

Apart from the two abovementioned cases, only one court
judgment has so far been issued, in 2010, following the
approval of Law No 7/2006 and the related introduction
of a specific form of criminal offence. See Judgment
No 279, Tribunale di Verona (court of Verona), condemning
a Nigerian woman for having violated Article 583 bis
(paragraph 2, on genital modifications: the case actually
concerned a sort of ‘symbolic’ slight cut which was almost
impossible to detect in the course of the forensic exams).
The woman was condemned to 2 years’ imprisonment, with
the contemporary suspension of the sentence. The case
examined was about two similar events. Nigerian parents,
in one case the mother, in the other case the father, asking
a woman, apparently an expert of the practice, to conduct
FGM on their daughters. In one case FGM was executed, in
the other case the police intervened just before she (the
woman) could touch the girl.

Ferraro thus describes the case and his personal approach
to it:

‘From the debate it emerged that the practice was
necessary to give the little girl her cultural identity. The
practice was not a mutilation but a small cut. In the
first case, the attorney demanded (and obtained) the
application of Article 582, second paragraph. In our last
case it was a small lesion of the clitoris.’

According to what one interviewee reports, his decision
acknowledged both the cultural value and implications
of the practice as well as the level of harm. This guided him to
the decision to apply the minimum sanction foreseen by
the law. Concerning this decision, he explains the measure
of punishment he chose to inflict.

‘For some, the sentence was too light. But in this case
I considered deeply the reason why FGM was practised
and I consequently evaluated the measures of
punishment. Law No 7/2006 is very severe concerning
the punishment, but one has to contextualise the
case because every case is different. Besides, any law
includes several measures of punishment ranging
from a minimum to a maximum. The measure of
punishment is decided by the judge according to his
understanding of what is right. In our case, we were not
in the circumstances described in the first paragraph.
There was no mutilation. We were in the circumstances
catered for under Article 582, second paragraph, such
as small lesion. The legislators considered the case
of small lesion including a light measure of punishment
for it. In our case, we verified that the lesion was very
small. It was a small cut that, according to the doctors,
did not affect the body and will not affect the sexual
health of the girl. It was more of a symbolic sign. This
was verified. The aim of the parents was not to harm
the girl. The little girl could have been rejected by her
peers and not accepted as a wife. However, I don’t
know why Nigerians believe in it. It is their belief.
A number of their fellow country people came to
court to confirm the cultural meaning of the practice.
Even a pastor came to explain why the practice was
important for them.’

For one interviewee the issue of FGM was totally new.
He said he did try to search for the existence of similar
cases in Italy, but he could not find any. All he did was
verify that in previous cases it was the Italian Penal Code
article concerning severe injuries that had been applied.
Furthermore, in order to adequately interpret the law and
better understand the specific case, he had facilitated the
development of a long and articulate debate led by several
experts and representatives of the Nigerian community.

‘It was a new issue for me. I did not have any precedent
judgments. The debate helped me to understand
especially the reasons behind the practice. Because
of the controversial nature of the case I let the lawyers
largely develop their arguments with the help of several
experts who came to express their knowledge of FGM.
Doctors, anthropologists and community leaders
contributed their experience to the debate. The lawyer
and the defendants never denied the request for and
the execution of the practice. They tried to explain why
they believed that it was important. I let the members of
the Edo (1) community explain their culture, why it was
important for them to do it and what the consequences
were if they did not do it. Then I decided according to
the best of my understanding.’

One interviewee affirmed that he also considered
international legislation on the matter as the reference
point to interpret and apply the Italian law.

‘I did not follow the parliamentary debate on the law
and I do not know who were the actors who promoted
the legislative intervention on FGM. My knowledge on
FGM derives from the case I handled years ago. When
I was involved in the case, I studied the law and several
legislative contributions and I understood that the law
is a response to several international instruments. In
my case, I referred to the Council of Europe and to the
European Parliament resolutions No 2035, 2001, which
called upon states to forbid and severely punish FGM.
At that time, I took these recommendations as guidelines in
interpreting the law.’

The ‘unconstitutionality of the law’ was pointed out as
a motive by the lawyers of the Nigerian woman accused of
practising FGM and risking imprisonment of 4 to 12 years
or 3 to 7 years (according to the level of harm). The lawyers
claimed the unconstitutionality of the Articles 583 bis and
583 ter of the 2006 law.

(1) The Edo are one of the Nigerian ethnic groups. They represent
the majority of the Nigerian immigrant population in Italy.
Some scholars and the lawyers of the defendants critically addressed the integration of the Penal Code with Articles 583 bis and 583 ter. They emphasised the cultural discrimination leading the intent of the legislators.

Concerning the reporting mechanism, the respondent quoted above further emphasised that the case emerged because the Nigerian woman was under investigation for other reasons not connected to the practice of FGM. The police found out what was going on because the phone of the woman was wiretapped. In this regard, the respondent is conscious of the difficulties of reporting and investigating the practice and, according to him, this is one of the main reasons for the absence of court cases.

‘At this point I believe that immigrants know about the law and also that the practice here is a crime. If they keep doing it, they do not talk about it. I tried to see if there were more cases on FGM but I could not find anything. I would like to believe that there are no cases because the law is working but I suspect that the truth is that FGM is very difficult to investigate. I think that the practice is extremely submerged and that it is hard to find good and effective mechanisms for reporting and investigating.’

According to the law, anyone can report cases of girls facing an imminent risk of being subjected to FGM. However, only one case has emerged, and even so only through the report from a non-member of the family or the community. Clearly one of the major obstacles that still remains is the willingness of the family and community members to report on cases of girls at risk.

According to the respondent, it is important to develop special protocols of investigation. He also emphasised the role of healthcare services in verifying the occurrence of the practice in women and young girls.

‘Maybe it will be useful to carry out a similar investigation initiative, but I am not sure about the best way to go about this. Investigators would know better how to set out special protocols on the issue. Maybe the healthcare service can verify the cases. However, it is very strange that no other cases have emerged. If these communities are practising FGM it is very strange that healthcare services would not realise this.’

According to the respondent, the main action to be carried out is prevention. He concluded during the court debate that the Edo community was not familiar either with the law or with any awareness campaign.

‘The law was enacted a few months before the case came to light. Maybe they thought that it was not a crime. We also contacted the local social services and they confirmed that they had not done an awareness and information campaign for the local community. The existence of the law was not divulged. I believe that prevention is the best measure against FGM because when the cases get to the court, it is too late.’

V.5. Provision of services

Provision of services focuses on services dedicated to victims surviving with FGM and to girls and women at risk of being subjected to FGM. Such services include healthcare and counselling activities.

Specialised centres for girls and women that have undergone FGM

Of the three centres of reference one is situated within San Gallicano hospital in Rome, one in Forli hospital, and one at Careggi hospital in Florence. So far, a number of training programmes for health workers have been carried out by the experts from these centres, thus making possible the transfer of basic competences and knowledge on FGM. One of the respondents is the major expert in Italy. Years back he was the first doctor to treat women with FGM in Italy, and is currently the head of the Centre for the Prevention and Care of Complications of Female Genital Mutilation at Careggi hospital in Florence.

The Careggi centre aims at preventing FGM and treating women with FGM-related health complications. Affected women from all over Italy and abroad refer to the centre for its unique competence and expertise in defibulation. The respondent started working on FGM when he was still a medical student in Italy. When he started his work, many of the women he was dealing with were undocumented and did not have full access to treatment. His first practice of defibulation took place in Italy. He declares:

‘I did not learn from anybody. I studied and invented the practice of defibulation. Now I train other people. Every defibulation is different because FGM is diversified reality. But the issue is not only the medical intervention. I have to talk with the involved couples, we have to agree on the final result. If I open too much the man may not be happy about it and the couple may later have problems. The family might break up. I have to talk with them, convincing them that what I want to do is good for them.’

The interviewee inaugurated his centre in the year 2003, initially without having benefited from any public funding. It was the governor of the Tuscany region, a very forward-looking person, who later understood the importance of the centre and decided to support its activities. He thus explains the main reasons for the high impact of the centre on the African immigrant community in Italy and abroad.

‘Women come to the centre when they have gynaecological complications. They come because they know that here they will find somebody who understands and knows what FGM is. They know that at the centre there is somebody who speaks their language and knows their culture. The main type of treatment is defibulation. I have only had one request for clitoris reconstruction and this was a young woman belonging to the second generation. I do see second-generation women with FGM too. Their families take them to Africa. I am not aware of anybody doing this in Italy. They are scared of doing this in Italy.’
Concerning the number of women accessing the centre he said that he treats almost 300 women every year. They come at least two times per year. The respondent said he does not have a structured team to work with. He has professionals, like a psychologist and an anthropologist, with whom he usually collaborates, but they are not permanent staff of the centre. They work together on specific research projects.

The centre also conducts training sessions for health workers and promotes capacity-building. The centre receives requests for training on the medical aspects of FGM, such as health complications and defibulation, from the healthcare services of several Italian hospitals. However, he also expresses his disappointment in the scarce interest shown by the majority of his colleagues concerning FGM.

‘This is an issue that is not very appealing to my colleagues. They do not care that much. In my hospital, for instance, I still haven’t taught anybody how to treat FGM. Nobody has ever asked me to do so. I often receive requests from other hospitals but not from this very facility.’

The centre also provides education and information concerning Law No 7/2006, and the medical and legal risks connected with the practice. Young couples also consult often the doctor concerning the practice.

‘We also work on prevention. Since we opened the centre, none of the women we have treated has ever practised FGM on their daughters. Today I met a young couple from Eritrea. The husband asked me: what do you think? Should we do it to our daughter? I told him: why do you have to do this? Do you know that there is law in Italy against it?’

The respondent quoted above collaborated with Morrone and with both the commission established by the Ministry of Health and the one created by the Ministry of Equal opportunities. He also makes reference to the international connections between his centre and similar entities and professionals working on FGM in Atlanta, Boston, Sweden and especially the centre based in Geneva.

Furthermore, the centre is also scientifically supporting research on FGM and sexuality. One of the key collaborators of the centre is currently studying new techniques for reconstruction of the clitoris. A similar study is also being conducted by a gynaecologist with recognised expertise on FGM and defibulation based in Geneva.

He also points out an important element that distinguishes Italy from other European countries. He outlines the peculiarity of the African immigrant women in Italy, highlighting the fact that the majority of them are still first-generation migrants. The type of medical treatment and assistance they require differs from second- and third-generation women. For instance, requests for surgical reconstruction are more common with women of the second and third generation. Since the beginning of its activities, the centre has only had one request for this.

‘In this centre there is a unique resource that is my culture. I come from the same country as many of these women. Besides, we are still dealing with the first generation and this is quite some progress if compared with what is happening in other countries. I see women of the first generation. I would say they are strong women. They have a strong cultural identity. And they do not question what was done to them. They do not have problems with FGM. We did some research and we found out that they have a happy sexual life when they have a man who loves them. Some of them have health complications but do not connect their problems to FGM. Some have infections, very painful menstruation, fibroids and cists. We know that some of these problems are connected to FGM, especially for the women who have had very invasive mutilation. So we tell them that their problems are linked to FGM. They do not condemn their family for what they did to them. However, when they become aware of the consequences of FGM they refuse to practise it on their daughters. The situation of the second and third generation is very different in Italy, but also in France and in northern European countries. They have serious identity problems. I would say they are, first of all, “mentally mutilated”. They do not have clear cultural references. They are in the middle of two cultures.’

Similar centres in Italy are operating through San Gallicano hospital and the hospital of Turin. The San Gallicano centre built its expertise at the beginning of 2000 when Morrone started working on FGM supported by a Daphne project.

The expansion of training and upgrading opportunities undertaken under programmes and projects funded by Law No 7/2006 has made it possible to significantly improve the quality and standards of the services provided to women subjected to FGM and girls at risk.

The provision of guidelines for healthcare workers has not only provided knowledge and indications concerning FGM, but also constituted the first step towards the establishment of a work protocol and a common standard for medical, cultural and psychological assistance in the field of FGM.

However, the guidelines seem to be underestimated by the health services.

‘The department sent the guidelines to all regions but they were not received with interest. People do not read them. FGM is not a problem that catches the interest of everybody.’

Other services have been provided by INMP projects funded by Law No 7/2006. The projects had the aim of supporting the promotion of capacity building concerning medical, social and cultural aspects of FGM. The projects culminated in a forthcoming scientific article, leaflets and training materials to be used in other contexts. The INMP also organised an awareness-raising campaign and produced a leaflet addressing issues such as cultural diversity, hygiene and also FGM. The same leaflets were distributed in hospitals and schools.
Another respondent also addressed the controversial issue of racism and discrimination towards migrants in the healthcare services.

‘Despite the fact that migrants are an important component of the national healthcare system, many doctors do not pay appropriate attention to them. They consider migrants second class patients. There are extraordinary doctors and very dedicated people but there are also many doctors working in services dedicated to migrants who act and work anyhow because they know that migrants will not report them. I also worked on research into discrimination in healthcare services. The research revealed the presence of a large amount of direct and indirect discrimination towards migrants in Italy. Healthcare workers still have stereotypes and prejudices about migrants, like for example thinking that they do not pay for health services. I believe we still need training courses, especially on the way we deal with cultural diversity. This should be part of the curricula of the faculties of medicine.’

The issue of racism and discrimination also affects the relationship between women with FGM and other women. She said that the immigrant identification centre where she collaborates recently received 30 young women from Somalia all of whom have been infibulated. One of them is pregnant and will need to be defibulated. She expressed her concern about how the healthcare workers will cope with such situation, since she is aware of cases of hospitals that had accommodated African women in a separate room simply because the other women did not feel comfortable about having to share the room with them.

‘In some cases they put these women in a separate room. This happens especially with pregnant women. Some Italian women did not want the Africans in their room. They said they were dirty. This is outrageous!’

According to the respondent the biggest challenge faced by the training programmes was reaching medical staff who showed a lack of interest in the topic, especially doctors. Another respondent made the same comment, expressing his disappointment for the limited interest that the question of FGM received from the majority of his colleagues.

‘This is an issue that is not very appealing to my colleagues. They do not care that much. In my hospital, for instance, I still haven’t taught anybody how to treat FGM. Nobody has ever asked me to do so. I often receive requests from other hospitals but not from this very facility. Italian universities and faculties of medicine should include FGM in their curricula. Gynaecologists and doctors do not know FGM. Dr Morrone and I are collaborating to write books and manuals for healthcare workers. These materials should be adopted by Italian universities.’

Helpline
The helpline was instituted by Law No 7/2006 and was activated in 2007. The service was meant to respond to the development of this area of action. However, the helpline did not meet the expectation of its supporters. Despite the many doubts on the efficacy of such a service expressed by experts, the helpline was created, but no calls have been received since. In this regard, the interviewees clearly restated their disagreement on the activation of the call centre. They explained the reasons why the freephone number did not and will not work.

‘Members of a community will never contact the number to denounce another member. Such an action would lead to the rejection of the member by the community and to her/his social isolation.’

‘We do not think the call centre is a good idea. We expressed our opinion several times. But the minister wanted to go ahead with it. From what I know, it never worked out. Nobody calls the line.’

‘The call centre does not have any meaning. I asked several times to reallocate the resources devoted to the call centre to other activities. People will never call to denounce relatives of a member of the community. Besides, the police officers in charge of the call centre were not trained on this matter. I have to say that the law promoted many training programmes but none of them was directly addressed at the police officers.’

‘The call centre is not working at all. The number got all kinds of inappropriate calls. The department of the interior itself never agreed on the idea of activating the number under the frame of prosecution. The best option would have been to activate the number at the Ministry of Equal Opportunities with the perspective of preventing FGM. The number is indeed under the wrong department and maybe is not the right measure to take. It isn’t effective.’

According to Law No 7/2006, the total budget dedicated to the activation and management of the call centre is EUR 500 000.

V.6. Partnership

A significant example of partnership in this field has been the creation of a multidisciplinary Commission for the Prevention and Combating of FGM that aimed at coordinating the Italian national and regional action plan to address FGM through the involvement of several stakeholders. Besides, the funded projects were carried out in a partnership bringing together CSOs, local institutions, research centres and universities. In this sense, the Italian approach on FGM significantly promoted both institutionalised and ad hoc partnerships, as well as facilitating networking between professionals and, therefore, enhancing the collaboration and sharing of competences and expertise on FGM.

Institutionalised partnerships have been built at both the Ministry of Equal Opportunities and the Ministry of Health. In this respect two commissions have been established with the aim of empowering a multilayered approach on FGM.
The Commission for the Prevention and Combating of FGM at the Ministry of Health has effectively linked up health professionals and experts, and it is the existence of such a synergy that has made it possible to draw up of specific guidelines for health services.

The Commission for the Prevention and Combating of FGM at the Ministry of Equal Opportunities has promoted an open dialogue between its members with a view to sharing diversified competences, skills and knowledge. Medical doctors, anthropologists, CSOs and African immigrant leaders have met regularly to frame the national plan on FGM and promote action to prevent and fight the practice.

However, one respondent stresses the limits of this latter model of partnership, commenting on the fact that the representatives of the government have always had the ‘final say’ in the proposals and requests formulated by CSOs and associations.

‘The relationship between the members is not on an egalitarian basis because the representatives of the government are the ones in charge of the final decision. They cannot obviously grant all the requests of the associations and experts. However, the commission has always encouraged an open debate and the possibility for everyone to get their request on the table of discussion.’

The experience of the INMP, AIDOS and the Centre for the Prevention and Care of Complications of Female Genital Mutilation outlines the successful collaboration in initiatives and actions involving a broad spectrum of subjects. For instance, one interviewee clearly recognises that one of the main successes of the INMP projects was the partnership between CSOs, universities and hospitals.

“We were successful in creating a network and a partnership joining together subjects that often do not communicate and work together. The other strong point was the coordination of Morrone. He monitored the activities of the partners daily to verify the correct development of the project.’

Concerning the experience of AIDOS, the respondent quoted above mentioned the long experience of national and international collaboration with CSOs. In Italy it has collaborated with associations focusing on research, prevention initiatives and information campaigns, including ‘Associazione Diritti Umani, Sviluppo Umano’ of Padua; ‘Culture Aperte’ of Trieste and ‘No Peace Without Justice’ of Rome.

‘At the moment, the partnership with African women’s associations in Italy is not very strong. AIDOS has a long history of relationships with associations of African women resident in Italy. Unfortunately, over the years, the human and economic resources, as well the “energy” to keep these partnerships alive, have drastically diminished. This, coupled with the difficulties faced by the said women’s associations in getting themselves adequately organised, has led to a temporary suspension of common initiatives.’ Partnerships can also be affected by lack of consensus concerning the approach to FGM. For instance, the collaboration between AIDOS and NPWJ (No Peace Without Justice), founded by Emma Bonino (Italian senate, former vice-chair), is currently suspended due to the lack of consensus concerning NPWJ’s approach to FGM. Bonino became aware of the practice in 1998, when she received the ‘Princes of Asturias Award for International Cooperation’. At that occasion she met a gynaecologist, native of Nigeria and residing in Sierra Leone, who has been working for more than 15 years on the abolition of female genital mutilation. That meeting deeply inspired her, and that she actively worked to create the necessary conditions for her association and AIDOS to join hands and collaborate in running FGM awareness and information campaigns. Initially they had even collaborated at international level to jointly bring the issue of FGM to the attention of the UN.

‘We initially collaborated with Emma Bonino and NPWJ. In 2000 we carried out a big awareness campaign. She asked us to work together on a project to present to the European Union. But it was very challenging because their approach to FGM was totally different from ours. NPWJ wanted to propose a UN resolution to ban FGM but we never supported this idea. How could Italy dare to propose a UN resolution against FGM?! We strongly believe that this has to be done by African countries. Their proposal was deeply focused on “banning and punishing” and, of course, we could not support this approach.’

Partnerships and local networks have also been promoted by FGM-focused Daphne projects and other projects funded under Law No 7/2006. Universities, hospitals, local authorities, research institutes and associations have worked together to implement ad hoc projects for training, education and awareness campaigns.

However, according to the respondent quoted above, partnerships between CSOs seem to be chronically confronted by difficulties of organisation and coordination. Moreover, the high level of competition for the few available resources has affected the spirit of collaboration, especially among associations.

Another challenge in the promotion of partnerships in Italy is the new regionalisation of public funding. One interviewee pointed out the consequences of regionalisation for the African immigrant women’s associations, especially the Somali association. According to him partnerships among African women have always had a positive impact, and especially in reference to women from Somalia. In his opinion the new regionalisation of funding arrangements will affect the possibility of grassroots associations working in partnership at national level, since their projects will only be allowed to have a local focus. The association of Somali women has branches all over Italy. They know each other and, in most cases, have family or ethnic/clan linkages. The new funding system will, therefore, end up by severely limiting their possibility of being able to work together in partnership.
V.7. Successes and challenges

This section will analyse how the respondents perceive the successes and challenges in the work on FGM in Italy.

Successes

The experience of the interviewees in working on FGM in Italy highlights some of the peculiar challenges and successes of the Italian approach, especially following the enactment of Law No 7/2006. According to the interviews, the Italian law is a comprehensive law and hence provides a model that can be shared with other countries.

The main achievements of the Italian approach to FGM can be grouped as follows.

Prevention

Prevention activities including training courses and awareness campaigns date back 2001. Two Daphne projects specifically dedicated to FGM successfully reached healthcare services and CSOs and constituted the basis for subsequent developments, including the first direct involvement of all the key stakeholders (social and healthcare institution and workers, African immigrant communities and CSOs).

Moreover, the mechanism of governance implemented by the Commission for the Prevention and Combating of FGM, the multidimensionality of Law No 7/2006 that was able to work beyond prevention and prosecution, and the international commitment of Italy are also identified as the main successes of the Italian approach.

‘Italy worked very hard to support African countries in presenting a resolution to the UN. Initially Italy wanted to present a UN resolution against FGM but then there was a reorientation towards the support of African countries as the protagonists of this resolution. The former minister Carfagna also brought the FGM struggle to the attention of the G8, including the issue in the agenda of the ministers. This was the first time in the history of the G8 meetings.’

Beneficiaries of training programmes were mostly social and healthcare services and African immigrant associations.

Protection

One of the assets of Law No 7/2006 is having explicitly and effectively provided for the resources necessary to implement the protective measures for girls at risk. In this sense, initiatives undertaken by actors include training courses for professionals of social and health services, training materials for public institution personnel, and audio and visual materials for public-awareness campaigns. The availability of such instruments has made it possible to improve the competences of stakeholders and provided affected immigrant communities with information and new legal and medical references on FGM.

Prosecution

Even though cases of prosecution have so far been scarce, the interviewees acknowledged the need for sanctions against perpetrators of FGM in open violation of the provisions expressed in the law and further spelt out by the Italian Penal Code. It is evident and clear that the law constitutes a valid legal deterrent against the practice. Nevertheless, the Italian approach does not take for granted such deterrent effects or the penal implications of the provisions, but at the same time caters for the increase in access to legal information connected to the enactment and application of the same law.

Provision of services

The expansion of training and upgrading opportunities undertaken under programmes and projects funded by Law No 7/2006 has made it possible to significantly improve the quality and standards of the services provided to women subjected to FGM and girls at risk.

The provision of guidelines for healthcare workers has not only provided knowledge and indications concerning FGM, but also constituted the first step towards the implementation of a working protocol and common standard of medical, cultural and psychological assistance in the field of FGM.

Partnership

The institution of the Commission for the Prevention and Combating of FGM has been recognised as a good mechanism of governance aiming at promoting partnership and sharing of knowledge among various actors. It also promoted a multidisciplinary and multilayered approach on FGM. Previous experience of partnerships dates back 2000 when AIDOS and NPWJ jointly implemented the first national awareness campaigns. Furthermore, the implementation of the two Daphne FGM projects created the conditions for healthcare services, public institutions, universities and CSOs to work in synergy and experiment with a local network of broad-based partnerships.

Prevalence estimate

Even though interviewees acknowledged the absence of a reliable database on FGM at national level, the involvement of public health services in projects funded by Law No 7/2006 has also had the clear objective of preparing the ground work for the gathering of data at the territorial level.

Challenges

Prevention

In addressing the challenges of the Italian approach one interviewee emphasised the need for the Commission for the Prevention and Combating of FGM to be more active in coordinating and monitoring the activities carried out by the diverse actors working on FGM at national level.

‘I think we have a good law, especially the first part concerning the provision of preventive measures. The other good point is the allocation of financial resources for the implementation of the prevention activities. The challenge of this first part is that it lacks guidelines and follow-up strategies. There is no monitoring regarding the achievement of the aims, the materials produced and the methods utilised to implement the projects. I believe the department and the Commission should...’
follow up the work and the materials produced by the CSO. Unfortunately not all the material produced is good. I think CSOs should be free to work, but they definitely need some guidelines.’

Furthermore, the Commission for the Prevention and Combating of FGM seemed not to be receptive to the requests of the CSOs concerning information about the budget and the time schedule for the release of the remaining resources provided for by the law.

Interviewees also highlighted the implications of the time interval between the first and second calls for proposals. In fact, the first call was issued in the 2007, following which there has been no information concerning the second call.

‘It would have been important to have a second round going back to the trained workers and seeing what happened to them, to their services and to their attitudes towards FGM after the training. But because of budget limits this was not possible. The first training course was provided in 2007. Now we are in 2012. That is such a long time!’

Prosecution
Concerning prosecution, there are several challenges emphasised by the interviewees. The main critique of the law is that it does not distinguish between the role of the parents and the role of the people carrying out the practice. This part should be carefully evaluated.

‘The second part of the law is too severe. The law puts at the same level the parents and the doctors or other people who carry out the practice. The people who carry out the practice, knowing that it is a crime, must be punished, but the parents are in a different position. Also, Italian law prescribes the same punishment for the family of mutilated girls coming from Africa to Italy. This means that the law has extraterritorial efficacy. We really believe that there must be a distinction between those who know that the practice is a crime and still execute it and the parents. Even for them the law prescribes 12 years’ imprisonment. This is an inappropriate punishment.’

In Italy there are only three court cases on FGM. Two of them date back to 1997 and 1998, and the third dates back to 2010. According to Law No 7/2006, anyone can report cases of girls facing the imminent risk of being subjected to FGM. However, after the enactment of the law, only one case has emerged, and even so only through the report from a person that was not a member of the family or the community. Clearly one of the major obstacles that still remains is the willingness of family and community members to report on cases of girls at risk.

Protection
The application of the measures for protecting for the girl at risk, which suspend parental authority and provide for social services to take custody of the girls at risk, are very complicated and controversial.

One interviewee emphasised the juridical achievement of the law, whereas another still seems sceptical of the real need to integrate special measures concerning FGM into the Italian Penal Code.

The application of the punishment measures and the debate led by the experts and lawyers involved in the first court case show the echoes of the debate that led to one respondent’s proposal and the controversy that followed the development of the law. The first application of the law witnessed the prevalence of a relativistic approach on FGM which recognised culture and tradition as justificatory argument to reduce the measure of punishment.

Concerning asylum protection, Italy has not recognised FGM as gender-based violence and as a form of persecution entitling women to the right of asylum.

Provision of services
Some of the actions proved less effective than others, such as the activation of a helpline, which did not achieve the result expected by the legislators.

Similarly, the level of awareness of the law, especially amongst the African immigrant communities, seems to be inadequate.

Other challenges emerged from the interviews concerning the target of the training activities and awareness campaigns. Interviewees reported the difficulty of involving African immigrant communities and their leaders. The experiences reported by the interviewees highlight the marginal role played by the African immigrant communities both as actors and as target groups of the projects. One interviewee for instance says that he did see some cultural mediators during training sessions, but according to him this was not enough. Another interviewee asserts that it was very difficult to involve African immigrants in their activities.

The aim of involving African communities seems very limited. A similar difficulty was reported concerning the doctors. They appeared not to be fully interested in the topic. The implemented actions were mainly carried out by Italian CSOs and institutions. Among the 21 legal representatives and coordinators of the projects there is only one African woman from Ethiopia. Interviewees referred to collaboration with African or foreigners as support staff in the implementation of training, research and information activities. The involvement of cultural mediators and African leaders in the training programmes and awareness campaigns was very scarce.

Moreover, the training activities focused mostly on health and social health workers. Police officers and judicial authorities were not targeted in any projects.

‘The police officers in charge of the call centre were not trained. I have to say that the law promoted many training programmes but none of them was directly addressed at the police officers.’

‘We, as a ministry, are thinking about keeping some resources from the national budget to tackle [the
criminalising] attitude. We would like to carry out a special training programme on the legal implication of the law, involving in particular the people in charge of its application.'

However, according to the respondent quoted above, the goal of the ministry is to develop a system sustained by a critical mass of experts and services organised at the structural level. The law and the actions promoted by the law should be recognised as the initial step toward the implementation of a permanent network of experts and services working on prevention, protection and provision of services. In this respect, the department should only assume the role of coordinator together with the Commission for the Prevention and Combating of FGM.

'The idea is to initially fund action research projects, training and awareness campaigns aiming at creating a permanent network of experts and services able to survive autonomously. The network will become self-sustained.'

**Partnership**
Better coordination and common vision was also demanded concerning the allocation of the national resources to be devoted to the fight against FGM.

Partnership between CSOs seems to be chronically faced with difficulties of organisation and coordination. Moreover, the large amount of competition for the few available resources has affected the spirit of collaboration, especially among associations.

Another challenge in the promotion of partnerships in Italy is the new regionalisation of public funding. One interviewee pointed out the consequences of regionalisation for the associations of African immigrant women, especially the Somali association. According to him partnerships among African women have always had a positive impact, and especially in reference to women from Somalia. In his opinion the new regionalisation of funding arrangements will affect the possibility of grassroots associations working in partnership at national level since their projects will only be allowed to have a local focus. The association of Somali women has branches all over Italy. They know each other and, in most cases, have family or ethnic/clan linkages. The new funding system will, therefore, end up by severely limiting their possibility of being able to work together in partnership.

**Data collection**
Data collection appears to be one of the weakest points of the Italian experience in the field of FGM. Several attempts have been made to get as close as possible to the prevalence of the practice in Italy. However, estimates still remain vague and are sometimes even contradictory. Some interviewees believe that estimate figures underestimate the prevalence on FGM within the African migrant population, while others say it strongly minimises its impact.

Proposals for experimenting with systems of data collection in big hospitals have been rejected by the Ministry of Health.

**Resources**
Concerning the availability of resources, the interviewees involved in the implementation of prevention, protection and service provision activities emphasised the need to have access to more resources.

Where funding is concerned, one respondent reveals that she is totally unaware of any availability of financial resources for projects on FGM. She attributes this lack of resources to the fact that FGM is perceived as a marginal problem in Italy.

The need for more resources and information on FGM was emphasised. Currently, AIDOS can only benefit from the annual funding available from the campaign ‘end FGM’ for the sum of EUR 2 500 per year.

'I have been working without resources for years. I only have my regular salary to keep this centre running. I never get an extra euro for what I do here.'

The law instituted a regional budget but in the case of the region of Tuscany, part of the funding was diverted to other priorities, such as abortion.

'We need funding in order to work, to have a structured team, and to do more research. The region of Tuscany diverted some EUR 200 000 originally meant for the FGM project to abortion. They said that EUR 200 000 for FGM was just too much.'

A similar circumstance is also reported by one interviewee, who explains that the budget made available by the law was very high in comparison with the real impact of FGM in Italy. He states that the Ministry of Equal Opportunities utilised EUR 2 500 000 of the budget for more urgent problems, such as human trafficking. He adds that the remaining budget should soon be available to the regions for the issuance of the last call for project proposals.

Furthermore, he also says that due to the pressure of the economic crisis, there are no guarantees about financing for the next year. Since its implementation, the law has had annual financing of EUR 200 000.

'We believe that the Italian commitment to stopping FGM will be affected by the economic crisis. We do not know if the law will be funded in future and, anyway, this wouldn’t mean that Italy does not care about it. In times of crisis budget cuts especially affect the issues that are not considered an emergency, like FGM.'

VI. POLICY LESSONS AND RECOMMENDATIONS

According to the interviewees, the key recommendations concerning the Italian policy lessons, in accordance with the ‘six Ps’, are the following.

**Prevention**
- Prevention activities including training courses and awareness campaigns date back to 2001. The mechanism of governance implemented by the
Prosecution

- Law No 7/2006 constitutes a valid legal deterrent against FGM. Nevertheless, the Italian approach does not take for granted such deterrent effects or the penal implications of the provisions, but also caters for the increase in access to legal information connected to the enactment and application of the same law. Interviewees emphasised the necessity of providing training courses and awareness campaigns concerning the legal implications of the law. Interviewees demanded more seminars and conferences targeting police officers, lawyers and judges.

Protection

- Law No 7/2006 explicitly and effectively provided for the resources necessary to implement protective measures for girls at risk. Training courses for social and health services professionals, training materials for public institution personnel, and audio and visual materials for public sensitisation campaigns were largely carried out. The interviewees demanded training courses and information targeting police officers and actors involved in application of the law and the protective measures for girls at risk. Also, according to the interviewees, awareness campaigns and training courses should be implemented in the centres for asylum seekers.

Providing services

- The expansion of training and upgrading opportunities has made it possible to significantly improve the quality and standards of the services provided to women subjected to FGM and girls at risk. The provision of guidelines for healthcare workers has not only provided knowledge and indications concerning FGM, but also constituted the first step towards drawing up a work protocol and common standards of medical, cultural and psychological assistance in the field of FGM. However, interviewees addressed the issue of helping local social and health service networks to move on from the approach of creating ‘ad hoc services’ to that of implementing ‘integrated and structural services’ for immigrants and women with FGM. Moreover, they suggested the incorporation of more information and training concerning FGM in the curricula of the faculties of medicine.

Partnership

- The institution of the Commission for the Prevention and Combating of FGM has been recognised as a good mechanism of governance aiming at promoting partnership and sharing of knowledge among various actors. It also promoted a multidisciplinary and multilayered approach on FGM. Previous experience of partnerships dates back to 2000, when AIDOS and NPWJ jointly implemented the first national awareness campaigns. Furthermore, the implementation of the two Daphne FGM projects created the conditions for healthcare services, public institutions, universities and CSOs to work in synergy and experiment with a local network of broad-based partnerships. The interviewees recommended promotion of partnerships among various subjects on which to carry out further research, international comparative studies, awareness campaigns and training. According to the interviewees, partnerships with African leaders and associations should be actively reinforced.

Prevalence estimates

- Data collection appears to be one of the weakest points of the Italian experience in the field of FGM. Several attempts have been made to get as close as possible to the prevalence of the practice in Italy. However, estimates still remain vague and are sometimes even contradictory. New research should be promoted in order to work out a systematic approach to data collection that should involve healthcare services in particular. Local databases or hospital databases should be established, together with the implementation of a common operational protocol to deal with all aspects of FGM.

Moreover, it is worth noting that the interviewees also suggested targeting the second generation of African-Italians concerning issues such as identity, culture, sexuality and FGM. One interviewee reflects on the importance of giving support to the second generation of Africans in Italy.

‘The last thing is to also look at the condition of the African-Italian second generation. We believe they are an entry point to work on gender identity and gender relations. We also believe that it is important to look at the situation of African women in a broader sense,
not only focusing on the practice of FGM. We need to work on reproductive health, sexual health and gender relations. FGM is part of the work to be done.’

‘We need to look at the second-generation Africans. We should support them in their challenge of being suspended between their parents’ culture and Italian culture. FGM is also part of it. (…) Very different is the situation of the second and third generation in Italy, but also in France and northern European countries. They have serious identity problems. I would say they are first mentally mutilated. They do not have clear cultural references. They are in the middle of two cultures.’

VII. POTENTIAL GOOD PRACTICES

Among the activities reported by the interviewees, some good and promising practices emerged.

Morrone coordinated an integrated and comprehensive centre for women with FGM. The centre offers women several services ranging from medical treatment to social counselling and support. Several professionals, including cultural mediators, were involved in counselling and helping the activities provided by the centre.

The third good practice concerns the awareness campaigns and the training material produced by AIDOS.

AIDOS has solid experience of FGM in Africa. The competences concerning the African cultures and languages have led the association to the development of an innovative strategy of communication on sexual and reproductive health. It includes various publications and awareness campaigns culminating in the production of printed materials and new multimedia tools.

Concerning the work carried out in Italy, AIDOS produced the first fiction-based documentary dealing with FGM. The DVD has now become an important part of the training materials and awareness campaigns targeting policymakers, immigrant communities and all actors working on FGM.

VIII. FINAL CONSIDERATIONS AND RECOMMENDATIONS

This section provides a summary of the analysis included in the previous sections and personal recommendations to improve the work on FGM in Italy.

The Commission for the Prevention and Combating of FGM instituted at the Ministry of Equal Opportunities should consider the following recommendations.

1. Be multidisciplinary and multicultural. The members of the commission should represent all the actors involved in the national strategy for prevention and prohibition of FGM. The commission should establish as compulsory the presence of CSOs with experience on FGM and representatives of the communities in Italy coming from FGM-practising countries.

2. Ensure that national action plans and strategies on the elimination of female genital mutilation are comprehensive, including a range of prevention and protection measures, and multidisciplinary in scope.

3. Incorporate clear targets and indicators in order to provide for ongoing monitoring and impact assessments and ensure coordination among all stakeholders.

4. Promote the participation of African representatives and African associations, CSOs and NGOs with experience of FGM in the drawing up, implementation, monitoring and evaluation of action plans and strategies.

5. Put in place systematic coordination mechanisms through dedicated staff. Information about timing and allocation of resources should be provided and be accessible thorough the commission’s website.

6. Promote research in order to effectively monitor and evaluate the impact of the law and of the funded activities in national institutions and social and healthcare services.

Training courses should include interactive classes, informal settings and role-playing. New innovative teaching methods and communication strategies should be adopted in order to reach the following goals.

1. To promote cultural sensitivity, tolerance, awareness of prejudice and knowledge of the legal aspects of racism and discrimination for those who work in schools, public services and social and healthcare institutions.

2. To confront the attitudes, customs, practices and gender stereotypes that relate to discriminatory and harmful acts and practices that are violent towards women, such as female genital mutilation. In this sense, training programmes should include a bottom-up approach aimed at revealing the attitude and deep feelings of the group that is participating in the training.

3. To promote the creation of a specialised socio-medical team of doctors, nurses and cultural mediators able to transfer their knowledge and expertise to healthcare institutions.

4. To target police officers and judicial authorities as well as all the subjects involved in the application of the law and the punishment measures it foresees.

5. To involve African leaders and cultural mediators, encouraging them to play a key role both as trainees and trainers. Their competences, expertise and commitment to training programmes should be adequately acknowledged.

Awareness campaigns should be inspired by a deep sensitivity to cultural diversity, respect and dialogue. New awareness campaigns targeting the general public should be implemented in order to tackle racism, intolerance and prejudices that still negatively affect work on FGM.

New multimedia tools accessible to African immigrants coming from FGM-practising countries and leaflets translated in the local languages of the African communities in Italy
should be distributed in the places where the communities meet, such as shops, churches, mosques and associations.

Following the positive results achieved in some countries where FGM is traditionally practised, religious institutions and their leaders should also become the targets of awareness campaigns and training programmes. Imams, pastors and priests should be involved in training programmes and the churches and mosques should be used as training spaces.

The government should acknowledge that communities as a whole have an integral role to play in the abandonment of female genital mutilation, and should support community-based abandonment initiatives that are targeted at changing behaviour and attitudes.

Medical faculties should integrate their curricula, taking into account the demographic change in the Italian population. The presence of a large population coming from Africa calls upon the universities to include courses aiming at providing scientific and cultural instruments to respond to the needs of the immigrant population. FGM should be included in the syllabus and in textbooks dealing with the medical needs of African populations in Italy.
Country report

Latvia
1. IDENTIFICATION

Country: Latvia

Researcher: Marita Zitmane

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Prevalence data were searched for using academic databases, following the ‘Guidelines for national data collection’. The following databases were searched for prevalence studies in Latvia (LV): Web of Science, Heinonline, PubMed, ProQuest, Social Science Research Network, Google Scholar and SAGE Journals Online, as well as the following LV academic search engines:


Key terms searched for, including Latvian terms: female genital mutilation, female genital cutting, genital cutting, female genital mutilation in Latvia/Baltic/eastern Europe; sieviešu ārējo ģenitāliju apgraizīšana, sieviešu apgraizīšana, kliterodektomija.

No documents were retrieved regarding FGM in LV.

I searched for magazine and newspaper publications about FGM as well. I was able to find several publications in Latvian regarding FGM. There are two publications (genre: human interest features) in magazines and three feature stories in newspapers.

Publications:

- Libeka, M., ‘Mani uzsēdināja uz klints, un viss notika …’, Lauku Avīze, 2 June 2001. (Title: ‘I was put on the rock and everything took place’. Newspaper: Rural News.)

In addition, an e-mail was sent to the Division for Equal Opportunities Policy and Department for Child and Family Policy of the Ministry of Welfare in order to verify if there is any data regarding FGM in LV. The answer from both divisions confirmed that there are no known cases of FGM in LV.

The Deputy Head of the Division for Equal Opportunities Policy provided information regarding the policy framework — Report about the Republic of Latvia’s fulfilments of its obligations under the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women (not the exact title, but the only information available).

The Head of the Department for Child and Family Policy provided information regarding the legal framework — Law on the protection of the rights of the child, Section 4 (objectives of protection of the rights of the child); Section 51 (protection of the child from illegal activities); Section 52 (child victims of violence or other illegal acts).

A phone conversation was held with representatives from the Asylum Affairs Division of the Office of Citizenship and Migration Affairs. The aim of interaction was to establish the number of asylum-seeking and refugee women from African countries of origin where FGM is performed. As it turned out, there is no official information available from the Office of Citizenship and Migration Affairs about the gender of asylum seekers in correlation with the country of origin (http://www.pmlp.gov.lv/en/statistics/asylum.html). The study was done by the senior officer of the Asylum Affairs Division, at my request.

2.2. Nature of prevalence studies/FGM registration systems

Regarding prevalence documents, I have found that there are none. There are no databases and no specific/appointed institution which collect such data. There is no FGM registration system in LV.

The number of asylum-seeking and refugee women from African countries of origin was established by the senior officer of Asylum Affairs Division at my request. She looked through the personal information of asylum
seekers and refugees establishing the number of women. This information is not publicly available.

2.3. Findings from the prevalence studies/registration systems

Since there are no studies or registration systems, there is no data to elaborate on either. The data I received from the Asylum Affairs Division regarding asylum-seeking and refugee women from Africa had no personal information. There is no information available regarding age, ethnicity or nationality, length of stay in country. Regarding country: Kenya — 1; Ghana — 1 (refugee status granted); Somalia — 2 (alternative status). I learned that the refugee from Ghana has a small daughter (born outside Africa). No information about the age of the child. This information is documented in a decree (cause No A420575011 A05750-11/19, 5 December 2011) granting refugee status to both the woman from Ghana and her child.

2.4. Reflection on prevalence studies

There are no representative studies regarding FGM in LV. The conversations I had with various public officials confirmed that FGM is not considered to be an issue relevant to LV. There has not been a known case of either the performance or discovery of FGM in LV. According to data provided by the senior officer of the Asylum Affairs Division, there are four refugee/asylum-seeking women from African countries in Latvia at the moment. There is no information about residents of African origin in LV (data from the Central Statistical Bureau of Latvia). LV is an ethnically homogeneous society. LV also is not an attractive destination for immigrants for various reasons (economic situation, welfare system, climate, etc.).

The aforementioned situation could explain why FGM is not an issue in LV and could explain the lack of information on FGM in LV as well.

FGM is generally regarded as a non-relevant topic for LV, but at the same time I got the impression that no one searches for this information, nor is there a wish to know about it.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Information on the policy framework was obtained by e-mail from the Deputy Head of the Division for Equal Opportunities Policy — Report about the Republic of Latvia's fulfilment of its obligations under the Convention of the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women (not the exact title, but the only information available).

3.2. Policies on FGM

The Division for Equal Opportunities Policy of the Ministry of Welfare is responsible for developing and maintaining policies and the legal framework on gender equality in LV. The Deputy Head of the Division for Equal Opportunities Policy confirmed that the issue of FGM would be the responsibility of the Division for Equal Opportunities Policy. In her e-mail she described the policy regarding information on FGM as 'Diemžēl vairāk par šo tēmu no mūsu pusēs nav nekas pieilstams (Unfortunately there is nothing more we can say regarding this subject)'. I consider this remark to be important to illustrate the situation on policies on FGM in LV.

The information one respondent provided was a letter of answer to the Ministry of Foreign Affairs of the Republic of Latvia. It states that there is no specific policy on FGM and that there is no need to have one since LV fulfils its obligations under the UN Convention of the Rights of the Child and the UN Convention on the Elimination of All Forms of Discrimination against Women. The letter states that Latvia has a high and evolving standard of protection of human rights and an effective administrative system in place should such instances occur.

My telephone conversations with a representative from the Ministry of Justice indicated that this issue is not regarded as relevant for LV and there are no plans to develop any legislation specific to FGM.

To sum up, there are no policies on FGM in LV, and at the moment there is no commitment to develop one. The UN Convention of the Rights of the Child and the UN Convention on the Elimination of All Forms of Discrimination against Women can be considered as forming the existing general policy applicable to FGM in Latvia.

3.3. Reflection on policies on female genital mutilation

There are no specific policies on female genital mutilation in LV. FGM is not considered to be a vital issue in LV. This is due to the fact that Latvia is a very ethnically homogeneous society (Central Statistical Bureau information on the resident population by ethnicity at the beginning of 2011: 59.5 % Latvians, 27.4 % Russians, 3.5 % Belarusians, 2.4 % Ukrainians, 2.3 % Poles, 1.3 % Lithuanians, 0.4 % Jews, 0.4 % Roma, 0.2 % Germans, 0.1 % Estonians, 2.5 % other nationalities). The representative from the Asylum Affairs Division, in her e-mail, stressed that LV is not a preferred place of destination for refugees. Though there are more refugees from African countries since 2011 due to the changes in trafficking routes (the amount of the increase was not specified), asylum seekers do not stay in LV. They do not wait until a resolution is passed on their status; choosing to go on to France or Belgium.

I can assume that there will be no important changes on policies on FGM until changes in migration routes occur.
4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

In order to obtain information on the legal framework I contacted the Deputy Head of the Criminal Law Department of the Ministry of Justice. We had a telephone conversation on the subject and later she e-mailed the numbers of Penal Code sections. This information was included in Penal Code Section 125 (intentional serious bodily injury), Section 126 (intentional moderate bodily injury), Section 139 (illegal removal of tissue and organs from a human being) and Section 174 (cruelty towards and violence against a minor).

All the laws, legislative acts and regulations are published on the Internet at http://www.likumi.lv with translations in English.

4.2. Criminal law

The respondent confirmed that there are no specific provisions in law regarding FGM and indicated which sections of the Penal Code can be applied in cases of FGM.

Penal Code:

- Section 125. Intentional serious bodily injury.
- Section 126. Intentional moderate bodily injury.
- Section 139. Illegal removal of tissue and organs from a human being.
- Section 174. Cruelty towards and violence against a minor.

The current version of the Penal Code entered into force on 21 May 2009. The criminal offences which could be applied in cases of FGM are: intentional infliction of such bodily injury as is dangerous to life or has been the cause of loss any organs or functions of organs (Section 125 (1)); intentional infliction of such bodily injury which has resulted in a continued health disorder (Section 126 (1)); illegal removal of tissue or organs from a living or deceased human being (Section 139); and cruel or violent treatment of a minor, if physical or mental suffering has been inflicted upon the minor and if such has been inflicted by persons upon whom the victim is financially or otherwise dependent (Section 174 (1)).

Based on information provided from both the Ministry of Justice and the Ministry of Welfare there have not been any court cases regarding FGM being performed or the intention to perform it. There is no public institution registering FGM cases.

4.3. Child protection laws/provisions

There are no child protection provisions and laws that deal specifically with FGM.

The Head of the Department of Child and Family Policy of the Ministry of Welfare, indicated which sections of the law on protection of the rights of the child can be applied in cases of FGM.

Law on protection of the rights of the child:
- Section 4. Objectives of protection of the rights of the child;
- Section 51. Protection of the child from illegal activities;
- Section 52. Child victims of violence or other illegal acts.

The measures in cases of violation of the law are removal of the child form the family and suspension of parental authority.

There is no national agency or register of child protection interventions that deal with FGM. Any information about child abuse is collected by orphan’s courts, a municipality’s local government social services or the State Inspectorate for Protection of Children’s Rights.

The respondent confirmed that there have been no cases of child protection interventions regarding FGM in LV.

4.4. Asylum law(s)/provisions

There are no specific asylum provisions dealing with FGM in LV.

The Head of the Asylum Affairs Division of the Office of Citizenship and Migration Affairs indicated which section of the Asylum Law can be applied in cases of FGM.

Asylum Law:
- Section 22. Grounds for prosecution.

The Asylum Law defines a ‘refugee’ as a third-country national who, on the basis of justified fear from persecution due to his or her race, religion, nationality, membership of a specific social group or political views, is located outside the country where he or she is a national, and is unable or due to such fear does not wish to accept the protection of the country where he or she is a national, or a stateless person who, being outside his former country of habitual residence, is unable or unwilling to return there for the same reasons and to whom the conditions in Section 27 (1) of this law do not apply. Such a person may apply for refugee status.

There is no national registration system for asylum cases related to FGM.

The senior officer of the Asylum Affairs Division provided information on one asylum case request based on FGM. The aforementioned court case granted refugee status to a female from Ghana and her daughter. FGM is listed as one of the grounds for granting asylum in this court case. Among other grounds, FGM is mentioned as a threat the asylum seeker’s minor daughter might face in her home country.

The telephone conversations with both representatives from the Asylum Affairs Division Office of Citizenship and Migration Affairs made me believe that there is a good level

of awareness about FGM and that FGM is treated as serious grounds for granting asylum in LV.

4.5. Professional secrecy provision(s)

There are no legal provisions with regard to professional secrecy concerning FGM.

Two general provisions can be applied in cases of FGM.

Medical Treatment Law
• Section 56.1, paragraphs (1) and (2).


• III. Rights and duties of inspectors of the inspectorate.

The Medical Treatment Law states that medical treatment institutions have a duty to report to the state police if the patient has suffered from violence and/or a violation of the rights of the child has occurred. The law states no disciplinary sanctions in case of non-reporting. Any complaints against medical treatment institutions are collected and examined by the Health Inspectorate. The aforementioned information has been confirmed by the Head of the Legal Division of the Health Inspectorate.

The cabinet regulation of the State Inspectorate for Protection of Children’s Rights states that inspectors have a duty to report when a violation of the rights of the child is established. The regulation states no disciplinary sanctions in case of non-reporting. The Head of the European and Legal Affairs Department of the Ministry of Welfare, indicated that in cases of non-reporting the state’s Civil Service Disciplinary Liability Law can be applied. The disciplinary punishments stated in the law include reprimand, decrease of monthly salary, demotion pro tempore until dismissal from office and dismissal from office without the right to apply for a job in the state civil service for one year.

There is no national registration system for reports of (suspected) FGM cases by professionals.

4.6. Reflection on legal framework

To sum up, there is no legal framework specific to FGM in LV.

Various general laws can be applied. There has been one court case where general law has been applied in case of FGM (court case granting refugee status, see Section 4.4).

All the representatives I have contacted in order to collect data have stressed that FGM is not a relevant topic for LV, which explains the lack of specific legislation and provisions. The impression I got was that all involved parties believe that this situation is not going to change. No changes in legislation or provisions are being planned.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

In order to establish the relevant actors in LV I have searched the Civic Alliance — Latvia (an umbrella NGO headquartered in Latvia) database, which lists all NGOs approved in Latvia (http://www.nvo.lv/elpa.php?lang=en&id=79).

The Ombudsman’s web page, which lists state and non-governmental institutions dealing with human rights, was also searched in order to find any relevant actors (http://www.tiesibargs.lv/eng/links/).

5.2. Actors

I found no organisations relevant to FGM. There are no NGOs representing people of African origin. There are NGOs and organisations dealing with women’s rights, child protection and human rights in general.

5.3. Reflection on actors on female genital mutilation

Since there have not been cases of FGM in LV, and there are no known victims of FGM in LV, there are no actors on FGM in LV. I presume that the Ombudsman, the Latvian Centre for Human Rights and Ethnic Studies and various women’s organisations can act as actors if needed.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

The methodological approach I used for collecting information on tools and instruments was e-mails and telephone calls to various representatives in state institutions.

• Ministry of Welfare. Deputy Head of the Division for Equal Opportunities Policy; Head of the Department for Child and Family Policy; Head of the European and Legal Affairs Department.

• Ministry of Justice. Deputy Head of the Criminal Law Department.

• Office of Citizenship and Migration Affairs. Līga Vijupe, Head of the Asylum Affairs Division, senior officer of the Asylum Affairs Division.

• Health Inspectorate of Latvia. Head of the Legal Division.

There was no information obtained on tools and instruments.

6.2. Tools and instruments on FGM

There are no tools and instruments on FGM in LV.
6.3. Reflection on tools and instruments on female genital mutilation

Since there have not been any cases of FGM in LV, and there are no known victims of FGM in LV, there are no developed tools and instruments on FGM in LV.

7. FINAL CONSIDERATIONS

To sum up, FGM is not considered to be a relevant issue in LV. There have been no cases of FGM and there are no known victims of FGM. There is practically no immigrant population from countries where the FGM is performed. The aforementioned consideration might explain the situation in LV.

All representatives that responded confirmed that existing legislation can be successfully applied if cases of FGM occur.
1. IDENTIFICATION

Country: Lithuania

Researcher: Dovilė Rimkutė

The methodological approach I have followed in collecting data is analogical and applicable to all sections (e.g. methodological approach for collecting documents on policies, the legal framework, relevant actors, tools and instruments). For this reason, the overlapping information describing the approach followed will be omitted and only new details (if there are any) will be introduced in each new section.

I started the collection of data by visiting Google Scholar and by Googling the keywords (both English and translated into Lithuanian language). Various combinations and synonyms of the keywords were tried. Key terms included Lithuanian terms: mergaičių/moterų apipjaustymas, moters lytinij organy žalojimas/apipjaustymas. I had access to international and local academic databases, therefore all of them were used to find primary information on prevalence and other information required on FGM in Lithuania (LT). This search brought some results (will be described in the following subsections).

However, more precise and updated information was sought by contacting relevant organisations, government institutions/agencies and actors (e.g. academics, professionals in this field) by e-mail, telephone or in person.

The next step was to consult experts or people who might have knowledge concerning FGM in order to seek some clarification of the data I found on the Internet by conducting preliminary desk research.

As the desk research based on the existing data on FGM in Lithuania was not fruitful, I decided to take an active approach and consult all possible organisations/institutions/actors that might know something about the issue. Firstly, I e-mailed the bodies/actors explaining to them the aims of the research and asking whether they know of any studies/databases/laws/etc. that are relevant to this study (the original e-mail text in Lithuanian can be found in Annex 1).

I received various responses on my request to provide information about FGM in Lithuania. Some people did not respond (I did not contact them by phone, assuming that they do not have any information if there are no relevant references to FGM on their websites and they do not respond to e-mails), others responded by saying that they cannot provide me with information on this topic because they do not have any information concerning FGM in Lithuania. Some people responded saying that they do not know anything on the issue in Lithuania, but they provided contacts and a list of organisations/individual experts that might know something. Luckily, there were several organisations that wrote me informative e-mails explaining what the situation in Lithuania was. As there was limited information gained from the independent desk research, I proposed meeting and discussing what they wrote in their e-mails in more detail. Information obtained in face-to-face consultations (I conducted three) were the most useful.

Interviews were organised with two representatives from two different organisations (the Centre for Equality Advancement (CEA) and the Women’s Issues Information Centre (WIIC)) and one practising gynaecologist who was indicated as an expert in this field, since she worked closely with the WIIC on the issue and had carried out various theoretical activities related to FGM. I asked questions in relation to the requested information (prevalence, legal basis, policies, actors, instruments and tools), so as to ensure that my desk research would be to the point.

The interviews in this fieldwork were relevant for the following reasons.

- They provided updated information on the issue in LT.
- As the desk research did not bring fruitful results, the interviews served as confirmation that the results of the desk research can be treated as reliable. For instance, it was unclear if there was only very limited information on the issue in LT or if this information was publicly unavailable. In short, several sources of information (i.e. triangulation of methods, desk research and interviews) ensured the credibility of the fieldwork in LT.
- The interviews revealed the reasons for the existence of limited information on the issue within the country and provided the researcher with substantial information.

All relevant governmental and non-governmental institutions and organisations were e-mailed, since desk research did not bring many results. Interviews and e-mail exchanges with individual experts were the most useful. Even though they did not add much to the desk research, they confirmed that there was very little on the issue as far as Lithuania was concerned.

Non-governmental organisations and experts approached individually were the main source of information. Governmental institutions (e.g. ministries, related departments) did not provide much information. They (1) responded that they did not have information about
the subject; (2) gave contact details for relevant non-governmental organisations and said that only NGOs could say something on the issue; or (3) did not respond at all and ignored the e-mails.

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Prevalence studies were obtained through academic database searches, following the ‘Guidelines for national data collection’. All databases (available through Vilnius University and Utrecht University) were searched for prevalence studies in Lithuania.

Key terms included Lithuanian terms: mergaičių/moterų apipjaustymas, moters lytinių organų zalojimas/apipjaustymas.

In addition, an e-mail was sent to various institutions (e.g. relevant ministries, agencies), organisations and individuals in order to find out at least something about the requested information. Representatives of relevant organisations (WIIC and CEA) emphasised that there are no studies on the prevalence of FGM in Lithuania. In addition, the gynaecologist who was interviewed stated that FGM cases are very likely to be dealt with by her institution (Vilnius maternity (birth) centre); however, she knows only two cases in which she made the acquaintance of two women with their clitoris removed. Another academic indicated that there are no studies on prevalence (or any other studies investigating the phenomenon specifically concerning Lithuania). As the issue is extremely sensitive, women are reluctant to speak. Research on the issue is difficult to conduct due to (1) the very limited prevalence of the phenomenon in LT (only several cases) and (2) ethical issues (e.g. permission to carry out such a study).

2.2. Nature of prevalence studies/FGM registration systems

There are hardly any sources of data about the prevalence of FGM in Lithuania. I succeeded in finding some statistical data in which the distribution of immigrants from African countries by sex is provided. However, as can be seen in the table (Immigrants from Africa in Lithuania 2004–10 (by country of birth and sex)) there are only few female immigrants in LT at risk of FGM.

I could find only a few academic works (master’s and doctoral theses) which indirectly (or in some cases directly) touch on the issue of FGM. However, they do not speak much about the prevalence of the phenomenon in Lithuania. Two of them concentrate on refugee law and gender-related persecution, looking at the issue from the legal perspective (refugee law) and compare EU-wide examples and cases on the issue. There is little concerning FGM in Lithuania. The third study investigates the phenomenon itself in the context of African countries without mentioning the Lithuanian context.

Besides the academic articles discussed, the researcher has found some online magazine articles (the most relevant ones are indicated in the endnote database). The most important of all the magazine articles is the following:


EN: Women’s Issues Information Centre Director J. Šeduikiene: ‘Instead of golden mountains — circumcision’.

The magazine article in which the director of WIIC was interviewed can be partly considered as a source of FGM prevalence data. However, as it is too vague and says nothing concrete about the prevalence of FGM in LT, it was included only in endnote database but not in the Excel database. In this article, the interviewee says that there is a risk of this phenomenon in the future as immigration from the specific countries increases. The interviewee mentions that the prevalence of this phenomenon in Lithuania is unknown. However, she mentions that in LT it is possible that not only women who emigrate to LT from the FGM-practising countries, but also Lithuanian women who marry a man from such a country (who requires their wife to be mutilated), are at risk of FGM.

The Director of the WIIC states that the prevalence of FGM in Lithuania is unknown because of the nature of this phenomenon. Victims are reluctant to reveal the fact that they have been circumcised, and they are not willing to talk about it in general. The expert also emphasised the trends of immigration in LT and noted that the capturing of the phenomenon is difficult, since there are very few people in LT at risk of FGM.

Furthermore, there are some online magazine articles available in Lithuanian about the phenomenon itself in Africa or west European countries. These magazine articles serve as awareness-raising information sources for Lithuanian society. They explain what FGM is and how dangerous it is. These magazine articles provide stories, pictures and videos about the phenomenon and warn that it is not only common in African countries (and several others), but also that FGM is spreading to west European countries together with the increased immigration trends. In addition, there are some magazine articles discussing good practices in dealing with the issue (e.g. Sweden, the UK). However, these articles were not included in the database since they do not mention anything about Lithuania. There is no information on FGM and its practices in LT.

2.3. Findings from the prevalence studies/registration systems

As the CEA representative indicates in her national report (covering the Lithuanian case), the issue of FGM is not addressed and discussed in Lithuania widely, since the context of migration is unfavourable to the spread of this phenomenon.

‘The Department of Migration identifies that there is only 1 % of migrants in Lithuania. The majority of migrants come...’
from neighbouring countries — Russia, Belarus, Ukraine and Moldova. The migration department provides data that approximately 2 000 citizens from Asian and African countries live in Lithuania. Thus neither society nor policy actors nor legal professionals are discussing or debating these traditional practices yet. (Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Lithuanian national report, Pilinkaitė-Sotirovič, V).

Below you will find summarised information which was obtained from the interviews with the experts concerning FGM and its prevalence in LT.

Interviewee 1 stated that the prevalence of FGM in LT is unknown. There is no data in LT about the prevalence of this phenomenon. Immigration from countries in which FGM is practised is very limited. It is also more common for male immigrants to come to LT from other countries. It is important to note that one of the reasons why this issue is underground in LT is that immigrant women are reserved. They do not speak about these issues publicly or they are not allowed to speak about this by their male partners. However, the most reasonable explanation for why the prevalence of the issue is not advocated publicly might be that there are few immigrants from countries in which FGM is practised (and most likely they are men).

Interviewee 2 stated that the prevalence of FGM in LT is unknown. The interviewee personally knows several gynaecologists who have faced patients with mutilated genitals. However, there are no studies/statistics which investigate/document/capture the prevalence of this phenomenon in LT. In addition to this, one professor at Vilnius University (I exchanged with her several extensive e-mails), who lectures YU students and medics on the subject of FGM, said that such a study would be very difficult to conduct bearing in mind all the ethical (bioethical) requirements a researcher has to observe. Moreover, the prevalence of the phenomenon is not great enough. On the other hand, she confirmed that she herself knows several cases of FGM in LT.

Interviewee 3 is a practising gynaecologist and academic scientist. She confirmed that she is familiar with two cases in practice. She is involved in the study of violence against women. She has much theoretical knowledge on the issue (training abroad). Throughout her career the doctor had only two cases in which women (Lithuanian women) were without their clitoris. According to the doctor their husbands were from Slavic countries where FGM is practised as well. However, the doctor states that these women were not necessarily the victims of FGM, since it is possible for the clitoris to be lost during delivery. She is not familiar (in practice) with other FGM cases or studies on prevalence.

The information provided in the table was publicly available. I contacted the Lithuanian Statistics Department and asked whether they have more detailed information (for example, immigrants distribution by country and sex).

Any other more specific information about the prevalence of FGM in Lithuania (to my knowledge and based on information provided by the people I contacted) is not available.

Immigrants from Africa in Lithuania 2004–10 (by country of birth (from African countries in general without dividing them into separate countries (1) and sex)

<table>
<thead>
<tr>
<th>Year 2004</th>
<th>Total 11.7.2012</th>
<th>Year 2008</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17</td>
<td>Male</td>
<td>24</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>Female</td>
<td>4</td>
</tr>
<tr>
<td>Year 2005</td>
<td>Total 23.7.2012</td>
<td>Year 2009</td>
<td>Total 33</td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>Male</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>Female</td>
<td>5</td>
</tr>
<tr>
<td>Year 2006</td>
<td>Total 28</td>
<td>Year 2010</td>
<td>Total 23</td>
</tr>
<tr>
<td>Male</td>
<td>22</td>
<td>Male</td>
<td>21</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>Female</td>
<td>2</td>
</tr>
<tr>
<td>Year 2007</td>
<td>Total 26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data obtained from Statistics Department (the statistical reports which were used to construct this table are indicated in the endnotes).

(1) The statistics presented in the table show the flows of immigrants by sex from African countries in general.
2.4. Reflection on prevalence studies

There is little to be said in this section, since the data on the prevalence of FGM in Lithuania is very limited. The experts interviewed emphasised that the main reasons for not investigating FGM and its prevalence in LT are: (1) only a few cases (few women who have their genitals mutilated) in LT; (2) ethical issues; (3) sensitive topic.

For future research in Lithuania, I would suggest a qualitative method of research (e.g. in-depth interviews) which aims at investigating the FGM phenomenon, its prevalence and features/nuances in the Lithuanian setting. As the current research has revealed, there may be slightly different reasons and motivations for FGM practices in LT compared to, for instance, FGM in other European countries. As one of the experts interviewed mentioned, there may be Lithuanian (not African) women who are at risk of being mutilated when they marry a Muslim man or a man from a Slavic country. This ‘argument’ needs empirical evidence, however, as based on the few expert interviews a firm conclusion about FGM nuances and prevalence cannot be drawn. These statements are shaky and lack a firm empirical basis.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Relevant information was obtained through academic database searches, following the ‘Guidelines for national data collection’. All databases (available through Vilnius University and Utrecht University) were searched for policies in Lithuania and other information provided on the websites of governmental institutions and non-governmental organisations.

Key terms included Lithuanian terms: mergačių/moterų apipjaustymas, moters lytinių organų žalojimas/apipjaustymas.

In addition, the websites of the following actors in Lithuania were scrutinised:

- • Ministry of Justice.
- • Ministry of Health Protection.
- • Ministry of the Interior.
- • Ministry of Social Affairs and Labour.

Also, e-mails were sent to various institutions (e.g. relevant ministries, agencies), organisations and individuals in order to find out information concerning policies in relation to FGM. Representatives of relevant organisations (the WIIC and the CEA) emphasised that there are no specific policies or laws specifically dedicated to cases of FGM. The two interviewees were the key informants about the existing policies in Lithuania that could be applicable to FGM practices.

Four policy documents have been included in the Excel database. The policies that have been included in the database were issued exclusively by national authorities.

3.2. Policies on FGM

There are no specific policies explicitly concerning FGM. However, there are several general policies which aim at preventing violence that could be applicable in cases of FGM in Lithuania. All four policies are briefly summarised below.

In 2003 the parliament (Seimas) of the Republic of Lithuania approved the national crime prevention and control programme. The programme provides the main framework for action on crime prevention and control, including the prevention and control of crimes of violence, particularly domestic violence. The programme outlines the following.

- • Crimes of violence, especially domestic violence, are often related to conflict situations. Thus, an important role in their prevention must be given to developing the ability to settle conflicts without violence.
- • Law enforcement institutions, cooperating with healthcare, social, education and other institutions, must receive necessary information about inharmonious families and asocial persons, control the situation and respond properly to threats of violence or its manifestations, and ensure the expeditious detection of crimes of violence.
- • Apart from administrative or criminal proceedings and other control measures, corresponding institutions (healthcare, education, social security, law enforcement, public organisations) must provide social security services for persons liable to commit violence.
- • People should be protected from repeated cases of domestic violence, violence at work, other forcible, desperate, violent actions, to expand and strengthen the network of institutions providing social psychological support in crisis situations.
- • More attention should be devoted to informing and educating the public about forms, methods and specific ways of self defence against violence.
- • Special attention should be given to restricting the promotion of violence in mass media. Before announcing information, persons must establish what impact it will have on the psychological state of the population and their attitude towards order in the state.
The government of the Republic of Lithuania has approved, by Resolution No 1330 of 22 December 2006 (Valstybės žinios (Official Gazette) No 144-5474, 2006), a national strategy for eliminating violence against women (hereinafter referred to as the strategy) and a plan for implementing measures 2007–09. The aim of this long-term strategy is to reduce domestic violence against women at the national level in a consistent, complex and systematic manner. In general, the strategy is based on the 3P approach — prevention, protection and prosecution. The main priorities of the strategy are: improvement of the legal framework in the field of combating violence against women; analysis of the situation in the field of domestic violence against women; effective prevention of domestic violence against women; provision of a complex set of methods of assistance for victims of domestic violence against women; sanctions against perpetrators; strengthening of institutional capacities.

The goals of the strategy have been set for the period until 2015, and measures for the implementation of the strategy will be developed once every 3 years. The first plan of measures covers the period of 2007–09.

The purpose of the national programme (the 2008–10 national programme on the prevention of violence against children and support for children) is to provide for complex measures for the elimination of violence against children in all its forms.

As far as the resolution concerning the prevention of violence in a closed environment is concerned, the government decided to delegate the Ministry of Social Security and Labour, together with the Ministry of Health, the Ministry of Justice and the Ministry of Internal Affairs, to submit to the government a programme (2013–20) and related budget plan concerning violence in a closed environment (e.g. a family).

3.3. Reflection on policies on female genital mutilation

As already stated there are no specific policies concerning FGM in Lithuania. All of the policies included are general and mainly concern domestic violence against women and children in general.

There are discussions about the issue in the parliament proposed by several activists acting in the gender field. However, these discussions are very superficial, since they do not concern the vast majority of Lithuanian society. People hardly know about the existence of this phenomenon.

There are policies that aim to prevent violence in family (or in general) against women and children in LT, but there is nothing specifically addressing FGM.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Relevant information was obtained through academic database searches, following the ‘Guidelines for national data collection’. All databases (available through Vilnius University and Utrecht University) were searched for legal frameworks in Lithuania and other information provided in the websites of governmental institutions and non-governmental organisations.

Key terms included Lithuanian terms: mergaičių/moterų apipjaustomas, moters lytinį organų žalojimas/apipjaustomas.

In addition, the websites of the following actors in the LT were scrutinised:

- The UN Secretary-General’s database on violence against women.
- This website contains very relevant information. There were links leading to all relevant policies concerning FGM. Mainly, all four policies were obtained by consulting this website. Of course, this information was double-checked with the experts and the information source mentioned above (the UN Secretary-General’s database on violence against women). In addition, all laws were accessed on the website of the parliament (Seimas) of the Republic of Lithuania or the web pages of the relevant ministries and the Lithuanian government.

Also, e-mails were sent to various institutions (e.g. relevant ministries, agencies), organisations and individuals in order to find out information concerning laws in relation to FGM. Representatives of relevant organisations (the WIIC and the CEA) emphasised that there are no specific laws concerning FGM in Lithuania. The two interviewees were the key informants about the existing laws in Lithuania that could be applicable to FGM cases.

Two legal documents have been included in the Excel database.

4.2. Criminal law

There is no specific criminal prohibition of FGM in Lithuania.

Only a few criminal laws could be applicable in the case of FGM (i.e. Section 18 Article 135 of the Penal Code and the law concerning protection against violence in a closed (family/domestic) environment). Only general criminal laws which foresee a punishment for serious bodily injury (FGM counts as such) are developed in LT.

Up until now there have not been any criminal court cases. The interviewee mentioned that there has not been a single case in which the general law has been applied to an FGM crime (nobody applied/complained). This was confirmed by the Ministry of Justice.

4.3. Child protection laws/provisions

Articles 7 and 10 of the law on the fundamentals of protection of the rights of the child also cover FGM, in which violence against a child is considered to be a serious crime (FGM counts as such). The practising of FGM on a child could result in the removal of the child from the family, suspending parental authority. If there is a real threat to the child’s health or life, the child protection authority of the
An e-mail seeking to identify relevant actors in Lithuania concerning FGM was sent to various governmental and non-governmental institutions and organisations. I received several e-mails suggesting contacting certain people/organisations who might know more. In this way (the snowball method) a pool of experts in LT on FGM was determined. The major source of information and the key actor in LT is the Women’s Issues Information Centre. They provided a list of actors (academics, activists, medical practitioners) relevant to the case of FGM.

Furthermore, a web-based search was carried out, as well as approaching actors in person or e-mailing them. Appointments were arranged in person to double-check whether the identified actors could be considered key actors.

5.2. Actors

It is difficult to name the actors acting in this field locally, since the problem is not sufficiently relevant in LT. However, organisations such as the Centre for Equality Advancement (CEA) and the Women’s Issues Information Centre (WIIC) provide information on the issue to wider society and specific groups.

The interviewee noted that her organisation (the WIIC) is participating in the End FGM European campaign. As there are very few cases of FGM in Lithuania, the WIIC decided to direct its activities not towards a consultation of the victims of FGM, but towards organising awareness-raising campaigns in LT. Basically, they organised capacity-building training courses for medical staff (e.g. gynaecologists); they trained doctors on how they should provide help for women with this problem (i.e. FGM); also, they arranged awareness-raising sessions concerning FGM and its consequences for women who might be at risk of FGM. The CEA has also organised several awareness-raising sessions and training courses, however not as extensively as the WIIC. Training courses were only organised a couple of times.

I succeeded in identifying four individual actors that have extensive theoretical knowledge on the issue and occasionally (when asked) organise lectures to their students and to a wider public. Some of them were asked to lecture in the awareness-raising campaigns on FGM-related issues organised by the End FGM awareness-raising campaign.

5.3. Reflection on actors on female genital mutilation

The WIIC actively works to prevent FGM in Lithuania and neighbouring countries. The representatives of the WIIC revealed that their main activities are related to awareness-raising activities in Lithuania. As soon as they became one of the partners of the End FGM campaign, they did research into activities which would be most useful for our region on the topic of FGM. They decided that two activities in particular could be useful to LT and its close neighbours.

- Training courses for medics/medical practitioners on
how to deal with patients with mutilated genitals. The WIIC organised various lectures for professional staff and students from various universities on how to help women with this problem. There were several capacity-building training courses.

• Prevention. Lithuania is one of the countries whose emigration rates are bigger than the immigration rates. Emigration from LT is based on various reasons and directions. Concerning FGM, as the expert indicated, it is becoming relatively common that Lithuanian women get married to men and adopt their belief systems. As a consequence, there have been several cases in LT that women with Lithuanian origin have had their genitals mutilated (this was confirmed by several experts). Due to this, the WIIC decided to organise the awareness-raising campaigns to familiarise women (who might be at risk) with the consequences of FGM and prevent them from doing this. According to the expert, this activity is crucial, since little is known about FGM in LT. There are many misconceptions and an underestimation of the consequences of FGM. However, again there are no official statistics regarding victims of Lithuanian origin.

To conclude, there are several NGOs involved in promoting awareness and discussions in communities and a current nationwide initiative involving educational programmes. Lithuania engages in the training of professionals or sustained capacity-building within or across state and non-state sectors. However, training and capacity building appears to lack focus and priority status, and there is little emphasis on basic training nationally for healthcare, youth and other front-line service providers. Furthermore, to my knowledge, there are few tools/instruments/manuals/guidelines on how professionals dealing with this issue should act in FGM cases.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Relevant tools and instruments in Lithuania were included in the database basically through one search strategy — contacting experts and asking them to provide the material which they use in seminars, lectures and awareness-raising campaigns. Also, the authors of surveys were asked to provide their material (i.e. studies), however I noticed that people are not willing to share this information. For example, if a lecturer has slides she/he is unwilling to give them away. Also, some experts are lecturing from translated material and do not have consistently prepared material. Or they used to have this material (usually hard copies) but they do not have it now. One academic indicated that she had forwarded her material to the library, however when I contacted the library asking for the material they said that they do not have it. Therefore, the database of tools and material is not as extensive as it should be, bearing in mind the activities of the WIIC and its pool of experts.

There has been one survey conducted in Lithuania and published in Lithuanian: ‘Female genital mutilation and its prevention: results from a survey of experts’. However, this survey investigated not Lithuanian society but African countries and its practices related to FGM. In a nutshell, the survey’s main objective was to analyse the causes of FGM for women in African countries and the possibilities for its prevention. Eight reproductive health experts from countries throughout Africa (Ethiopia, Nigeria, Somal, Uganda and Zamb) participated in the survey. This research was based on four open-ended and five closed-ended questions to find out the most efficient ways to prevent FGM based on the point of view of these experts.

Furthermore, the WIIC has a website on which information on FGM can be found. The wider public can become familiar with the phenomenon by accessing this website.

There are several tools (there could be more, however people are not willing to share or have lost the material) used as material for the provision of training and seminars to specific and wider audiences.

Tools have been developed for a relatively narrow range of target groups (if compared to west European countries), including health professionals and universities/academics.

6.3. Reflection on tools and instruments on female genital mutilation

The tools found were mainly developed when the European End FGM campaign started. Lecturers who have been involved in this campaign had to prepare for awareness-raising campaigns and for training courses for more specific audiences (e.g. medical staff, students studying medicine, academics in related fields). Thus, the European End FGM campaign can be named as a crucial factor stimulating all activities (not only tool creation) related to FGM at national level.

7. FINAL CONSIDERATIONS

Data on the prevalence of FGM in Lithuania is scarce. There are no studies investigating what the situation concerning the issue in LT is.

Regarding the policy framework on FGM, only general policies exist concerning the prevention of domestic violence and violence against women and children. These general policies protect against FGM, however they do not directly mention FGM and do not address the real nature of FGM.

In Lithuania, there are no specific criminal provisions, therefore current criminal law provisions, for example of assault, aggravated assault and bodily harm, can be applied to FGM. However, there are no legal cases concerning FGM. National experts attribute this primarily to the absence of significant migrant groups and this does not create a need for specific legislation.

6.2. Tools and instruments on FGM
In the case of laws concerning children’s rights, there are general laws against violence towards children; specific ones (specifically concerning FGM) do not exist. Furthermore, there are no registered cases in which general laws were used for FGM cases in LT.

As far as refugee law in relation to FGM is concerned, there is a special decision by the Migration Department at the Ministry of the Interior of the Republic of Lithuania which foresees that in case of FGM or threat of FGM (not mentioned specifically but can be applied in such cases), refugee status can be granted. Furthermore, there is one case when refugee status was granted to a girl because of the threat of FGM.

In Lithuania there is a law stating that healthcare institutions must immediately notify law enforcement institutions of injured patients (including injuries from FGM) whose injuries could have been caused by a criminal act.

Basically, there is one main actor acting in the field of FGM in Lithuania. This actor is an organisation called the Women’s Issues Information Centre (WIIC). They created the pool of experts (practitioners (medical staff), academics) who are able to lead training sessions, give a presentation on the issue and lecture various groups. A pool of experts was prepared by the WIIC and gathered into one active body working against FGM in Lithuania. This could be called a key local actor. Furthermore, besides the WIIC there are several individual experts (who cooperate with the WIIC) who have extensive knowledge of the issue and share their knowledge with students and colleagues. However, the issue of FGM is very rare. Therefore, the individual experts use their theoretical knowledge of the extremely rare cases.

As far as tools and instruments are concerned, these include many translated materials on FGM which are used for awareness-raising purposes, lecturing (e.g. university students) and informing women at risk and the wider society about the phenomenon.

The wide variety of actors involved in developing the tools, and the variety of groups targeted, does not seem to suggest that there are gaps in terms of actors that have no tools available to work on FGM.

As one of the aims of this study is to provide recommendations on data collection on FGM in the EU, the recommendations concluded from the Lithuanian case study/fieldwork would be as follows.

**Need for qualitative research**

The difficulty of finding any quantitative data can be explained by the prevalence of the phenomenon in the country. FGM is extremely rare in LT. This influences the fact that there are no specific criminal laws, organisations or policies aimed to fight FGM. Laws and other official documents become needed and relevant when the prevalence of the phenomenon is dense enough and concerns more than a few individuals (e.g. more than 5 or 10 within one country).
Country report

Luxembourg
Country report: Luxembourg

1. IDENTIFICATION

Country: Luxembourg
Researcher: Maxime Forest

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Following the ‘Guidelines for national data collection’, we first attempted to find prevalence studies through academic database searches. The following databases were searched for prevalence studies in Luxembourg (LU): Social Science Research Network, Sociological Abstracts (1), PubMed and Google Scholar. Key terms included: in French, excision, mutilations sexuelles féminines, mutilations génitales; and in German, Beschneidung weiblicher Genitalien, Genitalverstümmelung. No valid entries could be retrieved through this research. Luxembourg, with barely half a million inhabitants, understandably has a low record of academic publications and is often addressed by researchers covering other country cases such as Belgium or France within the framework of international comparative projects.

Additionally, we carried out a keyword search (using the same entries as mentioned above), through the following national websites.

- http://www.forum.lu/
  Website of the social science journal Forum, now published mostly online.
- http://www.police.public.lu/
  Website of the police of the Grand Duchy of Luxembourg
- http://www.ms.public.lu/fr/index.html
  Website of the Ministry of Health of the Grand Duchy of Luxembourg
- http://www.gouvernement.lu
  Website of the government of the Grand Duchy of Luxembourg
- http://www.mae.lu
  Website of the Ministry of Foreign Affairs of the Grand Duchy of Luxembourg

None of my affiliation institutions has access to the Web of Science database.

This additional research matched some valid results as regards FGM, including an academic reference found on http://www.forum.lu and some references to recent tools and instruments (TI). Yet, no references to studies on prevalence were found. The only data we could retrieve, which allow a rough approximation of the size of groups potentially at risk (migrants and asylum seekers), were national statistics issued by Statec (National Institute for Statistics and Economical Studies of the Grand Duchy of Luxembourg) and figures on international protection published in the annual reports on migration and international protection statistics issued by the University of Luxembourg and the government of the Grand Duchy in 2008 and 2009 for the European Migration Network (http://emn.intrasoft-intl.com/html/index.html).

In order to make our study as exhaustive as possible, we also contacted by phone and via e-mail various actors, including:
- a Director of Family Planning (Planning familial, http://www.pfl.lu);
- a member of the Raoul Follereau Foundation, Luxembourg, (http://www.ffl.lu);
- a member of the Women’s National Council of Luxembourg (http://www.cnfl.lu);
- a member of the NGO Cosmanie and director of the first documentary film on FGM ever made in Luxembourg;
- an expert in diversity and equality management, specialising in the politics of migration and asylum, member of the Centre d'études et de Formation Interculturelle et Sociale (http://www.cefis.lu) (Intercultural and Social Training Centre);
- a lawyer specialising in asylum applications and juridical assistance to migrants.
These contacts provided updated and valuable information on policy orientations, legal frameworks, awareness-raising actions and TI referred to in the next sections of this report. However, they did not mention any studies or data on the prevalence of FGM. Only one respondent mentioned a rough estimate made in mid-2005 by the Women’s National Council of Luxembourg (see below).

2.2. Nature of prevalence studies/FGM registration systems

No prevalence studies were found, and national experts contacted confirmed that to date, no studies on FGM have been carried out in Luxembourg.

The only reference to prevalence figures was made by a member of the Women’s National Council of Luxembourg. As far as she knows, a rough estimate giving between 60 and 80 girls at risk of suffering (or having suffered) FGM was made around 2005 by a member of the bureau of this organisation, drawing upon the figures of the latest national census, carried out in 2001. Left unpublished, and without further details about the methodology, this data is of limited relevance, though, and cannot be considered to be reliable, especially as the population of Luxembourg, which is subject to significant migration flows (positive and negative) from one year to another, has undergone substantial changes since.

2.3. Findings from the prevalence studies/registration systems

In the absence of a reliable prevalence study, we opted for collecting demographical data on the foreign population living in Luxembourg in order to make a rough estimate of the population groups potentially at risk due to their country or ethnic group of origin. The result of this additional research is reported below.

**Indications about the migratory context of Luxembourg**

The most comprehensive available data on migrant populations were last collected in 2001 (1). But even during the national census carried out that year, results were not systematically disaggregated per country of origin. The census only gave an indication that a total of 2,679 migrants originating from the African continent were legally registered in Luxembourg (2).

Information collected within the framework of the European Migration Network and published in the annual reports on migration and international protection statistics issued by the University of Luxembourg and the Government of the Grand Duchy for 2008 and 2009 is relatively more detailed and up to date. It consists of Eurostat data verified by national Luxembourg experts and completed by data collected from competent authorities in the areas of migration and population control. The population study comprises the residents of Luxembourg, and more specifically people concerned by migratory flows, including cross-border workers, migrants and asylum seekers. Data is disaggregated by nationality only for major countries of origin, which do not include countries with high FGM prevalence rates. In 2008, data indicated a population originating from ‘less-developed’ countries of 1,709 legal residents, of whom 861 were female and 842 male. The total underage (less than 15 years old) population of legal residents from ‘less-developed countries’ was estimated at 161. Besides, it was mentioned that out of 463 asylum applicants in 2008, only 79 (17.5%) were from Africa. That year, 632 decisions on asylum were made, of which 95 regarding citizens from African countries (mostly male). Fifty-two were granted protection (from Angola, Democratic Republic of the Congo, Cameroon and Nigeria) (3). In 2009, the population from ‘less-developed’ countries was estimated at 1,740 legal residents, of whom 880 were female and 860 male. Neither data on legal residents from ‘less-developed’ countries nor data on asylum applications collected in 2009 were disaggregated by country of origin (4).

2.4. Reflection on prevalence studies

The absence of prevalence data on FGM in Luxembourg shall be analysed in the light of the structure of the population. While Luxembourg had the highest rate of alien population in the EU-27 (43%) in 2010, foreign residents (excepting asylum applicants) mostly came from developed countries. Out of 216,345 foreign residents, 186,244 (86%) were from the EU-27 and 204,826 (95%) from a developed country (5).

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Given the structure of its population, which, despite its heterogeneity, includes very few people from countries where FGM is still performed, it is understandable that Luxembourg did not carry out any studies on this topic. It remains, though, that statistical data collected in Luxembourg only account for the nationality (citizenship) or country of birth of legal residents. Therefore, there is no information available on people who are born in Luxembourg and hold the citizenship of that country even though their parents were born abroad. Moreover, data are not systematically disaggregated by country of origin, with the only available category, as concerns countries where FGM is still performed, being the one of ‘less-developed’ country, which is not specific enough and might exclude other countries with significant prevalence rates, such as in north Africa or around the Indian Ocean.

In Luxembourg, it should not be inferred from the lack of data on populations from countries at risk and the absence of a prevalence survey on FGM that no FGM is — or has been — performed on girls (either in Luxembourg or abroad) having their permanent residence in the country.

(1) A national census was carried out in autumn 2011.
(5) Ibid and http://www.statistiques.public.lu
As has been confirmed by one interviewee from the maternity ward at the Bohler clinic in Luxembourg, there are cases of mutilated women consulting obstetrics or gynaecology services (1). However, from this information it cannot be deduced whether FGM was performed in the country of origin after these women established their residence in Luxembourg.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

As for prevalence studies, we first attempted to retrieve policy documents on FGM using an academic database search, following the ‘Guidelines for national data collection’. The following databases were searched for policies carried out in Luxembourg on FGM: Social Science Research Network, Sociological Abstracts, and Google Scholar (PubMed was not included as it was considered irrelevant for this topic). Key terms included: in French, excision, mutilations sexuelles féminines, mutilations génitales; and in German, Beschneidung weiblicher Genitalien, Genitalverstümmelung. This research yielded no valid entries.

Additionally, we carried out a keyword search using the same entries in French and German as mentioned above and broadening the scope of the research to related policies such as asylum rights and international protection, children’s protection and domestic violence (in French, droit d’asile et protection internationale, protection de l’enfance, violences intra-familiales, violences domestiques). This additional research was carried out through the following national websites:

http://www.ms.public.lu/fr/index.html
Website of the Ministry of Health of the Grand Duchy of Luxembourg:

http://www.gouvernement.lu
Website of the government of the Grand Duchy of Luxembourg

In addition, experts contacted for prevalence data were also asked to provide indications on policy developments as regards FGM and the abovementioned related fields of public policy, but limiting the scope of our study to policy developments presenting an interest for present or future policies on FGM.

Only two documents were found, communicated by the Women’s National Council of Luxembourg.

3.2. Policies on FGM

To date, no specific policy framework has been adopted in Luxembourg to address the issue of FGM, and no mention of FGM or any kind of sexual mutilation was made in any of the policy documents we could browse. This seems to be consistent with the absence of prevalence data and with the general structure of the population of Luxembourg in terms of origins.

Nonetheless, on the basis of information about isolated cases of families living in Luxembourg where FGM could be performed, and as result of networking activities at the EU level — notably as member of the European Women’s Lobby, the National Women’s Council (CNFL) issued two position papers in which it referred to this issue.

In ‘La politique d’égalité entre femmes et hommes du Gouvernement. Prise de position du Conseil National des Femmes du Luxembourg’ (2009), the CNFL encouraged the government to present a bill specifically criminalising genital mutilation and to adopt specific protection measures for girls at risk. In the same year, in its ‘Rapport alternatif Beijing+15’, it underlined its efforts to obtain such provisions.

3.3. Reflection on policies on female genital mutilation

There is no policy designed to tackle FGM in Luxembourg. However, the two abovementioned documents might succeed in triggering policy development. Indeed, during the conference held on the occasion of the International Day Against FGM, celebrated on 6 February 2012, the officials represented (including the Grand Duke) indicated that an amendment criminalising FGM in Luxembourg could be soon be presented to the parliament (1). These potential developments would occur in a context rather favourable to the emergence of FGM on the domestic public agenda. Indeed, we found that in Luxembourg, international cooperation and assistance to development are put high on the political agenda, as these two fields of public action largely contribute to putting Luxembourg on the map of international politics. Well known for their commitment with the governance of the European Union, the authorities of Luxembourg also play an active role within the Organisation Internationale de la Francophonie (OIF) and other international forums. In particular, Luxembourg is, with respect to its size and population, an important contributor to international development funds, such as the United Nations Population Fund (UNFPA), to which it is the 14th contributor. As such, Luxembourg has funded, since 2000, the ‘Projet d’Appui à la lutte contre les Pratiques préjudiciables à la santé de la femme et de l’enfant (PASAF)’ in Mali (project for the abolition of practices harmful to women and children) to the amount of about EUR 1.5 million (2).

This context certainly increased the awareness of public institutions regarding FGM as a global issue to be also addressed at the domestic level. In 2011 the Ministry of Equal Opportunities of the Grand Duchy thus co-financed the first TI ever produced on this question in Luxembourg.

(*) Information provided during a phone call made for the purpose of this study.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The main source of information on legislation we used was the website of the Official Journal of the Grand Duchy of Luxembourg (http://www.legilux.public.lu). We also referred to the website of the Ministry of Equality (http://www.mega.public.lu) and to the web page of the Collège médical du Grand-Duché du Luxembourg (http://www.collegemedical.lu) (Medical College of Luxembourg).

We also enriched our approach by consulting a lawyer and an expert in diversity management and public policies on past and future developments in the field of international protection.

In total, our research enabled us to identify 12 relevant acts, codes and recommendations documenting the legal framework.

4.2. Criminal law

There is no specific provision in Luxembourg addressing FGM. Similarly, we found no indications that any cases of FGM have been reported to the police or to the judicial services, or brought before a national/local jurisdiction.

Nevertheless, the Penal Code adopted in 1879 mentioned in Article 400 that 'intended' bodily harm causing a permanent illness, invalidity, the total loss of an organ or a severe mutilation is punished by a sentence of 2 to 5 years and fines of EUR 500 to EUR 5 000'. In 1971 Article 401 bis was introduced, stating that if the intended violation referred to in Article 400 is performed against a child under 14, the sentence is of 10 to 15 years, and if the perpetrator is a legal tutor or ascendant, such acts can be punished by a life sentence.

As already mentioned, it seems that an amendment could be soon presented that would specifically criminalise FGM.

4.3. Child protection laws/provisions

Child protection provisions are the only legislation explicitly referring to FGM in Luxembourg. Two relatively recent acts, passed in 2003 and 2008, have increased protection measures.

The act of 8 September 2003 on domestic violence thus stipulates in its first article that the perpetrator of intended bodily harm against a person with whom he/she regularly lives or his/her legitimate ascendants or descendants can be temporarily evicted from his residence. This protection measure can notably apply to violence against underage descendants. The act of 16 December 2008 on children and family assistance contains, in its second article, the first explicit reference to FGM in domestic legislation, prohibiting inhuman or degrading treatment and genital mutilation within families or educational communities. Yet the law does not establish specific protection measures, only providing a framework for measures of assistance to children at risk. Article 11 thus lists interventions that can be proposed with the support of parents or tutors and that are subordinate to possible legal prosecutions.

These provisions also establish two information collecting services, namely the Service d’Assistance aux Victimes de la Violence Domestique (Assistance Service for Victims of Domestic Violence) and the Office National de l’Enfance (ONE) (National Childhood Office) (10).

4.4. Asylum law(s)/provisions

To date, we have found no record of any asylum applications submitted on the grounds of a threat of FGM. However, data we could access on applications for international protection, although they strongly limit the perimeter of individuals at risk, do not provide fully reliable information on this specific aspect. Information on this subject was confirmed by a lawyer specialising in asylum applications and juridical assistance for refugees.

Until the bill on asylum rights and subsidiary protection was passed in 2006, the administrative courts of Luxembourg, competent to take decisions on asylum rights, referred to the definition contained in Article 1(A) (2) of the Geneva Convention (1951), with quite a restrictive interpretation. A first act was passed in 1996 (act of 3 April 1996 establishing proceedings for the examination of applications for asylum and temporary protection) which made the first reference to an alternative status (temporary protection).

The act of 5 May 2006 on asylum rights and subsidiary protection measures also refers to the definition of the Geneva Convention, but establishes that the status of refugee can also be granted by the mandate of the UN High Commissioner for Refugees. The definition of acts of persecution is detailed in Article 31, directly borrowed from the EU qualification directive (2004/83/EC), mentioning ‘acts of a gender-specific or child-specific nature’. This act also contemplates the possibility of granting subsidiary protection to those who do not meet the criteria stated above, notably if they are threatened with execution or at risk of suffering inhuman or degrading treatment (Article 37). Although it is not specified, it can be inferred from Article 31 that gender is one of the grounds considered for the recognition of membership of a specific social group.

The act of 11 July 2011, modifying the act of 29 August 2008 on the freedom of movement and immigration, and the act of 5 May 2006 on asylum rights and subsidiary protection measures, extended the validity of decisions made on subsidiary protection up to 3 years.

In 2008 the National Human Rights Consultative Committee (CCDH) issued a position paper on this act, recommending

(10) Although we could not check this with these institutions within the time frame of this study, we have questioned all our interlocutors about their knowledge about the reporting of FGM cases to any public institution or authority and none was aware of a single case.
paying greater attention to multiple forms of discrimination suffered by female asylum seekers, including FGM.

Despite these documents tending to shape a relatively favourable framework for international protection measures on the grounds of an FGM risk, it must be emphasised that the overall number of applications for asylum is very low in Luxembourg (480 in 2009), and men constitute about two thirds of requests. Moreover, over the past 10 years, asylum seekers overwhelmingly came from countries where FGM is unknown, such as Kosovo, Serbia, Bosnia and Russia. Most of the asylum seekers from Iraq are Christian, and asylum requests from countries at risk in Africa (Democratic Republic of the Congo, Somalia, Eritrea, Nigeria, Guinea) were usually submitted on political grounds, mostly by men.

4.5. Professional secrecy provision(s)

According to Article 458 of the Penal Code, doctors, surgeons, healthcare officers, midwives and other professionals bound to secrecy (who are not specified), can be requested to disclose information by courts.

This duty to report to the judicial authorities, only activated upon request in the document quoted above, is extended to any suspicion of criminal acts by the Code of Medical Ethics issued in 1991 by the Medical College of Luxembourg.

The Code of Criminal Procedures (2011) states that public officers, constituted authorities and other professions (public and private) with a mission of public interest (unspecified) shall report to the judicial authorities any legitimate suspicion of crime or torture.

4.6. Reflection on legal framework

As a country that has faced immigration from less-developed countries only quite recently and with limited absolute figures, compared to other countries/regions of origin, Luxembourg does not yet regard FGM as a domestic problem that would require a specific legislative or policy response.

Nevertheless, although FGM is not specifically addressed in general criminal law, there are several elements that provide a relatively favourable framework for further policy and legal developments on this issue.

(1) Severe mutilations are listed among aggravating factors for a criminal offence of ‘intended bodily harm’, and acts perpetrated against children and/or by ascendants or legal tutors are specifically addressed.

(2) As a result of an extensive (and gender-blind) conception of domestic violence, protection measures introduced since 2003 also cover child victims of violence at home. Moreover, the act on children and family assistance (2008) explicitly prohibits sexual mutilations.

(3) The provisions on professional secrecy have been made more explicit as regards the disclosure of information in 2011.

(4) Due to the central position held by international cooperation and development policies on the domestic political agenda in Luxembourg, the executive body seems to have gained increasing awareness on FGM, also as a potentially domestic issue, and further legislative developments can be expected.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

To be included into the database, an actor was defined as any organisation or individual actually performing activities related to FGM in Luxembourg, as specified in the ‘Guidelines for national data collection’.

Given that FGM is not a widely addressed issue in Luxembourg, we did not perform an academic database search. Instead, we mainly relied upon personal contacts and the web links we could retrieve by browsing the websites of relevant institutional actors.

The authors of publications incidentally dealing with FGM (press articles, book sections) who do not have a specific commitment on this issue were not included in the database.

5.2. Actors

In the absence of officially reported FGM cases in the country and due to the subsequent absence of policies and the weakness of legal provisions, the number of actors actually carrying out activities on FGM in Luxembourg is very limited. Only seven actors were included in the database.

To date, the National Women’s Council of Luxembourg has been the most active and informed organisation working on this issue. Dedicated to intermediation of women’s interests and to drawing up policy recommendations and awareness-raising campaigns, the CNFL works in issue-specific subcommittees. After identifying the fact that FGM could affect girls living in Luxembourg, it co-developed with Initiativ Liewensufank the first prevention and awareness-raising campaign, with the booklet ‘Non aux mutilations génitales des femmes’ (2011). Taking into account the high demand for this booklet, the CNFL also co-organised events (public screenings, conference and press release) on the occasion of the International Day Against FGM in 2012. The Ministry for Equal Opportunities, and the family planning authority, supported the distribution of the booklet and largely reported about the celebration of the International Day Against FGM (already from 2009 to 2011, and to a much greater extent in 2012).

Besides, in line with the interest expressed in Luxembourg for international cooperation and development projects, the Raoul Follereau Foundation launched a programme of education, training and awareness-raising specifically targeting women practising FGM in Mali, which received some attention from the media. This media coverage has also converted this project into a small-scale awareness-raising campaign on FGM in Luxembourg.

5.3. Reflection on actors on female genital mutilation
An advocacy network seems about to emerge in Luxembourg around the FGM issue, bringing together the National Women’s Council, the family planning authority and a couple of other NGOs with the support of the Ministry for Equal Opportunities. As an illustration of this convergence, the celebration of the International Day Against FGM in February 2012, in the presence of Waris Dirie, received a lot of public attention and exceeded the expectations of the convenors, thus shaping interest for further cooperation on this issue, as confirmed by several actors.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

An academic database search was performed using the online thesaurus of the University of Luxembourg. Additionally, relevant tools and instruments were identified through the web pages of the relevant actors.

6.2. Tools and instruments on FGM

As regards the creation of tools and instruments to tackle FGM, incipient signs of interest for the issue could only be tracked back to 2008, when the Medical College of Luxembourg issued a recommendation to all medical practitioners, gynaecologists and paediatricians, as a first step, to pay attention to symptoms such as regular urinary or gynaecological infections and to address the issue of FGM with patients from countries at risk.

In 2009 two students involved in international development projects directed a documentary film, Mila Tu. Devenir femme Massai sans l’excision, which was subsequently broadcast at various film festivals in Europe, on the occasion of different AR actions in Luxembourg and on a national television channel (RTL).

However, what constitutes to date the most important TI addressing FGM as a domestic problem is the booklet ‘Non aux mutilations génitales des femmes,’ published in 2011. Only available in French, this document provides basic information on FGM, including countries with high prevalence rates, typology of FGM, a series of questions/answers challenging widely shared assumptions about FGM, domestic, foreign and international provisions prohibiting FGM, and organisations able to offer assistance to victims. Ten thousand copies of this tool were issued in October 2011. Some 8,500 had been distributed, on request, by February 2012 (in a country of 500,000 inhabitants). Requests came from the police, hospitals and day-care medical centres, as well as schools and other public institutions. As indicated by our interlocutor at the family planning authority, no migrants’ non-governmental organisations have yet expressed interest in this booklet.

The family planning authority has also developed a training course in relation to FGM, in the form of brief, informative, issue-specific presentations (on prevalence, cultural background, potential complications, policy framework and surgical repair techniques) and the screening of a documentary produced in Québec (Dablal Excision, directed by Erica Pomerance). Due to recent changes to the management of the organisation, we have had no confirmation that this training has already been implemented.

The other TIs mentioned in the database are mostly press releases on projects on FGM carried out abroad by the Raoul Follereau Foundation and Unicef Luxembourg, and also de facto used as a domestic awareness-raising campaign.

6.3. Reflection on tools and instruments on female genital mutilation

The widely distributed booklet ‘Non aux mutilations génitales des femmes’ certainly constitutes a milestone in the development of relevant TIs on FGM in Luxembourg, as it is largely inspired by foreign experiences. Indeed, three pages in the booklet are borrowed from a similar tool largely distributed in France, while other examples were provided by TIs developed by the NGO Intact, in Germany.

7. FINAL CONSIDERATIONS

FGM is no longer a completely unknown practice in Luxembourg. While there is no record of any cases of FGM being officially reported so far to the police or judicial authorities, public attention has been drawn to this issue due to several developments since 2008, when a new act on child protection was passed, prohibiting sexual mutilation, and when the Medical College (main doctor’s governing body in LU) issued a recommendation calling its members to be vigilant in order to better diagnose potential FGM cases.

Since the late 2000s, the National Women’s Council and the family planning authority of Luxembourg have assumed some sort of leadership on this issue, organising awareness-raising events and issuing the first relevant prevention tool designed not only for groups at risk (which remain limited in absolute figures in Luxembourg), but also for healthcare professionals, social workers and public officers working with migrants and refugees.

Moreover, we identified some convergence between the public and private interest in development projects carried out abroad, with a growing attention to FGM and harmful practices and the increasing relevance of this issue at the domestic level, which helps to convert fund-raising actions into AR campaigns in LU.

As a plausible consequence of the actions of NGOs and other civil society organisations, further policy or legislative developments can legitimately be expected in the future on this issue.
Country report

Malta
1. IDENTIFICATION

Country: Malta
Researcher: Antoinette Camilleri Grima

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The attempt to collect data on prevalence took place in three ways: (1) through academic database searches, including the University of Malta electronic library, and search engines like Google and Google Scholar; (2) by asking for information via e-mails and telephone calls; and (3) by meeting up with some individuals working with irregular migrants. Each of these endeavours will be described in more detail below.

The use of the Internet provided some useful information in terms of write-ups in local newspapers, but yielded no results where academic information is concerned. I dedicated several sessions to looking for articles related to FGM in Malta in academic publications. At first I started looking up words in Maltese (namely mutilazzjoni, genitali, fizika) and various combinations of these, which lead me to the Malta Medical Journal (which is published in English) and is available online, but I discovered that nothing seems to have been published in it about FGM in Malta. I also conducted searches in Maltese and in English using various terms such as mutilation, female genital and even simply Malta, through Google and Google Scholar, and through the University of Malta electronic library which gives me very wide access to international literature in most international journals, but nothing was found in relation to FGM in Malta. I also conducted searches as recommended in the ‘Guidelines for national data collection’, and searched in each of the websites listed on page 3, but again this yielded no results. Therefore, as far as academic literature with reference to FGM in Malta is concerned, I cannot provide any data.

What I did find, though, were a few newspaper reports of some relevance. First of all, I would like to specify that nothing was detected in newspapers published in the Maltese language. However, the local newspapers published in English, i.e. MaltaToday which is published twice weekly, and The Times which is published daily, have each made some reference to FGM in Malta. I shall now explain what the articles say.

The first newspaper article to ever mention FGM in Malta is dated 19 November 2006 and appeared in the newspaper MaltaToday. It was written by correspondent J. Debono (http://archive.maltatoday.com.mt/2006/11/19/t8.html). In this article, Debono reports that an (opposition) Labour MP is calling on government to outlaw the practice of female genital mutilation in Malta. He briefly explains what FGM involves and says that in the interview that Coleiro gave to MaltaToday she stated, ‘We need to protect the rights of migrant women by introducing a legal mechanism to prosecute anyone practising this brutal practice’. Debono continues by saying that ‘persons working with immigrants who spoke to MaltaToday said they have not encountered any cases of genital mutilation practised in Malta. This can be attributed to the fact that very few young girls actually reach Malta, where males predominate among the immigrant population.’

Debono confirms that Coleiro ‘is not aware of any specific case of genital mutilation’ in Malta, but ‘we should ensure we have the legislation in place before confronting this problem’. Debono continues by saying that Coleiro has already raised the issue in parliament by asking the Health Minister … but the health minister simply replied telling Coleiro to ask her question to the appropriate minister — probably with reference to the Justice and Home Affairs Minister.’ I have looked up the website of the Maltese parliament (all the work of the parliament takes place in Maltese), however I did not manage to obtain access to the parliamentary debates. I only managed to track down a reference to ‘genital mutilation’ (not FGM), in Maltese mutilazzjoni genitali, which was mentioned during a parliamentary debate on 8 January 2007 (sitting number 478), but I was not allowed access to the content of the debate. I also checked the section on parliamentary questions by Coleiro, but did not find any reference to FGM. No link was given to me when I specifically checked for FGM on the parliament’s website. I sent an e-mail to Coleiro, and she replied to me briefly in Maltese saying that she did not follow up her request in parliament to enact legislation on FGM because the Maltese government does not seem to be interested in this issue and has replied to her by saying that this issue is covered by the Criminal Code.

The next article to appear in MaltaToday is dated 28 July 2010. The title is ‘Maltese doctors facing up to reality of female circumcision in pregnant refugees’ (http://www.maltatoday.com.mt/en/newsdetails/news/national/Maltese-doctors-facing-up-to-reality-of-female-circumcision-in-pregnant-refugees). In this article, the journalist refers to an activity at the national
general hospital of Malta, where a specialist midwife who campaigns for the eradication of female circumcision, is ‘organising modules’ at the hospital to teach them how to deliver babies when the mother is circumcised’ (‘them’ seems to refer to the Department of Obstetrics and Gynaecology). The doctor was invited to Malta by Médecins Sans Frontiers when they were working in Malta, according to the information that was given to me by the Jesuit Refugee Service. In the same article, the journalist quotes the Director of the Department of Obstetrics and Gynaecology as saying that as soon as pregnant asylum seekers hit the Maltese shores, ‘pregnant refugee women would go directly to them in labour. Problems arise when some of the women would have had FGM.’ The director is quoted as saying, ‘Unlike the Royal British College, in Malta we do not have guidelines which we could follow. So we had to follow the Royal British College ones.’

Another article in MaltaToday which makes reference to FGM in Malta appeared on 26 November 2010 (http://www.maltatoday.com.mt/en/newsdetails/news/national/Health-minister-launches-long-overdue-national-sexual-health-policy). The title is ‘Health Minister launches long-overdue national sexual health policy’. The reference to FGM comes at the end of the article when the journalist refers to Malta’s Health Director Ray Busuttil, who said that ‘FGM is one of many realities arising around sexual health which needs to be addressed in Malta. Government needs to establish a framework which will be responsible for the detection of the specific needs of minorities within the population of Malta.’

I managed to get in touch with the journalist. I spoke to her on the phone, and she told me that she had written the first report following information she was given by a contact she had in the hospital, and she wrote the second one when the sexual policy was published. She confirmed to me that she has never written anything else on FGM, and never wrote about it in the Maltese language because ‘it did not occur to her to do so’, and she did not follow up the subject at all.

I have also sent an e-mail to the Director-General for Public Health, and he replied to me the same day in an e-mail clarifying that ‘I do not recollect ever saying we need guidelines on FGM. Far from it, we have made it clear that we do not have any practices that can be considered as FGM. We have a Ministry of Health, and we have always been very clear about the need to protect women and girls who are subjected to FGM in their country of origin. The Ministry of Health has always been very clear in this regard, and we do not need any further information from the UN on this issue.’

The only other article appeared in The Times on 21 December 2011, and was written by Bertrand Borg (http://www.timesofmalta.com/articles/view/20111221/local/Torture-as-tradition.399340). In it he refers to Amnesty International’s campaign, the European Parliament’s resolution and the WHO’s estimates. In Malta he refers to the Migrant Health Unit, run by one of the respondents, which ‘provides health education to migrants, trains doctors and nurses to be culturally sensitive and also trains cultural mediators to be able to link migrants and healthcare professionals.’ More information was subsequently provided to me as mentioned below. I contacted Amnesty International and the volunteer EU team replied to me via e-mail saying that they have never conducted any research on FGM in Malta.

I also asked several actors for prevalence data as listed in the appendix. The Refugee Commissioner sent me an excel sheet as an e-mail attachment with the number of female applicants for asylum by age, country and year (2008–11). The Information Officer of the Open Centres (Agency for the Welfare of Asylum Seekers) gave me the statistics for women resident in the open centres by age and country for January 2012.

The third type of data collection was an attempt at gathering information through personal contact. The first person I met was the Director of the Integra Foundation. She told me that she cannot provide me with statistics as she has not managed to obtain them herself. The only information she could give me was that about 13 % of irregular migrants were women, and the majority of them came from Somalia. On this note, the Director of Kummissjoni Emigranti told me in an e-mail that about 20 % of irregular migrants are women, but that they cannot provide me with more precise information. The director also said that she is not aware of FGM taking place in Malta, and if the migrants do it they keep it a secret among themselves.

I have asked the police for the required precise information, first by an e-mail to the general address, and although I received an acknowledgement I have so far received no further information. I wrote again to two individuals (indicated to me as responsible for this area by the Refugee Commissioner) at the police headquarters, and they replied on the same day by saying that my request had to be processed through the proper channels.

In the next sections I will specify more precisely the information I managed to obtain.

2.2. Nature of prevalence studies/FGM registration systems

In Malta there is no FGM registration system. During my meeting with him, the Refugee Commissioner said that his office does not ask questions of asylum seekers about FGM. The general hospital does not seem to keep any statistical information, first by an e-mail to the general address, and although I received an acknowledgement I have so far received no further information. I wrote again to two individuals (indicated to me as responsible for this area by the Refugee Commissioner) at the police headquarters, and they replied on the same day by saying that my request had to be processed through the proper channels.

As stated above, I do not have specific studies of the prevalence of FGM in Malta.

However, in the next section I will make reference to two internal reports by the Director of the Migrant Health Unit of the Ministry of Health, and statistics I found in an academic paper. The other somewhat relevant statistical information was obtained by the Information Officer of the Open Centres (which are residential components for irregular migrants run by the Ministry of Justice and Home Affairs) and by the Refugee Commissioner.
2.3. Findings from the prevalence studies/registration systems

According to the internal report entitled ‘Female genital mutilation’, dated October 2009 and entitled: ‘Two hundred and forty-two women (242) from these countries arrived in 2008 alone’, where ‘these countries’ is defined as ‘African countries with a high prevalence of FGM’. The report details the aims and content of two focus group sessions, each of which was held in a different open centre with such women, and with interpretation being provided by cultural mediators who spoke English and the languages spoken by the African women. The main aim of the sessions was to educate these women on the significance on health of FGM. Attendance was on a voluntary basis. Session 1 was attended by seven Somalis and one Ethiopian woman. Session 2 was attended by 14 Somali women and one Eritrean. In my opinion this is a rather poor attendance and shows a general lack of interest in the topic among the women. Furthermore, some of the women declared at the session that ‘they would have the procedure done so that the daughter will not have problems relating to marriage when she grows up.’ Another mother said she will not have the drastic procedure done to her daughter, but will settle for type one where the hood of the clitoris is excised together with part or all of the labia minora.

One of the conclusions of the report is worth quoting: ‘At Mater Dei Hospital there does not seem to be a policy in place whereby a woman with FGM is offered the service of elective defibulation.’ Also, the respondent adds, ‘It is not known whether Maltese laws include any specification concerning the issue of reinfibulation.’

I refer to another internal report entitled ‘The benefits of child spacing’, which refers to a session on the topic of ‘child-spacing practices among Somali women residing in open centres in Malta’ dated August 2011. In this report the interviewee reports that, ‘at the time of writing this report there were 262 female migrants living in open centres in Malta. One hundred and fourteen (114) of these were mothers, and adds that most of the women were not employed due to their lower educational level and due to linguistic barriers. The sessions reported in this document were not about FGM, although FGM was referred to slightly when the topic of contraception was tackled.

An academic paper entitled ‘Obstetric outcomes in immigrants of African nationality’ was published in the *International Journal of Risk and Safety in Medicine* No 21, 2009, pp. 147-152, and was written by Savona-Ventura, C., Buttigieg, G. G. and Gatt, M. It deals with the number of births in Malta in the period 2003–07. The authors state that, in the said period, a total of 2174 births (6.0% of all births) were identified as occurring in non-Maltese nationals, while a further 198 births did not have the mother’s nationality registered. A total of 550 individuals (566 births) were identified as having an African nationality, with 380 women registered from the north African Maghreb region and 170 from the sub-Saharan region, with the majority of these (139 women) coming from the Sahel belt (Eritrea, Sudan, Chad, Mauritania, Niger and Nigeria) and the Horn of Africa (Ethiopia and Somalia). The authors say that ‘the larger majority of sub-Saharan women are irregular migrants’. The paper does not deal with FGM, but provides some more interesting statistics, namely that there were 255 asylum applications in 1999, which increased to 1380 in 2007, and between 1999–07 totalled 6185 (both men and women).

The above information can be summarised as follows.

- In August 2011 there were 262 female migrants living in open centres in Malta, and 114 of these were mothers.
- Between 2003 and 2007 there were 566 births in Malta from mothers of African nationality. One hundred and seventy (170) of these mothers came from the sub-Saharan and Sahel regions.

The most reliable data for January 2012 were obtained from the Information Officer of the Agency for the Welfare of Asylum Seekers. He wrote to me stating that they had 93 ‘female minors’ living in the open centres as follows: Eritrean (33); Ethiopian (17); Kurdish/Turkish (2); Nigerian (11); Somali (30). In the case of women over 18 years of age, the statistics are as follows: Cameroonian (1); Chadian (2); Eritrean (47); Ethiopian (1); Italian (1); Kurdish/Turkish (4); Moroccon (1); Nigerian (45); Somali (89); Sri Lankan (1); Togolese (1), which gives a total of 238.

‘I came across adult cases who were experiencing difficulties as a result of FGM but not anything related to the practice in Malta with regard to minors.

She is no longer in Malta as this person was resettled to France, but there was one lady who used to speak to me a lot who had problems herself and when she came back from Finland with a baby daughter she swore that she would never let her daughter go through the same horror she faced.

There is not really anything I can help you with on this as it is a difficult thing for the victims to talk about, especially to a male.’

Some further information possibly related to prevalence was given to me by the Refugee Commissioner. He sent me an excel sheet with information about the number of female applicants for asylum classified by age groups and country for the years 2008–11. I summarise the information I received in the table below.

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I received in the table below.

---
<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
<th>Under 19 years</th>
<th>Over 19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>Cameroonian</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Eritrean</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Ethiopian</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Georgian</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td>Ghanan</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Liberian</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Nigerian</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Palestinian</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sierra Leonean</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Somali</td>
<td>50</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td>Togolese</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Tunisian</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Ukrainian</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2009</td>
<td>Armenian</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Beninese</td>
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</tr>
<tr>
<td></td>
<td>Eritrean</td>
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</tr>
<tr>
<td>2010</td>
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<tr>
<td></td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>Eritrean</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Ethiopian</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Iraqi</td>
<td>0</td>
<td>1</td>
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<tr>
<td></td>
<td>Liberian</td>
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<td></td>
<td>Libyan</td>
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<td>1</td>
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<tr>
<td></td>
<td>Moroccan</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td>Nigerian</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Sierra Leonean</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
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<td>9</td>
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<tr>
<td></td>
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<td>1</td>
</tr>
<tr>
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<td>Tunisian</td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td>Turkmen</td>
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<td>1</td>
</tr>
<tr>
<td>2011</td>
<td>Cameroonian</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Chadian</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Following the statistics provided by the WHO (2008) provided in Annex 1 to the guidelines this would indicate that since larger numbers of asylum seekers and irregular migrants in Malta came from countries such as Somalia, Ethiopia and Eritrea, it is likely that FGM is prevalent in these communities in Malta.

2.4. Reflection on prevalence studies

All the persons I have spoken to or e-mailed have made it clear that it is probably impossible to know the real number of irregular residents in Malta, let alone the number of women. The reason for this is that some live on their own account and never report their existence, nor apply for asylum. Some of the registered persons sometimes disappear, and at times reappear. Some irregular residents are only discovered when they are caught in a criminal offence by the police. Indeed, as the paper by Savona-Ventura et al. reports, there were 198 mothers who gave birth and whose nationality is unknown (mother’s nationality is always requested by the hospital). Therefore, the only ‘community’ that the state somewhat caters for are those living in the open centres, and with whom the actors mentioned above can/do work.

My recommendation would be that Malta needs to make available all the statistical information relating to the arrival, departure and residence of females at risk of FGM, because from my standpoint as a researcher it has been next to impossible to obtain such data. Therefore it is not possible to observe trends or to cater for girls at risk.

From the statistical data and other information provided to me through interviews and internal reports, I can only assume that issues of FGM are relevant in Malta, especially due to the presence of Somali, Eritrean and Ethiopian female migrants. However, none of the actors I spoke to said that they were aware that FGM had taken place in Malta.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

My methodology for collecting documents on policies followed the same course I described in Section 2.1. above.

3.2. Policies on FGM

I encountered no policy documents on FGM in Malta.

3.3. Reflection on policies on female genital mutilation

In the absence of documents I cannot reflect very much, except that I find that the topic of FGM is being sidelined, as the Chair of the Malta Council of Women said in her e-mail: ‘Some social workers feel that basic needs such as food and shelter take priority over such an issue’. Furthermore, the Chair states that in one case ‘the wife had had the FGM done as a child and would do the same to their daughters when they have them’. Some of the women who attended her training session felt quite strongly about this, and the Refugee Commissioner also told me in an e-mail that ‘we are aware that not all women see FGM as a violation, they accept it as something normal, and there is no doubt that they may choose to expose their own daughters to such experiences in Malta. We have not had any direct experience of this.’

Therefore, it is admitted that there might be girls at risk of FGM in Malta. Within the open (detention) centres this is being tackled through education, namely by the Migrant Health Unit and by the Jesuit Refugee Service. However, with the irregular migrants living outside these centres no work can be done. I am not aware of any written policies on FGM.
4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

For the legal framework I looked up both the Maltese and the English version of the Laws of Malta, and I also asked the actors to whom I have sent e-mails about whether they can provide me with a link to any Maltese legal documents on FGM. I also conducted a general Internet search.

4.2. Criminal law

In the Laws of Malta online I did not find any reference to FGM. Chapter 9 of the Laws of Malta, which is the Criminal Code and dated 1854, refers to ‘physical mutilation’ in paragraph 54d(b)(x). However, this is done under the section ‘war crimes’. Below I quote it exactly in the English version of the Laws:

‘(x) subjecting persons who are in the power of an adverse party to physical mutilation or to medical or scientific experiments of any kind which are neither justified by the medical, dental or hospital treatment of the person concerned nor carried out in his or her interest, and which cause death to or seriously endanger the health of such person or persons’.

Furthermore, Article 214 of the same Criminal Code states that:

‘Whosoever, without intent to kill or to put the life of any person in manifest jeopardy, shall cause harm to the body or health of another person, or shall cause to such other person a mental derangement, shall be guilty of bodily harm.’

According to a lawyer, who produced a Malta country report for the Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence (European Commission, 2010):

‘Female genital mutilation is not recognised in national law and there is no current policy that considers this traditional practice. Nor is there information that this has occurred or occurs within Malta. However since FGM may cause bodily harm one could seek to frame this within the offence of grievous or slight bodily harm. However in doing so one would run the risk of failing in the prosecution and of adequately addressing the circumstances with which the victim is confronted.’

There have been no court cases, and although both the related respondent and the Refugee Commissioner do not exclude that FGM is being performed, this is done behind closed doors, and therefore there have been no confirmed cases of FGM having taken place.

4.3. Child protection laws/provisions

These do not exist specifically with reference to FGM.

4.4. Asylum law(s)/provisions

There do not seem to be such provisions.

I will here refer to one document available online (European Migration Network. Ad hoc query on female genital mutilation and asylum in the EU. Requested by SE EMN NCP. Compilation produced on 22nd March 2010), in which there was a response from Malta. Here it is stated that the ‘Office of the Refugee Commissioner has dealt with one case of FGM by a family from Ethiopia who claimed that they cannot return to Ethiopia because they do not want FGM to be practised on their minor daughter. In this case, asylum was not granted because according to the country of origin information, the Ethiopian government had banned the practice in 2004’

4.5. Professional secrecy provision(s)

One respondent confirmed to me in an e-mail that the only professional secrecy that may be of relevance is that ‘Medical professionals are bound to maintain confidentiality in any medical case’, and there is no specific provision for secrecy in relation to FGM.

4.6. Reflection on legal framework

It seems that issues related to FGM from a legal perspective are lagging behind because the irregular migrants have come to Malta with a view to moving on to somewhere else. They are not perceived as people willing to take up residence in Malta. However, some of them have indeed been living in Malta for some years now. Their situation is further complicated by the fact that they are ‘irregular’, and although they are given permits to work, they are not within the mainstream social services system. Also, it seems to me from what I was told that if they can they prefer to remain unregistered.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

To start with I was provided a list of actors by the core team. Furthermore, following my own knowledge of the Maltese context I contacted, in addition, the Kummissjoni Emigranti.

5.2. Actors

As I described in the sections above one relevant actor which has taken an active role with specific reference to FGM is the Migrant Health Unit of the Department of Primary Health. It is run by one of the respondents, and she has conducted a training course herself with some women as I explained in section 2.3. above.

The Jesuit Refugee Service is also providing training from a social, psychological, educational, legal and medical point of view on FGM for both male and female refugees resident at the centres. The main actor works full-time as a nurse as part of the Jesuit Refugee Service. She told
me that she is witness to the daily pain suffered by the women resulting from FGM that was performed on them prior to their arrival in Malta. She added that she is not aware of FGM being performed in Malta.

Médecins Sans Frontiers arrived in Malta in 2009 to set up a project to help the refugees held in detention centres. As part of their project, in 2010, they invited a doctor (as mentioned in Section 2 above) to provide training to medical professionals on how to deliver babies when the mother is circumcised. Médecins Sans Frontiers is no longer active in Malta. I tried to contact the Head of Obstetrics and Gynaecology at the Mater Dei Malta General Hospital, by e-mail, but to date I have received no reply.

5.3. Reflection on actors on female genital mutilation

My reflection lies in the fact that the actors do not/cannot know about all the women who have either experienced FGM or who are at risk. The latter do not seek help but prefer to remain in secret, and most of them actually declare that they want to continue this practice. Therefore, there is no pressure at all on any actors to take the lead in this area. It seems to me that if this practice is to be eradicated, there will need to be a more aggressive campaign. Nonetheless, the irregular migrants living incognito will continue to do as they will. They are neither protected, nor in serious danger of being caught by the police, unless they are caught red-handed committing a crime.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

As above.

6.2. Tools and instruments on FGM

The instruments that have been used so far have been educational ones, involving training sessions in groups, or on a one-to-one basis with irregular migrants residing in open centres. I have described these in Section 2.1. above. Furthermore, a respondent from the Jesuit Refugee Service told me that they also provide support and training on FGM on a day-to-day basis with both men and women at the open centres.

6.3. Reflection on tools and instruments on female genital mutilation

The fact that the educational tool mentioned above is provided only on a voluntary basis means that very few women can be helped. And even among the few who participated in the training, some were adamantly in favour of FGM being continued in their culture. FGM culture, found especially among the Somalis, is only changing very slowly. Similarly, while acknowledging that the medical profession has become more aware of the issues surrounding FGM, both expressed the desire for more to be done in this area.

7. FINAL CONSIDERATIONS

My final consideration is related to the fact that FGM does not seem to be a priority, neither for the females who are coming from an FGM culture nor for the local authorities.

To start with, it has been impossible for me to obtain clear and reliable prevalence data. Academic output on this issue is nil. Matters are complicated by the fact that FGM in Malta pertains to irregular residents, and therefore it is almost impossible for the police to keep track of them (as reported to me by the Refugee Commissioner and all the other actors I have spoken to).

There is no policy framework in place.

The legal framework relies on the issue of ‘physical mutilation’ mentioned in the criminal code, but as Dr Comodini Cachia said in her report, this is not a clear-cut issue. I have not been given any references to child protection regarding FGM, and asylum provisions do not cater for FGM either.

The actors that are somehow involved with irregular migrants and refugees are becoming aware of issues surrounding FGM. Others have not replied to my request for information.

The instruments are mainly educational, and are being implemented by the Migrant Health Unit and by the Jesuit Refugee Service. Both respondents expressed a desire for more to be done in the area of FGM in Malta.
Country report

Netherlands
1. IDENTIFICATION

Country: Netherlands
Researcher: Els Leye

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Prevalence studies were obtained through academic database searches, following the ‘Guidelines for national data collection’. The following databases were searched for prevalence studies in the Netherlands (NL): Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar.

Key terms included the Dutch terms *meisjesbesnijdenis*, *vrouwenbesnijdenis* and *vrouwelijke genitale verminking*.

The FGM library of the International Centre for Reproductive Health was also searched, and yielded the documents ‘A closer look at female genital mutilation — Measuring the magnitude. A research on the nature, magnitude and attitude among professionals and the risk group in Amsterdam and Tilburg’ and ‘Retrospective survey on the prevalence of FGM or female circumcision among midwives in 2008’.

I attended the expert meeting in The Hague, organised by the FGM focal point from the Netherlands, in September 2011. For the purpose of that meeting, a background document was prepared by the focal point that contained useful prevalence data.

In addition, an e-mail was sent to the FGM focal point in order to verify whether all prevalence studies for NL were included. She confirmed the existing three studies and adjusted some of the information. She also provided information on an upcoming prevalence study in the Netherlands, in 2012.

An e-mail was also sent to the Dutch FGM focal point to clarify issues regarding registration systems in NL. The document review showed that a number of policy documents discussed or ordered the instalment of registration systems, including:
(a) registration by public prosecutors;
(b) registration of FGM in perinatal registration;
(c) registration in advice and reporting point child abuse.

I requested that they confirm that those systems are in place and whether any data could be obtained. Furthermore, I also asked if there was any registration of FGM related to asylum cases. A response was given in which some answers were given to my queries. Moreover, they informed me that some other questions I raised on registration systems were distributed to relevant actors. The registration systems are discussed below in Section 2.2.

2.2. Nature of prevalence studies/FGM registration systems

Regarding prevalence documents, I have found four relevant texts that document prevalence data on FGM in NL. The first study was done in 2005, followed by a second one in 2009, and a third study will be performed in 2012. All three were commissioned by the Dutch Ministry of Health. In contrast, the prevalence data in the document ‘FGM/C situation analysis in European countries — Discussion paper for expert meeting, The Hague, 12 and 13 September 2011’ does not concern a study but a background document in which data from the website of the National Bureau of Statistics were included. These data were compiled by the national FGM focal point for the purpose of an expert meeting.

The documents ‘A closer look at female genital mutilation — Measuring the magnitude. A research on the nature, magnitude and attitude among professionals and the risk group in Amsterdam and Tilburg’ and ‘Retrospective survey on the prevalence of FGM or female circumcision among midwives in 2008’ are both based on surveys sent to professionals. The first study was a written survey addressing a mix of professionals in two Dutch cities, while the second one was a retrospective survey addressing only midwives in NL.

The 2012 study will use a methodology based on the extrapolation method (estimations of the prevalence of FGM based on data from the demographic and health surveys (DHS) and multiple indicator cluster surveys (MICS) and extrapolated to data from the National Bureau of Statistics), in addition to in-depth research to assess the influence of migration on social norms and behaviour regarding FGM, and performed among five groups.
Concerning the registration systems.

- Public prosecutors — The public prosecutors register, among others, abuse and FGM with a specific registration number. It was mentioned, however, that such registration is done by individuals, therefore the reliability of the system inevitably depends on the accuracy of the person attributing the right code to each case of FGM.
- Registration of FGM in the perinatal registration system — Since 2011, at the request of the National Ministry of Health, FGM should be registered in the perinatal registration system. The system registers the status of FGM in a (future) mother. The Dutch focal point on FGM confirmed that this registration should be done at national level by obstetricians, gynaecologists, general practitioners and paediatricians. However, they also mentioned that this system is not optimal yet, as a new dataset is currently being developed. They referred to the Netherlands Perinatal Registry Foundation, where data on FGM can be requested, upon payment (http://www.perinatreg.nl/).
- Registration of FGM with child abuse advice and reporting points — Data on FGM registered by advice and reporting points should be delivered to Youth Care Netherlands. Youth Care NL provides data on FGM but only if FGM is the reason for an investigation, hence only the number of times advice and consultations on FGM have been sought is provided. There is no registration of whether FGM has been assessed or not. Researchers can obtain data upon payment.
- Registration of FGM by the Council of Child Abuse — The Dutch FGM focal point has forwarded our request to the council. Upon the date this report was finalised, no response had been received.
- Registration of asylum requests based on FGM — The ‘Immigratie en Naturalisatie Dienst’ (IND, Immigration and Naturalisation Service) does not register motives for requesting asylum, including FGM. The focal point informed me that the only way to retrieve these data is by looking at all files.

2.3. Findings from the prevalence studies/registration systems

The most recent estimate of the number of women in NL coming from countries where FGM is practised (29 countries) is 64 000 (based on data collected from the National Bureau of Statistics, 2011). These data do not include the Kurdish community or Yemen. Some 44 % of these women are less than 20 years old.

The study among midwives showed that 40 % of pregnant women originating from countries at risk of FGM, who deliver in NL, have been subjected to FGM.

2.4. Reflection on prevalence studies

In NL, attempts have been made since 2005 to estimate the number of girls and women with FGM. However, the methodologies used so far to collect these data were not able to provide representative and reliable data. They were either limited to geographical areas (two major cities) or provide insights on the number of women with FGM addressing the health sector only. The studies that have been done, or that are envisaged, did not use the same methodology or study population, nor have they been repeated over time, so no conclusions with regard to comparability or trends over time can be assessed.

The extrapolation method whereby prevalence from FGM risk countries in Africa is extrapolated to numbers of women from FGM countries in the database of the National Bureau of Statistics has a number of limitations that cause a serious bias in assessing reliable prevalence data on FGM. These include: prevalence data in countries of origin might not be recent and thus might not reflect recent changes in the practice; the influence of migration context is not taken into account; the numbers of asylum seekers/refugees/non-documented migrants are not taken into account; second generation migrants are not taken into account; and prevalence data from national offices of statistics are not up to date.

The methodology of the upcoming 2012 study has not been communicated in detail. The upcoming study might solve some of the abovementioned problems and provide more reliable data than the studies done before, as the study was preceded by a consultation of EU experts on FGM and data collection in September 2011. Data from this study will be published by the end of 2012.

With regard to the registration systems that have been put in place, they seem to be suffering from teething problems, which are currently being taken care of. In order to receive data regarding FGM from these systems, fees need to be paid.

In NL, the prevalence estimations are mainly commissioned by the Dutch Ministry of Health.

In conclusion, at this time, there are no studies in NL that are representative and contain reliable data on the prevalence or incidence of FGM in NL.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Documents on policies developed in NL were obtained through a variety of sources. First we searched the academic databases, following the ‘Guidelines for national data collection’. The following databases were searched: Social Science Research Network, Sociological Abstracts, Web of Science and PubMed.

Key terms included the Dutch terms meisjesbesnijdenis, vrouwenbesnijdenis and vrouwelijke genitale verminking.

The FGM library of the International Centre for Reproductive Health was also used for any relevant policy documents for NL.

These two actions yielded only limited information regarding policies. Hence, the websites of the following actors in NL were scrutinised.
Before 2001, FGM was mainly mentioned briefly in policy notes regarding emancipation, asylum procedures for women and domestic violence. The letter from the Minister for Justice to the parliament from July 2001 detailed the policy of the Dutch government regarding FGM for the upcoming governing period.

In 2004 a new policy was developed following the publication of the report ‘Strategies to prevent circumcision in girls’ in 2003. This publication was the result of research on FGM in NL that was commissioned by the Ministry of Social Affairs and Labour. The government policy (issued by the Ministry of Health) included among its priorities research into the magnitude of the problem, prevention, early detection and intervention, removal of the principle of double incrimination in law and the establishment of a commission that should research the possibility of a monitoring system for girls at risk, and the opportunities for detection, reporting and monitoring girls/women at risk of/with FGM (de Boer, M., Desta, A., 2007, p. 19). The 2004 policy also viewed FGM as a form of child abuse, while in the 1993 policy FGM was primarily viewed as a form of female oppression (de Boer, M., Desta, A., 2007, p. 19).

This commission published in 2005 its advice for the government. This advice was formulated at the request of the government (VWS) by the Council for Public Health and Healthcare (RVZ), and contained a number of recommendations on improving prevention, early identification of cases, expanding the scope for prosecution and starting an intensive approach to combating FGM in six pilot regions with a high concentration of the so-called ‘at-risk’ population in order to increase the sense of urgency. The advice was followed by the Ministry of Health, which launched the pilot prevention project in six cities in that same year. The ministry did not follow up on the advice to have specific criminal law, nor to have systematic screening of girls’ genitals. The ministry also launched the development of a reporting code on child abuse, which was only implemented in 2011.

In December 2007 a policy brief entitled ‘Protected and able-bodied’ that dealt with violence in interdependent relationships, including FGM, was published by the Minister for Health (Jet Bussemaker). The work on FGM had three main aims: (1) immediate and safe care for victims at high risk; (2) victims should be detected early, quickly and are taken care of to start a new life; (3) all relevant professionals should be able to detect risk of FGM at an early stage and have knowledge on how to prevent it. A budget of EUR 4 million was invested in six pilot cities. The FGM project ran until January 2010.

A policy brief from 2009 from the Minister for Health provides a progress report concerning the implementation of the policy note of December 2007 as at 1 May 2009. It also gives future directions for the implementation of the plan. Regarding FGM, these future plans include the development of a medical certificate to prevent FGM, the enhancement of the chain approach in the six cities and its national roll-out, and putting FGM on the European and international agenda. The letter reports on the prevalence study by TNO, a research organisation, which was commissioned by VWS.

Thirty-three policy documents have been included in the Excel database. Policies that have been included in the database were exclusively issued by national authorities. Policies developed by other actors, such as NGOs or professional organisations, have been included in the sheet ‘Tools and instruments’.

3.2. Policies on FGM

Policy development in NL began as early as 1993, with the influx of the Somali community into NL. The first policy statement on FGM followed the publication of the report ‘s Lands wijs, ‘s lands eer’ in 1992 by Bartels and Haaijer, in which the Minister for Health declared that FGM was not allowed in NL. The report triggered a public debate in NL, caused by the controversial proposal to differentiate between mutilating and non-mutilating forms of FGM. Also following that controversial report, the National Public Health Inspectorate issued the first guidelines for health practitioners who are confronted with FGM.

UN Secretary-General’s database on violence against women.

Pharos, focal point on FGM.

Ministry of Justice. The site was searched under ‘Documents’ with the keywords ‘vrouwelijke genitale verminking’ (female genital mutilation), ‘meisjesbesnijdenis’ (girls’ circumcision) and ‘vrouwenbesnijdenis’ (female circumcision). The search yielded 52 hits. All documents were analysed and any relevant documents on policies in NL related to FGM were included in the database.

Ministry of Health. The site was searched under ‘Documents’, with the keywords ‘vrouwelijke genitale verminking’ (female genital mutilation), ‘meisjesbesnijdenis’ (girls’ circumcision) and ‘vrouwenbesnijdenis’ (female circumcision). The search yielded 127 hits. All documents were analysed and any relevant documents on policies in NL related to FGM were included in the database.

Ministry of Social Affairs and Labour. The site was searched under ‘Documents’, with the keywords ‘vrouwelijke genitale verminking’ (female genital mutilation), ‘meisjesbesnijdenis’ (girls’ circumcision) and ‘vrouwenbesnijdenis’ (female circumcision). The search yielded 21 hits. All documents were analysed and any relevant documents on policies in NL related to FGM were included in the database.

Ministry of Education, Culture and Science. The site was searched under ‘Documents’, with the keywords ‘vrouwelijke genitale verminking’ (female genital mutilation), ‘meisjesbesnijdenis’ (girls’ circumcision) and ‘vrouwenbesnijdenis’ (female circumcision). The search yielded 21 hits. All documents were analysed and any relevant documents on policies in NL related to FGM were included in the database.

Ministry of Internal Affairs and Kingdom Affairs (including asylum and migration). The site was searched under ‘Documents’, with the keywords ‘vrouwelijke genitale verminking’ (female genital mutilation), ‘meisjesbesnijdenis’ (girls’ circumcision) and ‘vrouwenbesnijdenis’ (female circumcision). The search yielded 8 hits. All documents were analysed and any relevant documents on policies in NL related to FGM were included in the database.

Ministry of Justice. The site was searched under ‘Documents’, with the keywords ‘vrouwelijke genitale verminking’ (female genital mutilation), ‘meisjesbesnijdenis’ (girls’ circumcision) and ‘vrouwenbesnijdenis’ (female circumcision). The search yielded 127 hits. All documents were analysed and any relevant documents on policies in NL related to FGM were included in the database.

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In November 2009 the Minister for Health gave an overview of the achievements regarding FGM (the development of action protocols for professionals; EUR 4 million being invested in six pilot schemes that aimed at training key persons from communities that practice FGM, at organising awareness-raising activities for at-risk groups and at training professionals) and stated that a national roll-out of the pilot schemes would start in 2010, and that knowledge would be spread among all health services in the municipalities (the so-called GGDs (Gemeentelijke Gezondheidsdienst) cover healthcare for the approximately 400 municipalities throughout the country). The letter also states that parents should be asked to sign a declaration in which they state that they will not circumcise their daughters while in their country of origin.

In the policy on FGM 2010–11, the Minister for Health outlined the following actions.

- The active policy of the Ministry of Health (VWS) on international developments regarding FGM, further development of medical care for women with FGM and the need for prevalence figures.
- The national roll-out of the prevention project on FGM (coordination by GGD NL within Youth Healthcare 2010–11). This included group information sessions in asylum centres, and national implementation of FGM prevention by community-based organisations and key persons, including in asylum centres.
- The active policy of the Ministry of Justice to increase the number of reports, to obtain evidence (including in case of asylum) and to present the results of the survey Criminal investigation and prosecution of FGM — The French practice.
- The interest of Ministry of Foreign Affairs in building bridges between Africa, Europe and NL.

The most recent policy brief by the Minister for Health (December 2011) mentions that FGM is one form of violence that fits within the category of violence in interdependent relationships. In this policy, however, no separate details were found on future activities and policies regarding FGM. According to the focal point, the national roll-out of the prevention project on FGM was finalised at the end of 2011, and tackling FGM became the responsibility of the municipalities as of 1 January 2012. The steering of the campaign against FGM at national level stopped as of 1 January 2012 (personal e-mail).

3.3. Reflection on policies on female genital mutilation

The major policymakers in NL are primarily the Ministry of Health, the Ministry of Justice, the government (interdepartmental policies) and the Public Health Inspectorate. Asylum agencies have also taken up the issue of FGM in NL. Research institutes are also important actors, as their research reports trigger debate and policy development.

The issue in NL came to the forefront following a research report in 1993 (‘s Lands Wij, ‘s Lands Eer’) by Bartels and Haaijer, and the same happened in 2005 with the publication of the report ‘Strategies to prevent FGM’, by Van der Kwaak et al. In the period 2004–10 the Minister for Health was pivotal in developing a policy towards FGM, as well as in its implementation. Budgets were provided to develop a pilot project for prevention that was evaluated and rolled out over the whole country from 2010 onwards.

The policy of the Dutch government (the Ministry of External Affairs) regarding international cooperation was not in the scope of this study, and has thus not been included in the database and country analysis.

With regard to asylum policies, a first reference to FGM was made in working instruction No 148, which dealt with women undergoing asylum procedures. This gender-inclusive approach was later on included in the ‘Aliens circular 2000’. This circular is further discussed in Section 4 (‘Legal framework’). Other working instructions produced by asylum agencies in NL are further discussed under Section 6 (‘Tools and instruments’).

Policies in NL have been quite comprehensive and coherent, in particular in the period 2005–12, when the Minister for Health (Jet Bussemaker) developed and implemented the plan ‘Protected and able-bodied’. Policies targeted major actors in this plan, i.e. child protection and youth care authorities, as well as the communities themselves (through working with and training of the key persons). After piloting and evaluation of the prevention project it was rolled out throughout the country, and as of 1 January 2012 the municipalities themselves took over responsibility for working on FGM.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Data for this section were retrieved from the following websites:

- the UN Secretary-General’s database on violence against women (VAW), accessed for information regarding the Aliens Act 2000 and any other relevant legislative work;
- Staatscourant;
- https://www.officielebekendmakingen.nl/, which contains all legislative documents.

The FGM library of the International Centre for Reproductive Health was also used, and the following documents were included in the desk study:

- Hagemann-White, C., Kelly, L., Romkens, R., Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Romkens, R.;
- Leye, E., Sabbe, A., Responding to FGM in Europe. Striking the right balance between prosecution and prevention, 2009;
- Nijboer, J. F., van der Aa, N. M. D., Buruma, T. M. D., Criminal investigation and prosecution of FGM — The French practice, Universiteit Leiden, 2010;
An e-mail was sent to J. H. Nijboer (Professor of Evidence and Law of Evidence at the Institute for Interdisciplinary Study of the Law at the University of Leiden), who was the author of the study on the French practice of criminal law, to check the accuracy of the legislative framework included in the database, but at the time this report was compiled no reply had been received.

4.2. Criminal law

There is no specific criminal prohibition of FGM in NL. FGM is liable to punishment on the basis of assault (Articles 300 to 304 DPC) or the prohibition against the performance of unauthorised medical procedures (Article 436 DPC). People who assist, aid, procure or pay a third party to undertake FGM are also liable to punishment, along with the one who actually performs the mutilation (Articles 47 and 48 DPC). The maximum penalty is 12 years' imprisonment, but this maximum can even be raised by a third if the FGM is carried out by the parents or the spouse of the victim (Article 304(I) DPC).

As for health law, physicians who cooperate in performing FGM can be tried on the basis of the medical disciplinary rules (Articles 47 and 96ff) of the Individual Healthcare Professions Act — Wet BIG (Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Römkens, R.).

Since 1 February 2006 the requirement of ‘double criminalisation’ has been abolished with regard to FGM. Dutch law also applies to persons with Dutch nationality or persons who are resident in NL if they have performed FGM abroad, even if the FGM is performed in a country that has not criminalised the behaviour (!) (Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Römkens, R.).

A more recent change is that the statute of limitations (after 20 years) for prosecuting cases of FGM has been prolonged. As of 1 July 2009 the period starts from the moment the girl reaches the age of 18. With very serious forms of FGM the limitation period even starts from her 20th birthday. This means that a woman has until her 38th birthday to file a report with the police (feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Römkens, R.).

Until now, there has only been one criminal court case (2009). As pointed out in Section 2 of this report, registration systems are put in place but these are not yet optimal.

4.3. Child protection laws/provisions

The proposed law on the mandatory reporting code for domestic violence and child abuse (Wet meldcode huishelijk geweld en kindermishandeling) will also cover FGM. Professionals will be obliged to have the reporting code available, to use it and to attend a course on how to use it (!). (Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Römkens, R.). The proposal for the law was introduced in the ‘Tweede Kamer’ on 27 October 2011, to enter into force at the beginning of 2012.

The child protection law (Article 254(I) and Article 261 of the Civil Code) provides for measures such as removing the child from the family or placing the child under supervision (Leye and Sabbé, 2009). Child abuse is reported to the child abuse advice and reporting points. By 1 December 2007 there had been 22 reports of suspicion of FGM at these advice points, of which eight were investigated, resulted in 14 recommendations. Since 2007, all 15 child abuse advice and reporting points have included FGM in their registration system. Registration can also be done at the Council for Child Protection or with the police. Issues with registration systems have been discussed in Section 2 of this report.

The guidelines for detection and prosecution of child abuse by the College of Public Prosecutors, from 2010, provides instructions for police and public prosecutors for the detection and prosecution of child abuse, including FGM. The instructions contain a code of conduct in cases of child abuse, child neglect or violence against themselves and/or others in their environment. The guidelines introduce the duty for the police and public prosecutors to register instances of child abuse, which will give more insights into its nature and magnitude (see Section 2 for issues regarding this registration system). The Dutch national report from the Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence (van der Aa, S. and Römkens, R., European Commission, 2010) states that the child abuse guidelines have the status of a quasi-law that contains binding rules for the police and public prosecutors.

4.4. Asylum law(s)/provisions

In 1997 the Immigration and Naturalisation Service (Immigratie en Naturalisatie Dienst) issued work instruction No 148 on women undergoing asylum procedures. This document promoted a gender-inclusive approach to the asylum procedure and it was the first time that FGM was mentioned in relation to asylum claims. In 2000, when the Aliens Act 2000 (Vreemdelingenwet, 2000) entered into force, major parts of work instruction No 148 were copied and pasted into the ‘Aliens circular 2000’ (Vreemdelingencirculaire 2000).

(!) More information on the proposed reporting code act is given in the domestic violence section.
The Aliens Act 2000 and the Aliens Decree (Vreemdelingenbesluit) do not contain specific provisions on FGM. However, Articles 28 to 32 of the Aliens Act provide the legal basis for girls and women in FGM cases who would like to apply for an asylum residence permit for a restricted period of time (verblijfsvergunning asiel voor bepaalde tijd). These girls and women have two options.

Option 1

A girl or woman who is (politically) opposed to the practice of FGM can be considered a ‘convention refugee’. (Political) resistance against FGM may, under certain circumstances, lead to the conclusion that the girl or woman can claim refugee status. In that case, Article 29(1)(a) of the Aliens Act 2000 can be applied and the girl or woman may be granted an asylum residence permit for restricted period of time. The conditions for a successful claim are further defined in the ‘Aliens circular 2000’ (paragraph C1/2.72).

Option 2

A girl or woman who is at real risk of FGM upon their return to their country of origin may be eligible for an asylum residence permit for a restricted period of time under Article 29(1)(b) of the Aliens Act 2000. The conditions are further defined in the ‘Aliens circular 2000’.

The ‘Aliens circular 2000’ stipulates that there may be a real risk of violation of Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) in a case in which a girl or woman at risk of FGM is returned to the country of origin.

The following conditions were set out in the ‘Aliens circular 2000’ (Chapter C4/3.2).
(a) The girl or woman does not want to continue the tradition.
(b) There is no alternative for relocating the woman in the country of origin (vestigingsalternatief).
(c) If the girl or woman does not undergo FGM, she will find herself in a socially outcast position.

If these conditions are met, the girl or woman may have qualified for an asylum residence permit for a restricted period of time.

An amendment to the Aliens Act 2000 (paragraph C1/4.3) from 2003 deleted two of the three conditions originally set in 2000: condition (a) The girl or woman does not want to continue the tradition; and condition (c) If the girl or woman does not undergo FGM, she will find herself in a socially outcast position. Also, girls born in NL who are at risk of FGM when they are returned to the country of origin of their parents became eligible for an asylum residence permit for a restricted period of time. In addition, parents who fear that their daughters are at risk of FGM became eligible for this residence permit (see Section 3.3.2). Other family members, other than the parents, were still not eligible for applying for this residence permit. For children from the same family who are not threatened with FGM, the possibility was provided (when certain requirements are met) to apply for a residence permit for restricted period of time on the basis of Article 29(1)(e) or (f) of the Aliens Act 2000.

The following conditions were set out in the 2003 amendment of the ‘Aliens circular 2000’ (paragraph C1/3.3.3).
• There is a real risk of FGM.
• The authorities in the country of origin are unable or unwilling to provide protection to persons who oppose the threat of FGM.
• There is no alternative for relocating the woman in the country of origin (vestigingsalternatief).

There is no distinction between the different types of FGM.

In 2007 and 2011 more amendments were made to the Aliens Act. The sentence ‘FGM is considered by the Dutch government a very serious violation of the integrity of the human body’ was added to the introduction of paragraph C2/3.2. The conditions for applying Article 29(1)(b) of the Aliens Act 2000 remained the same (see paragraph C2/3.2.3). However, with regard to condition (a), a real risk of FGM, the woman is provided the possibility of voluntary submitting a medical certificate showing that she has not undergone FGM, in order to further substantiate her claim.

Furthermore, the ‘Aliens circular 2000’ now provides explicit provisions/exceptions with regard to FGM for some specific countries (Eritrea, Ethiopia, Côte d’Ivoire, Liberia, Nigeria, Sierra Leone, Somalia, Sudan and Guinea). The Dutch government decided for example that conditions (b) and (c) are not applicable to women from Eritrea (see paragraph C2/9.3.5) and Somalia (see paragraph C2/24/3.4); that condition (b) is not applicable to women from Guinea (see paragraph C2/4/10a.3.3) and Sudan (see paragraph C2/24/3.4); and that condition (b) is not applicable to women from Sierra Leone and condition (c) is not applicable to minors from Sierra Leone (see paragraph C2/22.4.4).

It is unknown how many girls or women have been granted an asylum residence permit for restricted period of time in NL (based on Article 29(1)(a) or (b) of the Aliens Act 2000) since 2000. There have been quite a lot of court cases at the local courts in NL. In some instances girls and women also lodged an appeal against the decision with the Council of State (Raad van State — the highest general administrative court in NL). Most women and girls have based their claims in court cases on Article 29(1)(b) of the Aliens Act.

4.5. Professional secrecy provision(s)

Article 53, paragraph 3 of the Child Care Law stipulates that health professionals have the right to report (Leye, Sabbe, 2009).

The upcoming law on a reporting code for domestic violence and child abuse, which should enter into force in 2012, states that professionals have a duty to implement a reporting code in their own organisation and to build capacities on the use and knowledge of this code. Professionals that are targeted with this new code include the healthcare sector, education
sector, childcare, societal support (including welfare and sport), youth care and justice.

4.6. Reflection on legal framework

Discussions on whether to have a specific criminal law have popped up in NL over the years. However, the government maintains the general criminal law. There have not been any court cases in NL, except for one atypical case of a Moroccan father who abused his daughter by having her genital area mutilated.

NL has also searched for strategies to enhance the detection of cases, and hence the criminal prosecution of FGM in NL. One strategy to systematically perform gynaecological screening of girls, proposed by the Council for Public Health and Care in 2005, was not accepted by the authorities. Other measures were proposed following a motion of a member of parliament (De Krom) to enhance the implementation of the criminal law, focusing on enhancing the detection of cases by care providers, including the development of an e-learning module on FGM (by the Koninklijke Nederlandse Vereniging voor Obstetrisch en Gynaecologisch Zorg [KNOV, Royal Dutch Society for Obstetricians]), perinatal registration of FGM, development of the reporting of domestic violence and child abuse, and conversation and acting protocols for professionals. Moreover, the College of General Prosecutors developed a number of guidelines: child abuse guidelines, sexual abuse detection and prosecution guidelines, and domestic violence and honour-related violence guidelines. Finally, a study was ordered to assess the applicability of the French practice of criminal prosecution to the Dutch situation.

A number of reports of (suspicions of) FGM were reported to the child abuse advice and reporting points. Issues with regard to the registration of these cases are discussed in Section 2 of this report.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

In order to be included in the database, an actor was defined as any organisation or individual who performed any work on FGM in NL, as specified in the ‘Guidelines for national data collection’.

Relevant actors in NL were listed through a variety of search strategies.

An academic database search was performed, in accordance with the ‘Guidelines for national data collection’. The following databases were searched for prevalence studies in NL: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar. Key terms included the Dutch terms meisjesbesnijdenis, vrouwelijke genitale verminking. Any relevant actor, such as FGM experts or institutions, that appeared in those documents was included in the database.

All documents on FGM in NL that were available in the FGM library of the International Centre for Reproductive Health were also screened for any relevant actors to be included in the database.

The authors of documents that were studied, as well as those who issued the documents and those who commissioned the publication of the documents, were considered as actors included in the database.

There are numerous actors in NL that have worked and are still working on FGM. Given the limited time frame of this desk study, the list of actors in the database is not exhaustive. Forty-four actors have been included so far. Should any actor not appear in the database, I will communicate this new actor to the project coordinators with all the details necessary to update the database accordingly during the course of this EIGE project.

5.2. Actors

Sectors involved in the Netherlands include ministries, child protection agencies, youth care, asylum and migration, judiciary, municipalities, research institutes, civil society organisations, public healthcare, professional organisations from the health sector and consultancy firms.

Depending on the nature of the actor, activities include research, prevention activities, developing or implementing policies that were developed at national level and child protection.

The first FGM actors appeared in the early 1990s. The most important actors are the Ministry of Health, Ministry of Justice, the NGOs FSAN and VON, the public healthcare authority (GGD) and, of course, the national FGM focal point. They are responsible for the majority of policies, and tools and instruments that have been developed since 1990. The University of Amsterdam was also the most important research institute, contributing to increased knowledge on FGM in NL. A temporary actor, such as the commission of the Council of Public Health and Care, has also been an important player in terms of preparatory policy work. Child protection and youth (health) care have been strongly involved in the development of policies and activities with regard to FGM. Finally, it should be noted that a number of consultancy offices have provided punctual studies on FGM (evaluation of prevention projects, performance of EU studies, policy advice) for the authorities.

Since the list of actors is not exhaustive, as explained earlier, we did not calculate the number of actors per category.

5.3. Reflection on actors on female genital mutilation

Work on FGM in NL started through the work of the University of Amsterdam, as well as NGOs (VON, FSAN and Pharos), early in the 1990s. This was due to the influx of Somali refugees to NL in the late 1980s. In those early years (1990–00) the issue of FGM was taken up by the NGOs and the government. Medical organisations and experts also
paid attention to the problem of FGM, and issued a number of papers and guidelines.

FSAN and Pharos joined forces and worked together in the prevention activity ‘From policy to practice’ from 2000–02, and a first initiative was taken by NGOs (Pharos, FSAN and Defence for Children NL) to exchange experiences and activities at national level by creating the Coalition and Advisory Group on FGM. NGOs have also been involved in policy development by providing advice to the government, and, since mid-2000, some of the main actors in NL (Pharos, FSAN) have received financial resources to implement the strategies developed by the government. Since the early 1990s, a notable trend has been that more actors have been involved in NL, in particular the increasing involvement of child protection agencies, college of prosecutors and the police.

Actors operate in accordance with the existing policies of the authorities in NL, all the more so since mid-2000 when the government developed a policy on FGM. Over the years, more actors became involved. The Ministry of Health was pivotal in developing policies in NL from 2005 onwards. Particular attention should be paid to the fact that NL has a national focal point on FGM that has been working on FGM since 1993. Pharos’ focal point on FGM was involved in a number of policy implementation activities (such as the implementation of pilot projects in six cities).

A particular approach in NL is the so-called ‘chain approach’, typified by protocols that explain in detail how the problem of FGM should be handled and how the various key stakeholders in cases of FGM should cooperate to optimise prevention and care. With this approach, it can be assumed that no key actors are excluded in dealing with the problem of FGM.

Given FGM is the responsibility of the municipalities as of 1 January 2012, it would be advisable to have a monitoring system, to make sure the achievements of the past years are consolidated and FGM remains on the agenda.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Relevant tools and instruments in NL were included in the database through a variety of search strategies.

An academic database search was performed, following the ‘Guidelines for national data collection’. The following databases were searched for ‘tools and instruments’ in NL: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar. Key terms included the Dutch terms meijsjesbesnijdenis,女人被切’vegenital mutilation’ and vrouwelijke genitale verminking. Any relevant tool or instrument retrieved through the academic search was included in the database.

All documents on FGM in NL available in the FGM library of the International Centre for Reproductive Health were also screened and included in the database if relevant.

6.2. Tools and instruments on FGM

A wide range of actors have developed tools and instruments, as explained in Section 5. Tools include surveys, training modules and guidelines for professionals, manuals and handbooks, conferences and seminars, sensitisation projects, intervention projects, publications by academics, protocols, online learning tools, etc.

Tools have been developed for a wide range of target groups, including FGM-practising communities, policymakers, health professionals, the child protection sector, the asylum sector, police, the youth sector, school teachers, prosecutors, universities/academics and religious leaders.

Some tools have been ordered by authorities.

6.3. Reflection on tools and instruments on female genital mutilation

Tools have been developed from the early 1990s on by universities and NGOs that worked to prevent FGM among their own communities (mainly Somali). Until 2000, tools and instruments were not developed in coherence with policies from authorities. This changed during the 2000s when the work on FGM was steered nationally by the authorities, notably the Ministry of Health and the Ministry of Justice. Actors were given resources and trained, following a clear action plan.

The wide variety of actors involved in developing the tools, and the variety of groups targeted, does not seem to suggest that there are gaps regarding actors that have no tools available to work on FGM.

Academic research and subsequent publications, from 1992 and 2003 respectively, played a major role in triggering debate in NL, which was followed by policy developments on FGM. From 2005, especially, when a clear policy was developed by the Minister for Health, Jet Bussemaker, there was an impressive increase in the number of tools and instruments that were developed for a wide variety of target groups, including FGM-practising communities, child and youth protection, judiciary, health sector, teachers, etc. From 2011 more e-learning tools appeared, especially for the health sector.

Following particular policies, specific tools were developed. For example, following the announcement of the (upcoming) law on a reporting code for domestic violence and child abuse, a number of sectors (including gynaecologists and obstetricians and the youth sector) have developed protocols and training modules to put this reporting code into practice. The instruments will help professionals to better detect FGM risk cases and to weigh whether or not to report them. The law does not set out the duty to report, but does set out the duty of each sector to implement training courses on reporting cases of FGM.
7. **FINAL CONSIDERATIONS**

In as far as prevalence is concerned, several efforts to estimate the number of girls and women with FGM in NL have been made since 2005. Nevertheless, the methodologies used so far have not been able to provide representative and reliable data. They were either limited to geographical areas (two major cities) or provide insights into the number of women with FGM addressing the health sector only. The studies that have been carried out, or are envisaged, do not allow for the comparison of data or the assessment of trends over time because they did not use the same methodology or study population, nor have they been repeated over time. These limitations should be taken into account in further prevalence studies in order to obtain reliable and comparable data that may allow for the assessment of trends over time.

Regarding the policy framework on FGM in NL, the Ministry of Health, the Ministry of Justice, the government (interdepartmental policies) and the Public Health Inspectorate can be pointed out as the major players on FGM in NL. Asylum authorities have also taken up the issue of FGM in NL. It should be noted that research institutes play an important role in the policy development process, as their research reports trigger debate and policy development. Policies in NL have been quite comprehensive and coherent, notably in the period 2005–12, when the plan ‘Protected and able-bodied’ was developed and implemented. It seems that FGM is, as of 2012, the responsibility of the municipal healthcare authorities (GGD), and the question of whether the issue receives the same attention as it has in the past 7 years should be monitored.

Concerning the legal framework, NL does not have a specific criminal law for FGM. This issue has been popping up in NL over the years. There has been one atypical court case of a Moroccan father who abused his daughter by having her genital area mutilated.

It was possible to assess that NL has searched for strategies to enhance the detection of cases, and hence the criminal prosecution of FGM in the country. Proposed strategies that have been explored include the systematic (compulsory) gynaecological screening of the genital area of girls, but also other non-repressive measures were explored and some of them launched (e.g. child abuse guidelines and a reporting code for child abuse).

Civil society organisations and universities were instrumental in bringing FGM to public awareness. The issue was taken up quickly by the government following a heated public debate triggered by a research report in 1992, but it was only in the middle of 2000s that a more coherent policy and approach was developed and steered by the government, notably the Ministry of Health and the Ministry of Justice. An important trend over the years has been that more actors have been involved in NL, in particular the increasing involvement of child protection agencies, colleges of prosecutors and the police.

The wide variety of actors involved in developing the tools, and the variety of groups targeted, does not seem to suggest that there are gaps in terms of actors that have no tools available to work on FGM.
Analytical country report

Netherlands
Analytical country report

Identification
Country: Netherlands
Researcher: Els Leye
Date: 4.8.2012

I. INTRODUCTION
As defined in the guidelines for the in-depth study, provided by the core team of the ‘Study to map the current situation and trends of FGM’, the aim of the in-depth interviews conducted in the Netherlands was to assess successes and challenges in the work on FGM and to establish past and present good practices with reference to prevention, protection, prosecution, provision of services and partnership.

Six face-to-face interviews were conducted, five in Dutch and one in English. The interviews followed a semi-structured approach and focused on the ‘five Ps’, as requested in the guidelines. Interviews were planned following the briefing of the national researcher on June 23. All interviews were conducted between 5 and 18 July 2012.

All interviews were conducted by the national researcher (Els Leye), tape recorded, notes were taken and a summary was made for each interview (in English). Nevertheless, the time frame of one hour was very tight to cover all questions in the questionnaire. All interviewees agreed that the interviews were recorded and signed a letter of consent.

The summaries of the interviews have been forwarded to the respondents for review; as of 4 August only two of them had sent the summary back. As many respondents are absent due to the holiday season, they promised to send their comments later.

The report follows the structure suggested by the outline for the analytical report.

II. INFORMATION SOURCES

Overview table of the interviews

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<th>Date of the interview (dd.mm.yyyy)</th>
<th>Duration of interview (in minutes)</th>
<th>Observations</th>
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</tr>
<tr>
<td>18.7.2012</td>
<td>70 minutes</td>
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Brief description of each respondent
One of the respondents is a researcher and FGM programme officer at Pharos. She is responsible for the focal point on FGM within Pharos (see the ‘Partnership’ subsection for a detailed explanation about the focal point). The focus of her work is on juridical aspects, the child abuse advice and reporting points (Advies en Meldpunt Kindermishandeling — AMK), the acting protocol and medical care for women with FGM.

The second respondent is a senior policy officer to the Secretary of State for Health, Welfare and Sport. She has FGM in her portfolio. She is responsible for compiling and proposing the policy on FGM for the Secretary of State for Health, Welfare and Sport (1).

Another respondent was the FGM project leader within the Netherlands Municipal Health Service (Gemeentelijke…

(1) In the Netherlands, there is a Minister of Health, Welfare and Sport as well as a Secretary of State for Health, Welfare and Sport. The Secretary of State has violence in dependency relations under his/her jurisdiction. This includes child abuse, and FGM is considered a form of child abuse. The Minister of Health deals with curative care.
Gezondheidsdienst Nederland — GGD NL) from 2010 to 2012. She was responsible for the national roll-out of prevention of FGM within youth healthcare (YHC) in the Netherlands. Before that, she worked with GGD Utrecht where she was responsible for the local prevention of FGM.

The fourth respondent is a policy advisor at the department of law enforcement and the fight against crime (criminality and security, criminal detection policy) at the Ministry of Justice and Security. She is responsible for FGM policy (not child abuse policy).

The fifth person interviewed is an FGM programme manager within the Federation of Somali Associations in the Netherlands (FSAN).

The last respondent prepares and coordinates policies at Youth Care NL (Jeugdzorg Nederland). Youth Care NL is a branch association in which all Youth Care offices and all youth and educational aid organisations are united (see the subsection ‘Protection’ for a detailed explanation about Youth Care Netherlands). He is responsible for advocacy towards the ministries, obtaining input on issues and transferring it to the directors of the members of Youth Care. His portfolio contains AMKs and Youth Protection, among others.

Additional contacts and complementary sources of information

Additional sources of information are the country report and the database that resulted from the desk research performed by the same researcher during January and February 2012 within this study, and a series of documents and sources that are included in footnotes to this report.

III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

Triggers for and milestones in policy development

As stated in the country report of the Netherlands, policy development in the Netherlands began in the early 1990s with the influx of Somali communities into the country. The influx of the Somali communities as a trigger for policy attention on the issue of FGM was confirmed by a number of respondents. One stated that following the influx, not only was political and media attention given to FGM, but it also raised questions by professionals, key persons from the communities and society about how the issue of FGM should be dealt with. Another respondent considers that health professionals at that time found it very difficult to provide appropriate care for pregnant Somali women (who are usually infibulated).

As a consequence of the influx, two health professionals working in an asylum centre published the results of interviews they had done with Somali women in a report in 1992 (1). The report showed that Somali women were demanding that health professionals perform FGM on their daughters. The report triggered the public debate in the Netherlands, caused by the controversial proposal in the report that there should be a differentiation between mutilating and non-mutilating forms of FGM, and that the Netherlands should condone the non-mutilating form. One interviewee called this proposal the ‘medicalisation of FGM’ and confirmed that this report triggered the first policy statement by the Dutch government, issued in 1993. In a letter from the Secretary of State for Welfare, Health and Culture (16 March 1993), the Secretary of State for Health declared that FGM was not allowed in the Netherlands and that all forms of FGM should be stopped. The respondent said that with this statement the government acknowledged FGM as being prosecutable under the child protection law. Nonetheless, prosecution was considered not to be sufficient and discussions were then initiated on how prevention of FGM should be tackled.

No real milestones or triggers were identified by respondents between these early days in the 1990s and the mid-2000s. The desk study found that before 2001, FGM was mainly mentioned briefly in policy notes on emancipation, domestic violence or asylum. In July 2001 the Minister for Justice issued a letter to the parliament in which the policy of the Dutch government regarding FGM for the coming governing period was detailed.

As stated in the country report of the desk study, in 2004 an FGM policy was developed following the publication of the report ‘Strategies to prevent circumcision in girls’ in 2003 (2). This publication was the result of research into FGM in the Netherlands that was commissioned by the Ministry of Social Affairs and Labour. The suggested government policy (issued by the Ministry of Health) included among its priorities research into the magnitude of the problem, prevention, early detection and intervention, the removal of the principle of double incrimination in law, the establishment of a commission to research the possibility of a monitoring system for girls (at risk), and opportunities for the detection, reporting and monitoring of girls and women (at risk of being) subjected to FGM (3).

Following this policy, and still during 2004, the Dutch government (i.e. the Secretary of State for Health, Welfare and Sport) requested that the Council for Public Health and Healthcare (Raad voor de Volksgezondheid en Zorg RVZ)
establish an ad hoc commission (Commission Combating FGM) in order to examine the opportunities for an effective monitoring system and reporting, detecting and prosecution. It also had to assess the nature and magnitude of the problem of FGM in the Netherlands and make suggestions for setting up a registration system. The results of the findings were also to be used for targeted prevention. All the findings of the commission were published in an advisory proposal to the government in 2005 consisting of four documents:

(1) ‘Bestrijding vrouwelijke genitale verminking — Beleidsadvies’ ['Combating female genital mutilation — Policy advice'];
(2) ‘Bestrijding vrouwelijke genitale verminking — Onderbouwing advies’ ['Combating female genital mutilation — Substantiation for the advice'];
(3) ‘Vrouwelijke genitale verminking in juridisch perspectief. Achtergrondstudie’ ['Female genital mutilation in a juridical perspective — Background study'];
(4) ‘Vrouwelijke genitale verminking nader bekeken — Omvangsmeting — Een onderzoek naar de aard, omvang en attitude onder professionals en risicogroep in Amsterdam en Tilburg’ ['A closer look at female genital mutilation — Measuring the magnitude — A survey to the nature, magnitude and attitude among professionals and at risk group in Amsterdam and Tilburg'].

This was considered one of the milestones in policy development by many of the respondents.

The commission’s advisory proposal to the government contained a number of recommendations on improving prevention, early identification of cases, expanding the scope for prosecution and starting an intensive approach to combat FGM in six pilot regions with a high concentration of the so-called ‘at-risk’ population in order to increase the sense of urgency. The ministry did not follow up on the advice to have a specific criminal law, nor to have systematic screening of girls’ genitals to detect FGM. The ministry also called for the development of a reporting code on child abuse.

Parallel to these developments, the public debate was initiated by a Dutch member of parliament (MP) of Somali origin, who suggested in January 2006 that compulsory gynaecological check-ups should be allowed for all girls originating from countries where FGM is still practised. The proposal by this MP was rejected by the Dutch government as it was against the constitution (discrimination of a certain population group). The important role of the MP was however acknowledged by a number of respondents. The many parliamentary questions that were raised on FGM and the role of some politicians were also considered by some respondents to be important driving forces. Politicians that were considered to be driving forces, as mentioned by the respondents, were the Dutch MP Khadija Arib (MP from 1998 until now), Minister for Justice Ernst Ballin (2006–10), Secretary of State for Justice Nebahat Albayrak (2007–10), Secretary of State for Health, Welfare and Sport Jet Bussemaker (2005–09) and Minister for Health, Welfare and Sport Hans Hoogervorst (2003–07).

Following this advice, the Dutch government (i.e. the Secretary of State for Health, Welfare and Sport) published a reaction to the advice that same year (‡). This document contains the outlines of the policy on FGM, based on the commission’s advice. The policy followed two paths, prevention and prosecution. With regard to prevention, the Secretary of State for Health, Welfare and Sport launched projects in six cities in 2005/06, the so-called ‘pilot projects’, with the aim of strengthening prevention. These pilot projects were recognised as a major milestone by some respondents. At the same time, the Minister for Justice, Ernst Ballin, provided input towards policy development on the detection and prosecution of cases of FGM.

The pilot projects (2006–09) were initially financed to the total amount of EUR 3 million, and with a year’s extension this became EUR 4 million. EUR 1 million per year was available for FGM for 2009, 2010 and 2011, following the policy brief ‘Protected and able-bodied’ — ‘Beschermd en Weerbaar’, see paragraph below). With this budget of EUR 1 million, the national roll-out of prevention conducted by the GGD NL was paid for, as well as VON/FSAN’s national campaign (‘Say no to FGM; consisting of meetings in cities where people jointly sign declarations against FGM, information meetings for all kinds of target groups, etc.) and some smaller projects such as the international conference of November 2009. Now, as of 2012, there is an overall budget for violence in dependent relationships (§) (EUR 8.6 million for 2012, EUR 19.5 million for 2013 and EUR 20 million planned for 2014 — this concerns support and care in cases of violence in dependent relationships) and will mostly go to 35 cities/regions for women’s shelters. Nevertheless, the money is no longer ring-fenced.

In December 2007 a policy brief entitled ‘Protected and able-bodied’, which dealt with violence in interdependent relationships, including FGM (‘), was published by the Secretary of State for Health (Jet Bussemaker). The brief explained that work on FGM had three main aims:

(1) immediate and safe care for victims at high risk;
(2) victims should be detected early and fast and be taken care of to start a new life;
(3) all relevant professionals should be able to detect risks of FGM at an early stage and have the knowledge of how to prevent it.

‡ Kabinetststandpunt tav RVZ advies tav vrouwenbesnijdenis PG/OGZ 2.594.902 [Position of the Cabinet regarding the advice on FGM from the RVZ].
§ In the policy brief of 2007 by the Ministry of Health, Welfare and Sport ‘Beschermd en Weerbaar’ [‘Protected and able-bodied’], violence in dependent relationships is broadly defined: it concerns various forms of violence where the victim is dependent on the perpetrator and does not have sufficient opportunities to alter the unequal power balance. The policy brief distinguishes domestic violence (partner violence, elder abuse and child abuse, in particular honour-related violence and female genital mutilation) and human trafficking (Source: http://www.verwey-jonker.nl/doc/vitaliteit/Geweld-in-afhankelijkheidsrelaties_1477.pdf).
(‘) ‘Beschermd en Weerbaar, intensivering van de opvang en hulp bij geweld in afhankelijkheidsrelaties’ (Kamerstukken II, vergaderjaar 2007–08, 2834522894, No 51).
A policy brief from 2009 from the Secretary of State for Health provided a progress report concerning the implementation of this policy note from December 2007 up to 1 May 2009. It also gives future directions for the implementation of the note. Regarding FGM, these future plans include the development of the medical certificate to prevent FGM (certificate in which parents declare that they will not circumcise their daughters when travelling to their country of origin), the enhancement of the chain approach in the six cities and its national roll-out in 2010, and putting FGM on the European and international agenda.

Following an evaluation of the pilot projects, Pharos explained in the multiannual FGM programme 2011–12 the Secretary of State for Health’s policy on FGM. This is outlined below and an update is given about the status of these actions to date (July 2012).

- An active policy from the Secretary of State on international developments regarding FGM, further development of medical care for women with FGM and the need for prevalence figures. Pharos is currently undertaking a prevalence study/situation analysis (see section on prevalence for a discussion of the possible impact of this study for policy development and implementation). The need for further development of medical care is further discussed in the subsection on the provision of services.
- A national roll-out of the prevention project on FGM (coordinated by GGD NL within Youth Healthcare 2010–11). Respondents have identified the national roll-out and the subsequent activities such as the issuing of the ‘Standpunt’ and the embedding of the issue of FGM into the medical and juridical chain as a milestone (for a detailed description of this roll-out, the ‘Standpunt’ and the embedding, please see the subsection on prevention).
- An active policy by the Ministry of Justice to increase the number of reports, to obtain evidence (including in asylum cases) and to present the results of the survey Criminal investigation and prosecution of FGM — The French practice. The Ministry of Justice in 2009 commissioned the University of Leiden to research the comparison between the criminal approach in France and in the Netherlands. This initiative was taken following parliamentary questions on the reasons for successful prosecutions in France and not in the Netherlands. The research was finalised in 2010, and the Ministry of Justice published an official reaction to the report. In conclusion, the research did not reveal any lessons for the Netherlands to learn from France at this moment (coordinated by GGD NL within Youth Healthcare 2010–11). Respondents have identified the national roll-out and the subsequent activities such as the issuing of the ‘Standpunt’ and the embedding of the issue of FGM into the medical and juridical chain as a milestone (for a detailed description of this roll-out, the ‘Standpunt’ and the embedding, please see the subsection on prevention).
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According to one respondent, some instruments have been developed, including those below.

- The 2009 guidelines on child abuse from the College of Prosecutors (‘Aanwijzing Kindermishandeling College Procureurs’) in which FGM is specifically mentioned. This instrument contains guidelines regarding actions to be taken when prosecuting child abuse (including FGM), and is targeted at the police, prosecutors and probation officers.
- The protocol on reporting child abuse by youth care officers to police and public prosecutors, which has been in use since April 2011 and includes FGM (as FGM is a form of child abuse). It focuses on collaboration agreements concerning reporting serious (suspicions of) child abuse by youth care offices and AMKs to the police.

Currently, penalty guidelines are being developed on child abuse and will be published in 2013. Another instrument that is currently being developed is the reporting code on child abuse and domestic violence. This code, already proposed in the advice from the commission in 2005, should enter into force in the beginning of 2013. The proposal for the law on a reporting code for domestic violence and child abuse will make it compulsory for organisations and independent professionals to establish a protocol covering how professionals should deal with signs of domestic violence and child abuse. The law will apply to healthcare, education, childcare, youth care, welfare and justice (which includes asylum).

- The interest of the Ministry of Foreign Affairs in building bridges between Africa, Europe and the Netherlands. In 2009 there was an international conference organised by the Secretary of State for Health and the Ministry of Foreign Affairs. The conference, entitled ‘Building Bridges Between Africa and Europe’, nominated four international ambassadors on FGM whose mandate is to put FGM onto the agenda and to build bridges between Europe and Africa. Another respondent stressed the importance of building bridges and called for deeper involvement of the Ministry of Foreign Affairs, as the issue does not only exist in Europe, but also in Africa:

‘Communities in Europe should be aware of campaigns and interventions running in Africa, and people in Africa should be aware of the legislation in Europe and how this works in Europe.

The most recent policy brief by the Secretary of State for Health, Welfare and Sport (December 2011) \(^1\) mentions that FGM is one form of violence that fits within the category of violence in interdependent relationships. In this policy, however, no separate details were found on future activities and policies regarding FGM.

With regard to prevention, one respondent mentioned that the national roll-out of the prevention project on FGM was finalised at the end of 2011, and tackling FGM became the responsibility of the municipalities as of 1 January 2012. The steering of the campaign against FGM at national level thus stopped on the same date.

**Driving forces and key actors**

As demonstrated by the above chronological outline and as underscored by most interviewees, the driving forces have been politicians (in particular Ayaan Hirsi Ali and Jet Bussemaker) and their clear political will to tackle FGM.

\(^1\) Brief Staatssecretaris van Welzijn, Volksgezondheid en Sport, 14 December 2011, ‘Aanpak van geweld in afhankelijkheidsrelaties’ [Letter from the Secretary of State for VWS (Veldhuizen van Zanten-Hyllner), December 14 2011 to Tweede Kamer, ‘Dealing with Violence in interdependent relationships’]
Moreover, one respondent mentions that Secretary of State Bussemaker, when she took up the post of Secretary of State for Health, Welfare and Sport, took on the issue of FGM (although it was foreseen that it would be included in the portfolio of the Minister for Youth and Family).

Respondents also mentioned the international pressure and consensus that exist as driving forces to tackle FGM. In Europe there is a general consensus among politicians and in the public in general about the reprehensibility of FGM and that it should be stopped. One respondent claimed there was international pressure to do something about FGM and mentioned also that the ‘PVV phenomenon’ was important (i.e. the close eye kept by this political party on everything and everyone that comes from across the borders and their demand that barbaric cultures should not be condoned).

The role of the media was underscored as well.

Finally, respondents mentioned a number of organisations as being instrumental in policy development. These include Pharos, GGD NL, Youth Healthcare, FSAN, the Council for Public Health and Care, and the Secretary of State for Health, Welfare and Sports. Key figures from the communities and some individual professionals were also highlighted.

Hard facts underpinning policy development
Given the absence of prevalence data, policies in the Netherlands regarding FGM in the past have not been developed based on hard data. The only facts that are present in the Netherlands are that FGM exists in the world, that families originating from practising countries live in the Netherlands and that the Netherlands cannot condone the practice. Respondents refer to the fact that the figures published in the report of the Commission Combating FGM, ‘A closer look at female genital mutilation — Measuring the magnitude — A survey to the nature, magnitude and attitude among professionals and at risk group in Amsterdam and Tilburg’ of 2005 (1), have been widely used to underpin actions. This report stated that 50 girls are excised each year in the Netherlands. However, respondents also pointed out that these figures were very rough estimates (based on interviews with key persons and professionals in two cities, which were extrapolated to the whole country), but that they were widely used as it was the only ‘evidence’ to push for a policy. One respondent stated that policies were based on ‘noise’ from the community.

IV. PREVALENCE AND DATA COLLECTION
In the Netherlands, attempts have been made since 2005 to estimate the number of girls and women with FGM. However, the methodologies used so far to collect these data were not able to provide representative and reliable data. They were either limited to geographical areas (two major cities) or provide insights into the number of women with FGM addressing the health sector only. As concluded in the country report of the desk research phase of this study, the studies that have been done, or are envisaged, did not use the same methodology or study population, nor have they been repeated over time, so no conclusions with regard to comparability or trends over time can be assessed.

The first study was conducted in 2005 (2), followed by a second one in 2009 (3), and a third study will be performed in 2012. All three were commissioned by the Dutch Secretary of State for Health, Welfare and Sport. The prevalence data in the document ‘FGM/C situation analysis in European countries — Discussion paper for expert meeting, The Hague, Netherlands, 12 and 13 September 2011’ (2011) does not concern a study but a background document in which data from the website of the National Bureau of Statistics were included (numbers of women from the 29 countries where FGM is practised living in the Netherlands). These data were compiled by the national FGM focal point for the purpose of an expert meeting in September 2011 (see paragraph below). The 2005 and 2009 studies were both based on surveys sent to professionals. The first study was a written survey addressing a mix of professionals in two Dutch cities, while the second one was a retrospective survey addressing midwives only in the Netherlands.

In 2005 Secretary of State Bussemaker was not in favour of investing money in prevalence estimations. However, she discussed the collection of prevalence data at EU level with a European Commissioner, Viviane Reding, who stated that collecting prevalence data was the responsibility of Member States. The collection of prevalence data was also recommended by the conference ‘Uniting Europe and Africa to Fight FGM’, which was organised by the Secretary of State for Health, Welfare and Sport and held in The Hague in November 2009.

It was found to be important that, from the onset of drafting the methodological framework for the prevalence data collection, this framework should, ideally, be useful for other countries in Europe too. Therefore, and for the purpose of providing input to develop the methodology for the situation analysis in the Netherlands, an expert meeting was organised in The Hague in September 2011, with experts from several European countries, to discuss quantitative and qualitative methodologies for prevalence and incidence estimates, and behaviour change assessments.

The upcoming situation analysis from Pharos (to be published at the end of 2012 or the beginning of 2013) will include estimates of the incidence and prevalence of FGM, based on statistical calculations. These calculations are based on data found in a systematic review of demographic


(2) Kramer et al, op cit.

(3) Korfker, D., Rijnders, M., Detmar, S., ‘Retrospectief onderzoek naar de prevalentie van vrouwenbesnijdingen of VGV in de verloskundigen praktijk in 2008’ [‘Retrospective survey on the prevalence of FGM or female circumcision among midwives in 2008’].
Impact of the upcoming situation analysis on policymaking

Some respondents assume that the upcoming situation analysis on FGM in the Netherlands will have an impact on policy development, while others state that the impact will depend greatly on the results of the study.

- One respondent states that the study will have an impact on policy development. For the moment, he states, there is little sound evidence on the number of women subjected to FGM and the girls at risk. If a change in the law is needed in order to make it compulsory for parents to consent to gynaecological examinations of girls aged less than 12 years old (13), more data are needed and the upcoming prevalence data might assist in taking a decision in this regard.

- Another respondent believes the situation analysis, although welcome and necessary, comes too late, as efforts to deal with FGM have been undertaken for two decades now. The same respondent fears that if the situation analysis does not bring the figures to the surface, and the prevalence is consequently low, the figures will be used to claim that FGM is not an issue in the Netherlands and hence no resources or effort should be invested.

- A third respondent believes that the impact will depend on the outcome. The secretary of state has invested a lot of resources in prevention and they are keen to know how to proceed, either investing in a nationwide approach on prevention or dropping the investments if the situation analysis proves that communities have reassessed the issue of FGM and are not in favour of it anymore.

- A final respondent made a link between the lack of accurate knowledge on the number of victims and the better targeting of financial resources. This respondent believes that better knowledge of the magnitude will provide ways to adapt or enhance the current criminal policy.

Registration systems

During the desk study, a number of policy documents were identified that discussed or ordered the instalment of registration systems.

Registration by public prosecutors — The public prosecutors register, among other things, abuse and FGM with a specific registration number. It was mentioned, however, that such registration is done by human beings; therefore the reliability of the system inevitably depends on the accuracy of the person attributing the right code to each case of FGM.

Registration of FGM in the perinatal registration system — In the policy letter of Secretary of State for Health, Welfare and Sport Bussemaker of 29 May 2009 (13) it was announced that obstetricians would structurally register FGM to provide reliable data and contribute to future policy development. The letter also stated that obstetricians would receive training to better detect and discuss FGM and provide appropriate care during and after pregnancy (13). Since 2011, it has been necessary to register FGM in the perinatal registration system. However, one interviewee confirmed that the registration is still not operational, as there is an issue with the maintenance contract of the registration system that does not allow frequent updates. For the next round of updates, a compulsory field will be included that will state whether or not a woman who is observed by a gynaecologist and an obstetrician has been subjected to FGM. There is currently no knowledge whether or not the system would include information on the type of FGM or the nature of FGM-related complaints. The respondent states that prevention is important for the Secretary of State for Health, Welfare and Sport, and therefore they mainly want to know how many girls are at risk of undergoing FGM and not what types are performed. The number of women with complaints due to FGM is, nevertheless, important in order to assess the need for care. For health professionals it will be pertinent to know what type of care they should provide, while this is less relevant for policymakers.

Registration at child abuse advice and reporting points (AMK) — Within the AMKs, FGM has been systematically registered for a couple of years. Under the heading ‘nature of the abuse’, FGM should be ticked when a case is reported and upon closure of the file. One respondent states that in 2011 there were 45 reports of suspicion of FGM, 25 of which were taken further by discussing it with the parents. In cases where it appeared necessary, a contract was signed with the parents in which the


parents committed not to excise their daughter(s). The same respondent emphasises that these 45 reports are only the reports known to Youth Care.

Data on FGM registered by the advice and reporting points should be referred to Youth Care NL. Youth Care NL provides data on FGM but only if FGM is the reason for an investigation, hence only the number of recommendations and consultations on FGM are provided (16). There is no registration of whether FGM has actually been assessed or not. Researchers can obtain data upon payment.

Registration of asylum requests based on FGM — The Immigratie en Naturalisatie Dienst (IND, Immigration and Naturalisation Service) does not register motives for requesting asylum, including FGM. The focal point informed the researcher during the desk research phase that the only way to retrieve these data is by searching all files.

Registration of FGM in the digital file of the basic Youth Healthcare data set — The in-depth phase showed that an additional registration exists in the Netherlands, i.e. the registration of FGM in the digital file of the basic Youth Healthcare data set (15) in GGDs. One of the respondents states that this registration is currently being improved, although the process is rather complex as there are three different files (it would be easier if there was only one digital file), and no additions can be imposed. In two files, FGM has already been included, and in its way, and will include a signal or flag system to assist professionals in dealing with FGM: if a professional opens the file, he/she can immediately see if FGM is an issue to be considered. The management information from this registration is not yet available (due to other priorities, technical issues to be solved, etc.). This ‘management information’ means that Youth Healthcare is encouraged to monitor data from this registration, as soon possible.

- From the municipal basic registration, the number of girls with at least one parent from FGM risk countries can be deduced.
- The proportion of these girls where the ‘Standpunt’ (for details of the ‘Standpunt’ see the section on prevention — roll-out of pilot projects) was implemented, the share of girls assessed to be at risk (according to the five levels in the ‘Standpunt’) and what kind of actions were undertaken. These can be very interesting data, if registration is done properly and if the ‘Standpunt’ is implemented for all of these girls. This can provide a manager with useful information to assess the performance of the team, the use of ‘Standpunt’, etc.

However, in order to have good registration, constant monitoring is necessary. Especially now, when political attention on the issue of FGM is weaker, registration, even if it is carried out, might not be performed very accurately.

Various registration systems do exist, but are quite recent and are suffering from teething problems, which are currently being taken care of. No central system or analysis has been put in place. Moreover, another respondent confirms that FGM is registered by AMKs, the Council for Child Protection and the police, but that linkages between the systems do not exist. Finally, it is worthwhile noting that the Pharos FGM focal point does not perform any registrations of FGM.

Two respondents identified some suggestions for improving the current registration systems.

- One believes that developing a separate database is the only solution for creating systematic registration of FGM (hospital records, reports, asylum requests, etc.). Joining together different databases that currently exist will be very complicated and expensive, as each system has its own technical characteristics, security issues and privacy regulations. It is also important that data be registered adequately. He suggested that municipalities could, however, request such an adaptation, as they have an interest in knowing where the problem of FGM is most concentrated, what the nature of the problem is, etc., to better target their resources and services.
- The other calls for data collection through hospital records and asylum centres. The respondent considers data important in order to assess the impact of interventions and to better target future interventions.

V. POLICY APPROACH TO FGM

The attention of policymakers in the Netherlands has evolved over time, from prosecution over prevention to provision of services, as confirmed by most of the respondents.

While in the beginning, when FGM emerged, prosecution was thought to be the solution, soon prevention was prioritised. Prevention is confirmed by all respondents to have received most attention in the Netherlands.

Protection is considered to be equally important by most of the respondents; some believe it is part of prevention while another respondent stated that protection is needed when prevention has failed. Prosecution is seen as the last resort, when prevention and protection have failed.

More recently (since 2010), provision of services has come to forefront, with several initiatives that have been developed in the area of healthcare for women who have undergone FGM. Psycho-social care for women with FGM is thought to need more attention in the future (see ‘Provision of services’ below).

The FGM policy, developed following the publication of the advice from the Council for Public Health and Care
in 2005 \(^{(1)}\), which was outlined by the Secretary of State for Health, Welfare and Sport, focused on prevention and prosecution (prosecution to be considered for its preventative effect). With regard to prosecution, this advice stated that law enforcement through gynaecological screening was not possible, but it was recommended that reporting and prosecuting should be enhanced through Youth Healthcare, and a duty to report and detect was recommended for the AMKs. Neither measure has been put in place, but as explained above there is now a legal proposal for a duty to establish a reporting code that tells professionals how to act in case of suspicion of FGM. There was also a recommendation to implement capacity-building initiatives for professionals, as well as preventing FGM at local level; both have been established through the pilot projects and training courses (2006–09).

Two respondents acknowledged that the two-track policy of the Secretary of State for Health, Welfare and Sport did not focus on the provision of services. However, provision of services has had more attention recently, with the setting up of specialised consultations, development of a medical protocol, etc. (see ‘Provision of services’ below).

In contrast to the former Secretary of State Bussemaker (who clearly prioritised different forms of violence, which included FGM), the current secretary of state focuses on linking the different forms of violence that fall under ‘violence in dependent relationships’, and prefers a generic policy for all forms of violence in dependent relationships, rather than developing policies for specific forms of violence. If specific actions are needed it will be done, but priority is given to an umbrella policy. Since the new cabinet was established in 2010 with the new Secretary of State for Health Marlies Veldhuijzen van Zanten-Hyllner, FGM has disappeared a bit from the focus of attention. This is confirmed by another interviewee, who adds that communities from countries where FGM is still practised. They play an important role in raising and the training of key persons and professionals. In fact, key persons are the members of the ethnic communities in which FGM is still practised. They play an important role in their own community as well as outside that community. As regards the most important target groups for prevention, one respondent named the communities which FGM is still practised. They play an important role in raising and the training of key persons and professionals. As stated above, prevention has been the ‘P’ that has received most attention in the Netherlands. This is clearly a consequence of the policy choice of Secretary of State for Health, Welfare and Sport Bussemaker during the mid-2000s, in which girls had to be prevented from being subjected to FGM. According to her, prevention means preventing female genital mutilation from happening, in a structural way. One respondent mentions awareness raising and the training of key persons and professionals. Another respondent states that prevention in the Netherlands consists of information being provided to the communities by the key persons and Youth Healthcare and information being provided to the healthcare sector, as well as information being provided to asylum seekers on the legal situation of FGM in the Netherlands.

A milestone in prevention, as mentioned above, was the initiation of the pilot projects in 2006, which ran until 2010. In 2010 and 2011 a national roll-out was carried out for these pilot projects. Since 2012, prevention has been taken on by the GGD \(^{(2)}\), i.e. at municipal level. The full details of the ‘pilot prevention projects’ are outlined below.

The pilot projects on FGM in the Netherlands: chain approach, key persons, training courses and protocols

The pilot projects had three main pillars: (1) prevention/ information through the community-based organisations (information meetings for and by target groups and house visits by key persons \(^{(3)}\)); (2) information through Youth Healthcare (parents who come to the consultations or children who go to school doctors are informed about the hazards of FGM); and (3) training and informing the medical and judicial actors (chain approach).

Key persons are the members of the ethnic communities in which FGM is still practised. They play an important role in their own community as well as outside that community. They carry out home visits and organise informative meetings. Home visits offer specific opportunities and possibilities because they are small scale. They offer good opportunities for a confidential conversation, more so than during information meetings. New key persons can be detected during these home visits and meetings. Key persons are recruited by the management of community-based organisations, based on a profile drawn up by Pharos and FSAN. The pilot prevention projects learned that the effectiveness of the home visits is increased if there is an investment in capacity building and the equipment of key persons. Pharos offers training courses for such key persons, in collaboration with FSAN.

The chain at the time of the pilot projects consisted of Youth Healthcare (GGD) \(^{(4)}\), AMKs, the Council for Child Health, FSAN, the Jeugdgerechtshof and the municipalities.


\(^{(2)}\) Municipality Healthcare (Gemeentelijke Gezondheidsdienst).


\(^{(4)}\) In the Netherlands, youth healthcare consists of healthcare for children from 0 to 4 years (known as consultation offices and which may operate separately from the GGD) and youth healthcare for children 4 to 19 years, which are always included in a GGD. The GGD is the ‘Gemeentelijke Gezondheidsdienst’ (municipal healthcare). There are about 400 municipalities in the Netherlands, with 29 GGD offices.
Protection (21) and the police. The approach is characterised by a number of elements:

- the involvement of all relevant stakeholders;
- the role of each stakeholder in case of a report of FGM or a girl at risk being described in the ‘Standpunt’ (see section ‘Roll-out of pilot projects’ for details on Standpunt);
- regular meetings being organised so that each stakeholder knows the role of the other stakeholders;
- instruments being developed to support the activities of the actors;
- actors being trained.

Later on, the chain was broadened to include key persons, midwives, maternity care, general practitioners, gynaecologists, paediatricians and Pharos.

The pilot projects were developed in six of the Netherlands’ big cities, where most of the communities from countries where FGM is still practised were living (Rotterdam, Amsterdam, The Hague, Utrecht, Eindhoven and Tilburg), and the following activities were carried out.

- An acting protocol was developed for the juridical chain, in particular for the child abuse advice and reporting points (Advisie en Meldpunt Kinder mishandeling — AMKs) and the Council for Child Protection (Raad voor de Kinderbescherming — RvK) on how to react to reports of FGM affecting minors (22). A responsible focal person was appointed (aanachtsfunctionaris) in each AMK, as well as in the RvK (there are 13 or 14 AMKs, one in each province (12) and one or two extra) (23). Training is provided for the juridical chain.

- A medical protocol was developed for the medical chain, the ‘Medical care model protocol for women and girls with FGM — Prevention, guidance and treatment of women after FGM’. It provides recommendations for healthcare professionals delivering care (medical, psychosocial and sexual) to women and girls with FGM (developed by a number of health organisations and Pharos, and finalised in June 2010). Training is provided for the medical chain.

- With regard to the second pillar — information through Youth Healthcare — a conversation protocol was developed as far back as 2005. The conversation protocol was meant to guide doctors and nurses in Youth Healthcare in tackling the issue of FGM during regular contact moments with parents and families (originating) from countries where FGM is practised. The protocol assisted in assessing the risk, the moment at which such a conversation must be had and how it must be carried out (on a structural basis). This protocol was later revised to the ‘Standpunt Preventie van VGW door de Jeugdgezondheidszorg’ [Position on the prevention of FGM by Youth Healthcare] (24).

- An element of utmost importance in the pilot projects was the inclusion of key persons, the first pillar of the pilot projects. Key persons are members of the ethnic communities where FGM is still practised. They play an important role in the own community as well as outside that community. They were introduced as a strategy to tackle FGM within the communities from the beginning of the 2000s. It was considered important to involve people from the communities themselves in the prevention of FGM, as they speak the same language and have affinity with the subject of FGM.

‘Although Youth Healthcare can provide information on health, key persons can really enter into discussions regarding family pressure, religious aspects, group influences’ (25), etc.’

In the pilot projects, they carried out home visits and organised informative meetings. Home visits offered good opportunities for a confidential conversation, which was not always possible during the information meetings. New key persons can be identified during these home visits and meetings. Key persons are recruited by the management of community-based organisations, based on a profile drawn up by Pharos and FSAN. The pilot prevention projects learned that the effectiveness of the home visits is increased if there is an investment in capacity building and the equipment of key persons. Pharos offers training courses for such key persons, in collaboration with FSAN (26). Key persons provide information on FGM to their own communities and are trained to perform these tasks. It was agreed that key persons would be assigned to Youth Healthcare (healthcare), rather than child protection, as key persons did not want to be associated with AMK (child protection).

The pilot projects were evaluated and two evaluation reports were published (Bureau van Montfoort and B & A (27)). The evaluation showed that the taboo was broken and the subject was now discussed. However, she also stated that there was no hard evidence of the impact of the pilot projects, as there was no baseline assessment prior to the

(21) The RvK is contacted when the situation of a child and his family is precarious, the voluntary support is not (or no longer) sufficient or in case the family does not accept support (http://www.kinderbescherming.nl/wat_doet_de_raad).


(23) According to the AMK website there are 29 AMKs. The RvK is contacted when the situation of a child and his family is precarious, the voluntary support is not (or no longer) sufficient or in case the family does not accept support (http://www.kinderbescherming.nl/wat_doet_de_raad).


(25) Decisions are not taken individually when it comes to FGM, so the influence of the group is very important to tackle, which is done by key persons.


pilot projects. One interviewee mentioned that, following the evaluations, a lot of parliamentary questions were raised concerning the results (which were not always found to be SMART) and concerning the lack of prevalence data. Nevertheless, it was decided to roll out the expertise from the pilot projects at national level, and GGD NL was appointed to coordinate it.

The key achievements from the national roll-out include the following.

- The development of the ‘Standpunt Preventie van VGV door de Jeugdgezondheidszorg’ (Position on prevention of FGM by Youth Healthcare) (\(^\circ\)). This ‘Standpunt’ (\(^\circ\)) explains in detail the roles and protocols of each actor in the chain. Actors include Youth Healthcare, key persons, midwives, maternity care providers, GPs, gynaecologists, paediatricians and AMKs. The Healthcare Inspectorate monitors whether Youth Healthcare and school doctors work according to this ‘Standpunt’. In principle, when a girl at risk is identified at a YHC unit, the risk assessment is done following the ‘Standpunt’. Each municipality decides how the ‘Standpunt’ is incorporated in their structure and how key persons are integrated. The fact that the Healthcare Inspectorate is monitoring the use of the ‘Standpunt’ is considered to be a very important element in the implementation and monitoring of the use of the protocol, as well as a success indicator (an issue being dealt with by the inspectorate is very helpful in setting standards and pushing actors to act).

- Development of the statement opposing female circumcision, developed jointly by the Secretary of State for Health, Welfare and Sport and the Ministry for Security and Justice. This statement declares that FGM is illegal in the Netherlands and is supposed to help parents to resist family pressure to get a girl excised. It has been translated into several languages.

- Enhancement of the registration of FGM in the digital file of the basic data set of Youth Healthcare in order to include a signal or flag system to assist professionals in dealing with FGM (if a professional opens the file, he/she can immediately see if FGM is an issue to be considered) and to enhance management information from this registration (see ‘Registration systems’ above).

- Obstetricians were included in the chain approach to tackle FGM. An e-learning module was developed, which is also suitable for GPs and gynaecologists (see ‘Successes and challenges’ and ‘ Provision of services’ below).

- Public healthcare for asylum seekers was added in the approach as a pillar (as of 2010 and 2011). Instruments were developed, including the information DVD on FGM ‘An important decision’, and the script ‘Group information to asylum seekers for the prevention of FGM’, both published in November 2011.

- Care for women with FGM is now coming to the forefront with the proposal for funding by GGD to the Secretary of State for Health, Welfare and Sport to establish a number of consultations for women with FGM that key persons will promote among the communities. These consultations will be very culturally sensitive and targeted at providing answers to questions and providing care (see ‘ Provision of services’ below). Eventually they should be embedded in the regular provision of care, i.e. a hospital participating in these consultations will promise to finance (provided they see a sufficient number of women) the care for these women.

**Sustainability of the activities and results of the pilot projects**

The pilot projects were planned to run from 2006 to 2009, after which the municipalities were supposed to have included the issue of FGM in the GGDs, with budgets from the municipalities (\(^\circ\)). However, since the municipalities were not aware that budgets had to be set aside for this, the pilot projects 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 the embedding of the pilot project during these extension periods (extensions paid for by Secretary of State for Health). However, by March 2010, the pilot projects were still not structurally embedded. The secretary of state then decided to give a budget to the GGD NL for 2 years to make sure that the approach and use of the ‘Standpunt’ was embedded at municipal level, within Youth Healthcare (GGD). The secretary of state also provided a budget to FSAN and VON for a national campaign (\(^\circ\)). The idea was that after these 2 years the municipalities should really have it embedded.

The embedding of the issue in the medical and juridical sector is considered to be covered, as protocols have been developed. The follow-up of the ‘Standpunt’ by the Health Inspectorate is an important element with regard to sustainability. However, the main issue regarding sustainability is the embedding of the key persons at municipal level. Since the decentralisation of FGM policies (to the municipalities) has now been implemented, the financing of the key persons has dropped. This problem had already been acknowledged some years ago and reported to the Secretary of State for Health, Welfare and Sport. The secretary of state was, however, not allowed to finance once again the inclusion of the key persons in the chain approach (due to the issue of sharing responsibilities as stipulated by the societal support law, which states that key persons cannot be financed nationally on a structural basis). As the municipalities (418 in total) did not pick up this financing, this important pillar has dropped out.

\(^{(*)}\) In the Netherlands, local activities fall under the Law Societal Support and violence in dependency relations falls under this law; which means that municipalities are responsible for FGM. The authorities are only the “system-responsible”, which means that they have to monitor if the law works and if there are adaptations needed to the law. The implementation of the law is the responsibility of the municipalities. The authorities maintain a horizontal justification, i.e. municipalities should monitor if their citizens are satisfied, and this is measured through the elections (voting for a political party with a particular programme). The authorities hope that in this way, municipalities are doing a good job.

\(^{(*)}\) ‘Say no to FGM’ campaign.


\(^{(*)}\) Because the ‘standpunt’ is not based on evidence (no research was done to provide evidence of the effectiveness of this instrument) but on experience from the practice, it is called a ‘standpunt’, rather than a guideline.
‘This is a loss of capital, and a big disappointment as we invested a lot in training key people.’

‘The main problem is the municipalities not giving priority to the issue of FGM (as there are so many other priorities to attend to).’

One respondent mentioned that solutions are currently being sought to deal with this constraint (32).

According to one respondent, it is also important to take into account that, in the long run, there is a considerable flow of persons in the chain approach, and the mutual exchange of experiences among actors and inclusion of new actors needs constant monitoring.

Another remaining challenge regarding prevention is the fact that there are more than 400 municipalities, with their own policies and different sizes of communities from African countries at risk of FGM. Not every municipality will start a campaign for only 10 at-risk girls, so to speak. Although outreach is considered important, in practice it is scattered.

Finally, a barrier for prevention that was noted by one respondent was that people in favour of FGM are hard to reach for prevention, even by key persons. As the key persons are well known within their communities, those in favour of FGM know them as well and will not easily talk to a key person. The respondent stated that it is feasible to reach them, but that this is a long-term effort. People who are already sensitised are more easily reached. However, monitoring of this ‘easy-to-reach’ population group is advisable to assess whether their attitudes and behaviour change over time due to group pressure. Within YHC, which should report girls at risk, it is noted that socially acceptable answers are given when dealing with parents from countries where FGM is practised. They anticipate this by using specific conversation techniques, however these are only partially successful and socially acceptable answers should be taken into account.

V.2. Protection

Child protection

The laws and instruments with regard to child protection as detailed in the country report of the Netherlands are reiterated here, for the sake of clarity.

• The law on the mandatory reporting code for domestic violence and child abuse (Wet meldcode huiselijk geweld en kindermishandeling) also covers FGM. Professionals will be obliged to have the reporting code available, to use it and to attend a course on how to use it (33);
• The child protection law (Article 254(1) and 261 of the Civil Code) provides for measures such as removing the child from the family or placing the child under supervision (34) (Leye and Sabbe, 2009);

The guidelines for detection and prosecution of child abuse by the College of Public Prosecutors, from 2010, provides instructions for police and public prosecutors for the detection and prosecution of child abuse, including FGM. The instructions contain a code of conduct in cases of child abuse, child neglect or violence against themselves and/or others in their environment. The guidelines introduce the duty for the police and public prosecutors to register instances of child abuse, which will give more insights into its nature and magnitude. The child abuse guidelines have the status of a quasi-law that contains binding rules for the police and public prosecutors (35).

Youth Care Netherlands (Jeugdzorg Nederland) is one of the main agencies in charge of child protection. It consists of Youth and Pedagogic Support and Youth Care offices. Youth and Pedagogic Support (Jeugd en Opvoedhulp) contain all organisations, except Youth Care offices, that can assist children and their carers with pedagogic and parenting problems. Youth Care Netherlands counsels children and educators with educational and parenting problems. Experts from the Youth Care offices provide assistance or refer clients. They implement measures that are imposed by the juvenile court. The court may decide that children or young people need protection. Through Youth Care they can be placed under supervision or into custody. If the situation is critical, the court may take a child away from home immediately. Another form of forced youth care is juvenile probation; after their punishment, the judge can decide that young people need support for their reintegration into society. Child abuse advice and reporting points (AMK) are part of the Youth Care agency. Each Youth Care agency has an AMK ‘in house’.

One interviewee found ‘protection’ difficult to separate from ‘prevention’, and believes it falls under prevention. In the same respect, another respondent stated that once protection is needed, it means that prevention has been bypassed.

(32) Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Römkens, R.
(33) Ley, E. and Sabbe, A. Responding to female genital mutilation in Europe — Striking the right balance between prevention and prosecution, ICRH, Gent.
(34) Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Römkens, R.

There is currently a tendency to focus more on and provide funds for this type of functioning (for GPS, neighbourhood nurses, etc.) and the Secretary of State for Health, Welfare and Sport wants to see, with FSAN, how FGM can be embedded in such an operation. For example, if a girl is at risk, a key person can be employed (small fee and transport costs). But this embedding of key persons is a challenge, especially with regard to providing information on care to communities.
The respondent from Youth Care said protection is important: the moment there is a situation in which a girl might be submitted to FGM as action will be taken. The findings of research by the Ministry of Justice (not yet published) on reports of FGM to AMKs revealed that the majority of reports about (suspicions of) FGM occurred by reporting other issues such as neglect, homelessness or other threats to the child. In the case of children coming from an FGM-risk country, some AMKs considered this to be a possible ‘at risk situation’ and tackled the subject of FGM with the parents (questions asked included their opinion about FGM, their intentions regarding travel to their country of origin, the status of FGM in their daughters, their intentions regarding performing FGM on their daughters, etc.). In case of a threat, it is suggested to the parents that they could be forbidden to leave the country with the daughter. This is the case if a supervision order is issued. A temporary under supervision placement (jointly decided by AMKs, Youth Care, RvK) is necessary in case of any urgent and serious situation that requires the child’s removal from home. Allegedly, most parents will deny that they will carry out FGM, upon which a contract is signed that specifies that the girl is intact and in which parents promise that the girl will remain like that. Gynaecological check-ups could be done upon return, provided there is a supervision order, but the respondent believes that this measure has not been taken so far. Therefore, protection is difficult to tackle if the resources, i.e. check-ups, are not put in place to detect FGM in all persons where there is a possible risk. Prevention is hence more appropriate: talking with the parents about their intentions regarding FGM, their intentions regarding travel to their home countries, etc. Lack of sufficient training of professionals responsible for child protection might still be an issue, but the respondent believes the lack of cases is more important, as there are very few opportunities to gain experience and build capacities to deal with the issue. It may be that the issue of prevention within the offices of Youth Care might need to have some more attention, as there are very few opportunities to gain experience and build capacities to deal with the issue. The respondent acknowledges that protection and assessing the risk is not easy; although the subject of FGM is nowadays easily tackled with parents. The problem remains that not every girl is reported to the AMKs. There must already be a suspicion reported by a general practitioner, a Youth Healthcare professional or other problems identified, through which FGM came up. In case there is a real risk, for example if parents declare their intention to excise their daughter upon travelling to Africa, the supervision order is issued nearly immediately, and the parents are forbidden to travel. But so far, no parent has ever declared this.

The ‘at risk of FGM group’ as defined by the respondent of Youth Care NL relates to children born to a parent (or parents) that come from a country where FGM is practised (0–18 years).

Asylum protection
As regards asylum protection, one interviewee claimed that protection is provided in the Netherlands for asylum-seeking women and girls who fear being subjected to FGM, by granting them asylum for this reason. According to her, once 5 years of temporary permission have been granted, a decision must be taken and a medical check-up is done to assess if a girl has been subjected to FGM. This measure has in place since 2011.

V.3. Prosecution
There is no specific criminal law on FGM in the Netherlands. FGM is liable to punishment on the basis of assault (Articles 300 to 304 DPC) or the prohibition against unauthorised medical performances (Article 436 DPC). People who assist, aid, procure or pay a third party to undertake FGM are also liable to punishment, along with the one who actually performs the mutilation (Articles 47 and 48 DPC). The maximum penalty is 12 years’ imprisonment, but this maximum can even be increased by a third if FGM is carried out by the parents or the spouse of the victim (Article 304(1) DPC).

As for health law, physicians who cooperate in performing FGM can be tried on the basis of the medical disciplinary rules (Articles 47 and 96-ff of the Individual Healthcare Professions Act — Wet BIG).

Since 1 February 2006, the requirement of ‘double criminalisation’ has been abolished with regard to FGM. Dutch law also applies to persons with Dutch nationality or persons who are resident in the Netherlands if they have performed FGM abroad, even if the FGM is performed in a country that has not criminalised the behaviour (56). A more recent change is that the statute of limitations (after 20 years) for prosecuting cases of FGM has been prolonged. As of 1 July 2009, the period starts from the moment the girl reaches the age of 18. With very serious forms of FGM the limitation period even starts from her 20th birthday. This means that a woman has until her 38th birthday to file a report with the police (57).

The Netherlands does not consider it necessary to have a specific criminal law (despite parliamentary questions demanding such a specific criminalisation), as FGM is a form of child abuse and the laws that apply to child abuse are sufficient to punish FGM. She believes that a specific criminal law will not lead to more cases, and would only have a symbolic function. This respondent also considers that a specific criminal law is not necessary to set a clear public standard that FGM is forbidden and punishable. One interviewee underscores this and states that prevention and behaviour-change interventions are much more important.

The respondents underlined the preventative effect of the criminal law. One interviewee believes that the fact that FGM can be prosecuted is a preventative measure. This is highlighted by another respondent, who believes that although prevention is key — the law has an important role to play as communities are afraid of the law.

‘A woman said to me that she was afraid of performing FGM on her daughter as she did not want to go to prison, but that she still wanted her daughter to be circumcised.’


(57) Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Dutch national report, van der Aa, S. and Römkens, R.
The implementation of the law

Procedure to follow

The procedure that needs to be followed in cases of girls at risk of being subjected to FGM is an investigation that starts when there is a report of a child at risk to the AMK, for example by Youth Healthcare. Here, if necessary, the Council for Child Protection (Raad voor Kinderbescherming — RvK) is contacted. The Council for Child Protection is an independent official body, at national level, to advise children’s court judges on the necessity of measures for child protection and to monitor child protection (e.g. if it is safe enough for a child to return home). In case there is an urgent necessity to take action, direct access to the RvK is possible, and consultation with the AMKs/YC is skipped. But, in principle, any reports should first pass through the offices of Youth Care, so they can investigate. A temporary supervision order (jointly decided by AMKs, Youth Care and RvK) is necessary in the case of any urgent and serious situation that requires the child’s removal from home. No such supervision order has yet been issued for reasons of FGM.

If it concerns a case of FGM that has already been carried out, the police are contacted and a criminal procedure is started. The police will also contact Youth Care to make sure youth protection services are involved. Youth Care has four other tasks besides providing access to youth care: youth protection (this means implementing the measures of the children’s court judge, such as supervision orders (onderzoekstelling — OTS) and guardianship); youth probation (jeugdreclassering), which forms the criminal approach; the functioning of the AMKs; and the children’s helpline.

Number of cases reported/investigated, court cases

As of now there has only been one criminal court case (2009). This case was an atypical FGM case, since it concerned a Moroccan man (Morocco is not an FGM-risk country), who was accused of general child abuse and FGM. He was acquitted of FGM, but was convicted of child abuse.

Taking into account the information collected during the desk research for this study, child abuse is reported to the child abuse advice and reporting points. By 1 December 2007 there had been 22 reports of suspicion of FGM at these advice points, of which eight were investigated, resulted in 14 recommendations. Since 2007, all 15 child abuse advice and reporting points have included FGM in their registration system. Registration can also be done at the Council for Child Protection or with the police.

There have been no supervision orders relating to FGM so far. Before 2009 there had never been any reports of FGM to the prosecutor. In 2009 there were four cases, in 2010 three, in 2011 two cases, and in 2012, up to this point, two.

Challenges to implementation: non-reporting and lack of evidence

The lack of successful prosecutions was said to be a problem. Cases of parents that are prosecuted might be good to show that the law is not a ‘paper tiger’ (meaning something that looks dangerous but is not). Most respondents stated that the lack of successful prosecutions is due to difficulties in reporting and in finding sufficient evidence.

As demonstrated above, very few reports are done in this respect. This is because of professionals’ reluctance to report for fear that the parents will be sentenced to jail. These professionals draw parallels with France, where parents were punished with fines, while the perception in the Netherlands is that parents go to jail. One respondent, who also noticed a reluctance by youth healthcare organisations to report, confirms this. They are often confronted with other problems in families, and FGM is only one element of it. These professionals weigh their decision to report or not, and will act in the best interests of the child, which might be to prioritise keeping good contacts with the family instead of reporting to the police. The Secretary of State for Health, Welfare and Sport tried to find a solution for this to appoint focal persons on FGM within the AMKs, who are also better informed on procedures to be followed by prosecutors.

Another respondent believes that it is a partnership problem: subjecting all Dutch children to a gynaecological check-up by YHC to detect child abuse might be considered. The respondent finds it remarkable that all kinds of physical examinations are done to check the health status of children but genitals are not examined, even though this might have a strong preventative function. The respondent believes that health professionals will need training to be able to perform such examinations and to have the capacity to detect all types of FGM, and acknowledges that the examination itself is rather invasive as well, as the labia need to be opened in order to check the status of the labia and the clitoris.

A third respondent states that medical expertise regarding FGM is insufficient in the Netherlands due to the lack of cases. To deal with this problem, the Ministry of Justice organised a symposium in 2010 in collaboration with the Secretary of State for Health, Welfare and Sport to build capacities for medical professionals, i.e. to categorise an abnormality in the genitals as congenital or applied (i.e. FGM). The Ministry of Justice supported this symposium in order to increase the number of reports.
Respondents identified the following barriers to finding sufficient evidence to bring a case successful to court.

- A complicating factor for finding evidence is when a girl has been excised in the country of origin.
- The complicity of the parents is hard to prove, when they claim grandmothers or others did the excision in the country against their will.
- When others have performed FGM, prosecuting them is complicated from a criminal law perspective.
- Proving that FGM has been done before or after 2006 is complicated (as of 2006, the principle of extraterritoriality was introduced). According to the respondent, this will soon be a bit easier for girls born after 2006.
- For Dutch criminal law, evidence must be found to prove that parents have actively consented to FGM or facilitated the act (whereas in France this is different: parents have been sentenced on the basis of proof that they should have known that FGM could happen and that therefore they did not protect their girls).

Finally, one of the respondents tackled the issue of finding FGM practitioners (some of them do this for a living) operating in the Netherlands. She states that it remains a challenge to invest in detecting and prosecuting these persons in the Netherlands. As of now there are no concrete facts to prove that these persons are in the Netherlands. Some rumours exist that girls are taken to the UK or Africa to have the procedure done. The communities are particularly closed up about this and will not report an FGM practitioner or parent easily. To demonstrate this, the respondent mentions a survey among key persons to investigate whether they would report if they had knowledge of FGM or a girl at risk, and it proved that the willingness to report among key persons was nil. She also states that there has been a rumour that an FGM practitioner addressed the asylum centre in Alkmaar to present her services to women in these centres, whom she asked whether they had any daughters that still needed to be excised. Unfortunately, the asylum centre did not take any action at that time (some years ago).

This respondent also believes that in order to find FGM practitioners or detect cases, it will be important to make the population more aware.

‘Neighbours, who might see a lot of people go in and out of a house, or hear babies scream. But in order to raise awareness, a big public campaign is necessary and that is expensive.’

V.4. Provision of services

According to one respondent, provision of services is now given increased attention, in particular care for women who have been excised. This is confirmed by another respondent, who states that after the pilot projects, provision of services, i.e. care for women with FGM, came more into the picture, as this was not sufficiently taken care of during the pilot projects (this was assessed by the Secretary of State for Health, Welfare and Sport during working visits to the cities where the pilot projects were implemented). During the pilot projects, it was noted that women (who were targeted to prevent them from performing FGM on their daughters) started to link their health complications to FGM, due to the information given to them. The focus during the pilot projects was on prevention. Therefore, Youth Healthcare, which is focused on children, could not organise care for women who already had undergone FGM. Services have always given attention to primary (39) and secondary prevention of FGM, but that recently care is targeted at older women who enter services via their gynaecologist or obstetrician (tertiary prevention). One respondent also confirms that provision of services is gaining more attention now, and states that care for women should include provision of information and looking after the health complications of the women, as well as providing psychosocial care.

Several initiatives with respect to healthcare for women who have undergone FGM have been developed in the recent past or are currently being developed, so basically, the provision of health services for women with FGM was initiated in 2010. The initiatives on provision of health services, as mentioned by the respondents, are listed below.

- The ‘Medical care model protocol for women and girls with FGM — Prevention, guidance and treatment of women after FGM’ provides recommendations for healthcare professionals delivering care (medical, psychosocial and sexual) to women and girls living with FGM (developed by a number of professional health organisations and Pharos, 2010).
- The development of the e-learning module by the Royal Dutch Organisation for Obstetricians (KNOV), which will be published in October 2012, and will also be accessible by gynaecologists and GPs (see also ‘Successes and challenges’).
- The training of 10 expert obstetricians as reference experts concerning FGM (in 2010).
- The setting-up of low-threshold consultations for women with FGM in Rotterdam and Amsterdam. This initiative is still in the experimental phase. The consultations in Rotterdam stopped in April 2012 because of a lack of funds, and those in Amsterdam stopped because the pilot project was short and ran during the Christmas period in 2011, which resulted in lack of women coming to the consultations. Since July 2012, consultations have been initiated in The Hague (that will run until December 2012) where a nurse is referring women with FGM to appropriate care services. With regard to these consultations, one interviewee explains that in the Netherlands, it has been demonstrated that the threshold for those women to ask for help is rather high. In the Netherlands, people go first to their general practitioner (GP) when they have health issues. However, since the barriers to consulting GPs about FGM-related issues are high, there is the assumption that these women are not well

(39) Primary prevention is preventing FGM from being performed; secondary prevention is early detection of girls at risk or performed FGM; tertiary prevention is preventing the consequences of FGM from getting worse (based on definitions of prevention as provided on the website http://www.nationaalkompas.nl/preventie/wat-is-preventie).
looked after. The threshold is high because women are afraid that GPs will not know how to look after FGM-related complaints, since GPs only treat a few patients with such complaints (but also because women do not necessarily relate their health problems to FGM). It is also a possibility that GPs do not recognise complaints, e.g. menstruation complaints are frequently mentioned in FGM cases but might not be linked to FGM by the GP if he/she is not knowledgeable about this. One respondent states that these consultations will be very culturally sensitive and targeted at providing answers to questions and providing care, and eventually they should be embedded in the regular care systems, i.e. a hospital participating in these consultations promises to finance (provided they see a sufficient number of women) the care for these women.

- In the Amsterdam-based hospital ‘Onze Lieve Vrouw Gasthuis’, a team was established in 2010 to provide care for women with FGM (reconstructive surgeries), in collaboration with Pharos and the Nederlandse Vereniging voor Obstetrici en Gynaecologen (NVOG) [Dutch Society of Obstetricians and Gynaecologists].

It should be noted, however, that two respondents mentioned that psychosocial care should be provided for women that have been subjected to FGM. One of them states that provision of services, in particular care for women who have undergone FGM, should be embedded in a broader framework of health and care for the whole family, which has not gained a lot of attention so far. She particularly mentions the mental healthcare authority (GGZ — Geestelijke Gezondheidszorg) in the Netherlands that has, until now, not been involved in or taken up the issue. She finds this remarkable, especially since a study was done by Pharos on the psychosocial effects of FGM on women living in the Netherlands (40). According to her, some women are looked after within GGZ, but requests by Youth Healthcare to involve GGZ in the chain or to refer women with problems to them have so far been denied.

One interviewee considers that care for women with FGM in asylum centres should not be neglected. Another mentions that public healthcare for asylum seekers was added in the chain approach as another pillar (as of 2010 and 2011). In the beginning, this was not really taken up and was perceived as a missed opportunity because, upon entering the Netherlands, all asylum seekers are grouped together and more easy to reach in order to provide information on FGM. Information was provided but on an ad hoc basis. Now, instruments have been developed, including the information DVD on FGM An important decision, as well as the script ‘Group information to asylum seekers for the prevention of FGM’, both published in November 2011. When FGM is the basis for granting asylum, a medical declaration is provided (at the beginning of the procedure and at the end).

V.5. Partnership

The respondents identified a number of partnerships, which are described below.

The chain approach

As detailed in the section on prevention, the chain approach is a unique type of partnership created in the Netherlands to bring together all relevant actors that are involved in tackling the issue of FGM.

In the chain approach, all relevant actors are cooperating, each according to their role. For example, YHC can signal, but will not examine if a girl is actually at risk. This is not their task, and they do not want to do this, as they want families to continue to come to their consultation offices. The task of assessing if there actually is a risk or if FGM has been performed is provided by another actor. If there are gaps between the actors within a chain then it will not work. It is important that each actor knows about the other actors’ roles in the chain. For example, the public prosecutor requests to be involved at an early stage when there is a case, to understand how the issue is dealt with in the field, and for fieldworkers to understand what the role of the public prosecutor is. The chain approach includes all stakeholders in order to provide care for women as well as prevention and protection for their daughters.

Focal persons

One respondent states that working with focal persons (aandachtsfunctionarissen) in the chain approach (as is the case for Youth Care, which is part of the chain through the FGM focal persons within Youth Care) is used quite often, especially in cases where a problem is not very common, for example FGM. In that case, an organisation appoints one or two focal persons who have the issue in their portfolio. These persons are contacted with questions on the topic and they can refer to other specialists or deal with the topic. It is a strategy to ensure that expertise exists within the organisation without having to train everyone in the organisation. Focal persons from all Youth Care offices share their experiences with each other to keep their expertise up to date.

Key persons

Key persons are an important element of the chain approach, and are very important in the chain to link communities and professionals.

Pharos’s focal point on FGM

This is a national centre where everyone can address questions related to FGM. The Minister for Health Hans Hoogervorst assigned the name ‘focal point on FGM’ to Pharos in 2005. The main tasks are to map available knowledge that stems from research, practice and experience and to inform and advise others, i.e. ministries, policymakers, professionals and at-risk groups. Pharos is a ‘knowledge broker’, looking at and collecting available information, expertise and knowledge, bringing actors together and/or disseminating this information to relevant actors. Pharos also provides training for professionals and develops interventions. Interventions include the following.

(1) Monitoring the acting protocol for AMKs (through an advisory committee that contains the involved chain partners) and organising annual meetings for the AMK FGM focal persons. The advisory committee decides jointly if the acting protocol needs to be revised, and Pharos carries out the revisions, calls for meetings, etc.

(2) Co-authoring the ‘Standpunt’, which is monitored through YHC.

(3) Monitoring the low-threshold consultations once they are implemented.

(4) Producing awareness-raising publications (e.g. leaflets). Pharos’s work is based on an annual work plan, which contains a section on FGM (5). The work plan is submitted to the Secretary of State for Health, who finances the implementation of the work plan. The multiyear programme on FGM has planned the following activities:

- FGM in the Netherlands: a situation analysis (2011–13);
- ‘No to FGM: learn from successful approaches from Africa to changing behaviour (alternative rites of passage, behaviour change communication)’ (2011–13);
- medical and psychosocial care (2011–13);
- national focal point on FGM and actual cases and policy advice (2011–13);
- training (2011–13);
- the ‘No game’ project (2012–13).

Most of the activities are financed by the Secretary of State for Health, Welfare and Sport, but for some activities additional funding needs to be sought. Training courses are upon request and are paid for by clients (6). However, if the Secretary of State for Health decides that certain issues are no longer valid, these issues will be deleted from this work plan. At the moment, FGM is still in the picture, nonetheless future attention will depend on the forthcoming political situation. In 2006, at the start of the pilot projects, about 20 % of hours and resources were invested in FGM by Pharos, and in 2012 this was 13 %.

National steering group on FGM

There is a national steering group on FGM, initiated by the government, with the mandate to bring knowledge together and to monitor actions. It includes all the actors in the chain: the Ministry of Justice, Pharos, the Secretary of State for Health, Welfare and Sport; GGD, the Council for Child Protection, FSAN, VON, the public prosecutor, Youth Healthcare, Youth Care, key persons, etc. The initiative to call for meetings lies within the Secretary of State for Health. However, the steering group has been silent in recent years, as the programme officer on FGM within the office of the Secretary of State for Health prefers to work with ad hoc contacts, as this goes much more quickly and smoothly than planning a meeting with all stakeholders every month or two. This opinion is shared by most respondents.

International partnerships

One interviewee mentioned that international partnerships were also formed in the framework of Daphne projects.

Sustainability meetings

Following the finalisation of the pilot projects, some Youth Healthcare units from the cities involved in the pilot projects still meet regularly. They call these sustainability meetings (borgingsvergaderingen) to exchange current and new experiences and developments in the cities involved in the pilot projects. These meetings have also broadened their scope to cities that were not included in the pilot projects.

Platform meetings

Platform meetings are organised on the occasion of 6 February (International Day of Zero Tolerance to FGM). This is a partnership between FSAN, Pharos, Defence for Children — ECPAT Nederland (7), VON, GGD Nederland and SVOR (8).

VI. SUCCESSES AND CHALLENGES

This section details the successes and challenges identified by the respondents during the interviews, followed by an analysis within the framework of the ‘six Ps’.

Challenges in policy development and implementation

With regard to prevention:

- as mentioned in the section on prevention above, the fact that the prevention of FGM is now organised by the GGDs at municipal level remains a challenge;
- the embedding of the key persons, as detailed in the section on prevention;
- the sustainability of activities once project funding stops. This has particularly been noted with regard to the key persons;
- the change of governments over time may bring with it a loss of political will. This was particularly the case when Secretary of State for Health, Welfare and Sport Bussemaker left. It has been difficult to keep FGM high on the agenda following her departure.

With regard to protection and prosecution:

- the difficulty in detecting FGM cases and finding sufficient evidence to prosecute has proved to be challenging. Possible explanations for these barriers have been explained above, in the section on prosecution;
- detecting and finding FGM practitioners;
- in the chain approach, the actors involved in prosecution need to be reinforced. Many actors are involved and each has its own way of making decisions and taking action, which can hamper effective prosecution.

(5) Pharos is the national knowledge and advice centre that provides its expertise for high quality, effective and accessible healthcare for migrants, refugees and people with limited health literacy (http://www.pharos.nl/information-in-english/about-us, accessed 17 July 2012).


(7) ECPAT International is a global network of organisations and individuals working together for the elimination of child prostitution, child pornography and the trafficking of children for sexual purposes (http://www.ecpat.net/EI/Ecpat_vision.asp).

(8) Stichting Vluchtelingen Organisaties Rijnmond [Foundation for Refugee Organisations Rijnmond].

(9) References and links are not included in the natural text.
With regard to the provision of services:
- the provision of healthcare services for women who have been subjected to FGM has only recently been taken up (since 2010), so it is not yet being sufficiently attended to;
- despite the findings of a recent study, psychosocial care for women who have undergone FGM is not covered, as the mental healthcare authority is not part of the chain;
- schools, childcare, gynaecologists and general practitioners are difficult to reach. For schools and childcare, there is a document on FGM (‘Signaalwijzer’ [‘Signal indicator’]) that provides guidance in assessing if a girl will be or has been excised. However, FGM is not formally included in the protocols for staff working in schools and childcare. Gynaecologists and general practitioners have many issues to deal with, however it is important that they be sensitised as they see children very often;
- the registration of FGM by Youth Healthcare through the digital file, which has three separate providers, is challenging (see the section on prevalence).

**Successes in policy development and implementation**

With regard to prevention:
- the role of the Secretary of State for Health, Welfare and Sport, Jet Bussemaker, who played a very prominent role in pushing the issue with regard to the political agenda;
- the motivation among key persons and professionals within Youth Healthcare and other sectors to actually do something about FGM;
- the ‘Standpunt’ that is widely used and monitored by the Council of Public Health and Care;
- the sufficient resources set aside for the implementation of the pilot projects by FSAN, Youth Healthcare and Pharos;
- the taboo within the communities has been broken, FGM has become a discussable subject thanks to the training courses and information sessions, and the attention of the government.

With regard to protection:
- the fact that cases were reported to the AMKs, and that they succeeded in convincing the parents not to excise their daughters;
- the protection provided to women and girls who ask for asylum based on the fear of FGM.

With regard to prosecution:
- the change in the law in 2006 (removal of double incrimination, which allowed for FGM to be punishable even if committed in countries of origin). This was acknowledged by the target groups as a serious fact to consider;
- the statement against FGM.

With regard to the provision of services:
- the development of the e-learning module for health professionals proved to be an easy, relatively cheap way of training professionals that reaches a lot of people. It costs EUR 120,000, and at this point (July 2012) 1,800 professionals have already been trained. On-site training courses cannot be provided for that many people for the same budget. Moreover, with such an e-learning module, new people can be reached, while regular training is not that flexible.

With regard to partnership:
- the enthusiasm and involvement of stakeholders and their willingness to cooperate are identified as success factors in policy development and implementation. Most people are willing to tackle the problem by taking action, and not only by providing ‘lip service’;
- the chain approach, with its key persons, protocols and ‘Standpunt’, and training courses for professionals and key persons, is identified as a success. The involvement of Youth Healthcare in the chain is particularly important;
- the acknowledgement by the Dutch government of the communities in the fight against FGM, and their full involvement in the actions against FGM, are seen as a success. The full involvement of key persons/communities by institutions empowers the African communities, acknowledges them and ‘fills them with pride.’

In the Netherlands, a key success element has been the political interest in the subject and the commitment of the Secretary of State for Health, Welfare and Sport, Jet Bussemaker. This has resulted in some of the most important milestones for policy development and subsequent implementation.

Following the publication of the research report of 2003 (‘Strategies to prevent circumcision in girls’), the policy brief of 2004 recommended the establishment of the Commission Combating FGM, whose reports have triggered a chain of reactions. The most important consequence of the reports was the initiation of the pilot projects in six cities in 2006, and the subsequent roll-out of the pilot projects at national level in 2010 and 2011. 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 the policy briefs that detailed a clear policy on FGM, in collaboration with the Ministry of Justice, and financed the pilot projects. The clear choice for prevention, rather than prosecution and harsh measures, has led to a series of initiatives and interventions to intensify the prevention of FGM and the protection of girls and women from FGM.

Although following the evaluation the pilot projects were rolled out at national level, assessing the impact of the policy and its implementation remains problematic, as no baseline assessment was done prior to the start of the pilot projects. The measurement of the magnitude of 2005 as part of the policy advice was very basic to provide hard evidence of the prevalence (§). With regard to the upcoming situation analysis expectations are high, and overall, depending on the results, it will have an impact on future policy development and the subsequent targeting of resources.

Success elements in the pilot projects, characterised by the chain approach, are:

(§) Kramer, M., Dijkstra, P., Jorritsma, I., Tichelman, P., Verhoeff, A., Vrouwelijke genitale verminking nader bekeken — Omvangsmeting — Een onderzoek naar de aard, omvang en attitude onder professionals en risicogroep in Amsterdam en Tilburg ['A closer look at female genital mutilation — Measuring the magnitude — Research into the nature, magnitude and attitude of professionals and risk groups in Amsterdam and Tilburg'].
The mainstreaming of FGM in Youth Healthcare (GGD) and child protection, through protocols (the acting protocol, the medical protocol and the ‘Standpunt’) and the chain meetings, has brought the issue to the level of each municipality. In principle, this could mean that FGM can be prevented and girls protected from FGM nationwide. However, the effort to embed the issue at municipal level has proven to be a challenge, in particular with regard to the key persons (due to legal regulations). It should be noted that this process of embedding has only recently been implemented (2010–11), and it might need more time to be fully operational. Another challenge with the decentralisation of the issue of FGM to municipalities is that the number of women and girls that have undergone FGM, as well as girls at risk, might in some cities or regions be small and escape the attention of stakeholders. Solutions have been found through the training of focal persons in organisations, who are the responsible persons for FGM in an organisation.

With regard to prosecution and protection, the main challenges lie in detecting cases and finding sufficient evidence to bring a case to court. Indeed, the number of cases identified by the AMKs in 2011 (45) is low, and these cases were nearly all concerning suspicions of FGM. The lack of reports of FGM actually being performed and suspicions of FGM was explained by the respondents for reasons of prioritising working with the family in confidence, the impossibility of performing gynaecological examinations on girls and the insufficient expertise of medical professionals in assessing abnormalities in genitals as FGM. Apparently, none of the respondents mentioned the lack of awareness about FGM as an impediment to reporting. Solutions that have been installed to curb the lack of reports are the instalment of focal persons in AMKs, the development of the ‘Standpunt’ that has to be followed to assess the risk and guides how to act, the development of other protocols and the organisation of symposia for medical professionals on ‘detecting FGM’.

Finding sufficient evidence to bring a case to court has also been identified as a barrier, in particular when it comes to finding an FGM practitioner, proving that parents have actively consented to FGM on their daughter(s) or facilitated the act, proving that it was done before 2006, finding evidence when FGM was done in the country of origin or done by FGM practitioners in the country of origin. No solutions were suggested with regard to solving this problem.

The weak implementation of criminal laws in Europe in cases of FGM was researched earlier. The current findings from the Netherlands seem to confirm the findings of this study that analysed the implementation of laws with regard to FGM in the EU, i.e. that the lack of evidence and issues with reporting are the main barriers to bring a case to court (46).

VII. POLICY LESSONS AND RECOMMENDATIONS

The respondents’ views on what works and what does not with regard to policy development and implementation provided a series of recommendations. They also provided a number of lessons they want to share with others that mainly relate to the successes identified above.

The lessons that the respondent wished to share with other EU countries are summarised below, followed by an overview of their recommendations and a brief summarising analysis.

Lessons learned

The following is a list of lessons or practices that respondents think are important to share with other European countries:

- the chain approach, with the protocols, the involvement of child protection, Youth Healthcare and the communities (key persons) and the training courses;
- the involvement of key persons: provision of information and awareness raising by people from the same community is very different than it is when given from a western perspective. Professionals acknowledge this and use it very frequently and willingly;
- the pilot projects in the six cities and the subsequent roll-out of the prevention of FGM nationally were identified as good practices. However, a national coordinator to coordinate such a pilot project in six cities is necessary;
- the sustainability efforts done through developing protocols to ensure the approach continues after the pilot project stops. The embedding is very important, and should be taken into account from the very beginning when developing a project. It should be carefully considered where the embedding is possible to ensure sustainability, and if this is not possible, this should be pointed out at the onset of activities;

• the ‘Standpunt’ and acting protocol for minors, the medical protocol and the e-learning module for health professionals;
• the national steering committee that gives importance to the issue of FGM.

Recommendations
Despite these practices and the lessons learnt, there are some suggestions made by respondents for improvement.

On prevention:
• if a country starts a pilot project, it should be incorporated from the start that structural embedding after the project stops is necessary and a strategy for this embedding should be developed. A suggestion is made to integrate it into the approach with regard to child abuse;
• 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 much better placed to catch the signs of families at risk. A challenge with key persons is the high turnover, which requires constant monitoring in order to have new key persons: they are the most talented within the communities, and will more easily find a paid job. As a consequence, they drop out as key persons. Hence why structural embedding — and financing — of key persons is very important. This is not only important for the work they do with regard to prevention, but is also important in order to empower the key persons themselves;
• prevention and prosecution should go hand in hand;
• ‘bridges’ should be built between Africa and Europe, to learn from each other’s interventions, campaigns and other activities;
• the involvement of youth is paramount and more resources should be targeted at this group, as they are the future parents, future partners and future politicians. For this purpose, the use of social media and new technologies should be explored;
• interventions with regard to behaviour change should be initiated. Communities are now well informed, the taboo is broken, and there is, therefore, an urgent need to find ways to change behaviour. This will be a long-term goal and interventions should be developed in collaboration with research experts on behaviour change. A project of a few years cannot reach the set objective of changing behaviour. Six years might suffice to train professionals, but behaviour change takes a longer project (at least 10 years);
• the repetition of prevention efforts (rather than isolated efforts or one-off efforts) is important, for professionals as well as for the communities;
• FGM should be integrated into information sessions on other topics targeted at migrant populations, such as integration, sexuality, health, etc. This provides the advantage of giving more opportunities to repeat your message, and entry into a community is facilitated. In some communities it will be easier to tackle a subject such as women and health, rather than FGM.

On prosecution:
• more resources should be invested to trace FGM practitioners, as this is an area that has been under investigation. If girls are taken to other EU countries, this should be checked and investigated. How this should be done is a challenge, as laws need to be looked at;
• the gynaecological screening of girl’s genitals up to a certain age, for all girls born in the Netherlands, should be made possible to detect sexual abuse, including FGM;
• detection and reporting needs to be enhanced.

On provision of care:
• special attention should be given to women with FGM, as well as to the key persons themselves, as they have, in most cases, undergone FGM and might be still traumatised and, at the same time, have to inform families and communities about FGM;

‘The moment a demand is created, it is paramount that services be put in place to care for the victims, and this includes reconstructive surgeries of which little has been known until now.’
• psychosocial care should be part of the provision of care for women with FGM;
• under-represented groups should be involved, such as the education and welfare sectors and general practitioners.

On partnership:
• partnership (between organisations and systems, i.e. AMKs, Youth Healthcare, youth protection, researchers, Pharos, as well as within an organisation) and prevention are the most important to consider. Partnership means that all actors deal with the issue jointly and can contact each other quickly. This remains a challenge in the Netherlands in that many Youth Healthcare doctors have limited knowledge about the roles and responsibilities of the AMKs or youth care, which can result in non-referral of cases. It is important that all sectors be involved to tackle the problem.

On prevalence estimates (specifically on data collection):
• there should be more collaboration on data collection and a nationwide demand for this. Data collection should be steered nationally, because actors are now supposed to organise it themselves and this does not work;
• data collection should be given priority, in particular collecting data through hospital records and prevalence studies;
• evidence about the magnitude should be developed to set a baseline at the onset of developing activities;
• developing a separate database is the only solution for creating systematic registration of FGM (hospital records, reports, asylum requests, etc.). Joining different databases will be very complicated and expensive, as each system has its own technical characteristics, security issues and privacy regulations. It is also important that data be registered adequately. Municipalities could request such an adaptation, however, as they have an interest in knowing where the problem of FGM is most concentrated, what the nature of the problem is, etc. to better target their resources and services.

Finally, some general recommendations were made:
• it is important to provide monitoring and control. In the Netherlands, the use of the ‘Standpunt’ is monitored by...
the Healthcare Inspectorate, and the digital file of Youth Healthcare will, in the future, provide opportunities to extract management information (see the section on data collection);

- 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 the chain;

- protocols for each sector are very useful instruments. They stimulate organisations to reflect on the issue and to guide the daily practice on the issue. Of course, protocols should be integrated into the daily practice and not be stored somewhere. This can be very helpful especially for those who are not very often confronted with the issue of FGM, as protocols clearly specify the steps to be followed when action is needed.

Based on the respondents’ views on lessons learned and recommendations, the main priorities could be formulated as follows.

With regard to prevention, sustainability should be taken into account from the onset of any initiative by assessing strategies to embed the activities in routine structures on healthcare, child protection and schools and integrate into other issues (health, sexuality, integration, child abuse). Prevention should also focus more on behaviour change, as the taboo has been broken and FGM is being openly discussed within the communities.

Partnership is considered key, in particular to link up between actors that deal with the provision of (health) services, protection, prosecution and prevention, and most importantly with the communities themselves.

One respondent stressed that prevention and prosecution should go hand in hand.

‘Prosecution will be the last resort, when prevention and protection have failed.’

A call for a specific criminal law in the Netherlands has emerged consistently over time, but at this point no specific criminalisation is on the agenda. Some respondents thought it was important to have a court case, as it might show that the law is not a ‘paper tiger’. The Netherlands has sought to deal with prosecution through a number of actions to enhance reporting, such as the instalment and training of focal persons in the AMKs, the development of the child abuse guidelines, the involvement of juridical actors in the chain, etc., rather than by imposing harsh measures such as gynaecological check-ups for girls.

With regard to the provision of services, it was stated by one respondent that if a demand is created (with regard to reconstructive surgeries), the services should be put in place to meet that demand. In the Netherlands, health services are dealing with FGM, including reconstructions, but psychosocial care should be taken into account as well.

Prevalence was found to be very important, and given that the very rough and unreliable estimate that ‘50 girls per year are excised’ has been extrapolated to the whole country and used widely to underpin actions, it is recommended that sound evidence on the prevalence and incidence be collected. Therefore, respondents look forward to the outcome of the upcoming situation analysis. Respondents also suggested that data collection should be given more attention, in particular in seeking ways to centralise administrative data collection.

VIII. POTENTIAL GOOD PRACTICES

We have identified two practices with potential: the chain approach and the involvement of key persons.

The chain approach

The chain approach is a way of collaborating between a number of actors that deal with the same subject: FGM.

Such a chain approach is relevant when the issue of FGM touches several sectors and structures that do not fall under the same agency. Since FGM is a complex issue that requires the involvement of child protection, healthcare for children and older women, and psychosocial care, collaboration between these actors is important in order to provide adequate prevention, protection and care. Moreover, the strong cultural anchoring of the practice demands the inclusion of the communities themselves to provide adequate services and protection.

The chain approach uses existing structures to deal with FGM (Youth Healthcare, AMKs) and develops new instruments that can guide professionals in how to deal with cases of girls at risk (from risk assessment to referral), or women who already have undergone FGM. In the Netherlands this was done by developing the ‘Standpunt’ that is used by Youth Healthcare, which also includes care for children of asylum seekers, and the ‘acting protocol for minors’, which focuses on the role of the AMKs, the police and the Council for Child Protection. A model protocol for healthcare professionals was also developed.

The monitoring of the ‘Standpunt’ is done by an authority, i.e. the Healthcare Inspectorate, which is a stimulating factor for YHC to follow the ‘Standpunt’.

A very important elements to link between professionals and communities is the concept of key persons, detailed below, as we believe this is important enough to single out as a practice with potential.

The chain approach could be scaled up to those countries, provided they have responsible professionals dispersed across several agencies, such as in the Netherlands. The fact that FGM has now been integrated at municipal level proves that the authorities have actively sought to make the outcomes of the pilot projects sustainable. The chain approach was used during the pilot projects in the six cities, and after the project finished the approach was instrumental in keeping the benefits and experiences sustainable.

The pilot projects were evaluated, and although there were issues with the results, which were not found to be SMART enough, as well as the lack of baseline data prior to the pilot projects, the approach was scaled up and rolled-out nationally.
Unfortunately, the researcher did not have sufficient time to read through the two evaluation reports to provide more insights into how the approach can be improved.

Key persons

Key persons are one of the main pillars of the chain approach. They were introduced as a strategy to tackle FGM within the communities at the beginning of the 2000s. Key persons are members of the ethnic communities where FGM is still practised. They play an important role in the community as well as outside that community. It was considered pertinent to involve people from the communities in the prevention of FGM, as they speak the same language and have an affinity with the subject. Their role is to inform communities and raise awareness of FGM through home visits and informative meetings. The home visits offer opportunities for a confidential conversation, and opportunities to detect new key persons. Key persons are recruited by the management of community-based organisations, based on a profile drawn up by Pharos and FSAN. The pilot prevention projects learned that the effectiveness of the home visits is increased if there is an investment in building the capacity of key persons. Key persons provide information on FGM to their own communities, and are trained to perform these tasks.

Key persons liaise between the communities and the professionals and authorities. The involvement of the key persons as actors in the chain acknowledges their expertise, demonstrates the commitment of Dutch authorities and organisations to collaborate with communities and underlines the importance of working jointly with communities to end FGM. Although there are still issues with consolidating the key persons into municipal structures, it is important that key persons are structurally embedded to ensure continuity and maintain the link with the communities. In most cases, key persons have been subjected to FGM themselves, hence appropriate care for these key persons is important, both in terms of healthcare and psychosocial care.

Key persons are instrumental in fighting FGM in order to liaise between communities and authorities and to raise awareness in the communities. It is a strategy that is easily transferable to other countries.

IX. FINAL CONSIDERATIONS AND RECOMMENDATIONS

Policy development in the Netherlands began in the early 1990s with the influx of the Somali community in the country. Major milestones that characterise policy development in the Netherlands are as follows:

- 1992: the report by Bartels and Haaijer (*) triggered the public debate in the Netherlands caused by the controversial proposal in the report that mutilating and non-mutilating forms of FGM should be differentiated, and that the Netherlands should condone the non-mutilating form. As a consequence, the government issued a statement that FGM cannot be condoned in the Netherlands, and that all forms are forbidden.
- 2003/2004: a first FGM policy followed in 2004, after the publication of the report ‘Strategies to prevent circumcision in girls’ in 2003 (**). The suggested policy by the Ministry of Health included research into the magnitude of the problem, prevention, early detection and intervention, the removal of the principle of double incrimination in the law and the establishment of a Commission Combating FGM that should research the possibility of a monitoring system for girls (at risk) and the opportunities for detection, reporting and monitoring girls/women at risk of/with FGM (**). The policy of the Secretary of State for Health, Welfare and Sport outlined two paths, prevention and prosecution, whereby prosecution is to be considered from a preventative angle.
- 2006–09: the implementation of the pilot projects in six cities, with the aim of strengthening prevention.
- 2010–11: national roll-out of the pilot projects, following the evaluation of the pilot projects and the 2009 policy brief from the Secretary of State for Health, Welfare and Sports that outlines the future direction with regard to FGM.
- 2012: the embedding of the issue of FGM at municipal level is ongoing.

Major key actors in policy development in the Netherlands have been Pharos, with its focal point on FGM, the municipal health services (GGD) and their umbrella organisation GGD NL, the Youth Healthcare units, the Federation of Somali Associations in the Netherlands (FSAN), the Council for Public Health and Care, the Secretary of State for Health, Welfare and Sports, key figures from the communities, and the AMKs, child abuse advice and reporting points (Youth Care). The Secretary of State for Health, Welfare and Sport Jet Bussemaker also played an instrumental role in putting FGM on the agenda.

No hard evidence is available on the prevalence of FGM in the Netherlands. An upcoming situation analysis is eagerly awaited and hopes are high that the findings will have an influence on future policy development.


The attention of policymakers has evolved over time, from prosecution over prevention to provision of services.

It is recommended that, with regard to prevention, sustainability should be taken into account from the onset of any initiative by integrating activities into routine healthcare and child protection structures and in schools. Prevention should also focus more on behaviour change.

Partnership is considered key, in particular to link up between actors that deal with the provision of (health) services, protection, prosecution and prevention, and most importantly with the communities themselves.

Prevention and prosecution should go hand in hand. Prosecution should seek to have a preventative role. The example of the Netherlands, where a clear choice was made for prevention rather than prosecution and harsh measures, has led to a series of initiatives and interventions to intensify the prevention of FGM and the protection of girls and women from FGM. However, a baseline assessment prior to prevention efforts is recommended to assess the impact of the initiatives.

The provision of services should not forget to take into account psychosocial services, and given there is a demand for reconstructive surgeries by the communities themselves, such services should be put in place.

Identified good practices include the chain approach and the involvement of key persons.
1. **IDENTIFICATION**

Country: Poland  
Researcher: Małgorzata Miazek

2. **PREVALENCE OF FGM**

2.1. Methodological approach for collecting prevalence data

In order to gather data on prevalence of FGM in Poland, first an extensive search of academic databases was performed. The following databases were consulted: Social Science Research Network, Sociological Abstracts, Web of Science and PubMed. Due to the failure to get access to the HeinOnline database, the EBSCO database was used instead. Finally, the search was complemented by checking the Google Scholar search engine.

As the academic database search did not result in any relevant findings, either on prevalence or any other topic related specifically to the Polish context, I browsed online newspaper/magazine articles devoted to FGM in order to get some more knowledge on the issue and ideas for further research. In this respect, the article by Marta Gmiter entitled ‘Córki okaleczane w imię krwawej tradycji’ (1) published in the online edition of the Rzeczpospolita daily newspaper appeared to be very helpful. From there, I learned about the Psychosocial Initiatives Foundation (see Section 5), which carried out a ‘Stop FGM’ campaign. Unfortunately, the foundation has already suspended its activities. Via social network tools, I got in touch with two respondents, who were involved in this campaign. One respondent provided me with details on the Psychosocial Initiatives Foundation and the goals and scope of the ‘Stop FGM’ campaign (see Sections 5 and 6). She told me about the questionnaire survey on FGM awareness that she, as a volunteer in the Psychosocial Initiatives Foundation, conducted among Polish gynaecologists, endocrinologists and midwives. The scope of the survey was very limited as there were approximately 30 questionnaires distributed (16 came back) and because it was carried out in just two medical institutions. The raw data collected has never become the basis for an article, report or any other kind of publication; hence it is not included in our database. Regardless of the limitations of this survey, which makes it impossible to draw more general conclusions from the results, this study was the only attempt to gather some information on the prevalence of FGM in Poland that I encountered. The abovementioned raw data is in the possession of one of the respondents.

In order to confirm the impression of non-existence of any data concerning the prevalence of FGM in Poland, having done the academic database search I contacted a number of institutions, both governmental and non-governmental, to seek their assistance. The initial contact was made via e-mail, in which I introduced myself and listed the topics of our interest: prevalence of this phenomenon in Poland, public activities in relation to FGM, FGM in the light of Polish legislation, organisations/institutions dealing with FGM, and tools and instruments.

As the response rate was not very high, I did my best to follow up the majority of inquiries by phone or e-mail reminder. This resulted in some more answers, though usually either not relevant for the Polish context or confirming the lack of data on FGM. I am going to discuss some of the individual responses I received in the subsequent sections of this national report.

2.2. Nature of prevalence studies/FGM registration systems

No data on the prevalence of FGM was found.

In the absence of academic studies on the prevalence of FGM, I proceeded according to the guideline in point 3 of the FAQs. I did not look for statistics or numbers, e.g. of refugee women or asylum-seeking women of concerned countries through specific national bodies since, as explained, it was not the purpose of the study to collect primary data. However, I contacted relevant actors to seek information and check whether they have any registration systems for cases of FGM.

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(1) This report and the database produced for the project are interrelated and should be read together. The only article found which seemed to be related to the national context actually contained no information on FGM in Poland. It was rather a general overview of the issue with a comment that it could be of use for Polish gynaecologists. See: Rogowska-Szadkowska, D. and Niemiec, T., ‘Female circumcision — A new issue for gynaecologists practising in the EU countries?’, Ginekologia Polska, 80(2), 2009, pp. 118–123.

(2) Gmiter, M., ‘Córki okaleczane w imię krwawej tradycji’ [Daughters mutilated in the name of a bloody tradition], Rzeczpospolita, 2011. Available at: http://www.rp.pl/artykul/123162,692044.html. There were, of course, more non/quasi-academic articles on FGM found online, however they were of general nature and did not contribute any information on FGM specifically in Poland.
In an e-mail, the Central Statistical Office replied that it did not carry out any research on the issue of FGM. They suggested that I contact the Office for Foreigners or the Office of the Government Plenipotentiary for Equal Treatment.

The police informed me by e-mail that the national police headquarters did not have any information on the phenomenon of FGM. They also stressed that, as this act is not separately codified in Polish legislation, there is no separate statistical category for it. According to the best knowledge of the responding person in the field of offence against life, health and sexual freedom, there are no indications of this type of event in Poland. She underlined that, of course, they could have taken place but not be reported or be otherwise classified, e.g. as offences against life or health.

Following the advice I received I also contacted the Office for Foreigners, which deals with, among others, asylum and visa procedures in Poland. By e-mail, I was informed that ‘the office does not conduct monitoring activities of FGM cases and specifically does not gather statistics with regard to the place of stay within the territory of the Republic of Poland of persons who are victims of FGM or at risk of FGM in their country of origin. Moreover, the office does not gather statistics concerning the abovementioned categories of persons, who would declare this problem in the asylum claim applications’. The issue of information obtained on FGM-related asylum claims will be further elaborated upon in Section 4.4. of the report.

The responses from the Ministry of Health and Polish Gynaecological Society did not contribute any new information. The Ministry of Health stated that ‘this practice (FGM) has no application in Polish society’, however it suggested that due to the ‘growing immigration of people from India, Pakistan, and Arab and African countries, this problem may increase in Poland, especially among women and girls who emigrated from the societies in which this custom exists’ (e-mail). The Polish Gynaecological Society stated that they do not have any information on this issue and that ‘in Poland, one does not observe the phenomenon of female genital mutilation’ (e-mail).

I still have not received the response from the Office of the Government Plenipotentiary for Equal Treatment.

2.3. Findings from the prevalence studies/registration systems

n/a

2.4. Reflection on prevalence studies

To sum up, I did not manage to see any national studies concerning prevalence of FGM. The reason could be the limited amount of immigration by women from the countries where FGM is common, and consequently little scope for this phenomenon in Poland and no research on it. Additionally, as noted by the Polish police, not being directly referred to in Polish law, cases of FGM could simply be classified for statistical purposes under different headings.

As for the recommendations on gathering prevalence data, it would seem feasible, in my opinion, for the Office for Foreigners to collect data on FGM-related asylum claims. Further data could also be collected within the framework of the standard operating procedures on sexual gender-based violence (implemented by the same office) that will be discussed in detail in Section 5 of the report.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

As already mentioned, the academic database search did not result in any data relevant to the Polish context. The area of policy framework was not different in this respect.

In order to complement my research, I sent a request for information to the relevant ministries (Ministry of Justice, Ministry of Health, Ministry of Labour and Social Policy and Ministry of Education), as well as to the Government Plenipotentiary for Equal Treatment. Currently, the Ministry of Health and the Ministry of Justice are the only two to have answered. The response of the first has already been discussed above. The Ministry of Justice informed me that so far they ‘have not dealt with the phenomenon of female genital mutilation’. The ministry did not have any research results or statistical data on this issue either (e-mail).

A supplementary check of the web page of the Ministry of Justice resulted in finding only a national programme on counteracting domestic violence that, however, did not specifically mention FGM.

The Mazovian Centre of Social Policy, which is a voivodeship self-government organisational unit implementing the self-government tasks of the Mazovian voivodeship in the field of social policy, informed me that ‘the problem of FGM has never been reported to the centre by social welfare centres or other social welfare organisational units in the area of the Mazovian voivodeship’. Hence, the centre has never provided any training with respect to FGM. Nor does it carry out any research or analyses on this topic (e-mail).

I also searched the websites of the Polish parliament (http://www.sejm.gov.pl/ and http://www.senat.gov.pl/) to look for parliamentary questions (pol. interpelacje), inquiries (pol. zapytania), questions (pol. pytania) or parliamentary statements (pol. oświadczenia poselskie) concerning FGM. Finally, I browsed parliamentary papers. I found no relevant records.

3.2. Policies on FGM

Having applied the methodological approach described above, no relevant policy specifically concerning the issue of FGM was identified.

3.3. Reflection on policies on female genital mutilation

To sum up, no information could be found on policies directly related to FGM. It seems that the issue of FGM remains outside of the interest of Polish policymakers.
This can potentially be attributed to the limited scope and awareness of this practice in Poland and practically no research on it in the Polish context.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Following the unsuccessful search of academic databases, I based my research regarding the legal framework on the existing comparative literature which included the Polish context (i.e. Leye, E. and A. Sabbe, Responding to female genital mutilation in Europe — Striking the right balance between prosecution and prevention, International Centre for Reproductive Health, 2009 (7); Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Union, 2010 (Polish national report, Prof. E. Zielińska); Ad hoc query: female genital mutilation and asylum in the EU, European Migration Network — National Contact Point Belgium, 2010 (3)).

At the next stage, I accessed the legal acts described in the above publications on the web page of the Legal Acts Internet System of the Polish parliament (http://isap.sejm.gov.pl/). In the case of professional secrecy provisions, I was also helped by the text published on the web page of the voivodeship police headquarters in Bialystok concerning ‘Duties to report offences resulting from legal provisions’ (2).

The last step was to discuss my findings with a lawyer of the Polish Federation for Women and Family Planning.

4.2. Criminal law

Based on the materials gathered, it should be recognised that there is no specific criminal law on FGM in Poland. The general provisions of the Penal Code, which entered into force on 1 September 1998, can however be applied in cases of FGM. As a result of the analysis of the legal provisions mentioned in the above publications and the consultation with the lawyer, one can list the following criminal offences as of potential use:

- serious bodily injury (Article 156);
- bodily injury or an impairment to health other than specified in Article 156 (Article 157);
- exposure to danger of loss of life or serious injury to health (Article 160);
- not providing assistance to a person who is in danger of loss of life or a serious injury to health (Article 162).

The Ministry of Health, in their response to my e-mail, also underlined that such practices as FGM are subject to penalties in Poland and provided Article 156 of the Penal Code as a reference.

The Ministry of Justice confirmed that there were neither regulations introduced into Polish legislation with regard to FGM nor jurisprudence (pol. orzecznictwo) concerning this issue. They also referred to Article 156 of the Penal Code as being potentially applicable (e-mail).

Concerning the changes introduced to the Penal Code, Prof. Zielińska in her national report for Poland (delivering country data for the Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence), mentions the amendment that changes the type of accusation with regard to the offence described in Article 157(2) and (3) from private to public in cases in which the perpetrator is someone next of kin and lives with the victim (Ustawa o zmianie ustawy o przeciwdziałaniu przemocy w rodzinie oraz niektórych innych ustaw, z dnia 10 czerwca 2010, Dz.U. z 2010r. Nr 125, poz. 842; in force as of 1.8.2010).

As for the number of court cases regarding FGM, E. Leye and A. Sabbe refer to no cases of this type (1). In my research, I did not find any further information either supporting or undermining this finding.

4.3. Child protection laws/provisions

The research carried out shows no evidence of child protection provisions and laws that deal specifically with FGM in Poland. In her national report, mentioned above, Prof. Zielińska refers to the Family Code and potential application of measures such as restriction or deprivation of guardian rights in cases in which children are at risk.

E. Leye and A. Sabbe list suspension of parental authority, removal of a child from the family, non-authorisation to leave the country and withholding of a passport (in pending criminal procedures) as possible measures (5). However, there is no clear reference to the legal basis in their text.

The lawyer that was consulted also indicated a direct reference to the Law on Counteracting Domestic Violence, J. L. 2005 No 180 item 1493 (6) (with its amendment of 10/6/2004 (4)), which provides for measures such as removing a child from the family in the event of a direct threat to the life or health of a child (Articles 12a and 12b).

(2) Ibid, p. 30.
(3) Available at: http://isap.sejm.gov.pl/DetailsServlet?id=WDU20051801493
(7) Available at: http://podlaska.policja.gov.pl/programy/siec_pomocy/doc/5.pdf
(8) Available at: http://isap.sejm.gov.pl/DetailsServlet?id=WDU20101250842
4.4. Asylum law(s)/provisions

Regarding research on the asylum provisions dealing with FGM, my point of departure was the publication titled ‘Ad hoc query: Female genital mutilation and asylum in the EU’, by the European Migration Network — National Contact Point Belgium, 2010. This source indicated that there are no guidelines on FGM-related asylum claims in Poland, but it provided information on standard operating procedures on sexual gender-based violence (to be discussed in detail in Section 5) and three cases of asylum claims on grounds related to FGM (14).

In order to confirm this information, I contacted the abovementioned Office for Foreigners, which deals with asylum cases in Poland. In their e-mail, the office informed me that FGM is not a circumstance referred to by women applying for refugee status in the territory of the Republic of Poland, although they come from the countries where FGM is applied in practice. However, in case of examining the application for refugee status of a woman subjected to FGM or at risk of it, the Office for Foreigners would use the “Guidance note on refugee claims relating to female genital mutilation” by the UN High Commissioner for Refugees from May 2009. The definition of a ‘refugee’ is the one from the UN Convention relating to the Status of Refugees.

The issue of FGM not being a circumstance that women applying for refugee status in Poland provide as a ground for their claims drew my attention as it was in contradiction to the numerical data included in the ‘Ad hoc query: Female genital mutilation and asylum in the EU’, as well as the article by M. Gmiter on FGM published in *Rzeczpospolita*. In the latter article, the author refers to the statement by the spokeswoman of the Office for Foreigners, who provides information about one FGM-related asylum claim, which was, however, dismissed because the applicant voluntarily decided to go back to her country of origin (15).

I followed up this information in a phone conversation with the office and subsequent e-mail, and was informed that, indeed, such a case had occurred, though as it was dismissed at the request of the applicant and no content-based decision was issued, it was not mentioned in the first e-mail sent to me. Additionally, the office declared: except for this one case, in the last 5 years we have not taken note of any applications in which the reason to leave the country of origin was fear of FGM.

4.5. Professional secrecy provision(s)

Regarding the professional secrecy laws, I did not find any provisions referring specifically to FGM. According to E. Leye and A. Sabbe, in Poland the duty to report child abuse concerns such professions as doctors, social workers and teachers. Failure to report can result in sanctions (16). The exact legal basis for this statement is, however, not provided.

Based on the text published on the web page of the voivodeship police headquarters in Białystok on the duty to report an offence (17), the legal acts themselves and my exchange of e-mails and phone conversation with the lawyer, I chose the following legal acts, which are applicable with regard to the duty to report offences and departing from professional secrecy.

- **Civil Code**: Article 572.1 states that any person who is aware of an event that justifies the initiation of *ex officio* prosecution is obliged to inform the guardianship court thereof. In the light of Article 572.2, the above duty lies first of all on register offices, courts, prosecutors, notaries, bailiffs, local government bodies and government administrations, police, educational institutions, social workers, and organisations and institutions dealing with the care of children or mentally ill people (18).
- **Code of Criminal Procedure**: according to Article 304.1 (19), any person who learns about the commitment of an offence prosecuted *ex officio* has a social duty to inform the prosecutor or the police about it. Additionally, state or local government institutions that learn about commitment of such offence in relation to their activities are also obliged to immediately inform the prosecutor or the police about it (Article 304.2)(20).
- The law on counteracting domestic violence (with its amendment of 10/6/2004) states in Article 12.1 that ‘individuals who in connection with performing their official or professional duties conceived a suspicion about the commitment of an offence prosecuted *ex officio* involving domestic violence shall immediately inform the police or the prosecutor’ (21). ‘Duties to report offences resulting from legal provisions’ list doctors, nurses, social workers, teachers, court-appointed custodians and police as being particularly addressed by this obligation (22).
- The act of 5 December 1996, the professions of doctor and dentist, although obliging a doctor/dentist to keep secret any information relating to the patient and obtained while performing his/her profession (Article 40.1), provides also for exceptional circumstances when the provisions Article 40.1 do not apply. These are, among others, when the laws so provide (Article 40.2.1) or when respecting secrecy may


(16) Voivodeship police headquarters in Białystok, op.cit., p. 7.


(19) Voivodeship police headquarters in Białystok, op.cit., p. 7.
be dangerous to the life or health of the patient or other persons (Article 40.2.3) (20).

- The law of 6 November 2008 on patients’ rights and the ombudsman for patients’ rights also confirms the obligation of individuals performing medical professions to keep secret any information relating to the patient and his condition (Article 14.1). There are, however, exceptional circumstances when Article 14.1 does not apply. These are, among others, when the provisions of other acts so state (Article 14.2.1) or when respecting secrecy may be dangerous to the life or health of the patient or other persons (Article 14.2.2) (20).

As one can see from the above, in case of the three first acts there is a duty to report an offence involved. Sanctions can vary from no sanctions at all in the event of the so-called social obligation, through disciplinary responsibility for non-performance of duties, to penal sanctions in the case of public officials (20). The latter two acts describe how the right not to respect secrecy can be applied.

4.6. Reflection on legal framework

The research conducted shows that in the absence of specific provisions referring to FGM, this practice can only be discussed within the framework of general laws. What is worth underlining are the potential difficulties regarding conducting legal proceedings in cases related to FGM that were mentioned by the Ministry of Justice in their response to my e-mail. The ministry also noted that it seems that the introduction of regulations prohibiting this kind of practice, following the example of other EU Member States, would be most desirable.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

As the academic database search did not provide me with any hints with respect to potential actors in the field of FGM, I turned to press content. The abovementioned article by Marta Gmiter in Rzeczpospolita referred to two institutions dealing with this issue in Poland: the Psychosocial Initiatives Foundation and the Office for Foreigners.

Google browsing in search of the Psychosocial Initiatives Foundation website did not bring any results. By means of online social network tools, I got in touch with the two respondents who were actively involved in the activities of the foundation with regard to FGM. From them, I learned that the foundation had already suspended its activities, but they gave me via e-mail their permission to include their names as individual experts in our database.

The remaining actors were found through the web search, which started with the website of the Office for Foreigners and expanded to the web pages of other institutions involved with the Office in the implementation of the standard operating procedures on sexual gender-based violence (described below).

I also contacted via e-mail other organisations that could potentially be involved in activities linked to FGM. Regardless of phone follow-ups, some of them have never responded and others stated that they had never been active in the field of FGM.

5.2. Actors

The actors listed in the Excel database can be divided into two groups: those working on the ‘Stop FGM’ campaign and signatories of the agreement on standard operating procedures regarding sexual gender-based violence.

The aim of the ‘Stop FGM’ campaign initiated in Poland by the Psychosocial Initiatives Foundation was to provide access to reliable information on FGM and free psychological support for FGM victims living in Poland. The campaign had its own sub-website (on the foundation’s web page) with data on FGM as well as links to international organisations dealing with FGM and movies. A survey (mentioned in Section 2.1. of the report) was conducted within the framework of this campaign. The foundation established contacts with such organisations as the ‘Stop FGM’ campaign, Terre de Femmes, SOS FGM and the Waris Dirie Foundation. It also produced some poster projects and campaign video spots still available on YouTube. Two experts involved in this initiative — one a campaign coordinator and the other a volunteer — were also listed in the database as individual actors.

The other institutions mentioned in the database are the signatories of the agreement on the standard operating procedures on sexual gender-based violence (SOP on SGBV, 2008) (22). The main goal of this initiative is to recognise, counteract and react to cases of sexual or gender-based violence that may be experienced by persons placed in centres for asylum seekers. These cases include FGM. What is worth mentioning is the fact that although documentation linked to the procedures (general guide,
study (23) mentions FGM in the definition of sexual and gender-based violence, I did not find any other references to FGM (e.g. numbers, scope, etc.) in the context of SOP on SGBV, except for the data provided by the Office for Foreigners. Descriptions of training courses conducted and related to SOP on SGBV (available on the web page of the Office for Foreigners) seem not to specifically cover the issue of FGM either.

Contacting all the other parties to the agreement on the SOP on SGBV did not contribute any new relevant information regarding FGM (24).

All in all, among the actors related to the field of FGM, I listed two individual experts, three NGOs, one international organisation and two public institutions.

5.3. Reflection on actors on female genital mutilation

To sum up, the number of actors dealing with the phenomenon of FGM in Poland is very limited.

The activities of the Psychosocial Initiatives Foundation were inspired by the book Desert flower by Waris Dirie and its adaptation for the screen. Unfortunately, the foundation had to suspend its activities due to reasons not related to the ‘Stop FGM’ campaign.

The actions undertaken within the framework of the standard operating procedures on sexual gender-based violence do refer to FGM, but seem to handle it only at the margins of other types of sexual and gender-based violence. However, since the implementation of the SOP on SGBV is carried out in the centres for asylum seekers, which are the places where children and women already mutilated or at risk of FGM could potentially be found, in my view there is still some place within the framework of this initiative to focus more on FGM and gather more data on it.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

All the tools and instruments were discovered as a result of the identification of actors dealing with FGM activities.

Tools and instruments linked to the standard operating procedures on sexual gender-based violence were found on the web page of the Office for Foreigners (25).

Links (26) to the video clips produced by the Psychosocial Initiatives Foundation within the ‘Stop FGM’ campaign were provided to me by the campaign’s coordinator.

6.2. Tools and instruments on FGM

Within the framework of implementation of the SOP on SGBV, a special leaflet addressed to foreigners staying in the centres for asylum seekers was produced. It specifies exactly what sexual and gender-based violence is and gives female genital mutilation as an example. It also provides information on whom to ask for help if you are a victim of such violence and what rights you have. According to the web page of the Office for Foreigners, the leaflet is available in three languages: Polish, English and Russian. The web page also mentions posters, however they could not be downloaded from the site. The Office of the UNHCR, one of the signatories of the agreement, suggested the possibility of sending me some materials regarding the SOP on SGBV via regular mail, which I agreed to and provided them with my postal address. When these materials arrive, I will send them to Yellow Window.

Two video clips produced by the Psychosocial Initiatives Foundation were part of the ‘Stop FGM’ campaign. They encourage the fight against FGM and support for the campaign (http://www.STOP-FGM-NOW.com). As they were published on YouTube, one can assume that they are targeted at a general audience.

6.3. Reflection on tools and instruments on female genital mutilation

The scarcity of tools and instruments is, in my view, directly linked to the small number of actors dealing with the issue of FGM.

Taking into account that those individuals in medical professions (e.g. gynaecologists, paediatricians, nurses, midwives, etc.) are probably the most likely to meet women and children that have been mutilated or that are at risk of FGM, some awareness-raising and training materials specifically regarding conduct towards persons having suffered or at risk of FGM would seem very useful.

7. FINAL CONSIDERATIONS

To summarise, one can conclude that the phenomenon of FGM in Poland draws very little attention. No representative prevalence studies on this issue have been found, which

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(23) http://www.udsc.gov.pl/button,1,1053.html
(24) http://www.youtube.com/watch?v=ARutEWR_Szk&feature=mfu_in_order&list=UL
(25) http://www.youtube.com/watch?v=Nwk6_BOvqwg&feature=autoplly&list=ULXQ8-q9ZOR0&f=mu_in_order&playnext=1
(26) http://www.youtube.com/watch?v=59qacv5SO_Q&feature=related
allows the argument to be made that the actual scope of this phenomenon in Poland is still relatively unknown. In practice, all the institutions that were contacted, both governmental and non-governmental, confirmed the lack of information on FGM in Poland and, in some cases, clearly expressed their opinion of the non-existence of FGM in Poland.

The practice of FGM seems also to be a non-issue for policymakers. Consequently, there is no legislation that would address FGM specifically. In these types of cases, only general laws would be applicable, including criminal, child protection and professional secrecy provisions.

The number of actors dealing with FGM-related activities is also very limited, hence the number of tools they use is not substantial either.

As the only activities devoted directly to FGM that I came across were carried out by the Psychosocial Initiatives Foundation (which had already suspended its work), based on the research there are no ongoing initiatives regarding this practice in Poland. Although FGM is referred to within the framework of SOP on SGBV, there is no focus on it.
1. IDENTIFICATION

Country: Portugal

Researcher: Yasmine Gonçalves

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

The method used to get information regarding prevalence studies was academic database research, and as mentioned in the guidelines, I started to look for information on Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google.

The key terms used were: mutilação genital feminina, corte dos genitais femininos, MGF, CGF, circuncisão feminina, fanado, excisão and práticas tradicionais.

Moreover, the researcher established the following contact in order to obtain information on the prevalence of FGM in Portugal:

• A respondent from the Directorate-General for Health/Ministry of Health/Division of Reproductive Health, the focal person of the intersectoral working group of the programme of action for the elimination of female genital mutilation, was contacted, and the information provided is that it is not possible to get information on any studies regarding prevalence data on FGM and that there is no record regarding the number of women with FGM living in Portugal.

2.2. Nature of prevalence studies/FGM registration systems

Despite the fact that there are no data regarding prevalence or registration systems on FGM in Portugal, the 'Technical guidelines for health professionals — Female genital mutilation', which were officially presented on 6 February 2012, include guidelines for registration and referral of newborns ('risk' based on country of origin and if the mother has been subjected to FGM) and young girls at risk.

According to these guidelines, a child (newborn or not) should be referred to Hospital Units Supporting Children and Youth at Risk (Núcleos Hospitalares de Apoio a Crianças e Jovens em Risco — NHACJR) by filling in the requested form with ‘At risk of FGM’. Information for FGM registration will be obtained through the reports of ‘Health Action for Children and Youth at Risk’, which should contain information to identify referred cases of FGM that has been performed, or cases at risk of FGM.

In the same document, it is mentioned that hospital units and health unit groups (Agrupamento de Centros de Saúde — ACES) should include in the IT clinical record the item ‘FGM’ in order to identify, register and estimate centrally the number of cases. Whenever a woman is found to have suffered FGM, the information should be included in her clinical file.

In the same document, the risk countries and the estimated prevalence of FGM are mentioned in annex. (Information from the document Eliminating female genital mutilation: An interagency statement — OHCHR, Uaids, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem, WHO, World Health Organisation, Geneva, 2008.)

2.3. Findings from the prevalence studies/registration systems

No data on the prevalence of FGM was found.

2.4. Reflection on prevalence studies

At this moment it is not possible to provide any numbers regarding FGM in Portugal: there are no prevalence studies nor any registration systems that mention FGM. The scarce information available concerns estimates drawn up on the basis of the number of people/women from countries where FGM is prevalent and who are living in Portugal.

Throughout this report, the FGM-practising community from Guinea-Bissau is mentioned several times. This is related to the considerable number of migrants coming from that country. In Portugal, traditionally, migration flows come from former Portuguese colonies (including the Portuguese-speaking African countries (Países Africanos de Língua Oficial Portuguesa — PALOP)), such as Angola, Guinea-Bissau, São Tomé e Príncipe, Mozambique, Cape Verde and Brazil. The main newspaper articles about FGM mention Guinea-Bissau as being an FGM-practising community, including testimonies from migrant women coming from Guinea-Bissau and who have been subjected to FGM.

Regarding the foreign population in Portugal, according to the Portuguese Immigration and Borders Service (SEF) (http://sefstat.sef.pt/Docs/Rifa_2010.pdf), in December 2010 the foreign population resident in Portugal was 445,262 citizens (provisional stock).
According to the Portuguese Immigration and Borders Service’s report, the most represented countries are Brazil (119,363 persons), Ukraine (49,505), Cape Verde (43,979), Romania (36,830), Angola (23,494) and Guinea-Bissau (19,817). There has been a decline in the number of foreign residents in Portugal, with the exception of those coming from Brazil.

Based on the same report, information on the foreign population with a valid residence permit, or with a long-stay visa provided by the Portuguese Immigration and Borders Service, can be obtained (page 77 of the Portuguese Immigration and Borders Service’s report, 2010). If we analyse these data and select only the foreign population from countries with prevalence of FGM, we have the following information regarding Portugal (provisional stock).

Table 1 — Foreign population in Portugal from countries with FGM prevalence

<table>
<thead>
<tr>
<th>Country</th>
<th>TOTAL</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>32</td>
<td>30</td>
<td>2</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>16</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Cameroon</td>
<td>76</td>
<td>50</td>
<td>26</td>
</tr>
<tr>
<td>Chad</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>118</td>
<td>87</td>
<td>31</td>
</tr>
<tr>
<td>Djibouti</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Egypt</td>
<td>333</td>
<td>268</td>
<td>65</td>
</tr>
<tr>
<td>Eritrea</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>30</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>The Gambia</td>
<td>110</td>
<td>88</td>
<td>22</td>
</tr>
<tr>
<td>Ghana</td>
<td>169</td>
<td>112</td>
<td>57</td>
</tr>
<tr>
<td>Guinea</td>
<td>1,409</td>
<td>1,099</td>
<td>310</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>19,871</td>
<td>11,636</td>
<td>8,181</td>
</tr>
<tr>
<td>Yemen</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Mali</td>
<td>79</td>
<td>72</td>
<td>7</td>
</tr>
<tr>
<td>Mauritania</td>
<td>33</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>Nigeria</td>
<td>286</td>
<td>179</td>
<td>107</td>
</tr>
<tr>
<td>Kenya</td>
<td>41</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Senegal</td>
<td>1,677</td>
<td>1,314</td>
<td>363</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>55</td>
<td>45</td>
<td>10</td>
</tr>
<tr>
<td>Sudan</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Togo</td>
<td>50</td>
<td>33</td>
<td>17</td>
</tr>
<tr>
<td>Uganda</td>
<td>8</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>24,418</td>
<td>15,101</td>
<td>9,263</td>
</tr>
</tbody>
</table>

Table adapted from the Portuguese Immigration and Borders Service’s report, 2010.

It is important to mention that FGM has not been an issue tackled by any NGO or public body for a long time. Most of the NGOs that are currently working or have worked on the issue have integrated FGM issues into their working activities (such as the Family Planning Association — APF; Women’s Union, Alternative and Response — UMAR; Instituto Marquês de Valle Flôr — IMVF; Amnesty International Portugal — AI-Portugal; Immigrant Association from the Almada Municipality — AICA; Uallado Folai; Portuguese Platform for Women’s Rights (PpDM); Association of Women Against Violence — AMCV; Portuguese Council for Refugees — CPR).

It is mainly due to the release of some newspaper articles (from the Público newspaper) written by a journalist who started to publish a dossier of articles on FGM in August 2002 and due to some advocacy work done by NGOs (APF, UMAR, AI-Portugal) that FGM has been more debated in the political agenda and targeted by NGOs and other actors.

According to some newspaper articles, there are a significant number of cases of FGM in Portugal. For example, the article from February 2009 (from Jornalismo Porto Net, a digital newspaper of the Communication Sciences Department at the University of Porto), based on a study done by a respondent for her master’s thesis in social and organisational psychology, provides some figures. The study sample was made up of 52 professionals from Garcia de Orta hospital (Almada region), Fernando da Fonseca hospital (Amadora region),...
Regarding prevalence studies, it is important to highlight that the second programme of action for the elimination of female genital mutilation includes the following measures: developing some indicators for monitoring the number of girls and women with FGM; and developing a study on FGM in Portugal.

As other European countries have already developed some prevalence studies it would be important to share good practices, including the main aspects to be taken into account for the purposes of the collection of data on FGM. If such information were to be made available, it is recommended that it be sent directly to the Commission for Citizenship and Gender Equality (CIG), which is coordinating the second programme of action for the elimination of female genital mutilation.

### 3. POLICY FRAMEWORK

#### 3.1. Methodological approach for collecting documents on policies

Documents on policies were obtained through:
- the websites of official bodies,
- the UN Secretary-General’s database on violence against women,
- academic database search — social science research networks, sociological abstracts, Web of Science and PubMed.

However, most academic papers and other documents concerning FGM policies in Portugal were found through a search on Google.

The key terms used in Portuguese were: mutilação genital feminina, corte dos genitais femininos, MGF, CGF, circuncisão feminina, fanado, excisão and práticas tradicionais.

In order to give an overview of the trends regarding FGM, theses and papers produced at national level were also included in the endnote library. It can be seen that over the past few years, more universities and institutes have been working on FGM and debating the issue. This may be a result of the information, education, communication and advocacy initiatives, including sensitisation and awareness raising, which has taken place in Portugal over the last few years.

Policies regarding FGM are mainly developed under the Portuguese governmental mechanism for gender equality, the CIG (previously named CIDM — Commission for Equality and Women’s Rights). This governmental body is integrated into the presidency of the Council of Ministers and is currently under the supervision of the Secretary of State for Parliamentary Affairs and Equality.

To have access to the official date of policy implementation, a search was done on the website of Diário da República online (http://dre.pt/), where it is possible to have access to all legislative documents.

The UN Secretary-General’s database on violence against women was accessed. However, the information about Portugal and specifically on FGM was not updated as it referred to the first programme of action for the elimination of female genital mutilation and the constitution of the intersectoral working group that was developing the programme of action at that time (data from 2009).

The CIG was contacted in order to get information on policy development. The information provided by the CIG’s international relations officer, was that the Ministry of Foreign Affairs was in contact with the UN department in order to send updated information regarding policies on FGM, and as such to update the information regarding Portugal in the UN Secretary-General’s database on violence against women.

The websites from the following actors were searched, using the keywords: mutilação genital feminina, corte dos genitais femininos, MGF and CGF.

- High Commissioner for Immigration and Intercultural Dialogue. E-mails were sent to the focal person from the intersectoral working group of the programme of action for the elimination of female genital mutilation.
- Directorate-General for Internal Administration/Ministry of Internal Administration. No relevant documents were found. E-mails were sent and contacts by phone made to the focal person from the intersectoral working group of the programme of action for the elimination of female genital mutilation in order to verify the existence of relevant documents and data on FGM. The information provided was that there were no documents on FGM or policies (e-mail and phone contact).
- Directorate-General for Justice Policy — Ministry of Justice. No documents or policies on FGM were found. E-mails were sent and contacts by phone made to the focal person from the intersectoral working group of the programme of action for the elimination of female genital mutilation in order to verify the existence of relevant documents and data on FGM. The information provided was that no documents on FGM or policies were available (e-mail and phone contacts).
- Camões Institute of Cooperation and Language, former Instituto Português de Apoio ao Desenvolvimento (IPAD — Portuguese Institute for Support and Development). No policy documents were found. Nevertheless, it was possible to find general information on FGM, such as the programme of action for the elimination of female genital mutilation and FGM events that were carried out under the intersectoral working group of the programme of action for the elimination of female genital mutilation.
- Directorate-General for Health (DGS)/Ministry of Health/Division of Reproductive Health. On 6 February,
DGS presented the ‘Technical guidelines for health professionals — Female genital mutilation’. On the website it was possible to find general information on FGM, like the programme of action for the elimination of female genital mutilation and information on FGM events that were carried out under the intersectoral working group of the programme of action for the elimination of female genital mutilation.

- Institute of Employment and Professional Training (IEFP). No policy documents found, nor information on FGM events.
- Directorate-General for Curriculum Development and Innovation (DGIDC). No policy documents found. On the website it was possible to find general information on FGM, like the programme of action for the elimination of female genital mutilation and information on FGM events that were carried out under the intersectoral working group of the programme of action for the elimination of female genital mutilation.
- CIG. The documents found were included in the database.
- The websites from the members of the intersectoral working group of the programme of action for the elimination of female genital mutilation have information regarding events on FGM (since 2008), and is possible to find the first and second programmes of action for the elimination of female genital mutilation. It is also possible to find some of the tools and instruments that were produced under the programme of action for the elimination of female genital mutilation. Nevertheless, it was not possible to find any other policies.

3.2. Policies on FGM

The development of the FGM policy in Portugal began in 2003, with the second national plan against domestic violence (2003–06), issued by the Presidency of the Council Ministers — Resolution of the Council of Ministers No 88/2003, in which a reference is made to FGM in number 6 — Immigrant women: ‘The number of immigrants who live among us has a very significant dimension in the Portuguese society. (...) The government has been assuming that it will not accept any form of female genital mutilation and will act accordingly.’

This happened after an official discourse by Prime Minister Durão Barroso (2002), mentioning the possibility that FGM is being performed in Portugal by Islamised ethnic groups of Guinea-Bissau. In the same year, some newspaper articles stated that Durão Barroso requested that Amélia Paiva (in her first official event as President of the Commission of Equality and Women’s Rights (CIDM)) ‘take the issue of fighting female genital mutilation as a priority.’

Before 2003, and as mentioned earlier in the report, the issue of FGM was taken up by newspaper articles and through some advocacy work developed by NGOs. In 2003, on 25 November, a first international seminar on FGM was organised by the CIDM. The seminar involved a public speech by the Minister of the Presidency and the Minister for Foreign Affairs. The Family Planning Association’s first study on FGM with health professionals was presented at this occasion.

The next policy document is the third national plan for equality — citizenship and gender (2007–10), officially made public in the Diário da República, series I, No 119 dated 22 June 2007, Council of Ministers Resolution No 82/2007. In that document, female genital mutilation is mentioned explicitly, under ‘Area 4 — Gender-based violence’, and implicitly, under ‘Area 5’, where goals and measures of action for development cooperation are presented, namely those related to the promotion of better public healthcare and services for women and children from other countries, as well as its support for programmes that benefit health, and sexual and reproductive rights.

In the first plan for migrant integration, officially made public in the Diário da República, series I, No 85 dated 3 May 2007, Council of Ministers Resolution No 63-A/2007, female genital mutilation is mentioned in the section ‘Gender equality — 114 — Combating the vulnerability of immigrant women’ (‘Combating the vulnerability of immigrant women, which is the consequence of multiple causes, such as domestic violence or the rejection of some of the traditions from their community of origin (…), reinforcing their autonomy and self-determination. For this purpose a permanent residence permit must be provided for, independent of family reunification mechanisms, along with appropriate legal protection.’)

Meanwhile in October 2007, in the context of the implementation of a Daphne project, ‘Developing national plans of action to eliminate FGM in the EU’, the APF invited Jorge Lacão, former Secretary of State of the Presidency of the Council of Ministers and responsible for gender equality policies, to be the mentor of the first programme of action for the elimination of female genital mutilation. In January 2008 the first official meeting of the intersectoral working group of the programme of action for the elimination of female genital mutilation took place, with representatives from different bodies.

The programme of action for the elimination of female genital mutilation was presented on 6 February 2009, on the International Day of Zero Tolerance to FGM, and was integrated into the third national plan for equality — citizenship and gender that had already included FGM in ‘Area 4 — Gender-based violence’.

The CIG is in charge of the implementation of the programme of action for the elimination of female genital mutilation, along with the intersectoral working group of the programme of action for the elimination of female genital mutilation.

Since the constitution of the intersectoral working group of the programme of action for the elimination of female genital mutilation, the International Day of Zero Tolerance to FGM has been officially marked (2008, 2009, 2010, 2011 and 2012). This is quite relevant in order to keep FGM on the agenda of technical and political decision-makers, as well as in the media, and to guarantee the involvement of different actors.

On 10 December (2009 and 2010), International Human Rights Day was also marked by the intersectoral working group of the programme of action for the elimination of
female genital mutilation. In 2010 the event took place at the headquarters of the Community of Portuguese-Speaking Countries (CPLP), where the CPLP Youth Forum made a public statement regarding FGM.

In the second plan for immigrant integration (2010–13), issued by the Presidency of the Council Ministers through Council of Ministers Resolution No 74/2010, FGM is mentioned in measure 86 ‘Preventing domestic violence and gender violence among immigrant men and women — Contributing to the prevention of all forms of gender violence, including domestic violence and female genital mutilation, among immigrant men and women by providing them with access to information, producing information materials translated into several languages, creating forums where these issues can be discussed, and media.’

The third national plan for equality — citizenship and gender, including the first programme of action for the elimination of female genital mutilation, covered the period from 2007 to 2010. Therefore, in 2011, another document addressing FGM was needed. The second programme of action for the elimination of female genital mutilation was presented publically on 6 February 2011 by the former Secretary of State for Equality, Elza Pais. It was included in the Fourth national plan for equality, gender, citizenship and non-discrimination, 2011–13, which was issued by the Presidency of the Council Ministers through Council of Ministers Resolution No 5/2011.

In this second programme of action for the elimination of female genital mutilation, two new public bodies were integrated into the intersectoral working group of the programme of action for the elimination of female genital mutilation — the Directorate-General for Internal Administration/Ministry of Internal Administration (DGAI/MAI) and the Directorate-General for Justice Policy/Ministry of Justice (GDJP/MJ).

During 2011, due to the political and economical crisis, including anticipated elections and the establishment of a new government, the frequency of meetings of the intersectoral working group of the programme of action for the elimination of female genital mutilation was reduced and the implementation of measures was put on hold. However, at the end of 2011, some new activities were developed and planned.

The second programme of action for the elimination of female genital mutilation is included under the competence of the CIG, with the support of the Secretary of Parliamentarian Affairs and Equality. She was a member of the Portuguese All-party Group on Population and Development in 2003, when the political and public debate on FGM started with governmental support.

The last policy document was presented on 6 February 2012 by the Directorate-General for Health/Ministry of Health/Division of Reproductive Health. This state body released the document ‘Technical guidelines for health professionals — Female genital mutilation’, which contains information on how health professionals should proceed when confronted with a case of FGM, or with an eminent risk of FGM. It also provides information on the WHO criteria for FGM classification, as well as on physical consequences (immediate and long-term), psychological and sexual consequences, obstetric complications, how to provide family planning for women or young girls with FGM, and care during pregnancy and pre-conception, labour and puerperium of women or girls with FGM.

As mentioned in Section 2.2., the FGM registration information will be obtained through the reports of ‘Health Action for Children and Youth at Risk’ in which it will be possible to identify cases marked as being at risk or cases FGM in newborns or young girls.

3.3. Reflection on policies on female genital mutilation

The most important Portuguese actor regarding FGM is the CIG, which integrated FGM into the national plan of action on domestic violence and later into the national plan on equality — citizenship and gender. However, the implementation of the programme of action for the elimination of female genital mutilation is carried out through the intersectoral working group of the programme of action for the elimination of female genital mutilation and, therefore, the representatives that are part of this group are also important actors for the development of policies on FGM.

Since 2007/2008 there has been a permanent representation from the health, education, equality, cooperation and migration sectors in the intersectoral working group of the programme of action for the elimination of female genital mutilation. At this moment there are not many policies being developed, and only recently the Directorate-General for Health/Ministry of Health/Division of Reproductive Health launched the document ‘Technical guidelines for health professionals — Female genital mutilation’.

The first programme of action for the elimination of female genital mutilation did not have a specific financial budget for the implementation of activities, and nor does the second. The implementation of activities is integrated into the budget of the members of the intersectoral working group of the programme of action for the elimination of female genital mutilation and into the budget of the CIGs.

The official report of the first programme of action for the elimination of female genital mutilation is not yet complete because of the political situation. However, with the introduction of the second programme of action for the elimination of female genital mutilation, it is possible to see some of the activities being implemented.

In the first programme of action for the elimination of female genital mutilation, most investment was in awareness, prevention, information and training on FGM, either with specific groups (health professionals; teachers of primary, secondary and higher schools; technical and social intervention; intercultural mediators; technical support from helplines for victims of domestic violence and immigrants; cooperation agents) or with the general public.
The Directorate-General of Home Affairs/Ministry of Internal Affairs and the Directorate-General for Justice Policy/Ministry of Justice are at this moment analysing what kind of intervention the sector can propose to carry out.

There have been contacts (by the Secretary of State for Parliamentary Affairs and Equality) with the Director of the Committee for the Protection of Children and Young People at Risk to find out what kind of work the commissions are doing regarding FGM, and with the Portuguese Immigration and Border Services (SEF) in order to find out how this body can intervene in asylum cases involving FGM.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The information on this section was collected from the website of the Diário da República online (http://dre.pt/), where it is possible to have access to all documents related to legislative measures.

Phone calls and e-mails were exchanged with a lawyer who works for the CIG. He was one of the focal persons of the intersectoral working group of the programme of action for the elimination of female genital mutilation when the first programme of action for the elimination of female genital mutilation was drawn up.

Phone calls and e-mails were exchanged with the focal person of the Directorate-General for Justice Policy/Ministry of Justice, which is the department responsible for statistical data in the Ministry of Justice.

Phone call with a lawyer for CEJUR (the Legal Centre of the Presidency of the Council of Ministers).

4.2. Criminal law

In 2003, a proposal for a law for FGM typification was presented by the CDS/PP party (draft law No 229/IX — proposal for a law on FGM typification). However, this proposal was never accepted as the other parties considered that Article 144 (Offence against physical integrity) of the Penal Code covered this situation and that due to the non-existence of preventive measures related to FGM, this proposal would discriminate against and segregating the practising communities.

Only after September 2007 did Portugal specifically include the issue of female genital mutilation under Article 144 of the Penal Code.

Regarding this aspect, some documents stated that Portugal has a specific law for FGM, yet other documents mentioned that Portugal does not have a specific law on FGM. Therefore, contact was sought with Dinamene de Freitas, who works in the CEJUR. She was one of the persons involved in the preparatory work for the revision of the Penal Code and Article 144. At that time, Dinamene de Freitas was working as an assistant to the Secretary of the Presidency of the Council of Ministers, the member of the government responsible for citizenship and gender equality. She mentioned that this change in law came from a governmental proposal created by Council of Ministers Resolution No 113/2005 of 29 July, and that the change was very precise, as it was possible to see in the preparatory works that the change was done in order to integrate FGM.

‘Point 8 — The crime of serious injury to body starts to integrate a new circumstance — the removal or disruption of the capacity of sexual fruition, which includes practices such as female genital mutilation.’

Two respondents are of the opinion that it is not accurate to state that Portugal integrates FGM in a general law because, with the revision in 2007 of Article 144, the expression ‘the removal or disruption of the capacity of sexual fruition’, was integrated and may be applied to a case of FGM. As a result, Portugal does not have an autonomous law on FGM but has an article from the Penal Code that was changed specifically in order to include FGM.

Article 144 (Offence against physical integrity) does not mention FGM or name different forms of FGM, however it includes FGM because it can provoke damage to sexual fruition and fulfilment, and provides for a penalty of 2 to 10 years in prison.

‘Article 144 — Offence against physical integrity

Any person who injures the body or impairs the health of another in order to:

(a) deprive them of an important organ or limb, or severely and permanently disfigure them;
(b) take or affect their working, intellectual, procreation or sexual fruition capacities (sexual fulfilment), or the possibility of using the body, senses or language;
(c) cause them a painful or permanent illness, or a severe or incurable psychic anomaly; or
(d) cause them danger to life.

shall be punished with imprisonment of 2 to 10 years.’

There are no known court cases on FGM grounds and there is no information collection system or reports available (specifically for FGM cases).

According to the focal person from the Directorate-General for Justice Policy/Ministry of Justice, it is not possible to disaggregate data on FGM from the general data concerning the crime of serious harm to physical integrity as only the total number of crimes is recorded, and these are not brought into relation to each of the isolated subtypes covered by Article 144. From the point of view of criminality, FGM is mentioned in subparagraph (b) of Article 144 of the Penal Code; however, data on FGM are to be statistically processed under the type ‘serious offence’.

4.3. Child protection laws/provisions

Law 147/99 of 1 September — Protection of children and young people at risk — can be applied to a case or a risk of
FGM. In particular, this law can have a role in the screening and protection of children at risk or in danger (which FGM can be under) through the Commissions for the Protection of Children and Young People (Comissões de Protecção de Crianças e Jovens em Risco — http://www.cnpcjr.pt).

The Commissions for the Protection of Children and Young People are non-judicial official institutions with functional autonomy aiming to promote the rights of children and youngsters. In case parents, a legal guardian or any person responsible for a child or youngster poses a risk to his/her safety, health, training, education or development, or whenever such a risk is caused by the action or negligence of a third party or the child or youngster themselves (Article 3, paragraph 1), these committees prevent or put an end to this risk.

‘Law 147/99, Article 3, paragraph 2 considers that the child or youngster is in danger, for example, in one of following situations: (a) when the child lives by him/herself or has been abandoned; (b) when the child suffers physical or mental abuse or is the victim of sexual abuse; (c) when the child does not receive the care or affection appropriate to their age and personal situation; (d) when the child or youngster is forced to perform activities or is required to work in a manner excessive or inappropriate to their age, dignity and personal situation or prejudicial to their personal education or development; (e) when the child is subjected, directly or indirectly, to behaviour that seriously affects his/her safety or emotional balance; (f) when the child indulges in behaviour or activities or habits that damage seriously his/her health, safety, training, education or development and in case there is no action from the parents, legal guardian or whoever is responsible with the aim of removing the child from this situation.’

No cases of FGM have been reported. There is no information collection point, however these situations should be reported to the Commissions for the Protection of Children and Youth at Risk.

4.4. Asylum law(s)/provisions

In Portugal, grounds for asylum can be applied under Law No 27/2008 of 30 June (Diário da República, series 1, No 124), which establishes the conditions and procedures for granting asylum or subsidiary protection and the status of asylum, refugee and subsidiary protection to applicants. Article 5 paragraphs 2(a) (acts of physical or mental violence, including of a sexual nature) and 2(f) (acts performed specifically for reasons of gender or against minors) can be applied to a situation involving FGM. (English version available at http://www.sef.pt/documentos/56/Act27_2008_30June.pdf)

The law defines a ‘refugee’ as a foreign citizen, who, rightly, fearing to be persecuted as a result of an activity exercised in the state of his/her nationality or his/her usual residence, on behalf of democracy, social and national freedom, of peace among peoples, of freedom and human rights or due to his race, religion, nationality, political beliefs or belonging to a certain social group, is out of the country of his nationality and may not or, due to any fear, does not wish to request that country’s protection, or a stateless person who, being out of the country where he/her had his/her usual residence, for the same abovementioned reasons may not, or due to the abovementioned fear does not wish to come back to that country, and to whom the provisions of Article 9 do not apply’.

Information with regard to asylum granted on the grounds of FGM was searched for in the Portuguese Immigration and Borders Service’s report, however no data was available.

The 2010 report mentions that the Portuguese Immigration and Borders Service received 160 requests for asylum in 2010. Most applications were submitted by African citizens (63.75 %), with emphasis on Guinea (43), Angola (12), Guinea-Bissau (10) and the Democratic Republic of the Congo (9). Some 72.50 % of foreigners that requested asylum were male.

Refugee status was granted to six national citizens from African and Asian countries (in 2009 only 3), and within the framework of international protection 51 residence permits were granted for humanitarian reasons (45 in 2009), mainly to citizens from African countries (31) followed by citizens from the American continent (16) and Asia (4).

Compared to 2009, an increase in asylum requests of 15.11 % was observed. However, considering that the total number of asylum requests is relatively low, it is not possible to have a clear identification of the trends or patterns through the last decade.


In 2003, Público (a national newspaper) mentioned a case of a asylum request that was denied on the grounds of FGM (http://www.publico.pt/sociedade/noticia/portugal-negra-asilo-a-quetana-que-fugi-a-mutilacao-genital-feminina-1147915). In order to get more information about this case, the Portuguese Council for Refugees (CPR) was contacted. The reply confirms that some years ago there was a case of an asylum request based on FGM by a Kenyan citizen, but there were some problems in the sense that once the application was submitted, the woman concerned ‘disappeared’.
4.5. Professional secrecy provision(s)

Regarding professional secrecy provisions those are mentioned in the Criminal Procedure Code, Article 242 — Mandatory reporting.

1 — Reporting is mandatory, even if the agents of the crime are not known:
(a) for law enforcement authorities, for all crimes of which they come to know;
(b) for public functionaries, within the meaning of the Article 386 of the Penal Code, for information on crimes of which they come to know in the course of their occupational duties and activities.

2 — When several persons are obliged to report the same crime, disclosure by one of them dismisses the disclosure by the remaining ones.

3 — When referring to a crime for which the procedure requires a complaint or private accusation, reporting shall only give rise to an investigation if the complaint is filed within the period established by law.

Health professionals, social workers, teachers, and policies and public functionaries in general have to report if they consider that a girl may be at risk of or has been subjected to FGM (see Leye, S., 2009). Article 17 of Law 147/99 mentions the constitution of the Commissions for the Protection of Children and Youth at Risk, which have one member representing the municipality, one member from the social security services, one member from the Ministry of Education (teacher), one doctor representing the health services, one member from an IPSS (instituições de solidariedade particular) or NGO, one member from parents’ associations and youth associations, and one member from the national guard or the public security police (Guarda Nacional Republicana ou a Polícia de Segurança Pública).

Article 70 — Participation of crimes committed against children — When the facts that have determined the danger situation constitute a crime, entities and institutions referred to in Articles 7 and 8 should report them to public ministry or police authorities, without prejudice to communication referred to in previous articles. Article 7 — Intervention of entities with childhood and youth competences, and Article 8 — Intervention of the Commissions for Protection of Children and Youth.

The disciplinary sanctions in case of non-reporting for public officers are described in Law No 58/2008, of 9 September — Disciplinary status of public officers. Article 17 mentions suspensions (‘The penalty of suspension is applicable to staff who act with serious negligence or with serious disinterest in the fulfilment of functional duties and to those whose behaviour seriously disregards the dignity and prestige of the function’ (accessible in English at http://www.dgap.gov.pt/eng/media/Lei58_Estatuto_Disciplinar.pdf)).

There have not been any sanctions or issues regarding professional secrecy.

4.6. Reflection on legal framework

The legal framework in Portugal has changed over the past years, especially with the reformulation of Article 144 of the Penal Code in 2007. In spite of FGM being a public crime, this is not well known by most professionals, including lawyers and justice workers and the public in general.

It is necessary to work on preventive measures with the involvement of sectors like the Directorate-General for Internal Administration/Ministry of Internal Administration (DGAI/MAI), the Directorate-General for Justice Policy/Ministry of Justice and the Portuguese Immigrant and Border Service (SEF), with specific training of such professionals on FGM (an aspect that has not been covered under the first programme of action for the elimination of female genital mutilation).

There have not been any reported cases of children at risk, so the engagement and training of the professionals (namely from the health, education and social affairs) and professionals from the Commissions for the Protection of Children and Youth is essential in order to identify and protect girls at risk of FGM (in Portugal or by travelling to countries of origin).

The new policy from the Directorate-General for Health/Ministry of Health/Division of Reproductive Health regarding the ‘Technical guidelines for health professionals — Female genital mutilation’ might be an efficient way to report cases, but it should be highlighted that the law by itself can be used as a protective mechanism, and not only for punishment.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

The information on actors was provided after research on websites, information from institutional bodies and information provided at the beginning of the study by the core team. To validate the information, e-mails were sent and websites were consulted.

- E-mails were sent to AICA, the migrant association from the Almada municipality, after receiving information that this NGO was working on FGM (e-mail, phone call and other contacts).
- E-mails and phone calls were made to the Association for the Defence of Human Rights (ADDHU), the Portuguese Platform for Women’s Rights, the Portuguese Council for Refugees, the Portuguese Association for Victim Support (APAV), Intercoperation and Development (INDE), the International Organisation for Migration (OIM) and the Association of Women Against Violence.
- The website of the Community of Portuguese-Speaking Countries (CPLP) and Google research.
- Some of the actors are from the intersectoral working group of the programme of action for the elimination of female genital mutilation and official departments that have been contacted to gain access to information regarding POL and LEG (mention on the sections on POL and LEG).
The number of actors that are working in Portugal on FGM is not exhaustive and most of them do not have specific projects on FGM, but develop activities regarding information, education and communication activities, as well as sensitisation and awareness raising on FGM.

5.2. Actors

The following are considered to be actors: NGOs, official members of the intersectoral working group of the programme of action for the elimination of female genital mutilation (ministries) and experts. The Commissions for the Protection of Children and Youth at Risk and the Portuguese Immigration and Borders Service (SEF) are not considered to be actors as, so far, no concrete actions with regard to FGM have been undertaken by these two entities.

- The Family Planning Association (APF) at the beginning of 2000 to work on FGM in its advocacy work, mainly with members of the parliament and the goodwill ambassador, and in sensitisation sessions for health professionals, students and specific community groups. The APF has produced some materials, like books, factsheets and posters for advocacy campaigns on FGM.

- This NGO was also involved in the development of the first programme of action for the elimination of female genital mutilation. At this moment APF is a member of the intersectoral working group of the programme of action for the elimination of female genital mutilation, and the national partner, along with AI-Portugal, in the ‘End FGM’ campaign. Over the last several years, APF has been able to involve other actors in the issue, such as in the production of the book *For being born a woman — Another side to human rights* and in that book presented the second study done with health professionals, ‘Perceptions, attitudes and knowledge of health professionals with regard to FGM’ (this time in the Loures municipality). The APF has been in contact with NGOs, professionals, the government and platforms from Guinea-Bissau, due to the work developed in that country on maternal health and with the ODM development, and has been working with FGM-practising communities in Portugal and empowering women to become strong voices and activists for FGM abandonment.

- Women’s Union, Alternative and Response (UMAR) organised a first public event on FGM in 2002, with Paula da Costa who worked in Guinea-Bissau with a women’s international NGO on the *fanado alternativo. Fanado* is the name given in Guinea-Bissau for the ritual where the cut is done. The project’s aim was the reconversion of ‘fanatecas’ (women who perform FGM) and advocacy of an alternative ritual without the cut. UMAR is also a member of the intersectoral working group of the programme of action for the elimination of female genital mutilation. UMAR works on FGM sensitisation and training. On the UMAR website it is possible to have access to different information sources regarding FGM. This NGO has shelters for women who have suffered from any form of violence, especially domestic violence, and some of them may be women who have undergone FGM in their countries of origin.

- Another relevant actor is Sofia Branco, a journalist who has been publishing articles on FGM since 2002. In August 2002 she wrote an article in which she mentioned that FGM was being carried out in Portugal. It was due to this article that the Portuguese Prime Minister Durão Barroso started to advocate that the Portuguese government ‘would fight against FGM’ and that the issue was included in the national plan on domestic violence. In 2006 Sofia Branco published a book called *Cicatrizes de mulher*, edited by *Público*. The journalist received the Natali Prize from the International Federation of Journalists and the European Commission for her the newspaper article ‘Female genital mutilation — the silent holocaust of women whose clitorises continue to be removed’.

- At this moment she works for LUSA (a Portuguese news agency), and continues to write articles related to FGM in general, as well as regarding the programme of action for the elimination of female genital mutilation implementation. Sofia Branco has also published articles related to the ‘End FGM’ campaign, and recently articles dealing with the launch of the ‘Technical guidelines for health professionals — Female genital mutilation’. Some of Sofia Branco’s articles (from between 2002 and 2009) can be accessed online ([http://www.dininho.org/DOSSIERPUBLICOPTSOBREAMUTILACAOGENITALFEMININA.htm](http://www.dininho.org/DOSSIERPUBLICOPTSOBREAMUTILACAOGENITALFEMININA.htm)).

- The Commission for Citizenship and Gender Equality (CIG) which is since 2009 responsible for the implementation of the programme of action for the elimination of female genital mutilation. In 2003 CIG has organised an International Seminar on FGM with the participation of international speakers and NGOs from Guinea-Bissau. During that seminar the first APF study with regard to FGM and health professionals was presented. Along with the coordination of the programme of action for the elimination of female genital mutilation, CIG has also produced some leaflets and a poster on FGM for awareness raising in practising communities.

- The Instituto Marquês de Valle Flor (IMVF) has been working on FGM in Guinea-Bissau (development cooperation). In the course of the ‘Invisible Faces’ Project, a DVD — Fala di Mindjeris — was produced with testimonies of life stories of women living in Guinea-Bissau and in Portugal; FGM issue was part of the interviews. This project was financially supported by the former IPAD — Portuguese Institute for Development (currently named Camões — Instituto da Cooperação e da Língua). Phone contacts were made in order to see the trends. At this moment NGOD does not have any project on FGM.

- Since 2009, Amnesty International Portugal (AI-Portugal), together with APF, has formed the Portuguese partnership in the ‘End FGM’ campaign. Under this partnership advocacy work regarding FGM has been developed, covering press releases, TV interviews, the translation and revision into Portuguese of ‘Ending female genital mutilation’.

- In February 2009, Amnesty International Portugal presented the study ‘Female genital mutilation in Portugal’; prepared by Sandra Piedade as her master’s thesis in social and organisational psychology (2008). In this thesis, two studies were conducted in order to collect data on (1) the perspective and perceptions of women who have undergone FGM and the experts’ perspective and perception on FGM (qualitative study),
• Carla Martingo prepared her master’s thesis on FGM: ‘Female genital cutting — the case of Guinea’s women: exploratory study’ (2009). She is the focal person of the High Commission for Immigration and Intercultural Dialogue (ACIDI) in the intersectoral working group of the programme of action for the elimination of female genital mutilation.
• The ACIDI is an official department, under the auspices of the Ministers of Council of Presidency, and a member of the intersectoral working group of the programme of action for the elimination of female genital mutilation. FGM had already been integrated into the first plan for immigrant integration (measure 114), and it was integrated into the second plan of immigrant integration (measure 86).
• The activities developed and provided by this official department include training for professionals who work on the ‘SOS Imigrante’ helpline, and for the mediators from the CNAI (National Centres for Immigrant Support) and Uavidre (Victim Support Unit for Immigrant and Racial or Ethnic Discrimination).
• Through its newsletter a specific article on FGM was issued, written by the former Secretary of State of the Presidency of the Council of Ministers, Jorge Lacão: ‘Gender violence — the practice of FGM. It has also produced a specific reportage on FGM in a TV programme called Nós (‘We’).
• The Directorate-General for Internal Administration/Ministry of Internal Administration is an official member of the intersectoral working group of the programme of action for the elimination of female genital mutilation. It is responsible for implementing policies on public security, protection and rescue, immigration and asylum, and is still analysing how it can intervene in the FGM issue.
• The Directorate-General for Justice Policy/Ministry of Justice is a state central body of direct administration. Its main purpose is to give technical support within the scope of legislative production and legal assessment, to monitor policies and strategic planning for the sector, and to coordinate external affairs and cooperation in the area of justice. It is also responsible for statistical data in the Ministry of Justice. This official body was recently integrated into the intersectoral working group of the programme of action for the elimination of female genital mutilation and is still exploring what its contribution will be regarding FGM.
• Camões, the Institute of Cooperation and Language (previously the Portuguese Institute for Development — IPAD), is a governmental foreign affairs body, a member of the intersectoral working group of the programme of action for the elimination of female genital mutilation, and has financially supported the publication of the Portuguese edition of the interagency statement and the manual on FGM for health professionals ‘Female genital mutilation — Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A teacher’s guide’ (WHO) and the manual Eliminating female genital mutilation: An interagency statement — OHCHR, UnAids, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem, WHO (WHO, 2008). It has also been a member of the intersectoral working group of the programme of action for the elimination of female genital mutilation since the beginning. Recently it presented the ‘Technical guidelines for health professionals — Female genital mutilation’.
• The Institute of Employment and Vocational Training (IEFP), a public body under the Ministry of Social Security and Labour, which is responsible for the implementation of employment policies and training. A member of the intersectoral working group of the programme of action for the elimination of female genital mutilation, the IEFP is going to include the issue of FGM in training courses for trainers on sexual and reproductive health and rights.
• The Directorate-General for Innovation and Curriculum Development (DGIDC) is an entity of the Ministry of Education that is responsible for legal instruments and educational textbooks for schools and teachers. The DGIDC has trained teachers on FGM. As a member of the intersectoral working group of the programme of action for the elimination of female genital mutilation, DGIDC was responsible for the design of the leaflets on FGM produced under the programme of action for the elimination of female genital mutilation.
• The Community of Portuguese-Speaking Countries (CPLP) is a member of the intersectoral working group of the programme of action for the elimination of female genital mutilation and has been involved in two events regarding FGM. In 2009 a meeting at the CPLP headquarters was organised, where the Youth Forum of CPLP made a public statement regarding FGM (http://195.23.38.178/cig/portalcig/b0/documentos/Decla_f_Juventude.pdf).
• The CPLP’s involvement is important, and reflects the commitment regarding FGM from Portuguese-speaking countries. The strategic plan on gender equality and empowerment of women from the CPLP mentions FGM in measure 11 — Health — Combating FGM — ‘Exchange/adaptation of awareness-raising materials intended to increase the understanding of the population on the physical, psychological and
social consequences of FGM, in order to prevent and discourage FGM and similar practices in the context of sexual and reproductive rights.’ (http://195.23.38.178/cig/portalcig/bo/documentos/PECIGEM.pdf)

The other actors mentioned in the database were contacted. In spite of the fact that their activities were more temporary, some of them integrated FGM into their activity plans (see ACT sheet).

5.3. Reflection on actors on female genital mutilation

In this section, it is possible to see that over the past few years there have been several actors with activities related to FGM, and most of them are part of the intersectoral working group of the programme of action for the elimination of female genital mutilation.

At the beginning of 2002 the issue was put into the political agenda by several articles from Público (a newspaper) and some NGOs that started to develop advocacy activities related to FGM with the support of international agencies like UNFPA and with international funding. The issue started to gain national support and visibility with the international seminar that was organised by the CIDM (which is now the CIG) on 25 November 2003.

The issue was integrated into the national plan against domestic violence, though only in 2007/2008, with the implementation of a Daphne project and the subsequent constitution of the intersectoral working group of the programme of action for the elimination of female genital mutilation, was it possible to have a concrete programme for FGM with associated measures (but with no financial budget).

The main policy work in the last few years (since 2009) concerns the development of the ‘Technical guidelines for health professionals — Female genital mutilation’. In addition, several documents and leaflets were produced in order to inform communities and professionals about consequences of FGM.

It is possible to see that the involvement of NGOs is quite difficult, with some of them working temporarily on FGM and promoting debates and seminars on the issue but with no projects focused on the practising communities. It would be necessary to have more NGOs that actively involve practising communities. A problem identified by the Family Planning Association is the fact that migrants’ NGOs usually have male leadership, with only a few women actively involved in the work that is developed. The main reason is that women are working all day and after that they have to support their families, while most men from these communities do not work or are retired. Another important aspect is that there is no specific support for ‘immigrant NGOs/community-based NGOs, and that they do not have a strong background in applying for funding structures.

We can say that the activities developed are in ‘coherence’ with the existing policies and do mainly concern prevention activities, including the training of professionals on FGM.

The most significant actors can be divided into three categories:

1. those who are the promoters of activities (Family Planning Association (AFP); Women’s Union, Alternative and Response (UMAR); Sofia Branco; Carla Martingo, Commission for Immigration and Intercultural Dialogue (ACIDI); Camões/IPAD);
2. those who are partners in the process (Directorate-General for Health/Ministry of Health/Division of Reproductive Health; Commission for Equality and Gender (CIG); Institute Marquês Valle Flor (IMVF); Amnesty International Portugal (AI-Portugal); and Community of Portuguese-Speaking Countries (CPLP));
3. and those who are still exploring the field and identifying their specific role (Institute of Employment and Vocational Training (IEFP); Directorate-General for Innovation and Curriculum Development (DGIDC); Directorate-General for Justice Policy/Ministry of Justice; Directorate-General for Internal Administration/Ministry of Internal Administration).

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

In order to get information regarding tools and instruments (T & I), academic database research was carried out, together with a Google search and contacts (e-mails and phone calls) with key professionals.

The key terms used in Portuguese were: mutação genital feminina, corte dos genitais femininos, MGF, CGF, circuncisão feminina, fanado, excisão e práticas tradicionais.

There are many T & I on the issue and most of them were produced by the actors mentioned above.

6.2. Tools and instruments on FGM

Most of the T & I in Portugal are surveys or studies, factsheets, leaflets, posters and international documents that have been translated, revised and adapted into Portuguese (Eliminating female genital mutilation: An interagency statement — OHCHR, Unaid’s, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem, WHO, WHO, 2008, and Female genital mutilation — Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A teacher’s guide’).

The first programme of action for the elimination of female genital mutilation (2009) is considered to be a T & I because it can be used as an instrument and a source of information on FGM in Portuguese.

A leaflet on FGM was produced for professionals from health services, education, social services, justice, cooperative community leaders, and girls, women and families at risk of FGM or already subjected to this practice. This leaflet is an IEC (information, education and communication) tool on FGM that addresses the medical and legal consequences of this practice and identifies
services and institutions prepared to assist, and referral requests for medical and psychosocial support. The leaflet was also adapted to the Guinea-Bissau context and was distributed in collaboration with the National Committee for the Abandonment of Traditional Practices Harmful to Women’s Health and Children.

The international documents *Eliminating female genital mutilation: An interagency statement* — OHCHR, Unaids, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem, WHO and the WHO training manual for health professionals ‘Female genital mutilation — Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery. A teacher’s guide’ were translated, adapted reviewed and edited by the APF, and also reviewed by Directorate-General for Health/Ministry of Health/Division of Reproductive Health and financially supported by IPAD — one of the activities from the first programme of action for the elimination of female genital mutilation (measure 1 — activity 5).

The T & I are mainly for professionals (different areas), MPs, MEPs, technical persons, decision-makers and NGOs and the general public. Only the poster and leaflet ‘Say no to excision’ produced by the CIG has the practising communities as the main target group.

6.3. Reflection on tools and instruments on female genital mutilation

The tools and instruments reflect the diversity of actors and areas involved in the issue of FGM.

As described in the section above, it is possible to see that some of the most active actors on FGM are those who have produced several T & I on the issue.

The T & I have been produced over the last decade. Most of them were produced by NGOs and only in 2009, with the existence of the programme of action, have other actors been involved in the development of tools.

There is a need to develop T & I for practising communities and specific programmes to train professionals (like teachers, lawyers, board services, asylum officers) and the respective technical guidelines.

7. FINAL CONSIDERATIONS

Portugal started to work on FGM recently, and only in 2009 was the first programme of action for the elimination of FGM integrated into the third national plan for equality — citizenship and gender.

The most important actor at policy level is the CIG, which integrated FGM into the national plan of action on domestic violence, and later on integrate the programme of action for elimination of female genital mutilation into the national plan on equality — citizenship and gender.

Fewer activities than expected were developed within the programme of action for the elimination of female genital mutilation. This was probably related to the fact that no specific budget was granted. There is a need for more active involvement from a variety of actors, such as the asylum sector and the Commission for Child Protection.

It can be seen that some universities and institutes have taken on FGM as an issue for research and that some students have produced their master’s thesis on FGM. This certainly contributes to better knowledge about the FGM situation in Portugal, including the collection of more data on FGM and the promotion of a public discussion on the issue.

Portugal does not have an autonomous law on FGM, but the current legal framework is applicable to FGM. However, it seems that the general public and even professionals who could be confronted with FGM (teachers, health professionals, social workers and public servants) are not always aware about the fact that FGM constitutes a public crime.

NGOs and journalists were the main actors to bring FGM into the political agenda and their dedicated work provided the right ‘environment’ for the implementation of the first programme of action for the elimination of FGM.

Although we see the involvement of migrant NGOs from practising communities, through the organisation of seminars and debates, it is important to have more NGOs from practising communities developing projects for the abandonment of harmful traditional practices and FGM.

The activities developed are in coherence with the existing policies, consisting mainly of prevention activities, including the training of professionals on FGM.
I. INTRODUCTION

The qualitative in-depth study aims at assessing successes and challenges in the work on female genital mutilation (FGM) in nine selected countries (Portugal being one of the chosen countries) and establishing past and present good practices with reference to the ‘six Ps’ approach defined for the purposes of the ‘study to map the current situation and trends of female genital mutilation’.

According to the methodology defined by the core team, and taking into account the suggestions of potential key informants to be contacted, the researcher approached the respondents by e-mail on 12 June. The invitation process went smoothly and by 19 June all interviews were fixed to take place between 28 June and 12 July in Lisbon. However, the last interview had to be rescheduled due to an unexpected professional commitment of the respondent that would coincide with the date and hour of the interview. An alternative date for conducting the interview was easily found and there was no need to replace the key informant. A list of the key informants that agreed to collaborate in this study and a brief description of their profile are provided in the section below.

A set of six customised questionnaires were prepared and sent to each key informant in advance (at least 24 hours before the time of the interview). Although the information collected during the interviews proved to be very pertinent and interesting, the researcher considered it relevant to contact by e-mail three additional informants in order to get further clarifications on certain topics.

The present report will provide an analysis of the content of the six interviews, as well as other relevant information from other sources. The report will firstly clarify the historical context against which the current situation in terms of the approach to FGM is perceived by the respondents, and will identify the features and the actors that have been triggering the development of policies at national level. An analysis per ‘P’ on the approach to FGM will follow. Concerning the Portuguese case study, all the ‘Ps’ were subject to analysis during the interviews, although to different extents. Afterwards, the successes and challenges of the policy approach will be examined, followed by an identification of policy lessons and recommendations to improve it. Based on this analysis, potential good practices will be assessed against the criteria defined by EIGE. Finally, the main conclusions will be enumerated and some recommendations will be made based upon the information collected during the in-depth research.

II. INFORMATION SOURCES

Key informants

An overview table of the interviews conducted between 28 June and 11 July 2012 can be found herein. Six face-to-face interviews were performed in Lisbon, with durations of between 86 and 120 minutes.
A member of the intersectoral group about FGM, representing the High Commission for Immigration and Intercultural Dialogue (ACIDI). She has not yet answered the e-mail sent.

A member of the board of the NGO Women’s Union, Alternative and Response (UMAR) and represents this organisation in the intersectoral group about FGM. She provided some clarifications regarding UMAR’s intervention in the field of FGM.

A public prosecutor and project coordinator at the Centre for Judicial Studies. She recently conducted research on the number of investigations into/court cases on FGM. She has not yet answered the e-mail sent. The researcher was informed that she is on vacation.

III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

The historical context overview that is presented herein summarises the contributions of the key informants about the most relevant moments that have guided the approach to FGM in Portugal. Moreover, the researcher carefully cross-checked the information provided and added other pertinent details.

In 2000 the World Health Organisation (WHO) identified Portugal as an FGM risk country. The estimation of this risk was based on the assumption that there were/are immigrant communities living in Portugal that originate from countries where FGM is practised and that these communities may continue to perform it inside Portuguese territory, or on the occasion of trips to their countries of origin during school vacations and/or family visits. This statement came to the attention of the APF, which started to participate in several meetings with NGOs at the European level and with the WHO in order to understand the implications for Portugal to be considered an FGM risk country.

In 2002 UMAR organised the first initiative about FGM in Portugal (15 May), inviting for this purpose representatives of an NGO that, at that time, was developing a project in Guinea-Bissau about an alternative FGM procedure (fanado alternativo). One respondent identifies this event as the trigger moment that drew her attention to the topic, particularly a sentence of the speech by Paula da Costa (an FGM consultant on FGM projects in Guinea-Bissau): ‘Do not be surprised that this [FGM] can be happening here [Portugal]’: A journalistic investigation followed and, in that same year, the first articles about FGM were published in a daily newspaper. These articles triggered policy development.

In this same year, in September, the Prime Minister, Durão Barroso, publicly declared, upon the appointment of the new President of the Commission of Equality and Women’s Rights (CIDM, former CIG), Amélia Paiva, that FGM was a national concern. Moreover, the Prime Minister stated that this type of situation cannot be altered by
force of law, making it necessary to opt for other means to eliminate the practice.

In February 2003, a conservative right-wing political party (Partido do Centro Democrático Social — Partido Popular (Democratic and Social Centre — People’s Party), CDS-PP) took up the issue by proposing a specific criminal law to prosecute FGM that was discussed in the national parliament, but was not approved. In this same year, for the first time, FGM was included in a national plan. The second national plan against domestic violence (2003–06) refers to FGM under measure No 6 — Immigrant women:

‘The number of immigrants who live among us has a very significant dimension in Portuguese society. The coexistence of several communities with such different cultural values and references results in new problems, namely in the area of domestic violence. The government has been explicitly assuming that it will not accept the practice of any form of female genital mutilation in Portugal and will act accordingly.’

The activities defined for this sixth measure were:

• sensitis[e] immigrant communities about all forms of FGM being a violation of human rights;
• criminalise FGM;
• prepare healthcare centres and hospitals to provide assistance, if necessary, in situations of FGM among the communities in which it is practised, and to women and girls that look for help.

It was also in 2003 that APF conducted the first study, funded by the United Nations Population Fund (UNFPA), to identify the perceptions and knowledge of health professionals (including medical doctors, nurses, and social workers) concerning FGM. It was also intended to discover the number of cases that these professionals had dealt with. A questionnaire (based on previous questions from a WHO study on FGM) was distributed and interviews were performed in local healthcare centres and hospitals situated in areas with higher concentrations of migrant population (within some municipalities that compose the area of Greater Lisbon (¹), i.e. Lisbon and Amadora). This study was publicly presented in 2003, on 25 November, during the first international seminar on FGM that was organised by the Commission of Equality and Women’s Rights, and later published by the CIG in 2004.

The year 2007 is again a relevant mark in the Portuguese FGM context. In April 2007 there was a modification of the law to prosecute FGM that was discussed in the national parliament, but was not approved. In this same year, for the first time, FGM was included in a national plan. The second national plan against domestic violence (2003–06) refers to FGM under measure No 6 — Immigrant women:

In October 2007 the University of Gent, the European network Euro-Net FGM, the APF and other European organisations implemented a European project, funded by the Daphne programme, to develop national action plans to prevent and eliminate FGM in the EU. During this project, the APF presented to the former Secretary of State of the Presidency of the Council of Ministers, Jorge Lacão, and to the president of the CIG at the time, Elza Pais, its contributions to this project and proposed to these policymakers the creation of a working group on FGM. The secretary of state welcomed the idea by being the mentor of this group that was supposed to be composed of several sectors with different expertise that could have an intervention on FGM in Portugal. The APF suggested the organisations (and respective persons) that could take part in this group taking into account their experience and knowledge about other action plans that were developed in the framework of this project. The project ‘Developing national action plans to prevent and eliminate female genital mutilation (FGM) in the European Union’ is considered to be an important turning point that launched Portugal into developing a concerted and strategic intervention between public organisations, international organisations and NGOs.

As a result of the abovementioned project, the first programme of action for the elimination of FGM (2009–11) was launched on 6 February 2009. This programme of action, included within the framework of the third national plan for equality — citizenship and gender (2007–10), is the result of efforts by the intersectoral group composed of public administration organisations, intergovernmental organisations and NGOs. The first programme of action invested essentially in sensitising, preventing, informing and training specific target groups and the general population. Some advocacy interventions also took place targeting national, European and African political decision-makers. Several instruments were produced and translated during the implementation of this programme. On 10 December 2009 the Executive Secretary of the Community of Portuguese-Speaking Countries (CPLP) (¹) participated in a meeting during which he expressed his support for the programme of action and formally joined the intersectoral group. The CPLP’s Youth Forum presented on the same day a political declaration condemning FGM (subscribed to by the National Youth Councils of the countries that take part in the CPLP).

In 2010 an international seminar about FGM took place on 8 February. The first programme of action for the

(¹) The Community of Portuguese-speaking Countries (Comunidade dos Países de Língua Portuguesa) was created in 1996 and includes Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique, Portugal, São Tomé and Príncipe, and Timor-Leste. The CPLP aims at promoting: (1) a political–diplomatic agreement between its member states (to reinforce their presence at international level); (2) cooperation on education, health, science and technology, defence, agriculture, public administration, communications, justice, public security, culture, sports and media; and (3) a materialisation of projects for promoting and disseminating the Portuguese language.

(²) The area of Greater Lisbon (Grande Lisboa, NUTS III, PT 171) is composed of nine municipalities: Amadora, Cascais, Lisbon, Loures, Maia, Odivelas, Oeiras, Sintra and Vila Franca de Xira.
elimination of FGM was weighed up and the strategy of the ‘End FGM’ European campaign (‘Ending FGM: A strategy for the European Union institutions’) was presented. Lisbon was one of the five cities where the strategy was launched by local NGOs.

In 2011, the second programme of action for the elimination of FGM (2011–13), included in the fourth national plan for equality — gender, citizenship and non-discrimination, was officially approved on 18 January. New public organisations joined the intersectoral group in the areas of internal affairs and justice. Nevertheless, during 2011, due to the political and economic crisis which resulted in early elections and the establishment of a new government, the work of the intersectoral group and the implementation of the measures of the second Programme of action were put on hold, although some activities have been developed and planned.

More recently, in 2012, a guideline for health professionals about FGM (6 February) and a procedures guide about FGM for criminal police staff (28 May) were launched. These instruments are described in detail in the subsections ‘Provision of services’ and ‘Prosecution’ respectively.

Considering the historical background presented above, and taking into account the input from the interviewees, it is possible to identify the key actors that have been more active in pushing FGM into the public and political agenda. They are as follows.

- NGOs, namely the APF and UMAR.
- Policymakers at national level (e.g. members of parliament and members of government) and European level (e.g. Members of the European Parliament). All the respondents emphasised the current commitment of the acting Secretary of State for Parliamentary Affairs and Equality to mobilise efforts to push the topic of FGM forward.
- Public organisations, such as the CIG, the ACIDI and the Portuguese Institute for Development Support (IPAD).
- The media (particularly from 2002 onwards, when the first newspaper articles were published about the topic).

In spite of the fact that there is no estimate of the prevalence of FGM in Portugal, policies have been developed and implemented. As pointed out during the interviews, the following seem to be the issues that are underpinning policymaking.

- Recognition of the representative existence of immigrant communities that originate from FGM-practising countries (in the Portuguese case, particularly the community from Guinea-Bissau) (unanimously recognised by all the respondents).
- The assumption that FGM might be practised on national territory.
- Results of the studies conducted among health professionals and other testimonies that confirmed the existence of FGM in the country.
- The motivation of some organisations to have policies to combat FGM.
- International data and information on FGM.

Regarding this matter, two respondents can be quoted.

‘The truth is that we cannot, with regard to this difficulty of having a reliable quantitative picture of the problem, stop promoting policies against FGM when we are convinced — and we are — that it exists, and most likely does not only come from the outside, but it is also practised on national territory.’

‘Having a country that started with policies about FGM with numbers (even estimated or precise) … I do not know if there is any, sincerely … All [policy developments] started from the perception that the issue [FGM] existed. It was an issue that in terms of equality and empowerment of women and in terms of gender-based violence could not be put in second place independently of the number of women … or the risk of the occurrence inside the [national] territory … This is something to be assumed. In reality, we start from [knowing] few numbers, it is true, but it is not the numbers that matter.’

IV. PREVALENCE AND DATA COLLECTION

As mentioned above, Portugal does not have a prevalence estimate for the phenomenon. Although there have been some efforts to assess the magnitude of FGM, they are not country representative and are based on restricted samples of health professionals.

According to the second programme of action for the elimination of FGM, it is planned that a study about FGM will take place. This study has not started yet, but according to the information provided by a respondent, a protocol is going to be signed with the Foundation for Science and Technology (FCT) (under the responsibility of the Ministry of Education and Science) to perform this study in 2013. In the second half of August 2012, a meeting will take place with the recently appointed administrative board of FCT to discuss how this study is going to be conducted.

The following information may be helpful in providing an overall picture of the existing immigrant communities that are legally living in Portugal and that originate from FGM-practising countries. According to the most recent ‘Report on immigration, frontiers and asylum’ issued by the Portuguese Immigration and Borders Service in June 2012, the largest female immigrant community comes from Guinea-Bissau. An adapted table (only considering the countries that practise FGM) about the resident immigrant population (disaggregated by nationality and sex) from this report is presented below. The figures date from 2011.
<table>
<thead>
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<th>Country</th>
<th>TOTAL</th>
<th>Men</th>
<th>Women</th>
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<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Burkina Faso</td>
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<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Cameroon</td>
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<td>48</td>
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<td>3</td>
<td>1</td>
</tr>
<tr>
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<td>1</td>
<td>2</td>
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<td>70</td>
</tr>
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<tr>
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<tr>
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<td>Liberia</td>
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<td>5</td>
</tr>
<tr>
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<td>9 182</td>
<td>13 964</td>
</tr>
</tbody>
</table>

The interviews also yielded information about administrative datasets that are going to be put in place during 2012 in the fields of child protection and health, as described below.

**Child protection**

In Portugal there is a National Commission for the Protection of Children and Youth at Risk (Comissão Nacional de Protecção das Crianças e Jovens em Risco) that is formed by a network of local commissions that report to the national branch. The national commission issues a yearly report based on the information provided by the local commissions in order to summarise the interventions conducted during the year. This report provides a very complete set of information, of which we highlight for the purposes of this study the national numbers related to the main motives justifying child protection interventions by the local commissions (e.g. negligence, exposure to deviant behaviours, psychological abuse, etc.), disaggregated by the age and sex of the child. At this time, FGM is not mentioned under the list of the motives that justify child protection interventions.

According to the information provided by two respondents, a protocol is going to be signed (in August or September of 2012) with the National Commission for the Protection of Children and Youth at Risk in order to collect information about cases/interventions related to FGM at local level. Besides including this information in the annual report (e.g. in the abovementioned section), the information about these cases/interventions is supposed to be reported annually to the CIG, which will inform the government in due time. The measures of this protocol are expected to be put in place at the beginning 2013, after all local commissions are informed about the guidelines on how to register information on FGM-related interventions. At the end of 2013 or the beginning of 2014, data regarding FGM-related interventions should be available in the annual report produced by the national commission.

More information about the National Commission for the Protection of Children and Youth at Risk and the local commissions, as well as child protection interventions, can be found in the 'Protection' subsection of this report.
Health

The recent guideline about FGM for health professionals (DGS guideline No 005/2012), issued in February 2012, recommends (1) the identification and guidance of children, young women and women that are at risk or have been subjected to FGM. According to this guideline, health professionals are advised to record the following situations.

(a) Upon gynaecological observation, the medical doctor should register in the patient’s medical record the type of FGM observed and make a drawing of the appearance of the vulva in order to avoid an extra gynaecological examination.

(b) Identification of female newborns born to women that originate from countries where FGM is practised. Before medical discharge, health professionals should liaise with the hospital support unit for children and youth at risk (2), requesting continued monitoring of the newborn’s family. Moreover, health professionals should fill in Annex II to the ‘Practical guide to approach, diagnosis and intervention — Abuse of children and young people’. Within Section C of this document, in the motive for referral, health professionals should select the option ‘Others’ and write ‘At risk of FGM’.

(c) The same procedure applies in all cases in which a girl or a young woman is identified as at risk of being subjected to FGM.

The procedures described above can allow collecting data about girls and women that have undergone FGM and girls and women at risk of undergoing FGM.

The guideline about FGM for health professionals (DGS guideline 005/2012) recommends including a code for FGM in the clinical management software of health units (i.e. healthcare centres and hospitals) in order to register and estimate centrally the number of identified cases. Nevertheless, different software platforms are being used in health units and, therefore, different codes could be used. Consequently, both the fact that there is a recommendation (and not a mandatory procedure) to include a code and that different software platforms are being used at national level may be considered an obstacle to the collection of data on FGM through the health system. Despite these constraints, it will be possible to discover the number of cases at national level as long as there is governmental intervention to accelerate the introduction of this code in the health units’ clinical software. Regarding this matter, one respondent is negotiating with the Ministry of Health the inclusion of a specific code for FGM in the IT platforms used by health professionals to register information about the patients that attend public health services (specifically paediatric, gynaecological and obstetric health services, and general practice). There is no specific date planned for the introduction of this code, although the respondent expects that it will be put in place in the next 2 months, followed by a period of internal guidance on how to register FGM cases. As regards the confidentiality of the data, the respondent gave assurances that the identity of the person will not be disclosed. For instance, aspects that will be taken into consideration will age and place of excision.

In as far as the support units for children and youth at risk are concerned, according to DGS guideline 005/2012 a report to assess the health action for children and youth at risk is supposed to be produced on a yearly basis (3). The upcoming reports are expected to identify the number of cases referred to as ‘at risk’ and as ‘FGM practised’ at national level.

Regarding other potential sources of information that will feed into the health system, an interviewee mentioned that the infantile and juvenile health programme is going to be replaced in order to include a reference to FGM. This means that health professionals will be instructed to pay special attention to girls at risk in order to prevent FGM (e.g. by raising awareness with their families, talking about FGM and understanding what families think about the practice). DGS was working on a new version of this programme when the interview took place and on 5 July 2012 the national infantile and juvenile health programme was made available online for public consultation and further contributions during nearly one month. In the eighth objective of the health exams, the programme mentions: ‘Identify, support and guide the children and families that are victims of abuse and violence, such as: negligence, physical, psychological and sexual abuse, bullying, harmful traditional practices, namely female genital mutilation’. Moreover, the programme contains a list of aspects/parameters that health professionals should take into consideration in different developmental stages of children and adolescents. For example, with regard to FGM, in several developmental stages (i.e. the first year of life, 1–3 years old, 4–9 years old and 10–18 years old) health professionals should ‘look for signs of FGM in risk families’, taking into account DGS guideline 005/2012 about FGM.

The clinical software system in infantile and juvenile health will include a code for FGM so that it can be registered and gathered with the already-existing codes of the support units for children and youth at risk. This programme will be presented during this year to be implemented in the 2013.

(1) The Directorate–General of Health issues, under its competences, different types of documents (i.e. guidelines, norms and information) to inform health professionals about the normative procedures that shall guide their intervention in the national health service. These instruments have different types of professional bonding and compulsoriness. Therefore, the verb ‘recommend’ is used here because we are dealing with a ‘guideline’.

(2) There is a network of units of health action for children and youth at risk nationwide. Each unit is composed of a multidisciplinary team of professionals that support health professionals in infantile and youth interventions. In each geographical area where there are healthcare centres and hospitals with paediatric assistance services there shall exist a support unit for children and youth at risk. More information in Portuguese can be found online (http://www.dgs.pt/ps11/default.aspx?id=5526).

Finally, another source to be considered within the health system to collect data on FGM is the national health helpline ‘Saúde 24’, a DGS service. This helpline is intended to assist citizens in health matters by making available the following services:

- triage, counselling and referral in case of diseases;
- therapeutic counselling (to clarify questions regarding medication);
- public health assistance (e.g. heat/summer, flu, emergencies/intoxications);
- general health information (to inform about the location of the health units of SNS, and pharmacies).

One respondent stated that, last February, the call centre operators of this helpline were trained about FGM. After 6 months (i.e. end of August 2012) a monitoring assessment will provide information regarding the number of calls received, as well as the type of information and support that is being asked. This assessment will also allow definition of the follow-up that should be put in place according to the type of calls received. As of this moment few calls have been received. These calls dealt essentially with the problems that result from undergoing FGM, and also about sexuality (no one was referred to any professional for further assistance).

IV.1. Suggestions for estimating prevalence and for data collection

All the respondents acknowledged the importance of establishing administrative datasets to collect data related to FGM cases, namely in the following sectors: health, asylum, police, justice and education. One respondent adds that the establishment of administrative datasets should be implemented at government level, i.e. it should be the government that determines whether FGM should be registered in different systems. In order to improve and to ensure the effectiveness of the identifications/registrations in these administrative datasets, two of the respondents consider that the officers of the public sectors mentioned above should receive training with regard to FGM and to the procedures to register the cases.

Moreover, the respondents recognised the pertinence of having a centralised reporting mechanism, at national level, to gather the information and data collected about FGM through different sources. In this respect, two of the respondents suggested the creation of an observatory responsible for receiving all the records (like, for example, the ones already in place for human trafficking, and violence and gender), and one respondent believes that the CIG should be the organisation responsible for centralising all data due to its coordinating role in the programmes of action for the elimination of FGM. In addition, establishing this centralised reporting mechanism will not constitute a challenge, because the sectors of health, asylum, police, justice and education are represented by public organisations that are part of the intersectoral group.

As regards other initiatives to assess the magnitude of FGM in the country, one respondent suggested repeating a survey about the knowledge of health professionals on FGM, including whether they feel qualified to act when confronted with a case of FGM.

Finally, one interviewee expressed a concern regarding the consequences of having prevalence estimates about the phenomenon in Portugal. Although the respondent considers it important to have a quantitative picture of the problem, she fears that the non-representativeness of the number of cases found will hold back the development of policies to combat FGM.

‘We could conclude that there are 10 or 20 … And what? We will not make public policies if there are only 10 or 20?! I am afraid of this argument afterwards. I understand that prevalence is linked to public policies and that there is a need to have a notion but I think that they should not be hostages to numbers. And there are numbers; there are global numbers. There are numbers in the origins. Trying to obtain numbers in Europe is fantastic! … I am not devaluing it … Its [numbers] absence should not be an excuse for not continuing with the other Ps!’

Nevertheless, as expressed by two of the respondents, the absence of data on FGM has not interfered with policymaking. During the last decade, policies have been developed and implemented without a prevalence estimate, although there is an interest in investigating the statistical perspective of the phenomenon.

V. APPROACH TO FGM

V.1. Overall

Based on the ‘six Ps’ approach defined for this study (shared with the respondents before the interview), although there seems to be some agreement on ranking prevention and partnership on the first level, and prevalence estimates in the last position, there does not seem to be a common perception on how the policy focus has been evolving.
An overview of the respondents’ perception on how policy development and implementation have been progressing over time is presented in the table below.

Table 1 — Evolvement of the policy focus over time based on the ‘six Ps’ approach

<table>
<thead>
<tr>
<th>Respondent 1</th>
<th>Respondent 2</th>
<th>Respondent 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Partnership</td>
<td>1. Prevention</td>
<td>Transversal to all Ps and, therefore, not ranked: Partnership</td>
</tr>
<tr>
<td>2. Prosecution</td>
<td>2. Protection + provision of services + partnership</td>
<td>1. Prevention</td>
</tr>
<tr>
<td>4. Prevention</td>
<td>Prevalence estimates was not ranked.</td>
<td>3. Prosecution</td>
</tr>
<tr>
<td>5. Protection</td>
<td></td>
<td>4. Provision of services</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Respondent 4</th>
<th>Respondent 5</th>
<th>Respondent 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevention + provision of services + partnership</td>
<td>1. Partnership + prevention</td>
<td>1. Partnership + prevention</td>
</tr>
<tr>
<td>2. Protection + Prosecution</td>
<td>2. Protection + prosecution + provision of services</td>
<td>2. Protection + prosecution + provision of services</td>
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</tbody>
</table>

According to the respondents’ understanding of the ‘six Ps’ approach, partnership, through the intersectoral group of the programmes of action for the elimination of FGM, could be considered transversal to all Ps. Partnership has been the base underpinning the programmes of action for the elimination of FGM, and it has allowed other partnerships that share resources (e.g. human and financial) to achieve certain goals (e.g. translating and publishing an FGM manual, organising events). The organisations that compose this group have been working together for the elimination of FGM. Nonetheless, one respondent ranks this P in fifth position because she believes that there is a need to find agents of change (local partners) inside practising communities to implement preventive actions due to the complex and traditional nature of this practice.

Generally, prevention is regarded as the P that has received most attention over time, because several awareness-raising initiatives and training courses addressing different target groups have been taken place. Moreover, advocacy work has been recognised as a useful tool to draw attention to the problem. One respondent considers that there has not been a prevention programme but a set of isolated public initiatives to sensitise different target groups. The need for preventive actions targeted at practising communities has been stressed, although such actions have been difficult to implement because of the distance, gap and separation between the state and the migrant communities.

Most respondents consider that prosecution started to be considered in the FGM approach when actors from the justice and internal affairs sectors joined the intersectoral group during the second programme of action for the elimination of FGM (after 2009). On the other hand, two respondents highlight this P as one of the first to receive attention through the political discussion that it generated in two specific years: 2003 and 2007.

The respondents did not expand much on protection and provision of services, despite recognising that some policies have been developed in order to address these issues. For example, one interviewee mentioned that regardless of not having specific health services targeted at girls and women subjected to FGM or at risk of being subjected, health public services are prepared to provide an adequate answer to this target group. Moreover, the health sector has always been involved in the intersectoral group and the Ministry of Health has put some effort into qualifying health professionals to be aware and ready to recognise FGM.

Finally, although prevalence estimates have always been considered a concern and the fieldwork developed through the years has confirmed the existence of cases of FGM, having a prevalence estimate of the phenomenon has not been a priority at policy level.

To sum up, the Ps that have received most attention in terms of policy development and implementation are partnership and prevention. Since FGM got onto the public and political agenda, but especially after 2008, there has been a large amount of investment in involving relevant actors from different sectors at the national level in order to set up concerted actions to eliminate FGM. An example of this effort is the setting-up of an intersectoral group formed by public administration organisations, intergovernmental organisations and non-governmental organisations that is responsible for developing and implementing both programmes of action for the elimination of FGM. During the implementation of the first programme of action, and in the years that preceded it, there was a special focus on carrying out initiatives and preparing materials to raise awareness (targeted at professionals and to the general population), as well as on translating educational/training material. In addition, several training courses took place. Nevertheless, the first P tackled after the emergence of the topic into the public discussion was prosecution. As already described, a proposal for a specific criminal law was...
presented in the national parliament in 2003 and, 4 years later, there was a modification of the Penal Code, with regard to serious offences to physical integrity, to include a paragraph that more specifically mentions offences resulting from criminal acts related to FGM. However, during the last decade, only two cases have been investigated under the suspicion of subjecting two girls to FGM, and none were prosecuted under the legal framework provided to condemn these acts. During this same period (i.e., 2004 and 2008), efforts to assess the magnitude of FGM in Portugal were undertaken through research (both qualitative and quantitative studies) and, in 2012, administrative datasets to register information on FGM in the health and child protection sector are being put in place to allow the collection of records that may assist in understanding an approximate reality of the problem. Nonetheless, so far and despite these efforts, there is still no prevalence estimate of the phenomenon in Portuguese territory. It can thus be concluded that despite the fact that prosecution and prevalence estimates were taken into account in the Portuguese FGM approach, they were not, by far, the focus of attention at the policy level. More recently (2012) there have been achievements in the area of provision of services. The health and justice sectors have issued guidelines to assist the professionals of these areas in identifying FGM cases and in addressing them. There are national telephone helplines at the disposal of girls and women that have been or that are at risk of being subjected to FGM, and of the general population. Moreover, the healthcare system is allegedly prepared to deal with FGM cases (e.g., at childbirth). Finally, as far as protection is concerned, this is the area that seems to be most under-developed, despite the fact that the general law lays out measures to protect girls from FGM and that an asylum request on the grounds of FGM was accepted in 2012.

V.2. Prevention

Considering that prevention is one of the Ps that has been receiving most attention in terms of the policy approach, several initiatives have taken place during the last decade consisting mainly of seminars, conferences, training courses, and awareness-raising and advocacy initiatives. Generally, these initiatives have targeted the public at large and professionals, while few of these events addressed immigrant communities. Therefore, involving immigrant communities is now a political priority in the FGM intervention field.

As regards the main actors responsible for developing prevention work, the APF was identified as the organisation that did most advocacy (*) work over the years. The APF’s work is based on networking, and this approach along with their specialised department on advocacy has allowed FGM to be put on the policy agenda. Within the intersectoral group of the programmes of action for the elimination of FGM, other actors (besides the APF) seem to have been more active in prevention work, such as the CIG, ACIDI, DGS, UMAR, and EPJ.

Despite the initiatives that have been taking place, two interviewees were quite critical of the prevention approach of the last 10 years. Both consider that the moment has come to start developing other types of prevention work besides raising awareness through seminars and conferences, i.e., to work and involve immigrant communities in preventing FGM. Moreover, there has not been a prevention programme, but only isolated initiatives towards prevention.

As far as policies on FGM are concerned, the most recent policy instrument (the second programme of action for the elimination of FGM) is composed of five main measures, of which three measures (namely 1, 3 and 5) can be considered within the prevention framework (although within other measures some activities could also be included in this framework). The activities planned under each measure are described in the subsection ‘Partnership’.

All the other activities that were developed over the years seem to have been dependent on structural funding and on non-specific budgets of organisations (e.g., personnel expenditure). According to the information provided by two respondents, there is no specific budget attributed for the second programme of action for the elimination of FGM (integrated into the national plan for equality). For instance, in this specific case the CIG has an overall budget to implement the three national action plans (i.e., citizenship and gender equality, domestic violence and human trafficking) of approximately EUR 75 000. This year a budget of EUR 3 000 000 (fully described below) was also made available for calls for proposals for gender-based violence intervention projects (including FGM), as well as a monetary prize to finance FGM projects (the budget has not yet been disclosed). Exceptionally, the annual activities plan of UMAR includes FGM under the area of gender-based violence and lists its specific and operational objectives along with the planned execution dates and its respective budget (the amount of the budget was not revealed).

A description of the initiatives mentioned during the interviews (supplemented by other information collected afterwards) can be found below. Most of these initiatives are in line with the measures planned in the policies developed for tackling FGM.

Awareness-raising materials

Before the implementation of the first programme of action for the elimination of FGM, some awareness-raising materials already contained information about FGM. An example is a brochure developed by APF to promote their itinerant exhibition on ‘Human rights, sexual and reproductive health, and the millennium development goals’.

During the first programme of action for the elimination of FGM, a brochure and a poster were produced to raise

(*) Advocacy is to be seen as described in the first programme of action for the elimination of FGM, p. 20: ‘Advocacy is the term used to describe different forms of constructing political, public and financial support for a theme or a specific cause. We advocate in order to increase the support for a cause and to influence others, to build a favourable environment and, simultaneously, to try to promote a coherent and adequate legal background to this cause, for that implying promotion, defence and visibility’ (Grupo de Trabalho Intersectorial sobre a Mutilação Genital Feminina/C (2009). Programa de acção para a eliminação da mutilação genital feminina).
awareness about FGM. These materials targeted girls and women subjected to FGM or at risk of undergoing the procedure, as well as their families, professionals (health, education, social services, justice and cooperation), local and national governmental organisations, and community and religious leaders, among others. The brochure, available in Portuguese, includes information on the medical and legal consequences of practising FGM and identifies the services and organisations that are prepared to assist and provide information on medical and psychosocial support that are necessary to protect girls at risk of FGM. These materials were distributed in embassies, public organisations in the areas of equality, education and health of the member states of CPLP, immigrant organisations, city councils, city libraries, technical health schools, nursing schools, technical education schools, research centres, national and local centres to support immigrants (CNAI and CLAI), NGOs and schools, among others. Another brochure was produced but adapted to the context of Guinea-Bissau to be distributed there (it differs mainly in the explanation about the legal background and in the list of contacts provided). This brochure was developed in collaboration with the National Committee for the Abandonment of Harmful Traditional Practices affecting the Health of Women and Children. These posters and brochures were also disseminated in airports in order to inform immigrants that originate from practising countries of how FGM is to be understood in Portuguese territory (i.e. it is prohibited and punishable by law).

Nevertheless, this brochure did not catch the attention of the supposed target groups, because it was not aesthetically appealing to female migrants: the layout and colours were designed for ‘white women’ (the colours used were black, white and red); the logotype represented a big knife and it used the word ‘mutilation’.

Two other tools were translated, reviewed and edited by the APF and IPAD, with the collaboration of the WHO:

- Eliminating female genital mutilation: An interagency statement — OHCHR, Un aids, UNDP, UNECA, Unesco, UNFPA, UNHCR, Unicef, Unifem, WHO;
- ‘Female genital mutilation — Integrating the prevention and the management of the health complications into the curricula of nursing and midwifery’.

Similarly to the first programme of action, a poster and a brochure were prepared by the intersectoral group to be disseminated under this second programme of action for the elimination of FGM. These awareness-raising materials are based on and adapted from the previous materials of the first programme of action, and were developed to be appellative and easily accessed by immigrant communities (e.g. at healthcare centres/units and schools, where members of the communities are more likely to be found). These materials are also being prepared in Creole to specifically target the community of Guinea-Bissau living in Portugal.

### Awareness-raising initiatives

As mentioned by the respondents, several awareness-raising initiatives have been taking place in the last few years, targeting the general population, students, professionals and immigrant communities. Some of these initiatives are also taking place in mosques.

More specifically, the APF and UMAR shared a list of the initiatives developed. The APF has been conducting workshops, seminars, conferences, lectures, sensitisation initiatives and meetings for several years. Nevertheless, the period from 2009 and 2012 allowed for the provision of a more adequate and consistent answer to the requests to organise these initiatives because it coincide with the period of ‘End FGM’ European campaign funding. During this period, approximately 20 initiatives took place, essentially targeting health students. UMAR also conducted sensitisation initiatives about gender equality and gender-based violence which included FGM, targeting female migrants, young people and representatives of organisations from Guinea-Bissau. UMAR has also shared a list of the initiatives that will focus on FGM to be developed in the next 6 months:

- a workshop about the legal aspects regarding FGM (in collaboration with the APF);
- four sessions about FGM targeting young people within their project ‘BIIG — Itinerant Library for Gender Equality’;
- two sessions about gender (in)equality that will include the topic of FGM targeting the users of one of UMAR’s shelters;
- continue making information on FGM available on UMAR’s website.

The dates that celebrate the International Day of Zero Tolerance of FGM (6 February) and the International Day of Human Rights (10 December) have been used to promote awareness-raising initiatives to draw attention to FGM.

### Capacity-building initiatives for professionals

The ACIDI, one of the members of the intersectoral group, promotes awareness-raising training courses targeted at officers that work directly with immigrant communities and immigrant organisations.

The DGS has conducted training courses about FGM targeting health professionals.

The most recent capacity-building initiative dates from 28 May 2012. The Judicial Police School organised a conference about FGM. Nearly 120 people attended the conference:

- officers of the judicial police, the public security police, the republican national guard, the Immigration and Borders Service, the navy maritime police, the military judicial police, the information security services;
- judges (judicial and public prosecutor);
- representatives of other organisations (e.g. members of the intersectoral group);
- master’s and PhD students.

This conference aimed at promoting a discussion and the integration of good practices on the identification and criminal investigation of FGM. The programme of action for the elimination of FGM and the procedures guide
for criminal police staff were presented. The conference intended to provide a global perspective of the different approaches to the phenomenon for the security forces and services offices. A medical doctor representing the Directorate-General for Health, an officer of the ACIDI (who also developed a master's thesis on the subject), an officer of the Commission for Protection of Children and Youth at Risk and a magistrate collaborated on this initiative. This event included an intervention of the Secretary of State for Parliamentary Affairs and Equality. One interviewee underlined that it is important that security forces and services' officers be aware of the legal background that allows FGM to be prosecuted, but also of the health consequences inherent to this harmful practice in order to improve their further intervention.

'We made good use of the [different types of] knowledge so that people could understand the different sides of the phenomenon and become sensitised. Because, in fact, it is one thing to say that there is a type of crime, but if then people do not have a perception of the seriousness of the lesion that this crime causes, or can cause, people may not pay enough attention.'

Capacity-building initiatives for immigrants

The ACIDI develops awareness-raising initiatives targeted at immigrants that recently moved to Portugal, in which it has devoted some time to FGM (e.g. to clarify the legal background).

The Ministry of Education intends to develop awareness-raising initiatives in areas where there is a higher concentration of the African population and, therefore, that are considered as 'at risk' (e.g. Vale da Amoreira, located on the south bank of the Tagus River in Lisbon, and Cascais, a city located at 30 km from Lisbon). Within the intersectoral group, the Ministry of Internal Affairs suggested joining this activity through its ‘Safe school’ programme (1) in Cascais as a way of stimulating synergies among partners of the intersectoral group.

Involving practising communities

As recognised by most respondents, the involvement of immigrant organisations is not easy. Throughout the years, the APF has been trying to involve immigrant organisations to address FGM. It was upon a visit in 2007 by Khady Koita (President of the Euro-net FGM) that APF managed to gather together several NGOs of immigrant communities living in Portugal, thanks to the mobilisation of several of Khady Koita's contacts. Although the APF had already developed some seminars and conferences about FGM, this was the moment that enabled the APF to enter communities.

Nevertheless, immigrant organisations have, in the majority of the cases, male leaders, and this has posed some obstacles to the APF's intervention. In its fieldwork, the APF goes to meet female immigrants in their environment (where they live) outside working hours. In this work, it is important to be aware of the need for the sociocultural ‘adaptation’ of these women. The APF has regularly found people willing to share their experiences with them. There seems to be a ‘word-of-mouth’ effect in the female immigrant community of Guinea-Bissau. For example, when one of the Portuguese key informants was working at the Alfredo da Costa maternity hospital, she received many women subjected to FGM that were not referred by the APF. These women started to trust her and were looking to her to know more about ‘their’ FGM.

'It is fundamental that this trust-based relation exists … It is important to train these women … They do not know about the cuts. It is not because of being mutilated that she knows. … These women are victims but without the consciousness that they are, and, many times, they do not know what happened. And then, because the speech related to FGM is impregnated with issues related to culture, identity and even to religion, the deconstruction of all this is not easy. And it is definitely not … doing seminars and conferences … because these women have a high level of illiteracy … It is fundamental to understand that these women need time … We need to have sensibility to know how to approach and talk with these women, maintaining the empowerment techniques and skills. But it is important to understand that for them to talk about the topic, they need to feel comfortable before that. That is why we refuse [to provide contacts of women that can share their experience];

The work with communities is currently a political priority and direct intervention with immigrant communities that originate from practising countries is indeed needed. This conviction has been confirmed in meetings and informal conversations.

'This is precisely one of the areas that, to me, in the past was not sufficiently invested in, and it has, from now on, to correspond to a priority … As long as in Europe there is no penetration inside the communities and there is no work with the populations, it is very difficult to solve the problem … The work done within the populations … is producing useful work in some countries, namely African countries.'

Two of the respondents share the opinion that female leaders are needed to improve the work and involvement of immigrant communities. While female leaders that come from Guinea-Bissau to share their experience with female immigrants have a significant role in drawing attention to the importance of having female leadership in organisations, they can also take the role of ‘change agents’ inside their communities. There is therefore a need to go and meet the communities in their living environment and find change agents there that can work for this cause. However, there may be obstacles to this type of intervention, such as the lack of (financial) support for these women to actively

(1) The ‘Safe school’ programme (programa escola segura) was created in 1992 under a protocol between the Ministry of Internal Affairs and the Ministry of Education. Besides the permanent presence of police officers at the entrance to schools, this programme also develops awareness-raising initiatives and training courses targeted at the educative community, in order to invest in prevention.
intervene (due to the fact that they have their professional and family commitments). One respondent considers that the government may provide support to these change agents (e.g. financial resources) either by establishing a partnership with organisations with field experience and established relations with the immigrant communities (such as a governmental agency like the ACIDI, or an NGO like the APF) or by converting this into a paid job for these female leaders.

Some more inputs and recommendations with regard to the involvement of immigrant communities are as follows.

- Before approaching immigrant communities, it is of great importance to know them (their culture, how they think, how they act).
- Going to Africa to understand how the culture of these communities works can be very useful for improving intervention in the host countries.
- Raise awareness on FGM in mosques.

**Funding for gender-based violence intervention projects (including FGM)**

The National Strategic Reference Framework (QREN) constitutes the framework for the application of the EU’s policy for economic and social cohesion in Portugal covering the period from 2007 to 2013. The operational structuring of QREN is systematised through three thematic operational programmes and five regional operational programmes for continental Portugal and for the two autonomous regions (Madeira and Azores). One of the three thematic operational programmes is the human rights policy for economic and social cohesion in Portugal constituting the framework for the application of the EU’s funding to develop projects that are in accordance with the second programme of action for the potential thematic operational programme (POPH), structured around 10 priority axes, of which one tackles gender equality (Axis 7). The beneficiaries of this axis are legal persons of public law that belong to the central and local administration, and their agents; legal persons of private law, for-profit or non-profit; and civil society organisations that express in their goals the promotion of gender equality. Axis 7 is composed of the following seven intervention typologies:

1. 7.1. Strategic information and knowledge system;
2. 7.2. Plans for equality;
3. 7.3. Technical and financial support for non-governmental organisations;
4. 7.4. Support for training projects for strategic audiences;
5. 7.5. Awareness and dissemination of gender equality and prevention of gender violence;
6. 7.6. Support for entrepreneurship, membership drives and creation of entrepreneurial networks of economic activities managed by women;
7. 7.7. Intervention projects on the fight against gender-based violence.

Typologies 7.3., 7.4. and 7.7. allow the applicants to access funding to develop projects that, among others, prevent gender-based violence, including domestic violence, human trafficking and female genital mutilation.

The most recent periods for presenting proposals under these typologies are mentioned in the table below.

<table>
<thead>
<tr>
<th>Intervention typology</th>
<th>Last period for presenting proposals</th>
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<tr>
<td>7.3. Technical and financial support for non-governmental organisations</td>
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The most recent and available period to access funding for developing projects related to FGM was from 15 June to 23 July 2012 for intervention typology 7.7. Intervention projects on the fight against gender-based violence. The Portuguese CIG, as well as public or private organisations, could apply for funding to develop projects with a maximum duration of 36 months. The overall funding available for these projects is EUR 3 000 000. The objectives of this typology are as follows.

(a) To promote actions and projects that favour concerted interventions of different approaches relating to gender-based violence.

(b) To conceive and to implement prevention programmes regarding reincidence and revictimisation in the area of gender-based violence.

(c) To increase the quality of life, security and autonomy of victims of gender-based violence.

(d) To reduce discrimination related to gender-based violence.

Therefore, the organisations mentioned above could have applied for funding to develop projects that are in accordance with the second programme of action for the elimination of FGM, among other national action plans. One respondent stated that she would like to receive proposals for FGM-related projects that will actually intervene inside the communities, rather than the awareness-raising conferences and seminars that have been taking place in the last 10 years.

**Technical support for immigrant associations**

On 29 May 2012, a meeting about FGM with the Secretary of State for Parliamentary Affairs and Equality, the Secretary of State for Immigration and 11 African organisations took place. The respondent invited these organisations to move to a second phase, of a restricted nature, formed by smaller groups, where they could express their interest and present community intervention projects. The Portuguese CIG and the ACIDI were assigned to meet with the interested immigrant organisations to inform them about the different possibilities for applying for funding, and to provide them technical support to set out their ideas on FGM intervention projects targeted at their communities. One of the possibilities presented was the structural funding available in POPH’s intervention typology 7.7.
Since 2002 FGM has been present on media channels every decade, media have played an important role in bringing the subject forward for public and political discussion. As already described in the historical perspective on how the role of media can contribute to reducing the social pressure of undergoing FGM to be accepted in society. More information regarding the purpose of reducing the social pressure of undergoing FGM to be accepted in society.

This prize consists of monetary support for the three best feasible projects to intervene inside the community.

The regulations are being written at the moment by the CIG and are going to be analysed within the intersectoral group in September, so that the contest is launched in October and the prize is still awarded in 2012.

Awareness-raising initiative with university associations of immigrant students
A meeting about gender-based violence (including FGM) with immigrant students’ associations (at university level) was organised in cooperation with two association leaders. The meeting is expected to take place in the first two weeks of September in the Law Faculty of the University of Lisbon. According to one respondent’s knowledge and experience, many African students that come to study in Portugal have assumed political positions in their countries upon their return. Therefore, this initiative intends to create awareness about gender-based violence in general, but to touch upon the subject of FGM so that these potential leaders are sensitised about the topic and can possibly intervene in their countries in the future.

Role models of ‘FGM-free communities’
Based on a suggestion of the United Nations Special Representative of the Secretary-General on Violence against Children, and according to articles of scientific journals, in Senegal, socially recognised persons (‘idols’) have been involved in awareness-raising initiatives that intend to create an image of ‘FGM-free-communities’ with the purpose of reducing the social pressure of undergoing FGM to be accepted in society. More information regarding these initiatives is being gathered in order to assess its viability to be implemented in Portugal to prevent FGM.

The role of media
As already described in the historical perspective on how the issue of FGM has been approached during the last decade, media have played an important role in bringing the subject forward for public and political discussion. Since 2002 FGM has been present on media channels every timenew reports, information or data are published, and when an event of relevance occurs. Recently (1 year ago), a TV report about FGM (*) was shown.

One of the interviewees was the first journalist to write about the topic in Portugal. It is her opinion that information/news about FGM should be treated and presented carefully in order to avoid undesirable effects derived from misuse of information and lack of precision in the messages conveyed (e.g. extreme reactions against immigrants). She considers that media are aware/sensitised about FGM in Portugal, in the sense of considering this topic pertinent. Nevertheless, the respondent points out that, in general, media professionals are not prepared to deal with or to present topics related to human rights (there is a lack of training in this area directed towards these professionals). According to the respondent’s opinion, media should always be involved in prevention and advocacy work, and, for that, the most sensitised journalists (e.g. on women’s and/or children’s rights) should be identified to work on the topic, along with the implementation of training courses related to human rights.

V.3. Protection
In the Portuguese approach to FGM, protection has received least attention over the last decade. Still, some information about child and asylum protection was collected.

Child protection
The National Commission for the Protection of Children and Youth at Risk (CNPCJR) is responsible for planning the state’s intervention and the coordination, monitoring and evaluation of the action of the public organisations and of the community for the protection of children and youth at risk. The CNPCJR is formed of a network of local commissions (CPCJs) that report to the national branch. CPCJs are non-judicial official institutions with functional autonomy that aim at promoting children’s and youngsters’ rights, and preventing or ending situations that are likely to affect their safety, health, education or integral development. The following measures can be applied in child protection interventions:

- provide support to the parents;
- provide support to other family members;
- entrust the child to a suitable person;
- provide support to promote life autonomy;
- provide for foster care;
- provide for institutional care.

Children and youngsters at risk of being subjected to FGM are protected under Law 147/99 — law protecting children and youth at risk. Being at risk of FGM is a situation that justifies the intervention of the CNPCJR. One interviewee this year reported a case to the Cascais local commission for the protection of children and youth at risk, because there was...
a suspicion that a group of girls would be excised during a vacation trip to Guinea-Bissau. The national commission intervened and the local commission of Cascais investigated the case.

The desk research performed within this study during January and February 2012 revealed that there is no information about any child protection interventions based on FGM. Therefore, a brief analysis of the records registered under physical abuse has been done. According to the ‘Annual report of the evaluation of CPCJs’ activities’ of 2011, published in July 2012, 1,738 cases of physical abuse were reported to the local commissions in 2011 (of which only 118 were analysed/processed), and in total there were 4,824 cases of physical abuse being processed (70% of all types of cases). The cases reported in 2011 under physical abuses are more prevalent in girls aged 6–10 years old (248 cases), 0–5 years old (226 cases) and 11–14 years old (218 cases). Moreover, 369 cases of physical abuse were reopened in 2011.

As already mentioned in this report in the section ‘Prevalence and data collection’, a protocol is going to be signed with the CNPCJR in order to collect information on the cases that are related to FGM at local level. Therefore, from 2013 onwards, it is expected to have annual information on child protection interventions specifically with regard to FGM.

Asylum protection
The Portuguese Immigration and Borders Service (SEF) and the Portuguese Council for Refugees (CPR) seem to be the most relevant actors as far as asylum protection is concerned.

The SEF is a security service with administrative autonomy under the responsibility of the Ministry for Internal Administration that is in charge of executing/implementing immigration and asylum policies in Portugal (according to the law and the government’s directives), i.e. controlling the circulation of people at the borders, foreigners’ stays and activities in the national territory, and examining, promoting, coordinating and executing the measures and actions relating to these activities and to migratory flows.

The CPR is an NGO that, among other services, provides juridical counselling to refugees by assisting and supporting (for free) asylum and refugee applicants, as well as people in need of humanitarian protection. The CPR has assisted asylum applicants on the grounds of FGM.

The Administrative Court (under the Ministry of Internal Administration), an instance above these two organisations, rules/makes decisions on non-consensual cases.

One of the respondents has performed journalistic investigations into asylum requests on the grounds of FGM. According her investigations, there have been three asylum requests on the grounds of FGM in Portugal (of which one was rejected, one was granted and the other is still pending), although the SEF mentions in her last investigation (July 2012) that in the last 10 years Portugal has received, on average, one to two asylum requests yearly based on fear of FGM. A brief description of these requests is presented below.

A 37-year-old woman from Kenya requested asylum on the grounds of FGM in June 2002. After the death of her husband, she was inherited by the brother of the deceased husband who belonged to a political-religious group (mungiki) that defends FGM (even in adult women). Fearing that she would be subjected to FGM, this woman ran away and she presented an asylum request that was rejected. In the respondent’s opinion, the case was treated with insensitivity due to the lack of training and knowledge about FGM of the officers responsible for the case.

A 24-year-old woman from Sierra Leone requested asylum in Portugal after escaping from her country after being kidnapped and mutilated. On 5 April 2012 she was granted subsidiary protection valid for 2 years with the possibility of renewal for the same period.

There is also another pending case of an excised woman from Senegal that escaped in September of 2010 as she feared that her 2-year-old daughter would be excised as well. She has now two ‘provisional stamps’.

As far as asylum policies on the grounds of FGM are concerned, the respondent considers that these policies are underdeveloped at European level and that more discussion should be taking place on this topic. Moreover, she believes that a protocol should be signed by all Member States on this matter.

V.4. Prosecution
After the topic was brought into the public discussion, in February 2003, a conservative right-wing political party (Democratic and Social Centre — People’s Party) proposed the inclusion of a specific criminal law to prevent and punish FGM in the Penal Code (law proposal No 229/X).

In 2007 the discussion again came into the public eye. There was a modification of the Penal Code, specifically of Article 144 of the Penal Code, in order to integrate the acts of removing or affecting, in a serious way, the sexual fruition capacity of a person.

(\(\text{This category is, according to the researcher’s assessment, the one category available in which FGM cases could fit, and includes the following subcategories: physical offence, physical offence in the context of domestic violence and physical offence due to body punishment.)\)

(\(\text{Available in Portuguese at: http://www.cnpcjr.pt/preview_documentos.asp?r=3795&m=PDF}\)

(\(\text{Of these 118 cases, 56 correspond to physical offence in the context of domestic violence, 33 to physical offence due to body punishment and 29 to physical offence.)}\)
Since 2007 FGM has been considered a violation of common rights of physical integrity and can be prosecuted under Article 144 of the Penal Code as a serious offence against physical integrity. The Portuguese Penal Code applies even if the crime is committed outside the national territory, according to Articles 4 and 5 of the Penal Code.

Therefore, in Portugal, FGM is considered a public crime and the authorities are bound to act, even without a formal complaint and consent from the victim.

The responsibility to investigate a crime of FGM lies with the republican national guard (GNR) or to the public security police (PSP). Nevertheless, if this crime results in the death of the victim, the investigation of the crime will be the responsibility of the judicial police (PJ).

In order to clarify the intervention of the security forces (GNR and PSP) and services (PJ), a brief explanation follows.

The security forces are composed of the republican national guard (GNR), the navy maritime police (PM) and the public security police (PSP), whereas the security services are composed of the judicial police (PJ), the Immigration and Borders Service (SEF) and the Information Security Services (SIS).

The first two (GNR and PSP) ensure democratic legality, internal security and citizens’ rights according to the law. They differ in the sense that the GNR is the only security force in Portugal with a military nature and organisation. Both are ‘proximity police’, easily recognisable and accessible by the public. They are the closest representatives of justice that intervene directly within society and are expected, therefore, to have a stronger level of intervention as far as FGM is concerned.

The PJ assist the judicial authorities in investigations, and develop and promote prevention, detection and investigation actions within their competence. As mentioned, the PJ will only be involved in case a death results from an FGM procedure.

It is more important that the GNR and PSP are sensitised to FGM, rather than the PJ, due to the fact that the first two will be obliged to intervene in case a serious offence against physical integrity (where FGM is prosecutable) happens and/or is reported.

Taking into account that FGM is a public crime prosecutable as a ‘serious offence against physical integrity’, there is no special procedure to present a complaint against FGM. It can be presented at a security force station or directly to the court in the following ways:

- The police officer that knows that FGM has been performed or that is going to be performed can contact the victim (or her family) and/or investigate the situation.
- Any person that knows that FGM has been performed or is going to be performed, or that a certain person practises FGM, can inform the police about the situation.
- The victim (or someone that represents the victim) can inform the police.

The first two situations mentioned above are a denunciation and the third one is an official complaint. A preliminary investigation to confirm the crime (or intended crime) will follow in all the situations. The police officers should communicate the situation immediately to the public prosecutor, and then the criminal process (i.e. collection of evidence (13)) will be followed. The investigation can be conducted either by the security forces (PSP or GNR), or by the court, or by the PJ (in case a death has resulted from an FGM procedure), without the consent of the victim.

According to the research by the Centre for Judicial Studies (14) presented in the conference about FGM (more information about the conference below), there have been two cases of FGM that were identified by the PSP and later publicly prosecuted. However, both cases were closed because, according to the forensic pathologist’s assessment, the lesions were not considered ‘serious’ but a simple offence against physical integrity.

No cases of FGM have been reported to the PJ. According to an investigation conducted by her in 2011, there was only one PJ unit that reported a kidnap in which the victim had been subjected to FGM years before. Therefore, this was not the subject of the complaint, nor the focus of the PJ’s investigation.

Challenges to prosecution

Within the current legal framework that allows FGM to be prosecuted under Article 144 of the Penal Code, several challenges seem to emerge. First of all, FGM itself is a practice of a restricted and intimate nature. One interviewee believes that the dissemination of knowledge about the prohibition of FGM might have contributed to the practice becoming hidden. At the same time, she also considers that there might have been a reduction of the practice because it is known to be forbidden in Portugal. On the other hand, the non-prioritisation of the juridical/legal approach to prosecuting FGM at policy level might also be one of the reasons why the application of the law has been held back.

The security forces still have insufficient knowledge and awareness of FGM and how it can be prosecuted. One interviewee mentioned that, despite the fact that police officers are prepared to register complaints of offences against physical integrity, they are not conscious about the seriousness of FGM itself and they might (mistakenly) consider a complaint of FGM as a ‘simple offence against physical integrity’. Consequently, they will demand a formal complaint from the victim, which should not be the case for FGM, because, as mentioned, FGM falls under a ‘serious

(13) Collection of evidence consists of speaking to the victim, providing for medical examinations (for the girls and women that were subjected to FGM), determining the date, time and location when/where it was performed and identifying the person(s) that carried out the procedure, among others. After this information is collected, it should be sent to the public prosecutor to go to court.

(14) The Centre for Judicial Studies provides initial and ongoing training for judges and public prosecutors for courts of law and for administrative and tax courts.
offence against physical integrity’ and, therefore, only a single denunciation or knowledge of the situation is needed to proceed with a preliminary investigation.

Moreover, taking into account the results of the two cases of FGM that have been prosecuted in court, the forensic pathologist’s analysis strongly influenced the verdict of the trial, which can demonstrate a lack of awareness about the seriousness of the lesions and consequences of FGM. Both cases were considered to be a simple offence against physical integrity. The trial’s outcome of a simple offence is obviously different from a case of a serious offence.

Some efforts have already been made to overcome the challenges relating to prosecuting FGM in Portugal. Examples of these efforts are the visibility that one interviewee has been giving through her public speeches to the legal framework that allows prosecution of FGM, the conference about FGM targeted at security forces, services officers and judges (more information in the subsection about ‘Prevention’) and the procedures guide for criminal police staff (that was presented in this conference and is further described in this section). In order to solve the lack of awareness of police officers, forensic pathologists, public prosecutors and judges, a set of training courses should be organised. Moreover, special attention should be given to this topic in the initial training of these professional categories (as already happens within the Judicial Police School). As a final point, although the procedures guide has been disseminated, brief dissemination sessions should be conducted at local or regional level in order to ensure that all professionals know about its existence and how to proceed with regard to a case of FGM.

Need for a specific criminal law?
Most respondents consider that the current law perfectly covers the crime of FGM. Two respondents share the opinion that Portugal (and other European countries) does not need a specific criminal law to prosecute FGM (they are completely against it), and both are in favour of having specific criminal laws in countries where FGM is an ancient and rooted cultural tradition. One of the reasons pointed out by one respondent for being against FGM-specific criminal laws is the fact of stigmatising and discriminating against immigrant communities residing in a European country only because they originate from countries where FGM is practised.

‘This is what I think that is done in Europe when a specific law is approved. A finger is being pointed at a specific community, that has x elements, with a certain religion, that comes from ‘here and there’ …. How could [FGM] not be an attack to physical integrity?! I do not think that a judge will ever say that it is not an attack!’

Despite the fact that one of the interviewees considers that FGM is more problematic in the countries where it is socially accepted (rather than in Portuguese territories where FGM does not form part of national cultural traditions), she highlights that having a specific criminal law would be more advantageous to enable criminal procedures.

‘The benefit of having a specific law [to prosecute FGM] is that independently of having a simple or serious type, we would always have the same criminal procedure and that would ease the police intervention.’

Procedures guide for criminal police staff
The procedures guide for criminal police staff was written under the framework of the second programme of action for the elimination of FGM and based on the ‘London child protection procedures’ (suggested by the members of the APF that take part in the intersectoral group. The draft proposal of the procedures guide was written by two respondents who both work at the Judicial Police School and then sent to the intersectoral group for further suggestions for improvement. The procedures guide was publicly presented during the conference about FGM on 28 May 2012 and was updated afterwards.

Considering that there are many laws and different procedures and realities, the procedures guide was intended to assist police officers by compiling relevant information on FGM in a single document in order to avoid having to look for and request information on how to proceed in these types of cases. Additionally, the procedures guide has a user-friendly format (A5) so as to be easily accessed and not to be lengthy in order to prevent officers from refusing to read it. Therefore, the procedures guide includes information on FGM (i.e. types, health consequences, and juridical aspects) and descriptive procedures on:

- general procedures (e.g. find a female interpreter in case the victim herself presents the formal complaint);
- behavioural and attitudinal aspects (e.g. build a relationship of confidence and respect, do not treat the girl/woman as a victim, use the word ‘circumcision’ instead of ‘mutilation’);
- the identification of the victim;
- cases of suspicion of a girl or woman at risk of being subjected to FGM;
- cases of suspicion of a girl or woman having been subjected to FGM;
- criminal investigation;
- examination of the victim.

After its finalisation, the procedures guide was physically sent to all members of the intersectoral group and other organisations that attended the abovementioned conference and is available online on the judicial police’s website (1). Internally, it was sent by post to all security forces and services’ units at national level, requesting global dissemination among all police officers through an institutional service. It is considered to be an open document that can be copied and modified. Suggestions, additions and corrections are also being accepted for the next year’s new edition.

In the short/medium term, it is expected that the procedures guide and the sensitisation around it will reduce the practice of FGM in immigrant communities and

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(1) Available in Portuguese at:  
http://www.policiajudiciaria.pt/PortalWeb/content?id=08F746D6-0677-4D12-935A-05C3B77FS1B7
that the latter will share the prohibition of FGM among the citizens of their countries. Moreover, during this year and the next there will be the possibility of registering cases under ‘FGM’ (i.e. there will be a reference to FGM in the process of ‘serious offence to physical integrity’) due to this sensitisation.

V.5. Provision of services

Healthcare services
The Directorate-General for Health (DGS) is a central service of the Ministry of Health that regulates, orientates/guides and coordinates activities to promote health, prevent diseases, define technical conditions to provide healthcare and plan national policies for the quality of the Portuguese health system. Therefore, the DGS does not provide services (the national health service does), instead it regulates how they are provided.

Within the national health service there are some health units in the region of Lisbon and Vale do Tejo that have been dealing with FGM for several years due to their geographical position where migrant communities tend to concentrate, namely Alfredo da Costa maternity hospital (Lisbon), Hospital Garcia de Orta (Almada) and Fernando da Fonseca hospital (Amadora) (\*). Some of the professionals that work in these health units have developed expertise in dealing with FGM. Nevertheless, there is no specialised healthcare service/unit for girls and women that have undergone FGM.

Type I being one of the most common types of FGM performed in the migrant population residing in Portugal (types I and II are the most common), health professionals have been facing some difficulties in identifying it because this type of FGM has fewer health implications (e.g. during birth) than other types.

Guideline about FGM for health professionals — DGS guideline No 005/2012
Although the DGS has collaborated on translating into Portuguese several tools that are easily accessible online, there was a need to have an instrument that would be recognised as a ‘national tool’, with national data, to provide to health professionals. Therefore, a guideline was created for the Portuguese health sector. This guideline was written by a working group of representatives of several organisations from different medical fields (gynaecology, general practice, paediatrics, reproductive health, children and youth at risk, psychology, nursing, disease prevention and control, clinical sexology) and presented on the International Day of Zero Tolerance of FGM (6 February 2012) (revised one month later to include more references and to update the table of prevalence estimates).

This guideline integrates information about FGM, concrete ways of intervention in the area of sexual and reproductive health, intervention in the community and the description of how to identify/refer children at risk to the respective authority. The purpose of this guideline is to allow professionals all over the country to know what FGM is and what procedures should be taken into account when confronted with a girl/woman living with FGM, or a girl/woman at risk.

The guideline targets several professional categories, such as doctors (with different specialisations), nurses (general nurses and those with specialisations in obstetrics, maternal and infantile health, public health), psychologists, social workers, medical auxiliaries (\*\*) and administrative personnel. The last two categories should also receive information and training because they also deal with patients and might be the first to be in contact with the patient. One of the surveys (2008) to assess the knowledge of health professionals and the magnitude of FGM, conducted in certain health units in Portugal, also covered medical auxiliaries.

At the time the guideline was issued it was largely publicised through the media. It is available on the sexual and reproductive health department web page (http://www.saudereprodutiva.dgs.pt) and, according to the administrative procedures of the DGS, it was sent to each administrative health region that will disseminate the guideline to all health units (primary healthcare units and hospitals). Nevertheless, there is no way to know whether all professionals have read the guideline. One respondent mentioned that the guideline is also punctually disseminated in training courses.

Taking into account the information shared by one interviewee, the introduction of this guideline is expected to sensitize/raise awareness within different professional categories in order to guide them towards taking into account the established procedures, to prevent new cases of FGM and to produce social change in the communities.

Infantile and juvenile health programme
The infantile and juvenile health programme is going to be replaced in order to include a reference to FGM. Health professionals will be instructed to pay special attention to girls at risk in order to prevent FGM (e.g. by raising awareness with their families, talking about FGM and understanding what families think about the practice). Moreover, the clinical software system for infantile and juvenile health will include a code for FGM so that it can be registered and gathered with the already-existing codes of the Children and Youth at Risk Support Units. This programme will be presented during this year to be implemented in 2013.

The DGS was working on the new version of this programme by the time of the interview and, on 5 July 2012, the document was made available online for public consultation and further contributions for nearly 1 month. This document contains the following information references to FGM.

\* Almada and Amadora are cities located approximately 13 km from Lisbon.

\*\* Medical auxiliaries’ in Portugal do not have any training in medical assistance. These professionals are expected to collaborate, under the supervision of health professionals, in the provision of care to users, in keeping facilities clean and in supporting, logistically and administratively, the service and/or health unit integrated into a healthcare institution.
In the eighth objective of the health examinations, the programme mentions: ‘Identify, support and guide the children and families of victims of abuse and violence, such as; negligence, physical, psychological and sexual abuse, bullying, harmful traditional practices, namely female genital mutilation’. The programme contains a list of aspects/parameters that health professionals should take into consideration at different developmental stages of children and adolescents. With regard to FGM, in several developmental stages (i.e. the first year of life, 1–3 years old, 4–9 years old and 10–18 years old), health professionals should look for signs of FGM in risk families; taking into account DGS guideline 005/2012 about FGM.

Health helpline
Call-centre operators of the Portuguese health helpline (‘Saúde 24’ — +351 808242424) were trained about FGM last February. After 6 months (i.e. end of August 2012) a monitoring assessment will provide information regarding the number of calls received, as well as the type of information and support that is asked. This assessment will allow definition of the follow-up that should be put in place according to the type of calls received. As of this moment few calls have been received. These calls dealt essentially with the problems that result from undergoing FGM, and also about sexuality (no one was referred to any professional for further assistance).

Capacity-building initiatives regarding provision of services
The DGS has developed various training courses about FGM for health professionals over the last few years.

One respondent believes that there is a lack of financial resources to invest in capacity-building initiatives and a lack of policies to promote these initiatives. NGOs have been the bodies that have worked most in developing capacity-building initiatives. The respondent underlines the importance of deconstructing stereotypes, providing skills to professionals so that they can signal FGM cases to authorities and following up the application of the information conveyed in the training courses. There are two situations that were highlighted by the respondent regarding the lack of training and awareness.

- Since FGM has come into the spotlight, health professionals have not yet received any training to identify/signal/refer cases of girls and women who have undergone FGM and girls and women at risk of being subjected to FGM.
- After the modification of the Penal Code (2007), justice professionals did not receive any training regarding the inclusion of a new paragraph in the law related to a serious offence to physical integrity that is supposed to better address possible FGM prosecutions.

V.6. Partnership

The intersectoral group on FGM
During the Daphne project to develop national action plans, the APF presented to the former Secretary of State of the Presidency of the Council of Ministers and to the CIG’s president at the time their contributions to this project and proposed to these policymakers the creation of a working group on FGM. The secretary of state welcomed the idea by being the mentor of this group that was supposed to be composed of actors from several sectors with different areas of expertise that could intervene on the subject of FGM in Portugal. The APF suggested the organisations (and respective persons) that could be part of this group taking into account their experience in the Daphne project and the knowledge about the other action plans that were developed within this project. Although this group could be seen as a consultation group, it has to be regarded as a working group that puts together their strengths to achieve the measures listed in the programmes of action for the elimination of FGM.

As such, the intersectoral group can be considered a tool and a method for developing and implementing the policies planned to address FGM at national level. This group is composed of actors from different sectors.

- Public administration: Portuguese Institute for Development Support; High Commission for Immigration and Intercultural Dialogue; Portuguese CIG; Employment and Professional Training Institute; Directorate-General for Health; Directorate-General for Innovation and Curricular Development; Ministry of Internal Administration; Ministry of Justice/Directorate-General for Justice Policy/Judicial Police School.
- Intergovernmental organisations: International Organisation for Migration and Community of Portuguese-Speaking Countries.
- NGOs: Family Planning Association; Women’s Union, Alternative and Response; and Uallado Folai Association.

The most recent members of the intersectoral group are the CPLP (that joined the group during the implementation of the first programme of action), the Ministry of Internal Administration and the Ministry of Justice/Directorate-General for Justice Policy/Judicial Police School (the latter joined the group for the second programme of action). These actors joined the partnership in order to promote the broader intervention of other sectors relevant for the application of the measures defined to eliminate FGM in Portugal. Others actors might join the partnership if it is considered to be relevant for the good execution of the measures defined.

The CIG plays a coordination role and is responsible for ensuring the implementation of the measures listed in the programmes of action for the elimination of FGM. The CIG is a public organisation under the direct administration of the state, within the Presidency of the Council of Ministers, and is responsible for the implementation of public policies addressing citizenship, and promotion and defence of gender equality. On the other hand, the Secretary of State for Parliamentary Affairs and Equality presides over the meetings of the intersectoral group.

Since December 2011, when the intersectoral group was reactivated (after a period of ‘paralysis’ during 2011), five meetings have taken place. Thus a meeting has been organised approximately every month and a half. In each meeting, tasks are assigned to each member of the
There is no specific budget attributed to the intersectoral group, nor to 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. Therefore, some of the measures contemplated under the second programme of action will be funded by the CIG and others through the budget of the organisations that compose this group (e.g. personnel expenditure).

The intersectoral group is perceived as an innovative aspect of the Portuguese approach to FGM and good practice to be shared in other European countries. The following are seen as being the factors for the success of this partnership: its diverse composition that gathers different expertise from different backgrounds of the public sector, intergovernmental organisations and NGOs; and the shared responsibility in working together to achieve the same goal — to eliminate FGM.

‘This is a working group that tends to make use of the knowledge and intervention of each other towards the common welfare without the need for saying “I did this and that’ … This is a very big shared responsibility.’

Programmes of action for the elimination of FGM

There have been two programmes of action for the elimination of FGM in Portugal. Both programmes of action have a short period of implementation of approximately 3 years and are integrated under the third and fourth national plans for equality — gender, citizenship and non-discrimination (2007–10 and 2011–13, respectively). The first programme of action was launched in 2009 and the second programme of action was issued in 2011. One of the interviewees considers that having a programme of action is relevant in order to integrate the measures to be addressed at national level and to coordinate the policies that are to be implemented to tackle the problem.

The second programme of action reproduces a great share of the first programme of action, and can be seen as a ‘continuity task’ over time. The milestones proposed under the first programme of action could not be fully met, and thus there was a need to continue the work done under the first programme.

Both programmes of action include a background explanation that frames the existence of such programmes, information about FGM and the measures defined to address FGM. As regards the most recent programme of action for the elimination of FGM 2011–13, it is composed of three parts.

(a) Part 1, including the introduction, background and facts about FGM (definition and classification, terminology, procedure, possible justifications for the existence and/or perpetuation of FGM, physical and psychological consequences).

(b) Part 2, including a description of the programme of action, reasoning that supports the continuity of the work in this field and identification of the intervention sectors of the programme (community, health, education, training and research, justice and human rights, developmental cooperation).

(c) Part 3, including the measures defined for the programme: (1) Sensitise and prevent; (2) Support and integrate; (3) Training; (4) Know and research; and (5) Advocate. For each measure a set of activities is planned (identifying the target group, the members responsible for its implementation and the evaluation indicators).

The measures and respective activities of the second programme of action are listed hereafter.

Measure 1: Sensitise and prevent

- promote debates to discuss and organise working strategies with communities;
- support immigrant organisations in developing activities to eliminate harmful traditions, such as FGM, forced marriages and hate crimes;
- produce informative, educational and communicational materials;
- disseminate the interagency statement and the FGM brochure;
- promote the development of school projects about harmful traditions (including FGM) at basic and secondary school levels, in the context of health, civic and developmental education;
- sensitise university professors to the importance of including the topic of harmful traditional practices in the curricula of bachelor’s and postgraduate studies, namely in the areas of health, human, social and criminal sciences;
- encourage the development of campaigns that promote sexual and reproductive rights within the framework of human rights;
- create a micro-website about FGM on the CIG’s website to disseminate national and international campaigns and initiatives;
- promote debates and dissemination initiatives in the media to stimulate reflections on FGM and its relationship with sexual and reproductive health and education, and the development of human rights;
- create a network involving students that originate from countries where FGM is practised that are temporarily residing in Portugal.

Measure 2: Support and integrate

- increase the level of literacy and schooling of immigrant female population (girls and women) that originate from countries where FGM is traditionally practised;
- empower female immigrants (especially those that come from countries where there are harmful traditional practices, namely FGM) in order to combat inequalities and gender stereotypes, explicitly by encouraging them in active participation and/or the creation of associations, and entrepreneurship;
- promote individual counselling and psychosocial support;
- provide assistance and guidance to FGM situations (referring to the resources available) through telephone helplines in the domains of health, immigration, sexuality and violence;
- consolidate the referral/signalisation strategy of eventual
For example, for the training courses that are planned to concrete evaluation indicators to assess its execution. Besides the absence of time limits to implement the measures set in this second programme of action, it lacks the purpose of some measures is not very clear due to its blurred formulation. For example, the measure ‘Promote the phased introduction of indicators to monitor the number of FGM cases in girls and women (of fertile age)’ does not define which indicators and from which sectors are the number of FGM cases are to be retrieved (here again, the evaluation indicator is the ‘number of cases identified’).

There has not been an evaluation of the execution of the first programme of action. Two respondents were critical about the absence of an evaluation report and the lack of a timeline and concrete indicators on the first and second programmes of action. Therefore, according to one informant, an assessment of the impact of the policies developed/implemented under the second programme of action for the elimination of FGM is going to take place immediately after its end in order to incorporate the lessons learned from its implementation in the following programme of action. Moreover, an interim report to assess the execution of the current programme of action between 2011 and 2012 will be presented in the first trimester of 2013.

Other partnerships at national level
At the governmental level, one of the respondents has been trying to involve other members of the government in policy work related to FGM in addition to the ones that are already in the intersectoral group. For example, the Secretary of State for Immigration was present in the meeting organised with the immigrant organisations (mentioned above in the subsection ‘Prevention’) and the Secretary of State/Assistant to the Minister for Health (Fernando Leal da Costa) attended the launch of the campaign against FGM and the dissemination of guidelines for health professionals.

Partnerships at international level
The Community of Portuguese-Speaking Countries (CPLP) has an action plan (approved on May 2011) and a strategic plan for gender equality and women’s empowerment (2010) that specifically mention FGM. Very recently, one of the respondents and the Secretary of State for Foreign Affairs and Cooperation met with the Executive Secretary of the CPLP to ask him about how Portugal could support actions to accomplish the measures specified in these plans. Moreover, taking into account that the CPLP’s presidency is going to change (as well as its executive secretary), the respondent asked the current executive secretary not to disregard the topic of FGM when stepping down from his mandate. The respondent has already requested a meeting with the next executive secretary, who will formally assume his/her functions in September 2012, in order to bring his/her attention to the area of cooperation, specifically on FGM.

Another meeting took place with the Director-General for Cooperation and the Portuguese ambassador to the Community of Portuguese-Speaking Countries aiming at asking for their support to operationalise and stress

FGM cases (centralised in the specific support services for immigrants).

Measure 3: Training
- draw up an acting protocol with guidelines for the health sector;
- disseminate the manual ‘Female genital mutilation — Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery’ (translated in Portuguese);
- create a training benchmark on FGM for different intervention areas (education, justice, social/communitarian, cooperation);
- include the topic of FGM in benchmarks for health, development, citizenship and gender equality education;
- conduct training courses for different types of professionals (e.g. health, social-cultural mediators, officers working with immigrants, teachers, judges and police officers, media, call-centre operators).

Measure 4: Know and research
- deepen knowledge about FGM;
- conduct a study about FGM in Portugal through a protocol between the CIG and the FCT;
- organise a Euro-African seminar to disseminate good practices from several programmes addressing the elimination and abandonment of FGM;
- promote a phased introduction of indicators to monitor the number of FGM cases in girls and women (of fertile age);
- make information available online and provide hyperlinks about FGM.

Measure 5: Advocate
- develop seminars about FGM;
- develop communication and advocacy strategies and mechanisms for national, European and international organisations, namely those that carry out interventions in countries where FGM is practised;
- reinforce bi- and multi-cooperation agreements focusing on promoting girls’ literacy;
- encourage debate, the exchange of experiences, training and information between Portuguese NGOs and those from other countries;
- promote conditions for the development of projects and awareness-raising and training initiatives about human rights, children’s rights, infantile–maternal health, sexual and reproductive rights, and sexual transmitted diseases aiming at promoting the abandonment of all harmful traditional practices;
- encourage debate and information about asylum/refugee status for women and girls at risk of FGM, according to the international conventions that Portugal signed within the EU context.

Besides the absence of time limits to implement the measures set in this second programme of action, it lacks concrete evaluation indicators to assess its execution. For example, for the training courses that are planned to be conducted or the seminars about FGM, the indicator defined is ‘the number of training courses performed’ or ‘the number of seminars organised’, without providing a target number. Moreover, the purpose of some measures is not very clear due to its blurred formulation. For example, the measure ‘Promote the phased introduction of indicators to monitor the number of FGM cases in girls and women (of fertile age)’ does not define which indicators and from which sectors are the number of FGM cases are to be retrieved (here again, the evaluation indicator is the ‘number of cases identified’).
in preparatory works of the ninth Conference of Heads of State and Government of the CPLP (Maputo, 20 July 2012) the interest expressed by Portugal in reinforcing the importance of the commitment of the CPLP to respect the existent plans of action and strategic plans in which FGM is mentioned as an intervention area.

One interviewee suggested concrete measures on FGM to be included in the new programme of indicative cooperation (PIC) with Guinea-Bissau. Additionally, in conversation with the Guinean-Bissau Ministry of Equality, the interviewee proposed to apply for a United Nations fund to develop a cooperation joint project on FGM between Guinea-Bissau and Portugal. Both the PIC and the proposal for a joint project have been held back due to a military ‘coup d’état’ (illegal deposition of the government) that took place in Guinea-Bissau on 12 April 2012, the day before the second round of elections in that country. The CPLP does not legitimately recognise the current authorities of the country. These unexpected events do not allow the Portuguese state to maintain a dialogue with the current transitional government of Guinea-Bissau. Therefore, it was not possible to collect more information on the bilateral agreements that will take part in this PIC, as on the application for the joint project to be developed by both countries.

VI. SUCCESSES AND CHALLENGES

Work on FGM in Portugal has been going on for approximately 10 years, although it has been more intense and organised since 2009, when the first programme of action for the elimination of FGM was launched, along with the creation of an intersectoral working group that would be responsible for developing and implementing the measures set for the first, and then the second, programme of action. The history of the work on FGM allows the successes of the approach to be identified, but also some challenges that have held back intervention in the field of FGM. Both the successes and challenges are described hereafter.

Regarding the successes that mark work on FGM in Portugal, one respondent considers that it is an achievement to have the topic of FGM on the public agenda. Moreover, she also points out the importance of having, since 2007, a specific article in the Penal Code to broaden/specialise the scope of the general law as far as the offences related to FGM are concerned. The most important successes named during the interviews were the existence and intervention of the intersectoral group that is responsible for implementing the programmes of action for the elimination of FGM, and the interest and activism, with regard to FGM, of the current Secretary of State for Parliamentary Affairs and Equality. The governmental intervention in this matter was recognised as being of utmost importance to achieve the goals set. Finally, two respondents emphasised the publication of the guideline for health professionals as the most recent achievement regarding work on FGM.

Despite the successes, there are four main challenges holding back work on FGM, these being the weak involvement of immigrant communities, the lack of awareness about the topic, funding difficulties and the absence of numbers that would allow an understanding of the dimension of the phenomenon in Portugal.

The government’s lack of knowledge about immigrant communities and the lack of dialogue between them are obstacles to the implementation of actions towards eliminating the practice. One respondent also recognises the lack of involvement of these communities, although efforts to involve them are being made and plans put in place (some examples are provided in the subsection ‘Prevention’).

Despite the awareness-raising initiatives that mainly characterise the Portuguese approach to FGM, the lack of awareness about the topic was still pointed out as a challenge to policy development and implementation. The fact that FGM is not a Portuguese tradition can cause condescension, explained by the belief that it is a religious and cultural practice and it will not have other consequences. Another respondent adds to this statement by mentioning that Portugal ‘has been afraid’ of FGM for unsubstantiated reasons related to the practice, such as culture, tradition and religion. A third respondent adds to this lack of awareness the idea that the segmented geographical concentration of migrant communities in the region of Lisbon (and not spread all over the country) might be preventing the distribution of funds to finance the work on FGM (namely for training health professionals, and children’s and youth at risk officers, and for improving/modifying IT systems to register FGM).

The absence of figures that characterise the Portuguese reality with regard to FGM also seems to be hampering the work that is being done.

There have not been enough public funding initiatives to finance the work on FGM, and the current economic crisis that Portugal is facing (with cutbacks in the public sector) seems to be an obstacle to the implementation of actions aimed at eliminating FGM.

Finally, the difficulty of reversing the practice (due to its root causes), the lack of coordination of the work that is being done (because stand-alone actions are being implemented instead), the lack of technical ability to work on FGM manifested by certain public sectors and the change of civil servants and political positions every time elections take place (a briefing and adaptation period follow this change) were also mentioned as challenges to the work of FGM in Portugal.

Based on the information collected for this study (both in the desk and in-depth research phases), the researcher considers that the main successes of the Portuguese approach to work on FGM are:

• the commitment of non-governmental organisations and individuals (in a first phase) and public organisations in pushing FGM into the public and political discussion, as...
well as in working together to implement activities with the resources available;
• governmental involvement in setting FGM as a political priority (although this involvement is more visible nowadays through the proactiveness of the Secretary of State for Parliamentary Affairs);
• the intersectoral group that derives from the commitment of an NGO (i.e. the APF) and from the governmental interest in addressing FGM — this working group seems to be fundamental for putting in practice the policy measures established under the programmes of action for the elimination of FGM;
• the existence of a policy document that integrates milestones regarding the work of FGM — programmes of action for the elimination of FGM;
• the existence of a guideline for health professionals and a procedures guide for criminal police staff to guide the intervention of these professionals as far as FGM is concerned.

The key challenges to the work of FGM identified by the researcher and possibilities to overcome them are presented below.

Lack of involvement of immigrant communities that originate from countries where FGM is traditionally practised

Despite having an immigrant organisation within the intersectoral group, immigrant communities have been involved very little in the work of FGM. It seems of utmost importance to maintain a closer relationship with members of these communities since they are better placed to suggest actions that will get the communities’ attention. Although immigrants chose to live in Portugal, Portuguese policymakers and NGO workers are regarded as ‘outsiders’ that are trying to abolish a traditional practice that has been rooted in their communities for years and that they are not inclined to question. Therefore, the initiatives that are planned for the forthcoming months are a first step towards involving them in the work that is being done to eliminate FGM. Moreover, more immigrant organisations should be integrated into the intersectoral group.

Absence of prevalence estimates or other data on FGM

Although the development of policies is not dependent on the number of circumcised girls and women or those at risk, having a national prevalence estimate could be helpful to better target the needs of the excised female population, as well as their families. There are administrative datasets in place that could be adapted to collect information on FGM in the areas of health, justice (police investigations and court cases), child protection, asylum and telephone helplines for different sectors (health, violence and immigration). As already mentioned, efforts are being made to register FGM cases in the areas of health (medical records and helpline) and child protection, along with the setting-up of a study about FGM in Portugal.

Lack of monitoring and evaluation exercises regarding the policy documents, training courses, guidelines, etc.

The first and most striking example of the lack of monitoring and evaluation is the absence of an evaluation report on the execution of the first programme of action for the elimination of FGM and the development of a new one without a clear analysis of the previous one. Although the guidelines are very recent, there was no monitoring exercise to understand if they reached their target group. As regards other initiatives to raise awareness, there is no list of the activities developed so far. Moreover, no assessment reports of these initiatives seem to exist.

Application of the law

Notwithstanding the fact that the general law may cover criminal acts of FGM under ‘serious offence against physical integrity’ (Article 144 of the Penal Code), 5 years have passed since this legal article was modified without awareness about it being raised among police officers, public prosecutors and judges. This year a procedures guide for criminal police staff was published, but no training is planned to ensure that the guidelines are understood and put in practice. Therefore, it may not surprise that few investigations (two) have taken place and that, in the end, they were not prosecuted under Article 144 but considered a simple offence against physical integrity (possibly due to the lack of awareness about FGM). In addition, the use of the so-called ‘universal masculine form’ in legal texts may not draw sufficient attention to FGM, which is a crime committed against female citizens. Therefore, in order to overcome these constraints and to be in line with international and European policy documents, a specific criminal law could be created to prosecute FGM.

Lack of concerted initiatives

As already mentioned, a guideline for health professionals and a procedures guide for criminal police staff were issued this year. Nevertheless, no training courses or sensitisation activities were planned in advance to accompany these guidelines. Even though these instruments are very useful and important for tackling FGM, there should have been a concern to better disseminate them and to ensure that these guidelines are going to be properly used. Thus the public organisations responsible for these and future guidelines should plan a concerted initiative composed by the document itself and a set of training courses country-wide to disseminate it.

VII. POLICY LESSONS AND RECOMMENDATIONS

All the respondents were able to identify policy lessons from which other European countries could learn. From the Portuguese experience. The following lessons were referred to:
• To have a national programme of action (or national action plan) to address FGM that involves public organisations and NGOs. When drafting this policy instrument, it should be ensured that it is realistic and contains a time frame and indicators against which it can be assessed.
• To create an intersectoral group composed of ministries, intergovernmental organisations and NGOs in order to sensitise other organisations and to congregate efforts
and different types of knowledge and expertise to better target the problem in an efficient way. Moreover, this group should be presided over by a governmental authority to ensure the implementation of a national programme of action specifically to tackle FGM, and each organisation that is part of this working group should contribute (according to a commonly established plan) to the implementation of the defined measures and activities. Finally, the (compulsory) meetings of this group, fixed throughout the period of implementation of the programme of action, allow the rhythm and coherence of the measures established to be kept (even if the members of the group have different rhythms at different times according to the situation of each organisation).

• To improve data collection methodologies.
• To know the statistical dimension of FGM in Portugal.
• To promote partnerships between Portuguese and similar organisations based on practising countries.
• To discuss the topic of asylum at national and European level.
• To improve the protection system for children and youth at risk by promoting initiatives to provide information to families at risk and by supervising those families (e.g. consultation and verification of whether the child/teenager has been subjected to FGM, preventing the child/teenager going to their home country).

Protection

• To have an advocacy programme (e.g. the APF’s advocacy programme).
• To ensure that all awareness-raising, advocacy and training materials about FGM are free (and available in all Portuguese-speaking countries).
• To encourage the involvement of immigrant communities in the development of policies, as well as tools and instruments (based on the less positive experience of a brochure that did not get the attention of the intended target group, i.e. practising communities).
• To involve media (i.e. journalists) in the recognition of FGM as a social and public problem.
• To guarantee that policies do not stay only ‘on paper’. There is still a gap between what is settled in the ‘congress room’ and the actual work inside the communities.

The respondents identified the following priorities for further work on FGM in Portugal.

Prevention

• To stimulate a higher level of interaction with practising communities living in Portugal.
• To raise awareness about FGM among immigrant communities and to adapt the initiatives to the specificities of these communities (e.g. develop initiatives after working hours and at weekends so that they can participate).
• To promote awareness-raising and prevention initiatives for women.
• To issue specific policies for women and children (e.g. by introducing the subject of women’s rights, and more specifically of FGM, in school/educational curriculums through, for example, the existing civic formation).
• To develop specific projects to tackle FGM.
• To encourage a more proactive approach in the governmental area of education and training through the implementation of prevention programmes on FGM.
• To support preventive initiatives (e.g. supporting organisations that wish to work directly with the communities that originate from FGM-practising countries).
• To make funding accessible for the health and education sectors.

Prosecution

• To have an advocacy programme (e.g. the APF’s advocacy programme).
• To ensure that all awareness-raising, advocacy and training materials about FGM are free (and available in all Portuguese-speaking countries).
• To encourage the involvement of immigrant communities in the development of policies, as well as tools and instruments (based on the less positive experience of a brochure that did not get the attention of the intended target group, i.e. practising communities).
• To involve media (i.e. journalists) in the recognition of FGM as a social and public problem.
• To guarantee that policies do not stay only ‘on paper’. There is still a gap between what is settled in the ‘congress room’ and the actual work inside the communities.

The in-depth study allowed identification of a potential good practice based on the criteria defined by the EIGE,

VIII. POTENTIAL GOOD PRACTICES

The in-depth study allowed identification of a potential good practice based on the criteria defined by the EIGE,
namely the intersectoral working group about FGM. Detailed information about this group can be found under the subsection ‘Partnership’.

Other initiatives may be considered as potential good practices. Nonetheless, considering that they are still in an embryonic phase of implementation, it is not possible to assess them as being good practices, but as practices with potential that might be relevant for the work of FGM. These initiatives are described in the subsection ‘Prevention’ and target immigrant communities, immigrant organisations and other organisations working with immigrants, namely ‘Funding for gender-based violence intervention projects (including FGM), ‘Technical support for immigrant associations,’ ‘Prize for community intervention projects on FGM,’ and ‘Awareness-raising initiative with university associations of immigrant students’. Taking on board that there seems to be a lack of initiatives targeting immigrant communities across Europe, the researcher considers that, upon a positive formal assessment, these practices could be repeated over time and/or put together as a combined initiative (for example, by combining the access to funding and the technical support) and transferred to other European countries.

IX. FINAL CONSIDERATIONS AND RECOMMENDATIONS

The Portuguese approach to FGM started approximately 10 years ago, when, in 2002, the first initiative about the topic was organised by an NGO (UMAR) and a journalist published a series of journalistic investigations about the possibility of FGM being practised on Portuguese territory. The following years were characterised by public and political discussions around the issue, of which a proposal for a specific criminal law to prosecute FGM (2003) that ended years later in the modification of the Penal Code with regard to serious offences to physical integrity (2007). Moreover, since 2003 FGM has been recognised as a political priority. By 2007, upon the initiative of an NGO (the APF), an intersectoral group about FGM was created and mentored by the former Secretary of State for the Presidency of the Council of Ministers. This group, composed of public administration organisations, intergovernmental organisations and NGOs, developed the first programme of action for the elimination of FGM to be implemented in the period between 2009 and 2011. A second programme of action followed covering the period between 2011 and 2013. Both these programmes of action are integrated into wider national plans, namely the third and fourth national plans for equality. In addition, FGM has been addressed in other national plans, such as the second national plan against human trafficking, the fourth national plan against domestic violence and the second plan for immigrant integration (all covering 2011–13). More recently, in 2012, two instruments were issued to guide the intervention of health professionals and criminal police staff.

The work on FGM that has been developed throughout the last decade has focused mainly on prevention, including awareness-raising initiatives (e.g. sensitisation sessions and campaigns) and training of professionals. Although there has been some work involving immigrant communities, overall it has not been enough, as recognised by the respondents.

Side by side with the prevention work stands partnership. The partnership that emerged in 2007 has played a very important role in developing and implementing policies to tackle FGM. The researcher considers that it can be regarded as the driving force for putting in place measures to combat FGM in Portugal.

Regarding the other Ps, despite the recent efforts to put in place a comprehensive approach to FGM, Portugal still has to concentrate more on the areas of protection and provision of services. Although the general procedures of child and asylum protection may be prepared to address FGM-related cases, the lack of awareness of the officers working in these areas and the absence of codes and specific measures to register and address these situations may be compromising intervention at these levels and, at the same time, are not facilitating data collection that could allow a better understanding of the reality that Portugal is dealing with. As regards the provision of services, the insufficient number of training sessions for professionals and the lack of services for girls and women that have undergone FGM are especially striking. Nevertheless, the recent launch of a guideline about FGM for health professionals and a procedures guide for criminal police staff are worth noting. These instruments are considered to be important and deserve to be broadened into other areas, such as child and asylum protection and the immigration sectors. In addition to these instruments there is the effort to prepare the health telephone helpline.

As far as prosecution is concerned, the general law on serious offence to physical integrity is considered to apply perfectly to FGM crimes. Nonetheless, the lack of awareness of justice officers (e.g. police, judges and public prosecutors) again seems to be jeopardising the proper assessment of complaints and incriminations that can boost investigations to prosecute these crimes. Despite the arguments against having a specific criminal law, several international and European policy instruments address this need. A specific criminal law to criminalise FGM could ease the justice officers’ intervention and the prosecution of these crimes. Another alternative, taking into account the respondents’ views on this type of measure, is to promote a set of training courses and the proper dissemination of the procedures guide at national level, together with the creation of a specific code in the justice’s administrative datasets to register FGM cases (as having this code could get the attention of the officers and would allow the retrieval of data on FGM).

Finally, with regard to prevalence estimates, a study about FGM in Portugal is going to be conducted soon, and administrative datasets are currently being put in place to collect data on medical records and on child protection interventions related to FGM. The latter initiative could be progressively implemented in other areas, such as prosecution.

To sum up, the Portuguese approach seems to have improved during the last 10 years and can be seen as
a promising approach to addressing FGM in countries where it is not a rooted cultural tradition (e.g. other European countries). It should be highlighted here that Portugal is the only country in the EU-27 and Croatia that has renewed its national programme of action for the elimination of FGM and that intends to proceed with this practice. Moreover, the partnership that brings together the public sector, intergovernmental organisations and NGOs, coordinated by an equality body, and that shares responsibility for developing and implementing policies for the country seems to have a boosting effect on the members themselves (because they are not acting alone), as well as on the measures/activities for which promotion is planned. Finally, the instruments to guide interventions by professionals, the prioritisation of the work with immigrant communities and the efforts regarding the collection of feasible data on FGM (in the health and child protection sectors) are also to be emphasised in this approach that, step-by-step, seems to be building a coherent method to address FGM in many of its areas of intervention.
Country report: Romania

1. IDENTIFICATION
Country: Romania
Researcher: Monica Stroe

2. PREVALENCE OF FGM
2.1. Methodological approach for collecting prevalence data

The search about prevalence records was generally performed simultaneously with the search about policies, actors, and tools and instruments. The conclusion of the report Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, European Commission, 2010; Romanian national report, Romanita Iordache, which was provided to us by the core team, stated that no cases of FGM had been reported in Romania and that FGM did not constitute a topic of legal, academic or policy debates. I thus had reason to believe, given the reported absence of any activity on FGM by 2010, that any potential actor involved in FGM-related work, as a pioneer in the field, would have to approach the issue on several levels simultaneously, which may include prevalence research, policymaking, training courses, manuals, etc. as part of its activity.

As a first step, as indicated by the ‘Guidelines for national data collection’, searches were performed in the following databases: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar. The search included the following terms or combinations of terms:

In English:
- mutilation of female genital organs, Romania
- female genital mutilation, Romania
- female circumcision, Romania
- FGM, Romania
- infibulation, Romania
- clitoridectomy, Romania
- clitorectomy, Romania.

In Romanian:
- mutilarea organelor genitale femeieti
- mutilare genitala feminina
- circumcizie feminina
- excizie genitala feminină
- MGF
- infibulare
- clitoridectomie
- clitorectomy.

No documents were retrieved as a result, on either of the sites. I decided to narrow the search to more regionally or nationally focused databases. This stage of searches included:
- the database of the University Library in Bucharest (http://www.bcub.ro);
- the database of the sociology journal Sociologie Romaneasca (http://www.arsociologie.ro/sociologieromaneasca);
- the Central and Eastern European Online Library (http://www.ceeol.com/);
- the Central European University electronic theses and dissertations (Department of Sociology and Social Anthropology, Department of Gender Studies, Department of Public Policy, Law Department) (http://www.library.ceu.hu/ETD.html).

The same keywords were used, leading to no relevant search results.

In order to focus my search more, I created a database of Romanian organisations (institutions, NGOs, think tanks, feminist groups, etc.) working in the field of gender studies and policy, migration, children’s rights, medical ethics, domestic violence and human rights. I gathered a list of approximately 35 entities. I then selected the ones with an electronic database or with a valid website. A keyword search followed on the search engines of the following institutions/websites:
- Revista Romana de Bioetica (Romanian Journal of Bioethics) (http://www.bioetica.ro);
- the database of the Romanian Society of Feminist Analyses (http://www.anasaf.ro/ro/index.html);
- Centrul de Dezvoltare Curriculară și Studii de Gen — FILIA (Centre for Curricular Development and Gender Studies) (http://www.centruflilia.ro/index.php/biblioteca), and phone conversation with Andreea Molocea, member of the steering committee;
- Institutul Roman de Criminologie (Romanian Institute for Criminology) (http://www.criminologie.ro/SRCC/Lang/Romana/Study/).

The search of the Romanian Institute for Criminology yielded a study, mentioned below.
The Department of Sociology of the National School of Political Sciences and Public Administration was also contacted by phone and asked about potential studies, research or dissertations. I received an answer stating that no such document was available with the university.

After several phone calls to various specialists in social work, it was confirmed to me that the institution that registers detailed information on migration is the Romanian Office for Immigration, part of the Ministry of Public Administration and Internal Affairs. Neither the website (http://ori.mai.gov.ro/) nor the statistics and publications section (http://ori.mai.gov.ro/detaliu/pagina/ro/Statistici-si-publicatii/147) offered any relevant results. An e-mail inquiry was sent to the contact for public information requests. I contacted the institution twice and spoke to various departments in order to trace the route of my request. The response is still pending at the time of writing this report, as the institution has a 30-day reply deadline for the issuing of information of public interest.

The UN Secretary-General’s database on violence against women was also consulted, and proved the most advanced and relevant search engine, as it was very much focused on the topic. The search on http://sgdatabase.unwomen.org/countryInd.action?countryInd=1074 produced zero results for FGM measures in Romania.

A search was also performed on UNHCR Romania’s website (http://www.unhcr-centraleurope.org/ro/index.html), with no results. I have attempted to contact the UNHCR three times, by e-mail and by phone, on several phone numbers, with no reply.

A search on the database of UNHCR statistical online population database (http://apps.who.int/globalatlas/dataquery/viewdata.asp?LINK=1&PRG=UNHCR&AGR=distinct&SAVL=0&PRLST=false&YSTART=1990&YEND=2010&L=RO&PRTTYP=1&NDID=1020235&NDSG=21852&INDCT=440201020000&INDLVL=4&INDPRD=Y&RID=4&RSEL=1=080000000) yielded the per country data of refugees residing in Romania as well as other immigration-related statistics, but no statistics documenting female migrants and refugees or information on FGM.

The Romanian offices of the Soros Foundation were also contacted, as I have identified them as the most active organisation involved in migration research. I have downloaded several reports on immigration to Romania and refugees (from the website http://www.soros.ro/ro/index.php). No results were evident. I contacted the foundation by e-mail. I received a reply from the programme coordinator, admitting that there was no focus either on FGM or on female migration in their research or other projects. The informant was very helpful in assisting me to identify other potential actors.

Other websites were identified, none of which indicated any results:
• the National Centre for the Organisation and Provision of the Informational System in the Field of Public Health (Centrul Național pentru Organizarea și Asigurarea Sistemului Informațional și Informatic în Domeniul Sănătății) of the Ministry of Health (http://www.ccss.ro/);
• the National Institute for Statistics (http://www.insse.ro/cms/w/pages/index.ro.do);
• the National Association of Physicians (Colegiul Medicilor din Romania) (http://www.cmtr.ro);
• the Ombudsman Institution (Avocatul Poporului), consultation of annual reports (http://www.avp.ro/);
• the violence against women portal, a project of United Nations Population Fund;
• the Centre for Migration and Mobility Studies in Timisoara (http://www.migratratie.ro/);
• the National Child Protection Agency (Directia generala pentru protectia copiului) (http://www.copii.ro/);
• the Romanian police (Politia Romana) (http://www.igpr.ro/prima_pagina/index.aspx);
• the Save the Children (Salvati copiii) organisation (http://www.salvaticopii.ro);
• the migration portal of the Intercultural Institute Timisoara (http://www.migrant.ro/);
• apatrid.net, a Romanian blog about immigration (http://apatrid.net/index.php?option=com_content&view=article&id=143:cateva-statistici-solicitanti-de-azil-vs-refugiatii&catid=48:studii&Itemid=157);
• Centrul de Dezvoltare Curriculară și Studii de Gen — FILIA (Centre for Curricular Development and Gender Studies) (http://www.centrufilia.ro/index.php/biblioteca), phone conversation with a member of the steering committee;
• the (former) National Agency for Gender Equality (Agentia Nationala pentru Egalitatea de Sanse intre Femei si Barbati), phone conversation with former member of staff, Cristina Fometescu.

Further e-mails were sent to:
• Asociatia Femeilor din Romania (invalid contact details provided);
• Fundatia ProWomen (invalid contact details provided);
• Romanian Society of Feminist Analyses (no reply).

Lastly, the following contacts were also made:
• the Organisation of Refugee Women in Romania (Organizatia femeilor refugiate din Romania). Phone discussion. No activity or knowledge about FGM among migrants to Romania;
• phone discussion with Ioana Pal, coordinator of the Romanian Forum for Refugees and Migrants (Forumul Roman pentru Refugiati si Migranti — ARCA). The forum does not have knowledge of FGM practices in Romania;
• the Intercultural Institute in Timisoara. Phone discussion with the coordinator of refugee programmes. No activity on FGM;
• the Romanian National Council for Refugees (Consiliul National Roman pentru Refugiati) replied. They do have records on asylum requests on the basis of FGM, which had a court ruling. These cases are discussed under the section ‘Legal framework’; Subsection 4.4. Asylum laws/provisions.

The search tools indicated and detailed by the guidelines of this study did not yield any results, as the issue is not yet under academic debate in Romania and also because of the reduced likelihood that a Romanian language journal would be indexed in the respective databases.
2.2. Nature of prevalence studies/FGM registration systems

The search revealed a study published by a public research institute on domestic violence and female criminality, ‘Domestic violence and female criminality’. A second, Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, Romanian national report, provided by the core team, is a European Commission report analysing the national legislation, policy and prevalence of the Member States, including on FGM. Both sources specify that FGM has not been recorded in Romania.

A search on the database of UNHCR statistical online population database (http://apps.who.int/globalatlas/dataquery/viewdata.asp?LINK=1&PRG=UNHCR&AGR=distinct&ct=5ALVL=0&P&LST=false&YSTART=1990&YEND=2010&sl=E&RPTTYP=1&INDID=1020235&INDDSG=21852&INDCT=4402010200000&INDLVL=4&INDPRD=Y&RID=4&RSEL1=08000000) yielded the per country data of refugees residing in Romania as well as other immigration-related statistics, but no statistics documenting female migrants and refugees.

2.3. Findings from the prevalence studies/registration systems

The first report, ‘Violenta domestica si criminalitatea feminina’ (Domestic violence and female criminality) (2004), was done by a team of researchers led by Prof. Aurora Liiceanu for the National Institute of Criminology, a public body that is part of the Ministry of Internal Affairs.

The authors analyse domestic violence, focusing on violence suffered by women as well as violence inflicted by women. FGM is acknowledged as a possible form of violence against women, but the report states that there have been no reported cases in Romania. In attempting to establish an operational definition of domestic violence, the authors agree that women can be confronted with particular types of domestic violence according to the cultural context and relate FGM to African cultures.

The study only mentions FGM briefly, as it focuses on more prevalent types of domestic violence in Romania, as well as theorising domestic violence and female criminality.

The second document containing information on the prevalence of FGM in Romania is the EU Commission report entitled Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, Romanian national report, Romanita Iordache, published in 2010 as a volume coordinated by Hegemann-White, C., Kelly, L. and Romkens, R. The report analyses the topics announced in the title based on an analysis of national legislation, policy and prevalence of the Member States. The Romanian section of the report, dated 26 March 2010, states that no cases of FGM were reported in Romania and that FGM did not constitute a topic of legal, academic or policy debates.

No registration system was quoted in any study and the attempts to contact institutions and organisations did not yield any registration system in place. Even though no institution with a registration system for FGM cases was identified, one record of court cases was nonetheless identified in the archives of the Romanian National Council for Refugees (Consiliul National Roman pentru Refugiați). The cases are discussed in the ‘Legal framework’ section.

2.4. Reflection on prevalence studies

Disaggregated data on female migrants should be available in the records of the Romanian Immigration Office (Oфициул Roman pentru Imigratii) or in the records of UNHCR Romania, neither of which had provided a reply by the deadline for delivery of this report.

The specialists in gender, migration, asylum and children’s rights whom I have approached admitted to discussing FGM in Romania for the first time. They dismissed it as having no relevance for Romania. The reasons that most of them advanced were that the number of refugee women in Romania is extremely low and that Romania is at best a country of transition for refugees and migrants attempting to reach western Europe. The other reason for the absence of records that they advance is the taboo nature of the practice, which makes affected women reluctant to speak about it. An opposite claim suggests the normality of the practice for communities with high prevalence, which makes it ‘a fact of life’, not worth reporting. The court file of one of the asylum claimants on the basis of FGM states, as part of the defence of the refugee, that she did not report FGM initially because the counsellor at the reception office did not ask her explicitly during the interview. The legal counsellor at the National Council for Refugees, who pleaded in her case, advocated that it was the duty of the interviewer to be informed about the gendered practices in the country of origin of the refugee (Somalia, in that case) and to pose an explicit question about FGM. The employee at the Romanian Forum for Refugees and Migrants (Forumul Roman pentru Refugiați si Migranți) remarks that African women from high-prevalence countries who already have a form of protection in Romania do not mention the practice and that the disclosure of this information might occur solely for the purpose of asylum requests.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Policies were searched by performing the searches detailed in Section 2.1. Methodological approach for collecting prevalence data. As stated in Section 2.1., I had reason to believe, given the reported absence of any activity on FGM by 2010, that any potential actor involved in FGM-related work as a pioneer in the field would have to approach the issue on several levels simultaneously, which may include prevalence research, policymaking, training courses, manuals, etc. as part of its activity. I therefore performed all four searches — prevalence, policies, actors, and tools and instruments — as part of the same process, documented in Section 2.1. of the report.
3.2. Policies on FGM

No policies on FGM were found.

3.3. Reflection on policies on female genital mutilation

Specific policies on FGM are absent, but policies on broader topics, such as sexual violence, domestic violence and child protection could apply to the fight against FGM. However, it was not within the scope of this study to focus on these broader topics.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

I used the following databases:

- the legislation section of the parliamentary website (http://www.cdep.ro/pls/legis/legis_pck.frame);
- the legislation section of the Ministry of Justice;
- a very rich database recording up-to-date legislation, jurisprudence, judiciary practice and law journals (http://idep.ro/);
- http://www.dsclex.ro/meniu_r.htm;
- the database of legislation on refugees available on the website of the National Council for Refugees (http://www.cnrr.ro/index.php?option=com_content&view=category&id=41&Itemid=48&lang=ro);

The full text of laws is available for consultation free of charge from some of the abovementioned databases. For documents revealed by the keyword search but not available free of charge, I searched for references in the Romanian Official Monitor, the official bulletin that publishes Romanian legislation as it enters into force.

I studied hardcopies of the Penal Code, the Family Code and the Medical College Deontological Code.

I received advice on the interpretation of legal documents from two friends trained in general law, but no other free-of-charge specialised legal advice was secured in the time frame of the study.

A record of asylum requests made on the grounds of FGM was available for consultation under a confidentiality agreement with the Romanian National Council for Refugees, an NGO listed as a public utility, which I succeeded in contacting. I sent an e-mail to its offices, which was not replied to. I contacted them by phone, but the specialist on female migrants was on leave. Later I spoke to her over the phone and she was able to receive me the next day, when I could consult the court files of the four women, under an agreement of confidentiality. The four cases are detailed under the entry Law No 122/2006 regarding asylum in Romania, Article 23.

4.2. Criminal law

No criminal law dedicated to FGM is in place in Romania.

An evaluation of the legal provisions in place in European countries on topics related to violence against women was found in a report entitled ‘Legislation in the Member States of the Council of Europe in the field of violence against women 2009. Volume II: Moldova to United Kingdom’, published by the Gender Equality Division — Directorate-General of Human Rights and Legal Affairs — Council of Europe (http://www.coe.int/t/dghl/standardsetting/equality/03themes/violence-against-women/EG%282009%293-vol2_en.pdf).

The document concludes that the concept of FGM does not exist in Romanian legislation, but that the criminalisation of the practice could fall within the ambit of the legislation on assault and battery (Articles 180–184 of the Penal Code). Article 182 of the Penal Code states: ‘Aggravated bodily injury: The act which caused damage to bodily or health integrity necessitating more than 60 days of medical care is punished with 2 to 7 years in prison. If the act had one of the following consequences: the loss of a sense or organ, the cease in its functioning or a permanent physical or psychological infirmity, mutilation, abortion or endangering of a person’s life, the punishment consists of prison from 2 to 10 years.’

Order 1136/2007 issued by the Ministry of Public Health for the approval of legal norms of hygiene for beauty parlour services is a legal order issued in 2007 regulating the norms of hygiene for beauty parlour services. It is the only specific reference to FGM that exists in Romanian law. Under Annex 2, Article 7 the document states: ‘Under sanction of penal and civil responsibility, any form of genital mutilation, as well as any other procedure which can be defined as female circumcision, is forbidden. Women’s consent is not taken into consideration for any of the procedures defined as personal circumcision.’

Reference to the absence of specific legislation is a point made by the Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, Romanian national report, Romanita Iordache, which makes the same reference to the Penal Code.

No record of court cases of FGM with a plea based mainly on the Penal Code was found.

4.3. Child protection laws/provisions

Article 1 of Law No 217/2003 on domestic violence refers to other acts of domestic violence punished by the Penal Code, including bad treatment of a minor. Article 306 of the Penal Code punishes the act of ‘severely endangering, through measures or treatments of any type, the physical, intellectual or moral development of the minor, by parents or by any other person to whom the minor has been given to raise and educate.’
‘Governmental Decision No 49/2011 for the approval of the framework methodology for the multidisciplinary prevention and intervention units and networks on cases of violence against children and domestic violence and of the methodology of multidisciplinary and interinstitutional intervention on children exploited or under risk of labour exploitation, human trafficking as well as Romanian migrant children victims of other acts of violence on the territory of other states’ is in place, including genital mutilation under the definition of sexual abuse (Chapter II.2.1. Operational definitions). The framework methodology applies to all Romanian children as well as to the children of foreign citizens, with or without refugee status, who are present in Romanian territory.

4.4. Asylum law(s)/provisions

Romania ratified the Geneva Refugee Convention and applies the definition of ‘refugee’ stated in Article 1 of the convention. A refugee is a person ‘who, owing to well-founded fear of prosecution for reasons of race, religion, nationality or membership of a particular social group or political opinion, is outside their country of his/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or, who, not having the nationality or being outside the country of his/her former habitual residence, is unable or, owing to such fear, is unwilling to return to it.’

Law No 122/2006 regarding asylum in Romania includes this definition. The refugee status of a foreign citizen is recognised, upon request, following a justified fear of persecution for reasons of race, religion, nationality, political opinions or belonging to a particular social group.

The Romanian National Council for Refugees offers legal assistance for refugees. The institution’s lawyer pleaded in four cases of women who asked for asylum on grounds of sexual violence and FGM or risk of FGM, whose files I was able to consult. Two women from Somalia were granted asylum in 2006 by court order on grounds of being at risk of being subjected to infibulation upon return to Somalia. They were considered to be ‘under serious threat on grounds of belonging to a social group’, as stated by Article 1 of the Geneva Convention. The defence was made on the grounds of — among others — Article 5 of Governmental Ordinance No 102/2000, referring to fears that the woman is at risk of being subjected to torture and inhuman degrading treatments. One of the women’s medical records showed her to be a victim of type I FGM and the other was undocumented medically because of what seems to have been a technicality. The guidelines of the UNHCR regarding international protection and gender-based persecution and the UNHCR recommendation about the return of Somali citizens to Somalia were invoked.

One woman from Cameroon was rejected for refugee status on the grounds of a threat of FGM. Among the arguments was the claim that the woman was too old to be at risk (41 years old). A fourth court case, of another Cameroon woman, is underway. The case claims that she fears her mother; the leader of a group performing FGM in Cameroon might submit her to the intervention upon her return.

4.5. Professional secrecy provision(s)

The right or obligation of disclosure of FGM does not appear explicitly in the code of ethics of the medical profession or any other law regulating medical practice. However, an academic article, Morar, S., ‘Confidentialitatea in practica medico-legala/Confidentiality in medical legal practice’. Romanian Journal of Bioethics, Volume 4, No 2, 2006, refers to Governmental Decision H.G. No 774/2000 on the organisation and functioning of medical law institutions (Article 37). The right to confidentiality is limited under the conditions of suspicion on the part of the legal doctor of medical data indicating the possible occurrence of a type of crime that qualifies for automatic prosecution, when the examination is done at the request of interested parties (Article 37). The author mentions child abuse among the conditions that qualify for the disclosure and arguably FGM performed on a minor falls under this provision.

4.6. Reflection on legal framework

There is practically no law addressing FGM practices in Romania. It is most likely that the norms forbidding FGM performed in beauty parlours were conceived for hygienic reasons rather than stemming from moral principles. The norms probably refer to it as a genital intervention too invasive to be performed safely outside medical units.

From my discussions with the various contacts established during the study, I believe that there is a need for the creation of a legal toolkit with current legislation applicable to FGM which should also include specific guidelines for the legal defence of court cases. This would permit lawyers dealing with FGM cases in the future to have a standardised and holistic approach on such cases. This standardisation of the legal defence would also help establish a series of precedents which might constitute the basis for specific legal propositions on FGM.

A legal advisor could be involved for this purpose. The legal staff at the National Council for Refugees seems to have the most expertise and empathy for the issue among the established contacts.

The Romanian Immigration Office is the national body responsible for ruling on asylum requests. Its decision can be challenged in civil court. The study of the files of the four asylum cases in which the National Council for Refugees pleaded for the applicant and the Romanian Immigration Office pleaded against indicated a relative lack of training concerning the specificities of gender migration and asylum and also in matters of international trends in jurisprudence and legislation, which could be addressed by specialised training. The expected outcome of this possible solution would be to increase the awareness of immigration officers concerning gender in migration flows. The validity of my claim should however be verified by a trained legal expert.
5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

The search for relevant actors was approached as indicated in Section 2.1. Methodological approach for collecting prevalence data. As stated in Section 2.1., I had reason to believe, given the reported absence of any activity on FGM by 2010, that any potential actor involved in FGM-related work as a pioneer in the field would have to approach the issue on several levels simultaneously, which may include prevalence research, policymaking, training courses, manuals, etc. as part of its activity. Therefore, given the specificities of Romania's situation, I performed all four searches — prevalence, policies, actors, and tools and instruments — as part of the same process.

During the stage of my research dedicated to identifying potential key actors for data collection, I was confronted with the difficulty of receiving replies from public institutions. A drastic reform of the public sector in 2010 resulted in the disappearance of many state agencies, directorates and offices, as well as a massive job cuts, salary cuts and a freeze on the employment of new staff. This accentuated the typical malfunctioning of state institutions. Information that is not available online can usually be collected in accordance with the provisions of Law No 544/2001 on free access to public information, which stipulates a 30-day period to provide a reply. Staff are usually reluctant to provide answers over the phone, so one usually needs to make a written request on the basis of Law No 544. The 30-day deadline can easily be prolonged with various claims (e.g. lack of print paper).

I structured my data collection strategy to adapt to these particular conditions by performing several stages of research to identify potentially relevant public bodies. The first stage was to perform searches on their website and on the Internet in general about indications of their FGM-related activity. A further stage was to consult NGOs working in related fields (migration, asylum, gender, domestic violence, trafficking, child protection, etc.) about the institutions active in their field. The third stage was to contact the selected institutions directly (e-mail, phone).

5.2. Actors

The Romanian National Council for Refugees (Consiliul National Roman pentru Refugiati) is the only actor active on FGM in Romania. It is an NGO that has been in operation since 1998, listed as an institution of public utility as of 2003. It is the main partner of the United Nations High Commissioner for Refugees (UNHCR) in regard to the implementation of the assistance programmes offered to asylum seekers and refugees. It offers social assistance services and legal counselling through its specialised departments. In the field of FGM the NGO offers free-of-charge legal counselling to refugees requesting asylum on the grounds of FGM. As a secondary activity they have developed instruments, including a handbook for training social workers and a presentation destined for employees of a new refugee reception centre and judges.

The National Institute of Criminology is a public research institute, created in 2002, subordinated to the Ministry of Justice. It specialises in scientific research focusing on the criminality phenomenon in Romania. It carries out interdisciplinary diagnosis and prognosis studies and supports the government in the development of penal policies. The institute had a very limited contribution to the topic: it published a study on domestic violence that briefly mentioned FGM as a form of domestic violence, only to state that it is not encountered in Romania. The main author of the respective study, Dr Aurora Liiceanu, is however trained as a clinical psychologist and is considered a key figure on in the field of gender studies. She could be involved to raise awareness of the issue or to participate in the creation of potential tools or policies.

The Community Empowerment Collective is a Canadian organisation working on community development (mainly to create tools and instruments for community workers). It is a peripheral actor on the issue of FGM in Romania. Its contribution is limited to providing a Romanian translation of a manual on FGM for the use of ‘community mobilisers’. The field of activity of the latter does not extend to Romania.

5.3. Reflection on actors on female genital mutilation

Female genital mutilation is not currently addressed by institutions or organisations in Romania. Activity on gender violence gives a significant amount of attention to matters such as human trafficking, domestic violence (including spouse and child abuse), rape and sexual harassment. A part of the activity with a gender focus is directed at Roma women (the provision of educational and medical services).

The potential actor identified as being most likely to have an FGM-related activity was the Organisation of Refugee Women in Romania (Organizatia Femeilor Refugiate din Romania), run by a Congolese woman. However, its activity focuses on family planning, HIV prevention and human rights training courses, and does not include a focus on FGM.

Romanian language information explaining and discussing the practice is available online and the awareness of non-specialists is fairly high (and negatively correlated with age), as I could infer from bringing up the subject of FGM in casual conversations with friends and acquaintances. However, it is safe to say that the practice is not on the public agenda and it is very likely that actors will fail to appear in the absence of external/international pressure or of an increase in the visibility of female immigration from FGM-practising countries.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

The search for tools and instruments was approached as indicated in Section 2.1. Methodological approach for collecting prevalence data. As stated in Section 2.1, I had reason to believe, given the reported absence of any
activity on FGM by 2010, that any potential actor involved in FGM-related work as a pioneer in the field would have to approach the issue on several levels simultaneously, which may include prevalence research, policymaking, training courses, manuals, etc. as part of its activity. Therefore, given the specificities of Romania’s situation, I performed all four searches — prevalence, policies, actors, and tools and instruments — as part of the same process.

6.2. Tools and instruments on FGM

The most impactful tool found was the training material delivered by a member of staff of the National Council for Refugees to two different audiences — employees of a new refugee reception centre and judges — in December 2011. The material entitled ‘Specificities of the asylum procedure in the case of unaccompanied minors and of women (Particularități ale procedurii de azil în cazul minorilor neînsotiti și al femeilor)’ included a strong and documented argument for the approach of female asylum-seekers as a particular vulnerable group with special needs and demands. The document argued for the acknowledgement of FGM as a form of torture and as a violation of the right to physical and psychical integrity and the right to health. The training material advises on the principles which should guide refugee workers confronted with asylum requests based on gender abuse (interviewing guidelines, confidentiality, interpersonal and intercultural skills). The second, edited version for the training of judges also includes jurisprudence arguments.

Another tool developed by the Romanian National Council for Refugees is the ‘Guide for the assistance of immigrant communities from countries where FGM is practised (Ghid destinat asistentei comunitatilor de imigranti proveniti din tari unde sunt efectuate mutilari genitale feminine), prepared in 2008 to provide a training resource for social work students at the University of Bucharest. It is an adapted translation of a document issued by the Italian Ministry of Health. The original text contains the guidelines published by the Italian Ministry of Health in 2007 to help health professionals and professionals working with immigrants from countries where FGM is being practised in order to achieve prevention, and the assistance and rehabilitation of the women and girls subject to these practices. It contains definitions, classifications, prevalence, motives and legislation. The text contains no reference to Romania. The document circulates as an internal resource and was never published.

Other resources include a report on domestic violence, detailed under Section 2.3. Findings from the prevalence studies, and a manual which was also discussed under Section 2.3.

The target groups envisaged by the developers of the tools were the employees of a new refugee reception centre, judges, social work students and ‘community mobilisers’.

6.3. Reflection on tools and instruments on female genital mutilation

I consider that the first action that could allow policymakers and other potential actors to map and understand FGM in Romania would be the development of a prevalence study that includes fieldwork and primary data collection, and the development of a survey of professionals (medical and legal professions, social workers, etc.).

7. FINAL CONSIDERATIONS

Potential data on prevalence is still expected from the Romanian Immigration Office. The number of refugees registered by the UNHCR Statistical Online Population Database indicates 89 Somali refugees residing in Romania in 2010. This is the highest number of refugees from a country affected by FGM, so it is likely that the women who are part of this statistic are victims of or at risk of FGM. Regarding figures on refugees from other countries with a high prevalence of FGM present in Romania at the end of 2010, statistics record less than 15 nationals from any of these countries.

The most major lack in the approach to FGM in Romania is that of a public policy, on which no information has been discovered during this study.

As a non-specialist I think the lack of specific legislation on FGM does not constitute an absolute impediment to criminalisation of the practice, as the Penal Code has clear provisions on bodily harm and asylum laws and international treaties and recommendations have been used successfully in two court cases documented in Section 4.4.

I do however believe that there is need for higher cultural awareness of the practice in the professions that can be involved in combating the practice in the future (doctors, psychologists, social workers, lawyers, prosecutors and judges).

If the absence or the relative rarity of FGM victims in Romania is not clearly explained, one can definitely speak about the relative invisibility of the practice in the public sphere.

The most likely explanation for the invisibility of FGM in Romania, advanced by many of the specialists with whom I have spoken, is the small number of women who arrive in Romania as refugees, but it is also explained by the victims’ reluctance to speak about their situation. Specialists admit that at least women who are hosted in refugee shelters are supposed to be monitored from a medical point of view; they admit that there is no mechanism for the registration of the practice when discovered by a medical physician.

Many activists or specialists from related fields whom I have consulted try to refer me to more general issues/subjects of focus, generally violence against women, or relate the practice to human trafficking.

As a side note relating to a potential action to raise awareness on the topic of FGM among workers in related fields, my contact with them indicated a fairly high level of awareness of the topic; most of them used the official term of female genital mutilation, instead of older, incomplete
or more neutral terms such as ‘female circumcision’ or ‘female genital cutting’ that do not necessarily assume the incrimination of the practice. Moreover, they had a fairly high level of awareness of the geographical and cultural space where the practice is prevalent and did not associate it with Muslim communities, as routinely happens in casual knowledge on the topic.

The available information limited the possibility of assessing the evolution and trends of female genital mutilation in Romania along the lines of the design and structure of the present study. Romania — due to factors that are not the focus of the present report — does not constitute a typical destination for African migration to Europe and is definitely at a different point when it comes to the need to address FGM in policy and law. It is possible that Romania will be confronted with the phenomenon on a scale comparable to states such as the United Kingdom, Belgium, the Netherlands or Italy sometime in the future. For this reason, the approach, structure and aims of the present study on EU Member States might prove more targeted to Romania’s case at some future point in time.
Country report: Slovakia

1. IDENTIFICATION

Country: Slovakia

Researcher: Zuzana Ocenasova

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

In accordance with the ‘Guidelines for national data collection’ the following databases were searched: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar. Search terms in Slovak included *zenska obriezka* and *mrzacenie genitalii*. The database search of national (database of the Slovak National Library and database of Slovak Academy of Science) and international sources did not provide any relevant studies on the prevalence of FGM in Slovakia. In addition, the web pages of the following institutions were searched: the UNHCR office in Bratislava, the IOM office in Bratislava, Women Watch, the International Centre for Reproductive Health, the Advocates for Human Rights’ Stopvaw project and the web pages of the Ministry of the Interior and the Statistical Office of the Slovakian Republic.

In addition to the Internet and database search I contacted by e-mail the cultural anthropologist whose focus of interest is on migrants, and three NGOs working with asylum seekers in Slovakia — the Human Rights League, the Goodwill Society and the Slovak Humanitarian Council (SHC). She provided me with the study published by UNHCR in 2006 titled ‘Prevention of sexual and gender-based violence: a case of an asylum centre in central Europe’. Nevertheless, the study does not contain any mention of FGM, and according to the e-mail clarification she did not encounter any victims of FGM during the research. All three abovementioned NGOs were contacted by e-mail. Only the representatives of the SHC replied by e-mail to say that the organisation did not have any clients that were victims of FGM, but that it predominantly works with male asylum seekers. According to an SHC social worker, it is more than probable that women from Africa suffer from FGM but the organisation does not have any evidence of it. Furthermore, I contacted the Human Rights League and Goodwill Society by phone. Each organisation had one case of an asylum seeker with FGM.

Persons contacted are representatives of:

- Slovak Humanitarian Council, Bratislava,
- Slovak Humanitarian Council, Bratislava,
- Human Rights League, Bratislava,
- Faculty of Arts, Comenius University,
- Goodwill Society, Kosice.

2.2. Nature of prevalence studies/FGM registration systems

No prevalence studies were found.

2.3. Findings from the prevalence studies/registration systems

There are no studies on prevalence of FGM. Even the official statistics of the Bureau of Border and Aliens Police at the Ministry of the Interior (a body that keeps national statistics on refugees and asylum seekers) does not keep specific data related to FGM. It publishes yearly statistics on the number of illegal migrants in Slovakia, however the data have been stratified by gender only since 2008. The data give information on the number of illegal migrants in Slovakia in each year divided by country of origin (published data cover only the 15 most frequent countries), gender and age (two categories — up to 18 years of age and aged 19 and over). In addition, a table providing information on the nationality of persons with asylum status and citizenship granted during the years 1992–2010 is available on the bureau’s web page. Nevertheless, the data are divided only by country, not by gender and age, and they are aggregated for the time period without the possibility to view trends. The biggest number of both asylum seekers (224) and residents (73) came from Afghanistan. Among asylum seekers, the following countries of origin dominate: Iraq (54), Bosnia and Herzegovina (36), Armenia (34) and Russia (25). Applicants from Armenia (26) and Bosnia and Herzegovina (17) were successful in receiving residency status. Twenty-three persons from countries in which FGM is performed (Benin, Liberia, Cote d’Ivoire, Sierra Leone, Somalia and Sudan) were granted asylum, and three persons (from Liberia and Somalia) became residents. Overall, 661 persons were granted asylum and 207 were granted residency for the 9-year period.

From the statistics of the Bureau of Border and Aliens Police at the Ministry of the Interior the number of women from African countries where FGM is performed among illegal migrants in Slovakia can be deduced (available only as primary data). In the years 2008 and 2009, for which gender
disaggregated data are available, there were no female illegal migrants from the selected African countries in Slovakia. In 2008 there were 10 male migrants — nine from Nigeria and one from Sudan — and in 2009 there were 17 male migrants — 15 from Somalia, one from Nigeria and one from Eritrea.

2.4. Reflection on prevalence studies

The fact that there are no prevalence studies on FGM in Slovakia can be explained by the structure of refugees and asylum seekers in Slovakia, which covers different geographical regions and predominantly consists of men. Geographically, refugees and asylum seekers comprise mainly persons from the former Soviet Union (Moldova, Armenia, Georgia and Chechnya), Afghanistan and Pakistan. According to the statistics of the Ministry of the Interior, only 23 persons from countries where FGM is performed (Benin, Ethiopia, Liberia, Cote d’Ivoire, Sierra Leone, Somalia and Sudan) were granted asylum during the period 1992–2010, of whom three persons received Slovak citizenship. Unfortunately, these statistics are not gender desegregated. Nevertheless, according to the data from 2008 and 2009, as well as from 2010 (although this not divided per countries), the percentage of female refugees in Slovakia is significantly lower (12–13 %) than the percentage of male refugees. Studies of migration in Slovakia proved that a typical asylum seeker in Slovakia is young, single and male (e.g. Divinsky, 2004 and 2005). The combination of low female representation among refugees and asylum seekers and the small number of asylum seekers from countries in which FGM is performed suggests that cases of FGM in Slovakia are very rare.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

In accordance with the ‘Guidelines for national data collection’ the following databases were searched: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar. Search terms in Slovak included zenska obriezka and mrzacenie genitalii. The database search of national (database of the Slovak National Library and database of Slovak Academy of Science) and international sources did not provide any relevant studies on the prevalence of FGM in Slovakia. In addition, the web pages of the following institutions were searched: the UNHCR office in Bratislava, the IOM office in Bratislava, Women Watch, the International Centre for Reproductive Health, the Advocates for Human Rights’ Stopvaw project, and the web pages of the Ministry of the Interior and the Department for Gender Equality of the Ministry of Labour, Social Affairs and Family.

I analysed the following policy documents that could have been related to FGM:

- National strategy on prevention and elimination of violence against women and in families 2004,
- National action plan on prevention and elimination of violence against women 2005–08,
- National action plan on prevention and elimination of violence against women 2009–12,
- Migration policy of the Slovak Republic — Perspective until 2020,
- Conception of migration policy of the Slovak Republic.

None of the policy documents refer to FGM. The fact was also mentioned in the ‘Ad hoc query on female genital mutilation and asylum in the EU’ of the European Migration Network.

3.2. Policies on FGM

No policies were found.

3.3. Reflection on policies on female genital mutilation

Neither policies on gender equality and violence against women nor migration policies deal with FGM. The non-existence of specific policies is in line with the non-existence of specific legislation and institutions or actors focusing on FGM. It can be explained by the small number of women coming from selected African countries residing or asking for asylum in Slovakia.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

The starting point for the collection of documents on the legal framework was the report by Leye, Els and Sabbe, Alexia, Responding to female genital mutilation in Europe — Striking the right balance between prosecution and prevention. Later I consulted direct sources: Penal Code, Act No 300/2005 on the social and legal protection of children and social curatorship; and Act No 480/2002 on asylum. The information on the ‘Code of ethics of healthcare professionals’ and penalties in case of not reporting a serious crime was provided by the article by Peter Kovac, ‘Mlcanlivost zdravotnych pracovnikov [Secrecy provision of healthcare professionals], Via practica, 2005 (2) 6, pp. 329-330 (available at http://www.solen.sk/index.php?page=pdf_view&pdf_id=1670). The accuracy of information on criminal law and child protection was verified by e-mail with a lawyer and gender expert at the Slovak Academy of Science. Asylum law provisions were verified by phone with a lawyer cooperating with the Human Rights League. In addition, the web page of the Slovak National Centre for Human Rights was searched for reports on the protection of children’s rights.

Persons contacted:

- a respondent from the Slovak Academy of Science, Bratislava,
- an asylum lawyer, Zilina.

4.2. Criminal law

There is no specific criminal law on FGM in Slovakia. However, Articles 123, 155, 156 and 208 of Act No 300/2005
of the Penal Code can be applied to FGM cases. Article 123 provides a definition of bodily harm and bodily injury.

‘Article 123. Bodily harm.
(1) For the purposes of this act, bodily harm means any damage to the health of another person.
(2) For the purposes of this act, bodily injury means any damage to the health of another person requiring medical examination, intervention or cure and rendering the usual lifestyle of the injured impossible for a significant period of time.
(3) For the purposes of this act, the following serious health problems and illnesses are considered grievous bodily harm:
   (a) disability,
   (b) loss of or significant limitation to working aptitude,
   (c) paralysis of a limb,
   (d) loss of or significant limitation to the function of sensorial organs,
   (e) damage to an important organ,
   (f) disfigurement,
   (g) inducement of abortion or killing of the foetus,
   (h) torture,
   (i) health problems over an extended period of time.
(4) For the purposes of this act, health problems over an extended period of time mean health problems objectively requiring cure or even work absence, for a period of at least 42 calendar days during which the usual lifestyle of the injured has been altered in an important way.’

Articles 155 and 156 state penalties for bodily harm, bodily injury and serious bodily harm. Article 208 defines a crime of abuse of a person in a close relationship and of a person in care.

‘Article 208. Abuse of a person in a close relationship and of a person in care.
(1) Those abusing a person in a close relationship or a person in their custody or care, causing a person physical or mental suffering by:
   (a) beating, kicking, hitting, causing wounds and burns of different kinds, belittling, disrespectful treatment, constant surveillance, threatening, inducing of fear or stress, forced isolation, emotional blackmail or by other behaviour that puts their physical or mental health at risk or limits their safety,
   (b) unreasonably depriving them of food, rest or sleep or of necessary personal care, clothing, hygiene, healthcare, housing, upbringing or education,
   (c) forcing them to bag, carry out tasks beyond their physical or mental capacity in respect to their age or health condition or that could harm their health,
   (d) exposing them to substances that could harm their health, or
   (e) unreasonably limiting their access to property that they are entitled to use,

face imprisonment of 3 to 8 years.

The crimes of bodily harm and bodily injury are relatively permanent components of the Penal Code. In 1999, the term ‘person in a close relationship’ was introduced and the definition of the crime of abuse was extended. Further extension of the same article happened in 2002 by broadening the definition of a person in a close relationship and by specifying various forms of physical and psychological violence.

As there is no specific crime of FGM, any cases would be reported under the abovementioned articles. Consequently, it is impossible to collect data on FGM cases. Statistics on criminal cases are compiled separately by the police, prosecutor’s office and the Ministry of Justice.

4.3. Child protection laws/provisions

In Slovakia, there is no specific law or provision on the protection of children against FGM. The provision from Article 27 of Act No 305/2005 on the social and legal protection of children and social curatorship can be applied. The article states that in a situation in which the life, health or physical and mental development of a child is endangered, the organisation for the social and legal protection of children and social curatorship can suggest suspending parental authority or removing a child from a family. The court should approve the measure.

There are no reported cases of child protection interventions regarding FGM. The Slovak National Centre for Human Rights collects information and carries out surveys and research on the protection of children’s rights. On the centre’s web page (http://snslp.sk/#menu=1427), three reports on the protection of children’s rights are available, for the years 2007, 2008 and 2009. Nevertheless, none of them contain information related to FGM.

4.4. Asylum law(s)/provisions

There is no specific provision on FGM in Act No 480/2002 on asylum. However, FGM cases can fall under the definition of prosecution in the form of physical or mental violence, including sexual violence, and actions targeting a particular sex or children (Article 2).

Slovak legislation does not recognise the term ‘refugee’. The asylum law uses the terms ‘alien’ and ‘asylum seeker’. The latter is defined as an alien who has applied for asylum to the Ministry of the Interior, the institution that deals with the issue. Asylum is granted to applicants that have a well-founded fear of being prosecuted on grounds of race, ethnic origin or religion, or for reasons of holding certain political opinions or belonging to a particular social group, or to a person that has been prosecuted for exercising political rights and freedoms in their country of nationality or residence in case of a stateless person.

The ministries, namely the Bureau of Border and Alien Police and the Migration Office, are the institutions that collect information on all asylum cases. Unfortunately, their statistics do not provide any information on FGM. As a result, the only written information slightly related to the numbers of relevant cases can be found in the ‘Ad hoc query on female genital mutilation and asylum in the EU’ of the European Migration Network (EMN). According to the EMN document, there has been only one case in which FGM was claimed as
the reason for the commencement of the asylum procedure, but during the procedure an applicant had left Slovakia. The data for the ad hoc query were provided by EMN national contact points; in Slovakia it is composed of the International Office for Migration, the Ministry of the Interior, the Ministry of Labour, Social Affairs and Family and the Statistical Office of the Slovakian Republic.

In addition, two of the NGOs contacted dealt with a case of FGM. According to the lawyer of the Human Rights League, the asylum seeker was from Sudan, FGM was one of the reasons for the asylum procedure and the asylum was finally granted. The case was from 2007. Another organisation that provides legal aid to asylum seekers, the Goodwill Society, reported that in 2011 they represented a client from Somalia who stated that she was a victim of FGM. The client was granted asylum, though FGM was not the main reason. The discrepancy between the official statement for the EMN ad hoc query and the praxis of NGOs providing legal aid to asylum seekers suggests gaps in the data collection system.

Moreover, women from selected African countries often come with families, and as such they state as a reason for the commencement of the asylum procedure the prosecution of their husbands rather than FGM.

4.5. Professional secrecy provision(s)

The disclosure of information of professionals in case of abuse and violence (not explicitly FGM) is governed by several laws. According to the ‘Code of ethics of healthcare professionals’ these professionals are obliged to report information on abuse and cruel treatment, especially when concerning a minor. In addition, according to Act No 305/2005 on the social and legal protection of children and social curatorship, everyone is obliged to report the violation of children’s rights. Furthermore, not reporting a serious crime (including bodily injury and bodily harm) is punishable under the Penal Code by a term of imprisonment of up to 3 years. The reporting bodies are the police and the prosecutor’s office. There is no registration system for cases reported by professionals.

4.6. Reflection on legal framework

Although there is no specific provision regarding FGM in Slovak legislation, existing measures should in theory provide adequate protection against FGM. Nevertheless, as it seems that FGM cases in Slovakia are extremely rare it remains questionable how the system would function and how effective it could be in identifying girls at risk and what protection measures would be used. Although Slovakia has a different profile of refugees and asylum seekers at the moment, according to the information provided by NGO lawyers, the number of refugees from African countries, namely Somalia, has recently increased ('). In the future therefore, the number of women with FGM may grow and in a few years the first FGM cases may appear in Slovakia.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

There are no specific actors dealing with FGM in Slovakia. In theory, these would be the official institutions dealing with asylum seekers and migrants — the Bureau of Border and Alien Police and Migration Office, asylum centres and detention institutions, the UNHCR and IOM offices in Bratislava and NGOs helping asylum seekers and refugees. After the check of the web pages of the abovementioned institutions and web pages devoted to the issue of migration, no specific actor dealing with FGM was identified. I therefore contacted three main NGOs working with asylum seekers — the Human Rights League, the Goodwill Society and the Slovak Humanitarian Council. The first two have had direct experience with a client who had suffered FGM, the representative of the third suspects that some of her clients of African origin may have suffered FGM but the issue remained untouched both by the NGO’s social workers and the women themselves. None of the NGOs contacted has a special focus or policy on how to address FGM.

Web pages of institutions:

- Bureau of Border and Alien Police (http://www.minv.sk/?uhcp),
- Migration office (http://www.minv.sk/?migracny-urad-mv-sr),
- UNHCR office (http://www.unhcr.sk),
- IOM office (http://www.iom.sk).

Web pages on migration:

- Web page of the EQUAL project ‘Influencing public opinion of a majority society in order to facilitate the integration of asylum seekers and migrants’;
- Web page of the Asylum Legal Clinic led by the Human Rights League (http://www.utecenci.sk).

Web pages of NGOs:

- Human Rights League (http://www.hrl.sk),
- Goodwill Society (http://www.cassovia.sk/sldv/),
- Slovak Humanitarian Council (http://www.shr.sk).

(’ According to Ms Pisarcikova, the lawyer of the Goodwill Society, there was a significant rise in the number of asylum seekers from Somalia in 2011, many of whom were women. It is probable that they are victims of FGM but they do not directly state it. (Telephone interview.)
5.2. Actors

5.3. Reflection on actors on female genital mutilation

The low prevalence of FGM cases in Slovakia has meant that none of the institutions active in migration and asylum policies have been forced to develop a special approach or focus on FGM. Not surprisingly, those who seem to be more aware of the existence of FGM in Slovakia are the NGOs working directly with asylum seekers, providing them with social or legal aid. Despite their close contact with the possible target population they face difficulties in addressing the issue in their work. FGM is an issue that no one deals with or knows how to address, although it is known that some African women have suffered FGM. Nevertheless, women do not discuss it and the barrier is often reinforced by the presence of their husbands. Both lawyers that were interviewed confirmed the fact that women do not talk about FGM except in a situation where they are directly asked for the information as it can help the asylum procedure. Women are not aware that FGM can be considered a reason for commencement of the asylum procedure, so they admit it only when directly asked by a lawyer. Otherwise they state different reasons of persecution. As NGOs are the first to identify FGM cases, it is probable that they will also be the first actors that will introduce working with the issue into their responsibilities in the future, if the number of women from selected African countries asking for asylum rises.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

In accordance with the ‘Guidelines for national data collection’ the following databases were searched: Social Science Research Network, Sociological Abstracts, Web of Science, PubMed and Google Scholar. Search terms in Slovak zenska obriezka and mrzacenie genitalii. The database search of national (database of the Slovak National Library and database of Slovak Academy of Science) and international sources, the web pages of the responsible departments of the Ministry of the Interior, UNHCR, IOM and NGOs working with asylum seekers or web pages devoted to asylum and migration projects did not provide any relevant tools or instruments (T & I) on FGM in Slovakia. The only documents relevant to T & I in Slovakia were obtained from international sources — the International Centre for Reproductive Health, the European Migration Network and the United Nations Division for the Advancement of Women. Search results in Slovakia consisted only of academic studies related to African countries, Slovak development projects or discussions of the ethics of FGM in general.

6.2. Tools and instruments on FGM

The only documents relevant to T & I in Slovakia were the following studies published by international organisations:

• Leye, E. and Sabbe, A., ‘Overview of legislation in the European Union to address female genital mutilation, challenges and recommendations for the implementation of laws’;

• ‘Ad hoc query on female genital mutilation and asylum in the EU’, European Migration Network.

All three studies provide an overview of the FGM issue in several countries (27 for Leye and Sabbe and 18 for the EMN) and information on Slovakia is usually very brief. The publications of Leye and Sabbe deal with legislation related to FGM while the EMN document summarises responses to questions related to specialised institutions, specific guidelines and a number of cases. The information is based on questionnaires completed by gender experts from the Slovak Academy of Science (Leye and Sabbe) or the EMN national contact point composed of the International Office for Migration, Ministry of the Interior, Ministry of Labour, Social Affairs and Family and the Statistical Office of the Slovakian Republic. All three publications state that there is neither specific legislation, nor guidelines and institutions in Slovakia. The EMN document provides information on supposedly the only FGM case in Slovakia in which the asylum procedure was not finished. However, according to the interviews with lawyers of NGOs providing legal aid to asylum seekers, there have been at least two FGM cases, in 2007 and 2011, and in both cases asylum was granted to the applicant. (For more details see Section 2. Prevalence.)

6.3. Reflection on tools and instruments on female genital mutilation

It is significant that international institutions have published the only studies related to FGM in Slovakia, and Slovakia was always one of many countries concerned. All studies prove the lack of specific measures and institutions dealing with FGM in Slovakia. This fact is coherent with the results of this country study, finding no specialised policy measures, laws or actors dealing with the issue of FGM. The situation is a result of the low prevalence of FGM due to the small number of women from selected African countries residing or asking for asylum in the country or/and the difficulties for the actors concerned (public institutions and NGOs working with asylum seekers and refugees) in addressing FGM.

7. FINAL CONSIDERATIONS

Female genital mutilation is an invisible issue in Slovakia that is not covered by any specific legislation or policy. Similarly, there are no institutions, either public nor NGOs, working on the issue. As there are no qualitative or quantitative studies dealing with FGM, it can only be assumed that this invisibility is caused by the small number of women that have suffered FGM and are temporarily living or residing in Slovakia. This assumption is based on the available official statistics (unfortunately not desegregated by gender and country of origin at the same time), with the existing studies on asylum seekers in Slovakia confirming the strong majority of male applicants and information from NGOs working in the field. During the process of data collection in Slovakia, two types of information related to
Study to map the current situation and trends of FGM

FGM cases were gathered — information from the EMN official national contact point and from NGOs providing aid to asylum seekers. Nevertheless, there is a discrepancy between the two sources regarding the course of the asylum procedure in a case of FGM so it is impossible to assume whether it is the same case or not. This discrepancy also points to the non-existence of any data collection system.

Legislatively, FGM can be covered by general criminal legislation, and in combination with child protection and professional secrecy provision laws this offers adequate protection against FGM. FGM can be a reason for the commencement of the asylum procedure. According to information provided by asylum lawyers, in practical cases it has never been the sole reason asylum has been granted, although it is important to notice the low number of cases. Neither migration nor gender equality policies deal with the issue of FGM. None of the actors, public or private, has a specific focus on FGM. Despite the presumably small number of women with FGM, in recent years NGOs working in the field have reported a slight increase in the number of asylum seekers from African countries in which FGM is performed, including women. This fact may lead to a need to address FGM in the future, at least on a practical level. As NGOs are the first ones identifying FGM cases in their work, it is probable that they will also be the first actors that will include work with FGM in their portfolio, given that these cases will be on the rise. The non-existence of prevalence data, specific legislation, policies or actors results in the non-existence of tools and instruments produced in Slovakia. Even Slovak academic studies related to FGM situate the issue in Africa or perceive it as a theoretical ethical issue. Not surprisingly, the only studies referring to FGM in Slovakia are those produced by international organisations and providing an overview of the situation in the EU.
1. IDENTIFICATION

Country: Slovenia

Researcher: Katarina Župevc

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

I tried to obtain prevalence data in various ways.

(1) I searched for academic articles in the databases suggested in the 'Guidelines for national data collection' (Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, and Heinonline). I also used a Slovenian national database (http://www.cobiss.si) as well as a database which includes more than 300 different scientific databases of academic articles (http://www.nuk.uni-lj.si/nuk/mreznik.asp), Google and Google Scholar, and searched the web pages of UN Secretary-General and EMN.

I used different key terms in my searches. I used the Slovenian terms obrezovanje deklic (circumcision of girls), obrezovanje žensk (circumcision of women), genitalna mutilacija (genital mutilation), obrezovanje genitalij (circumcision of genitals) and obrezovanje (circumcision).

I also used different English terms as suggested in the guidelines — female genital mutilation, female genital cutting, female circumcision and female genital surgery.

(2) The main and most important ways of obtaining all data were e-mail and phone contacts. I started phoning and e-mailing institutions from the list that the core team of the project provided. I asked all my contacts if they had any further suggestions as to who I should contact. In this way I expanded my list of contacts considerably.

I also contacted researchers that I knew from previous collaborations, for example anthropologists whose professional interests is also African culture and/or migration. I asked them if they had any knowledge about FGM in Slovenia or if they knew of any such cases. I also asked if they are aware of any research or reports on FGM in Slovenia, and I contacted the authors of two academic articles on FGM.

(3) I checked the web pages of institutions. I searched for any kind of relevant data that could be directly or indirectly connected with FGM in Slovenia. I was especially interested in reports, statistical data and guidelines for dealing with FGM.

The biggest and most frustrating challenge I encountered during my work was the absolute lack of any kind of information about FGM in Slovenia. Every one of the individuals or institutions that I contacted (with just one exception) acknowledged that they knew nothing about FGM in Slovenia. Some also stated that no FGM exists in Slovenia. This would to some extent correspond to my data collection, which resulted in almost no findings.

2.2. Nature of prevalence studies/FGM registration systems

There are no national or any other studies on FGM in Slovenia and also no registration system. Therefore no statistical data can be provided, and no elaboration of the studies can be made. However, in my opinion this lack of studies could suggest two things: one would be that FGM does not exist in Slovenia, and the other, which is more likely, is that FGM in Slovenia has not yet been detected by any institution, sector or researcher. I would dare to make an assumption that it is highly unlikely that FGM has not appeared in Slovenia (in the case of migrant women or even in the case of second generation migrant women).

2.3. Findings from the prevalence studies/registration systems

As no study or system which would provide me with any kind of data on FGM exists, I cannot make any reference to them at this point.

2.4. Reflection on prevalence studies

From the above it is quite clear that no data explicitly concerning any aspect of FGM exists in Slovenia. Also, no scientific studies on this topic have been carried out so far.

According to a respondent from the African Centre of Slovenia, one reason could be the way of life of African migrants in Slovenia. African migrants in Slovenia are mainly male; there are relatively few women (which is also revealed by statistics of the Migration and Integration Directorate in Section 4.4.). Because of this the existence of marriages and partnerships between African men and Slovenian women is quite common, especially when compared to marriages/partnership between African spouses/partners. Therefore, this would result in the non-existence of FGM (Slovenian mothers do not want to subject their daughters to FGM).
Another reason could be that African migrants in Slovenia are not very tradition oriented. They usually have a high educational background and their values are more modern than traditional. They are also not ghettoised as are African migrants in some other European countries. And because they are not ghettoised and are fairly well assimilated and integrated into Slovenian society, the traditional structures that are the basis for traditional practices such as FGM do not exist. This would be one of the most important reasons that Africans in Slovenia do not practice FGM.

According to the statistics that I found in a bachelor of arts thesis about African and Asian immigrants in Slovenia, written by Urška Štucin, the number of African migrants in Slovenia who have obtained citizenship is not very high. Ms Štucin cites the following numbers, which apply to the time period between 25 June 1991 and 31 May 2009: three migrants from Cameroon, two from Congo, 12 from Egypt, two from Gabon, eight from Ghana, four from Guinea, one from Guinea-Bissau, nine from Kenya, four from Madagascar, four from Mali, five from Nigeria, six from Sierra Leone, one from Somalia, five from South Africa, eight from Sudan, two from Uganda, three from Yemen, one from Zaire, one from Zambia and one from Zimbabwe. However, a number of female and male immigrants are not stated (for more information on the number of asylum seekers please see Section 4.4.).

And the low number of African immigrants seems really to be the main reason for the absence of FGM practices in Slovenia. For almost the whole duration of the research I was not able to get any information on FGM. None of the institutions and individuals, except one, had encountered this practice in Slovenia, had ever heard of it being present (or performed) in Slovenia and had not done or come across any specific research or studies about it. So for the first few weeks of the research I thought I would not be able to acquire any relevant information about FGM. I did suspect, however, that it was rather impossible for FGM not to exist in Slovenia and at the same time be such a great problem in other European countries, including the neighbouring countries of Italy and Austria.

At the very end of my research I finally got in touch with the President of the NGO Association for Nonviolent Communication (DNK), who informed me that they had been contacted regarding two possible cases of FGM (for more information on this please see Section 5.2.).

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

I used similar methodological approaches for collecting policy documents to those described in Section 2.1. I searched all databases that were suggested in guidelines and also the database of the National Library. I also searched relevant web pages (for example the Office for Equal Opportunities and the Ministry of Justice).

3.2. Policies on FGM

No policies on FGM were found.

3.3. Reflection on policies on female genital mutilation

Since no policies on FGM were found, I cannot make any reflections on this point.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

I used a similar methodology for collecting legal documents to that described in Section 2.1., however the most important and fruitful way of trying to obtain any relevant information was e-mail contacts with legal experts.

I contacted a representative from the Peace Institute, who suggested which laws and acts could be applied in cases of FGM, since Slovenia has no laws/provisions that would address FGM explicitly. I also got some information about the legal situation and possibilities from Irena Badovinac Bjelič, a judge at the Supreme Court.

The document Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence, which was sent to me by Els Leye, was very useful for my research.

For acts and laws I searched the web page of the Uradni list RS (the official gazette of Slovakia).

4.2. Criminal law

No general or specific criminal law that would explicitly address FGM exists in Slovenia, however there are two laws that could be useful in the Slovenian context in case of FGM.

The Family Violence Protection Act that entered into force in 2008 contains Article 3, which defines family violence as any physical, sexual, psychological or economical violence by one member of a family against another member of the same family. This act was suggested to me by one of the respondents. It could be applied in a situation where one family member would intend to subject or has already subjected a girl from the same family to FGM.

Another law that could also be used in situations of FGM (not just in case of one family member subjecting another family member to FGM, but also in a broader context) would be Slovenian Penal Code, which also entered into force in 2008. Although FGM is not explicitly mentioned, it is quite clear from the Feasibility study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence that it could be applied in cases of FGM. Cases of FGM would be prosecuted under Article 123, which applies in cases of grievous bodily harm, or under Article 124, which applies in cases of especially grievous bodily harm. The maximum penalty for criminal acts committed under
There is no available data on whether any female asylum seekers applied for asylum on the grounds of FGM. I also wrote an e-mail to the Migration and Integration Directorate asking about this, and I received an answer on behalf of the director of the directorate stating that they do not have statistical data on whether any asylum applications have been made on these grounds.

However, a person from the asylum centre in Ljubljana said that he does not recall any cases of FGM as the grounds for the asylum application. As a volunteer from Slovenian Philanthropy informed me, there were only two women from African countries in asylum centres at the time of this research: one from Somalia in an asylum centre in Maribor and the other from Morocco in an asylum centre in Ljubljana. Neither of them requested asylum on the grounds of FGM.

From 1995 until the end of 2010, Slovenia positively dealt with 209 asylum applications: 97 asylum seekers were granted refugee status according to the Geneva Refugee Convention (64 men and 33 women), 89 were granted asylum for humanitarian reasons (56 men and 33 women) and 23 were granted subsidiary protection (17 men and 6 women). In 2010 23 asylum applications were positively dealt with.

No further statistical data that would be relevant for this particular research exist.

4.5. Professional secrecy provision(s)

According to the Patient Rights Code, Article 45, a doctor is permitted to report information about a patient’s medical condition in order to save a patient’s life or to prevent health damage to other persons.

However, if a patient is a child, a doctor is obliged to report any suspected criminal offences against life and body (Chapter 15 of the Criminal Code), against sexual integrity (Chapter 19 of the Criminal Code) and against wedlock, family and youth (Chapter 21 of the Criminal Code).

According to the Family Violence Prevention Act, Article 6, bodies and organisations, as well as NGOs, which encounter possible ongoing violence are obliged to inform the social work centre unless a victim is explicitly against this action and if it is not the case of a suspected criminal offence. This paragraph of Article 6 applies in cases in which the victim is an adult.

The second paragraph of Article 6 addresses situations in which the victim is a child. In such cases everybody, and especially workers in the medical, educational or care sectors, are obliged to contact the social work centre, police or prosecutor, despite their being bound to secrecy.

Although FGM is not explicitly mentioned, it is clear that professionals who theoretically encounter any such case have the possibility and also the legal permission to report it, as well as the obligation. I asked about possible knowledge of any such cases among medical establishments. My opinion was that although official medical experts are
not performing FGM, it could be possible that they were consulted in a case where complications appeared. Therefore I contacted two Slovenian societies I thought might have come across a case of FGM: the Slovenian Paediatric Society and the Slovenian Society of Obstetrics and Gynaecology. Again, their answer was similar to all other answers I received from the numerous individuals and institutions: FGM is not present in Slovenia; we have never come across any such case.

4.6. Reflection on legal framework

Slovenia has no law or act that would specifically and explicitly address FGM. FGM is not even mentioned as an example of physical violence, which would be prosecuted under Article 123 or 124 of the Criminal Code, but these articles of the Criminal Code could only be applied in cases where the FGM has already been done, and not in cases of prevention.

However, although not explicitly addressed, FGM could theoretically be prosecuted under Slovenian laws. But in my opinion this would just sanction the consequences and would not prevent the occurrence of FGM in the first place. While this traditional practice seems very distant from Slovenian reality, I would dare to speculate that it will not always be the case. I therefore think that the issue of FGM should be more thoroughly addressed and included in Slovenian legislation.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

The methodology for finding relevant actors consisted mainly of phone and e-mail contacts with any institutions and individuals I could think of that could possibly have any kind of information about FGM in Slovenia.

5.2. Actors

Among other institutions, I also contacted the Association for Non-violent Communication, which is a non-governmental, non-profit and humanitarian organisation dedicated to the prevention of violence and spreading the principles of non-violent communication. The organisation considers violence as a problem of society as a whole and of those who commit it, and has three primary objectives: to reduce society’s tolerance to violence; to help those who commit violence to change their behaviour; and to help those who experience violence.

I spoke with a representative of the association. She informed me that the association has been contacted in two cases of possible FGM. A social worker contacted them and asked what actions they would recommend (she had already reported the cases to the police). One respondent informed the social worker that they have no experience with such matters, but was still able to provide her with some advice (that it is important to work with all involved individuals, and also to give advice about where to get help). The respondent I talked to was not able to give me a direct contact for this particular social worker, but gave her my contact details.

The respondent also said that their organisation does not explicitly address FGM, but they do however mention it in the context of their lectures and education programmes.

5.3. Reflection on actors on female genital mutilation

Although FGM in Slovenia seems to be very rare I found it somehow surprising that no government organisations, and especially that no non-governmental organisations, address it in their agendas. For example, Amnesty International launched a big ‘End FGM’ European campaign in 2010. This act implies that FGM is a great problem also in Europe and does not exist only ‘far away’, among the ‘African others’. But Amnesty International Slovenia does not include it in its agenda and actions. I called their office in Slovenia and they acknowledged that they do not address FGM in the Slovenian context.

According to the respondent and the association’s experiences it is clear that FGM exists in Slovenia, but that its prevalence is not very high. In fact it is so low that it has not yet been detected by institutions.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

I used methods for collecting tools and instruments similar to those described in Section 2.1.

6.2. Tools and instruments on FGM

I found three academic articles on FGM but they do not explicitly address the situation of FGM in Slovenia. However, I will briefly go over their content at this point.

An article that could be interesting for the study was written by a lawyer and is entitled ‘Obrezovanje — nepravna banalnost kirurškega posega’. The article mainly addresses the circumcision of boys but could still be interesting and applied in cases of FGM. The author focuses on the question of whether circumcision of children for religious and/or traditional reasons (and not for medical reasons) should be allowed and seen as a parent’s right or should be condemned and seen as a violation of a child’s bodily integrity.

The author also cites the UN Convention on the Rights of the Child, which states that a child should be protected against all forms of physical and psychological violence, harm and abuse while under care of one or both parents. On the other hand, the Convention also states that a child can be religiously guided. The important question is whether circumcision is mere religious guidance or is it something more than that (Korošec 1995: 562).
For this particular research I think that author’s following words could be especially relevant:

‘Let me finish my thoughts on admissibility of circumcision of children out of religious and similar motives with a few words dedicated especially to girls. If we accept medical findings that there is absolutely no serious reason medical reason for circumcision of women regardless of their age, then legal experts can understand this kind of mutilation of woman only in terms of barbarism, violation of a right to physical integrity, a criminal offence of physical harm and a ground for enormous compensation as well.’ (Korošec 1995: 565)

In the article ‘Obrezovanje deklic — obred iniciacije ali mučenje in pohabljanje?’ the traditional practice of the circumcision of female genitalia is addressed and compared to the circumcision of boys. He states that these two traditional practices cannot not be understood as two sides of the same coin. Male circumcision (as a religious practice) is usually done under the supervision of trained medical staff and under general anaesthesia and could therefore be understood as a minor surgical operation with few or no negative medical/life threatening outcomes. On the other hand, FGM is done by untrained women with no anaesthesia and consequently with great physical and psychological consequences. Nevertheless, both circumcisions are done in the absence of any kind of medical reason for cutting off a piece of perfectly healthy male or female genitalia.

The author continues with an explanation about the origins of FGM and considers it to be probably the oldest surgical operation, supposedly already done in the Palaeolithic 10 000 years ago. He then describes three different methods of FGM and makes it clear that all cultures that practise FGM (as well as those that practise circumcision of boys) consider it to be a rite of passage. A woman who is not circumcised is considered by society to be impure, and she usually has no legitimate position in the social system (is not appropriate for marriage, endangers her family’s honour and status, etc.).

The author also links FGM to an archetypical fear of female sexuality. In some cultures the clitoris is supposed to be impure and dangerous when in contact with male genitalia and should therefore be eliminated. By doing so a woman becomes more accepted in her society. An interesting point that the author makes in his article is that FGM is an evident outcome of male domination and patriarchy and underlines this statement with an example: Australian aboriginal culture, which was very egalitarian, never practised FGM. On the other hand, many societies that show explicit traits of patriarchal subordination of women practise this cruel mutilation still today.

As far as situation in Slovenia is concerned author addresses it in a short passage on pg. 186:

‘Not much is known about the circumcision of girls in Slovenia, if we consider media attention and few professional articles — articles were published no earlier than the 1990s. Slovenia seems far away from habits that harshly violate human rights and the rights of the child.

With the downfall of the communist bloc, including the downfall of the Socialist Federal Republic of Yugoslavia, the non-aligned movement lost almost all political power, and Slovenia, which until then had relatively numerous contacts with countries of the so-called third world, where the practice of circumcision of girls is strongest, became very distant from this world. Slovenian political and cultural interests became focused on the west. With Africa, where according to some estimates 80 % of all circumcisions take place, we had contacts via numerous African students, but now these encounters became almost impossible. Only a few former students stayed here, and refugees are ghettoised.’ (ibid 2001: 186)

I also contacted the author and asked him if he has more information on FGM in Slovenia. He replied that his interest in writing this article was a coincidence (he started writing it while he was reading the book Desert flower by Waris Dirie, a Somali model and activist) and that he has no information on the Slovenian context. However, he kindly gave me the contact details of his friend, who is employed in an asylum centre in Ljubljana, and suggested I should contact him regarding FGM.

Another academic article that I found also does not focus on the Slovenian situation per se. If the former article addresses FGM from a more anthropological point of view and situates it in different cultural contexts, this article, ‘Obrezovanje deklic: kršitev pravic ali kulturna raznolikost?’ written by Suzana Kraljić, focuses more on the legal perspective.

At the beginning Suzana Kraljić contextualises FGM: she provides some statistical data on the prevalence of FGM in African countries. She also writes of different types of FGM and also reveals its negative and cruel side effects for girls’ health and psychological well-being. She then continues with the legal framework: she states that there is no explicit Slovenian act or law that would address FGM, but does acknowledge that it could be prosecuted under Articles 122, 123 and 124 of the Penal Code. She also says that an official proposal to change Article 124 was made in 2009 so it would more specifically address FGM as a form of very grievous bodily harm. Regarding this statement I contacted the author for more information but did not receive any answer. I also searched the web for this particular proposal, but was unable to find it. It is also clear that the change has not been made, as Article 124 of the Penal Code still addresses body harm in a very general manner.

The author also considers FGM in the context of human rights and the rights of the child. She addresses FGM in the context of the countries where it is forbidden by international acts and laws but nevertheless still exists as a practice of tradition and moral values.

One of the tools that I found is a brochure on sexual and reproductive rights, published by SLOGA (Slovenian NGOs for development cooperation and humanitarian aid) in 2001. A brochure addresses the general public and gives very thorough information on various NGOs in Slovenia that are connected in different ways with the topic of sexual and reproductive rights, for example organisations that promote the sexual and reproductive rights of
teenagers; that promote safe motherhood and fatherhood; that prevent sexually transmitted infections; that prevent violence against women, etc.

Although FGM is not explicitly addressed, it is mentioned on page 26 in the context of the presentation of Amnesty International Slovenia:

‘Progress is obstructed by violations of human rights, like circumcision of female sex organs, abortions in dangerous conditions, sexual violence, and early and forced marriages …’

And again on page 27:

‘Another extreme violation is represented by circumcision of sexual organs, to which 3 million women and girls are subjected every year; that is 8 000 per day. This is violence against women and girls which could also be understood as torture. We encounter it in some parts of Africa, Asia and in the Middle East. Girls and women are most frequently taken to their countries of origin during vacations, where they are circumcised. According to estimates of the European Parliament there are half million women and girls living in Europe who will suffer from consequences of circumcision of their sexual organs for the rest of their lives.’

6.3. Reflection on tools and instruments on female genital mutilation

Although not many tools have been found, I would still say they are relevant and can also serve as a starting point for further work on FGM prevention, awareness-raising campaigns and damage control. Articles offer some legal considerations on FGM and reveal that Slovenia also treats (or would also treat) FGM the same as other European and other countries — as a violation of human rights and the rights of the child, as a violation of bodily integrity and also as a form of physical violence — and is therefore not allowed, is criminalised according to the Penal Code and also punishable.

The brochure is of value as it seems to be the only such thing in Slovenia. It addresses the general public, is available for free and has a lot of other relevant information about different topics. It does not thoroughly address FGM, but nevertheless it does mention it briefly in two places and this could be seen as a start towards a more in-depth consideration of this practice as a problem that also exists in the Slovenian context.

7. FINAL CONSIDERATIONS

It is evident from my research that Slovenia has not yet begun to address the issue of FGM as a practice that also affects European women and girls and not just those living in Africa. FGM has not yet entered research discourse and policymakers have not yet included it in their agendas.

As far as the legal context is concerned, FGM is not explicitly addressed in any Slovenian laws, provisions or acts. All these could be applied in cases of FGM, however, therefore it would not stay unnoticed and would be prosecuted.

There are no actors in Slovenia that would explicitly address FGM in their work or that would collect statistics, do research and suchlike. I accidentally came across one NGO that had encountered two cases of FGM, but that is all. It seems so far that there is no need to more thoroughly address FGM, while the number of cases is still very low.

I found four documents. Three of them are academic articles on FGM that offer some starting points for further work on FGM. One is a brochure that in some manner offers a small amount of information on FGM.

All this suggests that Slovenia still thinks of FGM as a practice that does not really concern people living in Slovenia. FGM is still understood as an exotic and distant phenomenon that exists in societies far away from us. In my phone contacts I sometimes had to more explicitly explain what FGM is and often I triggered a very surprised response because of the focus of my interest. All this implies that FGM not only remains invisible in the Slovenian context, but is also quite unknown. I therefore think more should be done regarding awareness-raising and educating people about FGM (especially those working with children) so they would be able to react properly in case of encountering FGM.

I would also like to point out a debate that is going on in Slovenia at this very moment, which is quite a coincidence. As I was informed by a human rights ombudsman, the Ombudsman’s Office issued an opinion on 3 February 2012 regarding the circumcision of boys, which is practised among Muslim and Jewish communities in Slovenia. The Ombudsman’s official statement is that circumcision for religious reasons not based on any medical condition is not acceptable. The Ombudsman prepared this document following the opinion of the legal expert and also the UN Convention on the Rights of the Child. The opinion also builds its arguments based on the Slovenian constitution, which determines the physical and emotional integrity of a child.

The Muslim community in Slovenia reacted very strongly to the Ombudsman’s opinion. In the article ‘Medicina v dvorih, muslimani v precepu’, which was published in one of the main Slovenian daily newspapers, Dnevnik, its representative stated that the circumcision of boys is a common practice and was also carried out in Slovenia until recently (but if the grounds for circumcision are solely religious medical insurance does not cover it financially). In the autumn of 2010, the University Medical Centre Ljubljana decided that circumcision would only be done for medical reasons. As stated in the article, Muslim parents now take their children to Bosnia, Serbia and Macedonia to be circumcised. Therefore, even though doctors are quite reluctant to perform this procedure, alternative ways are sought out.

In my opinion this debate is relevant also for the practice of FGM, while it opened a discourse on bodily integrity and children from a different point of view than in the past. It also puts forward a strong opinion that circumcision, especially when done in improper and dangerous circumstances, could be damaging to the child and should therefore be avoided.
Spain

Country report: Spain

1. IDENTIFICATION

Country: Spain

Researcher: Alba Alonso Álvarez

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Prevalence studies were mainly gathered thanks to the website and the informants belonging to the most relevant research group on female genital mutilation in Spain. The Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices (GIPE) was set up in 2003 in the Autonomous University of Barcelona aiming at analysing, among other things, the prevalence of FGM in Spain. So far, it has published three maps on FGM in Spain. The contact details are the following:

• website: http://www.mgf.uab.es
• Adriana Kaplan.

The prevalence study ‘Female genital mutilation in Andalusia: Analysis and proposals’ was accessed thanks to the collaboration of one of its authors, María Luisa Grande, since this work has not been published yet.

A search of academic databases and relevant websites (official agencies, organisations working on FMG, etc.) was done, though no other prevalence studies were found.

2.2. Nature of prevalence studies/FGM registration systems

The four studies on prevalence that have been identified are as follows.


This study was done by three researchers, including Adriana Kaplan, who has led the GIPE since 2003. It was done within the framework of the IDIL-Daphne project 2001–03 (http://www.csapiemonte.it/document/project_idil.pdf). This project focused on defining and experimenting with strategies to prevent FGM among immigrant communities/families. For this purpose, the Spanish research team published in 2002 the first study on the prevalence of FGM in this country. The study gathers data on the population in Spain coming from 28 countries where FGM is performed. It allows the number of women as well as the number of girls under 15 years old from those countries to be identified. To collect this data three official sources were consulted: the Ministry of the Interior, the ‘Yearbook on migrations 2000’ and the Institute of Statistics of Catalonia. The study presents data covering the whole territory, although information disaggregated by autonomous community is only available in the case of Catalonia, Madrid, Aragon, Andalusia and the Canary Islands. As a result, prevalence data per region cannot be compared with the maps of FGM published in 2006 and 2010.

• Grupo Interdisciplinar para la Prevención y el Estudio de las Prácticas Tradicionales Perjudiciales, Mapa de la mutilación genital femenina en España, 2006, UAB, Barcelona, 2006.

This work presents the first prevalence study properly published by the GIPE. Its methodology builds upon the former study and it gathers data on the population in Spain coming from 29 countries where the FGM is performed. It allows the number of women as well as the number of girls under 14 years old coming from those countries, who are thought to be at risk of suffering FGM, to be identified. Additionally, data is disaggregated by age group (0–14, 15–29, 30–44, 45–64, 65 and over) as well as by autonomous community. Here, data from all the Spanish regions can be found, providing an exact description of the distribution of population coming from countries where FGM is performed. The methodology to collect this information was based on using a different source from the former study, that is, the Padrón. The Padrón is the main population register in Spain, which is managed by each municipality. It is thought to accurately reflect the presence of immigrants from other countries, since they need to register in their respective city councils in order to get access to healthcare, education services, etc.


The third map on the prevalence of FGM in Spain presents an update of the previous study aimed at reflecting the changes experienced by immigration flows since 2005. It also gathers information on the population coming from 29 countries where FGM is still performed. It allows the number of women as well as the number of girls under 14 years old coming from those countries to be identified. Additionally, data is disaggregated by age group (0–14,
15–24, 24–34, 35–49, 50–64, 65 and over) as well as by autonomous community. In line with the former study, the methodology to collect this information was based on using the Padrón.


This is the final report of the research project ‘Female genital mutilation in Andalusia: Analysis and proposals’, funded by the government of Andalusia. It aims at gathering data on the population in Andalusia coming from 19 countries where FGM is performed. It permits identification of the number of women as well as the number of girls under 15 years old coming from those countries. The latter are thought to be at risk of suffering FGM. Data is also disaggregated by age group (0–15, 16–44, 45–64, 65 and over) and by province. It provides a snapshot of the distribution of women and girls from those countries within Andalusian territory. Data comes from two sources: the National Statistics Institute and the Permanent Migration Observatory of Andalusia (OPAM).

To sum up, the GIPE has published prevalence studies every 3 to 4 years since 2002. Led by an anthropologist, Adriana Kaplan, the research group is formed of scholars from a wide variety of fields (nursery, medicine, education, etc.). By using the same methodology — though with minor modifications — as well as by keeping the same disaggregation criteria, the studies will allow interesting comparative work in the future. Additionally, the presence of data disaggregated by region might represent a useful way to identify those territories where prevention or attention measures are especially needed.

This work, along with the pioneering initiative of a research team of the University of Jaén, represents the existing data sources regarding the prevalence of FGM in Spain. As a result, academic studies are so far the only source of data when referring to this country.

One of the main strengths of the abovementioned works is their interest in disaggregating data by region and/or province. It will allow public policies against FGM to focus on those territories where there are more girls and/or women at risk. Secondly, those studies using the Padrón as a reference may well include almost all the population coming from those countries (those who have nationality or a residence permit and those who have not). Indeed, the Padrón is a local register where immigrants, regardless of their legal status, need to register in order to access public services (health, education, social services, etc.).

Limitations refer to the lack of data concerning, for instance, unregistered female migrants or women seeking asylum on the grounds of FGM.

2.3. Findings from the prevalence studies/registration systems

The four abovementioned studies provide data on the number of female residents in Spain from African countries where FGM is performed. However, they vary regarding the countries that are included in the database (from 19 in the study on Andalusia to 29 in the latest maps of the GIPE).

The map corresponding to 2009, for instance, states that there are 40 890 women registered in the Spanish Padrón who have come from one of the 29 countries included in the analysis (14 451 aged 0–14, 5 705 aged 15–24, 16 673 aged 25–34, 6 949 aged 35–49, 892 aged 50–64, 220 aged 65 and over). These studies mention The Gambia, Ghana, Mali, Mauritania, Nigeria and Senegal as the countries from which the majority of women included in the study come from.

Additionally, all the prevalence studies opt to include an age group (0–14 or 0–15 years old) that is considered to be at risk of suffering FGM. For instance, in 2009 10 491 girls aged 0–14 are thought to be at risk of FGM in Spain. Besides, it is possible to know not only their nationality of origin but also their presence by autonomous community, or province in the case of the most recent study focused on Andalusia.

The number of unregistered female migrants from African countries or of African origin is not available. However, the maps published by the GIPE are thought to include almost all the population coming from those countries (those who have nationality or a residence permit and those who have not).

The Asylum and Refugee Office of the Spanish government publishes an annual report on asylum processes. It includes data referring to the country of origin, sex and educational level of asylum seekers and refugees. However, there is no information concerning the reason for which the application has been made or for which refugee status has been granted.

With regard to the number of FGM cases that are registered by public services, a registration system was found in the case of Catalonia. The government of Catalonia gathers annual statistics on cases of gender violence, within which FGM is included. The reports include the number of cases of FGM detected by the Catalan police (Mossos d’Esquadra) as well as the number of girls that were seen by the police. There are specific reports for 2008, 2009, 2010 and 2011.

2.4. Reflection on prevalence studies

It must be noted that the existing data on the prevalence of FGM does not come from official sources. Rather, research teams with a special interest in these kinds of harmful traditional practices have been in charge of creating these pioneering databases. The long history and prolific work of the GIPE guarantees the high quality of their maps on FGM in Spain. Nevertheless, it would be feasible and appropriate for those national agencies gathering data on immigration and asylum issues or gender violence also to address FGM prevalence data. For instance, the Government Delegation for Gender Violence gathers data on different aspects of this type of violence in Spain (complaints, associated fatalities, protection measures, etc.), although it focuses almost exclusively on intra-partnership violence. It has not provided any information on FGM cases, complaints, etc. The Asylum and Refugee Office, on the other hand, uses software that gathers together all the data on asylum
processes and compiles a wide variety of variables (sex, age, education, etc.). However, there is no room for specifying the kind of persecution that has led to the asylum process.

It is worth noting that data included in the unpublished report ‘Female genital mutilation in Andalusia: Analysis and proposals’ cannot be included here. The authors authorised the quotation of the report but refused to make its data public at this point. However, it can be publicly said that they are preparing this study.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Policy documents relating to parliamentary activity at the national level (non-legal proposals, parliamentary questions and parliamentary debates) were obtained from the publications catalogue of the parliament of Spain, and more specifically from the official gazette of the Spanish parliament. It has a search engine that allows for all documents where a keyword —here, female genital mutilation (mutilación genital femenina) and ablation (ablación) — appears to be searched for. The list of documents was compared with the information included in the academic works that have been quoted in the endnote database as well as with legislation databases such as ‘La Ley’. It was checked that all relevant documents were mentioned.

Websites:
- Parliament: http://www.congreso.es/portal/pagina/portal/Congreso/Congreso/Publicaciones
- ‘La Ley’ database: http://www.laley.es/content/Inicio.aspx

The search engine of the Catalan parliament was also used in order to get the original text of Resolution 832/ VV that was repeatedly quoted by the literature on FGM. This tool was also used to search more documents by using the keyword female genital mutilation (mutilació genital femenina) and ablation (ablació).

Website:
- Catalan parliament: http://www.parlament.cat/web/documentaci/publications

Secondly, all women’s policy agencies official websites were consulted in order to find any reference to FGM-related policies. Indeed, all of them include thorough information concerning gender violence policies (protocols, plans, resources, etc.). Special attention was paid to policy plans concerning gender equality and gender violence, which were revised both at the national and the regional level. It was found that some regional plans include explicit references to the need to tackle FGM practices.

National women’s policy agencies:
- Women’s Institute: http://www.inmujer.es/

Regional women’s policy agencies and departments:
- Asturias: Women’s Institute of Asturias: http://www.institutoasturianodelamujer.com/
- Aragon: Women’s Institute of Aragon: http://www.aragon.es/iam
- Andalusia: Women’s Institute of Andalusia: http://www.juntadeandalucia.es/institutodelamujer
- Balearic Islands: Women’s Institute of the Balearic Islands: http://www20.gencat.cat/portal/site/ichocoes
- Catalonia: Women’s Institute of Catalonia: http://www.gencat.cat/ichocoes/
- Castile-La Mancha: Women’s Institute of Castile-La Mancha: http://www.institutomujer.jccm.es/
- Canary Islands: Equality Institute of the Canary Islands: http://www.gobiernodecanarias.org/icigualdad/
- Extremadura: Women’s Institute of Extremadura: http://imex.gobex.es/
- Murcia: Women’s Institute of the Region of Murcia: http://www.carm.es/chac/deportemujer/contacto.html
- Madrid: Directorate-General for Women of the Community of Madrid: http://www.madrid.org/cs/Satellite?pagename=ComunidadMadrid/Estructura&language=es&idListCons1=1109265447106&IdContent1=1109266187728&PackagedArgs=IdOrganismo%3D110926628570%26cid%3D110926628570%26c%3EDCM_Agrupador_FP&buscar
- Galicia: General-Secretary for Equality of Galicia: http://igualdade.xunta.es/

The collection of information focused on the women’s policy agencies websites and key informants. Autonomous communities also have competences on healthcare services, minors and immigration, among other things, and have their respective plans and actions in all of these fields. In order to meet the deadlines, and considering the amount of time needed to check all these policy departments and their respective policies in 17 regions plus the central government, women’s policy agencies were chosen as the main informants at the regional level. Assuming that in case any relevant policy regarding FGM has been undertaken, information would be provided by these agencies.

Along with the careful revision of all official websites, telephone and e-mail contact was established with the Government Delegation for Gender Violence.
At the regional level, direct contact was established with those autonomous communities where any policies on FGM were detected (laws, protocols, etc.) in order to get information on the presence of new actions.

- Aragon: Women's Institute of Aragon
- Catalonia: Women's Institute of Catalonia
- Andalusia: Women's Institute of Andalusia
- Valencia: Directorate-General for Family and the Woman
- Madrid: Directorate-General for the Woman
- Canary Islands: Women's Institute of the Canary Islands.

3.2. Policies on FGM

Policies on FGM started at the end of the 1990s with the approval of the first non-law proposals — a kind of non-binding norm — in the Spanish parliament. Even though the first cases of this practice were detected in Catalonia in 1993, during these years policies were mostly aimed at eradicating FGM in other countries. Thus, a non-law proposal issued in 1997 and its parliamentary debate in 1998 focused on collaborating with those countries where FGM is performed in order to fight this practice.

Nevertheless, during the last decade attention was paid instead to FGM in Spain. Non-law proposals, issued mostly by left-wing parties, started to urge the government to take actions to fight this practice in Spain. The objective was to develop a wide variety of actions from protocols to prevention plans and training activities. However, in 2001 the first non-law proposal seeking legislative change was presented. This policy document was followed by several parliamentary questions asking the government to revise the legal framework in order to improve protection for women against FGM. One of the elements explaining this growing interest in legal change is the presence of several women against FGM. One of the elements explaining this growing interest in legal change is the presence of several court cases in which parents were not punished after having their daughters mutilated. Consequently, a debate arose and the Criminal Code was modified in 2003 to include an explicit reference to genital mutilation in Article 149.2.

In addition, from 2005 onwards, FGM starts to appear as a sub-type of gender violence in different regional plans. This shift was especially relevant since it meant that all resources targeted at assisting victims of gender violence were also available for women suffering from FGM. Here, regional women's policy agencies appear as emerging actors with regard to FGM policies. Along with other regional departments (healthcare, police, education, etc.), these agencies have contributed to the development of key instruments such as protocols and guidelines.

3.3. Reflection on policies on female genital mutilation

Policy documents show an evolution when referring to FGM-related policies. First, policy actors start by focusing their attention on other countries where this practice is frequently performed. Accordingly, they ask the government to cooperate with some African countries in order to eradicate FGM. It was not until 2001 that the first proposals arose regarding the need to take specific action relating to women and girls at risk living in Spain. At that point the debate shifted, pointing to the increasing number of female residents coming from African countries where FGM is performed and the need to develop prevention and care measures.

Secondly, it must be emphasised that the type of actors that have been involved in FGM policies has changed over time. First, policies were mainly adopted by the Spanish parliament through the approval of non-binding measures. An exception would be the resolution of the Catalan parliament. This resolution was the precedent for the approval of the first protocol to eradicate FGM ever published in Spain.

From 2005 onwards, other kinds of actors gained momentum. First of all, women’s policy agencies, especially at the regional level, began to include FGM as part of their gender violence-related policies. In parallel, policies and legislation aimed at combating FGM sharply increased with the help of such agencies, but also with contributions from regional government departments dealing with healthcare, education, social services and immigration. This is true because all of these policy fields constitute a regional competence. As a result, different policies and actors are to be identified in each autonomous community. The number of actors involved in FGM policies in Spain is therefore quite numerous and the scope is quite fragmented.

The lack of policies at the national level raises some doubts as regards the (in)equality of women depending on their region of origin. Thus, whereas some regions have broad policies to combat FGM, others lack policy plans and non-binding measures. It would be worth exploring the need for the national government to develop some measures at the state level.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Information on the legal framework was obtained from several sources.

First, criminal legislation was obtained from the database belonging to the publications catalogue of the Spanish parliament.

Website:
- Parliament: http://www.congreso.es/portal/page/portal/Congreso/Congreso/Publicaciones

When referring to laws on gender violence making explicit references to FGM, the official websites of the regional and national women’s agencies were consulted.

National women’s policy agencies:
- Women’s Institute: http://www.inmujeres.es/
Regional women’s policy agencies and departments:

- Asturias: Women’s Institute of Asturias: http://www.institutoasturianodealmujer.com/
- Andalusia: Women’s Institute of Andalusia: http://www.juntadeandalucia.es/institutodelamujer
- Balearic Islands: Women’s Institute of the Balearic Islands: http://www.20.gencat.cat/portal/site/icdones
- Catalonia: Women’s Institute of Catalonia: http://www.gencat.cat/icdona/
- Castile-La Mancha: Women’s Institute of Castile-La Mancha: http://www.institutumoruemjcc.es/
- Canary Islands: Equality Institute of the Canary Islands: http://www.gobiernodecanarias.org/icigualdad/
- Extremadura: Women’s Institute of Extremadura: http://imex.gobex.es/
- Murcia: Women’s Institute of the Region of Murcia: http://www.carm.es/chac/deportemujer/contacto.html
- Madrid: Directorate-General for Women of the Community of Madrid: http://www.madrid.org/cs/Satellite?pagename=ComunidadMadrid/Estructura&Language=es&idListCons=1109265444710&idCons=110926187278&packedArgs=2&Department=21&DescriptionOrganismo%3D0&a=ID%3D1109266228570%26cid%2D1109266228570%26c%2D0&F6ID=581871457&F1=0&F3=0&F2=0&F0=0&F4=0&F5=0
- Galicia: General-Secretary for Equality of Galicia: http://igualdade.xunta.es/

In order to know whether there is any register of cases on FGM (complaints, sentences, etc.) a public prosecutor of the Court of Compostela on Gender Violence was consulted. She contacted colleagues from other regions and concluded that there is no public record of FGM cases (with the exception of the Catalan register), even though the General Council of the Judicial Power (Consejo General del Poder Judicial) publishes statistics on gender violence on a regular basis (see http://www.poderjudicial.es/cgpj/es/Temas/Violencia_domestica_y_de_genero/Actividad_del_Observatorio/Datos_estadisticos). In line with Organic Act 1/2004 on measures for integral protection against gender violence, the national law in this respect, this institution focuses on registering cases of intra-partnership violence.

The Women’s Institute of Catalonia and the Victim Support Unit were contacted in order to know more about the Catalan statistics on FGM cases.

Women’s Institute of Catalonia: http://www20.gencat.cat/portal/site/icdones
Victim Support Unit: http://www20.gencat.cat/portal/site/interior/menuitem.28f88cc1be4e4d25dca86da5bb0c0e1a0/vgnextoid=a6c3450ecbc0310VgnVCM1000008d0c1e0aRCRD&vgnextchannel=a6c3450ecbc0310VgnVCM1000008d0c1e0aRCRD&vgnextfmt=default

Several NGOs working on FGM were also consulted about the presence of a register in their respective regions (see list in Section 5.1).

- Child protection measures were first gathered through the website of the La Ley database and searched for in the corresponding official gazette (regional or national).

‘La Ley’ database: http://www.laley.es/content/Inicio.aspx

The presence/absence of registers of cases was confirmed with the help of the manager of the annual statistics book of the Asylum and Refugee Office. Judicial preventive measures were first gathered thanks to the official website of the Ministry of the Interior which compiles all legislation on asylum, refugee and immigration.


The lack of data concerning asylum cases based on FGM was confirmed with the help of the manager of the annual statistics book of the Asylum and Refugee Office.


- Legislation regarding professional secrecy provision was obtained with the guidance of the academic references included in the Endnote Library as well as through the LA LEY legislation database.

‘La Ley’ database: http://www.laley.es/content/Inicio.aspx

The presence/absence of registers of cases was consulted with a public prosecutor of the Court of Compostela on Gender Violence, the Victim Support Unit of Catalonia, the SubDirectorate for Infancy of the Ministry of Health, Social Services and Equality and several NGOs working on FGM prevention (see the list in Section 5.1.).
4.2. Criminal law

In line with what has been already said about the policy framework, criminal legislation began to be questioned in 2001. It was at that point that the left-wing groups of the Spanish government aimed at modifying the Criminal Code in order to include an explicit reference to FGM and to revise the law on the judiciary so that these practices can be prosecuted in Spain when committed in other countries.

The Criminal Code was amended in 2003 by Organic Act 11/2003 on concrete measures in the field of citizens’ security, domestic violence and the social integration of aliens, which entered into force on 21 September. This piece of law modified Article 149 of the Criminal Code by adding the following statement: ‘Anyone who causes another person to suffer any form of genital mutilation shall be punishable by imprisonment between 6 and 12 years. In case the victim is a minor or an incapable, the withdrawal of parental authority, custody or foster care will be applicable for a period of 4 to 10 years.’ Even though injuries and/or the loss of a main organ were already punished by Article 149 of the Criminal Code, this new text makes the specificity of genital mutilation offences visible. Besides, it defines this practice in a broad manner since it refers to any form of genital mutilation. What is more, the absence of any reference to female genitals would allow the application of this article also to male genital mutilation.

In 2005, Organic Act 3/2005 of 8 July on the judiciary was passed. Since then, FGM has been one of the offences to which universal jurisdiction is applicable, allowing Spanish judges to prosecute this crime even if it has been committed abroad. The sole condition is that the offender must be found in Spain. It must be highlighted that this condition is not to be applicable when referring to other offences such as terrorism or piracy.

In parallel with the approval of these key pieces of legislation, FGM started to be considered a type of gender violence by the regional laws concerning this issue. Act 16/2003 regulating prevention and integral protection of women and against gender violence in the Canary Islands was the first norm to do so. It stated that FGM entails ‘all kinds of procedures implying the partial or total removal of external genitalia or any injury to the female genitalia based on cultural or religious reasons, or in general those that are not based on strict therapeutic purposes’. Similar definitions are included in gender violence legislation approved in Cantabria, Madrid, Murcia, Aragon and Catalonia. These norms are complementary to the abovementioned criminal legislation. Their main goal is to develop a wide array of resources targeted at preventing gender violence and looking after victims, as well as to recognise the rights of those women suffering from gender violence. The inclusion of FGM allows the women who have suffered this practice or who are at risk to have access to all of these resources.

No record was found as regards court cases or the number of cases. However, the database of the General Council for Judicial Power (Consejo General del Poder Judicial) permits jurisprudence to be searched for using a keyword, here female genital mutilation or ablation (mutilación genital femenina, ablación).

CGPJ website: http://www.poderjudiciales/search/indexAN.jsp

For instance, this search engine allows consultation of the first court decision in Spain concerning FGM (court decision 26/2011 of the Provincial Court of Teruel), which condemned the parents of a girl who has been mutilated to imprisonment, as established by Article 149.2 of the Criminal Code.

It must be noted again that since 2008 the Catalan government has developed a register of cases of FGM. Thus, the Victim Support Unit of the Department of the Interior publishes annual statistics on cases of gender violence in Catalonia. It differentiates several sub-types of gender violence, including FGM. Data is gathered through the police records of the Catalan police (Mossos d’Esquadra). It includes detected cases of FGM and girls assisted by the Catalan police. For instance, in 2008, 66 cases were detected and 114 girls were assisted by the Catalan police.

4.3. Child protection laws/provisions

Child protection laws are a competence of both the national and the regional level. First there is a main piece of law at the national level, Organic Act 1/1996 on the legal protection of minors. It regulates the obligation of the state public agencies to intervene in case a minor’s health or security is at risk, or when the minor has been abandoned. This norm could therefore be applied in case of risk of FGM or when it has been already performed. Article 158 of Organic Law 9/2002 modifying the Civil Code, on the other hand, has been especially relevant for cases of FGM, since it has allowed judges to adopt preventive measures. For instance, in Court Resolution 1342/2007 of the Court of Gerona, the judge decided to adopt the following measures by invoking this norm: a prohibition against leaving the country, a mandatory check-up made by a medical examiner and, after that, the need to ask for court permission in order to travel abroad.

Along with this nationwide regulation, child protection laws have also been approved by all the autonomous communities since the end of the 1980s. Generally speaking, all norms have analogous contents. Their first goal is to include the protection of minors as a regional competence. With regard to FGM, these pieces of law are relevant due to the provisions they include on the protection minors. All of them state that their respective public agencies have the duty to intervene in case of risk or neglect, as well as to exercise custody of the minor when necessary.

Additionally, it is interesting to note that the most recent regulations approved in Valencia and Catalonia include explicit references to FGM offences. Law 12/2008 for the integral protection of childhood and adolescence of the Community of Valencia states in Article 9 that FGM is a kind of mistreatment that should be tackled by the regional authorities. Law 14/2010 on the rights and opportunities during childhood and adolescence in Catalonia, on the
other hand, establishes specific measures to combat FGM. Indeed, according to Article 76, Catalan public agencies should identify the risk of FGM, report and make a complaint to judges.

No register on child protection interventions dealing with FGM was found. However, the database of the General Council for Judicial Power (Consejo General del Poder Judicial) permits jurisprudence to be searched for using a keyword. Here, female genital mutilation or ablation (mutilación genital femenina, ablación).

CGPJ website: http://www.poderjudicial.es/search/indexAN.jsp

Thanks to this tool, examples of cases where preventive measures have been undertaken can be identified easily. As has been said, the most common measures adopted by judges are the following: mandatory check-ups by medical examiners or doctors, the withdrawal of the girl’s passport, the prohibition against leaving the country or the commitment of the parents not to mutilate their daughters. With regard to the latter, the regions of Aragon and Catalonia have a ‘letter of informed commitment’ provided by the healthcare services. It is signed by the parents, who commit not to mutilate their daughters and who admit that they have knowledge of Spanish legislation concerning FGM.

See the Catalan version here: http://www.mgf.uab.es/docs/8g.pdf

4.4. Asylum law(s)/provisions

Legislation concerning asylum and refugees does not include any specific provision dealing with FGM. However, Law 5/1984 regulating asylum rights and refugee status (already derogated) allowed women who were at risk of suffering FGM to allege that they had been persecuted because of the social group they belonged to. In some of these cases, refugee status was recognised by the Spanish authorities. Nevertheless, many applications were rejected, arguing that persecution based on gender was not included in the Geneva Convention, by which this piece of law was inspired.

As a result, Organic Law 3/2007 for effective equality between men and women added a disposition stating that a refugee might also be ‘any foreign women who escape from their country of origin due to a well-founded fear of suffering persecution based on gender issues’ (additional disposition 29). This disposition allowed women who might be mutilated to have greater opportunities to get refugee status in Spain.

In line with this norm, Organic Law 12/2009 regulating asylum rights and subsidiary protection broadens the kind of persecution that can be alleged. It states that ‘refugee status is recognised for any person who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it’ (Article 3). Therefore, it adds gender and sexual orientation to the types of persecution that were already included in the Geneva Convention.

This norm might be applicable to both past and future persecution. Thus it states that a well-founded fear of being persecuted is enough to get refugee status. However, Article 6 includes a list of acts of persecution, some of them implying that the asylum application takes place after the persecution has had an effect (e.g. lack of legal custody).

No registration system was found for asylum cases related to FGM. The Asylum and Refugee Office of the Ministry of the Interior collects information on asylum requests that refers, for instance, to the age, nationality, education, etc. of the asylum seekers. Nevertheless, there is no information that refers to the reason why the application has been presented, accepted or denied.

In any case, the database of the General Council for Judicial Power (Consejo General del Poder Judicial) allows relevant jurisprudence on asylum cases based on FGM to be searched for.

CGPJ website: http://www.poderjudicial.es/search/indexAN.jsp

4.5. Professional secrecy provision(s)

First, the Criminal Code establishes a general mandate for all citizens to report any crime. Specifically, Article 450 states that all persons have the duty to impede a crime affecting a person’s life, integrity or health, liberty or sexual liberty when possible and/or to report it to the public authorities. In case of non-reporting, sanctions might be applied of 6 months to 2 years’ imprisonment in case of crimes affecting life and fines to be paid over a period of 6 months to 2 years in the other cases.

With regard to professionals, two pieces of law must be referenced. On the one hand, Articles 262 and 263 of the Law on criminal procedure state that anyone who due to their status or profession has knowledge about a crime that has been committed has the duty to report it. This duty is applicable to all professions with the exception of lawyers, examining magistrates and priests who have the right to keep professional secrecy. On the other hand, Organic Act 1/1996 on the legal protection of minors includes a specific provision referring to the protection of minors. Thus it states that any person, and especially anyone who due to their status or profession might have knowledge about a minor at risk or abandoned, has the duty to report it to the public authorities as well as to assist the minor. This provision is of special interest with regard to FGM cases. It obliges key professionals, such as doctors or teachers, to report those cases of girls who might be or might have been mutilated.

No registration system was found for reports of (suspected) FGM cases by professionals.
4.6. Reflection on legal framework

To begin with, it must be noted that the legal framework is also affected by the quasi-federal nature of the Spanish state. Thus, whereas asylum and professional secrecy legislation are national competences, regions have a remarkable role regarding the legislation on protection of minors and gender violence.

Generally speaking, a trend can be easily identified regarding FGM legislation. From 2001 onwards, this type of offence gained relevance in the Spanish legal framework. First, since 2003 it has been explicitly prohibited by the Criminal Code and since 2005 it has been one of the few kinds of offences to which universal jurisdiction is applicable. Secondly, gender violence legislation approved at the regional level has given more and more visibility to FGM practices by stating that they represent a type of gender violence. This recognition implies that all available resources to fight gender violence are to be used to eradicate FGM too (protocols, counselling, shelters, etc.). However, only six out of 17 regions have these sorts of provisions. This means that resources to eradicate this practice might be uneven and that inequalities among women living in different regions might arise.

Regarding legislation on the protection of minors a slight evolution should be also noted. At both the national and the regional level, general and specific legislation guaranteeing the protection of minors has been developed since the end of the 1980s. Nevertheless, the most recent pieces of law, approved in Valencia and Catalonia, have gone a step further by including explicit references to FGM. Especially noticeable is the case of Catalonia, which has had a pioneering role on FGM-related policies in Spain.

With regard to asylum norms, a gender perspective has been progressively introduced. Whereas the first piece of law concerning asylum and refuge approved in 1984 was limited to the kinds of persecution included in the Geneva Convention, the law currently in force recognises the right to asylum for those persons persecuted because of their gender. This provision broadens the opportunities for women at risk of being mutilated to get refugee status in Spain.

It must be highlighted that in all of the legislative fields there is a lack of data on FGM cases, complaints, etc. This is true in spite of the numerous and thorough databases existing in the Spanish state in relation to gender violence, at both the national and the regional level. Regarding the former, both the National Observatory on Gender Violence and the General Council for Judicial Power gather regular information on gender violence cases (complaints, deaths, protection orders, etc.). Similar data is collected by regional women’s policy agencies, many of which have their own observatories on gender violence. Nevertheless, this kind of database focuses mainly on intra-partnership violence and does not include information on FGM cases.

The exception of this tendency is the annual statistics of the Victim Support Unit of the government of Catalonia. They include different types of gender violence, such as FGM, forced marriages and intra-partnership violence.

It would be strongly recommendable to use the extensive existing resources on gender violence (observatories, reports, statistics, etc.) to gather information disaggregated by type of violence. This would allow identification of FGM cases. The same recommendation is applicable to the annual report of the Asylum and Refugee Office, which has already gathered a broad set of variables describing asylum seekers’ characteristics.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

In order to identify the main actors dealing with FGM, several sources were used. Concerning NGOs and civil society organisations, protocols, document-gathering tools and materials, as well as newspaper articles, were especially useful. For instance, the Catalan protocol identifies four main organisations dealing with FGM in the region. To complement this information and to know more on each organisation’s activities their websites were carefully searched.

Websites:

- Odam ONGd: http://odamongd.org/
- Medicus Mundi Andalusia: http://www.medicusmundi.es/andalucia
- UNAF: http://www.unaf.org
- prouablaciones.cat: http://prouablaciones.cat/
- Paz y Desarrollo: http://pazydesarrollo.org/
- Medics del Mundo: http://www.medicosdelmundo.org
- e-krea@: http://www.ekrea.org
- Fundación Dexeus: http://www.fundaciondexeus.org/
- Amnistía Internacional: http://www.madrid.es.amnesty.org
- Fundación Kirira: http://www.fundacionkirira.es/
- CEAR: http://www.cear.es/
- Themis: http://www.mujeresjuristas Themis.org/
- ONG Intercanvi d’Acció Social i Cooperació Internacional
- Red Activas: http://www.redactivas.org/
- Fundación Mujeres Progresistas: http://www.fundacionmujeresprogresistas.org/es
- FUDEN: http://www.fuden.es
- Enfermeras del Mundo: http://www.ong.enfermundi.com
- Fundación Mujeres: http://www.observatoriovio.in/violencia.org/category.php?id=21
- GIPE: http://www.mgf.uab.es

In addition, direct contact with relevant persons was established for the following organisations:

- Odam ONGd
- Medicus Mundi Andalusia
- UNAF
- prouablaciones.cat
- Paz y Desarrollo
- Medics del Mundo
- EQUIS
- ekrea@
- AMAM
- GIPE.
All of them provided information on their organisations’ activities and on relevant actors in different regions.

It must be noted that there is no register or network of organisations dealing with FGM practices. Therefore there may be some NGOs that have not been identified.

With regard to institutions, the excel database includes all agencies and departments that have taken any measures on FGM. Generally, such measures consist of publishing tools or materials, awareness-raising campaigns or project funding. This information was gathered thanks to a thorough revision of women’s policy agencies’ websites along with direct contact with some of those institutions. For the list of websites see Section 3.1.

Direct contacts:
• Aragon: Women’s Institute of Aragon
• Catalonia: Women’s Institute of Catalonia
• Andalusia: Women’s Institute of Andalusia
• Valencia: Directorate-General for Family and Woman
• Madrid: Directorate-General for Women
• Canary Islands: Women’s Institute of the Canary Island.

5.2. Actors

The analysis has allowed identification of up to 22 NGOs/civil society organisations that have undertaken specific actions to eradicate FGM. More concretely, a distinction between three types of organisations can be posed.

• The first group of NGOs would be those focusing on promoting gender equality in a broad sense (see for instance Federación de Mujeres Progresistas, Fundación Mujeres, etc.). Their main activities regarding FGM are based on awareness-raising campaigns, most of them linked to the International Day Against FGM.

• The second group would be formed by a wide array of organisations dealing with health issues (NGOs, professional associations, etc.). These kinds of actors have had a prominent role in FGM-related activities (see for instance Médicos del Mundo, Médicus Mundi Andalusia, etc.). They have not only published key tools and materials, but have also provided training to key professionals both in Spain and in African countries. What is more, many of these organisations have their own experts on FGM practices.

• Finally, a small group of NGOs from Catalonia has the eradication of FGM as their main goal (see AMAM, EQUIS). It must be emphasised that women asking for counselling or information concerning FGM in this region are referred by the Catalan authorities to these specialised organisations.

Generally speaking, the tendency is for the number of organisations dealing with FGM to increase. For instance, if researching NGOs linked to healthcare issues, it can be easily perceived that their interest in FGM-related activities has grown over time and progressively focused on Spain rather than on African countries. A quick overview of their projects and materials shows indeed that most of them correspond to the last 3 years. Anyhow, it must be noted that relevant organisations such as Medicus Mundi Andalusia have had specific projects since 2006.

According to their scope of activities, the most prominent organisations in Spain are the following.

• Medicos del Mundo: Has a specific project called ‘Sexual and reproductive health for immigrant women and prevention of FGM’ that has been developed already in Aragon, Navarre and Catalonia. It is expected to be carried out soon in other autonomous communities.

• UNAF: Has a programme aimed at preventing FGM in which, among other activities, training-the-trainer courses on FGM have been carried out. It also has several experts on this issue.

• Médicus Mundi Andalusia: Has had a specific project on the prevention of FGM in Andalusia since 2006. It has published several key materials on this issue and has a specific website gathering together relevant tools and actors.

• ekre@: One of the most relevant organisations dealing with FGM in Catalonia. It collaborates with the Catalan institutions on the design and development of the Catalan protocol.

• GIPE: The activities of the GIPE deserve to be highlighted. It is the first and most relevant research group in Spain. It is responsible for the existing prevalence studies, the publication of several tools, the development of training courses, etc. Adriana Kaplan is the main researcher of the GIPE as well as the most relevant academic expert on FGM in Spain.

With regard to institutions, only a small group of actors dealing with FGM have been found. On the one hand, several departments of the Catalan government have played a relevant role in FGM-related policies. Thus, the Catalan Institute for Health, the Directorate-General for Immigration and the Department of the Interior are key actors for the development of the Catalan protocol and its related activities (training, statistics, etc.). On the other hand, other regional institutions such as the Women’s Institutes of Aragon or Andalusia must be referred to due to their pioneering activities on FGM. Again, the lack of public institutional actors may well be linked to the uneven development of policies on FGM in the Spanish regions as well as to the lack of activities at the national level.

5.3. Reflection on actors on female genital mutilation

An increase in the number of actors dealing with FGM can be easily observed. First, institutional actors dealing with FGM have appeared just recently, with the exception of the government of Catalonia which played a pioneering role in Spain. Second, NGOs and civil society organisations show a growing interest in these kinds of practices, with most of their projects and materials having been developed in the last few years.

However, when comparing both kinds of actors, the work of the latter should be emphasised. Thus, most of the tools, materials and studies that have addressed FGM in Spain so far come from civil society organisations, NGOs and research groups. There is indeed a lack of public institutional actors involved in such activities.

Accordingly, the involvement of all the relevant institutions (those dealing with gender equality, health, immigration,
police, etc.) acting at the regional level is strongly recommended. Here, the Catalan example should be especially taken into account. Its regional protocol on FGM works with the contribution of a wide variety of departments of the regional government, as well as with the help of NGOs specialising in such type of offences.

Considering that the national level has competences on key issues such as asylum rights or gender equality, the involvement of their respective institutions is also quite recommendable. For instance, it would be of special interest to get the Governmental Delegation for Gender Violence to develop nationwide actions.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

In order to identify tools and materials three websites were of special interest:
- UNAF: http://www.unaf.org
- GIPE: http://www.mgf.uab.es
- Medicus Mundi Andalusia

They gather together many relevant tools and materials from several sources.

Additionally, websites belonging to other NGOs and civil society organisations were thoroughly searched (see the list in Section 5.1). Direct contact with the following persons helped in finding some specific documents:
- O’dam ONGd
- Medicus Mundi Andalusia
- UNAF

With regard to documents published by public institutions, the revision of women’s institutes’ websites (see the list in Section 4.1) along with the help of the following contacts was especially helpful:
- Aragon: Women’s Institute of Aragon
- Catalonia: Women’s Institute of Catalonia
- Andalusia: Women’s Institute of Andalusia
- Catalonia: Victim Support Unit

Academic publications were found thanks to the PubMed database.

6.2. Tools and instruments on FGM

In Spain, a wide variety of tools on FGM has been published so far. Five main types of tools can be observed.

- First, many guidelines and leaflets on FGM have been published and aim at providing basic information on these practices, that is to say they address the concept of FGM, the types of FGM, where it is performed, the consequences for women’s health, etc. They are targeted at a wide array of professionals (teachers, social workers, doctors, nurses, etc.) with the purpose of increasing their awareness and knowledge.
- A second group of documents is formed by those protocols published by institutional actors. Here, protocols published by the Catalan institutions are of special relevance. Indeed, these kinds of instruments are available at the regional, the provincial and even the local level. However, the government of Aragon has recently started to develop its own policies regarding FGM with the development of a protocol and a specific plan to eradicate this practice.
- Third, the commitment of the Catalan institutions to the prevention of FGM has led to the publication of specific statistics on cases of FGM. The Victim Support Unit publishes annual statistics gathering information regarding the number of cases of FGM detected by the police in Catalonia and the number of girls that have been assisted.
- The GIPE has been especially prolific, publishing not only prevalence studies but also surveys and other academic works.
- Finally, there are a couple of tools which are specifically targeted at families whose daughters are at risk of being mutilated. The CDs ‘On vacations to visit family’ and ‘Changing the songs’, published by e-kre@ and O’dam ONGd respectively, are pioneering instruments to work with these families in a direct and respectful way.

Despite the presence of very different instruments, it must be noted that most of them have been published by NGOs, civil society organisations and research groups. Once again, public institutional actors have played a secondary role.

6.3. Reflection on tools and instruments on female genital mutilation

There has been a tendency for the number of tools and instruments to increase over time. Most of them have indeed been published in the last few years. More specifically, in 2011 eight new documents appeared.

This positive trend is due to the growing involvement of civil society actors on FGM-related policies. It is true that most of the first instruments published in Spain were developed by public institutional actors, namely by the Catalan authorities. Nevertheless, civil society actors have progressively gained momentum, being responsible for most of the available tools.

There is therefore a lack of tools provided by institutions as well as uneven development depending on the region under consideration. In fact, only three out of the 17 regions have published a specific instrument to eradicate FGM: Catalonia, Cantabria and Aragon. It must nevertheless be noted that the Canary Islands, Murcia and Madrid approved their respective norms on gender violence, which include an explicit reference to FGM. This means that resources addressing gender violence in these regions (protocols, shelters, information centres, etc.) are also available for women suffering FGM. In any case, there is a remarkable gap in the case of Spain, since neither the national level nor most of the regions have specific tools to deal with FGM.

Generally speaking, available tools and instruments do not specify which target group they are aimed at. Only protocols and some guidelines make explicit that they
aim at involving a broad group of professionals, ranging from teachers to police or social workers. They show a comprehensive and complex approach.

7. FINAL CONSIDERATIONS

With regard to prevalence, it must be noted that the existing data on the prevalence of FGM does not come from official sources. Rather, research teams with a special interest in these kinds of harmful traditional practices have been in charge of elaborating pioneering databases. The long history and prolific work of the Gipe — the main research group — guarantees however the high quality standards of their maps on FGM in Spain. These maps, published since 2002, gather information on the population coming from countries where FGM is still performed. It allows the number of women as well as the number of girls under 14 years old coming from those countries to be identified. Additionally, data is disaggregated by autonomous community, which allows identification of those territories where the presence of FGM practices is more likely (Catalonia, Aragon, etc.).

Regarding policies on FGM, a tendency can easily be perceived. Whereas at the end of the 1990s and the beginning of the 2000s non-binding norms aiming at promoting a broad strategy to fight FGM prevailed, in the last years the inclusion of FGM in gender violence and equality-related plans became quite common. This trend marked a shift both with respect to the level of government that is more prominent on FGM policies — now the regional level — and concerning the type of actor that is more frequently involved in such policies — now women’s policy agencies and other regional departments.

With respect to the legislative framework on FGM, a positive trend must be noted. Since 2001 this type of offence has gained relevance in Spain. First, since 2003 it has been explicitly prohibited by the Criminal Code and since 2005 it has been one of the few kinds of offences to which universal jurisdiction is applicable. Second, gender violence legislation approved at the regional level has given more and more visibility to FGM practices by stating that they represent a type of gender violence. In a similar manner, most recent pieces of law on the protection of minors, approved in Valencia and Catalonia, include explicit references to FGM. Finally, legislation on asylum and refugee currently in force recognises the right to asylum of those persons persecuted because of their gender. Despite this broad legislative framework, there is a remarkable lack of data on FGM cases, with the exception of Catalonia.

Concerning actors, a positive trend must also be remarked upon. Thus, both institutional and civil society actors have increased their concern as regards FGM practices. However, most of the tools, materials and studies that have addressed FGM in Spain so far come from civil society organisations, NGOs and research groups. There is indeed a lack of public institutional actors involved in such activities.

Finally, there has been a tendency for the number of tools and instruments to increase over time, with most of them being published in the last few years. This positive trend is due to the growing involvement of civil society actors on FGM-related policies. What is more, with the exception of Catalonia, Aragon and Cantabria, there is a remarkable lack of tools provided by public institutions.

To sum up, the number of policies and actors addressing FGM has increased over the last 10 years. However, given the quasi-federal model of the Spanish state, the development of such policies should be dramatically broadened in order to embrace the whole territory. Otherwise, inequality among women living in different regions will persist/
Analytical country report

Spain
I. INTRODUCTION

Spain has a very complex territorial model, which has been labelled as quasi-federal, decentralised, asymmetric, competitive and multinational (see for instance Watts, 2006). This means that the Spanish regions have legislative and administrative competences concerning many issues. Moreover, the autonomous communities manage the core of the Spanish welfare state since they are responsible for the healthcare system, the education system and social services. The asymmetric character of the Spanish state of autonomies nonetheless determines that regions do not have the exact same set of competences (for instance concerning police, judiciary, etc.). The national level, on the other hand, is in charge of approving basic legislation, so that a certain level of harmonisation is guaranteed.

With regard to gender-based violence-related policies, the situation is quite similar. The national government has approved key legislation such as Law 1/2004 on measures for integral protection from gender violence. This norm is to be implemented in the whole territory, providing a specific set of services and recognising some concrete rights to be protected. It therefore entails the collaboration of a broad set of actors (healthcare professionals, police, social services, etc.) at national, regional and local levels. However, the autonomous communities not only have competences regarding essential welfare-related areas (health, social services, etc.), but also have their own gender-equality policies. Due to this, most of them have also approved plans, laws and programmes addressing gender-based violence. As a result, the map of policies is quite complex and fragmented.

What is more, if we focus on FGM policies we will see that this type of violence has been tackled in some specific regions. More concretely, policies have been developed mainly in Catalonia, and more recently in Aragon, Navarre and the Balearic Islands. The main actions that have been undertaken so far refer to the approval of gender-based violence laws that include FGM as sub-type of violence, the creation of specific protocols to coordinate government action against FGM, and the commission of training activities targeted at key professionals.

This report takes into account this multilevel and complex landscape when exploring FGM policies in Spain. It aims at capturing the development policies related to FGM at the state level, while paying special attention to the case of Catalonia, a region that has implemented pioneer policies. On the one hand, some interviewees were selected in order to provide a broad picture of FGM policies in Spain at large. More specifically, a representative of the Spanish Governmental Delegation for Gender Violence provides a general overview, while showing the differences among territories that might have arisen due to the decentralisation process. On the other hand, half of the respondents belong to the Catalan government. Catalonia has played a pioneering role in Spain with regard to FGM policies. It was the first region to publish a specific protocol in 2002. Furthermore, this region has developed the most complex and comprehensive approach to deal with those practices. All respondents indeed agree that good practices with potential are to be found in Catalonia.

The interviews therefore embraced three experts on FGM policies in Spain, one representative of the national government specialising in gender-based violence and three representatives of the Catalan government dealing with some of the most relevant areas with regard to FGM policies in this region: police services, the Immigration Department and the Department for the Protection of Minors.

Despite this balance, this report will mainly focus on the Catalan approach to dealing with FGM. This is due both to the lack of actions at the national level, which have hitherto focused on intra-partnership violence, and to the emphasis of all the interviewees on the relevance and the transferability of the Catalan experience.

Although all respondents provided very useful and dense information, some minor difficulties are to be noted:

• Interview with a respondent from the Spanish Governmental Delegation for Gender Violence: the time frame of the interview was approximately 30 min. Information provided is not quite interesting in terms of finding good practices. This interview was useful to confirm the findings of the desk research as regards the lack of actions on FGM at the national level and the prominent role of the regional level.

• Interview with two respondents from the
Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices (GIPE). They provide a general picture of the GIPE’s activities and its attached structures but they were not able to thoroughly reflect on the evolution of FGM policies in Spain or to give many specific details. Besides, they refused to disclose any data concerning the budget of the GIPE.

- Interviews with the Catalan representatives: the questionnaire had to be adapted to some extent during the interviews since the information provided was very rich and there was a need to go into more depth on some aspects that came up.

- Three interviews were carried out with the help of three respondents (please see section hereafter). They are included in the letter of consent and in the list of interviewees. When quoted in the text, a reference to the specific respondent is included.

- Data concerning budget was not provided. Due to the Catalan interdepartmental approach, there is no specific budget aimed at FGM policies. Rather, each department is provided with its own resources.

### II. INFORMATION SOURCES

<table>
<thead>
<tr>
<th>Date of the interview (dd.mm.yyyy)</th>
<th>Duration of interview (in minutes)</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7.2012</td>
<td>66’</td>
<td></td>
</tr>
<tr>
<td>4.7.2012</td>
<td>115’</td>
<td></td>
</tr>
<tr>
<td>4.7.2012</td>
<td>90’</td>
<td></td>
</tr>
<tr>
<td>5.7.2012</td>
<td>59’</td>
<td></td>
</tr>
<tr>
<td>5.7.2012</td>
<td>69’</td>
<td></td>
</tr>
<tr>
<td>9.7.2012</td>
<td>36’</td>
<td></td>
</tr>
</tbody>
</table>

The first respondent is the coordinator of the Unit for the Detection of and Protection against Child Mistreatment (Udepmi). The unit belongs to the Directorate-General for Children and Adolescents of the government of Catalonia. It is in charge of looking into any cases of child mistreatment detected in Catalonia. Furthermore, the unit represents one of the key actors of the Catalan protocol to prevent FGM.

The second respondent is one of the legal advisors of the Udepmi. She has a special role in the unit’s FGM-related activities. She is the person in charge of coordinating the unit with the other actors taking part in the protocol. In addition, she represents the unit in the Catalan National Commission for Coordinated Intervention against Gender Violence, which has a specific working group on FGM.

The third respondent is the Sub-director for Institutional Coordination of the Governmental Delegation for Gender Violence of the Spanish government. The delegation has the duty to develop policies to tackle gender-based violence, as well as to foster coordination between institutions and between levels of government in this respect. However, FGM is not yet considered a type of gender-based violence.

The fourth respondent is a professor at the University of Valencia. He has long experience in studying FGM legislation and policies in Spain. He has taken part in several international comparative projects at this respect.

The fifth respondent is the coordinator of the Victim Support Unit of the government of Catalonia. This is a specialised unit of the Directorate-General for Public Security and the Catalan police services (Mossos d’Esquadra). It focuses on managing all the actions related to the policies against gender-based violence in this department, including those aimed at eradicating FGM practices.

The sixth respondent is the Head of Territory of the Directorate-General for Immigration of the government of Catalonia. He has worked on Catalan FGM-related policies since the very beginning. He was one of the few members of the working group that drew up the first protocol in 2001. Currently, he occupies the position of head of the working group on FGM of the Catalan National Commission for Coordinated Intervention against Gender Violence.

The seventh respondent is the scientific director of the GIPE of the Autonomous University of Barcelona. This is the most relevant research group addressing FGM practices and policies in Spain. Its main goal is to carry out applied research in order to implement a comprehensive approach to eradicating FGM practices both in The Gambia and in Spain. So far this applied research has led, among others, to the following publications and activities: the maps on the prevalence of FGM in Spain, several guidelines aimed at professionals, training and awareness-raising activities and research publications.

The eighth respondent is a researcher of the GIPE of the Autonomous University of Barcelona. She is currently doing a PhD focused on exploring FGM policies at the Spanish regional level.

### III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

*The turning point: first FGM cases in Catalonia (1990s)*

The history of FGM-related policies has to be described by distinguishing between levels of government. If we refer to the regional realm, that is, to Catalonia, the first element to be noted is the immigration flow that took place in the
1980s, when many Africans, and more specifically many Gambians, came to this region. This meant a great shift for Catalan society, which up to that moment had only received immigrants from other Spanish territories.

It was not until the beginning of the 1990s that the first cases of FGM were detected. Although they had an impact on the mass media, the public authorities did not intervene. There was a worrying lack of policies at this point.

‘Immigrants from The Gambia started to come to Catalonia in the 1980s. They come with their own “luggage”, and there are some things that you are aware of and others that you are not. In the 1990s we knew of the first cases of FGM, which in that moment caused great alarm and were new for us. I’d say that during these years nothing was done. This was considered to be the best solution. You do nothing and nobody says anything’.

From 2000 onwards the situation changed. New cases causing great social concern appeared. In response, some professionals in the county of Gerona did pioneering joint work in order to assist the victims. Both elements — detection of cases and the concern of some particular professionals — triggered the first specific actions (coordinated work, meetings with immigrant communities, etc.). What is more, this initial work had an impact on the Catalan parliament, which approved a resolution urging the government to draw up a protocol to combat FGM (1). The professionals involved in the first cases in Gerona (police officers, paediatricians, etc.), along with some representatives of the Catalan government, worked for a year to draw up the regional protocol, which was published in 2002 (2). One respondent describes this joint work as follows.

‘The departments involved in the protocol were talking with each other for a year. The idea was to see the responsibilities of each of us. We debated how to approach this issue. Especially, we wanted to specify what the differences of addressing FGM from a preventive perspective, in case of risk and when the FGM has already performed, are. For a year, we were working on attaching each task to a specific department; who does what. Now the situation is quite different. But at that point it was an ‘issue’ … it was difficult for the departments to take it on, to agree to deal with it.’

The protocol embraced a wide variety of professionals: teachers, healthcare professionals, police, social services and professionals who assist minors at risk. Given the complexity of coordinating those actors, an interdepartmental commission was set up and the Immigration Department assumed the leadership of this structure. Since then, the commission has had regular meetings in order to improve the implementation of the protocol. Both the Catalan protocol and the interdepartmental coordination constituted pioneering policies in Spain.

It is worth mentioning that the work of the professionals in Gerona also led to the approval in 2003 of a specific protocol for this northern province (3).

The debate reaches the national level: legislative reform in the 2000s

At the beginning of the 2000s the debate concerning FGM policies reached the national level as well. Several non-law proposals and parliamentary questions aimed at tackling this issue were presented in the Spanish parliament (4). Most of them were issued by Catalan political parties and politicians who were aware of the emergence of this practice in Spain, and especially in Catalonia. In parallel, the EU approved a resolution urging the Member States to pass specific legislation prohibiting FGM. As a result of this emerging concern, the Penal Code was amended in 2003 by Organic Act 11/2003 on concrete measures in the field of citizens’ security, domestic violence and the social integration of aliens. This law modified Article 149 of the Penal Code by adding an explicit reference to FGM as a serious offence. Even though injuries and/or the loss of a main organ were already punished by the Penal Code, this new article made visible the specificity of genital mutilation offences. In 2005, Organic Act 3/2005 of July 8 on the judiciary was passed. Since then, FGM has been one of the few offences to which universal jurisdiction is applicable, allowing Spanish judges to prosecute this crime even if it has been committed abroad.

Most of the respondents emphasise the impact of both legal reforms, which are considered to contribute to the prosecution of FGM as well as to the development of broader policies to combat this practice. For instance, one informant states the following.

‘The Organic Law of 2003 modifies the Penal Code and includes FGM as an offence. But it was not enough because the families tended to perform it abroad. This is why the Organic Law of 2005 also reforms the law on the, the judiciary stating that Spanish courts are competent to judge cases of FGM that were practised out of the Spanish territory … What have we done since that moment? Attention and protection … Since then people are more concerned and those actions are promoted.’

In parallel with these new legal provisions, the national level has improved asylum legislation by including persecution based on gender issues among the motivations that can be alleged to get refugee status. This possibility is recognised by Organic Law 3/2007 for effective equality between men and women and Organic Law 12/2009 regulating asylum rights and subsidiary protection, approved in 2007 and 2009 respectively. Both norms allow women who could be mutilated to have greater opportunities to get refugee status in Spain.

(1) Resolution 832/VI of the parliament of Catalonia on the adoption of measures against the practice of ritual female genital mutilation.

(2) Protocol of measures to prevent FGM, government of Catalonia.

(3) Protocol to prevent FGM in the county of Gerona.

(4) See for instance the non-law proposal urging the government to undertake all measures that might contribute to eradicate FGM, issued by the Parliamentary Group of the Socialist Party, 2001.
Learning from experience: the Catalan protocol and the legislative reform

In 2005 the Catalan protocol began to be updated in response to several factors. First, there was a need to include these new national norms, which had greatly modified the legal framework. Second, the work with the migrant women’s associations specialising in FGM was much more intense at this point. Those organisations represented key allies of the Immigration Department in order to carry out awareness-raising campaigns with immigrant communities. Due to this, these organisations had to be explicitly mentioned in the new protocol.

Finally, the process of revising the protocol showed a new remarkable weakness, that is, the lack of work at the local level. The protocol was not well known by the local authorities and relevant professionals were not being involved — teachers, primary healthcare services, local social services, etc. The main strategy to improve networking was to set up local networks on FGM (xanxes locals de prevenció de la mutilació). These are coordinating structures similar to the one attached to the protocol. The local networks aim at reproducing the regional approach based on interdepartmental cooperation and a proactive perspective. They embrace a wide set of professionals, professionals who have direct and permanent contact with the target group.

• Local social services.
• Local technical experts on migrations and/or on gender equality.
• Representatives from the education centres.
• A paediatrician or someone from the primary healthcare services.
• A representative of the Catalan police services and/or of the local police services.
• A representative from the local Team for Children and Adolescents.

The aim is for these actors to easily detect risk situations, to follow up each case and, more importantly, to work with immigrant communities on awareness-raising activities.

Since 2006, up to 70 local networks have been set up to work at the local level. One respondent explains their development as follows.

‘From 2005, when we started to update the protocol, we began to work on what we call the local prevention networks …. We started basically in Gerona, but then the model was spread across the territory. And now I would say that we have up to 70 local networks. In some instances they are municipal networks. In other cases they are organised in a specific neighbourhood, since in big cities it is more complicated. In other areas it is placed at the county level, like in Lleida for instance.’

All these changes — legal framework, immigrants’ organisations and local networks — were introduced in the updated Catalan protocol published in 2007.

More recently, the Catalan policies to eradicate FGM have been profoundly affected by the approval of two regional laws. On the one hand, Law 5/2008 on the right of women to eradicate sexist violence in Catalonia was passed in 2008. It included FGM as a type of gender-based violence (Article 5). This means that all rights (protection, specialised support, economic subsidies, etc.) and services (shelters, services for recovery, etc.) included in this norm are also available for girls who could suffer or who have suffered FGM. In addition, this norm has also meant a shift with regard to the Interdepartmental Commission attached to the protocol. Since its approval this commission has been included in the National (1) Commission for a Coordinated Intervention against Gender Violence, and has been known as the Working Group on FGM. This working group is also led by the Immigration Department, but it has a more plural composition.

• Catalan Agency of Cooperation for Development
• Directorate-General for Religious Issues
• Education Department
• Health Department
• Department of the Interior
• Catalan Women’s Institute
• Directorate-General for Children and Adolescents
• Women’s Council of Catalonia
• Catalan Association of Midwives
• Professional Association of Doctors of Catalonia
• Barcelona Network against Violence against Women.

The second turning point in the Catalan context was the approval of Law 14/2010 on rights and opportunities during childhood and adolescence in Catalonia in 2010. It is one of the first regional norms concerning the protection of minors that includes specific measures to combat FGM. Article 76 establishes the following elements: the actions to be undertaken to prevent FGM, to assist a girl who is at risk or to prosecute the offenders when FGM has been already performed. It means a very positive shift from several points of view. First, it makes some of the main elements of the protocol compulsory, such as the need to establish indicators or to report cases. Second, it allows work to be carried out on providing assistance to girls who have been excised in a very different way, since it recognises their right to a full recovery (physical, psychological and social).

(1) The word national used to refer to Catalonia, not to the Spanish government.
Both reforms have been very relevant for the betterment of the Catalan comprehensive approach to dealing with FGM. Nonetheless, legislation including explicit references to FGM has also been approved by other regions in the last few years. Concerning gender-based violence, the Canary Islands, Cantabria, Madrid, Murcia and Aragon have included FGM in their respective regional norms (6). This permits women who have suffered this practice or who are at risk to have access to all available resources (shelters, counselling, etc.). Aragon also approved in 2010 a specific protocol to deal with FGM following the Catalan example (‘Protocol for preventing and addressing FGM in Aragon’). With regard to the protection of minors, Valencia has passed a pioneering law stating that FGM is a kind of child mistreatment that should be tackled by the regional authorities (Law 12/2008 for the integral protection of childhood and adolescence of the Comunitat Valenciana, 2008).

Several regions have complemented these policy measures with training activities aimed at key professionals. The GIPE has carried out many of these training activities and so far has trained up to 2 500 professionals. More specifically it has worked with institutions from the following regions: Catalonia, the Basque Country, Andalusia, Valencia and the Balearic Islands. Training activities were adapted to the target group at hand. So far the GIPE has provided training courses on FGM to the following professionals: healthcare professionals (doctors in primary health services, gynaecologists, midwives, etc.), social services, teachers, professionals from sexual and reproductive health centres and police officers. These courses are requested and commissioned by the public institutions, though in some specific cases the GIPE does awareness-raising activities on its own.

government. Other regions have just started to follow the Catalan example by approving their own protocols and by undertaking training activities. Although the territorial model determines that most of the relevant competences belong to the regional level, the national legislative framework must not be disregarded. It has meant a remarkable impulse both to improve the prosecution of FGM and to include this practice in asylum legislation.

Table 2 — Main shifts in the policy framework in Spain and Catalonia

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980s</td>
<td>First immigration flows from African countries to Catalonia.</td>
</tr>
<tr>
<td>1990s</td>
<td>First cases are detected in Catalonia. Some professionals start to do networking in the county of Gerona.</td>
</tr>
<tr>
<td>2001</td>
<td>Resolution of the Catalan parliament urging approval of a regional protocol. An informal working group is set up to work on the Catalan protocol.</td>
</tr>
<tr>
<td>2002</td>
<td>The ‘Catalan protocol to prevent FGM’ is published. The interdepartmental commission attached to the protocol is set up.</td>
</tr>
<tr>
<td>2003</td>
<td>The Penal Code is reformed to include an explicit reference to FGM (Article 149.2). The protocol of the county of Gerona is approved.</td>
</tr>
<tr>
<td>2005</td>
<td>The law on the judiciary is reformed to prosecute FGM extraterritorially. The Catalan protocol starts to be updated.</td>
</tr>
<tr>
<td>2006</td>
<td>The first local networks on FGM are set up.</td>
</tr>
<tr>
<td>2007</td>
<td>The updated version of the Catalan protocol is published.</td>
</tr>
<tr>
<td>2008</td>
<td>The Catalan law on sexist violence is approved. The Working Group on FGM is set up.</td>
</tr>
<tr>
<td>2009</td>
<td>National asylum law is reformed to include persecution based on gender issues.</td>
</tr>
<tr>
<td>2010</td>
<td>The Catalan law on the protection of minors is approved.</td>
</tr>
</tbody>
</table>

Source: Own data.

IV. PREVALENCE AND DATA COLLECTION

Nationwide data: the maps on FGM prevalence

As has already been noted, FGM policies in Spain have not been developed thanks to the presence of official prevalence data. In fact, so far there has been a clear lack of information in every aspect of this phenomenon: court cases, asylum cases, social services intervention, etc.

The first attempt to address the prevalence of FGM practices in Spain was carried out by the GIPE of the Autonomous University of Barcelona. The GIPE published its first map of FGM in Spain in 2002. The study gathered data on the population coming from the 28 countries where FGM is performed. It allowed the number of women as well as the number of girls under 15 years old from those countries to be identified. A similar approach was adopted in the second and the third maps published in 2006 and 2009 respectively. These reports are useful for identifying those regions or cities where this population is concentrated, while contributing to focusing preventive actions on these territories. The maps are based on the information provided by the Spanish Padrón, the local register of population, which is thought to be the most accurate source of information concerning immigrant populations. This is due to the fact that it gathers information on the population regardless of their legal status.

Table 3 — Number of women from the countries where FGM is performed

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>10,451</td>
</tr>
<tr>
<td>15–24</td>
<td>5,705</td>
</tr>
<tr>
<td>25–34</td>
<td>16,673</td>
</tr>
<tr>
<td>35–49</td>
<td>6,949</td>
</tr>
<tr>
<td>50–64</td>
<td>892</td>
</tr>
<tr>
<td>65 and +</td>
<td>220</td>
</tr>
<tr>
<td>Total</td>
<td>40,890</td>
</tr>
</tbody>
</table>


Despite the inclusion of the data on population and the percentage of prevalence for each country, the maps do not estimate the number of women/girls that might be mutilated. The respondents argue that a percentage might be low for a country at large but very high for a specific region or a specific ethnic group within the same country. Therefore, the publication of an estimation of cases may well be misleading. It might contribute to professionals underestimating the risk situation for girls coming from countries where prevalence is low. The maps seek thus to point out where the population is concentrated but without estimating prevalence. One respondent explains this specificity as follows.

“We did the maps on our own. It was an academic work lasting many years. It started in 2002, then the map was updated in 2004, and the last version includes data from the Padrón of 2008 … [We do not calculate prevalence]"
because there are countries in which, although prevalence is quite low, immigrants come from a specific region where prevalence is 100 %, as happens in Nigeria.’

It is interesting to note that these maps are the sole prevalence data available at the national level. The Government Delegation for Gender Violence gathers data on different aspects of gender-based violence in Spain (complaints, associated fatalities, protection measures, etc.), although it focuses exclusively on intra-partner violence. The main reason is that the observatory works to evaluate the implementation and the impact of Law 1/2004 on measures for integral protection from gender violence, which equates gender-based violence with intra-partnership violence. This structure has thus not provided any information on FGM cases, complaints, etc. The Asylum and Refugee Office, on the other hand, uses software that gathers together all data on asylum processes and compiles a wide variety of variables (sex, age, education, etc.). However, there is no room to specify the motive that led to the asylum process. A similar situation occurs with regard to court cases or sentences. There is no register showing all the cases, only search engines that allow some instances to be found by using keywords (for instance female genital mutilation, ablation).

Catalonia: multifaceted prevalence data

The case of Catalonia is of special interest when referring to data relevant for prevalence estimates. First, the Victim Support Unit of the government of Catalonia publishes the number of FGM cases on an annual basis. It is the sole official, public data concerning this practice in Spain (1). The indicator that has been published so far is the ‘number of girls that were assisted by the Catalan police services’ (during a year). This means the number of girls that have been assisted by the police services, regardless of whether this was in a preventive or in a reactive manner. This information is also disaggregated by police district (there are 10 police districts in Catalonia). It should be noted that, according to the existing data, cases of FGM, as defined by the police services, have progressively decreased. More research is needed in order to find out the reasons behind this positive data.

However, the unit has unpublished data concerning other aspects such as the type of intervention (preventive, reactive), the country of origin and the age of the girl. They do not make this data public because it is considered to be very sensitive information. This information is only disclosed in specific and important cases. One respondent points to these potential pitfalls:

‘We do not make this data public because this is very sensitive information [country of origin, age, etc.]. We have disclosed it in specific and important cases. But we are very careful with this kind of information because it can lead to misunderstandings. The problem might be minimised. If in 90 % of cases the girls are not mutilated, there is not such a big problem. They tell you, ‘you have assisted just 28 girls? Then this is not a serious problem’. If you do not give the information properly, it might be difficult to explain the complexity of the phenomenon.’

Anyhow, the unit is already working with a new computer programme that has a lot of potential for generating data relevant for FGM prevalence estimates. It is called the SIAV (Integral System for the Follow-up of Victims). Currently, this programme works only for cases of intra-partnership violence. However, in 2013 the SIAV will be ready to gather data relating to the number and the type of cases of FGM, to the follow-up and to the intervention. These new sources of information will allow more complex indicators to be established. The respondent elaborates on this potential uses as follows.

‘The computer programme will allow automatic calculations to be done. We will see if there is a follow-up of a case of risk 1, what has been done, whether it has been done properly. We will be able to do more qualitative analysis. This will be used for our internal work, to monitor the quality of our work.’

With regard to the Unit for the Detection of and Protection from Child Mistreatment, there are no official data on FGM. The unit nevertheless has some unpublished figures on the cases they have dealt with in the last few years (2009, 2010 and 2011). A new computer programme is to be introduced in the near future in order to gather specific information on FGM cases. This shift is due to the fact that the new law on the protection of minors considers FGM as a form of child mistreatment. As a result, information on FGM cases will be thoroughly gathered.

‘I can tell you the cases we have dealt with … When we talk about prevalence, we say that in 2011 our department intervened in 10 cases. But you can see that we are not aware enough. Our information system does not allow a file to be opened and FGM to be registered as the motivation. Because of this we included FGM in the observations box. Due to that, if I use our database I cannot know the number of cases. But this is going to be modified thanks to the approval of the new law on the protection of minors … But we have counted the number of cases since 2009. In 2010 we had two cases, in 2011 10 cases. And this year three cases. These are girls that have been assisted in general.’

### Table 4 — Number of girls assisted by the police services of Catalonia

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of girls assisted by the police services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>114</td>
</tr>
<tr>
<td>2009</td>
<td>55</td>
</tr>
<tr>
<td>2010</td>
<td>28</td>
</tr>
<tr>
<td>2011</td>
<td>36</td>
</tr>
<tr>
<td>2012 (up to July)</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Victim Support Unit (1).


(1) See http://www20.gencat.cat/portal/site/interior/menuitem.0-8548000cd4d8bc9d4ca86dc3c95cb0310/sgn/VCIM1000008d0c5e0a0aRCD&vgnextchannel=78a6524c3cc3cc0310/VgnVCIM1000008d0c5e0a0aRCD&vgnextfmt=default
The local networks on FGM also constitute a potential source of data. As explained in the previous section, these networks are interdepartmental structures embracing a wide set of professionals working at the local level (paediatricians, teachers, police officers, etc.). They were set up from 2006 onwards in order to effectively implement the protocol at the Catalan local level. Each network has a local register of all the girls that might be at risk, that is, all the girls belonging to an ethnic group or a country where FGM is performed. The idea is for the local networks to work with their families on prevention and to undertake a follow-up of each case. To make this register, the local networks use three main sources of data: the list of girls registered in each school, the healthcare services card (which indicates the patients attached to each of the healthcare centres of the municipality); and the Padrón, that is, the local register of population. One interviewee emphasises the usefulness of these sources of data.

‘Here we have some very helpful sources of data. On the one hand, school registrations, healthcare services cards … And those exist thanks to the Padrón. We have an advantage with respect to other European countries and it helps us a lot in working on prevention. Although we are not always aware of that fact. It is said “no, do not allow people to register in the Padrón!”. But they are going to be here anyway. And you will have to carry out preventive measures anyway.’

The registers gathered by the local networks are confidential and they can only be used for the purposes of the preventive work carried out by the professionals (teachers, police officers, doctors, etc.). In the words of the respondent:

‘Each local network organises its respective work to carry out a follow-up of all the cases. It might be the case of a town which has 47 girls having some characteristics and you say we have to work with those families. While preserving intimacy and keeping confidentiality, since it is a very complicated issue.’

Finally, the GIPE has been working in collaboration with some healthcare institutions at the local level in Catalonia. The idea is to improve their information system by adding some codes that allow FGM cases to be registered. The register will contain the number and the type of case (girl at risk, girl that has suffered FGM). In the near future, it will allow more data to be gathered concerning, for instance, the number of girls that have been assisted in a preventive manner. That is, cases in which the professional has, for example, carried out genitalia check-ups. The GIPE will carry out an analysis of this new database. One of the respondents describes this new tool as follows.

‘What we are trying to do is to register cases with the help of paediatricians and gynaecologists. Some codes have been created and included in the clinical records. So the paediatrician or other professional introduces ‘mutil’ and a code appears … Then there are descriptive codes saying mutilation detected or FGM prevention … These codes will allow the cases to be studied and how many women were assisted to be known.’

Table 5 — Sources of data relevant for FGM estimates in Spain and Catalonia

<table>
<thead>
<tr>
<th>Institution</th>
<th>Published</th>
<th>Unpublished</th>
<th>Forthcoming</th>
</tr>
</thead>
<tbody>
<tr>
<td>GIPE</td>
<td>Number of girls/women and country of origin</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Victim Support Unit (Catalonia)</td>
<td>Number of girls that were assisted by the Catalan police services</td>
<td>Country of origin</td>
<td>Level of risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age</td>
<td>Type of intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type of intervention</td>
<td>Quality indicators</td>
</tr>
<tr>
<td>Unit for Detection of and Protection from Child Mistreatment (Catalonia)</td>
<td>-</td>
<td>Number of girls assisted by the unit</td>
<td>All the data included in the child mistreatment files (age, type of mistreatment, type of intervention, etc.)</td>
</tr>
<tr>
<td>Local networks on FGM (Catalonia)</td>
<td>-</td>
<td>Number of girls, address, country of origin, school, etc.</td>
<td></td>
</tr>
<tr>
<td>Local healthcare services with the contribution of the GIPE (Catalonia)</td>
<td>-</td>
<td>-</td>
<td>Level of risk</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Type of intervention</td>
</tr>
</tbody>
</table>

Source: Own data.

To sum up, data concerning different aspects of FGM practices in Spain is quite scarce and patchy. Regarding nationwide data, the maps of the GIPE represent the sole reference. The national government has made a great effort to gather data on gender-based violence, though it has disregarded FGM cases. With regard to Catalonia, information sources offer great potential. Many thorough registers will be working in the near future. However, data relevant for FGM estimates is currently quite fragmented and vastly unpublished.
Interviewees are quite aware of this fact and point to prevalence estimates as being one of the weakest of the ‘Ps’. They recommend working on prevalence in a double sense. On the one hand, information gathered concerning the intervention process will help in evaluating the work of the professionals involved in FGM policies. This is a pending task in Catalonia, even though they have been dealing with FGM cases for more than a decade.

‘For us this is very important. There was a time when we had larger numbers of assisted girls. It has decreased in the last few years. So we want to know whether the number of girls at risk and the number of girls who are mutilated is growing or not … We want to know if this practice is decreasing in Catalonia or if we are not being so effective in detecting the cases … We are at this point. We have advanced quite a bit and we need to look back. The main goal is to evaluate the work that has been done so far.’

On the other hand, new maps showing the population coming from countries where FGM is performed are needed. A more accurate picture pointing to the specific neighbourhoods, counties or cities where this population is concentrated will allow more effective preventive work to be undertaken.

V. APPROACH TO FGM

V.1. Overall

In relation to the main approach to dealing with FGM policies, a distinction has to made with regard to the informants providing an overall assessment of policies in Spain and those focusing just on the Catalan approach.

Concerning the former, respondents agree on the fact that the main approach in Spain, and notably at the national level, is centred on prosecution and protection. The abovementioned legal framework — penal code, extraterritoriality — aims indeed at prosecuting the perpetrators and protecting victims through preventive measures. Consequently, there is a remarkable lack of actions concerning prevention, prevalence or provision of services. As will be noted, all of these approaches are well developed with regard to intra-partnership violence. Thorough databases, specialised professionals (judges, prosecutors, psychologists, etc.) and tailor-made protocols are available in the whole territory both at the regional and at national level. Resources specialising in tackling FGM cases are rather to be found just in some specific regions, and especially in Catalonia. In line with this patchy development, respondents point to the need for a nationwide intervention. This could foster coordination and ensure the availability of resources in the whole territory.

With regard to the Catalan approach, the interviewees emphasise very different Ps depending on the activities of their respective departments. The interviewees from the unit for the protection of minors point to the prominent role of protection and provision of services. Their functions according to the Catalan protocol are indeed to protect girls at risk (to report to the judge/prosecutor, to ask for preventive measures, etc.) and to coordinate with the other services in order to facilitate integral assistance and full recovery (psychological, physical and social recovery). The Immigration Department, on the other hand, puts the emphasis on prevention and partnership as the main Ps. This position is in accordance with the main activities developed so far. As will be noted in the following sections, awareness-raising activities and partnerships with the immigrants’ associations have been of paramount relevance for this policy area. Finally, the respondent in charge of the Victim Support Unit, attached to the Catalan police services, highlights prevention as the main approach. Though the police services have the duty to protect and to prosecute, awareness-raising activities aimed at immigrant communities deserve to be noted. In fact, this constitutes quite an innovative approach for a police service.

In spite of this diverging assessment of the main approaches, informants from the Catalan institutions do agree on the fact that prevalence is the weakest P. They note that information concerning FGM cases is quite scarce and fragmented so far. Additionally, thorough prevalence data is depicted as one of the main ways to undertake more effective policies.

However, an overview of the whole Catalan policy framework shows that all the Ps have been to some extent addressed. We can summarise this broad approach as follows.

- Prevention: awareness-raising and educational activities targeted at professionals and at immigrant communities.
- Protection: urgent measures to protect girls who are at risk or who have been mutilated (shelters, withdrawal of passport, custody, etc.).
- Prosecution: procedures to report the risk situation or the performance of FGM to a public prosecutor or a judge.
- Provision of services: public services targeted at victims of gender violence and of child mistreatments (healthcare, counselling, economic assistance, recovery surgery, etc.)
- Partnership: interdepartmental coordination and collaboration with immigrants’ associations (see the following sections).

Although the protocol seeks to keep a balance between all of the Ps, we could argue that up to now prosecution is to be understood as the less developed approach. This fact may well be linked to the successful implementation of the other Ps, which might have hindered many mutilations. This point is still to be proved by further policy evaluations.

Finally, it is interesting to mention that respondents from the GPE provide a comparative assessment of the approach favoured by the Spanish regions. The interviewees consider that whilst that Catalonia has emphasised protection and prosecution, Aragon or the Balearic Islands have adopted a more preventive approach.

‘The Catalan protocol was done by social services, education, health and interior [police services]. If you have a look at the press releases the police services are pioneers in implementing the protocol. But, was it not
collaborates with organisations specialising in combating FGM such as AMAM, Yamarikafo, e-kre@ or EQUIS. In addition, it works with general associations of immigrants who are usually organised according to their nationality. They idea is for these CSOs to help with activities related to awareness raising (meetings, lectures, etc.). They do so by inviting their fellows, by helping with the creation of ties with their respective communities, etc. All of these activities are aimed at opening a debate on these kinds of harmful traditions, while increasing concern on their negative effects. One interviewee explains this narrow collaboration:

'It is crucial to work with the organisations in the field. We have a special area related to participation and collaboration with the organisations. When referring strictly to the protocol, we have worked with AMAM, EQUIS, e- kre@. And there is also one called Yamarikafo. I think that taking into account that they are specialised in FGM, the fact of having five or six is remarkable. In addition, you do have to work with Musukafo, the federation of Senegalese associations, or the ones from The Gambia, from Nigeria. It is important to 'enter' this way … We work with federations and non-specific organisations because when we organise meetings, their support is crucial to get people to come.'

The work with the specialised organisations has also led to the creation of awareness-raising materials, namely a CD called On vacations to visit the family. It is a cartoon movie targeted at the families providing information on how to take care of their daughters’ health when visiting their countries of origin.

On the other hand, the Immigration Department has a prevalent role on prevention actions thanks to its collaboration with the local networks on FGM. Although these structures focus on following up cases, they also work with immigrants’ associations in order to change attitudes concerning FGM (with individual contacts, meetings, etc.).

Activities developed by the Department of the Interior and the police services
The Department of the Interior and the police services have also undertaken prevention actions. Here, the role of the Offices for Relations with the Community of the Catalan police services is crucial. These structures focus on working directly with immigrant communities. They provide information, work on awareness-raising activities (meetings, lectures, etc.) and seek to find strategic allies within the communities. The idea is to help them build alternative ways of dealing with such traditions, while deactivating all the social constructions related to FGM.

‘The fact that police services were involved in a preventive approach was quite shocking. We did not have much experience in this kind of intervention … From then on, they started to work on bringing the police services and the communities closer together. The police officers gave lectures to the communities, especially to women from those ethnic groups that still practice FGM. They explained all the consequences of FGM. The idea was to work on awareness raising, to question the myths around

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First, the work of the Immigration Department is of special interest. On the one hand, this department works with several civil society organisations in a very close manner. It

V.2. Prevention
Lack of national prevention policies
At the national level has not been carried out any specific action aimed at the prevention of FGM practices. The Spanish law on gender-based violence (Law 1/2004 on measures for integral protection from gender violence) does emphasise prevention policies. It states that gender inequality (stereotypes, roles, etc.) constitutes the root of the problem of gender-based violence. Therefore, educational and awareness-raising measures are paramount to tackle this phenomenon. Nevertheless, FGM is not taken into account and prevention is thus focused on intra-partnership violence.

Catalonia: awareness raising, training and materials
With respect to Catalonia, the situation is quite different. As has been noted, this region has implemented quite a complex approach to dealing with FGM. The main tool, the regional protocol, highlights that its first aim is to work on prevention. However, in the case of this protocol, prevention means avoiding the practice of FGM and working in a proactive manner. It thus not only entails prevention, but also protection and provision of services.

If we refer to prevention as understood in the Ps model defined for this study, though, some specific actions are to be noted.

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Further research is therefore needed in order to explore other regional policies and to assess their approach in a comparative perspective.

Generally speaking, the vision of the informants goes in line with the fragmented Spanish policies to deal with FGM. Thus, the relevance of the respective Ps depends on the region, the level of government or the policy area at stake. If considering the case of Spain as a whole, we could argue that prosecution and protection are to be understood as the main Ps, while prevention, partnership, prevention and to a lesser extent provision of services are clearly underdeveloped. This is due to the fact that the national legal framework only guarantees the implementation of prosecution and protection measures. Additionally, it is up to the different regions to complement this legalistic and limited approach with further policies.

The work with the specialised organisations has also led to the creation of awareness-raising materials, namely a CD called On vacations to visit the family. It is a cartoon movie targeted at the families providing information on how to take care of their daughters’ health when visiting their countries of origin.

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this practice, to build partnerships with the communities, to identify women that might be an ally on this process.'

To do so, the Department of the Interior has also put the emphasis on providing specific training to the police services. So far, up to 300 police officers have been trained on FGM-related practices as well as on the proper way to carry out an intervention (assessment of the level of risk, procedures, etc).

**Capacity-building initiatives**

The unit for the protection of minors has also commissioned training activities related to FGM, though in a less systematic way. The Health Department has trained a wide variety of professionals as well, although we do not have specific information in this respect.

It is worth noting that the GIPE has had a prominent role in these training activities. First, many courses targeted at Catalan professionals were provided by the GIPE’s main researchers, while being commissioned by the Catalan institutions. Second, guidelines and tools published by the GIPE have been crucial not only for working on these training sessions but also for disseminating knowledge on FGM to a wide variety of professionals (*). Some of these materials were in fact commissioned by Catalan public institutions, as is the case for the manual for healthcare professionals of the Catalan Health Institute. The impact of the GIPE’s two-fold strategy — guidelines and training — does not affect only Catalonía. Rather, some other regions such as Aragon and the Balearic Islands have collaborated with this research group in order to organise training activities and to use all the materials.

‘We calculate that we have trained about 2500 professionals … We trained professionals at the hub of the problem. Social services, health, education. The minors’ assistance teams, the centres for sexual and reproductive health … To increase concern first, and then to train. What FGM is, consequences and especially what the best way to deal with families is.’

To sum up, in Spain prevention activities have been mostly promoted in Catalonía, along with the proactive approach informing both the Catalan protocol and the Catalan legal framework. There are three main outcomes of this preventive perspective: awareness-raising activities aimed at immigrant communities, training activities targeted at key professionals and the publication of tools and materials which seek to be used both by those professionals and by the public at large. To do so, the roles of the Catalan public authorities, the immigrants’ organisations and the GIPE have been crucial. These actors have made possible the successful development of all of these outcomes.

**V.3. Protection**

**Child protection: regional responsibility in a national frame**

Child protection policies are a competence of both the national and the regional level. First, there is the main piece of law at the national level, Organic Act 1/1996, on the legal protection of minors. It regulates the obligation of the state public agencies to intervene in case a minor’s health or security is at risk, or when the minor has been abandoned. This norm might therefore be applied in case of risk of suffering FGM or when it has been already performed. Article 158 of Organic Law 9/2002 modifying the Civil Code, on the other hand, has been especially relevant for cases of FGM, since it has allowed judges to adopt preventive measures. The most common are the following: mandatory check-ups, passport withdrawal or prohibition against leaving the country.

Along with this nationwide regulation, child protection laws have also been approved by all the autonomous communities since the end of the 1980s (*). Generally speaking, all norms have analogous contents. Their first goal is to include the protection of minors as a regional competence. With regard to FGM, these pieces of law are relevant due to the provisions on the protection of minors. All of them state that their respective public agencies have the duty to intervene in case of risk or neglect, as well as to exercise custody of the minor when necessary. In line with this legislation, protocols relating to child mistreatment have been approved at the regional level. The autonomous communities are in fact responsible for managing child protection-related policies and services.

**The Catalan case: the regional circuit for child protection**

Concerning the protection of girls at risk of being mutilated, the case of Catalonía is once again of special interest. The Catalan protocol specifies different procedures depending on the type of case at stake. The first type corresponds to those cases of girls who belong to an ethnic group or a country where FGM is performed. They are considered to be at risk. However, those girls generally represent non-urgent cases, that is to say cases where an imminent situation of aggravated risk has not been detected (vacations, vaccines, family refuses to sign the ‘letter of commitment’, etc.). Here, the idea is to follow up the situation of such girls through the local public services (schools, doctors, social services, etc.), although in a focused and specific way. All professionals must be aware of the type of case and report any indicators of aggravated risk (trips, vaccines, etc.) In those territories with a local network on FGM, this follow-up will be carried out by its professionals. One informant provides an accurate description of this kind of attention.

‘But we refer the case to social services indicating that they must follow up the case by coordinating with the paediatrician of this zone and with the girl’s school and her siblings. This is very specific and focused coordination to get special healthcare assistance. We want them to apply not only the “protocol for a healthy child”. It is not only that, but also to pay attention to FGM. Now we are trying to get paediatricians to register “girl of a family that might practice FGM” in their files. The idea is that the next professional knows that he/she has to pay attention to that … And there must be coordination

(*) See for instance Female genital mutilation — Prevention and assistance, 2006 (Catalan Health Institute).
because families tend to move across the territory. That is why the coordination with the schools is so important. It allows us to know exactly where families are at each moment.'

Each case is thus followed up by the Catalan institutions. However, informants do not refer to any specific mechanism to continue this work in case the family moves to other region.

Procedures are quite different when an urgent case is detected, namely when a girl is going to travel soon and/or her parents refuse to sign the ‘letter of commitment’. This letter is an official document of the Catalan healthcare system. It must be signed by the parents of girls at risk (*) in order to confirm their knowledge regarding Spanish legislation on FGM as well as their commitment concerning the protection of their daughters from being excised. Although families do not have the duty to report their trips, when professionals detect an upcoming visit to the countries of origin they automatically ask the parents to sign the letter (if they have not done it yet). This is usually the case when they visit the paediatrician in order to get vaccinated or when the teacher knows of an upcoming trip. If the parents do not sign the letter or if there is any other evidence indicating that the girl is at risk (for instance, the family tells someone that the girl is going to be mutilated; the parents might not come back; her mother is mutilated; etc.) the urgent procedures of the protocol are activated. This means that the case is reported to the police services, concretely to the victim support groups (GAV), which specialise in assisting and protecting victims of any kind of gender-based violence. Those groups will provide the following services: assisting the victim, providing information and counselling; assessing the level of risk; providing the protection measures established by the courts. In addition, the GAV will activate the specific protocol on FGM of the Catalan police services (‘Protocol for preventing and addressing FGM of the police services’, 2008). This document gathers the information included in the general protocol, specifying the procedures to be followed by police officers.

In addition, the Unit for the Detection of and Protection against Child Mistreatment (Udepmi) reports the case to a public prosecutor and asks for preventive measures. Here, the Catalan laws on the protection of minors and the law on gender-based violence, which explicitly mention FGM, have broadened the set of preventive measures: restraining orders, prohibition against traveling, withdrawal of the passport, etc. Generally, Udepmi demands all the existing measures with the exception of the withdrawal of custody. The aim is to protect girls without separating them from their family. This is a very innovative approach that did not happen in the past when dealing with child mistreatment, and does not happen now in other regions.

The services for the protection of minors will act as follows.

‘When we are going to protect, we demand all the existing preventive measures, as if we had custody of the minor, although we do not have it … We try to do things exactly the same way as we do when we have custody but without separating the minor from her family … Nowadays it is working. We ask for the preventive measures included in the Penal Code. Prohibition against traveling, withdrawal of the passport, etc. … For me it is very important to have these measures without separating the family. When a father or a mother does not go, for instance, to the regular medical check-ups [established by the court], then we will demand custody of the minor, just when this happens.’

During this process, all departments involved in the protocol (health, social services, schools, etc.) must be coordinated in order to ensure not only the protection of the girl at risk but also her well-being.

When a case of a girl that has been mutilated is detected, there is no need to activate coordination mechanisms with other departments. The case is reported to Udepmi or to the police services and then to a prosecutor or to a judge. Preventive measures are also taken in this case. Here, the work focuses on prosecution and on providing all available services (see below).

The protocol is the main tool guaranteeing interdepartmental coordination and the presence of these standardised procedures (level of risk, steps to be taken, etc.). To improve its implementation, most departments have provided specific training on FGM, and more specifically on the Catalan protocol, to their respective professionals. Nevertheless, these professionals are not fully specialised as is the case for those dealing with intra-partnership violence (i.e. psychologists).

As we have already noted, there are several informal sources of data concerning protection measures (minors, local networks and local healthcare professionals). Still, the sole official and public database corresponds to the police services and does not specify the type of intervention. Child abuse records will soon include information concerning FGM cases.

(*) The protocol includes a list of countries where FGM is performed.
Protection for asylum seekers

With regard to asylum seekers, both those persons who have applied for refugee status and those who have applied for subsidiary protection have access to a broad set of rights, such as the following: not to be expelled; to get an identification document; to access employment, health and education services; to family reunification; etc. No specific protection measures are noted in the current legislation (Organic Law 12/2009 regulating asylum rights and subsidiary protection). Yet, since the reform of the Spanish legal framework, judges have been in favour of providing refugee status to those women alleging the fear of being excised.

Finally, with regard to adult women, regional laws on gender-based violence including FGM (Catalonia, Aragon, Murcia, Madrid, Cantabria and the Canary Islands) would provide protection measures regardless their legal status. Therefore, they would have access to resources such as shelters, police protection, restraining orders, etc. Still, none of the respondents has given any examples of an adult woman being assisted.

To summarise, the national level provides a basic legislative framework on protection of minors and asylum rights. Concerning the former, the autonomous communities nevertheless play a major role. All of them have specific legislation, protocols and services targeted at protecting minors from mistreatment and neglect. In the case of Catalonia, both the protocol to prevent FGM and the existing legislation establish the procedures to be applied for each type of case (non-urgent, urgent and mutilated). This helps in determining the role of each actor (police, minors’ protection offices, social services, etc.), as well as the measures to be applied.

V.3. Prosecution

Prosecution: civil and penal cases

As has been pointed out, the national legal framework has been modified in order to include a specific reference to FGM practices as well as to permit the extraterritorial prosecution of these sorts of offences. In parallel, regional legislation on gender-based violence and the protection of minors has reinforced these provisions by making explicit references to FGM.

According to the respondents, prosecution procedures can be divided up as follows:

- Civil cases (via civil) — These are cases in which a girl is at risk of being subjected to FGM. As has been noted above, these cases are usually detected by a professional (doctor, teacher, etc.) and reported to the office for the protection of minors, the police services and/or the social services. Social services will make a report on the case, while either the office for the protection of minors or the police services (usually the former) will ask the courts to undertake preventive
measures (withdrawal of the passport, prohibition against traveling, withdrawal of custody in the most extreme cases, etc.).

- Penal cases (via penal) — These are cases in which FGM has already been performed. They are usually detected by healthcare professionals in the regular check-ups that are mandatory for children. In Spain, people are obliged to report any kind of crime, though this provision is even more compulsory in case of a professional who due to their status might have knowledge of a crime that has been committed (see for instance Law 1/1996 on the legal protection of minors). Therefore, the doctor/paediatrician/nurse has the duty to report the case to the police services, to the office for the protection of minors or directly to a public prosecutor or a judge. The report will initiate a penal procedure (procedimiento penal), in which the court has to gather corresponding evidence (medical reports, witnesses, evidence of travel, etc.) in order to prosecute the perpetrators as well as to protect the victim.

Most cases correspond to the civil procedures, while about six penal cases have been identified in Spain so far. It is worth highlighting that, with the exception of a very recent instance, all of these penal cases were dismissed.

Lack of proof has been the main reason behind the lack of convictions. That is, it has been difficult to prove elements such as who performed the FGM, where and when it was practised, etc.

The most recent case, which took place in Teruel in 2011, was exceptional in this respect. It was possible to prove that it occurred in Spain and when it happened. This is because of the healthcare check-ups that proved when the FGM had been performed. Besides, the public prosecutor was able to prove that the family had not travelled during that period, demonstrating that the mutilation had been performed in Spain. The father and the mother were condemned to 6 and 2 years’ imprisonment respectively. Concerning the mother, the judge applied a mitigating factor called ‘error in law’. It means that a crime is committed due to a lack of knowledge or a lack of understanding of domestic legislation. In this specific case, it was proved that the mother had just arrived to Spain and that she did not know the language or the existing legislation.

Challenges relating to prosecution

In accordance with these tendencies, the interviewees point to three main challenges to be overcome. First, the difficulty in gathering proof represents a major weakness. One respondent recommends regular screening targeted at girls at risk in order to improve knowledge of their physical well-being. Yet he warns that this kind of procedure might be stigmatising and/or excessively invasive; thus, they have to be thoroughly discussed. In his own words:

‘One of the things that is recommended in other countries, and that is problematic, is screening. That is, undertaking selective regular check-ups. This implies that you are selecting a specific target group. This would improve the gathering of information and therefore the gathering of proof, but at the same time you will be pointing to the same group of people all the time … It is a bit of a Big Brother situation. We will be controlled and no crime is going to be committed.’

Second, there is a remarkable lack of data concerning both civil and penal cases. Although the database of the General Council for Judicial Power (Consejo General del Poder Judicial) allows searches for jurisprudence using a keyword (i.e. female genital mutilation), no systematic record is available. This represents a major challenge that should be overcome by building national and regional court cases databases.

Third, some respondents emphasise that judges and prosecutors do not have enough knowledge of FGM practices and of the existing legal framework. Two respondents thus recommend training activities directed specifically at those professionals. Finally, it must be noted that both respondents point to an emerging challenge, that is, the presence of forced marriages in Catalonia. They claim that there is a need for the national government to reform the Penal Code so that these kinds of traditional harmful practices are prohibited as well. This reform will help to prosecute perpetrators while improving the protection of victims. It will also complement the policies that have been implemented in Catalonia such as the specific police protocol on forced marriages.

‘[The national government] is not aware of the fact that FGM much of the time goes hand in hand with forced marriage, which is not yet considered a crime. Forced marriage is a crime if other crimes are committed too. For instance if the woman is raped … The Catalan law on the protection of minors should have included a protocol related to forced marriage. It does exist. The Catalan police drew up a specific protocol to deal with forced marriage.’

To sum up, the national legal framework does guarantee the prosecution of FGM cases as well as the protection of victims. Additionally, regional norms on gender-based violence and the protection of minors provide complementary provisions. However, with regard to the prosecution of the practice of FGM several challenges are still to be faced: difficulties in gathering proof; lack of data on cases, interventions, etc.; and lack of knowledge on the part of judicial professionals.

V.4. Provision of services

National services targeted at the victims of violent and sexual crimes

With respect to the national level, FGM has not been recognised as a type of gender-based violence in the Spanish legislative framework. As a result, the services guaranteed by Law 1/2004 on measures for integral protection from gender violence (counselling, shelters,
economic assistance, etc.) are not available for girls/women who have suffered or might suffer FGM. It is important to mention, however, that those women would have access to all the resources aimed at the victims of violent or sexual crimes. Concretely, the Spanish Ministry of Justice has several Offices for the Assistance of Victims of Violent Crimes and Crimes against Sexual Freedom (\(^\text{1}\)). These offices have the duty to provide victims with information concerning a variety of issues (legal procedures, legal rights, economic assistance, social services, etc.), to facilitate their access to medical, psychological and judicial assistance and to coordinate all these actions with other relevant institutions (courts, police services, etc.). These provisions guarantee that services are available in the whole territory.

‘The Organic Law establishes that gender violence is that which takes place between persons who have a relationship, be it marriage, living together or ex-partners. The other kinds of violence against women are included in our Penal Code, that is to say, there is not a lack of regulation. There are also mechanisms to act in such cases (information telephone lines, offices for the assistance of victims, etc.) ... What it is true is that gender violence, as understood in the law, is a huge phenomenon that has been tackled in a specific and comprehensive way.

The situation is quite different at the regional level. Seven regions have approved laws concerning gender-based violence that explicitly include FGM. This is the case for Catalonia, Aragon, Murcia, Madrid, Cantabria and the Canary Islands. This reference is of paramount relevance (legal procedures, legal rights, economic assistance, social services, etc.) ... What it is true is that gender violence, as understood in the law, is a huge phenomenon that has been tackled in a specific and comprehensive way.

Catalonia: new legislation and the provision of services

Focusing in Catalonia, Law 5/2008 on the right of women to eradicate sexist violence in Catalonia has meant a clear shift in terms of the provision of services. It specifies that all rights (protection, specialised attention, economic subsidies, etc.) and services (shelters, services for recovery, etc.) included in this norm are available to girls/women who might suffer or have suffered FGM, regardless of their legal status.

‘The law says that all women suffering gender violence and their children have the rights recognised in the norm. Women in any kind of situation. They do not need any papers [concerning citizenship] ... And the norm states that FGM is a form of gender violence and for me this is very important. It is a pioneering norm.’

To illustrate the broad set of services to be embraced, it can be noted that the Network for the Assistance and Full Recovery of Women Suffering Sexist Violence coordinates, among others, the following services (Article 54):
- helpline services
- information and attention services
- urgent services for attention and shelter
- shelter and recovery services
- meeting point services
- police attention services.

Interestingly, this legislation addresses also the full recovery of women suffering gender-based violence. With regard to FGM, this means that Catalan authorities should provide not only psychological or medical assistance, but also the medical care needed to reconstruct the genitalia (Article 75).

Law 14/2010 on rights and opportunities during childhood and adolescence in Catalonia goes in line with this norm. First, it makes explicit reference to FGM as a type of child mistreatment as well as a cause of neglect (Article 76, 105). It guarantees that all available resources are aimed at girls who are victims of FGM (helplines, child mental health services, child shelters, educational programmes, etc.). Second, it mentions the right to full recovery, which would include the medical care needed to reconstruct the genitalia. The inclusion of the right to full recovery has meant a turning point. It adds a new approach to the treatment of cases of excised girls. The public authorities will not limit their intervention to prevention, protection and prosecution, but will also assist victims through all the process of physical, psychological and social recovery. For instance, the Udepmi is working with some private clinics in Barcelona which offer recovery surgery for free (\(^\text{2}\)). This is a very recent approach so it is still to be developed and to be fully provided by the Catalan public services. Anyhow, these new services help by working with the families in an innovative way. In the words of one informant:

‘Now the parents come with the girls already mutilated. They are aware of the fact that FGM is a crime. What happens? Given that they know it is a crime they come here with their daughters mutilated. The aim now is to tell them ... it will be worthless to mutilate the girls. We will do as much as possible so that when she reaches 18 years old or even before she has her genitalia reconstructed. There are several clinics, especially the Dexeus, which act as an NGO and that are performing such reconstructions for free.’

In spite of the comprehensive legal framework of Catalonia, some respondents claim that the implementation of these new laws has been problematic so far. Judges have been reluctant to apply Law 5/2008 on sexist violence when addressing FGM cases. They still conceive of gender-based violence as defined in national Law 1/2004 on measures for integral protection from gender violence, which limits such offences to intra-partnership violence. Due to this narrow definition, some cases of girls at risk of being excised have

\(^{\text{1}}\) See http://www.mjusticia.gob.es/cs/Satellite/es/1288774766880/EstructuraOrganica.html

\(^{\text{2}}\) See for instance Fundación Dexeus: http://www.fundaciondexeus.org
not been considered as gender-based violence. One of the respondents explains this pitfall as follows.

‘Since we are talking about gender violence we try to ensure that judges specialising in gender violence (**) manage these cases [on FGM]. But those judges move the cases to non-specialised courts [juzgados de guardia] … We want them to realise that when dealing with women it does not matter whether they are 1 year old, 1 month old or 75 years old. Curiously enough, they say that they are competent when referring to FGM cases only when the husband has performed the FGM on his wife. That is a matter of interpretation of the law. It is absurd. Now we are using both laws [Law 5/2008 on gender violence and Law 14/2010 on the protection of minors].

In response to these difficulties, the interviewees highlight the need for training and awareness-raising campaigns targeted at judicial professionals (judges, public prosecutors, etc.). They detect indeed that a lack of knowledge combined with a lack of concern represents a challenge to the protection of girls and the provision of services.

Figure 3 — Provision of services in Catalonia

<table>
<thead>
<tr>
<th>LAW 5/2008 ON SEXIST VIOLENCE OF CATALONIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Helpline services.</td>
</tr>
<tr>
<td>- Information and attention services.</td>
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<tr>
<td>- Urgent services for attention and shelter.</td>
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<tr>
<td>- Shelter and recovery services.</td>
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<tr>
<td>- Meeting point services.</td>
</tr>
<tr>
<td>- Police attention services.</td>
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<tr>
<td>- Legal and psychological counselling, etc.</td>
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<tr>
<th>LAW 14/2010 ON THE PROTECTION OF MINORS</th>
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<tbody>
<tr>
<td>- Helpines.</td>
</tr>
<tr>
<td>- Child mental health services.</td>
</tr>
<tr>
<td>- Child shelters.</td>
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<tr>
<td>- Educational programmes.</td>
</tr>
<tr>
<td>- Healthcare services.</td>
</tr>
<tr>
<td>- Recovery Surgery, etc.</td>
</tr>
</tbody>
</table>

- ATTENTION
- PROTECTION
- FULL RECOVERY

Source: Own data.

To summarise, the provision of services is quite complex and quite fragmented in Spain. On the one hand, services aimed at assisting the victims of violent or sexual crime are available throughout the whole territory. On the other, some regions include FGM in their respective gender-based violence norms. This means that all the specialised resources will be also available for girls/women at risk or for those who have been mutilated. Catalonia once again offers the most comprehensive approach. Drawing on the work that had been done on the protocol, specific provisions relating to FGM were included both in the legislation concerning gender-based violence and in the norm relating to child protection. What is more, both regulations make explicit the right to recovery, which would entail also the reconstruction of the genitalia. This is a pioneering experience in Spain that is still to be fully developed.

V.5. Partnership

Multilevel coordination concerning gender violence policies

The complex territorial model in Spain determines that competences regarding gender-based violence belong both to the regional and to the national level. Besides, the asymmetric character of the Spanish state of autonomies means that regions do not have the same set of competences.

‘With regard to institutional coordination within the framework of Law 1/2004, there is no single and exclusive competence. Rather, competences are distributed among the different levels of government. Moreover, due to the complexity of the Spanish state of autonomies this distribution is not even. For instance, concerning security issues, the Ministry of the Interior has a competence embracing the whole territory with the exception of those regions with regional police services like Catalonia, the Basque Country and Navarre. When talking about the judiciary system, up to 10 regions [out of 17] have their own competences.’

Due to this complexity, Law 1/2004 on gender-based violence included several coordinative mechanisms to guarantee an integral and transversal action to combat such phenomenon. The main mechanisms to coordinate departments as well as levels of government are the following.

- The Governmental Delegation for Gender Violence itself.
- The Sectoral Conference [Conferencia Sectorial] on Gender Equality Issues, which gathers representatives from each region and from the national government. It helps to coordinate and create common actions and strategies.
- The Sectoral Conferences of each of the ministries with competences concerning gender-based violence (health, justice, interior, etc.). It is a mechanism for the coordination and creation of common approaches.
- The national plan for awareness raising and the prevention of gender-based violence. This is a national plan but was agreed with all the regions. Therefore, the idea is to embrace both levels of government in the preventive strategy.
- The national protocols on gender-based violence. For instance, those protocols referring to the healthcare system or to the police. These are national protocols, although each region has to implement and sometimes to adapt them.
- The collaboration with the local level through the Spanish Federation of Municipalities and Provinces.
- The National Observatory on Gender-Based Violence. This is a consultative structure of the national government. It gathers representatives from different public administrations, as well as from the women’s organisations, the trade unions, etc.

However, it is worth highlighting that none of these structures have paid attention to FGM as a type of gender-based violence. Respondents have pointed out that this is a major weakness of the Spanish FGM policies.

(**) Since the approval of Law 1/2004, Spain has set up several courts specialising in gender-based violence-related offences.
Although some regional policies such as the ones implemented in Catalonia are of great value, a nationwide intervention is strongly needed as well. It would help in fostering coordination, responding to population mobility or addressing the international nature of the problem.

‘Most of the competences belonged to the regions but the planning must be at national level. This should be so for one reason, because these problems are not only national but international. And these competences do not belong to the regions. Also we detected that when mass media or police pressure increased in Catalonia, families moved to Aragon. I think that it is absurd that there is no national coordination’.

**Partnership in Catalonia: work with immigrant communities**

As noted in the ‘Prevention’ subsection, the Catalan policy approach to eradicating FGM does include partnership activities in conjunction with the immigrants’ associations. On the one hand, the Immigration Department collaborates with organisations specialising in combating FGM such as AMAM, Yamarikafo, e-ke@ or EQUIS, as well as with general associations of immigrants who are usually organised according to their nationality. The idea is for these CSOs to help with activities related to awareness-raising (meetings, lectures, materials, etc.) and to the creation of ties with their respective communities.

For instance, a specific project was developed in 2009 and 2010. It was an awareness-raising project based on organising meetings to address FGM practices with immigrant communities. To do so, two Catalan organisations specialising in FGM (AMAM, EQUIS) and two organisations coming from The Gambia and Senegal worked together, while the Catalan authorities provided all the required resources. The meetings consisted of lectures given not only by very different professionals (nurses, doctors, etc.) but also by religious authorities such as an imam. They proved to be very helpful in increasing awareness and in opening a debate on harmful traditions.

‘In 2009 and 2010 we did intense work with the immigrant organisations. It was a publicly funded project led by the directorate-general. It was done by the organisations but it was commissioned by us because they do not have the resources to do it themselves … We worked with AMAM and EQUIS here and with Gamcotrap [The Gambia Committee on Traditional Practices Affecting the Health of Women and Children] in The Gambia and Tostan in Senegal … We did a 2-week project. People from these organisations came from there to visit specific communities here … We held meetings with immigrant communities in different cities and small towns. Who came? There was a doctor, a social worker, a technical expert on youth, an imam. An imam, and I emphasise this because it was crucial. Because we all know this is not a religious issue, but it is something that has been incorporated. And the imam discussed and argued with the imams from here … And many things that we did not know came up. Gender equality issues, forced marriages, health problems, etc.’

This project was therefore very interesting due to its impact in terms of increasing concern regarding FGM. Additionally, the interviewee argues that in order to eradicate this practice more intense work with the country of origin is needed. He indeed claims that ‘this battle is not to be won here but there.’

The Department of the Interior and the police services have also collaborated with immigrant communities. As has been noted, the Offices for Relations with the Community (ORC) of the Catalan police services focus on working directly with immigrant communities. They provide information, work on awareness-raising activities (meetings, lectures, etc.) and seek to find strategic allies.

A similar approach is adopted by the local networks on FGM, which embrace a broad set of professionals, including police officers and technical experts on immigration issues. They also aim at working hand in hand with the local immigrants’ CSOs.

This kind of partnership is in line with the pre-eminence of CSOs regarding FGM-related policies in Spain. Although in Catalonia public institutions play a major role, generally CSOs have been crucial for developing specific materials, awareness-raising campaigns or research in other territories.

**Partnership in Catalonia: interdepartmental and multilevel coordination**

The complex Catalan approach to eradicating FGM embraces several departments and several different levels of government. Coordination structures are thus greatly needed. As far as the regional protocol is concerned, it has worked with an interdepartmental commission since its very beginning. This commission initially involved all the departments involved in implementing the protocol (health, minors, social services, immigration, police), while being led by the Immigration Department. Its contribution permitted the designing of a coordinated intervention and to keep the protocol updated.

Currently, the protocol forms part of a broad strategy to fight sexist violence, based on Law 5/2008 on the right of women to eradicate sexist violence in Catalonia. In accordance with it, the interdepartmental commission, now called the Working Group on FGM, takes part in the National Commission for Coordinated Intervention against Gender Violence. This shift contributed both to consolidating this coordinative structure and to embracing new actors, such as some professional associations.

‘What is important here is that we have a law and a working group that was set up thanks to this legal framework … Moreover, this working group is not only formed by governmental departments, but civil society is also integrated. The Catalan Association of Midwives, the Doctors Association … The important thing is that we have included associations and not only governmental structures.’

Concerning the local level, the local networks on FGM reproduce this interdepartmental and coordinated approach by gathering a diverse set of professionals too. In
addition, their work is monitored and coordinated by the Immigration Department. Here, partnership therefore has a multilevel character.

‘To set up the networks, we [someone from the immigration department] go there and we explain to the professionals what we are doing. We try to ensure immigrant communities are there, that is, someone from the associations we usually work with. We explain what the aim of the networks is, who is involved. But we always expect the local authorities to lead the network. We support them but we expect local leadership.’

To sum up, partnership in Spain has been both horizontal and vertical. With regard to the national level, a broad set of vertical coordination structures are in place, though they have hitherto been directed only to tackle intra-partnership violence. In Catalonia the picture is more complex. First, institutional actors and CSOs tend to collaborate both at the regional and at the local level. Specifically, the immigration department and the police services have worked with immigrants’ associations on a regular basis. They aim at building alliances in order to improve work on prevention and awareness raising. Second, institutional actors have tended to collaborate both horizontally and vertically. With regard to the former, the interdepartmental commission attached to the protocol shows the pre-eminence of networking as the best way to give a comprehensive response to FGM cases. Concerning the latter, the Immigration Department has had a prominent role in building a set of local networks on FGM. These structures will reproduce the regional approach by relying on interdepartmental coordination and partnership with the immigrants’ associations.

VI. SUCCESSES AND CHALLENGES

According to the respondents the following are the main successes to be reflected upon.

• The national legal framework: As has been stated, three main national laws were reformed in order to strengthen prosecution of FGM as well as victim protection. The Penal Code and the law on the judiciary include FGM as a type of serious offence that can be prosecuted extraterritorially. According to the interviewees, this shift meant a clear turning point in the Spanish context. It contributed to putting the issue on the agenda, to fostering the debate and, of course, to including FGM as one of the few types of crimes that can be prosecuted even if it is committed abroad. Furthermore, the legal reforms also had a social impact. Immigrants’ organisations indeed argued that it was much easier for them to work on the eradication of this practice since they can warn of the legal consequences. With regard to asylum legislation, the norm approved in 2009 meant a clear step forward. From then, on, the asylum seekers alleging FGM have much more chance of getting refugee status.

• The ‘Catalan protocol to prevent FGM’: There is a general consensus on the fact that the Catalan protocol represents good practice and an example of a successful approach to eradicating FGM. Respondents emphasise first the impact of its interdepartmental approach. Several governmental departments and offices were involved from the very beginning. They worked together to draw it up and contributed with regard to functions and responsibilities according to the role of each actor (Who does what?). This means that all of the departments have a specific role and none of them is imposing its specific approach (protection, prosecution, etc.). One respondent explains this complex approach with these words: ‘The positive side was that, even with all the difficulties stemming from the complex division of competences, actors were aware of the wide variety of areas to be involved … Second, they tried to be coordinated. When it worked it was because no one claimed to have a prominent role. All said we will do a protocol and all took part in it.’ In addition, all of them provide their expertise and their own resources, since the protocol does not have its own budget. What is more, the work of the interdepartmental commission attached to the protocol has allowed its implementation to be improved constantly. Learning processes and internal informal evaluations have indeed been favoured by this collaborative work. Respondents then emphasise that the protocol entails a proactive approach. It is mainly targeted at avoiding FGM practices. Although it includes provisions focused on assisting girls who have been mutilated, the main goals are to change cultural views concerning FGM and to protect girls who might be at risk. To do so, not only are relevant departments involved (minors, health, police, etc.) but also immigrant communities, which have a major role in eradicating this practice. Respondents agree on the fact that this proactive approach has been successful in terms of avoiding many FGM performances (though there is no evaluation in this respect).

• The local networks on FGM: Most of the interviewees emphasise that local networks on FGM are one of the most promising practices in Catalonia. Their creation stems from the fact that the protocol itself had not been able to effectively embrace all the professionals dealing with key areas. As a result, prevention and protection measures were not as successful as expected. The local networks followed the regional approach based on interdepartmental cooperation and a proactive perspective. They embrace a wide variety of professionals, professionals who are at the hub of the problem, who have direct and permanent contact with the target group. The networks therefore can easily detect risk situations, follow up each case and, more importantly, work with immigrant communities on awareness-raising activities. These structures have been working since 2006 and do not cover the whole Catalan territory. There is in fact a lot of work to be done to better their impact on FGM policies in Catalonia.

• The Catalan legal framework: Despite the consolidation of the protocol as the main tool to fight FGM in Catalonia, most interviewees report on the new legal framework as a turning point. The law on sexist violence and the law concerning the protection of minors are depicted as promising mechanisms to foster work on FGM cases, especially with regard to the protection of girls at risk and the provision of services. With regard to the former, respondents argue that both norms
contribute to making the protocol compulsory, i.e. procedures, actors to be involved, etc. are now included in a binding measure. This shift is expected to contribute to the effectiveness of the protocol. Concerning services, all resources available to assist women suffering gender-based violence and to minors who are victims of mistreatment are also available in cases of FGM. The inclusion of the right to a full recovery is strongly emphasised. It allows work on the reconstruction of the genitalia for the very first time, giving to FGM policies a whole new perspective.

• The work with immigrant communities: Many respondents put the emphasis on the involvement of immigrant communities both at the regional and at the local level. On the one hand, they have contributed to the implementation of the protocol by being key allies of the immigration and police services departments. Here, organisations specialising in FGM have been of added value due to their strong commitment to the eradication of this practice and due to their great contribution as key mediators. In fact, the updated version of the Catalan protocol includes their specific role as well as their names and contact details. Non-specialised immigrants’ associations were rather relevant in spreading the work of the Catalan authorities, helping to organise awareness-raising activities and facilitating contacts between families and institutional actors. All in all, CSOs have been of special relevance when referring to prevention-related policies.

• The letter of commitment: One of the specific tools that is often highlighted is the letter of commitment. As has been stated before, this is an official document of the Catalan healthcare system. It must be signed by the parents of girls at risk in order to confirm their knowledge regarding Spanish legislation on FGM as well as their commitment concerning the protection of their daughters from being excised. According to the respondents this tool has been useful from several points of view: First, it helps healthcare professionals in addressing the issue of FGM with the families, which tends to be a difficult topic to bring up. Second, the refusal to sign the letter is an indicator of aggravated risk, so it contributes to activating the urgent measures of the protocol. Finally, some respondents point out that it has also helped parents to resist family pressure when they travel to their countries of origin. The letter is a way to warn them of the legal consequences of this practice in Spain.

In addition to the successes named by the informants, it would be relevant to note as well that the Catalan legal framework has contributed to defining the problem of FGM in a very broad manner. The former approach, based on the intervention of several professionals/areas, already addressed FGM as an issue of health, security, immigration, education, etc. Nevertheless, the inclusion of this practice in the gender-based violence law means that gender inequality starts to be considered as part of the definition of the problem too (diagnosis). Law 5/2008 defines gender-based violence as ‘the violence that is practised against women in the framework of discrimination and of a system of unequal power relations between men and women’ (Article 3). Accordingly, gender equality policies are to be understood as part of the solution (prognosis).

Since the approval of this norm, indeed, the regional equality body is increasingly involved in FGM policies. This body is currently leading the National Commission for Coordinated Intervention against Gender Violence in which the Working Group on FGM is included. With regard to child protection legislation, these new provisions mean the inclusion of a gender perspective in a policy area that has been traditionally gender blind. The two-fold approach based on considering FGM as a type of gender-based violence and a type of gendered child mistreatment can thus be depicted as a success. It permits transversal inclusion of gender inequality as one of the main roots of FGM practices. This approach was rather disregarded in the former Catalan FGM-related policies.

It is worth noting as well that all of these policy successes appear to be strongly related to some specific factors. In the case of Catalonia, policy development has undoubtedly been linked to the work of key professionals both at the regional and at the local level. Their contribution has been crucial for keeping the issue on the agenda and for constantly improving the policy tools and strategies. The immigrants’ associations, especially those focusing on eradicating FGM practices, have also represented a major success factor. They contributed to building alliances with immigrant communities, while giving FGM policies a less invasive character. With regard to Spain, more research is needed. However, the conjunction of the detection of cases during the 1990s, the presence of the Catalan example and the pressure stemming from the international legal framework on FGM may well be the factors behind the betterment of the legal framework in the 2000s.

The respondents also make clear the presence of the following main challenges.

• Multilevel perspective: The Spanish territorial model is very complex. This feature deeply affects the implementation of FGM policies. On the one hand, the national level has the responsibility to approve basic legislation on relevant issues such as health, education or gender-based violence. The regional level has the capacity to complement this legal framework and, what is more important here, has the duty to provide all the services established both by the abovementioned national norms and by those approved at the regional level. The Spanish regions therefore have both legislative and administrative capacities. With respect to FGM, this complex landscape has led to the uneven development of policies. The national level has provided a legal framework focused on protection and prosecution. This ensures that FGM offences can be tackled in the whole territory. Nevertheless, policies at the regional level have only been developed in a few regions, such as Aragon and Navarre, and notably in Catalonia. As a result, specific resources aimed at combating this practice and assisting girls at risk or mutilated are only available in a small part of the Spanish territory. What is more, aspects such as prevention, provision of services or prevalence estimates have only been addressed in some regions. One interviewee expresses this challenge as follows: ‘The protection provided by the legislation is enough. The problem is what you do in relation to intervention, because the law does not solve everything … The
presence of services would depend on the autonomous community or on the local governments. It depends on the fact that they set up an institution or an office, or that they designate someone to work on it. It is worth noting that most of the at-risk communities (\(i\)) are concentrated in those territories where policies have already been implemented. However, respondents are asking for the national government to work on a multilevel coordination policy and to promote the implementation of the Catalan approach in the other territories.

- Training for key professionals: Most respondents put a special emphasis on the need for specific and systematic training aimed at professionals. It is true that training activities have been carried out in several regions and have reached different types of professionals. However, the interviewees claim that there is still a lot of work to be done in this respect. For instance, the level of knowledge and expertise is still quite low in comparison with other types of gender-based violence, namely intra-partnership violence. In the words of one respondent, ‘We do have serious deficiencies concerning the provision of services, the level of specialisation. We have worked a lot on intra-partnership violence. We have very good professionals working on that issue, a lot of resources. But we have to provide these professionals with more knowledge, so that they can deal with other forms of gender-based violence as well … It is very hard to find professionals or resources specialising in FGM, or forced marriage, or sexual abuse.’ Moreover, there are two specific aspects that should be improved. First, respondents have detected that the judicial professionals (judges, public prosecutors, etc.) show an alarming lack of knowledge combined with a lack of concern. This fact represents a challenge to the protection of girls and the provision of services. Second, the GiPE’s circular approach to FGM shows the positive effect of the inclusion of FGM in the curricula of the university degrees related to education, social assistance, economic assistance to dependant people (handicapped people, the elderly, etc.). This means that the Spanish regions will have a much more limited budget to manage all of these services, and accordingly to implement FGM policies as well. This backlash has especially affected Catalonia, one of the regions with the biggest public debt. Further research is needed in order to explore how and to what extent these changes might affect Catalan FGM policies.

- Prevalence data: In Spain, data relevant to prevalence estimates is quite scarce and quite fragmented. It is true that the work of the Catalan institutions will soon provide more complex and thorough indicators. A nationwide overview of this phenomenon is anyhow missing. In fact, there are no official available data on relevant aspects such as court cases, asylum cases, population from countries where it is practised, etc. Respondents point out repeatedly that in order to implement effective policies a broad set of data is needed. On the one hand, the impact of policies must be aimed at those neighbourhoods, cities and counties where the risk communities are concentrated. The more information exists about the population, the more effective and efficient the policy will be. The local networks on FGM in Catalonia are a good example in this respect, since they build a register of cases and focus on those areas where intervention is needed. On the other hand, prevalence data is crucial for carrying out any kind of evaluation. Some respondents thus note that the forthcoming sources of data will allow the Catalan approach to dealing with FGM to be monitored and evaluated. This is the case, for instance, for the new police database called SIAV. According to one respondent, ‘we will see if there is a follow-up of a case of risk 1, what has been done, whether it has been done properly. We will be able to do a more qualitative analysis. This will be used for our internal work; to monitor the quality of our work.’ This kind of work will place the Catalan protocol on a whole new stage.

- Emerging practices: Some respondents point to the presence of two emerging practices representing a major challenge. First, there are cases in which the girl is excised but does not come back from the country of origin. So far, there is no provision in the Catalan protocol or in the legal framework that allows for intervention in these specific cases. The crime can be prosecuted only if it is prohibited in the country of origin, while there is no way for the Spanish authorities to get custody of the minor. Secondly, the growing presence of forced marriages is of special concern. So far this practice is not considered a crime by the Penal Code. Catalan authorities have nevertheless implemented some policies in this respect since forced marriage is recognised as a type of gender-based violence in the regional law against sexist violence. These are pioneering practices in Spain.

Though the abovementioned challenges are remarkable, it deserves to be highlighted that the current economic and financial crisis along with the presence of a conservative political party in office is having a deep impact on the Spanish welfare state from several points of view. On the one hand, the national government has applied several huge budget cuts aimed at key services, namely healthcare, education, social assistance, economic assistance to dependant people (handicapped people, the elderly, etc.). This means that the Spanish regions will have a much more limited budget to manage all of these services, and accordingly to implement FGM policies as well. This budget cuts have been used as an alibi to undermine immigrants’ rights. Since the 1990s, all the people living in Spain had access to key public services (education, health, social services, etc.) regardless of their legal status. The sole condition was to be registered in the Padrón (the local register of population). Currently, however, the national government has modified the legal framework in order to establish that full healthcare services will not be available to foreigners who are not registered as residents (\(i\)). The sole exceptions are minors, emergencies and pregnant women. Support for minors will help to maintain the existing services targeted at FGM cases. This legal reform may nevertheless have some indirect negative consequences, such as dissuading...
VII. POLICY LESSONS AND RECOMMENDATIONS

These are the main policy lessons and recommendations stemming mainly from the Catalan experience.

- Interdepartmental and multilevel approach: Respondents agree on the fact that FGM practices can only be tackled by adopting an interdepartmental and coordinated approach. The complexity of the phenomenon determines the need for the work and the expertise of a wide variety of professionals. This is especially so when a comprehensive approach is applied. For instance, when several Ps of the model are to be addressed, as happens in Catalonia. Indeed, in this region the ‘problem’ of FGM practices has been defined in a broad manner. It is thought to be not just a problem of ‘security’, but also a matter of health, the protection of minors, gender equality, the integration of immigrants and so on. This complex definition goes as expected with a complex policy approach based on coordinating key elements such as institutions, norms and protocols. Additionally, the multilevel perspective of the Catalan approach is also considered to be of added value. Thus, respondents point out that the work of the professionals on the ‘front line’ is essential. Due to this, local networks specialising in FGM cases are strongly recommended. The Catalan approach is thus considered as a good practice to be transferred to the other Spanish regions.

- Respectful work with immigrant communities: It is interesting to note that most respondents point to the work with immigrant communities as one of the main achievements of the Catalan policies. The partnership between public institutions and CSOs is understood to be crucial to work in a preventive manner. First, the contribution of immigrants’ organisations facilitates the creation of networks with immigrant communities, while helping to successfully carry out awareness-raising and information campaigns. Second, this partnership gives the communities a major role in the eradication of their own harmful traditions. In line with this, respondents recommend that a respectful approach be adopted and the communities be given the opportunity to lead this process of change. In the words of one respondent, ‘We understand that the only way to deactivate this practice, the least harmful way, is by giving information, by offering other models, by explaining the negative consequences … Many times it is a matter of giving the communities the possibility to work on their own. We only give our support … In this sense, prevention is our main way of intervening.’

- Work with the countries of origin: In line with this, work in the countries of origin is thought to be crucial as well. Respondents describe FGM eradication as a long-term goal which can be only achieved by working in collaboration with the countries of origin. International cooperation is strongly recommended here. In this respect, the GIPE’s circular approach is of particular interest. It is based on working both in Spain and in The Gambia, while favouring feedback processes. The respondents from the GIPE pointed out specific examples of the benefits of a circular approach. For instance, the letter of commitment of the Catalan Health Institute has been used by Gambian families when they visit their countries. It has helped them to convince their families not to practise FGM.

- Communication with society at large: Respondents warn that the provision of information relating to FGM policies and practices is quite problematic. First, information must be transmitted in a very careful way in order to avoid a two-fold risk: that society would stigmatise some groups or that immigrant communities would become more closed. In this regard, some respondents point to the need to develop a tailored communication strategy aimed at raising concern on the topic, though without triggering social alarm or xenophobic responses.

- The anthropological approach: With regard to the GIPE, a specific proposal for intervention is recommended. Ethnographic research has been carried out in order to design a methodology to provide an alternative to the practice of FGM. The proposal is called ‘Initiation without mutilation’. As explained by one respondent, ‘This is an anthropological proposal. It was done in the framework of an ethnographic study. An anthropologist reviewed all the stages of this ritual and proposed to keep the ritual but without the physical part. Thanks to this proposal we have been able to work in The Gambia. With the previous approach based on “Stop mutilation” posters or on the rituals centred on throwing the knives away, prevalence data had not decreased … This is a very different vision. The social and cultural aspects remain the same but the physical part is avoided.’ They recommend working with this methodology both in Spain and in the countries of origin.

In line with these lessons and recommendations, and taking into account the situation described in this report, the following are the main lines of work to be strengthened in Spain.

- Prevention: Prevention activities are only available in a small part of the territory. The national prevention policies feature quite a comprehensive and structural approach based on considering that gender-based violence is rooted in the presence of structural gender inequalities. However, these activities focus only on intra-partnership violence. Their expansion to address other types of practices, namely FGM, would have a very positive impact, both in terms of coverage (nationwide) and in terms of approach (gendered). The Catalan example should not be disregarded. The approach based on building alliances between the institutional actors and immigrant communities has proved to be effective, yet it is still to be adopted by the other regions in order to guarantee that preventive actions are available in the whole territory and in the different levels of government.

- Protection: The presence of a national legal framework concerning protection measures allows a case of FGM (risk or excised) to be dealt with effectively in the whole
VIII. POTENTIAL GOOD PRACTICES

This section will address those practices that have been repeatedly flagged by the respondents as good practices with the potential to be transferred to other territories. The assessment of these practices in relation to the evaluation criteria will nevertheless be based on the researcher’s reflections.

The ‘Catalan protocol to prevent FGM’

The Catalan protocol was consensually recognised as a good practice and an example of a successful approach to eradicating FGM. As noted in the previous sections, the protocol is a specific tool that was designed in 2002 to deal with FGM cases. It includes a wide variety of professionals and their corresponding departments. The main goal is to establish the steps to be taken by each actor in each type of case (non-urgent, urgent and mutilated). Thus, the protocol specifies key elements such as the type of intervention, the professional in charge, the indicators of risk, etc. In terms of the ‘five Ps’ approach, it could be argued that with the exception of prevalence all the types of intervention are to some extent covered. The ‘five Ps’ are addressed as follows.

- Prevention: Awareness-raising and educational activities targeted at professionals and at immigrant communities.
- Protection: Urgent measures to protect girls who are at risk or who have been excised (procedures, actors in charge, etc.).
- Prosecution: Procedures to report the situation of risk or the performance of FGM to a public prosecutor or a judge.
- Provision of services: Procedures to move delegate cases to the corresponding public services (healthcare, protection of minors, etc.).
- Partnership: Interdepartmental coordination and collaboration with immigrants’ associations.

In addition to these elements, the protocol can be considered good practice with potential due to the following evaluation criteria.

- Sustainability: The protocol is based on interdepartmental cooperation. It has thus worked thanks to the resources and the expertise of very different policy areas. Indeed
it has never had a specific budget. As long as all the departments remain concerned about FGM, the sustainability of the protocol is ensured.

- Impact: An evaluation of the protocol has not been undertaken yet. Still, it can be argued that some elements point to a remarkable impact of this tool. First, this research has shown the extent to which some departments of the Catalan government have developed specific policies to deal with FGM cases. That is, the respondents emphasise how the computer programmes or the training activities have been adapted to tackle this type of violence. Second, the work of the actors that take part in the protocol has contributed to place the issue of FGM on the policy agenda. New norms approved in Catalonia in fact rely on this text to include FGM practices.

- Effectiveness: The protocol has proved to be effective in modifying the previous models of intervention. That is, for instance, the model to assist child mistreatment and mistreatment has been adapted to include the specificities of FGM cases, such as the assessment or the indicators of risk.

- Transferability: With the exception of the police services, all the Spanish regions have the same set of services/areas included in the Catalan protocol. Therefore, this tool can easily be transferred to other territories.

- Learning: The Catalan protocol has led to the creation of two innovative tools that could be worth transferring to other territories. The interdepartmental commission has been crucial for the correct implementation of the protocol as well as for its updating. In addition, the letter of commitment has proved to be a very useful tool to deal with families and to detect situations of risk. The government of Aragon has in fact copied both elements in order to implement its regional protocol.

The local networks on FGM

Most of the interviewees emphasise that local networks on FGM are one of the most promising practices in Catalonia. They started to be set up 2006 after an evaluation of the regional protocol. Their creation stems from the fact that the protocol itself had not been able to effectively embrace all the professionals dealing with key areas. As a result, prevention and protection measures were not as successful as expected. The local networks aim at reproducing the regional approach based on interdepartmental cooperation and a proactive perspective. They embrace a wide set of professionals, professionals who have direct and permanent contact with the target group (teachers, paediatricians, etc.). The aim is for these actors to easily detect situations of risk, to follow up each case and, more importantly, to work with immigrant communities on awareness-raising activities. The structures proved to be effective and currently there are up to 70 local networks in Catalonia.

The local networks on FGM can be considered relevant in relation to the following evaluation criteria.

- Sustainability: In line with the regional protocol, the local networks do not have a specific budget. In case all policy areas and the local government agree to be involved, the network can be sustainable. Additionally, the Immigration Department is in charge of supporting these structures and guiding their work.

- Impact: No evaluation has been carried out so far. However, the respondents make clear that the work at local level has long proved to be necessary for the effective implementation of the protocol. Specifically, the local networks have contributed to having more accurate data relevant for FGM estimates as well as to undertaking a closer follow-up of the cases of girls at risk. The main goal is to intervene in a preventive manner and to increase concern regarding the negative effects of FGM.

- Transferability: The professionals involved in the local networks are present in all Spanish municipalities, with the exception of unpopulated areas. This means that these structures can easily be transferred to other towns and cities. The experience in Catalonia has been quite successful in this respect, with 70 networks created in 6 years.

- Learning: The work of the networks provides two specific tools that can be transferred to other territories. On the one hand, their interdepartmental character and the involvement of CSOs are of special interest, since they allows FGM to be addressed in a comprehensive manner. On the other hand, the local register of cases is quite an innovative experience. It allows the situation of each girl to be individually monitored, though some concerns on privacy and stigmatisation might arise.

The Catalan legal framework on FGM: gender violence and protection of minors

Despite the consolidation of the protocol as the main tool to fight FGM in Catalonia, most interviewees report on the new legal framework as a turning point. The law on sexist violence and the law concerning the protection of minors are depicted as promising mechanisms to foster work on FGM cases, especially with regard to the protection of girls at risk and the provision of services. Law 5/2008 on the right of women to eradicate sexist violence in Catalonia was passed in 2008. It included FGM as a type of gender-based violence (Article 5), meaning that all the rights (protection, specialised attention, economic subsidies, etc.) and services (shelters, services for recovery, etc.) included in this norm are also available for girls who might suffer or who have suffered FGM. Law 14/2010 on rights and opportunities during childhood and adolescence in Catalonia is one of the first regional norms concerning the protection of minors that includes specific measures to combat FGM. It states that actions must be undertaken to prevent FGM, to assist a girl who is at risk or to prosecute the offenders when FGM has already been performed. It therefore makes some of the main elements of the protocol compulsory, such as the need to create indicators or to report cases. Furthermore, it allows work on assistance for girls who have been mutilated in a very different way, since it recognises their right to full recovery (physical, psychological and social).

This new legal framework can be considered good practice according to the following evaluation criteria.

- Impact: With regard to FGM, both norms rely on the approach of the Catalan protocol to prevent FGM. Therefore they contribute to making some of its elements (procedures, actors to be involved, definition of FGM, etc.) compulsory. This shift is understood to contribute to the more effective implementation of this tool. Moreover, these norms guarantee a broad set
of rights and services for the victims of gender-based violence and child mistreatment respectively. All of them will thus be available to girls at risk or that have been excised. These provisions have helped professionals to provide a wider set of services (counselling, shelters, social assistance, etc.) and to work towards the full recovery of the woman/girl. For instance, the law on the protection of minors has allowed the reconstruction of genitalia to be worked on for the very first time in Spain.

• Effectiveness: It is too soon to assess the effectiveness of both laws. However, professionals dealing with FGM cases do emphasise that the new legislative framework has hitherto been a powerful tool to enlarge the provision of services, to guarantee a proper level of protection and to broaden the intervention approach by working also on the full recovery (physical, psychological, social).

• Relevance: The new norms along with the regional protocol contributed to the definition of the problem of FGM in a very broad manner. The former approach based on the intervention of several professionals/areas already addressed FGM as an issue of health, security, immigration, education, etc. Nevertheless, the inclusion of this practice in the gender-based violence law means that gender inequality is starting to be considered as part of the definition of the problem too. Accordingly, gender equality policies are to be understood as part of the solution. Since the approval of this norm, in fact, the regional equality body has been increasingly involved in FGM policies. It is currently leading the National Commission for Coordinated Intervention against Gender Violence in which the Working Group on FGM is included. With regard to child protection legislation, these new provisions mean the inclusion of a gender perspective in a policy area that has traditionally been gender blind.

• Transferability: With regard to Spain, the Catalan legal framework can easily be transferred to other regions. What is more, the national legal framework will certainly be improved if it embraces other types of gender-based violence. This shift will allow all the resources targeted at eradicating intra-partnership violence to be available to tackle FGM cases as well. In addition, policies will be evenly developed in the whole territory, guaranteeing that women suffering FGM will be properly assisted regardless of their region of origin.

• Learning: The two-fold approach based on considering FGM as a type of gender violence and a type of gendered child mistreatment can be of added value. It allows gender inequality to be transversally included as one of the main roots of FGM practices.

The national level has been crucial for the improvement of the legal framework. First, the Penal Code was amended to include an explicit reference to FGM as type of serious offence. Given that FGM tended to be performed in the countries of origin, the Spanish parliament also reformed the law on the judiciary in 2005. From then onwards, this practice can be prosecuted abroad in accordance with the principle of extraterritoriality. Second, the asylum law was reformed in order to include persecution based on gender issues as a motivation to apply for refugee status.

This legislative framework has thus had a positive impact in terms of prosecution and protection. However, policies addressing other types of approaches (provision of services, prevention, etc.) have been vastly disregarded at the national level. Policies related to gender-based violence have been notably developed in the last decade. Many specialised resources are currently available to tackle this kind of violence as well as to assist the victims. Interestingly, the definition of gender-based violence in the national legal framework is quite narrow. Although it depicts gender-based violence as a multifaceted phenomenon rooted in structural gender inequalities, it focuses only on intra-partnership violence. FGM is thus not referred to. This narrow concept means that all the rights and the resources mentioned in the norm will not be available for women/girls suffering FGM. Rather, subsidiary resources targeted at the victims of violence and sexual crimes will be provided to women at risk or excised.

The Spanish regions have nevertheless played a pioneering role in mitigating this lack of involvement of the national institutions. The regional level in fact has competences concerning remarkable issues such as health, education, gender equality, social services, etc. Furthermore, some regions like Catalonia have their own police services (Mossos d’Esquadra). In response to these legislative and administrative capacities, some autonomous communities started to develop FGM policies, especially those regions in which the population coming from the countries in which FGM is practised is concentrated (Catalonia, Aragon, the Balearic Islands and Navarre). Generally speaking, the main strategy has been to approve legislation on gender-based violence, including FGM practices, to commission training activities targeted at key regional professionals and, in some cases, to approve a specific protocol to deal with FGM. All of these actions have to some extent improved the interventions relating to protection and the provision of services.

The case of Catalonia is of special interest. This region has undertaken pioneering policies since the 2000s. In response to the detection of some FGM cases at the end of the 1990s, several professionals started to work on a specific protocol. This protocol was published in 2002, representing a clear milestone for FGM policies in the Spanish context. From that moment on, a wide variety of professionals have worked in a coordinated manner in order to guarantee harmonised intervention. Besides, the idea has been for the protocol to embrace not only protection or prosecution measures, but also to put the emphasis on prevention, partnership, provision of services and, more recently, on data relevant for prevalence estimates. This comprehensive

IX. FINAL CONSIDERATIONS AND RECOMMENDATIONS

With regard to FGM policies, the Spanish complex territorial model determines that competences concerning key issues are either shared (health, education, gender equality, etc.) or national (asylum, penal code, extraterritorial prosecution) or regional (police services in Catalonia). To analyse FGM policies is therefore necessary to take into account both levels of government as well as the area of intervention at stake.
approach has had an impact on the most recent actions to eradicate FGM. First, the creation of several local networks on FGM draws on the preventive and interdepartmental approach of the regional protocol. These structures seek in fact to deepen the protection of minors, gather data and improve work with immigrant communities. Second, the new laws on gender-based violence and the protection of minors contribute to incorporating some of the main elements of the protocol in a binding norm. Interestingly, they also include new relevant provisions such as the right to a full recovery.

In spite of the Catalan comprehensive approach, FGM policies are far from being developed equally in the whole territory. This fragmented landscape might entail women not receiving equal access to key services and, more importantly, to specialised resources (for instance access to trained professionals). A nationwide intervention is therefore strongly recommended.

Nevertheless, it deserves to be highlighted that the current economic and financial crisis along with the presence of a conservative political party in office is having a deep impact on the Spanish welfare state. Thus, the national government has applied several huge budget cuts aimed at key services, namely healthcare, education, social assistance and economic assistance to dependant people (handicapped people, the elderly, etc.). This means that the Spanish regions will have a much more limited budget to manage all of these services, and accordingly to implement FGM policies as well. These budget cuts have also been used as an excuse to undermine immigrants’ rights. The national government has for instance modified the legal framework in order to establish that full healthcare services will not be available to foreigners who are not registered as residents.

To sum up, Spain features some promising practices at the regional level. The current political and economic situation, however, invites us to continue exploring the implementation of these practices and to make sure that the increasing disappearance of the welfare state in this country does not affect FGM policies.

References

Country report: Sweden

1. IDENTIFICATION

Country: Sweden
Researcher: Sara Johnsdotter

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

I searched the academic databases (Social Science Research Network, Sociological Abstracts, Web of Knowledge/Web of Science, PubMed, Heinonline, Scopus, EBSCO, JSTOR and also the database on UN Violence against Women and Google Scholar) and talked to experts that would know if such studies existed. From working with this issue for many years, I know there is no central body collecting data on prevalence. To make absolutely sure, I discussed the issue with a respondent at the National Board of Health and Welfare. If such prevalence studies were in fact going on, he would know, being the principal responsible person in Sweden at a governmental level.

The only prevalence data existing are the studies published by Kangoum et al. (2004), Elgaali et al. (2005) and Tamaddon et al. (2006).

There is also my own survey from October 2010: my archive of police reports and investigations. This collection of data was made through calls to all 21 police districts, since there is no way to aggregate these data at a national level.

There is no central register within the healthcare system. According to the chief physician at Uppsala University Hospital, FGM expert and senior lecturer in International Maternal Health at Uppsala University, no effort to collect data has been made at a national level due to poor quality of the data (see below).

When it comes to asylum seekers, there is no central register, according to information given by the Board of Migration.

2.2. Nature of prevalence studies/FGM registration systems

Kangoum et al. on the prevalence among African women in the county of Östergötland is the only prevalence study published, besides the Tamaddon et al. study published in 2006. There is also the Elgaali et al. (2005) study, which I think is problematic to include as a serious contribution to prevalence estimates.

The study by Kangoum et al. was conducted by a physician and co-workers and published in the academic field. The Tamaddon et al. study published in 2006 was a quantitative study targeting healthcare professionals and published in the academic field.

Healthcare professionals register FGM in medical records (in schools, at delivery wards, etc.). There has been no known attempt to collect all this data to get an overview.

A limitation of this healthcare medical record registration is that ‘FGM’ is a broad concept, so a note about that in the record says little about the type. Few healthcare professionals know how to distinguish between different kinds of FGM and even experts have difficulties assessing what has been done and what is a normal variation.

- The Swedish medical birth register: At delivery, the status of the genitals of the birth-giving mother is recorded. It would be possible to aggregate all the data at a national level, but nobody has done it so far. The quality of the data would be too poor. Data is difficult to interpret, since there are no uniform diagnosis codes for the different types of FGM.
- The Swedish patient register: registration of in-patients. This register would record patients that seek help for medical complications after FGM. It would be possible to look at the data at a national level, but it has not been done so far. Again, the quality of the data would be too poor.
- Child health services records: there are records for all children, but there is no way to look at the data at a central level since the quality is too poor. In addition, there is no compulsory screening for FGM (even though we may expect the child health services to deal with this issue in many regions).
- School health record system: Medical records exist, but there is no central database. Status regarding FGM may be recorded if the school nurse/physician has added it (which is often the case in areas with large immigrant populations), but there is no nationwide requirement to do so.

The limitation of my study ‘Female circumcision/FGM in Sweden — A knowledge and research review’ with cases of suspected FGM (police reports and investigations) is that many of these cases were not ‘real’ cases. The number of ‘cases’ thus has little to say about actual prevalence.
2.3. Findings from the prevalence studies/registration systems

- Number of girls at risk of FGM in your country from African countries or of African origin

Not known by anybody, since nobody has defined the criteria for ‘at risk’. What is possible is to give a rough number of girls born to mothers from countries where FGM is practised.

- Number of unregistered female migrants in your country from African countries or of African origin

Not known. They are unregistered, so there is no register to look for figures like that.

- Number of women seeking asylum on grounds of FGM in your country from African countries or of African origin

The only information I have found is: ‘Number of cases where asylum was granted [because of fear of FGM] up to now [2002]: 39 (11 male applicants out of these, since they were part of concerned families)’, on page 9 of the document ‘Praxisgenomgänge: Förföljelse på grund av sexuell läggning — grunder för uppehållstillstånd’ [Scrutiny of practices: Persecution on the grounds of sexual orientation], by the Migration Board. According to information from the National Migration Board there is no central register that aggregates all these data.

Number of asylum seekers in Sweden 1984–2010:

From Somalia 36 766 (about half of them can be expected to be women).

From Ethiopia 10 574 (about half of them can be expected to be women).


Number of granted permission to stay as refugees 1980–2010:

From Somalia: 25 996 (about half of them can be expected to be women).

From Eritrea 4 998 (about half of them can be expected to be women).

From Ethiopia 10 266 (about half of them can be expected to be women).

All African countries: 50 550 (about half of them can be expected to be women).


Some of the immigrants from these countries obtain permission to stay for family reunification reasons rather than for asylum.

Source: The Migration Board (http://www.migrationsverket.se/download/18.46b604a812bcdd7a80008288/Beviljade+uppeh%C3%A4llstillstånd+C3%A5nd+och+registrerade+uppeh%C3%A4llstillstånd+C3%A4tter+2010.pdf).

- Number of refugee women in your country from African countries or of African origin

No information.

- Number of women in your country from African countries or of African origin that address healthcare or are treated by health professionals for any health issue related to FGM

Not known. There is no aggregation of data from medical journals at a national level.

- Number of FGM cases in your country that are registered in any registration system by services: health services, social services, police, asylum agency, etc.

Not known. There is no central registration points that can yield that kind of data.

2.4. Reflection on prevalence studies

- Are there any national studies that have been done that are representative and have reliable data? If there is no information, or very little, please reflect on the reasons why.

No such studies. The act of FGM is a criminal act and therefore not easily investigated.

Already-circumcised women may have the state of their genitals recorded in medical records but so far no one has tried to aggregate the data in these registers.

- Is there an evolution in the number and nature of the studies over the years?

No. There is a general lack of studies with this focus, probably because the quality of the data that could be aggregated is too poor.

- Please reflect on the methodologies used in the prevalence studies, using the following criteria: accessibility of data, relevance of data, accuracy and reliability, comparability, coherence of data. Are there any issues regarding confidentiality of the data, regarding quality management, timeliness and punctuality? Any considerations regarding costs?
There is, to the best of my knowledge, no attempt to aggregate existing data to get an overview at the national level. The few prevalence studies that have been conducted are very limited and of restricted reliability.

I see a general difficulty in the confusion between prevalence and incidence (the number of European African girls and women who are circumcised versus the number of European African girls and women who are being circumcised, that is, illegally). The first category is, in some obscure way, often used to suggest figures for the second category.

If prevalence is the focus of investigation in Sweden in the future, some measures are needed to collect reliable data; a more systematic system to record the status of the genitals in medical records at hospitals, maternity clinics, in school and other sectors where FGM may be of relevance. This would necessitate a national decree where professionals are required to record this information, and it would also involve better education of professionals (for instance, to know something about different types of FGM). The requirement to record this kind of data would not be costly, however the education of professionals would be.

- Are prevalence data collected at national level by any agency in your country, and if not, is such a data collection necessary and feasible?

**Police**

There is one study with existing police reports involving cases of suspected FGM (‘Female circumcision/FGM in Sweden — A knowledge and research review’). This study shows that it is hard to say what is in reality a ‘case of FGM’.

**Social services**

Cases concerning girls at risk of FGM may exist, but there are ethical issues that prevent such a register ever being created.

**Asylum**

The Board of Migration could possibly create a register of asylum cases involving FGM, but no such register exists today. What would be needed is a political decision to register such cases.

**Healthcare**

The existing data is of poor quality (limited reliability and often not distinguishing between the various types of FGM). A political decision to start recording these data more systematically would require better knowledge among professionals. Even in that case it would be hard to obtain reliable data.

2. Gynaecological examinations for classification: Gynaecological examinations are subjective too. Classifications may vary between doctors (interindividual assessment), but also one doctor may draw different conclusions at different points in time (intraindividual assessment). This phenomenon is well documented in other fields, e.g. in radiology and CTG interpretation. In addition, normal female genital anatomy comes in so many varying forms even when no cutting has taken place. This makes it difficult to say what normal genitals look like — and even harder to say what has been removed once the tissue has healed.

Thus, it may never be possible to obtain reliable data on prevalence.

There is the political will in Sweden to take the issue of prevalence (and probably incidence) seriously, the principal person responsible for FGM at the National Board of Health and Welfare (personal communication during this study).

3. **POLICY FRAMEWORK**

3.1. **Methodological approach for collecting documents on policies**

My POL sheet builds primarily on searches in the parliamentary archive. In there all the political initiatives to deal with the FGM issue. In addition, all the sources mentioned in the ‘Guidelines for national data collection’ were searched. The search words in Swedish were kvinnlig omskärelse, kvinnlig könsstympning, könsstympning av kvinnor, könsstympning av flickor and omskärelse av flickor.

The websites of the following governmental bodies were checked for information on relevant policies:

- Regeringen (the government)
- Riksdagen (the parliament)
- Socialstyrelsen (the National Board of Health and Welfare)
- Migrationsverket (the Migration Board)
- Folkhälsoinstitutet (the Institute of Public Health)
- Diskrimineringsombudsmannen (the Ombudsman Against Discrimination)
- Allmänna arvsfonden (the Swedish Inheritance Fund)
- Nationellt centrum för kvinnofrid (National Centre for Knowledge on Men’s Violence Against Women)
- Justitieombudsmannen (the Parliamentary Ombudsman).

The websites of the following NGOs were searched for any policy-related documents:

- RISK (National Association for Ending Female Genital Mutilation (FGM))
- Female Integrity
- Kvinnororum (Foundation Forum for Women)
- Amnesty (Sweden)
- Rädda Barnen (Save the Children Sweden)
- RFSU (National Association for Information on Sexuality).

3.2. **Policies on FGM**

The search in the parliamentary archive took quite some time. The number of hits in this archive is summarised (there may be overlapping) below.
In total:
[female circumcision]: 674 hits
(genital mutilation): No number given, since there are more than 1 000 hits

1980–89
[female circumcision]: 26 hits
(genital mutilation): 3

1990–99
[female circumcision]: 89 hits
(genital mutilation): 113 hits

2000–09
[female circumcision]: 175 hits
(genital mutilation): 993 hits

2010–12
[female circumcision]: 36 hits
(genital mutilation): 60 hits

Policies began in the late 1970s. Mass-media articles claimed that FGM was going on in Sweden (1979) and there was a general request for specific legislation to ban FGM. In 1982 the Ministry of Justice produced a government proposition on a new law ‘Government Proposition 1981/82:172 ‘Prohibition of circumcision of women’. It came into force in 1982 (Act 1982:316 prohibiting the genital mutilation of women).

At the beginning of the 1990s the Somalis start arriving in Sweden (until then there were only Eritreans and Ethiopians with milder forms of FGM in Sweden). Many professionals who encountered women with type III FGM started asking for more information and also political measures to combat the practice. Hence the sudden activity from the parliament in the mid-1990s.

In 1993–99 the Gothenburg Project was conducted in Gothenburg and served as a national government-appointed group for dissemination of knowledge and best practices (the Gothenburg Project (Phase I): Health-promoting measures for women and children: FGM and the Gothenburg Project (Phase II)). In 1999 the removal of the principle of double criminality (Government Proposition 1998/99:70 ‘Genital mutilation: Removal of the principle of double criminality’), was suggested in Act 1982:316 prohibiting the genital mutilation of women.

From 1998 onwards the National Board of Health and Welfare had responsibility for measures taken and was the national centre of knowledge building (Government Proposition 2000/01: ‘Draft budget for 2001’). In 2001 public opinion was also stirred up because of a nationally aired television documentary, The Forgotten girls (produced by Sveriges Television). This film was also discussed in parliament.

In 2002 the National Board of Health and Welfare issued a publication with guidelines for various professional groups (‘Female genital mutilation: A guide for schools, social services and the healthcare sector’). It was during this year and the following years that the issue of FGM was spread to many sectors in society, so that the issue became discernible in policy documents from other governmental bodies than the Ministry of Justice and the Ministry of Health and Welfare.

In 2003 the first discussions about asylum on the grounds of FGM were raised. It was also the year when the government launched the plan of action on FGM and the year when the major national/international conference on FGM took place, organised by the government.

In the mid-2000s the issue of asylum got more and more attention with questions in parliament regarding how well women at risk of FGM were protected through asylum. The National Board of Health and Welfare was given more funding to cover their ongoing work against FGM. In 2005 the National Board of Health and Welfare succeeded in having four prominent religious leaders in Sweden sign a document banning all forms of FGM.

Some laws were changed to facilitate taking FGM cases to court, such as the secrecy act and legislation on the period of limitation. In 2009 Nordic cooperation at governmental level was intensified: Nordic cooperation aimed at protecting girls in the Nordic countries from FGM was suggested and approved of in the Nordic Council of Ministers. It was established that FGM is illegal in all Nordic countries and that there is a duty to report to and for authorities in all countries. The Nordic Council of Ministers decided to take a closer look at the issue of FGM and work towards measures that prevent girls in the Nordic countries from being subjected to FGM (see the account from the Swedish delegation of the Nordic Council about its activities during 2008).

3.3. Reflection on policies on female genital mutilation

• Is there a trend in policy development by national authorities? When did it start, by whom and how did it change over time (different authorities involved, more policies developed, did the content of policies change over time?)?

In the 1990s the official policies on FGM were to a great extent localised in Gothenburg. In subsequent years, and since then, the National Board of Health and Welfare has been the most important actor. The government and several ministries have been active through the years in implementing policies against FGM through funding for preventive work and through changes in legislation. NGOs (primarily RISK) have been active participants in preventive work, but it was the sudden influx of African immigrant women affected by FGM in the 1990s that spurred the government initiatives.

• An assessment of the coherence and comprehensiveness of the policies put in place

There have been policies and political activities going on for three decades now, although it is possible to discern that the issue has been more intensely discussed at certain points in time: at the beginning of the 1990s, when the Somalis arrived in Sweden; in 2001 and the subsequent
years as a result of the televised documentary; and after 2006 when two cases of FGM were taken to court.

• Would you have any suggestions for future policy measures that need to be developed, existing gaps that need to be covered or any recommendations for enhancing existing measures?

I would suggest that future policies involve the concerned immigrant groups to a higher extent than is the case today. For instance, there is a second wave of Somali immigrants in Sweden now. Large groups of newcomers who are unfamiliar with the position taken by Swedish society on FGM would benefit from receiving culturally sensitive information about Swedish legislation and the position of their well-integrated countrymen. Well-established Somalis should be the ones having a key role in preventive work.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

Information on legislation gathered in an earlier project was checked for recent changes. Additions were made concerning asylum legislation and the period of limitation. Through the survey of the parliamentary archive it was possible to trace all legal changes, since they are discussed in the parliament. The parliament also has a database with current legislation easily accessible.

4.2. Criminal law

• Specific legislation (Act 1982:316 prohibiting the genital mutilation of women).

Section 1: Operations on the external female genital organs which are designed to mutilate them or produce other permanent changes in them (genital mutilation) must not take place, regardless of whether consent to this operation has or has not been given.

Section 2: Anyone contravening Section 1 will be sent to prison for a maximum of 4 years. If the crime has resulted in danger to life or serious illness or has in some other way involved particularly reckless behaviour, it is to be regarded as serious. The punishment for a serious crime is prison for a minimum of 2 and a maximum of 10 years. Attempts, preparations, conspiracy and failure to report crimes are treated as criminal liability in accordance with Section 23 of the Penal Code.

Sweden has had legislation against female circumcision since 1982. In 1998 the law was revised, with a change in terminology, from ‘female circumcision’ to ‘female genital mutilation’, and more severe penalties were imposed. The law was further reformulated in 1999 to allow the prosecution in a Swedish court of someone carrying out female genital mutilation even if the act was performed in a country where it is not a criminal act.

FGM court cases

Since 1982 two cases have ended up in court, both in 2006. Since then no cases have been taken to court.

I. Malmö, 2006

A 16-year-old girl tells her school welfare officer that she has been physically abused by her mother for several years, her mother using various objects during the beating of her daughter. She also says her mother had her subjected to FGM when she was 11, during a trip to her mother’s home country Somalia in 2001. Now she fears for her life, since her mother has tried to hit her with a frying pan while she was asleep. Her sister had stopped their mother. She also says that her mother has repeatedly checked her genitals trying to find out if she had had sexual intercourse. Certificates from experts in forensic medicine supported that she has been circumcised (type II) and physically abused. Additionally, records show that during the years the girl’s mother reported to the police six times that her children had been raped.

During the police investigation and court proceedings the girl claims that her two sisters (in 2001 aged 12 and 7) were also circumcised on the same occasion. Both these young girls were genitally examined by physicians when they were younger, in connection with the rape reports filed by their mother. These investigations from an earlier point in time showed that these girls had not been subjected to (any extensive form of) FGM and, thus, if circumcised now it must have been done in an unlawful way. Hence, if they had been genitally examined by forensic experts at a point in time subsequent to the trip to Somalia, circumcision could possibly have been proven in court. The police and prosecutor had the possibility to use the ‘Act on special representatives for children’ to take the girls to compulsory genital examinations against their mother’s will, in an effort to find evidence of circumcision. However, they refrained from that. A possible explanation could be that the girls during interrogations denied their sister’s allegations and defended their mother with fervour (this despite the fact that one of the sisters admitted that she was in fact circumcised). In any case, the court did not seem to doubt that all the girls were circumcised in Somalia in 2001. The formal charge, however, concerned only the first girl.

The woman, aged 43, was charged with FGM and serious violation of bodily integrity in regard to the girl, and she was sentenced to 3 years in prison.

Source: Police investigation and court verdict, 2008.

II. Gothenburg, 2006

A 14-year-old girl, born in Sweden but her parents being from Somalia, turns to the Swedish embassy in Addis Ababa. She has been living with her father and brother in Mogadishu since she was 10 years old, but now she has run away with a man. She says that her father has beaten her and abused her psychologically for years, that he has threatened her with a gun, that he has sent her to jail for some time, that he plans to marry her away by force, and that he has had her circumcised. Medical examination shows that the girl has been subjected to FGM, type II.
Section 1: The tasks of the municipal social welfare committee include the following:
- assuming responsibility for the provision of care and service, information, counselling, support and care, financial assistance and other assistance for families and individuals in need of the same.

Section 5: … When a measure affects a child, the child’s attitude shall be clarified as far as possible. Allowance shall be made for the child’s wishes, with regard to its age and maturity.

Chapter 5. Special provisions for various groups

Children and young persons

Section 1: The social welfare committee shall
- endeavour to ensure that children and young persons grow up in secure and good conditions,
- promote, in close cooperation with families, the comprehensive personal development and favourable physical and social development of children and young persons,
- be especially observant of the development of children and young persons, who have shown signs of developing in an unfavourable direction, ensure, in close cooperation with families, that children and young persons in danger of developing in an undesirable direction receive the protection and support which they need and, where justified by consideration of the young person’s best interests, care and upbringing away from home …’

[Selection of sections by the Swedish Board of Health and Welfare, 2002:44; translation by the Ministry of Health and Social Affairs, 2003a].

In a discussion about the Social Services Act in relation to the issue of FGM, the Swedish Board of Health and Welfare gives guidelines to officials in the social sector concerning actions and measures in a variety of situations: ‘If there is an impending risk that FGM is about to be performed’, ‘If the parents have a positive attitudes toward FGM’, ‘If there is a suspicion that FGM has been performed’, etc. (the Swedish Board of Health and Welfare, 2002:49f).

‘Chapter 14. Reporting of abuses

Section 1: Any person receiving information of a matter which can imply a need for the social welfare committee to intervene for the protection of a child should notify the committee accordingly.

Authorities whose activities affect children and young persons are duty bound, as are other authorities in healthcare, medical care and social services, to notify the social welfare committee immediately of any matter which comes to their knowledge and may imply a need for the social welfare committee to intervene for the protection of a child. The same applies to persons employed by such authorities. The same duty of notification also applies to persons active within professionally-conducted private services affecting children and young persons or any other professionally-conducted private services in health and
medical care or in the sphere of social services. Where couples counselling services are concerned, the provisions of subsection three shall apply instead.

It is the duty of persons employed in couples counselling to notify the social welfare committee immediately if in the course of their activity it comes to their knowledge that a child is being sexually abused or maltreated in the home.

It is the duty of public authorities, officials and professionally active persons as referred to in subsection two to furnish the social welfare committee with all particulars which may be material to an investigation of a child's need of protection.

The provisions of Section 3 of the Children's Ombudsman Act (1993:335) apply concerning reports by the Children's Ombudsman.'

Staff at schools and in children's day care, and ordinary citizens have a duty to report any suspicion of FGM to the social services. An official who fails reporting commits breach of duty and may be prosecuted. In the guidelines published by the Swedish Board of Health and Welfare, it is stressed that a citizen suspecting performed or future female circumcision has an obligation to report it: 'Note that it is not a matter for the person suspecting FGM to investigate "to know for sure" before reporting it' (the Swedish Board of Health and Welfare 2000:32.) It is possible for citizens to turn in a report anonymously.

In summary, all citizens have a duty to report knowledge of performed or fear of future FGM to the social services.

Care of Young Persons (Special Provisions) Act

‘Section 6: The social welfare committee may decide to immediately take someone under the age of 20 years into custody, if:
1. it is likely that the young person needs care under the auspices of this law, and
2. awaiting a court decision concerning care poses a danger to the young person's health or development, or because the investigation may be made seriously more difficult or further measures may be obstructed.

Social services have the opportunity to use compulsion

Social service interventions for children and young people must primarily be provided in voluntary form with the support of the Social Services Act. Only where this is not possible can the Care of Young Persons (Special Provisions) Act (LVU), be applied. LVU is a supplementary protective act which regulates the circumstances in which a young person can be taken into care or protected without his or her consent. LVU is used when the young person has a need for care or protection which cannot be met by means of voluntary solutions.

The social welfare committee does not only have the authority to intervene to protect a minor but also an obligation where the criteria set out in LVU are met. The application of LVU does not require that voluntary interventions have previously been attempted.

For LVU to be applied, three criteria must be met:
- a deficiency must exist in the young person's home environment (what are known as environment cases) or the young person's own behaviour (what are known as behavioural cases);
- the deficiencies must lead to there being a manifest risk of damage to the young person's health or development;
- the necessary care cannot be given by voluntary means.

In certain emergency situations the social welfare committee can immediately take a minor into care temporarily while awaiting a final decision on the care issue.

The aim of care under both the Social Services Act and LVU is for the minor to be able to return to his or her home or own accommodation. In other words, care is to be seen as a temporary measure.'

(The Swedish Board of Health and Welfare 2000:32.)

In their guidelines to different groups of professionals, the Swedish Board of Health and Welfare points out that the LVU can be used if there is a clear risk that a girl may be circumcised and there is no other way to protect her (2002:49).

When there is a suspicion that FGM has been performed, a genital examination by a physician is recommended by the Swedish Board of Health and Welfare, but such a procedure requires a cooperative attitude from the parents. An immediate intervention applying the LVU must not take place, if its only purpose is to have a genital examination performed (2002:49-50). If the parents do not allow a medical examination, a prosecutor may apply for a special representative for a child, in accordance with the law 1999:997 described below (Swedish Board of Health and Welfare 2002:50).

In summary, the LVU law, permitting the social services to take a young person into care using compulsion, can be applied when there is no other way of protecting a girl from pending circumcision.

‘Act on special representatives for children’

(Lag (1999:997) om särskild företrädare för barn)

‘Section 1: When there is reason to believe that a crime, the punishment for which can lead to a prison sentence, has been committed against someone who is younger than 18 years of age, a special representative for the child shall be appointed if:
1. a custodian is suspected of having committed the crime, or
2. it may be feared that a custodian, because of his or her relationship to the person suspected of having committed the crime, will not safeguard the rights of the child.

A special representative for a child is appointed by the prosecutor heading the police investigation. Such
a representative (lawyer) can allow a medical investigation of a child, even when the child’s parents refuse to grant permission for such an examination.’

In summary, this law enables genital examination by a physician, even if the child’s parents object to such an examination.

In Sweden there are no child protection provisions or laws that deal specifically with FGM. There is no data available on the number of child protection interventions regarding FGM. I discussed the issue with a key person at the National Board of Health and Welfare in 2008 (Mr Winnerljung, when doing the EU Daphne project in 2008) and he stated that the reasons for child protection interventions are not noted in any formal register (but are filed as court cases for instances). It is regarded as being highly ethically questionable to aggregate registers concerning ethnic background/country of birth with data on child protection interventions.

4.4. Asylum law(s)/provisions

The definition of a ‘refugee’, as provided in the law, is someone who:

‘is outside the country of the alien’s nationality, because he or she feels a well-founded fear of persecution on grounds of race, nationality, religious or political belief, or on grounds of gender, sexual orientation or other membership of a particular social group or because of his or her fear is unwilling, to avail himself or herself of the protection of that country.’

There are no specific asylum provisions dealing with FGM. There seem to have been quite a number of cases before 2008, where women/families were granted asylum on the grounds of FGM, then in connection to ‘torture’. In 2008 the Board of Migration went public stating that FGM was now a ground for asylum according to the phrasing in the law regarding persecution due to gender.

There is no national/central registration system for asylum cases related to FGM. A personal communication with an informant at the National Board of Migration confirmed that there are no central registers, and no public official has a total overview of the cases (which are handled by several officials).

4.5. Professional secrecy provision(s)

Professional secrecy is regulated by the ‘Public Access to Information and Secrecy Act’ which was updated in 2009.

Public Access to Information and Secrecy Act (2009:400)

Professionals in the social welfare sector and in the health sector are bound to observe secrecy in their work. Secrecy applies if disclosure of the information will presumably cause significant harm to the person to whom the information relates or to a person close to him.

Professionals working in the healthcare sector are obliged to report any suspicion of child abuse, or any knowledge that a child’s welfare is threatened, to the social services, according to the Social Services Act.

The social welfare committee is usually prevented (due to the secrecy provision) from reporting crime to the police, unless there are specific circumstances allowing such reporting. In 2006 the law was reformulated with special regard to FGM: when suspicions arise concerning a minor having been subjected to FGM, the case can be reported regardless of the type of procedure (i.e. also very ‘mild’ types that may give short or perhaps no time in prison can be reported). See Public Access to Information and Secrecy Act (2009:400) — Observations.

If the social services suspect that FGM has been performed, they can open an investigation and decide to report the case to the police (‘A report to the police shall be done without a standpoint regarding guilt from the social welfare committee: it is not up to the committee to take a stand and investigate this’, 2002:50).

There is no absolute obligation for social services to report serious crimes to the police authorities. In case of a crime involving a child, ‘the social welfare committee shall consider if it is appropriate to make a police report, based on what is regarded as the best interests of the child’ (the Swedish Board of Health and Welfare, 2002:50). However, when it comes to suspicion of FGM, reporting to the police seems to be the procedure recommended by most local social welfare offices.

There is no nationwide or central system for the reporting of suspected FGM cases by professionals.

4.6. Reflection on legal framework

Sweden was the first western country to introduce legislation against FGM in 1982 (Act 1982:316 prohibiting the genital mutilation of women), yet no cases were taken to court before 2006. In public discourse it has been argued that the lack of court cases on FGM has been a problem. Consequently, the general tendency in recent years has been that other legislation has been introduced or changed in order to facilitate the taking of FGM cases to court. This includes the removal of the principle of double criminality (change of paragraph 3 in 1999), the introduction of the ‘Act on special representatives for children’ (which was the result of a failed suspected FGM investigation in Gothenburg 1995), the change of the legislation on secrecy where FGM is now explicitly mentioned as an exception so that suspected cases can always be reported (Public Access to Information and Secrecy Act (2009:400)), the extension of the period of limitation regarding FGM crimes (amendment to the Penal Code, Chapter 35, Section 4 (Period of limitation for FGM crimes)), etc.

There is the legal possibility to take young girls into custody if the child is at risk of having to go through FGM (Care of Young Persons (Special Provisions) Act (1990:52), but up until today there have been no known cases where the law has been applied for this reason. It cannot be precluded
that there are cases, however there is no central register where this kind of data can be accessed. Such a register is considered to be ethically questionable.

A compulsory genital examination in Uppsala in 2005 resulted in a court case where the municipality of Uppsala had to pay damages to the girl and her parents for discrimination. More cases of compulsory genital examination (none of them proving FGM) are being processed by the governmental body Diskrimineringsombudsmannen (the Ombudsman against Discrimination).

It is hard to say whether the novel phrasing of FGM as a ground for asylum in 2008 (see Section 4.4.) has led to an increase in cases where more women/families are granted asylum for FGM, since there is no register where this kind of data is collected.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

Since I have been researching the field of FGM since the late 1990s, I knew beforehand who the actors are. I contacted a few of them to discuss some of the issues of this project, but basically I had the picture and any gaps were filled during the systematic research conducted according to the ‘Guidelines for national data collection’ provided by the core team.

5.2. Actors

In the ‘Actors’ sheet I have listed the governmental bodies, academic experts and major NGOs in this field.

Governmental actors include primarily the Ministry of Health and Welfare and the Ministry of Justice, the National Board of Health and Welfare, the National Centre for Knowledge on Men’s Violence Against Women, the National Police Board, the Swedish Prosecution Authority, the Swedish Association of Local Authorities and Regions, county councils, the School Health Service and miscellaneous official actors such as municipalities, hospitals and county boards.

The NGOs include RISK, Save the Children Sweden, Amnesty Sweden and RFSU. There are also a number of immigrant groups working on projects to prevent FGM that have disappeared after some time.

5.3. Reflection on actors on female genital mutilation

I found it rather problematic that the options for the slot D (Organisation/person type) were limited. Many of my actors had to be referred to as ‘Other’ (such as the very important ombudsmen and also the national boards, which are governmental bodies, but neither embassies/ministries nor local/regional).

In Sweden there is broad participation of governmental bodies as actors in the field of FGM, and this has been the case for more than a decade. There is also cooperation between the actors, such as the National Board of Health and Welfare, which cooperates with other governmental bodies but also with NGOs. There is also local cooperation in networks at municipal level, including among others the police, healthcare sector and social services.

I have included the most important media incident in the ‘Actors’ sheet (the actor being Sveriges Television, the national broadcasting company), but the impact of media in other ways has not been considered.

There is a tendency that when there is an increase in public attention on the issue the politicians allocate more funding, and more actors are absorbed in preventive work. The actors in the field are generally acting in accordance with existing policies, with the exception of some academic researchers who occasionally go public with more critical views of the public discourse.

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Much of the information in this section was based on my private research archive in addition to conversations with key actors in the field. Furthermore, it was helpful with the academic database search (Social Science Research Network, Sociological Abstracts, Web of Science, PubMed, Heinonline, Scopus, EBSCO, JSTOR and also the database on violence against women and Google Scholar) and the searches for the ‘Policy’ sheet, primarily in the parliament archive.

In addition I went through a huge number of hits on Google. A Google search for the Swedish words for ‘female genital mutilation’ + ‘guidelines’ renders 15 900 hits, and one for ‘female genital mutilation’ + ‘plan of action’ 12 000 hits. I tried to narrow it down by adding certain more specific search words, such as ‘plan of action’, ‘school’, ‘healthcare’ ‘social services’, ‘police’, etc. Basic criterion for selection of documents was relevance at a national level. A few examples of local initiatives have been added for the sake of illustration.

The criteria for selection of my examples of existing resources and guidelines were as follows: (1) those that were top results in Google when people search for more information on FGM with search words in Swedish; (2) those that targeted specific groups of professionals in a broad sense (such as teachers, or healthcare staff); (3) a few examples without a broad scope were included to show that also very specific services are available (such as medical certificate services for migration officers dealing with asylum seekers, or local information to newly arrived immigrants in the area).

My private archive was started in the late 1990s. I have quite a few early documents (the early 1990s), however nothing from the 1980s. What I have collected in my archive is, obviously, not a systematic collection of material. If I have documentation from the 1993
Stockholm conference and the 1999 Malmö conference, there were probably a number of conferences in various parts of Sweden during the 1980s and 1990s that I never got to know about and thus never documented. There are also no traces of them on the Internet (like there are no traces of the 1993 Stockholm conference or the 1999 Malmö conference).

Regarding the tools and instruments, I had personal communications with:
- a respondent from the Board of Migration,
- a respondent from the Centre for Development at the National Prosecution Authority,
- the principal leader of the Gothenburg Project,
- a respondent who was for many years chair of RISK,
- the key NGO actor at RISK and SIMKO,
- a medical expert on FGM,
- the principal responsible person regarding FGM at the National Board of Health and Welfare,
- the knowledge pool at the National Board of Health and Welfare.

6.2. Tools and instruments on FGM

At the beginning of 1990s there were the first attempts to deal with the issue of FGM. There were scattered conferences and leaflets produced and also the first local guidelines in the healthcare sector.

From 1993 onwards the preventive work was somehow more systematised through the Gothenburg Project. They worked with seminars, publications and all kinds of instruments targeting both professionals and immigrant groups. They also continuously published reports disseminating good advice on best practices and their own experiences in the project. They were also active when it came to cooperation with other European actors in this field.

The major NGOs published texts with basic information about FGM. The first studies with empirical data from Sweden were published (‘As we were created by God: Attitudes to female circumcision among Somalis in Malmö,’ ‘Nobody asked me: A report about female genital mutilation in Sweden’). Smaller immigrant organisations are given funding for preventive work (‘Female genital mutilation, ‘The way to integration’ (2003), ‘The way to integration’ (2004)).

In the late 1990s the main responsibility for the development of tools was given to the National Board of Health and Welfare. After a couple of years they had created nationwide guidelines for professionals in the social, school and healthcare sectors. They published information about FGM in several languages: Somali, Amharinya, Tigrinya and Arabic, and also Swedish.

In 2003 the plan of action was launched, which set up the parameters for preventive work at all levels of society, targeting professionals, municipalities, counties (\(^\d\)\(^1\)), NGOs, immigrant groups, etc. This plan was followed by a national/international conference on FGM, orchestrated by the Ministry of Health and Welfare and the Ministry of Foreign Affairs.

A couple of academic theses on FGM in Sweden were published. Special centres were created at the Prosecution Authority, and the centre in Gothenburg was responsible for FGM. They published guidelines for the police and prosecutors in 2005. The National Board of Health and Welfare created a web-based knowledge pool, where guidelines, basic information and a collection of best practices were published. In 2008, as a response to a commission from the government, the National Centre for Knowledge on Men’s Violence Against Women (NCK) created a knowledge pool including the issue of FGM and published a report on FGM in 2011.

In time more and more websites appeared, with basic information on FGM in addition to advice about how to handle the issue and where to turn if one is affected. It is now possible to find all kinds of guidelines online: for school health staff, for immigration officers, etc.

6.3. Reflection on tools and instruments on female genital mutilation

At some point in the early 2000s the whole issue of FGM exploded with regard to guidelines, website resources and local action plans. The issue was now expected to be included in documents at all levels of society.

The instruments developed worked well with existing policies, since governmental bodies to a great extent were those who developed the instruments. Since governmental bodies are often key actors in this field it has been possible to make changes, with time, to legislation to adapt to the desired routines (instruments).

There are guidelines for all professional groups concerned. However, it is hard to say how well these guidelines are known by all professionals. The issue of FGM is known to be integrated into the curricula of many professional training establishments (for nurses, doctors, police education, etc.), however, as of now there has been no systematic study to see where the issue is in fact a part of the education and where there are gaps.

Professionals have several sources of information: they have the guidelines issued by the National Board of Health and Welfare and there are probably regional guidelines to consider, as well as possibly local ones at the hospital/school/social service where they work. African immigrants, especially Somalis, could probably also be seen as being targeted by several tools and instruments.

7. FINAL CONSIDERATIONS

Prevalence data in Sweden is scarce. A few minor studies have been performed, but no national representative study has been done so far. Prevalence data is not accessible at national level, since that kind of register does not exist. In the healthcare system the national registers exist, but the quality of the data on FGM is too poor to be useful.
The person ultimately responsible for preventive work policies in Sweden, the respondent at the National Board of Health and Welfare, specifically emphasised the need of correct prevalence figures for future work (personal communication).

Policies began in late 1970s and have been going on since then, more intensely in some periods than in others. The decade of the 2000s saw a great increase in governmental policies. It was during this period that the National Board of Health and Welfare took over the responsibility for preventive work in Sweden (after a period where the Gothenburg Project had a commission to work at a national level), and the issue of FGM permeated other governmental bodies beside the Ministry of Justice and the Ministry of Health and Welfare. In the mid-2000s the question of asylum in relation to FGM reached its peak amount of public discussion.

The specific law banning FGM was launched in 1982. Other legislative efforts to facilitate cases being taken to court were introduced much later (the removal of the principle of double criminality and the introduction of the ‘Act on special representatives for children’ (1999:997)), in 1999. The Secrecy Act was changed in 2006 to facilitate reports of FGM, and the period of limitation was extended in cases of FGM in 2010. Child protection legislation was already in place and the issue of FGM was smoothly integrated into that existing framework. Asylum legislation has been in place for a long time, but the issue of FGM has been highlighted more markedly in the last several years.

The key actor in the field is the National Board of Health and Welfare, and this has been the case since more than 10 years. The Ministry of Health and Welfare and the Ministry of Justice have been important actors through the years. Among the NGOs, RISK stands out as a key actor and important moulder of opinion. The actors and moulders of opinion in the Swedish FGM field also include some academicians (in contrast to Denmark, for example, with basically no academic voice in the debate).

The tools and instruments circulating in the Swedish society are innumerable. To build this account I used my private archive, discussed the matter with FGM experts in the field and conducted systematic searches on the Internet. In the first decade of activities, basically the 1990s, much of the preventive effort was localised in Gothenburg. This was probably because the immigrant services office in Gothenburg already had well-established work with HIV and STIs, where concerned immigrant groups were involved. During those years there were local guidelines appearing here and there, and seminars and conferences in different parts in Sweden. At the end of the 1990s, when the National Board of Health and Welfare took over responsibility, the efforts became more systemised. National guidelines were issued for several professional groups. Publications disseminated over the entire country were issued, as were publications for concerned immigrant groups in several languages. The preventive work was further increased with the 2003 plan of action issued by the Ministry of Health and Welfare. In the mid-2000s also the police and prosecutors had national guidelines in place.

At that point in time the issue had spread basically to all sectors of society, and local guidelines and plans of action at hospitals, schools, social service centres, etc. were in abundance.

Today the National Board of Health and Welfare is still in charge of preventive work against FGM. Also, NCK, the National Centre for Knowledge on Men’s Violence Against Women, is a key actor. The most important organisation is still RISK. Academic research is going on among the abovementioned scholars.
Analytical country report

Sweden
**Analytical country report**

**Identification**
Country: Sweden  
Researcher: Jonna Arousell  
Date: 5.8.2012

**I. INTRODUCTION**

The overall aim of this report is to deepen the understanding and knowledge of the current approach to FGM in Sweden. Specific aims are to highlight milestones in the Swedish policy development on FGM, to analyse the driving forces behind policy development and implementation, and to assess successes, challenges and past and present good practices in the Swedish work on FGM. The analysis of all components will be made with reference to prevention, protection, prosecution, provision of services and partnership, hereafter referred to as the 'five Ps'. The report also aims at deepening the understanding about prevalence estimates in Sweden.

To achieve these aims, six interviews were conducted. The respondents contributing to the in-depth understanding in this report are key actors in relevant fields with regard to FGM in Sweden, from national state agencies, municipality institutions and prosecuting authorities to key actors within civil society and the academic field. Three respondents were recommended by the core team, and the remaining three were selected based on their position and contributions in fields covered by one or more of the ‘five Ps’. The respondents were invited to participate in the study via an official invitation letter sent by e-mail providing information about the study’s aims and methodological approach. Additionally, the respondents received a customised questionnaire with the forthcoming interview questions in their own language.

The interviews were carried out in quiet and undisturbed environments chosen by the respondents themselves, mostly in the interviewees’ private offices. Three of the interviews lasted around an hour, and the remaining three on average around an hour and a half. In terms of quality, the extended length of some of the interviews did not have a negative impact on the interview as a whole: the difficulties of holding to the time limit can be explained by the respondents' willingness and desire to share useful information.

As a whole, the recruitment process, the interviews and the analysis of data have been smoothly carried through. Still, obstacles were encountered in the recruitment of some respondents due to summer vacations stretching over the weeks when the interviews were to be conducted. All respondents (except one) agreed to participate. A consultant at the Swedish Refugee Advice Centre was unfortunately not available for interviews due to her summer holiday and time constraints upon returning to the office. She was also invited to conduct a telephone interview, but declined the suggestion. Also the Swedish Migration Board was invited to participate in the study to deepen knowledge on asylum protection but no experts were available at the time for data collection due to the summer holidays. Since no respondents from the field of asylum protection were available, a project leader for the Gothenburg Project in the 1990, was recruited instead. This respondent was asked to participate as she had a key position in the first preventive initiatives taken in Sweden. Thus, six interviews were conducted in total.

The interviews with the respondents participating in the study were conducted between 26 June and 13 July 2012.

<table>
<thead>
<tr>
<th>Date of the interview (dd.mm.yyyy)</th>
<th>Duration of interview (in minutes)</th>
<th>Observations</th>
</tr>
</thead>
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<td></td>
</tr>
<tr>
<td>2.7.2012</td>
<td>73</td>
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</tr>
<tr>
<td>3.7.2012</td>
<td>68</td>
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</tr>
<tr>
<td>6.7.2012</td>
<td>94</td>
<td>The respondent would like to clarify that her insight in her current work on FGM is limited: her experiences only relate to the period between 1990 and the beginning of the 2000s.</td>
</tr>
<tr>
<td>6.7.2012</td>
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</tr>
<tr>
<td>13.7.2012</td>
<td>98</td>
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</tr>
</tbody>
</table>
Introduction of the 'Act on special representatives for children'.

The NBHW participates in a European initiative formulating an agenda for action for European countries, where the

Removal of the principle of double incrimination.

The NBHW develops and distributes guidelines and handbooks to all groups concerned: professionals as well as

The Ministry of Health and Social Affairs allocates SEK 3 million (about EUR 328 000) to the NBHW to conduct

The government allocates SEK 2.7 million (about EUR 295 000) to the NBHW for further preventive work on violence

The Gothenburg Project is initiated by the NBHW. At least SEK 2.4 million — (EUR 280 500) is allocated between

1993 The Gothenburg Project is initiated by the NBHW. At least SEK 2.4 million — (EUR 280 500) is allocated between 1993 and 2001.

1998 The government allocates SEK 2.7 million (about EUR 295 000) to the NBHW for further preventive work on violence against women, including FGM. The NBHW is assigned national responsibility for work on FGM, and establishes a knowledge pool.


1999 Removal of the principle of double incrimination.

2001 Public opinion is stirred up due to the television documentary The forgotten girls.

2002 The NBHW develops and distributes guidelines and handbooks to all groups concerned: professionals as well as practising communities.

2002 The NBHW participates in a European initiative formulating an agenda for action for European countries, where the question on FGM as grounds for asylum is brought up.

2003 The Ministry of Health and Social Affairs allocates SEK 3 million (about EUR 328 000) to the NBHW to conduct work on FGM in accordance with the formulations in the national action plan. Project finalised in 2006.
Changes in the Secrecy Act give staff in social services the possibility to breach secrecy to give reports to the Intensified Nordic cooperation, initiated by the Nordic Council of Ministers.

The third milestone: the ‘quietness’ of today

Great efforts were thus made in the field of FGM in the 1990s, and the majority of initiatives were taken at government level, with the NBHW assigned as the coordinator for the initiatives. However, in the last several years, less effort seems to have been made at national level. The head of Female Integrity (a local branch of RISK) explains that the money allocated to NGOs to work on FGM seems to be getting smaller. She says:

‘It [the money allocated] decreases every year, less and less and less. We believe that the NBHW, or the state on the whole, seems to think that we have done enough on FGM … They have not really said it, but we have this feeling. Because they do not want to give the money to FGM that we used to get. Everything goes down, and down, and down.’

The coordinator for the cooperative network in Gothenburg also says that the NBHW activities seemed to have stopped after the finalisation of the national action plan in 2006: the only thing left is a website with information on FGM. Another respondent has had a similar experience: there was a lot of activity at the national level in the 1990s, but it has to some extent declined over time.

In the policies formulated by the Swedish government, it is clearly established that the NBHW has the overall national responsibility for ensuring all children’s well-being in Sweden. The NBHW’s responsibility to conduct work on FGM in particular is not spelled out, but this is, as one respondent points out ‘a part which is naturally included in the overall work task, since children obviously do not feel well when being circumcised’. However, the respondent also says that most initiatives in the work on FGM were taken in the period between 1998 and 2006. Thereafter, the activities changed.

‘I have not always been in this field. I started 1999 and worked until 2002, and then I was away from the question for many years. I think I got back to it in 2008/2009 at some point … And then, when I came back into this around 2008/2009, the level of activity was very low, and since then, it has not happened much at all.’

To sum up: From the respondents’ narratives, three milestones in the development of FGM policy can be identified: the first milestone with introduction of the legislation in the 1980s; the second milestone in the 1990s, identified by great efforts being made at a national level; and a third milestone now, when national initiatives seem to be less comprehensive than they have been before. Rather than maintaining or increasing the efforts of earlier years, the third milestone is thus characterised by a lack of policy development and implementation.

Driving forces for the development of FGM policy

Despite the lack of prevalence estimates on FGM in Sweden, both legislation and policies have been developed and implemented over a period of more than 20 years. One explanatory factor for the initiatives taken during the 1990s and the 2000s is that they were triggered by public debates on FGM. One respondent says that there is a clear tendency towards ‘topicality turns’ in the development of FGM policy in Sweden: every time discussions have been initiated (as they were, for example, after the television documentary The Forgotten Girls in 2001 and after the first cases of prosecution in 2006), routines, guidelines and method materials have been developed and legislation has been strengthened.

However, the reasons behind the triggering of policy implementation (thus despite available prevalence estimates) can be given additional explanations. The respondents’ narratives reveal three general driving forces for policy development with regard to FGM in Sweden, which can be summarised as follows.

(1) National consensus on FGM as a severe criminal assault

People in Sweden have, in general, a common understanding of FGM as a severe crime and a procedure that no child should be exposed to. This consensus has, in turn, contributed to the development of policies in Sweden. When politicians have taken action against FGM, no one has objected. The phenomenon evokes strong feelings, particularly among Swedish people, and that the emotional aspect attached to the practice might be a reason why the political initiatives were taken in the 1990s.

(2) FGM was and is considered to be a serious problem

The first national action taken in the field (i.e. the Gothenburg Project) was initiated after alarming testimonies from the healthcare sector indicating the existence of FGM among many — if not all — women that originated from FGM-practising countries. Considering the fact that many people coming from practising countries immigrated to Sweden at that time, one of the interviewees states that it would have been irresponsible to ignore the fact that some women might be negatively affected by the practice. There was, thus, a predominant belief that FGM was a serious and widespread problem.

‘Our notion when we started working with this was that it [FGM] was extremely common among these groups, and that the practice was more or less always used … And it naturally costs the society a lot, considering the morbidity following the circumcision … We never heard about any scratching. Rather, the practice concerned infibulation.’
However, as time went by, professionals became aware of the fact that the practice of FGM was being partly reassessed within the immigrant community.

‘But of course, there was an ongoing change in the years to come since more information was available and the phenomenon was always discussed in different contexts within the immigrant community. The evaluations that were conducted [in the Gothenburg Project] showed that people wanted to give up the tradition … So there was an immense change going on in peoples’ attitudes, knowledge and behaviour.’

Also, academic research, for example one respondent’s doctoral thesis from 2003, indicates a certain level of reassessment regarding FGM within immigrant groups in Sweden. But despite these ‘hard facts’ formulated by the first Swedish researchers in the field and indicating that FGM may — to some extent — be abandoned by well-established immigrant groups, new initiatives to combat FGM were taken at the national level. As a response to this statement one interviewee mentioned that the measures initiated in the 1990s and the years thereafter were motivated by the level of seriousness of the procedure, rather than the actual number of women and girls living with FGM or being in the risk group to be circumcised. Thus, the level of seriousness of the procedure may have called — and calls — for national initiatives to be taken, even though prevalence estimates are scarce.

(3) Existence of political willingness to promote change

Several respondents stressed the role of politicians’ engagement in issues related to FGM as an important factor for policy development and implementation. One respondent says that the first initiatives taken could be explained by a general political willingness to be in the front line for questions related to gender equality, and thus also in the area of FGM. Also, one respondent experienced a common concern among key actors at a national level, when knowledge about FGM increased at the beginning of the 1990s. The willingness to promote change might, in turn, derive from the dominant position regarding immigration politics in the 1990s, strongly promoting social, cultural and religious inclusion.

‘It has of course changed a lot in the ideas behind the integration policies, but there was a real willingness to prevent increased xenophobia at that time. More than what we see nowadays … But that is of course related to my personal attitude to the integration politics I see now. But, at that time, it was a lot about avoiding stigmatisation … And there was of course also a conviction that people may be less willing to contribute to society if they are treated in a racist manner. But I think that there was a genuine willingness to help. That was at least what we felt, and what we proceeded from.’

(4) All key actors in the field have something to gain from keeping the discussions alive

One reason for the continuous work in the field on FGM — despite the lack of prevalence estimates — can be found in the key actors’ own interest in keeping their position as it is. Having a key position in the field also means prestige, status and financial resources.

Factors explaining the decrease in the NBHW’s activities

All respondents state that activities initiated by the NBHW in the field of FGM have declined over the past few years, in comparison with the activities that took place during the 1990s. Many respondents expressed their dissatisfaction with the NBHW’s current work in the field, and the smaller numbers of initiatives are seen as an expression of the state’s lack of interest in FGM. As one respondent said: ‘The state as a whole seems to think that we have done enough on FGM’. However, there might be other explanatory factors behind the cut in activities that has been experienced. One of the interviewees elaborates on two plausible explanation models.

• Firstly, the great efforts being made in the 1990s frame the work conducted today. Guidelines, routines and handbooks are still in place and in use among all professional groups concerned, changes in legislation have been made and important institutional mechanisms are in place. A shift in activities has occurred, but not necessarily at the expense of the system’s efficiency.

‘We can see a certain shift in activities, that things have been kept alive within the welfare system. And we can see, concerning police reports and such things, that it works: there is a structure in place that works. We have a structure in place … we have specialist clinics, we have knowledge within the healthcare system.’

• Secondly, the respondent states that the current climate of debate surrounding FGM can partly explain the decrease that has been experienced in the NBHW’s activities. Her own role as a well-known researcher might have had an impact on the way FGM is discussed in the public debate.

‘I know that I influence the debate in this question … In the 1990s there was no research into the area, and it was not until the beginning of 2000 that the research developed … But those in the Ministry of Health and Social Affairs know that they are being challenged if they say silly things. This could actually be an explanation as to why it has been quiet in the field lately.’

The respondent draws attention to the discursive understanding of FGM in Sweden: during the 1990s and at the beginning of the 2000s an intense debate — boosted by media productions such as the television documentary The forgotten girls — surrounded the field, and the activities of the NBHW were simultaneously introduced. Sweden had at that time a problem with high sensationalism in the mass media, leading to a public ‘moral panic’. But a few years later, when university scholars began to conduct research on FGM, state authorities and politicians faced difficulties in exploiting sensational statements about FGM without sufficient supporting research. Consequently, the debate on FGM became quieter and state authorities might have felt a higher demand for evidence-based knowledge in formulating their manifests in the area. The decline in the
public debate characterising the last few years may thus be an explanatory factor regarding the respondents’ feeling of simultaneous decreases in national activities.

**Conclusion**

When analysing the driving forces behind policy implementation in Sweden, one can fairly easily conclude that issues related to FGM easily arouse a heated public debate. Starting with the radical feminist movement successfully pushing for changes in legislation in the 1970s, policy developments have been triggered by a political willingness to promote change. There is a striking consensus in Sweden that FGM is a severe criminal offence and that FGM has been frequently performed in several immigrant groups, and it is believed that the political desire to work against stigmatisation and xenophobia has boosted the initiatives taken at a national level. The debate has also been aroused by ‘topicality turns’, where single events such as the television documentary *The forgotten girls* in 2001 and the first court cases of FGM in 2006 contributed to a strengthening of the system. Also, another reason to the continuous work on FGM in Sweden — despite the lack of prevalence estimates — is that all key actors gain by joining the movement. Prestige, status and resources are available for key actors as long as their engagement in the field is extensive.

Many respondents mentioned the lack of initiatives taken by the NBHW in the last years. In fact, and as concluded by the person responsible for FGM at the NBHW, there has been a general cut in activities. This could have two plausible explanations: (1) the majority of institutional structures and educational materials are considered to be in place in order for successful work on FGM to be carried out; (2) the NBHW and the Swedish government in general keep a lower profile on issues related to FGM now than in the 1990s, due to the demand by university scholars that the information provided must be evidence based and not reliant on ‘sensationalism’.

**III. PREVALENCE AND DATA COLLECTION**

**Data collection registers at national level**

Currently, there are no central registration systems where FGM is recorded. There are, however, a few existing systems with more or less potential to be developed for the inclusion of FGM. These systems are described in the table below:

<table>
<thead>
<tr>
<th>Existing registers for possible data collection of FGM.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Swedish medical birth register</strong> At delivery, the status of the genitals of the mother is recorded. It would be possible to aggregate the data at a national level, but no one has done it so far. The quality of the data would be too poor, i.e. the data is difficult to interpret since there is no uniform diagnosis code for FGM.</td>
</tr>
<tr>
<td><strong>The Swedish patient register</strong> Registration of in-patients. This register would record patients that seek help with medical complications after FGM has been performed. Using this register, it would be possible to collect data at a national level, but it has not been put in place so far. Again, the quality of the data would be too poor.</td>
</tr>
<tr>
<td><strong>Child health services records</strong> There are records for all children in Sweden, but there is no way to look at the data at a national level since the quality is too poor. In addition to this, there is no compulsory screening for FGM in Sweden.</td>
</tr>
<tr>
<td><strong>School health record system</strong> Medical records exist, but there is no central database. School nurses/physicians can add FGM to patient records, and if this is done, the status regarding FGM can be recorded. School nurses/physicians in areas with large immigrant populations can add FGM to patient records, however there is no national requirement to do so.</td>
</tr>
</tbody>
</table>

**Obstructing factors and solutions with regard to national data collection**

Even though there are various medical records in place, there have been no known attempts to collect data on a national basis to get an overview of FGM cases in Sweden. The respondents’ narratives reveal two main reasons behind the difficulties in data collection.

(1) The concept of ‘FGM’ covers a broad scope of procedures

Few healthcare professionals know how to distinguish between different kinds of FGM and even experts have difficulties in assessing what is normal variation and what is not. The data collected would thus be of poor quality and not fully reliable.

Solution?

A solution to this dilemma could be to introduce a system of categorisation that is less detailed than the normally used ‘Type I, II, III and IV’ classification of FGM. Instead, a broader scale of classification could be introduced, using a scale of ‘mild’ or ‘severe’ mutilation so that healthcare professionals can register these alterations. In addition, the system could involve an indication of whether the report is based
on the patient’s self-description or on a gynaecological examination performed by a professional. By doing so, patients’ own experiences of FGM could also be registered.

(2) Lack of appropriate diagnosis criteria in the Swedish patient register

Today, there are mainly two diagnosis criteria used within the healthcare sector: ICD10 (a system for physical disease diagnosis) and DSM4 (a system for psychiatric disease diagnosis), but none for injuries such as FGM (which is, according to the respondent, to be seen as an injury and not as a physical nor a psychiatric disease). There is, thus, no appropriate registration for recording cases of FGM.

Solution?

Another diagnosis system must be developed in addition to ICD10 and DSM4 to enable recording of FGM. These measures must be taken at the international level (by the WHO), since the diagnosis criteria are based on an international system.

A note on the prevalence discussion

There is a general belief in Sweden that FGM is being practised in immigrant communities, and that the scarcity of reports and court cases on FGM is due to the welfare state’s inability to discover cases. Simultaneously, a minority of actors in the field have the opposite opinion, namely that FGM is a partly abandoned practice — at least among well-established immigrants.

Estimates of the number of girls at risk in Sweden are commonly made by counting the total number of immigrant women and girls (not necessarily separated) from countries where the WHO has estimated the prevalence of FGM to be high. By doing so, a group of ‘girls at risk’ is estimated. Yet the measurement does not reveal anything about the actual prevalence. In fact, one respondent says that the system for defining girls at risk was, to some extent, ‘constructed’ by the NBHW in the 1990s. He and his colleagues were concerned at not being seen as an injury and not as a physical nor a psychiatric disease). There is, thus, no appropriate registration for recording cases of FGM.

IV. APPROACH TO FGM

This section of the report provides information on the approach to FGM in relation to the ‘five Ps’. The first subsection provides the broader picture and the focus on (or respectively balance between) the Ps. The next subsections zoom in on the different Ps.

IV.1. Overall

The ‘five Ps’ are identified as prevention, protection, prosecution, provision of services, and partnership.

Based on the analysis of the respondents’ explanations about Swedish policy development in terms of the ‘five Ps’, there seems to be a clear trend in the national efforts: the majority of the respondents emphasised prevention as an area that has gained comprehensive attention. That the area of prevention has gained so much attention could be explained by the general tendency to prioritise grass-root initiatives and NGOs cooperating with practising communities, rather than introducing legislative measures to combat FGM. The attention drawn to the area of prevention can however be partly explained by several respondents’ own backgrounds in NGOs or state-financed projects assigned to work with — in particular — attitudinal and behavioural change in practising communities. Respondents whose main activities are not focused on prevention take a more distanced stance: instead, prevention initiatives must, according to some, be strengthened, evaluated and more efficiently coordinated.

 Provision of services is also ranked highly by several respondents. But in contrast to the preventive work that has been conducted continuously since the 1990s, when the first discussions on FGM occurred, the adequate provision of services is an area that has evolved over the years. Capacity-building initiatives in form of training courses and distribution of handbooks and guidelines began at the end of the 1990s (by the Gothenburg Project) and early 2000s (by the NBHW). All handbooks and guidelines addressing both professionals from concerned sectors in the welfare system and people from practising communities are still in use.

Regarding prosecution and protection, institutional mechanisms such as legislation, routines and methods have been in place for many years, both to facilitate prosecution and to ensure children’s protection. In terms of policy development emerging over the years, the areas of prosecution and protection diverged from the remaining Ps due to one reason in particular: institutional mechanisms such as legislation and routines for child protection never needed to be developed only to facilitate work on FGM because they were already in place when the big wave of Somali immigrants came to Sweden in the 1990s. The system has been strengthened and improved over the years, but in comparison to,
for example, prevention and provision of services (where methods were developed as FGM emerged as a desired area for action), a basic level of measures for prosecution and child protection was already in place within institutional structures as development of the FGM policy in Sweden was initiated. Only a few respondents mentioned prosecution and protection as prioritised areas in the Swedish policy approach. The majority of the respondents, however, do not pay attention to these two Ps. One plausible explanation may be that the institutional structures are naturally internalised in people’s conceptions of the components of the Swedish welfare system, and therefore remain, to some extent, non-reflected.

The respondents provide a scattered view regarding partnership: some refer to partnership within or between CSOs and/or practising communities (for example the Gothenburg Project and the Cooperative Network of Professionals in Gothenburg), whereby a positive stance is taken. On the other hand, others interpret partnerships in terms of the NBHW’s (lack of) partnership with NGOs and practising communities, whereas their assessment here is negative. Still, and similarly to the other Ps (except prosecution and protection), standard procedures for partnerships in terms of FGM were not in place before the issue attracted attention in Sweden, but were initiated shortly thereafter.

IV.2. Prevention

The following section contributes an analysis of the preventive work on FGM in Sweden. Firstly, reflections are made on the development of the preventive work conducted by different key actors in the field. Secondly, detailed information is provided about the leading NGO for preventive work on FGM in Sweden, RISK.

Development of preventive initiatives in Sweden with regard to FGM

A number of important measures regarding preventive work were developed in the 1990s and at the beginning of the 2000s. One of the first initiatives taken in the field of FGM was on preventive work in the Gothenburg Project, financed by the NBHW. At this time, most efforts were made in close collaboration with people from practising communities, and information material and guidelines were distributed on a small scale to all groups involved. In 2003 the level of public debate on FGM had increased and the topic became a larger priority at a national level. When the Gothenburg Project was finalised at the beginning of the 2000s, the NBHW took over national responsibility for preventive work in Sweden. The guidelines and handbooks initially designed by the Gothenburg Project were further developed and harmonised, and spread to all professional groups concerned. Simultaneously, the NBHW was assigned national responsibility for issues regarding FGM and established a knowledge pool of research and learning about FGM.

One of the most successful initiatives taken by the NBHW during this time was the involvement of religious leaders in preventive activities on FGM. In 2005, an initiative was conducted on ad hoc basis as part of wider strategy combating violence against women. Several Ps, including partnership and prevention, were addressed in the initiative, which aimed at including men — and primarily religious leaders — in the work on FGM. The initiative consisted of training courses and dialogue with the religious leaders involved. The preventive work addressing the religious leaders proved to be successful: it finally led to the publication of a leading article in one of Sweden’s most read newspapers, Dagens Nyheter, where five religious leaders from different faith systems condemned the tradition of FGM.

The changes involved in the settings of the preventive work from the 1990s until today mostly concern the key actors involved in the direct preventive work, namely RISK and the NBHW. Previously, the NBHW had a more active role in preventive initiatives, mostly thanks to the establishment of a national knowledge pool that gathered together expert competences under the NBHW’s administration. Today, the knowledge pool no longer exists due to a lack of resources. However, guidelines and handbooks are still in place and distributed to concerned groups.

Having a look at the current preventive work in detail, it becomes clear that the greatest efforts are made mainly by one NGO, namely RISK. Some preventive work on FGM is also conducted by the NGO Somali Women in Sweden (SWIS). However, it would be an understatement to claim that the NBHW lacks initiatives regarding preventive work. In fact, RISK is solely financed by so-called state subsidies allocated on an annual basis by the NBHW. Thus the preventive work conducted in Sweden nowadays, where RISK is a key actor, is also an example of a well-established partnership between the NBHW as a state agency and RISK as representative for leading NGOs. Money from the NBHW is allocated to RISK and SWIS as follows.

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<th>Year</th>
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<tr>
<td></td>
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<td>(EUR 5 800)</td>
</tr>
<tr>
<td>2009</td>
<td>SEK 500 000</td>
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</tr>
<tr>
<td></td>
<td>(EUR 58 300)</td>
<td>(EUR 5 800)</td>
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<tr>
<td>2010</td>
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</tr>
<tr>
<td></td>
<td>(EUR 46 600)</td>
<td>(EUR 23 300)</td>
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<tr>
<td>2012</td>
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</tr>
<tr>
<td></td>
<td>(EUR 49 000)</td>
<td>(EUR 35 000)</td>
</tr>
</tbody>
</table>

Source: Socialstyrelsen (NBHW) http://www.socialstyrelsen.se/statsbidrag/aktuellastatsbidrag/rikstackandeorganisationersomb.

Preventive work conducted by RISK

The work conducted by RISK is thus primarily attached to preventive initiatives. When RISK started, in the 1990s, all initiatives were focused on the distribution of information and the education of both professionals and immigrant communities on FGM.
In 1997 and 1998 RISK conducted a 1-year project called IDIL (which means ‘whole’ or ‘untouched’ in Somali). A group of Somalis who were active in RISK initiated the project, which was financed by the NBHW and carried out in the Stockholm region. The overall aim of the project was to promote behavioural change and awareness-raising among FGM-practising communities. For that, information officers were trained to serve as instructors on issues regarding FGM. The following table shows the structure of the project.

Design of the IDIL project coordinated by RISK

<table>
<thead>
<tr>
<th>Participants in the project</th>
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</thead>
<tbody>
<tr>
<td>Twelve women from African countries. The information officers were recruited through a general request addressed to people in immigrant communities, in which interested people were asked to contact the recruitment team. The 12 women who were recruited were trained to become information officers.</td>
</tr>
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<table>
<thead>
<tr>
<th>Duration</th>
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<tbody>
<tr>
<td>Eight weeks of full-time training was dedicated to instructing the women. During the remaining months of the project, information officers were actively out in community groups, and carried out study visits to different hospital settings.</td>
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</table>

<table>
<thead>
<tr>
<th>People responsible for training the information officers</th>
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<tbody>
<tr>
<td>Nurses and teachers were responsible for conducting the training courses in Swedish. Teachers were present to overcome language difficulties for some participants.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Content of the training courses</th>
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<tbody>
<tr>
<td>Information about the body’s functions and the medical consequences of FGM, and study visits to maternity units in hospitals to understand the procedure women go through before birth giving (i.e. if circumcised). The purpose of the training courses was to educate the information officers for ‘own gain’, with the overall aim of enabling the information officers to inform members of practising communities about the health complications on FGM.</td>
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<table>
<thead>
<tr>
<th>After the training courses — the information officers’ role in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the 8-week training period was finished, the information officers began the preventive work within practising communities. The information officers talked to people within concerned immigrant associations, to their own family and to relatives. The meetings were not formally organised in seminars or workshops, rather the information was distributed in day-to-day activities within the immigrant groups. Many immigrant associations already have organised groups where people meet for dinner, or to talk, cook or sew. According to her, these forums were ideal to promote attitudinal and behavioural change regarding FGM.</td>
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<table>
<thead>
<tr>
<th>Resources</th>
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<tbody>
<tr>
<td>The project was financed by the NBHW. The respondent cannot provide any information about the exact amount due to lack of information about the financial resources received at that time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation of the project</th>
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</thead>
<tbody>
<tr>
<td>Considering that the NBHW financed the project, one of the respondents assumes that there must have been an evaluation made. However, the respondent cannot provide any further information because of a lack of information. From the respondent’s experience the project was well received by people in the immigrant communities. The respondent continually talks about a changing process; all ideas and perspectives are still alive among all people who were in contact with the project at the end of the 1990s.</td>
</tr>
</tbody>
</table>

Currently, RISK’s activities are mainly focused on two areas: organisation of seminars/workshops and coordination of youth groups. The two areas are described below.

1. Seminars

   General aspects: At least three to four seminars are organised each year. The seminars last for a couple of hours each time and commonly take place during a half-day session. The seminars are organised in all local organisations belonging to RISK in Sweden.

   Participants: Invitation letters are sent to all immigrant associations and other organisations that might have any interest in joining, as well as to various institutions in the welfare sector such as schools and social services.

   Content of the seminars: The seminars involve, for example, lectures and speeches given by invited guests. Priests, imams, nurses, historians and medical doctors have been invited to several seminars. A gynaecologist with special expertise on FGM has often been invited to hold lectures on the topic.

   Example: A seminar was held in Nyköping’s municipality for all school and pre-school teachers in the municipality, in which 52 professionals participated.
IV.3. Protection

The information regarding protection consists of the knowledge shared by various respondents participating in the study. The general insight into asylum protection has been low: the discussions have mostly concerned protective measures addressed at children. The following description regarding protection thus only concerns protection measures for girls at risk.

Key actors involved

The Swedish social services are the most prominent key actors in the field of protection. A number of respondents have reflected on the topic and concluded that the social services are the only governmental institution with both the obligation and the legal ability to take several judicial measures for a child’s protection.

‘We have quite a good system for protection, which is implemented through the Social Services Act and routines around the handling process. This mostly works out well. And we can see that mechanisms are in place to conduct good work … The system is alert and functions as desired.’

Existing protection measures for girls at risk

The measures in place to ensure the necessary protection for girls at risk are mainly brought to the fore by legislative measures applied by the social services. This can be explained by the social services’ role within the Swedish welfare system and the reporting mechanisms in place when cases concern children. When the legislation is correctly applied by all parties (i.e. professionals as well as private persons), all information will ultimately reach the social service.

Regarding children’s protection, several laws are relevant for the social services to enable an adequate handling process. Firstly, the Social Services Act (SoL, Socialtjänstlagen) establishes that the municipality (i.e. the social services) has the ultimate responsibility for ensuring children’s health and well-being. In the NBHW’s guidelines (supplementing SoL’s regulations) it is stated that social services must take action in several situations with regard to FGM, for example ‘if there is an impending risk that FGM is about to be performed’, ‘if the parents have positive attitudes towards FGM’ or ‘if there is a suspicion that FGM has been performed’ (1). SoL also establishes that ‘authorities whose activities affect children and young persons are duty bound … to notify the social welfare committee immediately …. Thus, professionals in schools, pre-schools and kindergartens, in the health sector and in the social service have a duty to report all forms of child abuse to the social services. Also, ordinary citizens have the legal ability to take judicial measures for a child’s protection.

Secondly, the Care of Young Persons (Special Provisions) Act (LVU, Lag (1990:52) med särskilda bestämmelser om vård av...
 allocated at the state-municipality level. Of the municipality structure, the financial resources are differently (considering recourses available) from other day-to-day management. Cases of FGM are not handled Protection interventions are a part of the social services' Budgets for protection interventions research did not yield any results on this. not provide any information on this topic, and the desk record systems for child protection, the respondents did courses are not always conducted on a structural, nationwide basis.

No special institutions or initiatives are in place within the social services to work on FGM in particular. This is nothing remarkable. Social workers within the social service have the knowledge to protect children, and overemphasising cultural or religious backgrounds among clients may, in the worst case scenario, lead to unjustified measures. On the topic of maintaining a balance between the protection of children, specific knowledge about cultural particularities and respectful communications with the families involved, one respondent says:

‘The other day, I had for example a phone call from an officer in the social services who asked if they had dealt with the case correctly after a report was received from the kindergarten. What to do with the assumed risk of a younger sister also getting [circumcised]? And there is nothing special I can tell them, other than to treat all families exactly as usual. When these kind of risks are identified, nothing special should be done just because the case concerns FGM or because it is Somalis involved. The case should be handled in the same way as other risks being discovered.’

Record systems for child protection and asylum requests
There is no national registration system for asylum requests or grants considering cases related to FGM. As regards record systems for child protection, the respondents did not provide any information on this topic, and the desk research did not yield any results on this.

Budgets for protection interventions
Protection interventions are a part of the social services’ day-to-day management. Cases of FGM are not handled differently (considering recourses available) from other cases of child protection. Since the social services are part of the municipality structure, the financial resources are allocated at the state-municipality level.
Recent changes and adjustments have been made in laws relating to FGM with the overall aim of facilitating child protection and taking cases of FGM to court. Firstly, changes have been made in the Secrecy Act, where it is now established that cases of FGM always constitute grounds for breaching secrecy. This means that professionals within the social services have the ability — but not the duty — to report cases of FGM to the police service. Previously, the social services were not always able to report cases to the police unless certain criteria were fulfilled (such as level of seriousness of crime, length of imprisonment, etc.). Secondly, the ‘Act on special representatives for children’ has been introduced, enabling genital examinations to be carried out without parents/caregivers’ consent. Thirdly, the principle of double incrimination has been removed, which means that all circumcision performed on Swedish girls after 1999 (when the principle was removed) can be proven to be illegal. And lastly, the period of limitation has been prolonged. The period of limitation is now 10 years from the day the child turns 18, or should have turned 18. Thus, several changes and adjustments have been made in national legislation to facilitate prosecution and protection.

Different explanations as to the driving force behind these initiatives can be given, but among the respondents there is primarily one explanatory factor mentioned: the desire of the Swedish prosecution authorities to take cases to court.

Analysing the development of measures related to prosecution of FGM, the measures taken from the 1970s until today can be seen as an expression of the political climate surrounding the field of FGM. As initially stated, the act prohibiting FGM was not a necessary measure to take to enable prosecution of FGM as sufficient legislation was already in place. Further, the following legislative measures taken to facilitate the prosecution of FGM can be seen as normative demonstrations, emphasising the societal consensus on FGM as a severe form of child abuse. But despite the enforcement of various legal measures to facilitate the prosecution of FGM, several obstacles still prevail. As we will see, some challenges are strongly attached to applying the law in appropriate ways considering how the public debate’s ‘sensationalism’ regarding FGM may influence the normative decisions taken. Other challenges related to the prosecution of FGM can be found in the ability of professionals to determine procedures and their relationships with patients. Again, the obstacles recurring are not primarily related to the legislation itself, but to the usage of it.

**Challenges and solutions regarding the prosecution of FGM**

Four challenges were identified regarding the prosecution of FGM in Sweden and are listed hereafter.

- Over-sensitivity and tendencies of stereotyping
  When asked about challenges to prosecution and how these challenges can be overcome, the respondents were unanimous in their suggestion: the most prominent issue to deal with nowadays is the nearly overemphasised desire to take cases of FGM to court. Stereotyping and prejudices regarding offences falling under the law prohibiting FGM may lead to an over-sensitive judicial system.

- ‘The most prominent offenders [regarding FGM] are not men. But the judicial system in Sweden seems to have difficulties in accepting this awareness. In general, men are the offenders in cases concerning violence against women. This is the general understanding of the problem, especially when the discussion concerns physical violence. But in this case [of FGM], it is not sure that the offender is a man, he might be a person only in the periphery. But when it comes to the legislator, it has, at least from what has been seen here in the western part of Sweden, been shown that the person the police perceived as the main offender was freed, whereas the man was convicted to 5 years in prison. The persons involved in this investigation saw the verdict in this case as an indicator of our general understandings of things, and this view does not necessarily have to be compatible with the view of the involved persons.’

Another respondent also shared her opinion with regard to this challenge:

‘I would say that there are the same challenges making our legal system a signifier of the rule of law. A high level of evaluation of proof is needed, for example … I am of course affected by the Ali case (1) as well. The prosecutors really wanted to have a case to court, so much so that they were willing to compromise on the rule of law. This is of course frightening. There have been a few cases where it has been close, but where it is realised that [the evidence] is not sufficient. If so, the case must be closed: that’s how it is in a system striving to uphold the rule of law.’

- How to assess if FGM has been performed
  Healthcare professionals have been experiencing difficulties in distinguishing between, in particular, types I, II and IV, and thus in determining if FGM has been performed or not.

**Solution?**

One respondent suggests that more extensive education addressed at healthcare professionals should be initiated. More knowledge is needed, both to deflate myths surrounding FGM (to avoid stigmatising) and to learn more about the medical implications.

- How to date when FGM was performed
  In Sweden the law on FGM was reformulated in 1999, removing the principle of double incrimination. This means that not all forms of FGM performed on girls domiciled in Sweden before 1999 can be classified as illegal, as long as the FGM has been performed in a country where such acts are not considered criminal. Consequently, the removal of the principle means that if a Swedish girl born after 1999 is circumcised, the act is illegal.

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1. Ali was the name of the man who was sentenced to 2 years in prison for violating the act prohibiting FGM. One respondent has written a book about the case, in which the prosecution process is analysed, and partly criticised.
Solution?

The solution of the problem of dating when the FGM was performed has already been partly solved as the principle of double incrimination has been removed. The remaining problem (i.e. to conclude that FGM was performed on girls before 1999) will be solved as time goes by. The problem gets smaller and smaller every year, as it can never be claimed that girls born after 1999 have been legally circumcised.

• How to find cases
One respondent says that one of the obstructing factors regarding the prosecution of FGM is related to the discovery of cases. For an investigation to be initiated, a report must have reached the police service.

Solution?

The idea of screening girls’ genitals has been frequently debated, but no measures have been taken. The respondents consider that ethical aspects must be considered in detail.

Moreover, there should be closer cooperation between state authorities and more capacity-building initiatives within the healthcare sector. The establishment of good relationships between professionals (i.e. healthcare and social services) is essential to get to know personal stories on FGM. In the two cases that have been taken to court in Sweden, the girls concerned initiated contact with the authorities. As one respondent explains:

‘From all the examples of the genital examinations that have been made, I can see that, with good communication, families can agree to quite a lot. This means that genital examinations performed by force [i.e. in accordance with the “Act on special representatives for children”] … It can certainly be a good tool … but very much can be achieved through good communication and a respectful approach. I hope that ways can be found to work with this in a good way, to avoid genital examinations being carried out by force.’

Available records for court cases, investigations and convictions
No records are kept at a national level regarding court cases, investigations and convictions. To gather this information, each of the 21 police districts in Sweden must be separately contacted, but the information provided may not be sufficient reliable since it is not sure that all concerned cases have been coded as FGM — established notifications and investigations may have been coded as, for example, infliction of body injury, therefore it may be difficult to trace the cases in the archives. However, this could mostly be a problem in the large city districts. In the smaller cities, cases such as FGM tend to draw enough attention to be remembered by professionals within the police force irrespective of under which criminal code they have been registered.

Brief description of court cases, investigations and convictions
Referring to her previous research and mapping of cases of FGM within the judicial system, one interviewee says that 14 out of 21 police districts have never experienced cases of FGM. The remaining seven districts have received reports and carried out investigations concerning FGM. The majority of the cases have been centralised to Stockholm county and Gothenburg county.

Thirteen of the 46 police reports that reached the police service were closed immediately. The cases were, for various reasons, not relevant to be handled under the act prohibiting female genital examination.

Another 13 police reports were closed because the judicial investigation had not given reason to believe that a crime under the act had been committed.

In 20 cases a genital examination was performed as part of the investigation. In 11 cases it was concluded that no FGM had been performed, and in nine cases it was concluded that FGM had been performed. Of these nine cases, seven were closed due to the fact the police could not assess whether the girls had been illegally circumcised.

The remaining two cases were taken to court.

Oversensitivity on FGM?
One of the respondents is among the researchers in the field of FGM who object to the idea that there are large numbers of unknown cases of FGM in Sweden. Currently, indicators of the widespread practice of FGM in Sweden are few. A small number of cases relating to FGM have been confirmed, and for those cases the affected girls themselves have turned to the authorities for assistance. There are two possible scenarios relating to the scarcity of court cases on FGM in Sweden.

(1) The estimated number of unknown cases is large, and authorities and key persons in the Swedish society never get to know about them due to the high level of segregation between immigrant communities and the Swedish majority population.

(2) Practising groups’ resistance to performing FGM makes it difficult to find cases (that is, FGM is not widely practised).

However, the number of police reports and initiated investigations reveals a highly alert social welfare system where school and pre-school staff, social services and healthcare professionals perform a high level of supervision and show a willingness to report suspected FGM to the police. Although the alert system is assumed to be beneficial for children’s protection and well-being, there are tendencies indicating an ‘over’ alert system. For example, there are a number of cases where Swedish kindergartens have suspected FGM and where genital examinations have shown that no FGM had been performed. So far, there are no examples of cases within any kindergarten in Sweden where FGM has been performed.
In conclusion, Sweden has for many years proved to have a highly alert system in which different groups of professionals are both observant and willing to report cases of suspected FGM. However, an alert system also involves a risk of initiating unjustified measures. The balance between protection and facilitation of prosecution may thus be difficult to retain.

**Available record systems for police interventions**

There is no central register, and information must therefore be collected through correspondence with each police district.

However, the police service may be centrally governed in the future and, if this takes place, a central register for investigations and interventions would likely follow.

**Reporting mechanisms in case of performed FGM**

This subsection describes the referral model for investigations on FGM within the police service, when a complaint is given. It is to be noted that the police service has an absolute duty to immediately report cases of FGM to the social services.

1. When the police service receives a report of FGM, the police service has an obligation to establish a notification. Thereafter, it is up to the investigator to evaluate the information received. Either the case is closed or it becomes subject to further investigations.
2. If suspicions remain, the victim is taken to the women’s refuge unit within the police service, where initial steps are taken. For example, questioning can take place. As soon as possible, the case is given over to the specialists on crimes within close relationships.
3. If the crime has been committed, the case will be run by the public prosecutor due to the seriousness of the offence. The public prosecutor can apply for a special representative for a child (if necessary), and the certificate from the physician is awaited. The certificate should, preferably, be issued by a specialist, and to ensure that this is being done the police service has contacts with medical doctors to carry out examinations.
4. Firstly, when the medical certificate is issued by a physician and received by the police service, the ‘real’ handling process can begin.
   a. The girl may be taken into care by the social services.
   b. The girl is questioned. Representatives from the social services are always present when children are questioned, and this normally take place within the children’s home (more information provided below).
5. If the medical examination shows that FGM has been performed and it is concluded that the procedure was illegally performed, the prosecutor can take the case to court.

**The SARA model**

When the police receive a complaint and they establish a notification, a certain model/method has been introduced to facilitate this step in the investigation process. The model — called the SARA model — was introduced to enable risk assessments to be made. Every time the police receive information about a woman exposed to any form of domestic violence, a risk and threat assessment should be made (for example, to be able to establish the risk of future exposure). This risk and threat assessment constitutes the grounds for future decisions taken by the police service in the specific case. This risk and threat assessment could also be used in cases of FGM.

**Reporting mechanisms in case of girls at risk**

Chapter 14 of the Social Services Act establishes regulations for the reporting of abuses, stating that ‘authorities whose activities affect children and young persons are duty bound … to notify the social welfare committee immediately …’. Thus, professionals in schools, pre-schools and kindergartens, the health sector and the police service have a duty to report all forms of child abuse to the social services. Also, ordinary citizens should report suspected cases of FGM to the social services. The wording of Chapter 14 of the Social Service Act thus establishes everyone’s duty to report cases of FGM to the social services.

Concerning reports to the police service regarding cases involving girls at risk, a respondent says that all citizens and some professionals who are not bound by the Secrecy Act (i.e. school and pre-school teachers) have a duty to report crimes committed against children to the police. All professionals who are bound by the Secrecy Act (i.e. healthcare professionals, the police service) have an absolute duty to report cases of FGM to the social services but not to the police.

In sum, the referral model regarding the reporting mechanism in cases of (suspected) FGM involves an absolute duty for everyone to notify the social services. Healthcare professionals are bound by the Secrecy Act and therefore are not allowed to report cases of FGM to the police. They must, however, notify the social services. The social services have, in turn, the possibility of reporting cases to the police, but not the duty; the decision must be taken in the best interests of the child. Irrespective of how cases of FGM come to the knowledge of the social welfare system or the public, information will always reach the social services, but not always the police service.

**Prosecution of professionals who do not report**

Officials who fail to report cases of FGM to the social services are prosecutable, since they commit a breach of duty. Still, no cases of prosecution of professionals have occurred.

**Recommendations for changes in the laws/provisions in force**

Despite the fact that the legislation seems to target adult women rather than children, few respondents in this study have objections to the legislation or its formulation. The general opinion seems to be that the act enables the protection of children as well as an efficient prosecution process when cases occur. In all, the act prohibiting FGM is seen as a clear demonstration about the seriousness of the crime. However, one respondent explains that there are a few scholars in Sweden who argue for changes in the legislation, to make it more adjusted to children’s...
interests. The act may have overemphasised the meaning of FGM to which (adult) women are subjected, and that a reassessment of the legislation should take place. The respondent expresses her ideas when describing a discussion with other professionals in the field during a meeting in Norrköping.

‘Why do we call it FGM? What it actually is, is an example of child abuse … And we ended up in, we concluded, that maybe we should not call this FGM at all. Maybe we should only define it as child abuse? It makes it very much stronger than to say FGM. … That gives the impression that this [FGM] happens to (adult) women … FGM is severe child abuse, in all ways. Physical, psychological. They can actually die.’

IV.5. Provision of services

Specialist healthcare clinics
A respondent at the NBHW, the institution with overall responsibility for national work on FGM (also in the healthcare sector) lacks detailed knowledge on the services provided within the healthcare system. Another respondent, on the other hand, is well informed about the healthcare system’s provision of services at national level. She considers that Sweden has a good system for providing adequate help to girls and women subjected to FGM or at risk of being subjected to it. Currently, this help is primarily provided by a number of specialist health clinics around the country. The gynaecologist interviewed was responsible for a specialist clinic at Malmö University Hospital (MAS) until 2007/08, to which a large number of circumcised women came to receive assistance. Today, this clinic, with the aforementioned gynaecologist at its head, has moved to Uppsala University Hospital. Also, Stockholm South General Hospital (SOS) has a specialist clinic for circumcised women, led by the gynaecologist Meri Liljegren. Even though there are few specialist clinics, they have received patients from the whole country (and also from other European countries, such as Germany).

The clinics mentioned above are all integrated into the public healthcare system. Private actors are thus not involved. Consequently, the centres providing specialist healthcare for women who have undergone FGM are financed within the county council’s budget.

Specialist children’s homes
In one interview, a fairly unique setting of provision of services is described, namely the activities going on in specialised children’s homes. Children’s homes have been established in several cities in Sweden (Malmö, Linköping, Stockholm, Gothenburg, Uppsala, Umeå and Sundsvall, possibly others), with the aim of providing child victims help and support from all concerned professional groups at the same time, in the same institutional setting. According to Save the Children’s website, 22 institutions were defined as children’s homes in 2010. They are all different regarding size and set-up, and it is therefore difficult to provide general recommendations for future improvements (and also, naturally, due to the lack of information collected about the initiative).

IV.6. Partnership

Talking about concrete initiatives of partnership in Sweden, the most prominent example is the cooperative network of professionals in Gothenburg. The cooperative network is a unique form of organisation in the work on FGM in Sweden. As a matter of fact, there are currently no other cooperative networks of professionals in Sweden besides the cooperative network in Gothenburg. Nevertheless, informally organised networks of professionals from various sectors may exist in different cities in Sweden. For example, the respondent from the police service explains that police investigators have ‘informal’ contact with professionals from other fields for guidance, and that occasional collaborations take place when cases of FGM are reported to the police. However, the cooperation is not established on a structural basis. The cooperative network in Gothenburg is thus the only initiative now known with a structural set-up of professionals from different working fields, working together on issues related to FGM.

Initiators and coordinator(s) for the cooperative network in Gothenburg
When the Gothenburg Project was running in the mid-1990s, it became clear that it was necessary to create some systematic forms of cooperation between the different groups of professionals who may come in touch with FGM-related questions in their daily work. Four people who were engaged in the Gothenburg Project initiated the cooperative network in Gothenburg, and also got political support for the idea. Since then, there has been a political decision guaranteeing, and requiring, the existence of the cooperative network in Gothenburg.

Participants of the cooperative network in Gothenburg
The cooperative network in Gothenburg consists of two medical doctors (child and youth specialists), two gynaecologists with special expertise on FGM, one prosecutor, one police officer, one person responsible for child healthcare in the city of Gothenburg and one person responsible for school healthcare in the city of Gothenburg.

Role of the partnership in terms of policy implementation
The coordinator of the cooperative network explains that the network in Gothenburg has been given a political mandate/mission to run the activities of the network on a structural basis. The activities of the cooperative network in Gothenburg can be divided into two parts: capacity-building within the framework of the partnership itself; and capacity-building initiatives aimed at various professional groups for the improved provision of services when working with FGM clients/patients. Each activity will be described hereafter.

(1) Capacity-building within the partnership
The network’s most important functions are, according to the respondent, its ability to create a forum for discussion, awareness-raising and keeping knowledge of FGM alive among the representatives constituting the network. The cooperative network meets at least two times per semester, i.e. four times per year. The network functions

...
first and foremost as a discussion forum, where the representatives from the different professional sectors can reflect on questions on FGM that have arisen within their respective professional fields, ask for advice concerning cases and share new knowledge on topics within the field.

It is worth mentioning that the network is not a forum for professionals to report on and ‘hand over’ specific cases between professionals with different competences and authority. Cases shall, naturally, be reported directly to the responsible authority as soon as possible.

(2) Capacity-building initiatives for concerned professional groups

On a systematic basis, the cooperative network invites professionals who are in contact with children, young people, parents or families in their daily work in the city of Gothenburg to distribute information and to run lectures on FGM. Various topics are covered during the lectures, such as physical, psychological and legal aspects related to FGM, as well as information about how to conduct preventive work. The lectures target professionals from different working fields in the city of Gothenburg in order to develop/share knowledge about FGM, and also to give adequate support on how to handle issues related to the practice.

But giving professionals new insights also means that they must be able to ask questions if they face difficult dilemmas regarding FGM. For this purpose, the cooperative network of professionals also serves as a knowledge pool for professionals seeking support. One respondent explains as follows.

‘There are needs for supportive activities [for professionals]. And it is of course important that support is given … If we go out to professionals to inform and encourage them to be alert in these questions [on FGM], then they must also be able to get support … And that I think is good, that we can give them this support. It is good that they can contact us.’

It also happens that the cooperative network is invited to other municipalities around Gothenburg, both with requests to inform about FGM and to share their own experience of setting up a cooperative network within the field.

Resources for and organisational structure of the partnership

There is not much to say about funding, since the cooperative network does not receive any funding and it does not cost anything. The reason is that all participants are joining the network as a part of their ordinary employment within the municipality, in state authorities or in the county council (i.e. in the healthcare sector). The cooperative network exists as a consequence of a political decision taken by the municipal government of Gothenburg, where the network is given the mandate to ‘inform, spread knowledge, and be an expert and resource group regarding FGM for professionals within the city of Gothenburg’. No special guidelines regulate the work within the cooperative network (i.e. no more than the mandate given by the municipal government), and there is no evaluation, no regular control and no persons assigned to check whether the (non-existent) guidelines are being implemented or not.

Challenges and success factors for the cooperative network

The respondent says that no major challenges have been faced by the participants in the cooperative network. One might believe that the cooperative network has faced difficulties in cooperation, since it consists of professionals from different sectors with possible divergent opinions on the issue of FGM, but the respondent says that the variation in people’s competences has instead been an asset. Discussions may, of course, occur, but everyone is open to each other’s perspectives and willing to learn. The participants have known each other for many years, which may ease the cooperation process.

The respondent states that the partnership itself is a success factor for the work on FGM in the municipality of Gothenburg. With all expertise gathered in the same place, professionals from all concerned sectors know where to turn for help. In addition, the network has been an active and key participant in discussions, conferences and meetings, and thereby made itself a recognised name in the field of FGM.

Role of the cooperative network in policymaking and implementation

For the cooperative network in Gothenburg, the largest efforts are made in policy implementation (as declared in detail above) rather than in policymaking. However, the network is fairly well known by other actors in the field of FGM in Sweden; therefore they can have a role in pushing the agenda regarding policymaking in Sweden. There are currently two main topics discussed within the network: firstly the network takes a critical stance on the lack of initiatives by the NBHW; secondly they have recently discussed the topic of the FGM legislation in Sweden, questioning the relevance of calling it ‘FGM’ and not, instead, clearly emphasising that the offence is a severe form of child abuse.

Partnership within children’s homes: an uprising activity

The respondent from the police service in Gothenburg provides a brief description of the activities in the so-called children’s homes. The children’s homes serve as a good example of a comprehensive partnership between all professionals needed for prosecution, protection and sufficient provision of services when a child has been subjected to FGM. However, the respondent does not have detailed information about the activities. Instead, supplementary information has been collected through other sources and is described hereafter.

On the Save the Children website, the children’s homes are described as an institution addressing all children who might have been subjected to violence or sexual assaults, FGM included. In the children’s home, all relevant authorities are collaborating for the best possible protection and support of the child. Several
professionals must participate in the structural set-up for a children’s home to be approved as such, namely representative(s) from the police service, prosecuting authority (prosecutor), children’s medicine and child psychiatry. The overall aim is to prevent children being forced to repeatedly retell their stories about the assault/FGM procedure to different authorities to find out about the situation, instead, all relevant actors investigate the offence together. The police interrogations are, for example, led by an investigator with expert competence regarding child victims, and all other professionals can follow the whole conversation via a headphone and television screen in a neighbouring room. By doing so, the child only has to recall the happenings for one person, but still receives help from the whole specialist team. Each children’s home is individually organised with regard to coordination responsibilities and provision of services, but in general, the children’s homes offer:

- counseling,
- consultation and a common ground approach between authorities,
- coordination of interventions,
- assistance in investigation processes,
- crises management,
- support and treatment,
- medical examinations,
- child interrogations in crime investigations,
- capacity-building initiatives.

V. SUCCESSES AND CHALLENGES

Successes and success factors in the Swedish work on FGM

Sweden has an essential consensus on FGM

According to one respondent, everyone, both professionals and ordinary citizens, agrees that FGM is a serious crime that has to be accurately handled. Thus, there have never been any problems with motivating politicians or employees within state authorities to engage with the question and to initiate actions.

The state’s insight into citizens’ lives

Thanks to the personal identity number given to all people registered in Sweden, a family can never ‘disappear’ in Sweden. This naturally enables investigations (both within the police and social services) to be carried through. Many people find that the social services have a big insight into their lives, which may also have a preventive effect regarding FGM.

Successful policy implementation by developing guidelines for all professional groups

Two of the respondents emphasised the strengths related to the development and distribution of guidelines and handbooks on FGM to the whole care sector within the healthcare services (maternity clinics, child clinics, school healthcare and the healthcare system as a whole), as well as to the police service, social services, and school and preschool sector.

Development of efficient methods for preventive work

Two of the respondents emphasised the success involved in conducting preventive work with a ‘bottom-up approach’, i.e. using ‘culture-specific methods’ in interactions with immigrant communities. Using information officers to promote awareness raising and behavioural change in their own communities in their native language, and enabling people from the communities concerned to have a key role in project design/management (as was the case in the Gothenburg Project) have been — and still are — evident success factors in the preventive work.

Positive changes and adjustments in legislation to facilitate taking cases of FGM to court

The following should be mentioned: (a) the changes made in the Secrecy Act; (b) the principle of double incrimination has been removed; (c) the ‘Act on special representatives for children’ has been put in place; and (d) the period of limitation has been prolonged (it is now 10 years from the day the child turns 18, or should have turned 18).

Key challenges in Swedish work on FGM

Lack of coordination at a national level

The NBHW has the national responsibility to ensure that work on FGM is adequately coordinated and conducted. However, many respondents have found that the NBHW lacks an overview of different initiatives in Sweden and the initiatives taken are too scarce. Preventive efforts in particular have been less prioritised and no evaluations have been made.

‘There is a clear absence of coordination by the NBHW. I do not really see that they have … They have done a lot of things and have come far compared to other countries, but I wish they had more sparkle — a better overview of what is going on in the country in different areas. What happens in the healthcare sector? And what happens in the refugee reception unit? What happens in the social services? … And the whole educational system: how does it work with the content of curricula in different programmes?’

To find a balance between prevention/protection and prosecution

There has been a recurring problem with sensationalism in the mass media, leading to a high level of ‘moral panic’. Consequently, the system has sometimes been over-sensitive and, in line with this, more genital examinations have been initiated by force than has been justified. Thus, in the desire to find cases for prosecution, the authorities have exposed girls to (unjustifiable) genital examinations rather than having protected them. The authoritative power must be handled with care.

‘One must think about the harm that may be caused considering genital examinations: are we doing more harm if we revictimise someone? The case must of course be investigated but it requires considerable finesse in the way the work is conducted.’

(1) Available at: http://www.goteborg.se/wps/portal/barnhus
**Challenge regarding the generational shift**

Several respondents mention that people within institutional structures change continually, i.e., large groups of newly graduated professionals replace professionals of retirement age, whereby many years of experience disappear.

**Challenge of achieving trust within immigrant communities**

Many respondents consider that it is often difficult to reach and to address people living in segregated groups. The project leader for the Gothenburg Project in the 1990s shares her own experience working with immigrant populations from segregated areas.

‘The big challenge is to establish trust within the groups. If trust is lacking towards Swedish authorities, it becomes very difficult. There was a lot of fear that we had some sort of “hidden agenda”, that what we actually wanted was to get information about something else, send people out of the country or split up families. When we, for example, began talking about the social services’ role, very much fear was created. A lot of energy and effort must be dedicated to this [to achieve trust], and we were successful to some extent but of course also failed in the approach to some groups.’

**To sum up**

Regarding the successes and success factors, the respondents’ narratives reveal a highly alert and knowledgeable system, where guidelines and methods regarding preventive work have been developed, legislation changed and special healthcare units for circumcised women established. Furthermore, the Swedish system of personal identity numbers — and the social services’ comprehensive insight in people’s lives — enables protective as well as preventive measures to be taken. Analysing the successes and success factors from the ‘five Ps’ approach, it can be suggested that the most prominent successes can be found in the areas of prevention, prosecution, provision of services and protection.

What is not directly declared by the respondents, but still worth mentioning as a factor of success, is the organisational set-up of the Swedish welfare system as a whole. All institutional mechanisms for enabling good work on FGM seem to be in place within Swedish authorities: the social services have a profound knowledge of child protection and may use legislative measures for a child’s protection (legislation which, thus, is already in place); specialist healthcare clinics can provide victims with customised service; the prosecution processes seem to work as expected after a complaint reaches the police service; and, above all, the establishment of children’s homes offers child victims of sexual assaults, physical or psychological violence and FGM a unique form of service and protection. However, this organisational set-up can, at the same time, be a disadvantage to national work on FGM. This will be discussed below.

Regarding the key challenges mentioned by the respondents, large obstacles are found in the field of preventive work. Firstly, it seems difficult to address people in segregated groups. Secondly, there are no evaluations available regarding NGOs’ work in the field of prevention (subsidised by the NBHW), and there is insufficient coordination by the NBHW concerning the overall work on FGM in the country. Coordination, evaluation and the efficient conduct of preventive work seem to be important key challenges, which may benefit from stronger organisational work on the NBHW’s side, including more comprehensive partnerships with immigrant communities.

Some respondents reveal problems with ‘sensationalism’ in the mass media, leading to a high level of ‘moral panic’. Consequently, the system has sometimes been over-sensitive and, in line with this, has initiated more genital examinations by force than have been justified. In the context of this, the Swedish comprehensive welfare system, the legislative mandate and the authorities’ insight in peoples’ lives (which was earlier mentioned as a success factor in the work on FGM), the handling of the system itself can be seen as a prominent key challenge. More capacity-building initiatives among professionals to deflate myths and prejudices and to spread knowledge about how work with clients living with circumcision/at risk of FGM can be conducted may improve the handling of cases regarding FGM in various professional sectors.

Finally, generational shifts within state authorities are mentioned as a problem. Large groups of newly graduated professionals replace professionals with long experience, therefore useful expert capacities disappear. Again, continuous training on FGM for all professional groups concerned is needed.

**VI. POLICY LESSONS AND RECOMMENDATIONS**

Several recommendations and lessons learned are revealed in the respondents’ narratives. In some cases, the lessons learned are closely related to the recommended priorities for future work in Sweden. The following section provides an overview of the lessons learned from the Swedish experience and recommendations for future initiatives, as formulated by the respondents.

**Distribution of information to professionals**

The development and distribution of handbooks and guidelines is said by several respondents to be a success in the Swedish work on FGM, and a lesson for other countries to learn from. However, many respondents also emphasise the need for continuous education of professionals in concerned groups, since new employees are entering the work force on a regular basis. The need for more capacity-building initiatives seems to be strongest in the healthcare sector, because professionals in hospital settings are among the first to discover FGM, and knowledge of FGM does not seem to be sufficiently developed among employees in general (knowledge is naturally higher in specialist clinics,
but not necessarily in maternity clinics in general). Thus the topic of capacity-building initiatives for professionals is both a good lesson to learn from and a topic for future priorities.

Preventive work addressing immigrant communities in Sweden

A major lesson revealed in many respondents’ narratives is the need for unceasing education, training and awareness-raising initiatives among immigrant communities. In Sweden, as in other countries, newly immigrated people arrive on a continuous basis, and there is therefore a need for institutional mechanisms to ensure educational efforts are always in place. Several Swedish initiatives with regard to preventive work can serve as examples of successful activities, for example the Gothenburg Project and the preventive work conducted by information officials within RISK. Another lesson to be learned is regarding the benefits related to awareness raising among religious leaders. The NBHW made a comprehensive effort in this area in the mid-2000s, which led to the publication of a leading article in one of Sweden’s most read newspapers, Dagens Nyheter, where five religious leaders condemned the tradition of FGM.

Enhancing trust in the social welfare system within concerned immigrant groups

Closely linked to the previous lesson/recommendation is the respondents’ recurrent emphasis on increasing trust in the social welfare system within immigrant groups. One of the lessons derives from a key challenge the project team in the Gothenburg Project met, namely the initial obstacles in receiving the participants’ trust. As learned in the Gothenburg Project, an essential ‘recipe’ for success is to involve people from immigrant communities in preventive initiatives as much as possible. Perhaps it would even be a good idea to increase the dialogue between immigrant communities and the social services in particular, for both parties to learn about each other’s perspectives and perceptions. Also the respondent says that trusting relationships between professionals and clients/patients may be the most efficient way to work on FGM, considering both protection and prosecution. All cases regarding FGM until today have been initiated after the girls had notified the Swedish authorities. For Swedish authorities to be informed of cases of FGM, efforts must be made to establish trusting relationships rather than to exert control.

‘This is something to reflect upon: how is trust achieved? Again, I think this is very much about …. letting landsmen work in their own groups and to thereby increase trust in the Swedish system …. And the kind of forceful measures we have is rather about consuming or destroying trust.’

Establishment of cooperative networks for professionals

As emphasised by several respondents, since Sweden has an extensive social welfare system with many actors involved it has been important to establish cooperation initiatives among different professionals to work on FGM. Having forums in place means that discussions on FGM can be kept alive, and that information can be distributed and knowledge shared. However, developing a system of cooperative networks may be a future priority. Currently there may be a number of informally organised networks in place, but it could be beneficial to identify these networks and to strengthen the groups to conduct cooperation on a more structural basis.

State authority with overall responsibility for national work on FGM

A negative feature regarding the Swedish work on FGM is continually repeated by all respondents: as mentioned earlier, several respondents have objections to the NBHW’s work on FGM, or rather the authorities’ lack of coordinated initiatives. Giving national responsibility to a single state authority is a recommendation formulated to other countries, and also an example of something that does not work as desired in Sweden, at least not nowadays.

‘There must be a national direction of volition, or rather a national authority that has overall responsibility for the question. And which also sees what this [FGM] is, namely a severe form of child abuse and not an example of a cultural tradition that can be negotiated and not taken seriously. Or that someone says that “these milder forms [of circumcision] are not so bad.” Because if we continue as we are now [without national coordination/responsibility], we indirectly formulate the message that … this is nothing to be so bothered about.’

‘And what other countries should not do is to be inactive, as we actually have been since 2006. But it is actually very difficult to have more than one large question at a time.’

Discussion in light of the ‘five Ps’

This subsection provides an analysis of how the Swedish work on FGM can be improved or strengthened, referring to the main priorities mentioned by the respondents. Many of the priorities mentioned will show similarities to the lessons learned in the section above. Apparently, the main lessons learned about what has worked well and what has not in Sweden are also the fields in need of improvement and extra efforts. In sum, the national initiatives regarding preventive work, provision of services (capacity-building) and partnership are the main priorities. Protection and prosecution initiatives are not mentioned at all as priorities for future work.

Regarding partnership, the respondents provide two main priorities for future work. Firstly, the NBHW must take greater responsibility for the coordination of the work on FGM at national level. The NBHW must have a better overview of the activities in place today and initiate activities on FGM where it may be needed, for example within the municipalities’ refugee reception units. The NBHW thus has a great responsibility to establish partnerships with both NGOs and institutions at municipal level and, by doing so, ensuring that the work on FGM is in place on a continuous basis within all relevant sectors involved. Furthermore, there is
a deliberate need to conduct evaluations of the national work that has been, and is being, conducted. Without evaluations, it is profoundly difficult to establish which practices work and which do not work. Thus, a more sufficient evidence-based approach is needed to ensure that initiatives are carried out in the best possible way.

Secondly, a closer partnership between immigrant communities and state/municipal actors must be put in place. Respondents mentioned that a condition for fruitful preventive work is that the immigrant community trusts the Swedish welfare system and the authorities within. A larger exchange of perspectives/knowledge/perceptions between the social services and the immigrant communities is needed. Also, one respondent considers that people from immigrant communities must be involved in actions to a much larger extent than is so today.

Regarding prevention, the most urgent priority seems to be the coordination of efforts for the continuous dissemination of information targeted at immigrant groups. Interestingly, the preventive work in Sweden has previously been described as a success factor among the respondents: good educative material is available and good method material for developing preventive work has been created. However, it must not be forgotten that newly immigrated persons are in need of information on FGM. There is thus a constant need to distribute information and conduct educational initiatives within immigrant communities. And preferably, well-established representatives from practising communities shall have a key role in preventive work within their communities.

The topic of provision of services/capacity-building shows similarities with that of prevention — the development and distribution of guidelines and handbooks for all concerned professional groups have been described as success factors in the Swedish work on FGM. Nevertheless, there must be mechanisms in place to enable continuous capacity-building initiatives within various welfare sectors — especially considering that new employees constantly join the welfare institutions. The need for capacity-building seems to be of the highest relevance within the healthcare sector — unless the clinic concerned specialises in FGM (as is the case in a few places in Sweden), healthcare professionals may face difficulties in determining if FGM has been performed or not. Staff within the healthcare sector are often among the first to discover FGM (either through genital examination or according to patients’ self-assessment), and both must therefore have the competence to provide the best possible support for the patient, as well as the willingness to report cases of FGM to the social services for further protection/support. Thus, increased capacity-building initiatives for all professional sectors are needed to increase the quality of the service provided.

Several respondents mention the need to collect prevalence data as a future priority. There is a need to improve administrative datasets within healthcare settings (i.e. in maternity clinics, birth clinics, child healthcare, school healthcare). To achieve this, the introduction of another classification system for healthcare professionals could be considered, that is, the labelling of FGM as ‘mild’ or ‘severe’ for healthcare professionals to make a more reliable assessment. Moreover, a system of self-classification could be introduced, in which healthcare professionals ask patients about their genital status. Using this method means that a map of prevalence can be made even though no genital examination is made. Also, the respondents suggested that enhanced collection of qualitative data that includes the analysis of each group’s condition could be carried out while waiting for better data registers for prevalence estimates to be developed.

Neither protection nor prosecution were considered to be priorities for future work by the respondents. The absence of suggestions from the respondents can be interpreted as a sign that the necessary mechanisms are already in place (even though they may need improvements, the desire does not outweigh the need in other areas).

VII. POTENTIAL GOOD PRACTICES

Under this section, good practices or practices with learning potential will be presented and analysed in light of the term ‘good practices’, as formulated by the EIGE. Addressing religious leaders as a part of preventive work, customising police investigations and hearings with regard to children’s specific needs and working with FGM within cooperative networks of professionals are defined as potential good practices.

Firstly, the involvement of religious leaders in preventive activities on FGM was identified as a need. Efforts in this area were made in 2005, but not all religious faith systems were addressed. However, the results in 2005 proved to be successful. At that time, the initiative was conducted on an ad hoc basis in a wider strategy combating violence against women, and several P’s, including partnership and prevention, were addressed. The activity was initiated by the NBHW and aimed at including men — and primarily religious leaders — in the work on FGM. It consisted of training courses and dialogue with the religious leaders involved. A future initiative could preferably be designed in a similar setting, in Sweden or elsewhere; the partnership and the preventive elements involved in the action are clearly transferable to other contexts and regions. To ensure sustainability and effectiveness, the initiative could preferably be coordinated by the NBHW, as the responsible authority, for evaluations and the organisation of partnerships to be conducted at a national level.

Secondly, the adaptation of police investigations and hearings with regard to children’s specific needs is identified as good practice. This involves, for example, the training of special children’s investigators in the social service. Such an initiative would thus be in place on a structural basis and financed by the police authority, thereby ensuring the sustainable survival of the activity.

Thirdly, the establishment of cooperative networks of professionals has proven to be an efficient and effective
measure to gain and maintain a high level of knowledge of FGM among key actors from various professional sectors in a municipality/region. The cooperative network in Gothenburg has, for example, proved to be a successful actor, with a growing impact on gender policies nationwide. Using the Gothenburg Project as an example, similar actors in other parts of Sweden and Europe would gain from a structural set-up, ensuring the initiative's sustainability.

Showing the overall structure of methods/activities defined as good practices among the participating respondents, the following subsection will contribute with a more detailed description of two promising practices with good learning potential.

Cooperation between practising communities and CSOs/social services

The respondents emphasised the need for more preventive initiatives, such as conducting preventive work in close collaboration with members from practising communities, as well as introducing methods for the exchange of experience between social services and (newly) immigrated population groups with little knowledge about the Swedish welfare system as a whole.

Certainly, preventive work with members from practising communities as key persons in the organisational setting has the potential to become good practice. The Gothenburg Project and activities within RISK are inspiring proves. The question is rather what forms this activity should take in order for effectiveness, efficiency and sustainability to be ensured. RISK is, as mentioned earlier in the report, a key actor in preventive work in Sweden today. For cooperation and the exchange of experience to be increased between social services and immigrant populations (whether they practise FGM or not), RISK’s current activities (awareness raising and distribution of information in practising communities) can be defined as ‘promising practices’ for future work. However, for the activities to be conducted on a more structural basis there seems to be a need for an enhanced partnership with the NBHW. RISK is, to some extent, dependent on annual funding from the NBHW. The NBHW could be both a contributor of financial resources and an overall coordinator of cooperation between immigrant communities and social services. Moreover, the NBHW would have to take greater responsibility for the evaluation and enhancement of evidence-based methods in preventive work.

Establishment of children’s homes

A very promising practice that has not been thoroughly addressed by the respondents, only briefly commented on by the respondent from the police service, is the concept of children’s homes in a few cities in Sweden. In short, the children’s homes are characterised by a comprehensive partnership between prosecuting authorities, healthcare and social services. The services provided in the children’s homes address children under the age of 18 who have been subjected to sexual assault, violence, abuse and FGM. Comprehensive description of the activities in the children’s homes is provided under the section ‘Partnership’.

Analysing the children’s homes as a promising ‘good practice’ with regard to the ‘five Ps’ approach, it can easily be concluded that the initiative stretches over several Ps, including protection, prosecution, provision of services and, most importantly, a fairly unique method of partnership between all professional groups needed to give girls subjected to FGM all necessary support. Moreover, the current system of financing, cooperation and political mandating ensures forthcoming sustainability, effectiveness and efficiency, and the activity as a whole is a good example for learning how to think and act appropriately when searching for solutions for prosecution in collaboration with other Ps. However, the level of transferability to other countries may not be sufficiently high, because it will depend on the institutional structure of the country. The children’s homes’ activities very much rely on a broad collaboration between welfare institutions where money is allocated from the respective sectors’ budgets rather than from external resources (such as ad hoc financing, projects, etc.) (4).

However, for the children’s homes to develop into an even better practice, they would presumably benefit from creating a stronger profile with regard to FGM. This does not necessarily mean that the children’s homes need to improve the facilities offered to victims of FGM — these are already in place. Nonetheless, the children’s homes could gain a political mandate if information about their activities were better spread to other sectors in society, including key actors in the work on FGM. In an evaluation from 2008 it is concluded that the children’s homes have strengthened children’s rights in some aspects. Cooperation between professional groups has increased, and the activities are strongly characterised by professionals having a children’s perspective. There are, however, areas that could be improved for the forms of cooperation to develop: responsibility for each professional group should be more clearly established, secrecy between professional groups discussed more documentation introduced. The evaluation is, however, from 2008, and changes in the set-up of the children’s homes may already have been made.

VIII. FINAL CONSIDERATIONS

The final considerations presented here are based on a brief summary of the main aspects drawn up in the report.

Policy development, priorities and challenges in Sweden in light of the ‘five Ps’ approach

The first milestone in Swedish policy development can be dated to the 1970s, when a public debate on FGM arose after a Swedish gynaecologist and head physician declared that he and his colleagues had performed FGM on immigrant women. The radical feminist movement pushed for changes, which eventually led to the introduction of the Act Prohibiting Female Genital Mutilation in 1982.

(4) Available at: http://www.polisen.se/Uppsala_lan/Om-polisen/lan/Up/op/Polisen-i-Uppsala-lan/Verksamheter/Barnahus
However, the area of prosecution was not a prioritised topic in Sweden during the first decade. No cases were taken to court, and no supplementary changes in other legislative acts were made to facilitate the implementation of the law. Instead, preventive initiatives and the provision of services were boosted as a result of the large influx of Somalis in the early 1990s. During this second milestone, the NBHW was soon assigned overall responsibility for issues regarding FGM in Sweden, initiating various activities, primarily in the fields of prevention and the provision of services. The driving forces behind the initiatives could, according to several respondents, be explained by a growing political willingness to demonstrate the seriousness of the procedure. The NBHW’s initiatives are said to have decreased in the past few years. The lack of current comprehensive activities from the NBHW can be described as the third milestone. Different explanations have been given for the NBHW’s smaller role in the national work on FGM: firstly, it is proposed that the major mechanisms for enabling work on FGM are already in place; secondly, it is said that the NBHW is keeping a lower profile in the public debate due to a growing demand from university scholars that the information provided must be based on evidence and must not rely on ‘sensationalistic figures’.

Analysing the efforts being made in various areas in light of the ‘five Ps’ approach, comprehensive initiatives have primarily been made in the area of prevention, but also with regard to provision of services and partnership. Currently there are several specialist health clinics providing personalised assistance to women who have undergone FGM, and efforts have been made towards capacity-building for professionals within different sectors in order to enhance the quality of services provided. Prevention is closely related to partnership, characterised by a desire to work from a ‘bottom-up approach’, giving community members a key role concerning distribution of information within practising communities. Furthermore, and in the area of partnership, the cooperative network of professionals in Gothenburg constitutes a good example of how professionals from various sectors can gain and enhance their knowledge of FGM in collaborative settings.

However, the Ps concerning prevention, provision of services and partnership are also the areas to which the highest priorities must be given. The priorities also draw on the key challenges in the areas, namely the lack of coordination at a national level and the problems attached to achieving trust for Swedish authorities within practising communities. In short, it is firstly said that the NBHW must increase its partnership with NGOs (such as RISK) and other relevant actors to enhance the preventive work. The preventive work must, according to some, be nationally organised in order to include representatives from practising communities to a greater extent than is currently the case. Moreover, evaluations must be made and the NBHW must take greater responsibility for coordinating current activities and promising arenas for preventive efforts to be initiated. New immigrants continuously reach Sweden, and there must be structural mechanisms in place in order to distribute information on FGM. Thus, the preventive work seems slightly scattered and in need of increased coordination. The NBHW is assigned ultimate responsibility by the Swedish government for ensuring that these services are in place.

Regarding the provision of services, several respondents have experienced a challenge in obtaining a high level of knowledge and expertise within the healthcare system or the police service. An ongoing generational shift within the welfare institutions tends to replace experienced professionals with new graduates. Thus, a structural form of training on FGM for professionals within all concerned fields is emphasised as a priority.

Regarding the two remaining Ps, protection and prosecution, the respondents say that all necessary institutional mechanisms to enable the accurate handling of cases of FGM seem to be in place, that is, when a complaint reaches the social services (as the main institution responsible for young people’s well-being and protection) or the police service, the investigation processes are managed as expected. Taking into account that cases of FGM are handled in the social services’ regular structures of child protection, no further changes in legislation and/or procedures (other than capacity-building) have been created to enable a sufficient handling process. Within the field of prosecution, several changes in legislative measures have been made to facilitate cases of FGM being taken to court. Two respondents in particular report on a highly alert social welfare system in which professionals are very willing to report cases of FGM — both to the social services and to the police — using all the legislative measures in place for their support. However, the comprehensive legal system enabling professionals to take various measures on (suspected) FGM has also created obstacles to implementation. Both respondents say that the system tends to be over-sensitive and, for example, unjustified genital examinations of girls are being carried out. A key challenge for the social services and the police service may thus be to ensure a balance between prosecution and protection. On the one hand the alertness must be kept high to protect girls from FGM, and on the other hand this alertness and willingness to protect girls from FGM must not turn into ‘spectacles’ where ethnic groups are stigmatised and where the integrity of individuals is violated in the system’s desire to take cases to court. Thus, the challenges in the areas of prosecution and protection are not related to a lack of initiatives, but rather to the system’s (too) high alertness in cases concerning FGM, as mentioned by the respondents.

Swedish prevalence estimates: challenging and encouraging factors

Little has been done to collect prevalence data in Sweden. Currently there are no central registers in place to record data on cases of FGM taken to court, asylum cases related to FGM or the number of police reports and/or police investigations. Several potential registers for the recording of FGM in Sweden are in place, for example...
various medical registers, but no system can sufficiently meet the requirement of obtaining data of reliable quality. The respondents provided several reasons: firstly, FGM is a broad scope of procedures (i.e. type I, II, III, IV), therefore it is difficult for healthcare professionals, without sufficient experience, to determine if FGM has been performed and, in if so, to what degree. A solution to the problem would be to introduce a broader scale of classification, such as ‘mild’ or ‘severe’ FGM. Secondly, appropriate FGM diagnosis criteria to enable registration in the usual hospital records are lacking. Supplementary diagnosis criteria must be introduced at an international level in order to be used by the Swedish healthcare system.

Moreover, it must be mentioned that only two cases of FGM have been taken to court since the act prohibiting FGM was put in place in 1982. One of the interviewees says that the scarcity of court cases could have two plausible explanations: (1) the level of segregation between practising communities and the Swedish majority population is high, which consequently would mean that Swedish municipality authorities have little insight into practising communities’ day-to-day activities, therefore there is a risk that Swedish authorities never get to know about cases; (2) practising groups’ resistance to performing FGM makes it difficult to find cases (that is, FGM is not widely practised). There is thus a possibility that the practice of FGM has been re-evaluated and partly abandoned among (previously) practising communities in Sweden, particularly in well-established groups. Two respondents consider that the measures normally used for ‘girls at risk’ (i.e. counting the number of immigrant women and girls from countries where the prevalence of FGM is high, and thereby establishing it as ‘at risk’) offer a simplified estimate. Instead, level of segregation, time in Sweden, family background, etc. could be analysed to allow estimates of girls at risk of being subjected to FGM.
Country report

United Kingdom
Country report: United Kingdom

1. IDENTIFICATION

Country: United Kingdom
Researcher: Eiman Hussein

2. PREVALENCE OF FGM

2.1. Methodological approach for collecting prevalence data

Documents on prevalence were searched for using the academic databases, following the ‘Guidelines for national data collection’. There was one prevalence study which I obtained through the academic database. The following databases were searched for prevalence studies in the UK: Social Science Research Network, PubMed, Web of Science, BASE, Cinahl Plus and Google Scholar.

The key terms for my search included: female genital mutilation, female genital cutting and female circumcision.

One document was retrieved — ‘A statistical study to estimate the prevalence of female genital mutilation in England and Wales’.

In addition, the Forward website was visited to see if the search would yield any further information.

With regard to registration, the document review did not provide any information, but I also accessed the website of the Office of National Statistics to search their registration system, including maternity, and live and still births records.

2.2. Nature of prevalence studies/FGM registration systems

In the PREV sheet of the UK database it is noted that there are only two prevalence documents. Only one prevalence study has been conducted and documented in the UK. This was ‘A statistical study to estimate the prevalence of female genital mutilation in England and Wales’. The study was conducted by Forward in 2007 and was a collaboration between the London School of Hygiene and Tropical Medicine and the Department of Midwifery of City University. The study was funded by the Department of Health.

The methodology used for the Forward study was through extrapolation of prevalence data from FGM-practising communities in Africa (mainly through DHS surveys in most of the countries, if available, or other sources of prevalence data) using the UK census data of 2001. The overall FGM rate found in the country of birth was multiplied by the number of women aged 15–49 included in the 2001 census as being resident in England and Wales.

The study had several limitations including the following.

- It was based on census data, therefore excluded women who were not registered in the census (undocumented migrants).
- The study used data from the 2001 census, therefore any migration from after 2001 was not included, which would have added substantially to the numbers affected by FGM.
- The study did not identify second generation women who might be subjected to FGM.

The success of using this method for the Forward study was that it provided a much-needed estimate of the FGM situation in the UK. The findings provided by the study were the only reference used, and they have been widely quoted in all policy documents, articles and guidelines, providing an insight into the magnitude of the problem.

The second document is an ongoing national survey on FGM among young people in the UK that is being conducted by Forward. The research is part of a 3-year project that has been funded by the Esmee Fairbairn Foundation and is a collaboration between Forward and the University of East London. The research has received ethical clearance from the University of East London and is targeting males and females, 16–25 years of age, from FGM-practising communities living in the UK. The methodology that will be used in the study is a mixed approach of both quantitative and qualitative research methods. With the quantitative part of the research being an online survey for males and females that was launched live on 6 February 2012 on the International Day of Zero Tolerance to FGM, to be kept online for 4–6 months, based on the response rate. The qualitative part of the research will be through focus group discussions that will be held with males and females separately (10–12 in each group) and will carry out an in-depth probe into some of the issues that were raised by the questionnaire. The Forward national survey is a large-scale study that will be conducted with young people from FGM-practising communities. It is expected that the results obtained will provide an estimate of the prevalence of the number of 16- to 25-year-old women currently living in the UK who have experienced FGM. This is a much-needed estimate as there has been no study on this scale with this specific population.
With regard to the availability of registration systems to collect information on FGM there is currently no routine data collection system on FGM by any governmental or non-governmental body in the UK. However there is non-systematic collection of data.

- FGM information is collected during antenatal visits in some NHS health authorities in a few boroughs as well as in some cities in the UK, however it is not routine data collection and is mainly based on a postcode lottery system (the inequalities in the services provided amongst the different NHS trusts).
- The Metropolitan Police Service, via project Azure (which deals specifically with FGM), only provides data on the number of cases which are under investigation. There is no identified registration system and no clear indication whether the cases under investigation identified as ‘at risk’ are followed up or undergo any check in the future.
- Neither the Asylum and Immigration Tribunal nor the Home Office Borders Agency officially record the number of applications for asylum on the grounds of FGM. This is a question which has been raised on several occasions by MPs during House of Commons debates, but until now nothing has been done. However, the Home Office issues annual reports of the latest immigration and asylum statistics, providing information on the number of applicants for asylum, their gender and their country of birth. With regard to applications for asylum, information is provided based on whether the person was granted asylum as a refugee, granted humanitarian protection, given discretionary leave to remain or refused asylum. However this information is not broken down into further details and the grounds for applying for asylum are not included.
- The National Society for the Prevention of Cruelty to Children (NSPCC) provides annual child protection register statistics. These contain confidential details of children who are at continuing risk of physical, emotional or sexual abuse, or neglect, and for whom there is a child protection plan. Registers cover each local authority area in the UK and are managed by individual social services departments, but FGM is not specifically mentioned.

The issue of registration of FGM is not available as a protocol or guidance to be adhered to systematically. There is no clear system put forward to register the number of women with FGM or the number of girls that could be at risk. However, in the African Well Woman Clinics (specialist FGM clinics — altogether there are 15 clinics in the UK), the number of cases of FGM seen are recorded. But again it is not clear how the information is used by them.

2.3. Findings from the prevalence studies/registration systems

The main objectives of the Forward study were to estimate the number of women from FGM-practising countries resident in the UK, to estimate the number of maternities (registered live or still births) to women with FGM and to estimate the number of girls under 15 years at risk of FGM in England and Wales. Scotland and Northern Ireland were excluded as during the time of the research they had minimal migrant populations. Based on the findings by Forward, it is estimated that there are nearly 66 000 African women resident in the UK who have experienced FGM, nearly 16 000 girls under the age of 15 at high risk of type III FGM and over 5 000 girls at risk of types I or II FGM.

As for the estimated number of maternities (registered live or still births) to women with FGM, data on the country of birth specific rates of FGM were applied to the birth registration data in each of the 4 years from 2001 to 2004. The estimated percentage of all maternities in England and Wales to women with FGM increased over the time period from 1.06 % in 2001 to 1.43 % in 2004. There was also considerable geographical variation.

A recent estimate of the number of births to women with FGM in the city of London only was calculated by one of the researchers who was involved in the Forward 2007 study. This revealed an increase from 4 238 women with FGM giving birth in 2000 to approximately 7 000 in each of the years from 2007 to 2009.

2.4. Reflection on prevalence studies

In the UK, with the increase in the number of migrants, the Forward study provided a much-needed estimate of the number of women who had experienced FGM that were resident in the UK. The limitations of the study were already discussed in Section 2.2. However, it is important to note that the study’s methodology was through extrapolation, and although the findings provided an insight into the situation in the UK, more recent, reliable and representative data is required.

Some other limitations of extrapolating of estimates using the 2001 census for the study were as follows.

- Projecting estimates using rates of FGM prevalence in women from FGM-practising countries in Africa did not take into account the change in practice that might occur in communities due to migration.
- The country of origin prevalence data might not have reflected the recent changes in the practice in the country.

There have been no other studies to document the prevalence of FGM in the UK since the Forward study in 2007. To conduct a major prevalence study would be expensive, but Forward, as a lead actor in the UK, has been pushing forward the agenda on the need for data and its importance over the past 2 years. Other organisations have also joined in the campaign regarding the need for data, such as Equality Now and the Iranian and Kurdish Women’s Rights Organisation (IKWRO).

It would be interesting to conduct a similar prevalence study using extrapolated data to provide a comparison between the two studies, in particular given that the UK census of 2011 has taken place.

As for the upcoming research, the Forward national survey on FGM amongst young people from FGM-practising communities aged 16–25 years, this aims to develop a deeper understanding of the perceptions, experiences and
knowledge of FGM of young people in the UK, as well as an estimate of the prevalence. It will be the first study on FGM in Europe to work with young people through the use of an online survey. The survey tool was developed in consultation with an advisory team of research experts who provided their valuable input and feedback to the questionnaire.

The survey is currently online and is expected to continue for a few more months to ensure that there is a good response rate. An advertising campaign was implemented prior to the launch to ensure that a large number of youth groups, organisations, universities and colleges heard about the survey. In addition, social media sites such as Facebook, Twitter and others were made use of extensively to spread the word.

As data collection for this study is still in its early days it will be hard to speculate upon a precise date for publishing of the study, but it is estimated to be available by the end of 2012 or in early 2013.

3. POLICY FRAMEWORK

3.1. Methodological approach for collecting documents on policies

Documents on policies were searched for using the academic databases, following the ‘Guidelines for national data collection’. The following databases were searched for policy documents in the UK: Social Science Research Network, PubMed, Web of Science, BASE, Cinahl Plus and Google Scholar.

The key terms for my search included: female genital mutilation, female genital cutting and female circumcision.

The search on academic databases did not yield any documents, therefore I researched again checking the following websites.

- Home office — The site was searched using the general search function and yielded a very large number of documents. The search term was ‘female genital mutilation’. I changed the search term to ‘female genital mutilation policy’ and again there was a large number of documents, but I found FGM under the VAW page. All the documents were reviewed and analysed and the relevant ones were saved in the database folder.

- Department of Health — The site was searched for publications and yielded a large number of documents. I then searched again for documents and reports which were under reports and consultations. The search yielded 134 results. I scrutinised all the relevant documents carefully and saved the relevant documents.

- Department of Education — The site was searched using the search term ‘female genital mutilation’, which yielded only three hits. Under health and well-being I accessed ‘safeguarding children’ and got 30 hits. All documents were reviewed carefully and the relevant ones were saved in the database folder.

- Foreign and Commonwealth Office — I searched the general website with the search term ‘female genital mutilation’ and got 51 results. Each document was carefully reviewed and all the relevant material was taken.

- UK parliament — A general search was performed, yielding more than 20 000 hits. Within the results I limited the search to parliamentary business, but this also yielded a large number of documents. I scrutinised the documents and took the relevant ones. I then searched http://www.theyworkforyou.com, which provides searches for documents related to the UK parliament.

- Equality and Human Rights Commission — I searched in the general using the search term ‘female genital mutilation’ and got nine hits. Each document available was carefully scrutinised. I then changed the search filter to the whole website, which yielded 66 results. Each was reviewed carefully.

- All-Party Parliamentary Group (APPG) on Population, Development and Reproductive Health — I searched for publications and from found references to ‘female genital mutilation’. The relevant documents were reviewed and saved. I also carefully scrutinised the different debates and discussions and saved several of them.

- Website of the Scottish government — I searched for publications using the keyword ‘female genital mutilation’, getting 93 results. I carefully read through the material and saved the relevant documents.

- Website of the Welsh government — I used the search term ‘female genital mutilation’, which yielded no hits, then looked at the publications and searched for ‘child protection’. I carefully scrutinised the documents I found in my search.

Twenty-seven documents have been included in the policy section. There were numerous parliamentary debates and written evidence but I took only the relevant debates which had useful or interesting points. Some documents were guides that I included with the tools and instruments. All policies of NGOs and professional bodies and agencies have been included in the tools and instruments.

3.2. Policies on FGM

UK policies with regard to FGM began as early as the 1980s, when public interest in the issue was raised. This was through two crucial events in that period: (1) the publication of the Minority Rights Group report ‘Female circumcision, excision and infibulation: the facts and proposals for change’ in 1980; and (2) a debate in the House of Lords in 1982 that raised the issue of FGM in parliament. The latter was the first parliamentary discussion on prohibiting the practice in the UK. The proposed act introduced was blocked by the House of Lords, but following lobbying by concerned politicians and activists specific legislation came into force in 1985, resulting in the Prohibition of Female Circumcision Act 1985.

Following the new law, there were no clear guidelines on prosecution or how to protect a child at risk or who had experienced FGM. However, in some authorities, it was incorporated into child protection procedures at the local level.

In 1989 the government passed a new law on the protection of children (the Children Act 1989). In 1991 the Department of Health revised its document ‘Working
together: A guide to arrangements for interagency cooperation for the protection of children from abuse’, which came as a guidance supplement to the new Children Act 1989 on what interagencies should do for the protection for abused children.

In 1992, Forward, an NGO that was established in 1983 specifically to advocate and campaign against FGM, held the First National Conference on FGM: Unsettled Issues for Health and Social Workers in the UK. The conference brought together over 150 health, education and social workers and representatives from ethnic minority communities in the UK. A heated debate was generated and it was concluded that FGM constituted a form of child physical abuse. Some of the recommendations of the conference were as follows.

- The then Department of Health and Social Services (DHSS) should raise the awareness of authorities on the existence of FGM.
- DHSS guidelines should include FGM within the ‘child at risk’ register.
- Training should be provided to all front-line professionals on FGM.

In 1999 the Department of Health, the Home Office and the Department for Education jointly issued the policy document Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children. This policy document set out guidelines on how all agencies should work together to promote the welfare of children and protect them from abuse and neglect. The guidelines provided a structure within local authorities to deal with issues of child protection. FGM was also specifically mentioned in the chapter ‘Child protection in specific circumstances’. Local authorities were able to exercise their powers under Section 47 of the Children’s Act 1989 if they felt a child was at risk or had undergone FGM.

In 2000 the APPG on Population, Development and Reproductive Health (a group of MPs that has been active in lobbying and advocating against FGM in the UK) organised a 2-day hearing in parliament, on 23 and 24 May 2000, on FGM. The objectives of the hearings were to develop and implement appropriate legislation, with consultation with all concerned groups. Prior to the hearings a survey was sent out to leading organisations working in the field both in the UK and abroad, as well as local authorities, health professionals, social workers, and representatives from UN agencies and the WHO. Expert witnesses were called upon to provide oral evidence to a panel of APPG members. As a result of the 2-day hearing and the results of the survey, the APPG members put forward government recommendations, which included amendment of the existing Prohibition of Female Circumcision Act 1985. Other recommendations were that supplementary guidance to Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children should be developed that dealt specifically with FGM. The government should also fund projects to develop women’s leadership and literacy skills, and all health professionals and other relevant authorities would be required to report incidents of FGM.

In 2002, following the recommendations provided by the APPG hearings, a Labour MP, Ann Clwyd, presented a private members’ bill to amend the 1985 act. A series of debates and readings of the draft bill put forward were held in the House of Commons.

There were concerns about the new proposed bill of 2003 from NGOs working against FGM in the UK, including Forward, the Research Action and Information Network for the Bodily Integrity of Women (Rainbo) and Black Women’s Health and Family Support (BWHAFS). Their concerns included the following.

- Forward was critical of restricting the bill to specific groups, thus failing to protect girls who were not UK nationals or permanent UK residents, in particular as newly arrived communities were the ones most likely to want to take their girls to undergo FGM.
- Rainbo had concerns that the attempt to differentiate cosmetic surgery for reasons of mental health created a loophole to allow non-therapeutic operations to continue. It felt that, in order to close any existing loopholes, it should be applied to all non-consenting minors under 18 years of age regardless of their race or religion.
- The BWHAFS was concerned that without any prosecutions the new law will be undermined by communities who will not believe that it is serious. It also raised concerns on how the law will be implemented, how will it be monitored and the need for the government to consult with NGOs and CBOs.

The Female Genital Mutilation Act 2003 was finally approved and enacted in 2004. A policy circular in 2004 distributed by the Department of Health was sent to all concerned agencies to inform them of the change in the bill and what the amendments were.

Changes were gradually implemented in the UK to incorporate FGM within most of the existing documents. Nevertheless, introducing a specific new issue into the existing policy agenda had its implications, and gaps began to appear in particular with the increasing number of migrants coming to the UK from FGM-practising countries — such as health needs and issues of application for asylum on the grounds of FGM.

Over the years the subject of FGM has been raised frequently in parliament by concerned MPs in debates and during special selected committees on child protection and violence against women, in particular due to the fact that since the enactment of the 2003 FGM act in 2004 no prosecutions had taken place. In addition, questions were raised on how the statutory sector dealt with FGM and the issue of FGM as grounds for asylum. The following provide a snapshot of some of the discussions and points raised in parliament on FGM: Hansard debates for 8 December 2005; ‘Tackling the health and mental health effects of domestic and sexual violence and abuse; Cohesion and equality: guidance for funders; and National guidance for child protection in Scotland.’

In 2007 the London Safeguarding Children Board (LSCB) issued a guideline called ‘Safeguarding children at risk...
of abuse through female genital mutilation’. The LSCB is a team of representatives from all 32 boroughs of London, the police, health sector, and voluntary and community agencies who provide advice and support to all 32 boroughs. The significance of the document was that it dealt specifically with FGM and collated all existing work on FGM into one, including identifying a child at risk and the role of the social services and the police, and the procedures that will take place to protect a child at risk or suspected to have undergone FGM.

For Wales the guidance was called ‘Safeguarding children — Working together’, issued in 2007 under the Children Act 2004.

In 2009 the UK government issued an FGM factsheet which was distributed widely in the relevant departments as well as to the police, voluntary and community-based organisations, etc. In addition, following a government consultation to develop a strategy to end violence against women, the policy document ‘Together we can end violence against women and girls: A strategy’ was issued in 2010 (1) (this has not been included in the database). One important follow-up from the strategy document was the appointment of a cross-government FGM coordinator in September 2009 to provide a single point of contact for stakeholders within and outside government and to lead the work on FGM. One of the targets of the FGM coordinator was to work with the relevant departments in developing multi-agency guidelines to deal specifically with FGM.

In 2010 the Department of Education issued the policy guidance Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children. The significance of this document was that it included supplementary guidance on promoting the welfare of children in Chapter 6, which specifically included FGM, and that under Section 47 of the Children Act 1989 a local authority could exercise its powers if it believed a child was at risk of FGM.

The year 2011 saw the successful launch of the policy and the guidance document Female genital mutilation: Multi-agency practice guidelines. This was a welcome development as the document provides clear instructions and guidelines for all front-line professionals that might deal directly with FGM. The document provides advice and support to front-line professionals who have responsibility for safeguarding children and protecting adults from abuses associated with FGM. It provides information on:

- identifying when a girl has been subjected to FGM and how to respond appropriately to protect her;
- measures that can be implemented to prevent FGM.

A policy protocol was also issued in Wales. Other relevant policies included the issuance by the Home Office of the Call to end violence against women and girls: Action plan, which was a follow-up from the ‘Together we can end violence against women and girls: A strategy’ policy guide. The importance of the action plan is that it also identifies which departments will be responsible for FGM in the government’s ‘six P’s’ strategic plan (policy, perspective, prosecution, prevention, provision and protection).

Another development in the UK on FGM was the Crown Prosecution Service issuing its legal guidance for FGM, which provided guidance in cases where FGM was suspected and outlined the different legal considerations.

Unfortunately, despite the new developments, in 2011 the post of the cross-government FGM coordinator was abolished. This has caused concern among various stakeholders as it was the only position that was devoted to working solely on FGM in the UK. Questions were again raised in parliament on why the post was abolished, as well as what the next steps will be for the government following the departure of the FGM coordinator.

At the end of 2011 the House of Commons Education Select Committee heard written evidence on the child protection system in England. This was an important event due to the evidence provided by various important stakeholders that were involved or worked in child protection, and evidence was provided by organisations which dealt with FGM, including health professionals, the police and organisations including Forward and the IKWRO, among others.

In addition, a new all-party parliamentary group specifically for FGM was created and Jane Ellison MP was appointed as the chair of the group. The new group is made up of over 50 MPs and peers from all the main political parties and has been formed to raise awareness of FGM in the UK and overseas and to work with the government and NGOs towards ending FGM.

3.3. Reflection on policies on female genital mutilation

In the UK the main players in the government have been the Department of Health, the Department of Education, the Home Office and the Foreign and Commonwealth Office. There is also the role of the police and social services in child protection. The multi-agency guidelines that were published in 2011 have been much needed as FGM is a cross-departmental issue that requires the various departments to coordinate their work together.

Once the issue of FGM surfaced in the UK policies on it gradually started to be put in place by the government. But it has taken a considerable time and required constant lobbying and advocacy work to include the issue on the agenda. Some of the main lobbyists have been concerned MPs who brought the matter to parliament to be discussed,

However, despite the current existence of various policy guidelines which are available and have been developed to incorporate FGM within their instructions, there are a few matters of concern.

- There is still no clear national strategy on FGM in the UK. There are multi-agency guidelines but without a clear structure or an accountable body to direct the policies and guidelines that have been developed. The words are being spoken but are not being backed up by actions.
- There needs to be more consultation with organisations that work directly with the community as they can represent the voices of these different communities so that the policy approach is not simply a top-down approach.
- The discontinuation of the position of the FGM coordinator has been a cause for great concern amongst the various stakeholders as it was the only position that related specifically to FGM.
- The fact that there have still been no prosecutions reduces the communities’ accountability and trust in the government. This concern was voiced several times by women from FGM-practising communities during qualitative research that was conducted by Forward.
- There is no registration system available that can provide accurate figures on FGM thus hindering the monitoring and following-up of policy instructions.
- There is very limited funding for NGOs and community-based organisations (CBOs) that are currently working with black and minority ethnic women, leading to a vicious circle of reduced service provision, limited staff and the possibility of organisations closing down.
- The new proposal for NHS reform (2) has made it unclear what the future will hold for specialist FGM clinics.

It seems that a lot still needs to be done to ensure that all front-line professionals are trained on FGM, so that all concerned work in a more coherent structure. In addition, more funding should be provided for organisations that are at the forefront of working with communities so that they are more engaged and aware of FGM as a child protection issue.

There is also a need for a clear registration system to be put in place in order to monitor and record the number of girls from FGM-practising communities resident in the UK, the number of women who attend clinics due to their FGM and the number of women who have applied for asylum on grounds of fear of FGM being done to them or to their daughters.

4. LEGAL FRAMEWORK

4.1. Methodological approach for collecting documents on the legal framework

For the various subsections within the legal framework, I accessed the following sites:

- UK national legislation (http://www.legislation.gov.uk). For the search I used the following keywords: ‘female genital mutilation’ (three hits) and ‘Children Act’ (more than 200 hits — only the relevant ones were used).
- For the asylum and refugee provisions I visited the website of the UNHCR (http://www.unhcr.org/refworld). The keywords were: ‘female genital mutilation’ (144 hits) and ‘FGM as grounds for asylum’ (166 hits). I carefully scrutinised the results and took the relevant documents. I also looked for specific cases which I had already read about in another document, and searched for ‘Yates’ and ‘Fornah’ as examples of cases in which asylum in the UK was granted.
- Crown Prosecution Service (http://www.cps.gov.uk). I searched the site using the term ‘female genital mutilation’. The search returned 27 hits, which were carefully scrutinised and the relevant documents taken.

Following the search the relevant sections/articles in the laws were validated and cross checked to ensure that they were the most relevant ones. I then included them in the database.

4.2. Criminal law

FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed in June 1985. Based on the act:

- Section 1(1)(a) of the 1985 act considers it a criminal offence ‘to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person’ (i.e. includes FGM types I, II and III);
- Section 1(1)(b) makes it an offence ‘to aid, abet, counsel or procure the performance by another person of any of those acts on that other person’s own body’. Thus it is also illegal to assist, advise or seek the assistance of someone else to undergo FGM;
- an offence under Section 1(1) is punishable with up to 5 years’ imprisonment, an unlimited fine or both;
- Section 2 of the 1985 act provides an exception for necessary surgical operations and operations carried out in connection with childbirth. However, this will only apply if the operation is carried out by a registered medical practitioner or registered midwife or a person training to be one.

The Prohibition of Female Circumcision Act 1985 came into force in September 1985. The law extends to Northern Ireland and does not include Scotland.

Since the act came into force there have been no prosecutions, and in 2000 at the APPG on Population, Development and Reproductive Health hearing on FGM it was discussed that there was an existing loophole in the Prohibition of Female Circumcision Act 1985 which enabled families to take their children abroad to undergo FGM. It was recommended that the act be amended so as to close the loophole and prevent girls from being taken abroad.

(2) The proposed reform is still under discussion and has been a proposal since 2011. It will involve giving general practitioners (GPs) responsibility for the bulk of the health budget, under the supervision of a new NHS commissioning board, ending the 152 primary care trusts in England and providing increased competition between specialist services for funding.
In 2002 the MP Ann Clwyd introduced the Female Genital Mutilation Act in a private members’ 10-minute bill. This was to repeal and re-enact the 1985 act. In 2003 the Female Genital Mutilation Act 2003 was passed and the 10-minute bill came into force in March 2004.

The Female Genital Mutilation Act 2003 repeals and re-enacts the 1985 act. The amendments were as follows.

- The title of the act was changed to describe more accurately the prohibited acts and acknowledged the practice as an act of mutilation.
- The act gave extraterritorial effect to the existing provisions, and thus it became an offence for a UK national or permanent UK resident to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice may be legal.
- The act increased the maximum penalty for performing and procuring FGM from 5 years’ to 14 years’ imprisonment and/or a fine or both.

The Female Genital Mutilation Act 2003 extends to Northern Ireland.

In Scotland the Prohibition of Female Genital Mutilation (Scotland) Act 2005 came into force in September 2005. The changes it made were as follows.

- It changed the definition of female circumcision to female genital mutilation. The definition of female genital mutilation in Section 1 of the act is ‘to excise, infibulate or otherwise mutilate the whole or any part of the labia majora, labia minora, prepuce of the clitoris, clitoris or vagina of another person’ i.e. FGM types I, II, III and IV are all illegal.
- It made it an offence for UK nationals or permanent UK residents to carry out or aid and abet FGM abroad.
- The maximum penalty was increased from 5 years’ to 14 years’ imprisonment and/or a fine.

There have been no criminal cases relating to FGM in the UK. As mentioned above in Section 3 the Metropolitan Police Service does not have a register to record the number of girls at risk, but it does record the number of cases under investigation.

4.3. Child protection laws/provisions

In the UK, altogether there are four child protection laws which have been identified and FGM can be identified within the laws as a cause of significant harm, and normal child protection procedures to prevent the child from ‘significant harm’ should be involved.

The Children Act 1989

Section 47 of the Children Act 1989 (protection of children) provides legislation which does not specifically include FGM, but the practice can be classified as a cause of significant harm to the child. Section 47 states that when a local authority has ‘reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare.’

Child welfare officials, when they suspect that a child is at risk of FGM, can intervene by means of the following measures: withholding authorisation to leave the country (by withholding the parent’s passports, witholding the girl’s passport), suspension of parental responsibility and, in extreme cases, removal of the child from the family as a last resort.

The Children Act applies only to England and Wales. Since its enforcement, a report by the Minority Rights Group in 1992 stated that seven successful interventions have been undertaken by local authorities in suspected cases. But there are no clear details of what measures were undertaken.

The Children (Northern Ireland) Order 1995

Section 65 of the Children (Northern Ireland) Order 1995 (Removal and accommodation of children by police in cases of emergency) states that: (1) Where a constable has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, he may — (a) remove the child to suitable accommodation and keep him there; or (b) take such steps as are reasonable to ensure that the child’s removal from any hospital, or other place, in which he is then being accommodated is prevented. (2) For the purposes of this Order, a child with respect to whom a constable has exercised his powers under this Article is referred to as having been taken into police protection’. If there is any suggestion that the family still intends to subject that child to FGM the first priority is the protection of the child and the least intrusive action should be taken to ensure a child’s safety. Measures taken under Section 65 can include: an emergency protection order; keeping the child safe far from their family in suitable accommodation; taking any reasonable steps to ensure that the child’s removal from the place she is being accommodated in is prevented (Police response to FGM, April 2011).

The Children (Scotland) Act 1995

Section 55 of the Children (Scotland) Act 1995 (Child assessment orders) states that: ‘A sheriff may grant an order under this section for an assessment of the state of a child’s health or development, or of the way in which he has been treated (to be known as a “child assessment order”), on the application of a local authority if he is satisfied that — (a) the local authority have reasonable cause to suspect that the child in respect of whom the order is sought is being so treated (or neglected) that he is suffering, or is likely to suffer, significant harm; (b) such assessment of the child is required in order to establish whether or not there is reasonable cause to believe that the child is so treated (or neglected); and (c) such assessment is unlikely to be carried out, or be carried out satisfactorily, unless the order is granted.’ Measures taken under Section 55 might include removing the child from their home or keeping them in a specified place to allow for an assessment to take place, where the local authority suspects that the child is suffering or likely to suffer significant harm.

The Children Act 2004

Section 11 of the Children Act 2004 (Arrangements to safeguard and promote welfare) states that: ‘Each person and body to whom this section applies must make arrangements for ensuring that — (a) their functions are discharged having regard to the need to safeguard and promote the welfare of
characteristic they cannot change and which defines a particular social group is defined as follows: if individuals practised she may be a member of a 'particular social group'.

The legislative framework in England and Wales for the child protection system is based upon the Children Act 1989; in Northern Ireland it is based upon the Children (Northern Ireland) Order 1995; and in Scotland it is based upon the Children (Scotland) Act 1995. As mentioned earlier a child 'at risk' of FGM is considered to be under threat of significant harm and the relevant child protection procedure needs to be followed as provided for by the Children Act.

It is important to note that the Children Act 2004 does not replace the Children Act 1989 but it has made changes to the way children's services are structured in England and Wales. This was due to the establishment of local safeguarding children boards in each area in the UK.

The number of child protection interventions specifically due to FGM is not available in any registration system or recording system. As mentioned in Section 2 above, the NSPCC has records on the number of children who have been placed under child protection procedures or plans, but with no details on the reason. However, I did find in one document not included in the database (Westminster’s joint strategic needs assessment — Violence against women and girls’, 2010, published by Westminster City Partnership) that there was one recorded case of a multi-agency risk assessment conference (MARAC) because of FGM in the borough of Westminster in 2009. MARAC’s are referred to during high-risk cases as they exercises timely interventions and only practitioners can make a referral to a MARAC if they suspect a high risk. Therefore there could very well be ad hoc records based on the policy underlined in that local safeguarding children board or city.

4.4. Asylum law(s)/provisions

There is no specific asylum UK national legislation dealing with FGM, however the immigration rules (HC395) referring to the 1951 UN Convention relating to the Status of Refugees codify the way in which the UK regulates entry into and settlement in the UK, including asylum claims. Women and girls applying for asylum in the UK for fear of FGM can apply on the following grounds: ‘If there is a well-founded fear, which includes evidence that FGM is knowingly tolerated by the authorities or they are unable to offer effective protection, and there is no reasonable possibility of relocation in her own country, an applicant who claims that she would on return to her home country suffer FGM may qualify for refugee status.’ If the applicant belongs to an ethnic group amongst which FGM is practised she may be a member of a ‘particular social group’.

A particular social group is defined as follows: if individuals share a common background which is an immutable characteristic they cannot change and which defines the group by giving it a distinct identity in the society in question and has nothing to do with the actions of the future persecutors, then the group exists independently of the feared future act of persecution. Women who may be subjected to FGM have been defined in some courts as belonging to a particular social group.

The UK also adheres to the European Convention on Human Rights, where a claim to asylum on the grounds of FGM can be considered based on Article 2 (the right to life), Article 3 (prohibiting cruel and degrading treatment) and Article 8 (the right to respect for family and private life). A human rights claim can be part of the asylum claim under the refugee convention or it can stand alone.

If a female applicant has already been subjected to FGM, the UK Border Agency (UKBA) would not consider her to face a risk of persecution on the basis of FGM in the future. However, it can be considered if there is substantial proof that there might be a risk of forced marriage or that the woman might be at risk of having the procedure redone after delivery of a baby. In addition, in some circumstances future cases can apply if there might be a risk of FGM being performed on the daughters of an already genitally mutilated woman.

A ‘refugee’ as defined by Article 1(A)(2) of the refugee convention is a person who ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.’

In the UK there is no national or central registration system for asylum cases related to FGM. As such it is not known how many claims for asylum have been made on the grounds of fear of FGM, but it has been reported by organisations working with refugees and asylum seekers such as Asylum Aid that there have been a number of applications for asylum on the grounds of FGM (but no exact figure provided).

However, throughout the years there have been documented cases of asylum applications on the grounds of FGM that have been successful.

• In 2000 there was the case of a 17-year-old girl v Secretary of State for the Home Department (Appeal No 00TH00493). She was a Muslim Ivorian asylum seeker. The girl applied for asylum for fear of being subjected to FGM and being pressured by her own family to undergo it. The appeal was granted as it was believed that the appellant was from a state unwilling to protect her against FGM.

• In 2004 there was the case of P & M v Secretary of State for the Home Department (Appeal EWCA Civ 1640). Both women were from Kenya. The first had experienced domestic violence at the level of torture and the second faced FGM as a result of her father joining the Mungiki sect (the mother of M had been subjected to FGM and had died from it and her sister was also forced to undergo FGM). Both women were granted asylum as it was held in both cases that the state had failed to protect them.
• In 2006 the case of Fornah v Secretary of State for the Home Department (EWCA Civ 680) set a new precedent in terms of the refugee convention and females fleeing a well-founded fear of FGM and forming a ‘particular social group’. Fornah was from Sierra Leone, 15 years old. The majority of the court held that the appellant could not be held to be a member of a particular social group because the practice was not discriminatory as it would not set her apart from society. The case went all the way to the House of Lords, where for the first time the House of Lords ruled in favour of Fornah and she got recognition as a refugee.

There is not a lot of clear structure or guidelines on how decisions are made on asylum cases, and most decisions are determined as ‘case based’ and are not consistent. The Home Office has prepared country reports which provide information on the status of FGM in some of the countries in Africa that practice FGM, but it is not clear how accurate they are in terms of the situation as they may have only general information on FGM that is not detailed enough.

In 2007 the Home Office introduced the new asylum model (NAM). The intention behind the asylum model was to improve on the significant delays in the asylum process. After screening the case would be allocated to a case owner within the United Kingdom Border Agency (UKBA). The case owner is then supposed to ensure that the individual claimant understands the process, is aware of their entitlement to seek legal advice and should arrange a date at which the claimant would be interviewed in order that the individual would be able to set out the full basis of their asylum claim. Following the interview the individual claiming asylum is given a short period of time within which to make written representations and a decision is supposed to be made immediately thereafter.

There has been concern that the new, quick process of the NAM does not provide enough time for preparation of the case, thus even the strongest of cases might not have been prepared adequately due to the short time provided. One particular issue of concern is that the system has been very harsh on vulnerable asylum seekers. Women in particular find it difficult to disclose sensitive information at an early stage; in addition the case worker might be a male, thus making it more difficult to talk about her situation.

4.5. Professional secrecy provision(s)

In the UK, there is no specific law on professional secrecy concerning FGM, however under the Children Act 2004 all professionals have a statutory responsibility to safeguard and promote the welfare of a child. The professionals envisaged include all health workers, teachers, social services workers and police officers, in addition to others. All front-line professionals have a duty to report when it is considered that a child might be at risk of harm or abuse.

4.6. Reflection on legal framework

The UK has come a long way from when the Prohibition of Female Circumcision Act 1985 was introduced into the political agenda in 1982. With the enactment of the 2003 FGM act and the changes in the terminology used from ‘circumcision’ to ‘mutilation’, introducing extraterritoriality as well as the increase in the number of years’ imprisonment, the concern that FGM has raised in the country is well reflected. But despite strengthening of the new legislation there have still been no prosecutions at all, this has led to question marks with regard to the reliability of a law that has not had not even one court case held because of it.

It is as though the UK government is trying to have it both ways (toughening the law but at the same time being careful not to offend practising communities). But even women from practising communities have stated that ‘if the government does not put anyone in prison to set an example no one in the community will fear the law’.

FGM is a form of child abuse and should be treated accordingly, but there needs to be a more holistic approach to how it is dealt with, including working and engaging with communities so that they are also part of the process, thus working in a way that takes into account cultural sensitivity to ensure that the communities do not feel alienated or discriminated against.

All organisations need to work together, but in a more coordinated, systematic manner with a more defined monitoring system. In addition, all policies and plans that are put into action need to be done so in consultation with the NGOs and CBOs from the voluntary sector that are currently working with communities. Women and girls who have undergone FGM also have specific health needs which need to be addressed effectively and with cultural sensitivity.

5. RELEVANT ACTORS

5.1. Methodological approach for collecting relevant actors

In order to be included in the database, an actor was defined as any organisation or individual who performed any work on FGM in the UK, as was specified in the ‘Guidelines for national data collection’.

For the actors I used various approaches, including the following:

• Performing a general search on Google for ‘female genital mutilation in the UK’ and for organisations working in the UK on FGM. This was also filtered based on the organisations and individuals that I already had come across.

• Some of the actors were already in the database, therefore I cross-checked the available list and either excluded or included based on the criteria specified in the guidelines.

• Following the development of a list of actors, each actor was searched for separately to access their contact details, including the website and address, in addition to the work they have done on FGM, etc.

There are a large number of actors that are working or have worked on FGM in the UK. Due to the time constraints this list is not exhaustive. In case I have not included a relevant actor, I will communicate the details to the project coordinators to be updated accordingly.
5.2. Actors

The UK has a large number of actors who work specifically in the field of FGM, as well as those who work on a broader base but have incorporated FGM within the realms of their work. Included within the database are: government ministries (the Department of Health, Department of Education, Foreign and Commonwealth Office, Home Office and social services), the Crown Prosecution Service, local safeguarding children boards, all-party parliamentary groups (the APPG on Population, Development and Reproductive Health and the newly developed APPG on FGM), the 15 African Well Woman Clinics (providing specialist FGM services) and professional bodies (Royal College of Nursing (RCN), Royal College of Midwives (RCM), Faculty of Public Health (FPH), British Medical Association (BMA) and Royal College of Obstetricians and Gynaecologists (RCOG)). In addition there are non-governmental organisations and community-based organisations that work specifically on FGM or within the broader aspect of reproductive health and rights, international NGOs, the NSPCC, the Refugee Council, the Equality and Human Rights Commission and the Women’s Health and Equality Consortium.

The range of activities that the NGOs provide is variable but includes advocacy, training, research, counselling and awareness-raising, as well as working with communities in various projects (such as Forward’s women’s leadership programme).

With regard to NGOs, the first actor to appear in the field of FGM was the Minority Rights Group, established in 1980. As an organisation that worked to raise awareness through information and research, the Minority Rights Group developed a research report ‘Female circumcision, excision and infibulation: the facts and proposals for change’. One of the respondents, who was involved in their research, left the group and together with other African women activists founded the Foundation for Women’s Health Research and Development (Forward) in 1983. Since its establishment Forward has been at the forefront of work on FGM, with its main aim being to advance and safeguard the reproductive health and rights of African women and girls in both the UK and Africa.

At the same time, Black Women’s Health and Family Support (BWHAFS) was founded by Shamis Dirir in 1982. The main aim of the organisation was to promote the sexual and reproductive health and rights of African women. BWHAFS was previously known as the London Black Women’s Health and Action Project. It works mainly with the Somali community, and in collaboration with the London School of Hygiene and Tropical Medicine conducted the research project ‘How experiences and attitudes relating to female circumcision vary according to age on arrival in Britain: a study among young Somalis in London’ in 2004.

Important actors that have worked to develop government policies that were either specific to FGM or could be used in the campaign against it have been the Department of Health, the Department for Education and Employment (now known as the Department of Education), the Home Office and the Foreign and Commonwealth Office. Policies have been influenced by the APPG on Population, Development and Reproductive Health, who campaigned vigorously to get FGM on the political agenda (the APPG is a group which is formed of MPs that are interested and active in working to fight against FGM). Other institutions that have influenced policies throughout the years are the Equality and Human Rights Commission, the Refugee Council and the NSPCC. Their role has been in advocacy, research and advice.

Professional bodies such as the RCM, the RCN, the RCOG and the BMA have all highlighted their position against the practice by issuing statements, as well as developing guidelines for their staff. Other actors have mainly been individual experts: nurses, midwives and doctors with a special interest in FGM whose work has been published in the academic field. They have contributed by writing about their clinical experience in working with women who have experienced FGM. Some of these individual experts with health expertise formulated the FGM National Clinical Group in 2007.

5.3. Reflection on actors on female genital mutilation

Along with Forward and the BWHAFS, some of the other actors that appeared during the 1980s that began to raise awareness on the issue of FGM were concerned members of parliament such as Lord Kennet (who was the MP who introduced the Prohibition of Female Circumcision Act in the UK to the House of Lords in 1982). It was mentioned in the ‘From the heritage collections’ section of the RCOG website, to mark the International Day of Zero Tolerance to FGM on 6 February 2012, that ‘press reports of female circumcision being performed in London clinics in 1981 caused a sensation in the UK, and led to the introduction of a private member’s bill into the House of Lords, aiming to ban the practice. The bill was drafted by Lord Kennet (1923–2009), who has been described as “a crusading left-wing journalist who transferred his deep concern for the world to the chamber of the House of Lords when he inherited his peerage.”’ (3)

Some of the important events in the 1980s were as follows: the establishment of the two NGOs that are still continuing the work towards ending the practice of FGM — Forward and BWHAFS; the passing of the Prohibition of Female Circumcision Act 1985; and the development of research on FGM by the Minority Right Group to inform policies. In addition, in 1989 the Children Act 1989 was introduced and approved. The Children Act 1989 is a landmark framework that has assisted in articulating all future policies on the issue of child protection, safeguarding children and promoting their welfare.

In the 1990s Forward organised the first conference on FGM in the UK; over 150 people attended. At that crucial event it was agreed that FGM was a form of child abuse. The first African Well Woman Clinic, a specialist FGM clinic, was opened at Northwick Park Hospital in 1992 with the help of Forward. In 1999 the Department of Health issued the first

(3) http://www.rcog.org.uk/what-we-do/information-services/-collections/-heritage-collections-zero-tolerance-female-genital-mutilation
policy document on safeguarding the welfare of children. Forward also developed research reports on FGM and continued its advocacy and campaign against FGM.

There has generally been an increase in the number of actors who have started to incorporate FGM into their agenda. Most of them are NGOs that used to work on more general violence against women. Other research consultancy organisations, such as the Options consultancy, were introduced to the work of FGM by Forward as consultants to conduct PEER research with FGM-practising communities living in London.

There have been a few actors who were formulated as a group to work on issues related to women and issues of violence against women. These include the Women's National Commission, which was formed as an independent advisory body on women in government. This was established in 1969 and it closed down a few years ago. The role of the WNC was as a bridge between the government and women's organisations and groups working for women's equality. Part of the WNC's role in FGM was in setting up an FGM working group that aimed to gather together all concerned organisations and individuals working against FGM to influence policy and develop a national FGM strategy. It was also pivotal during the formulation of the FGM Act 2003.

Another actor, the Women's Health and Equality Consortium (WHEC), was established in 2008 and is a strategic partner of the Department of Health. The WHEC was developed as a partnership of women's charity organisations to provide a direct link between the voluntary sector and the Department of Health. The consortium consists of seven organisations (Forward, Platform 51, Positively UK, Imkaan, Women's Resource Centre, Rape Crisis, AWA and Maternity Action) and its main aim is to advance policies and practices to improve women's and girl's health.

One key actor that had had a crucial role in the work of FGM was the cross-departmental FGM coordinator who had been appointed by the government. The FGM coordinator was the only governmental role appointed to work on preventing FGM. Part of their responsibility was to link between all government departments and organisations and coordinate the work, but unfortunately the position has been abolished by the government as mentioned earlier.

A key approach of some of the actors has been the development of joint partnerships, in particular in the area of research and influencing policies. As an example, one research report developed by the WHEC was on the sustainability of small voluntary sector organisations working with black and ethnic minority communities. Unfortunately it can be observed that most organisations do not share experiences or work together to reach the goal of ending FGM. Examples of good practice should be shared amongst the different actors so that the wheel is not reinvented all the time.

The actors mentioned are operating in coherence with the existing UK policies, but there needs to be more analysis of the quality of services that is being provided by the various actors, including the training courses they provide, for example what sort of training is provided? Is it consistent? Who is the training provided for and who provides the training? In addition, if there are clinical services such as in the African Well Woman Clinics, what are the types of services provided? What is the quality of services? Is there any follow up?

6. TOOLS AND INSTRUMENTS

6.1. Methodological approach for collecting information on tools and instruments

Documents for tools and instruments were searched for using the academic databases, following the 'Guidelines for national data collection'. The tools were included based on their relevance to FGM. The following databases were searched for tools and instruments: Social Science Research Network, PubMed, Web of Science, BASE, Cinahl plus and Google Scholar.

The key terms for my search included: ‘female genital mutilation’, ‘female genital cutting’ and ‘female circumcision’.

In addition I looked into some of the organisations’ websites and searched their publications, in particular those that had a more active role on FGM, and these were screened accordingly.

Altogether, 69 tools and instruments were included in the database and were ordered chronologically. Again, due to the time constraint the list of tools and instruments in the database is not exhaustive.

6.2. Tools and instruments on FGM

There have been a large number of tools and instruments that have been developed by the various actors. These include awareness-raising publications, training tools, guidelines for professionals, protocols, surveys and studies.

The most popular tools developed by most actors have been guidelines and protocols on dealing with FGM, as well as awareness-raising initiatives. The tools that have been developed are targeted at a wide population including health professionals, social workers, teachers, policymakers, anti-FGM activists, NGOs, CBOs, women's specialist services, funders, prosecutors and caseworkers working in the Crown Prosecution Service, members of the judicial system and members of the police force, in addition to members of the public.

Some of the tools have been commissioned or ordered by governmental departments. Some of the tools developed specifically for health professionals have been ordered by professional bodies.
6.3. Reflection on tools and instruments on female genital mutilation

In the UK tools have been developed since the 1980s, when the Minority Rights Group published its awareness-raising initiative publication on FGM. FGM was at that time an issue that did not receive a lot of interest from the public or from policymakers. But there were also a few academic articles that were published in the British Medical Journal during that period, in which FGM was referred to interestingly as ‘one of the diseases that the black and Afro-Caribbean migrants came with, in addition to other diseases such as blood disorders, etc.’

With FGM being debated in the House of Lords and the introduction of the Prohibition of Female Circumcision Act 1985 to ban it from being practised in the UK (based on reports of clinics in the UK performing it), FGM slowly began to gain public interest. It was also mentioned that the BBC had broadcast a documentary about FGM which had captured the interest of people, including Lord Kennet who then raised the issue in parliament.

Since its conception, Forward has worked on the development of further tools, mainly small scale surveys to provide an understanding of the situation of FGM in the UK as well as highlighting some of the important issues that were starting to become apparent, such as child protection, and the development of practical guides for midwives and nurses and an FGM information pack that contained comprehensive information on FGM and its context.

Following on from that period guidelines started to be developed for front-line professionals, and one study was conducted on young Somalis in London by BWHAFS in collaboration with the London School of Hygiene and Tropical Medicine. At that time the Somali community was one of the largest migrant communities to come to the UK.

It is interesting that the various actors in the UK, particularly those working in the voluntary sector, and especially those organisations that were African led, were the ones that influenced and pushed authorities to develop policies.

As health professionals and other front-line professionals began to face FGM during their work, more academic articles began to be published to document their experiences. The tools also began to be more focused and most of the professional bodies had developed guidelines on what to do with cases of FGM.

Forward also provided and still provides custom-made training courses for professionals working in the statutory sector. There are also other organisations which have followed in Forward’s footsteps in the provision of training courses to professionals, but it would be interesting to know the number of people that have been trained, their geographical location, their profession and whether they were able to use what they learnt effectively or not.

Some actors like the African Well Woman Clinics have only developed minimal tools, if any, and most have been academic articles by individual staff members. But again the development of tools requires resources and most of the clinics have minimal funding, are understaffed and sometimes have staff members working in three clinics. However they are important actors in the field of FGM, and as such they do require a lot of support. It is also likely that the tools that they have might be more for their internal use, but it would be interesting for this to be clarified. In addition, even in the areas where there are African Well Woman Clinics sometimes the community does not even know that such a clinic exists (this was mentioned during PEER research conducted in Bristol with women from FGM-practising communities), and the clinic only opened once every two or three weeks.

As for teachers and social services staff, both front-line workers, there are limited numbers of tools developed by them. In addition, young people are a target group needing extra attention. Currently the major actor that specifically targets young people in its work is Forward, with its innovative project ‘Young people speak out’. The only Well Woman Clinic that was specifically categorised for young girls and women was in Waltham Forest, but the youth worker who had worked there has currently co-founded a new organisation called Daughters of Eve. It is expected that when the results of the Forward national youth survey come out there will be a much clearer picture on some of the needs of young people, as well as some of the issues that they are facing with regard to FGM.

It is important that the tools that are developed be of good quality and standard. One tool which would be important to have is standardised monitoring or registration forms that can be used to ensure that the local authorities and departments start to develop a robust FGM registration system.

7. FINAL CONSIDERATIONS

In the UK there is only one prevalence study, conducted by Forward in 2007. The methodology used was extrapolation using the 2001 census data. The methodology had several limitations as undocumented migrant women were excluded, second generation women were not identified and any migration following 2001 was not included. The findings of the study are the only reference used in the majority of policy documents and guidelines. Forward is conducting a national survey on FGM among young people (males and females of 16–25 years old). The methodology that will be used is a mixed approach of both quantitative and qualitative methods. The results of the survey are expected to be available at the start of 2013. It is hoped that the new study will provide a more accurate picture of FGM amongst young people. There is a strong need for accurate and reliable data to further inform policies on FGM.

As for the policy framework in the UK, the main players in the government include the Department of Health, the Department of Education, the Foreign and Commonwealth Office and the Home Office. The police and social services play a major role in child protection. The multi-agency guidelines published in 2011 have been much needed, as FGM is a cross-departmental issue. It has taken time for FGM
to be pushed into the policy agenda. Nonetheless some of the main lobbyists include concerned MPs who have brought the matter of FGM into parliament, the APPG on Population, Forward and the EHRC. Other agencies which have taken FGM on board are organisations working on asylum. Despite all the efforts there is still no clear strategy on FGM in the UK and very limited funding is available for NGOs and CBOs that are working with black and ethnic minority communities. This has led to a vicious circle of reduced service provision, understaffing and the lack of sustainability.

FGM has been a criminal offence in the UK since the introduction of the Prohibition of Female Circumcision Act 1985. This act was amended in 2003 by a change of title, the introduction of extraterritoriality and the increase in prison terms from 5 to 14 years. There have not been any prosecutions due to FGM, but FGM is a form of child abuse which needs to be dealt with. The legislative framework in England and Wales for the child protection system is based upon the Children Act 1989. As for women and girls applying for asylum in the UK for fear of FGM, they can apply on the grounds that there is a well-founded fear, based on the 1951 UN Convention relating to the status of refugees. Asylum is considered if the applicant may be believed to be a member of a ‘particular social group’. There have been some successful cases of asylum granted because of fear of FGM, but decisions are determined as being ‘case based’ and are not consistent. In 2006 the Fornah case set a new precedent in terms of females fleeing a well-founded fear of FGM and belonging to a particular social group. There is no law on professional secrecy concerning FGM in the UK but all front-line professionals have a duty to report when it is considered that a child might be at risk of harm or abuse.

The UK has a large number of actors who work specifically in the field of FGM, as well as those who work on a broader base but have incorporated FGM within their work. Important actors that have worked to develop policies are the Department of Health, the Department of Education, the Foreign and Commonwealth Office and the Home Office. There has generally been an increase in the number of actors who have started to incorporate FGM into their agenda. The actors are operating in coherence with the existing UK policies, however there needs to be an in-depth analysis of the quality of the training courses provided.

A large number of tools and instruments have been developed since the 1980s. The most popular tools have been guidelines and protocols on dealing with FGM, and awareness-raising initiatives. The tools target a broad spectrum of professionals. Some of the tools have been commissioned or published by governmental departments. It is important for good practice to be shared amongst professionals and for the tools developed to be of good quality and a good standard. There are some gaps that still need to be developed with regard to the tools produced and the relevant actors.
Analytical country report

Identification

Country: United Kingdom
Researcher: Eiman Hussein
Date: 17.8.2012

I. INTRODUCTION

‘Female genital mutilation has nothing to do with culture, tradition or religion. It is a torture and a crime, which needs to be fought against.’ Waris Dirie (1)

On 7 April 2011 the Committee of Ministers of the Council of Europe adopted a landmark new Convention on Preventing and Combating Violence against Women and Domestic Violence (2). The resolution condemns FGM as a violation of fundamental human rights, as well as a savage breach of the integrity and personality of women and girls, and therefore considers it to be a serious crime in the eyes of society. It is estimated that every year in Europe 180 000 women undergo or are at risk of undergoing this procedure. But the actual magnitude of the problem in Europe is not clear. This qualitative in-depth research is part of a pan-European study to map the current situation and trends of FGM in the 27 Member States of the EU and Croatia. The study was commissioned by the European Institute for Gender Equality.

Goals and methodology

The main aim of this report is to provide an in-depth understanding and analysis of the United Kingdom’s approach to FGM. The analysis is based on information that has been provided in the following ways:

• Five semi-structured interviews conducted with key persons involved in the work of FGM.
• An additional three contacts whom were sent questionnaires via e-mail.
• The UK country report already prepared, which consists of desk research conducted during the first phase of the study.
• Other resources including documents, research papers and media sources.

The rationale of the in-depth research, phase two of the study, is to assess successes and challenges in the work of FGM in the UK and to identify past and present good practices with reference to the ‘six Ps’ approach defined for the purposes of this study: prevention, protection, prosecution, provision of services, partnership and prevalence estimates (the latter not being the focus of the interviews of the in-depth study).

The methodology was to consist of conducting six in-depth interviews with key respondents involved in various areas of work on FGM. For the interviews, three of the respondents were already pre-identified by the core research team. As for the other three respondents, two of them were identified by their affiliation but were not named persons (the London Safeguarding Children Board and project Azure of the Metropolitan Police Service). The sixth respondent was chosen to be from a body responsible for prosecution (later selected to be from the Home Office, the main body accountable for prosecution). All the last three respondents were suggested by the third respondent and the identified persons were then validated by the core research team.

All respondents other than the third one were contacted formally by e-mail and were sent letters inviting them to participate in the study. They were also provided with further information on the research as well as provided with a definition of the ‘six Ps’ approach. All the respondents also received a customised questionnaire prior to the interview as well as details on the expected length of the interview, etc. With the customised questionnaire it was also planned to adapt the interview questions based on the circumstances of the individual interview (expanding or shortening the questions by response and time of the respective respondents). All respondents contacted were very enthusiastic and interested in the research. They were also all ready to provide their valuable time and input.

The interviews were conducted during the period 10–18 July 2011. They were then summarised and the main points have been included in the annexes.

(1) Waris Dirie is a Somali model and outspoken activist against FGM, having been genitally cut herself at the age of 5.
(2) The convention is the first legally binding instrument in the world creating a comprehensive legal framework to prevent violence, to protect victims and to end the impunity of perpetrators. It defines and criminalises various forms of violence against women (including forced marriage, female genital mutilation, stalking, physical and psychological violence, and sexual violence).
II. INFORMATION SOURCES

Table 1 — Overview of interviews conducted

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</tr>
<tr>
<td>13.7.2012</td>
<td>90</td>
<td>Two persons were interviewed</td>
</tr>
<tr>
<td>18.7.2012</td>
<td>135</td>
<td>None</td>
</tr>
</tbody>
</table>

Brief description of each respondent

The first respondent is a detective chief inspector in the Metropolitan Police child abuse investigation command. She has served as a police officer for 25 years. She is the continuous improvement team manager for the child abuse investigation command. Her role in the continuous improvement team includes managing staff delivering specialist child abuse training, the partnership team (project Azure), the quality assurance team, learning from serious case reviews, and policy and governance. All these areas have been identified as critical to the continuing development and improvement of child abuse investigations by the Metropolitan Police.

The second respondent is a midwife specialising in the field of FGM and public health. She began her career as a nurse and, over the past 30 years, has received numerous academic and professional awards in the field of FGM. In 1997 she set up the African Well Woman Clinic at Guy’s and St Thomas’ Hospital, which is one of the first few clinics in the UK dedicated to caring for women from FGM-affected communities. She is a passionate and renowned advocate against FGM and has provided her expert advice in several different forums, both within the UK and internationally.

The third respondent is the executive director of the Foundation for Women’s Health Research and Development (Forward), the lead agency working in the UK to respond to FGM. In the 4 years since she joined Forward she has been instrumental in leading the scaling-up of Forward’s work on FGM in the UK, with a focus in particular on empowering women and young girls from FGM-affected communities to become strong advocates against the practice and agents for change. She had also served as the chair of Forward during her work in the International Planned Parenthood Federation (IPPF). Her work on issues of FGM and child marriage have extended over 2 decades, during which she has contributed with passion and commitment towards effective work against the practices both in the UK and worldwide.

The fourth respondent is the head of the sexual violence team in the Home Office. The fifth is the sexual violence policy advisor as well as the FGM lead in the cross-government FGM steering group in the Home Office. The sexual violence team is part of the Violent and Youth Crime Prevention Unit in the Home Office. The work that the team is involved in includes: sexual violence, FGM, domestic violence, forced marriage and honour-based violence, prostitution, lap dancing and sex-offender management.

The sixth respondent is the policy and research manager at Asylum Aid. She has been working for Asylum Aid for the past 8 years, and is a committed lobbyist and campaigner for the rights of women seeking asylum. Her organisation is one of the UK’s leading charities providing free legal representation and advice to asylum seekers. It has also led a successful campaign resulting in the introduction of gender policies in the asylum process.

Additional contacts and complementary sources of information

The advocacy director for FGM programmes in Equality Now. She is a recognised public health expert on FGM. Her pioneering work on FGM in the 1980s contributed to the international recognition of FGM as a public health and human rights issue. In 1983 she along with other activists founded the organisation Forward. Efua was instrumental in the enactment of the 1985 UK law on FGM. Her lifelong career has been filled with dedication and commitment towards ending the practice.

The policy manager of the Children, Families and Health Inequalities section in the Department of Health. The Department of Health is a member of the cross-government FGM steering group that is led by the Home Office. FGM falls under the ‘violence against women and girls’ portfolio of work.

The senior policy advisor for the Crown Prosecution Service. She leads on a number of areas of national policy including domestic violence, stalking and harassment, honour crimes, forced marriage and female genital mutilation, all under the umbrella of the violence against women strategy. The Crown Prosecution Service is a member of the cross-government FGM steering group.

Other sources of information that have been drawn upon in this report include more recent publications (including government policy documents and research reports).
III. HISTORICAL CONTEXT AND POLICY DEVELOPMENT

The historical context provided in the interviews is based on the input of the respondents, all of whom have been dedicated activists in the campaign against FGM in the UK since its inception. The following information is drawn from the interviews, along with the desk research and additional sources that have been accessed (references are provided).

Historical context of FGM and policy development in the UK

Over the past 40 years, interest in FGM has gradually been growing in the UK. FGM first came to public notice in the early 1970s, in particular when women from the Horn of Africa came to seek refuge in the country. In that period the United Nations Decade for Women (1975–1985) also had a role in raising the issue as part of the spotlight thrown on the situation of women in the developing countries. For the UK, the first point of contact for women with FGM was with health professionals during pregnancy and labour (Kwateng-Kluvitse, 2005). The third respondent explained that at that time the health system did not really know how to deal with infibulated women, mainly because of the lack of knowledge of FGM, and most often the women were treated inappropriately. Because of that lack of understanding on what to do, the health professionals delivered the women by caesarean section. This course of treatment, along with being treated as objects of curiosity in hospitals, was something which made the women unhappy with the services provided.

With the migration of communities their traditions, cultures and beliefs came with them, and FGM was one of the things that they introduced to the UK. Prior to the 1970s there were patchy encounters with and mentions of FGM. Interestingly, one article in the British Medical Journal in the 1960’s referred to FGM as ‘one of the diseases that the black and Afro-Caribbean migrants came with, in addition to other diseases such as blood disorders, etc.’.

The 1980s — Birth of the campaign

More profound interest in the issue of FGM began to form during the 1980s. During that time three crucial events brought the topic of FGM into focus.

- A report published by the Minority Rights Group in December 1980 entitled ‘Female circumcision, excision and infibulation: the facts and proposals for change’.

The report was published during a time when the practice was becoming known in the international community but the facts were distorted and inaccurate. The aim of the published report was to raise awareness of the issue, but with accurate information in a coherent, logical manner. The publication brought attention in both the UK and the international media. The respondent interviewed also said that, following the report, ‘the Minority Rights Group set up a women’s action group on female excision and infibulations to promote development education on FGM’. This was known as the Women’s Action Campaign against Excision and Infibulation (WACAEI). The newly developed group worked under the umbrella of the Minority Rights Group. The campaign group carried out fact finding missions to Africa. One of the first people to join the group was a Ghanaian woman who was resident in the UK and working as a health worker. In 1982, under the auspices of the Minority Rights Group, this interviewee presented the issue of FGM to the UN Commission on Human Rights as a human rights issue (*)

- A debate in the House of Lords in 1982 that raised the issue of FGM in parliament. This was the first parliamentary discussion on prohibiting the practice in the UK.

In 1981 the press revealed evidence that FGM was being conducted in England, including the verbal admission of a GP of referrals for excision as well as proof of excision being performed in London in 1981. This information raised public concern and, based on this new evidence, Lord Kennet (an MP) introduced a private members’ bill to prohibit the performance of FGM in the country, however his motion was not supported by the Conservative Party, which was then in power.

- A BBC documentary film entitled Female circumcision, broadcast in March 1983.

With the help of the WACAEI the BBC produced a documentary film entitled Female circumcision, which was broadcast in March 1983. The film was a 40-minute documentary that showed the health complications that occurred in women because of FGM. The documentary was on FGM in the Sudan, and at the end of the documentary there was a short clip which showed that FGM was practised in the UK by Harley Street private doctors. This caused public outrage and raised further public interest in the issue. The public concern led to parliamentary discussion culminating in a private members’ bill that received the overwhelming support of the majority of the House of Lords. The amended bill, ‘Prohibition of Female Circumcision Bill’, was introduced in June 1983.

An interesting analysis that is worth mentioning here, from an article published in 2010 (†), is that the delay in passing the act was caused by disagreement over two sentences, one referring to ‘mental health’ and the other to ‘custom or ritual’ and the relationship between the two. The bill as originally introduced said that the operation of female circumcision must not be performed except when necessary for the health of the patient. But a concerned Conservative, Lord Glenarthur, was afraid that with the original wording of the act surgery of a cosmetic nature


that was not due to physical or mental health reasons would not be allowed. Therefore it was said that the government would not give its blessing unless it was amended to allow surgery where necessary for the physical or mental health of a person. However, in determining whether there was a threat to physical or mental health, no account should be taken of beliefs based on ritual or custom. It was suggested that there were 8 000 legitimate operations carried out on women’s genitals each year and 10–20 trimming operations. Behind this discussion the author noted that there was clear, well mobilised pressure from medical colleges and bodies to block any new law that could prevent them from carrying out these ‘trimming’ procedures.

In summary, some of the important effects of the events which occurred in the early 1980s were the birth and establishment of two of the leading organisations that would set the scene for future work against FGM: the Foundation for Women’s Health Research and Development (Forward), which was founded in 1983; and Black Women’s Health and Family Support (BWHAFS) (1), which was founded in 1982. Another ground-breaking result was the passing of the Prohibition of Female Circumcision Act in 1985. The UK was one of the first European countries to develop a criminal law against FGM.

Following the new law there were no clear guidelines on prosecution or how to protect a child who was at risk of or who had experienced FGM, but it was incorporated into child protection procedures at the local level, in some authorities. Nevertheless, with regard to FGM, throughout the campaign it has always been a challenge to safeguard girls from the practice as it was believed to be a cultural practice performed by otherwise loving parents.

‘A recurring obstacle to safeguarding girls from FGM by UK professionals is a belief that FGM is a cultural practice and “an act of love” by parents. Where minors disclosed to front-line professionals about fears of pending FGM, such cases were not followed up but ejected to women’s groups or to the voluntary sector and girls failed to get the protection they needed.’

In 1989 Forward convened the first National Conference on Female Genital Mutilation: Unsettled Issues for Health and Social Workers in the UK (2) and Social Workers in the UK (3). A heated debate was generated and it was concluded together over 150 health, education and social workers, and Social Workers in the UK (4). The conference brought actors from Europe together to take action against FGM, in order to develop a more coordinated approach towards ending FGM.

In 1985 the UK was one of the first European countries to pass a new law on the protection of children (The Children Act 1989 — 16 November 1989). Although FGM was not specifically mentioned, it was covered by the Children Act because it was a form of child abuse.

The 1990s — Setting the agenda

In 1992 Forward convened a conference called ‘A First Study Conference on FGM in Europe’, which was the first of two to be held in Europe (the second conference was held in Sweden in 1998). The main aim of the conference was to bring actors from Europe together to take action against FGM, in order to develop a more coordinated approach towards ending FGM.

Also in 1992 the first African Well Woman Clinic was established in Northwick Park Hospital in London. This was a specialist clinic that aimed to tend to the needs of women with FGM, including providing them with obstetric and gynaecological care. Forward was instrumental in opening the clinic and supported the clinic by paying an interpreter to work there. Following on from the opening of Northwick Park African Well Woman Clinic, it became a model for other NHS bodies, and other clinics followed suit and successfully opened in other areas.

Meanwhile, still, no convictions were obtained in the UK. But in 1993 a medical practitioner was brought before the General Medical Council charged with performing FGM despite it being illegal, and he was struck off (5).

In 1996 the Royal College of Midwives produced its first position statement on FGM. In 1999 the Department of Health issued the first policy document on safeguarding the welfare of children. Forward also developed research reports on FGM and continued its advocacy and campaign against FGM. One study which Forward undertook in 1996 was a 2-year study on what policies were available (6).

The 21st century — Taking steps forward

In 2000, as discussed in the country report, the All-Party Parliamentary Group (APPG) on Population, Development and Reproductive Health (an active group of MPs that has been active in lobbying and advocating against FGM in the UK) organised a 2-day hearing in parliament on 23 and

(1) During that time it was known as the London Black Women’s Health and Action Project.

(2) Please note the initial country report had mentioned the conference but, it was mixed up with another conference held in 1992 which was ‘a study of FGM in Europe’, also hosted by Forward.

(3) DHSS guidelines should include FGM in the ‘child at risk’ register (7).

(4) Training should be provided to all front-line professionals on FGM (social workers, teachers, police, lawyers, judges, etc.).

(5) A consultative body within social services departments incorporating black community members should be set up as a bridge between communities and professions so that there can be community cooperation with respect to the issue.

(6) In the same year, following the conference, the government passed a new law on the protection of children (The Children Act 1989 — 16 November 1989). Although FGM was not specifically mentioned, it was covered by the Children Act because it was a form of child abuse.

(7) The child register listed five categories denoting a child at risk.


24 May 2000 on female genital mutilation. The objective of the hearing was to develop and implement appropriate legislation, with consultation with all concerned groups. Prior to the hearings a survey was sent out to leading organisations working in the field both in the UK and abroad, as well as to local authorities, health professionals, social workers and representatives from UN agencies and the WHO. Expert witnesses were called upon to provide oral evidence to a panel of APPG members. As a result of the 2-day hearing and the results of the survey the APPG members put forward 47 recommendations to the government, which included the following:

- amendment of the existing Prohibition of Female Circumcision Act 1985;
- the development of guidance supplementary to Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children that dealt specifically with FGM;
- the government should fund projects to develop women’s leadership and literacy skills;
- all health professionals and other relevant authorities should be required to report incidents of FGM.

The all-party parliamentary hearing and the document that was produced were said by the third respondent to be very critical of the work on FGM. The recommendations were to her very central to the UK and she believed they had the actual basis for an effective action plan against FGM. But she pointed out that the only thing that was implemented from the recommendations that there was a push for the law to be updated. This fact was also emphasised by a statement that, ‘Only two of the recommendations were picked up — the amendment of the UK Law and that the name of the Female Circumcision Act be changed to incorporate FGM. She pointed that cynics might say that these were the cheapest and most visible recommendations for the government to accept.’

In December 2000 another doctor (2) was struck off by the General Medical Council for being willing to perform FGM on three girls. The doctor was secretly filmed for a Channel 4 documentary entitled Black bag: cutting the rose. The news of the doctor being struck off was welcomed by the third respondent as a push for the law to be updated. This fact was significant in terms of policy developments in the work on FGM.

In 2005, because of the limited availability of data on what the extent of FGM was in the UK, Forward lobbied and pushed for a study to provide an estimate of the prevalence of FGM. The Department of Health funded the research, which was conducted by Forward in collaboration with City University and the London School of Hygiene and Tropical Medicine. The findings of the prevalence study were published by Forward in 2007, and according to the third respondent they changed the policy environment. The study is still widely quoted in all policy documents and in any research or strategy, as it is the only reliable set of statistics on the issue of FGM in the UK. The statistics are also mentioned during the majority of hearings and debates in the Houses of Parliament. However, the study was ‘a guestimate’, with the figures being extrapolated from FGM-practising communities in Africa.

In 2006 an unprecedented asylum appeal case that reached the House of Lords then changed history in interpreting what a member of a ‘particular social group’ might be in applying for asylum in the UK. That case, known as ‘Fornah’, happened to be about a young woman who was at risk of FGM. One person was from Sierra Leone and applied for asylum as she feared that, upon returning to her country, she might undergo FGM. Her request was refused and her appeal reached the House of Lords, where she was then granted asylum by the judges who believed she belonged to a particular social group. Although that case was of FGM in terms of case-law, the case could be and is still being used in other cases not only referring to FGM.

Three major events occurred in 2009 which were very significant in terms of policy developments in the work on FGM.

Notes:
(2) http://www.forwarduk.org.uk/news/news/100
(1) In September 2009 a cross-departmental FGM coordinator was appointed by the government, a joint position between the Home Office and the Foreign and Commonwealth Office. The main aim of the role was to have a lead person who would be able to plan and lead the work on FGM, and coordinate between stakeholders inside and outside government.

(2) In November 2009 a resource pack on FGM for professionals was developed by the London Safeguarding Children Board, including guidance on what to do in terms of safeguarding and child protection. The document was the result of the London Safeguarding Children Board working with an expert steering group of health professionals.

(3) The government published its ‘Together we can end violence against women and girls: A strategy’ policy document. The strategy drew heavily on the outcomes of one of the largest public consultations, which was held over 3 months and involved 300 victims of violence who participated in 24 focus group discussions undertaken by the WNC. It also relied on other documents. The policy document grouped all forms of violence against women and girls into one strategy that recommended key themes to guide future action plans on VAWG, including:

- protection, with the objective of delivering an effective justice system;
- provision, by helping women and girls to continue with their lives;
- prevention, by changing attitudes and preventing violence.

The proposed government strategy reframed FGM, forced marriage and honour-based violence within the broader context of violence against women, a shift that would guide the future strategies and action plans of the government.

Recent policy development on FGM

In November 2010 the coalition government launched a document entitled Call to end violence against women and girls. The document aimed to outline the future guiding principles and directives in tackling violence against women and girls. The guiding principles for the strategy were the following:

- To prevent violence from happening by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it.
- To provide adequate support where violence does occur.
- To work in partnership to obtain the best outcome for victims and their families.
- To take action to reduce the risk to women and girls who are victims of violence against women and ensure that perpetrators are brought to justice.
- Prevention work was placed to be at the core of the strategy.

The strategy document indicated that the main emphasis of the coalition government was on decentralisation of policies ensuring the development of the ‘big society’, thus giving a stronger voice to the local people and local authorities. The ‘big society’ is Prime Minister David Cameron’s vision of shifting of power from central government to communities and volunteers in order to mend what is called the ‘broken society’.

Also in 2010 the Department of Education issued the policy guidance document Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children. The significance of this document was that it included supplementary guidance on promoting the welfare of children in Chapter 6, which specifically included FGM, and that under Section 47 of the Children Act 1989 a local authority could exercise its powers if it believed a child was at risk of FGM.

In February 2011, prior to the publishing of the action plan to implement the VAWG strategy, the government launched the document Female genital mutilation: Multi-agency practice guidelines. A publication jointly developed by the Home Office, the Department of Health and the Department of Education. The main aim of the document was to provide advice and support to all front-line professionals who have the responsibility to safeguard children and protect adults from abuse because of FGM. The guidelines have been a welcome development. They provide information on:

- identifying when a girl might be ‘at risk’ of being subjected to FGM and how to respond appropriately to protect her;
- identifying when a girl has been subjected to FGM and responding appropriately to support her;
- measures that can be implemented to prevent FGM.

In the long term the guidelines aim to support efforts to ensure that more girls and women are protected from the severe consequences of FGM, provide support to girls and women living with the physical and mental consequences of FGM and reduce the prevalence of FGM in the UK.

However, it is indicated in the document itself that the guidelines are intended to set out a multi-agency response and strategies to encourage agencies to cooperate and work together, and that it is an awareness-raising document not a statutory document.

The government’s Call to end violence against women and girls: Action plan was launched in March 2011, thus providing an overview of what actions the government would take to tackle violence against women and girls. Altogether it contained 88 actions to take forward with its key partners to deliver the VAWG strategy. Each action is defined, including which department will be responsible to executing it and the timeline for completion. There were four specific commitments in the VAWG action plan on FGM, as follows.

1. Work on the development of learning programmes for the police on sexual and domestic violence, including FGM, forced marriage and honour-based violence (Home Office).
2. Support community engagement work to tackle FGM, an ongoing action to be undertaken through the government-chaired FGM Forum (Home Office, Department of Health and Department for Education).
3. Develop guidelines for prosecutors dealing with...
potential cases of FGM (Crown Prosecution Service).
(4) Review the use and effectiveness of the multi-agency guidelines for dealing with FGM and forced marriage, with the review to be completed by 2012 for FGM (Home Office, Department of Health and department of Education).

One action which was not specific to FGM but affected women and girls claiming asylum on the grounds of FGM was ‘work to ensure that the asylum system is as gender-sensitive as possible’, for which the UK Border Agency had responsibility.

As already discussed in the country report of the desk study phase, the importance of the action plan is that it also identifies which departments will be responsible for FGM in the government’s ‘six Ps’ strategic plan (policy, perspective, prosecution, prevention, provision and protection).

The next significant development in the UK on FGM was the Crown Prosecution Service issuing its legal guidance on FGM in July 2011. The aims of the document were to provide guidance in cases where FGM was suspected and to outline the different legal considerations. Some of the considerations include the challenges that prosecutors might face in bringing a case to court (this will be discussed in more detail in Section V.4). Unfortunately, despite the new developments that had occurred in 2011, the post of the cross-government FGM coordinator was abolished in March 2011. This caused concern amongst various stakeholders as it was the only position that was devoted to working solely on FGM in the UK. Again questions were raised in parliament on why the post was abolished as well as what would be the next steps that the government would undertake following the departure of the FGM coordinator. The government response to the role of the FGM coordinator being abolished has been that the job has not ended but that the work will be carried forward by the individual departments, who will come together regularly as a steering group. It is believed that this will be a more integrated set-up (4).

In October 2011 the Home Office launched a GBP 50 000 fund for front-line organisations working with communities against FGM. Through the fund, each applying organisation could be awarded with a grant of up to GBP 5 000.

In November 2011 the government published the document Call to end violence against women and girls: Action plan progress review. The main aim of the document was to review the progress made to implement the action plan on violence against women and girls.

At the end of 2011 a new all-party parliamentary group specifically for FGM was created. The new group is made up of over 50 MPs and peers from all the main political parties and has been formed to raise awareness of FGM in the UK and overseas and to work with the government and NGOs towards ending FGM.

Recently, in March 2012, the government issued an updated version of the VAWG action plan Call to end violence against women and girls: Taking action — The next chapter. This new document reviewed the previous actions and updated the actions. The number of actions was also increased to 100 from the 88 outlined previously.

Current government responsibilities
As mentioned above, the government approach with regard to FGM has been a cross-disciplinary approach. In each of the following departments there is now a person responsible for FGM: the Home Office, the Ministry of Justice, the Department of Health, the Department of Education, the Foreign and Commonwealth Office, the Department of International Development and the Crown Prosecution Service.

The policies and work on FGM all currently fall under the VAWG strategy and action plan. FGM is also mentioned as a form of violence against women in all of its overarching documents, although in reality FGM is still marginalised and is not even recognised as a gender-equality issue. As such, in the Departments of Health’s single equality scheme 2009–12, there is no mention of FGM, nor is there any reference to FGM in the department’s equality materials.

The Home Office has the lead responsibility for the implementation of the VAWG action plan. Within the various cross-government departments each person responsible for FGM has their own responsibilities on FGM. They are all part of the cross-government FGM steering group. They meet regularly, in particular the representatives of the Home Office and the Department of Health, to discuss any new developments, etc. This was seen as quite useful by one of the Home Office officials.

‘From my perspective, the Home Office working in a cross-governmental approach is quite useful because there is a person in each department who has quite in-depth knowledge of each aspect of FGM. This is much better, as the thing that I have learnt about FGM is that you cannot be just one person in one department, but you have to know what is happening in each other’s departments. It also ensures that all the departments are plugged into the issue and that it does not just fall onto one person.’ (Home Office official)

The FGM Forum
The Home Office is also responsible for the chairing and coordination of the FGM Forum, a stakeholder meeting that meets quarterly with stakeholders from the voluntary and statutory sectors to instigate dialogue and discussions with partners on issues of FGM. Currently there are 40 members of the FGM Forum.

In its initial stages the FGM Forum developed a strategic approach were there were different hubs such as a training hub, a community hub, a policy hub, etc., and the original plan was to see how the different hubs would develop in the forum. But according to the third respondent this initial plan did not progress and currently the members meet every other month.

(4) Response from Baroness Verma from the Government Whip’s Office in response to the questions raised during the debate on FGM on 30 June 2011 in the Houses of Parliament.
The FGM Forum is like a talking shop. If you have 40 people around the table, and you come around for an hour-and-a-half meeting, there is really no time for any policy decisions. So even that forum should be strategic. Unfortunately, because its membership is so wide, there is really little opportunity to engage effectively and influence or inform any decision-making.

New government initiatives

It was mentioned by the Home Office officials that the department was working on the development of a ‘Declaration against FGM’ document, a tool that is similar to the ‘Statement opposing female circumcision’ in the Netherlands. It is expected to be ready by autumn 2012, and it will be developed with the aim that families can take it with them when they travel back to their homes as a means of protecting their girls.

The media: positive impact on or negative deterrent to the campaign?

The media has had quite an influential role in raising awareness and public interest on the issue of FGM. Initially during the early 1980s the media had a negative impact as the information that was provided was also misinformed.

Some spectators still follow the media with caution as it is believed that it can also cause a backlash through what is published or force people to go underground through its negative publicity. But recently, since early 2012, there has been quite a rise in the media, in particular due to the issue of the lack of prosecutions in the UK. Articles have been written almost weekly on the issue of there being no prosecutions in the country. There was also an undercover newspaper report (14) that discovered two a GP and a dentist who were ready to circumcise girls for a price in Birmingham. Both are on bail and decisions are awaited.

A recent two-episode Newsnight programme (15) on FGM was broadcast recently. Guests on the programme included the respondents working in the field, as well as young girls from Bristol charity Integrate. Integrate recently produced a film called Silent scream, a film developed to raise awareness about FGM. Muna Hassan, one of the charity’s volunteers, spoke very candidly in the programme:

‘The statistics show that MPs are terrified to do anything about FGM. They are hiding behind cultural stereotypes. What would you do if the girl had blonde hair and blue eyes? Would FGM still be going on in this country?’

The young girls in the programme believed that the government was not taking any action with regard to prosecution and the protection of girls. They felt that it was important to prosecute and, if necessary, to conduct medical examinations on girls in order to ensure that they were not cut during the holidays. During the programme there was a comparison with France, which has been so successful in prosecution, whilst Britain was believed to be a ‘soft touch’ in Europe for its failure to prosecute, thus encouraging people from many communities to send their daughters to the UK to have FGM done on them. The impact of the programme is that it has further added public interest in the issue of FGM. This has put the government in a tight position, having to show that it is doing something about FGM and that it is committed towards ending it. And the pressure still continues from the media.

Driving forces for policy development

Some of the important driving forces behind policy development that were mentioned by the respondents are as follows:

- Individual interest and commitment, which the first respondent described as ‘emotive’, while the second described it as ‘having the drive’. The interest/driver was especially provided by individuals who were interested in the issue.
- An interesting perspective was provided by the third respondent, who felt that when the issue of FGM initially appeared in the UK, the driving force that pushed for policies was ‘health’, when the issue was that health professionals did not know how to react and deal with women who had suffered FGM when they began seeing them in hospitals (their first point of contact for pregnancies and deliveries). Following that the driving force that framed FGM became that of ‘safeguarding’, when FGM began to be seen as an issue of safeguarding children. During that period children were taken away from their families without the consequences of such actions even being looked at. Finally FGM began to be reframed around the issue of ‘criminalising’, when FGM started to be perceived as a crime, but she also mentioned that even during earlier times the language used was that of FGM being a criminal act.
- Professional bodies like the Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Nursing and British Medical Association began to develop their own policies and guidelines. These included their positions with regard to FGM as well as clinical guidelines on dealing with women who had experienced FGM.

‘This would have been a big issue if they were presented with a case scenario of a woman coming into labour with FGM ending up having a third- or fourth-grade perineal tear, either because of the lack of awareness or experience of the attending health professional.’

- Pressure from the voluntary sector, through constant campaigning and the release of documents and reports on research conducted. Some of the most notable have been: Forward’s prevalence study in 2007 whose figures have been used and referenced widely; and PEER research conducted by Forward with women from FGM-affected communities. The quotes from some of the women have also been used extensively in recent government

(15) ‘Hidden world’ was a two-part Newsnight report broadcast on 23 and 24 July 2012.
documents.
- As mentioned above, media interest in the issue draws the attention of the public and politicians to FGM, so the driving force in that case would be a need to react. This occurs not only specifically with regard to FGM but also in other cases, in particular when it involves child protection.

**Key actors involved**

All the respondents unanimously believed that the NGOs were the key actors involved in pushing for any policies. It was also believed that other interested individuals, in particular politicians, played a crucial role in pushing forwards the policy agenda.

NGOs clearly have an important role in the work of FGM, through their advocacy and campaigning role. Some of the organisations mentioned by the respondents were: Forward; BWHAFS; Equality Now; Imkaan; Daughters of Eve; Integrate. But these were just a few of the large number of organisations that are currently working in the UK against FGM. Some of the organisations began at the very beginning of work against FGM, whilst others are newcomers to the field of FGM, but it is Forward and BWHAFS that have spearheaded the campaign against FGM from the beginning. The work that NGOs have undertaken on FGM includes:

- preventive work raising the awareness of communities and of professionals via training courses, workshops, research;
- advocacy and campaigning;
- the lobbying of politicians to influence them;
- the development of tools (such as guidelines, research reports, films).

NGOs were also believed to have a pivotal role in working directly with the communities. In fact, it was seen by some of the respondents that the work with communities was left entirely to the NGOs.

‘The NGOs had and continue to have a role and they are doing a lot of work.’

‘Unless we have that kind of engagement with communities and at the moment it is actually NGOs who are pushing to work at the community level. But we feel we have a responsibility, we feel that we have a role. I mean Forward is an African diaspora-led organisation, and for us, our role is to ensure we meet the needs and raise the voices of the communities we serve and at the end of the day we will continue to push that.’

Some politicians have been pushing for policies and for an end to the practice. Those mentioned in particular were: Boris Johnson, the Mayor of London; Baroness Ruth Rendell; Jane Ellison MP; Christine McCafferty MP; and Ann Clwyd MP. There were others that have not been mentioned, but these committed and interested individuals are at the forefront in pushing for policies and change. MPs have been able to open debates and ask questions in parliament, and throughout the campaign against FGM in the K, there have been several crucial and pertinent questions raised by them, including the following.

- Why there have been no prosecutions?
- What has the government done to protect girls at risk of FGM?
- Why did the government abolish the position of FGM coordinator?

In contrast, the government was seen as not being committed enough to the work against FGM. It was also seen as not taking the lead in the work done towards ending FGM, as well as not doing enough.

‘FGM is now one of many competing priorities and is very much dependent on who can shout out the loudest at the time. This can change as governments as well as individuals might change their priorities, and what the focus is for one person might not necessarily be the focus for someone else. As an example the current Mayor of London, Boris Johnson, has the issue as one of his priorities. Through him a harmful practices task force was developed, which when he was re-elected this year has continued, because he is still the mayor. If Boris had not returned, there would have been no guarantee that this task force would have continued because there is no continuity. But I think there is no concerted focus at stakeholder strategic level which has FGM as a priority — it is more an element of lip service.’

‘There isn’t any commitment from the government’s side to FGM. FGM happens to migrants, it happens to refugees, it happens to asylum seekers. They are not seen as British citizens and at the end of the day if they are not seen as British citizens, nobody is holding them accountable. Yes we can shout, but when you do not have a champion who is pushing for the vulnerable we have a situation where we are not really going to deal with this issue of FGM. This whole piecemeal approach actually shows the lack of commitment. If a country is really committed to FGM they need to address issues around the “Ps”, they need to address data.’

**EU influence on national/regional approaches to FGM**

As mentioned in Section III, the first study conference on FGM in Europe was held in London in 1992. The conference was hosted by Forward. The conference resulted in the London declaration on the grave physical and psychological consequences of FGM, calling for the eradication of the harmful practice. The conference raised awareness in the media about FGM.

The second conference on female genital mutilation in Europe took place in Sweden in 1998 under the auspices of the Committee of the Regions of the European Union in collaboration with the WHO. The second conference came up with recommendations for an action plan for Europe. The significance of the two conferences was that they brought the different representatives working on FGM in the different European countries together in collaboration.

The European Commission also requested that the International Centre for Reproductive Health organise an expert meeting in 1998 bringing together different experts from Africa, Europe and the USA in order to develop a strategy
towards ending FGM in Europe \(^{16}\). Several meetings were held in order to reach a common strategy for ending FGM in the EU, and in 2002 the European Network for the Prevention and Eradication of Harmful Practices affecting the Health of Women and Children, in particular FGM (Euronet FGM) was formed. One of the organisations from the UK that regularly attended and participated in the different meetings and key initiatives was Forward. Forward is also the key organisation from the UK that acts as a partner to the ‘End FGM’ European campaign.

‘At the moment Forward is working with an EU project funded by Amnesty International and that element is enabling us to look at developing a framework for developing a framework for engaging with communities, which we do not really have.’

Another European initiative which Asylum Aid is part of is Gensen, where recently nine European countries conducted research on asylum policies and gender issues. It seems that the EU has had a positive influence within the work on FGM in the UK, either directly through the funding of initiatives or indirectly by supporting other initiatives and organisations in Europe and learning from shared experiences.

The UK has also recently signed the Council of Europe Convention on Violence against Women, which was seen by the third respondent as a positive step towards developing clearer policies on FGM.

Table 2 — Key milestones

<table>
<thead>
<tr>
<th>Year</th>
<th>Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>Minority Rights Group report ‘Female circumcision, excision and infibulation: the facts and proposals for change’</td>
</tr>
<tr>
<td>1982</td>
<td>First debate in the House of Lords on prohibiting female circumcision, introduced by Lord Kennet</td>
</tr>
<tr>
<td>1983</td>
<td>BBC documentary <em>Female circumcision</em> broadcast in UK</td>
</tr>
<tr>
<td>1982/1983</td>
<td>Establishment of BWHAFS and Forward respectively</td>
</tr>
<tr>
<td>1985</td>
<td>Passing of Prohibition of Female Circumcision Act</td>
</tr>
<tr>
<td>1989</td>
<td>First national conference on FGM in the UK — Forward</td>
</tr>
<tr>
<td>1992</td>
<td>First African Well Woman Clinic established in Northwick Park Hospital</td>
</tr>
<tr>
<td>1999</td>
<td>Department of Health first policy document on safeguarding the welfare of children</td>
</tr>
<tr>
<td>2000</td>
<td>APPG hearing on FGM 23 and 24 May 2000</td>
</tr>
<tr>
<td>2002</td>
<td>10-minute private members’ bill introduced by Ann Clwyd to amend FC act</td>
</tr>
<tr>
<td>2004</td>
<td>FGM bill enacted</td>
</tr>
<tr>
<td>2006</td>
<td>‘Fornah’ case: asylum granted on grounds of FGM</td>
</tr>
<tr>
<td>2007</td>
<td>Findings of Forward prevalence study published</td>
</tr>
<tr>
<td>2009</td>
<td>FGM coordinator appointed, LSCB FGM resource published and ‘Together we can end VAWG’ strategy</td>
</tr>
<tr>
<td>2010</td>
<td>Call to end VAWG released, along with the policy guideline <em>Working together to safeguard children</em> (Department of Education)</td>
</tr>
<tr>
<td>Feb 2011</td>
<td><em>Female genital mutilation: Multi-agency practice guidelines</em> (DH, HO and FCO)</td>
</tr>
<tr>
<td>Mar 2011</td>
<td><em>Call to end VAWG: Action plan</em></td>
</tr>
<tr>
<td>July 2011</td>
<td>Crown Prosecution Service releases FGM guidelines</td>
</tr>
<tr>
<td>2011</td>
<td>Abolition of post of FGM coordinator</td>
</tr>
<tr>
<td>Oct 2011</td>
<td>Home Office launches a GBP 50 000 FGM fund</td>
</tr>
<tr>
<td>Nov 2011</td>
<td><em>Ending VAWG: Action plan progress review</em></td>
</tr>
<tr>
<td>Dec 2011</td>
<td>All-Party Parliamentary Group on FGM developed</td>
</tr>
<tr>
<td>Mar 2012</td>
<td><em>Call to end VAWG: Taking action — The next chapter</em></td>
</tr>
<tr>
<td>Jun 2012</td>
<td>UK signs the convention on violence against women</td>
</tr>
</tbody>
</table>

IV. PREVALENCE AND DATA COLLECTION

Prevalence

There is only one prevalence study that has been conducted and documented in the UK. This study, ‘A statistical study to estimate the prevalence of female genital mutilation in England and Wales’, has been mentioned by all respondents. The study was conducted by Forward in 2007 in collaboration with the London School of Hygiene and Tropical Medicine and City University Department of Midwifery. The study was funded by the Department of Health.

The Forward study provided a much-needed estimate of the situation of FGM in the UK. In fact, the findings provided by the study have been the only reference used that provide an insight into the magnitude of the problem in the country.

\(^{16}\) *Strategies for female genital mutilation prevention in Europe*, Els Leye.
Based on the findings by Forward, it is estimated that there are nearly 66,000 African women resident in the UK who have experienced FGM, nearly 16,000 girls under the age of 15 at high risk of type III FGM and over 5,000 girls at risk of types I or II FGM. As for the estimated number of maternities (registered live or still births) to women with FGM, data on the country of birth specific rates of FGM was applied to the birth registration data in each of the 4 years from 2001 to 2004. The estimated percentages of all maternities in England and Wales to women with FGM increased over the period from 1.06% in 2001 to 1.43% in 2004. There was also considerable geographical variation.

A recent estimate of the number of births to women with FGM in the city of London (only) was calculated by one of the researchers who were involved in the Forward 2007 study. This has revealed an increase from 4,238 women with FGM giving birth in 2000 to approximately 7,000 in each of the years 2007 to 2009.

**Data collection and data records**

With regard to the availability of data collection methods to collect information on FGM, there is currently no system for the routine collection of data on FGM by any governmental or non-governmental body in the UK. The data available are non-systematic data that can be gathered from various places: maternity and antenatal records; African Well Woman Clinics; the Metropolitan Police; and asylum records. Not all the data is accessible and it is not routine. The type of data that might be collected is provided in Table 3 below.

<table>
<thead>
<tr>
<th>Information available/data set</th>
<th>Antenatal/maternity</th>
<th>Specialist FGM clinics</th>
<th>No of cases — Police reports</th>
<th>Asylum records</th>
</tr>
</thead>
<tbody>
<tr>
<td>By age group</td>
<td>Age would be recorded</td>
<td>Yes, in some could be grouped</td>
<td>Not clear</td>
<td>Not specific but either dependent or non-dependent</td>
</tr>
<tr>
<td>Type of FGM</td>
<td>If available yes</td>
<td>Yes</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Country of origin</td>
<td>Not always specific</td>
<td>Yes but might not be specific</td>
<td>Not clear</td>
<td>Yes</td>
</tr>
<tr>
<td>Routine collection</td>
<td>Not in every hospital/trust/or borough or city</td>
<td>Not in all FGM specialist clinics</td>
<td>Recorded in the Crime Report Information System</td>
<td>Recent asylum records include gender</td>
</tr>
<tr>
<td>Other information</td>
<td>Reason for attending clinic</td>
<td>Age at circumcision Number of years living in UK</td>
<td>No of reported incidents of concern that girl at risk/FGM has been done</td>
<td>With children or not Reason for asylum not included</td>
</tr>
</tbody>
</table>

**Maternity**

During antenatal visits FGM information is collected in some NHS health authorities in a few boroughs as well as in some cities in the UK. But it is not routine data collection and is mainly based on a postcode lottery system (the inequalities in the services provided amongst the different NHS trusts).

Maternity records which are currently included for all antenatal bookings contain the following:
- patient personal information (name, age, NHS number, address, next of kin information, ethnicity, religion, origin, occupation, type of accommodation, need for interpreter),
- patient obstetric and gynaecological history (last menstrual cycle, previous births, miscarriages, type of delivery if more than one pregnancy, any gynaecological disease, birth outcome),
- patient medical history (familial diseases, any other chronic illness or history of surgery).

According to an informant from the Department of Health, data on women affected by FGM is not routinely collected. But she explained that the maternity and children’s dataset will be implemented from April 2013 and will be providing comparative data including information on incidence and care. She indicated that the current approved data collection does not include FGM but there is a process in place to revise and refresh the dataset.

**African Well Woman Clinics/FGM specialist clinics**

Currently data is collected specifically on FGM in the FGM specialist clinics, but again the information that is collected is very much dependent on the clinic itself. Within all the clinics there is no uniform data collection done by all the clinics and each clinic works independently of the other. The second respondent also pointed out that the clinics do not share or collate the data they have with each other.

In the clinic at St Thomas’ led by the second respondent, because it is based in and part of St Thomas’, the hospital data collected is part of the central intranet data collection system. The second respondent explained that there were two points for data collection.
- An electronic patient record that collects data for all clinics run by the Well Woman Clinic, including the number of women and girls seen, those who did not attend
Another clinic that was mentioned by the third respondent was the Acton Well Woman Clinic, which she commended highly for the detailed information that they routinely collect, including: where the women came from; who has accessed the services, including their age group and the age when they accessed the clinic; age at which they FGM was performed; reason for attending the clinic; and number of years living in the UK.

The Metropolitan Police Service

Data provided by the police only concerns data on the number of cases which are under investigation. All reported cases are logged in the Crime Report Information System (CRIS). The first respondent explained that this information was not accessible to persons other than police officers due to the Data Protection Act 1998. The Data Protection Act governs the protection of personal data in the UK. The CRIS might contain information including any reports of girls suspected to be at risk of FGM or girls suspected to have undergone FGM. She also mentioned that the team at project Azure will be able to access the information as it is also flagged for them, in order that they can follow up on the information.

However, the third respondent commented that even the information that is reported by the police is unclear in terms of whether it has been analysed or not.

‘I had to contact the police on several occasions just to get information on the number of cases that have been investigated. To date we do not have an analysis of the data on the numbers who have been investigated on FGM. Yes we are given a figure, but if we do not have an analysis of why these cases were successful, we are not able to learn from the process. Over and over again we have to push for it. If the police are doing their work then clearly that needs to be a critical part of it: doing an analysis; doing a review; evaluating their work; identifying what has gone wrong; what have been the issues as well as why have those cases have not been effective.’

In February 2012, in accordance with the Freedom of Information Act (the Freedom of Information Act gives everyone the right to request information from any public body and that organisation must provide the information within 20 days), an individual requested information from the police including whether there were any cases within the police boroughs where there was a reported risk of FGM by either parents or professionals (within the last 5 years), and what the police’s policy on safeguarding children was. The Metropolitan Police Service’s response was that in the 2 years from 3 June 2009 a total of 75 ‘incidents’ in London included FGM concerns. Two cases in 2009 were investigated as crimes, with arrests but no charges. There have been no prosecutions to date.

‘It is true there were these allegations but when the police followed them up, not all of them were real cases to follow up on. It could as an example just be a teacher who had suspicions that a child might undergo FGM because she was going back home for a holiday.’

The Asylum and Immigration Tribunal and the Home Office Borders Agency

Neither of these officially record the number of applications for asylum on the grounds of FGM. This has been one question which has been raised on several occasions by MPs during House of Commons debates, but until now nothing has been done. However, the Home Office issues annual reports on the latest immigration and asylum statistics, which provide information on the number of applicants for asylum, their gender and country of birth. With regard to applications for asylum, information is provided based on whether the person was granted asylum as a refugee, granted humanitarian protection, given discretionary leave to remain or refused asylum. However this information is not broken down into further details and the grounds for applying for asylum are not included.


The NSPCC provides annual child protection register statistics. These contain confidential details of children who are at continuing risk of physical, emotional, or sexual abuse or neglect, and for whom there is a child protection plan. Registers cover each local authority area in the UK and are managed by individual social services departments, but FGM is not specifically mentioned.

It was agreed by the majority of the respondents that the issue of FGM data recording is not available as a protocol or guidance in order to be adhered to systematically. There is also no clear system to register the number of women with FGM or the number of girls that could be at risk.

Recent developments on data recording

On 22 and 23 March 2012 a workshop on methodological issues (1) was held to explore the methodological options for the collection of robust prevalence data on FGM in England and Wales. The workshop was organised jointly by Equality Now, Forward, University College London and the Elizabeth Garrett Anderson Institute for Women’s Health, and was funded by the Home Office. The workshop was attended by epidemiologists, demographers, statisticians and social scientists from the UK, Belgium, the Netherlands and Germany, in addition to practitioners in public health, midwifery, gynaecologists, psychologists and representatives of NGOs. Some of the key recommendations which came out of the workshop included the following.

(1) There should be a staged approach to deriving and improving estimates of the prevalence of FGM.

- In the short term, up-to-date estimates of the prevalence of FGM in England and Wales should be derived using routine data about the numbers of
women in the 2011 census, age-specific birth data, available migration statistics and new country-specific FGM prevalence rates from surveys in countries of origin.

- The revised estimates should be complemented with an updated review of FGM literature.
- In the longer term, primary data should be gathered through a clinical audit to determine the prevalence of FGM among women giving birth in England and Wales, with the aim of trying to overcome the main constraints such as underestimation of undocumented migrants, asylum seekers or refugees who may be reluctant to participate in the census.

(2) It was also agreed by all the participants that the focus of research on FGM should not just be on the numbers but also on the attitudes of communities living in England from countries where the prevalence of FGM is high, such as Egypt, Eritrea, Ethiopia, The Gambia and Sierra Leone. There have already been a number of studies on communities from Somalia and Sudan.

(3) Research is needed to understand the obstacles to the implementation of FGM policy and guidelines amongst professionals in health, social care, education and the justice system. It was also recommended that this be linked to a training strategy for professionals. This was required as there are existing guidelines on FGM but they are not being followed. It was also seen that the implementation of FGM policy was patchy and ad hoc and that it varied between local authority and NHS organisations.

Suggestions to improve data collection

Data collection was considered to be very important by all the respondents as it would assist in informing policies and in assessing what interventions should be carried out and what was working effectively. The table below identifies some of the suggested ways to improve data collection.

<table>
<thead>
<tr>
<th>Recommendation for data collection</th>
<th>Recommended by</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>For health professionals to collect data that would assess/identify girls at risk</td>
<td>First respondent</td>
<td>Health professionals</td>
</tr>
<tr>
<td>Improving the information collected by the census, in particular with regard to ethnicity as currently this does not necessarily define the country of origin (too vague)</td>
<td>Second respondent</td>
<td>Office of National Statistics who collect census data</td>
</tr>
<tr>
<td>Electronic patient record was believed to be a good means of data collection</td>
<td>Second respondent</td>
<td>-</td>
</tr>
<tr>
<td>To know the grounds for asylum by asylum applicants in order to inform policies, in particular if the decision-making was equal or differential, whether there was particular training needed</td>
<td>Sixth respondent</td>
<td>UK Border Agency</td>
</tr>
<tr>
<td>FGM should be part of the routine data collection in the UK, in particular in the NHS, and specifically in GP surgeries and maternity records</td>
<td>Third respondent</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Reported cases should be streamlined, especially between the areas of safeguarding and reported cases from the police (which should be thoroughly analysed)</td>
<td>Third respondent</td>
<td>LSCBs and Metropolitan Police service</td>
</tr>
<tr>
<td>At maternity it should be mandatory to ask a woman if she has had FGM so this can be included in the antenatal notes</td>
<td>Additional respondent</td>
<td>Department of Health</td>
</tr>
<tr>
<td>At delivery, record whether women have FGM and the type, using a standard format which should be derived and included in all delivery records</td>
<td>Additional respondent</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Daughters considered to be at risk based on their mother’s FGM status and prevalence in their country of origin should be included in safeguarding registers</td>
<td>Additional respondent</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Unification of data collected at the African Well Woman Clinics so that all clinics collect similar information. This could then further be collated, synthesised and analysed frequently</td>
<td>Personal suggestion</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Health visitors are a good point of contact to assess if a girl could be at risk of FGM, therefore develop a monitoring system for at-risk families to ensure due follow-up</td>
<td>Personal suggestion</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>

Other issues that should be considered with regard to data recording and collection in the UK are the need to obtain the information in a sensitive manner so as not to discriminate against, stigmatise or generalise amongst different communities. In order to ensure this, there must be a priority of community engagement interventions so that the community is part of the process and not simply a ‘top-down government approach’ which would alienate the community.
V. APPROACH TO FGM

This section provides an overview of the approach to FGM in relation to the ‘six Ps’ defined in the in-depth study guideline. The first subsection will provide the overall picture, as well as which ones have been most emphasised in the UK. Following that, each P will be discussed separately, including its state of development and the challenges faced, among other topics.

V.1. Overall

Table 5 — Ranking of the Ps

<table>
<thead>
<tr>
<th>P/Respondent</th>
<th>Prevention</th>
<th>Protection</th>
<th>Prosecution</th>
<th>Provision</th>
<th>Partnership</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>First respondent</td>
<td>1</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Second respondent</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Third respondent</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Fourth and fifth</td>
<td>1</td>
<td>1</td>
<td>NA</td>
<td>2</td>
<td>Cross-cutting</td>
<td>NA</td>
</tr>
<tr>
<td>respondents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sixth respondent</td>
<td>NA</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

The responses from the respective respondents were different. In addition some of them felt that they would not be able to provide an accurate ranking for the different Ps as their expertise was in one or two of the particular Ps.

Prevention and protection were ranked as one group by three of the respondents. They all felt that prevention and protection was the most emphasised, as well as the most important to be emphasised, in the UK. The first respondent felt that both these Ps should be the priority of all work in the UK. This was also agreed by the Home Office officials. Meanwhile, the second respondent believed that prevention and protection should be grouped together but that there was still a lot of work to be done to improve their state of development. In terms of protection she believed that there were good guidelines available, and as for prevention it was progressing slowly but there was a strong need to focus on raising awareness and training of professionals. Prevention to her meant the full involvement of all actors, in particular front-line professionals, which she felt was currently lacking in the UK. On the other hand, the third respondent ranked prevention in fifth place as she felt that the emphasis on it was minimal as the government did not feel responsible for it. Prevention to her was left to the NGOs because they were much closer to the communities. But she emphasised the question of how, without the resources and the support, were the NGOs going to be able to engage with the communities effectively.

Protection was ranked as the number one priority by the sixth respondent as the work that Asylum Aid does focuses heavily on this particular area. As for the third respondent, she believed that, following provision of services, protection was the second most emphasised facet in policies, in particular with regard to protection being seen as an issue of ‘safeguarding’. However she also believed that there was still a lot of work to be done in terms of the safeguarding element.

During the respective interviews, the respondents were requested to rank the different Ps based on how they viewed the state of development of each one in the UK, as well as how much policy emphasis was on that particular P. The majority of the respondents felt that the exercise of ranking or placing the different Ps based on emphasis was not an easy task and depended on the different priorities. Below is a table to show how the different respondents ranked the Ps in the UK.

Provision of services was believed by both the second and third respondents to be the one with most emphasis. They both agreed that this had more emphasis and this was attributed by the second respondent to there being a number of specialist clinics available in the UK that provide support to women and girls with FGM.

Prosecution was ranked by only the second and third respondents. It was said by the third respondent that there was a lot of emphasis put into prosecution as an issue but that there was no effort to acknowledge the issue of prosecution. As such she felt it should be ranked as the fourth most emphasised P. As for the second respondent, she believed that prosecution should be last, as despite the availability of two laws against FGM, no prosecutions have been carried out.

Partnership was seen as a cross-cutting theme by the Home Office officials, who believed it was an important part of their work and needed to be prioritised. The third respondent ranked partnership as the third P, as she believed that it did not require any commitment, that it was easy to bring partnerships together and that it did not have to be funded. This differed interestingly in comparison to the second respondent’s justification and ranking, as she felt that partnership was a major issue that was lacking in emphasis. As such she ranked it in fifth place.

‘We all have fantastic work that we are doing, and a lot of the NGOs are doing a fantastic job in the UK. But there is no coordination; we lack coordination, we lack partnership.’

Prevalence estimates was also ranked only by the second and third respondents. They ranked this P differently, with the third respondent ranking it as the P with the least emphasis in the UK and the second respondent in fourth place. The third respondent believed that prevalence was
not taken as seriously as it should be and that nobody was leading on it. Meanwhile the second respondent felt that there was no data available as the existing prevalence rates are those from the Forward study in 2007, which were also only an estimate.

Below is a detailed description of the different Ps based on the information provided by the respective respondents.

V.2. Prevention

This section will discuss the prevention work done in the UK, including what type of prevention measures are available, who the main actors involved in prevention are and who the groups being targeted by prevention measures are. It will also describe some of the relevant prevention measures available in the UK and discuss some of the challenges that are faced.

**Prevention work in the UK**

Prevention work in the UK began very early after the start of the campaign against FGM, in the 1980s. Initial prevention measures evolved to provide information to reduce and clarify any misconceptions about the practice. The main prevention strategies that have been undertaken in the UK have included:
- awareness-raising campaigns,
- development of educational materials and resources.

**Awareness-raising campaigns**

The initial work on prevention evolved due to the need to raise awareness about FGM, in particular as women affected with FGM began to arrive in the country. With their coming to the country it was important to target awareness-raising campaigns towards different groups at the community level and towards various professionals, including those in the health, social work and education sectors.

The main target groups at the community level have included: women and girls; men; youth and religious leaders. Usually the community members are from the migrant communities. Part of the strategy of working with communities has been to engage with communities, and to change attitudes towards some misconceptions linked to the practice, such as incorrect beliefs about FGM being part of religion, etc.

Different, innovative and creative methods have been used in working with communities, for example providing a space for community members — in particular women and girls — to talk openly and engage with each other. Other methods used as community engagement initiatives have included talking about FGM in community events or at schools to raise awareness about the issue; the use of different types of media, such as drama and radio; women and girls getting together for coffee mornings (weekly coffee mornings where women find a space to talk and discuss with each other about FGM are organised by Forward); and teaching new skills to women and girls, for example through literacy classes.

‘One of the women who attends the coffee mornings had visited Puntland in Somalia and she talked about how her intervention had actually helped to raise awareness. So one of the things that we are actually seeing is the ripple effect beyond the UK; women who are part of this programme want to go back to their countries and actually want to intervene and play their role.’

Awareness raising has also been targeted at professionals through the provision of training courses, presentations, workshops, seminars and conferences about FGM. Most of the training courses that are provided are ad hoc and several of them are based on demand. Training courses are provided to professionals in both the voluntary and the statutory sector. The main aim of the training courses is to equip key professionals to have the confidence and understanding to be able to respond to FGM. Different training courses have been provided to health professionals, social workers, teachers, police officers and the voluntary sector.

**Development of educational material and resources**

Different resources have been produced that have been targeted at specific groups, along with more general resources. Materials have included:
- leaflets and posters to raise awareness about FGM (developed by the Home Office);
- factsheets and information packs about FGM;
- documentary films and educational DVDs, such as a clinical DVD developed for health professionals by the FGM National Clinical Group on how to carry out surgical defibulation, an educational resource developed for teachers in schools that project Azure developed in collaboration with Kids Taskforce (an NGO that works with the emergency services and other third sector institutions to create personal safety learning programmes for primary and secondary schools) and a DVD developed by the Department of Health.

**Main actors in prevention**

The main actors involved in prevention work have been NGOs and public authorities.
- NGOs such as Forward, BWHAFS, Iranian and Kurdish Women Organisation (IKWRO), as well as other organisations working in London and those outside in other cities.
- Public authorities including the project Azure team from the Metropolitan Police, the local safeguarding children boards in the different boroughs (some of them provide training courses on FGM, but it is not systematic). The African Well Woman Clinics also provide training courses. The Home Office and the Department of Health have produced leaflets on FGM and posters that have been distributed in different areas.

**Relevant initiatives on prevention in the UK**

**FGM special initiative**

A very significant and recent initiative, the FGM special initiative is a UK-wide initiative that was established by three independent charity organisations: the Esmée Fairbairn Foundation; Trust for London; and Rosa (the UK
fund for women and girls). All three organisations have collaborated to provide funding for organisations working with communities towards developing preventive work to safeguard children from FGM. One million pounds has been invested in 14 organisations all over the UK that have been provided with funding for a 3-year period. All projects began in January 2010. Forward was able to successfully lobby one of its funders, Trust for London, with regard to providing funding for organisations working with communities on FGM. The initiative has been so successful that there might even be a possibility of a second phase for the project.

‘Unfortunately, if you look at the government, it has not been strategic, so last year they said they were locating GBP 50 000 towards FGM community work. The special initiative organisations have together spent more than one and a half million pounds towards FGM community work over 3 years. So if you look at the FGM initiative and you look at what the government is providing, what is that GBP 5 000 going to do to each organisation? Clearly the government is not committed to engaging with communities, but if you are not working with key communities how will you be able to engage with communities to stop the practice?’

Bristol FGM community development work

The Bristol FGM community development project is a 2-year project that has been commissioned by NHS Bristol to deliver a community-based prevention approach to FGM. It is a project working with African FGM-practising communities living in Bristol to safeguard girls by enabling families and communities to abandon the practice of FGM and to improve sexual and reproductive rights and access to health entitlements.

The project is based on three core principles:

1. Women’s leadership and empowerment is central to change;
2. Partnership working with individuals and community organisations is more sustainable;
3. Training, mentoring and capacity development is necessary for both individuals and community organisations.

The NHS commissioned the project in 2009 and it is being implemented by Forward in partnership with Refugee Women of Bristol and Platform 51. The Community Advisory Group is a multi-disciplinary group made up of representatives from NHS Bristol, Refugee Women of Bristol, project volunteer community health advocates, Platform 51 and Forward. The group meets approximately four times a year to review progress against the project’s logical framework, plan activities and address challenges.

‘What has actually been very good has been that as a result of our work the communities are now more engaged in policies as well as strategic processes, and that in itself is critical’.

V.3. Protection

This section will look at the two areas of protection: child protection and asylum protection. Given that there was not the possibility to interview a key person from a safeguarding children board, the information provided will be drawn from the other key persons interviewed, the country desk research report and other sources.

Child protection

Based on what has already been mentioned in the desk research phase, in the UK there are four child protection laws under which FGM can be identified as a cause of significant harm, and normal child protection procedures to prevent the child from ‘significant harm’ should be involved.

Section 47 of the Children Act 1989 provides legislation which does not specifically include FGM, but the practice can be classified as a cause of significant harm to the child. It states that when a local authority has ‘reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare’. Child welfare officials, when they suspect that a child is at risk of FGM, can intervene by undertaking the following compulsory measures: withholding authorisation to leave the country (by withholding the parent’s passports or withholding the girl’s passport), suspension of parental responsibility and, in extreme cases, removal of the child from the family as a last resort.

In situations where it is feared that a child is at risk of FGM, professionals have a duty to inform social services or the police in line with Section 47 of the Children Act 1989. The professional will refer the child as a ‘child in need’ and the local authority should exercise its powers to make enquiries to safeguard a girl’s welfare if there is reason to believe that she might be subjected to or has been subjected to FGM.

Below are the steps taken to undertake existing protection measures for a child at risk.

• On receiving a referral from a professional, a strategy meeting should be convened within 2 days and should involve the police, children’s social services, education, health and voluntary services. Health providers or voluntary organisations with expertise must also be invited.
• The strategy meeting must first see if either the parents or the child have had access to information about the harmful aspects of FGM and the law in the UK. If not, they should be given the appropriate information.
• An interpreter and, if possible a community advocate, appropriately trained in all aspects of FGM, must be present during all interviews with the family.
• Every attempt should be made to work with parents on a voluntary basis to prevent the abuse. It is the duty of the investigating team to look at every possible way that parental cooperation can be achieved. But the child’s interests are always paramount.
• If no agreement is reached, the first priority is protection
of the child and the least intrusive legal action should be taken to ensure the child’s safety.

- The primary aim of the process is to prevent the child from undergoing any form of FGM rather than removal of the child from the family.

If a child is believed to be at imminent risk of harm.

- If there is a suspected risk, the first respondent explained that the police can use ‘police protection’. She pointed out that very occasionally police protection is used but that would only be for 72 hours.
- However there must be a very strong conviction that the child might imminently suffer significant harm. The police must also inform children’s social services and ask them to assist in finding safe and secure accommodation for the girl.
- After 72 hours the child must be returned to a parent or a carer with parental responsibility, unless 72 hours have passed and the child is still believed to be at imminent risk of significant harm, in which case children’s social services may apply for an emergency protection order.
- Police officers also have the powers, under Section 17(1)(e) of the Police and Criminal Evidence Act 1984, to enter and search premises in order to protect life or prevent injury.
- An emergency protection order authorises the applicant to remove the girl and keep her in safe accommodation. It will only be granted to safeguard the girl’s welfare. It lasts for up to 8 days but may be renewed for up to a further 7 days.

The first respondent confirmed that for police protection work they refer to both Section 17 and Section 47.

Main actors involved
The key actors involved in child protection, as well as their respective responsibilities in the process, are the following.

- Children’s social services, who might receive a referral from either another professional or from the police.
- The local safeguarding children board, which comprises all the organisations that work together to safeguard children, protect them from harm and promote their welfare. The LSCB coordinates what is done by the different agencies.
- The police, who will conduct an investigation to follow up the report.
- Other key actors, including education and health services, and representatives from the voluntary sector, might be involved in the strategy meeting.

Training for professionals
With regard to training, initial front-line professionals, in particular teachers and social services, had limited awareness regarding what to do in cases of FGM and identifying a child at risk. The first respondent believed that FGM was not seen as a priority by teachers and that they would most probably feel very uncomfortable talking about the issue.

‘It is not mandatory for social workers to be taught about FGM. Teachers also do not really have a good idea about it because they also are not taught about it. This is despite the fact that some of their pupils might be undergoing it and they are also one of the main professionals in terms of point of contact with children.’

The document Female genital mutilation: Multi-agency practice guidelines, developed by the Home Office, was believed to be a good document which contained useful information. But it was also pointed out that the multi-agency guidelines needed a lead person in order to push for their implementation and steer the process, and this was now missing.

‘I was there at the launch [of the multi-agency guidelines] and I said to one of the participants “yes it is very good we have the guidance, but will it be mandatory statutory guidance?” And she said “no”. I asked if there was going to be any training rolled out, and she said “no”. I asked if there was going to be any dissemination for it, and she said “no”, they had only printed 1 000 copies and for more copies you would have to download from their website. So if you didn’t know about that information how were you going to access it on their website? So clearly, even the key document, and even in terms of the key actions in the VAWG strategy, it has been ticked that the guidelines are one of the areas that has been successfully implemented!’

As for protection, the third respondent felt that despite the fact that protection was a key element of safeguarding, it seemed that FGM was not included as part of it. She further illustrated that if someone attended a training course on safeguarding, FGM was not necessarily one of the issues included. She also emphasised that over and over again they have found there were teachers who informed them that they attended a training course on safeguarding but that FGM was never even touched on in the training. To her, that meant that FGM did not come up as a core area of safeguarding.

‘The safeguarding training is provided by the safeguarding boards, and they will do other forms of violence such as sexual abuse, domestic violence, related neglect, etc., but FGM does not seem to fit very squarely as a form of abuse, although they say that it is a form of child abuse. In reality it is either touched on in passing or it is not done so in detail. Over and over again we see that we are not even able to address or get a clear document on what safeguarding should do.’

She explained that there were different people coming up with different ideas in terms of safeguarding but that the policy environment to bring things together did not seem to be there.

With regard to record systems for child protection investigations on FGM, it is not very clear who will have the data. If it becomes a police matter then it would be reported in the police CRIS mentioned previously. If it is kept under the responsibility of the LSCBs then the case files would be with them. According to the NSPCC (2)

(2) ‘Child protection fact sheet: Guidance on child protection records retention and storage (England and Wales), NSPCC, 2007.'
recording and data storage system for child protection, the information that is available in a child’s record for any case of abuse would be the following:

- the date and time of the incident/disclosure and the parties who were involved, including any witnesses to an event;
- what was said or done and by whom, as well as any action taken by the organisation to look into the matter;
- where relevant, the reasons why a decision was taken not to refer those concerns to a statutory agency;
- any interpretation drawn from what was observed, said or alleged should be clearly recorded as such;
- the name of person reporting the concern, the name and designation of the person to whom the concern was reported, date and time, and their contact details.

Usually, data is stored for 6 years and is then destroyed under the regulations of the Data Protection Act.

**Asylum protection**

As was mentioned extensively in the country report developed in the desk research phase of this study with regard to asylum laws and provisions in the UK, there is no specific asylum UK national legislation dealing with FGM. However the immigration rules (HC395) referring to the 1951 UN Convention relating to the Status of Refugees codify the way in which the UK regulates entry into and settlement in the UK, including asylum claims. Women and girls applying for asylum in the UK for fear of FGM can apply on the following grounds: ‘If there is a well-founded fear, which includes evidence that FGM is knowingly tolerated by the authorities or they are unable to offer effective protection, and there is no reasonable possibility of relocation in her own country, an applicant who claims that she would on return to her home country suffer FGM may qualify for refugee status.’ If the applicant belongs to an ethnic group amongst which FGM is practised she may be a member of a ‘particular social group’. Women who may be subjected to FGM have been defined in some courts as belonging to a particular social group.

The UK also adheres to the European Convention on Human Rights, where a claim to asylum on the grounds of FGM can be considered based on Article 2 (the right to life), Article 3 (prohibiting cruel and degrading treatment) and Article 8 (the right to respect for family and private life). A human rights claim can be part of the asylum claim under the Refugee Convention or it can stand alone.

If a female 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, it can be considered if there is substantial proof that there might be a risk of forced marriage or that the woman might be at risk of having the procedure redone after delivery of a baby. In addition, in some circumstances future cases can apply if there might be a risk of FGM being performed on the daughters of an already genitally mutilated woman.

**Protection measures for women and girls seeking asylum on grounds of FGM**

The main protection measure for women seeking asylum on the grounds of FGM is to get some form of status to live in the UK. This could be by acquiring refugee status or some other form of leave to remain (humanitarian protection, or discretionary leave to remain). In the meantime, whilst she is claiming and awaiting the decision she will get accommodation, financial support and some access to healthcare. The difficulty is that if the claimant does not get any form of leave to remain or status (as the number of appeals are limited), and if she does not have any children with her or other exceptional circumstances (such as disability), then she could be thrown out of the accommodation by the UK Border Agency. She will also have no financial support and will not be allowed to work or have healthcare access. The idea is that either she should go voluntarily back to her country or she will be deported. There are therefore several scenarios which might happen.

- She might be detained and then deported, which means that she will be back at risk;
- If she is not detained or deported she will be left with nothing and will become ‘destitute’. The sixth respondent points out that it is also known for women who are destitute to end up on the streets, leaving them vulnerable to sexual exploitation and sexual violence. A recent Oxfam report (*) talked about women engaging in transactional sexual activities, trading sex for a roof over their head.

As mentioned above, during the waiting period for the decision asylum applicants receive accommodation and financial support specific to an asylum seeker (a reduced amount of money, almost three quarters less than UK citizens receive in income support). She explained that the system had changed because of public criticism that UK citizens’ welfare was being taken from them and given to asylum seekers. As such, even the accommodation is now not in council houses but other forms of accommodation. When all the appeals are exhausted by the claimant then all support will be cut off. But if the claimant has exceptional circumstances or children then she might be able to stay in that accommodation, or if at a later stage she puts in a fresh claim then she can apply for Section 4 support, which would consist of accommodation and sometimes money or vouchers. Section 4 of the Immigration and Asylum Act 1999 provides support inclusive of accommodation and vouchers to purchase items, but to qualify for Section 4 support the applicant must prove that she is destitute as well as meeting other criteria.

In order to appeal a decision or make an application for asylum, most of the women seek legal advice. Asylum Aid is one of the organisations in the UK that can provide free legal advice to applicants seeking asylum. Usually the legal case workers will take the case and help the client prepare her documents and prepare for the interview with the UK Border Agency, if she has not already had the interview.

Some of the challenges the sixth respondent has described with regard to women seeking asylum are based on the findings of a recent study that Asylum Aid conducted,

contained in the document ‘Unsustainable: the quality of initial decision-making in women’s asylum claims’. These findings included the following.

• There was a general culture of disbelief displayed by UK Border Agency case owners with regard to all asylum applicants, whereby they simply did not believe the women.
• According to the new asylum model (NAM) each asylum applicant was supposed to be assigned one case owner who would be with the applicant from start to finish, unfortunately this was not always the case.
• The quality of initial decisions was very poor due to:
  • the culture of not believing asylum applicants;
  • some UK Border Agency staff having little understanding of the refugee convention;
  • some UK Border Agency staff not engaging with ‘particular social groups’;
  • the prepared Home Office country of origin information being used very selectively by Border Agency staff;
  • case-law not being used properly and not being applied correctly.

The sixth respondent mentioned two points which it is important to include to provide a picture of some of the challenges for the implementation of asylum policy.

‘So, for issues like FGM, sexual violence or other forms of GBV [gender-based violence] women generally found that it was easier to talk to other women, so they did that [provide interpreters that were female as was recommended by Asylum Aid], but what they didn’t always do was to provide a female interpreter. If you do not want a male interviewer surely it will also mean that you wouldn’t want a male interpreter? But they do not quite understand that.

What came up in our study “Unsustainable” was that a woman asylum seeker was interviewed and during the interview she mentioned female circumcision, and the interviewer asked her “what is this female circumcision?” We had thought that they would all by now understand what FGM was.’

**Main actors in protection**

The main actors in protecting people from GBV in their country of origin are the UKBA, which is the executive agency of the Home Office, and also the Appeals Tribunal, which is independent to that and has two different levels — the first tier and the upper tier. Following these two courts, further appeals could be made to the High Court and then to the Supreme Court. In addition there are the legal caseworkers and solicitors who can provide legal advice to the asylum claimant. Organisations such as Asylum Aid and others who work on advocacy and campaigning for the rights of asylum seekers also play a major role in protection.

**Training for UK Border Agency staff**

When the NAM was introduced in 2007 the UKBA provided training for everybody in the agency as well as newly appointed staff members. Gender issues were included in the training package. The information on gender issues was very general and not extensive, but it was satisfactory. It did not contain specific details on FGM but on the broad issues of gender-based violence, and more specifically on gender sensitivity during interviews, etc.

She added that very recently, after ‘Unsustainable’ was published, it was decided by the UKBA that there would be some additional training — a 1-day training module that was specifically on gender issues and women’s issues. The training is compulsory for all UK case owners at every level, including senior level. She mentioned that they were currently conducting the training as it was still a very new activity. It is an internal training module, and both Asylum Aid and the UNHCR were involved and consulted on the training material. She herself had also been attending the pilot workshops. All forms of GBV are mentioned in the training module, including FGM.

**Existing data recording system for asylum requests**

As mentioned in the country report, as well as in Section IV, the sixth respondent confirmed that there were no existing recording systems in the UK for asylum requests. The UKBA only keeps asylum claim statistics relating to gender, dependence and children. It was her belief that it was partly complicated because people might have more than one reason. She also mentioned that within Europe only Belgium provided a more detailed breakdown of the asylum information.

Other relevant information that could be accessed was the outcomes of the decisions, the total number who applied and the outcomes after the initial interview and the appeal.

‘So we do not know how many women come because of claims relating to their political activity and how many are to do with GBV [details such as country, age, sex and other subsections].’

**Budgets for protection interventions**

In the UK the government provides funding for legal aid to help people protect their rights and get a fair hearing. Through legal aid fund schemes the government funds solicitors and advice agencies in the UK. Legal aid is overseen by the Department of Justice. Asylum Aid and other organisations that provide legal services are provided with funding for asylum seekers by the government. The sixth respondent also mentioned that legal aid has undergone some major changes with regard to funding (general cuts), but that they will still be funding asylum requests.

**V.4. Prosecution**

This section will discuss the issue of prosecution of FGM in the UK. The issues that will be addressed are the challenges to prosecution and how they can be overcome, the available record systems and the reporting mechanisms in case of girls at risk of FGM and performed FGM. Some of the recommendations provided by the respondents are going to be listed. The section will also draw on the feedback provided by a respondent from the Crown Prosecution Service.

As mentioned during the country report produced during the desk research phase of this study, the UK has gone a long way from when the Prohibition of Female Circumcision Act 1985 was introduced into the political agenda in 1982.
With the enactment of the FGM Act 2003 and the changes in the terminology used from ‘circumcision’ to ‘mutilation’, introducing extraterritoriality as well as the increase in the number of years’ imprisonment, the concern that FGM has raised in the country is well reflected. But despite the strengthening of the new legislation there have still been no prosecutions at all, and this has led to question marks with regard to the reliability of a law which has not had not even one led to court case.

According to the respondent from the Crown Prosecution Service, there are a number of factors which affect prosecutions related to FGM. At the time of mutilation, victims may be very young and vulnerable, or afraid to report offences and give evidence in court. She also felt that the success of the 2003 act cannot be measured by the number of prosecutions alone. To her, prosecution after the act of FGM does not relieve the victim of a lifetime of pain and discomfort. The 2003 act is aimed at preventing FGM in the first place and the increased maximum penalty, from 5 to 14 years’ imprisonment, is designed to deter and prevent this unacceptable practice.

The procedure following referral from police

The respondent from the Crown Prosecution Service provided an explanation on how the CPS prosecuted cases once a file was referred to them by the police.

‘Prosecutors are required to review each case in accordance with the two-stage test set out in the “Code for Crown Prosecutors” when deciding whether or not to bring a prosecution. They must first be satisfied that there is sufficient evidence to provide a realistic prospect of conviction against each suspect on each charge (the evidential stage). If the case does not pass the evidential stage, it must not go ahead, no matter how serious or important it may be.

If the case does pass the evidential stage, prosecutors must then go on to decide if a prosecution is needed in the public interest (the public interest stage). A prosecution will usually take place unless there are public interest factors tending against the prosecution which outweigh those tending in favour.’

She further added that the process of review and decision-making required a full analysis of all the relevant facts and circumstances bearing on the individual case, noting that the primary function is to prosecute and that the CPS works closely with the police to identify and build strong, robust cases to enable a charge to be brought. (In order to prosecute there must be irrefutable doubt that the child will be at risk of FGM, thus the building of a strong case with evidence or proof would be required.)

The first respondent felt that in the UK it was as if we were a bit complacent about prosecution. She went on to explain that it was very difficult to get a prosecution in the UK because of the nature of the judicial system, which demands that you have to prove beyond ‘reasonable doubt’ that FGM was going to occur or has occurred.

‘In most cases I believe that this puts more emphasis and pressure on the child to give evidence against the parents, for what is seen as “a one-off act in an otherwise loving family”. And if you are faced with the prospect of testifying against your mother and possibly sending her off to jail for 14 years, that is an awful lot to ask a young child to do. I think it is a very difficult thing for a child to say.’

The first respondent also felt that even if a child had been cut and there was another sibling in the family, prosecution might also not be possible unless there was credible evidence to prove it. She believed that prosecution was a difficult issue for several reasons.

- This would mean that the courts would have to rely heavily on a child who has been cut to say who allowed the cutting to happen.
- She also acknowledged that even if the person who practised the excision was known, it would not prevent the parents from going to a different one to perform FGM.
- It also expected the child to give evidence against her loving parents.

‘People think that prosecution is going to be an easy route — it is not and it throws up a lot of issues. Most girls will not tell you how it happened. They will nearly always say it happened outside of the country and they will nearly always say that it happened when they were on their holidays abroad. So that it is not [the responsibility of] anyone from the family, not someone who could be prosecuted like “mum did not know it was going to happen”, or “my Nan insisted”. So we usually do not have a case as simple as that.’

The CPS guidance

The respondent from the Crown Prosecution Service explained that as part of its commitment to the violence against women and girls action plan, the CPS published the first legal guidance on FGM on 7 September 2011. The legal guidance on FGM was developed to assist prosecutors in understanding the background and challenges when prosecuting cases involving FGM. In addition, the CPS has been monitoring and evaluating every case which is referred to them by the police for a period of 12 months. To her, this reflected the CPS’s commitment to taking positive action to address the issue of FGM.

It was also stated by her that it was illegal for FGM to be practiced in the UK, as it falls under the Violence Against Women and Girls Act. As such policies against it were robustly implemented. Research suggested a number of barriers to prosecution, including pressure from the family or wider community, leading to cases going unreported. Despite a lack of prosecutions to date, the Female Genital Mutilation Act 2003 provides a clear message that FGM is an unacceptable and illegal practice in England and Wales. The 2003 act has also been a catalyst for outreach work and has helped to raise awareness of FGM amongst local communities.
As for prosecutors, she added that they have been made aware of the issues relating to this subject in the context of domestic violence training. All prosecutors are required to undergo domestic violence training and would therefore complete FGM training. The legal guidance is designed to help prosecutors make prosecution decisions on cases referred to them by the police.

The fact that there was a very long period between the issuance of the guidance and legislation was highlighted by the third respondent. According to her there has also been no training rolled out to enable the prosecutors and staff within the Crown Prosecution Service to understand their role.

‘The law was revised in 2003, and if you have guidance which comes out in 2011 there clearly is no framework that is supporting and backing the effectiveness. So we have a number of challenges when it comes to these core areas.’

It was pointed out by two respondents that the law did not protect all individuals in the UK but only UK citizens and permanent residents. As such, a temporary resident or a person with no status or an illegal migrant would not be covered by the law.

Challenges to prosecution

It seems that the issue of prosecution is very complicated, in particular as there are several different strands which had to all come together in order to make a case, including the initial reporting, the building of a case that will not fall through, the need to have substantive evidence, etc.

Some of the challenges to prosecution that have been mentioned by the respondents can be found below.

• The challenges of prosecution and people believing that the existing legislation has to be used to set an example to others (regarding which the first respondent stressed that people did not understand the difficult position that the child would be put under through having to testify against her family or community).

• The challenge that prosecution might not actually solve anything.

• The challenge of engaging and training professionals:
  • schools are the best place to identify girls, but teachers were the last people to attend any training on safeguarding, and as such it is a challenge to engage them in the process and enable them to make decisions;
  • The guidance for the Crown Prosecution Service (CPS) was only developed in 2011 and it is not known whether the staff have been engaged and trained.
  • Cultural taboos and reluctance to report the crime to the police are major factors of concern.
  • There are various legal requirements that must be met for the offence to have been committed under the legislation. Where the offence takes place overseas, the offender must be a UK national or a permanent UK resident.

With regard to prosecution, when the process reaches the investigation stage it becomes very difficult.

‘If the key areas in terms of information sharing are not done, the multi-agency guidelines aren’t followed, then clearly there isn’t that effort to bring in the necessary players to make things happen … I think there was one police case in Camden that did not go through. The challenges faced were the lack of information sharing in the multi-agency support, as well as the difficulties in actually pushing girls who have been affected to give evidence. The girl was under pressure from her community to change her story and she changed the story so many times that finally the case fell through. In France there is the duty of professionals to report. In the UK that duty seems a little bit weak and we are not really sure, and people are not really clear what their duty is in terms of reporting. If you are not clear in terms of your duty to report it really becomes very difficult.’

Other considerations

Regarding prosecution, it is as though the UK government is trying to have it both ways (toughening the law but at the same time being careful not to offend practising communities). But even women from practising communities have stated that ‘if the government does not put anyone in prison to set an example no one in the community will fear the law’ (20).

Following a recent discussion of the All-Party Parliamentary Group on FGM, the director of public prosecutions will be holding a round-table meeting on 28 September 2012 with a number of interested parties and experts to discuss: (1) why there have been no criminal prosecutions to date; and (2) what evidence will be needed to proceed with prosecutions if the victim is unwilling to give evidence or withdraws from the case.

V.5. Provision of services

This section provides a description of the services that are available in the UK for women and girls with FGM. It will mainly concentrate on the healthcare services currently in the UK, but will also briefly highlight any other services that may exist.

The response 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 in Northwick Park Hospital. The clinic was also supported by Forward, which provided a Somali speaking interpreter. 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’ by the second respondent. She explained that her clinic was identified by a multi-agency group in 1995, because at that time there were a lot of women referred to Guy’s and St Thomas’ because of FGM-related problems

(20) FGM is always with us — Experiences, perceptions and beliefs of women affected by female genital mutilation in London — Results from a PEER study, Forward, 2009.
and nobody knew what to do. So they had a multi-agency group that met for over a year and made lots of recommendations, one of which was to have a support service, and that was how the clinic was established. The multi-agency clinical group consisted of doctors, nurses, counsellors and psychosexual counsellors within the Lambeth, Southwark and Lewisham boroughs, which were all faced with the issue.

‘That was about 16 to 17 years ago, when FGM was still a hush-hush, quietened sort of thing that even the communities didn’t even speak about, and people got egged if they raised the issue. That’s why I always say to people that we shouldn’t get frustrated that things are not changing; we have really moved on and made small changes that are significant in terms of changing attitudes and mind-sets. Now there are the younger ones who come out and can talk of their experiences, earlier ago we didn’t have that, now they are doing that.’

By 1999 there were four clinics operating in the UK to tend to the needs of migrant women with FGM (2). Currently there are 15 FGM clinics in England, specifically for women and girls that have been affected by FGM. The clinics are all run by doctors and midwives, with the majority being midwife led. The services provided include:

- defibulation,
- psychological and counselling support,
- clinical management of complications due to FGM, such as cysts, abscess, infections, etc.,
- provision of advice.

Because all the clinics are NHS clinics, treatment is free and in the majority of cases referral is important and is either by a midwife, a nurse or a GP. The health sector has also produced guidelines and protocols on clinical management as well as making its position clear on FGM.

Below, a general overview of the African Well Woman Clinics will be provided, then a more detailed picture will be drawn of the clinic at Guy’s and St Thomas’ that is operated by the second respondent.

**African Well Woman Clinics**

As mentioned above there are 15 clinics that are currently fully operational in England, with another clinic in Manchester that is not operational. It is noted that in Scotland and Wales there are no FGM specialist clinics. The largest distribution of the clinics is in London, where a large number of the migrant population resides. Altogether there are 11 clinics in London, with one clinic each in Liverpool, Bristol, Nottingham and Birmingham.

Initially, after the second respondent’s clinic was opened, women used to come to her from other cities. As the distances were far, Comfort encouraged other midwives to open their own clinics, and, for instance, she was instrumental in the opening of the AWWC in Birmingham (where she went and provided them with training support; the midwives also came to her clinic to get experience), as well as the Acton clinic in London.

Unfortunately, the clinics are not always open, and some of them open just once every 4 weeks whilst other clinics operate once a week, so there is no consistency in terms of opening times and accessibility to the clinics. In addition, all the clinics were opened ad hoc; it was not a structured service. The clinics provided their services to migrant and refugee women and girls originating from FGM-practising communities.

Research was conducted for Forward by so-called ‘mystery shoppers’. Forward requested that two young women access the African Well Woman Clinic services and give their views on their perceptions and the attitudes of providers. This revealed the following:

- All the clinics had different operating times and were very difficult to access if you were not literate.
- Referral pathways were quite difficult, with some patients having to go through their GP, self-referral being possible for some and some not being able to access the services because they lived outside the borough.
- Quite a number 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 when accessing the services.

The data is not compiled routinely or consistently within the different clinics, but there are some figures which have been provided by the following clinics:

- University College London Hospital saw 169 cases over 2 years in 2009 and 2010, with 97 cases being new referrals and 72 being follow-up patients.
- Whittington Hospital saw 120 cases over a year in 2004/2005 and 194 cases in 2007/2008 (2). 

**Guy’s and St Thomas’ African Well Woman Clinic**

The clinic is operated by three members of staff but the second respondent performed the majority of the work. She has one midwife who works with her once or twice a month and a senior consultant who oversaw the clinic as well as managing complicated cases due to FGM. She explained that her post is included as one of the women’s services provided in the hospital so she was part of the hospital system, unlike other AWWCs that might have a clinic as a standalone project. Being part of the hospital system was positive in that there was less worry in terms of funding and sustainability. To her the largest role that the AWWC has is to reduce the operations list and the waiting time for women and girls, because prior to the clinic opening women and girls had to be kept on a waiting list for weeks or months in order to be seen by the gynaecologist.

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(2) Memorandum delivered to the Houses of Parliament in 1999.

As for the number of clientele that the clinic sees, one informant estimated that she might see up to 300 or 400 women and girls every year. But she emphasised that this was very variable and the numbers of clients attending are not consistent from week to week.

Training

Based on her experience, the second respondent felt that there was a clear need for midwives to be more informed on how to deal with FGM, and because of this apparent need she talked with her manager at St Thomas’ to see if they could set up a training course module at the university. FGM is not included in any educational curriculum for health professionals and is not part of the curriculum for midwives although there have been several requests for it to be included. Due to the need for such a course to be provided they spoke with Kings College (the university that is affiliated to St Thomas’ Hospital). They met with one of the senior lecturers who worked on issues of domestic violence and human rights issues. She is a senior lecturer in midwifery and women’s health studies in the Florence Nightingale School of Nursing and Midwifery. She was also a very experienced lecturer, and together with the second respondent developed a course module called ‘A clinical and academic programme of education on female genital mutilation for midwives and doctors’. The course ran for 2 years at the Florence Nightingale School of Nursing and Midwifery from 2008, and was the first ever course specifically on FGM for health professionals in the UK. It was six full training days, held once a week.

Unfortunately, the second respondent explained, the course had to be discontinued after the 2 years due to funding problems. Other training that she is involved in is provided for training professionals (health and social workers, teachers, etc.). All training courses are delivered on an ad hoc basis (on demand), but there was no structured training. She believed that training was important for raising awareness and also for providing information on what to do in certain scenarios and how to have a sensitive attitude in dealing with FGM-practising communities.

Other existing services

Other services that have been mentioned include the development of guidelines for healthcare professionals. The guidelines and protocols have usually been developed by professional bodies, including the Royal College of Obstetrics and Gynaecology, the British Medical Association, the Royal College of Midwives, etc.

Another service that is available is a telephone hotline for the Metropolitan Police. The telephone connects directly to the project Azure team. Usually it is available for colleagues who want to receive further information or advice, but it can also receive external calls from the general public.

V.6. Partnership

This section will explore the existence of partnerships in the UK related to FGM work. This will address the actors involved in the partnership, initiators and coordinators, as well as the role of the partnerships in policy development, and successes and challenges to the partnership.

During the interviews the issue of partnership was mentioned frequently by the respondents (particularly emphasised by the Home Office officials). In this section some of the partnerships that have been mentioned by the interviewees in relation to FGM will be highlighted. What has been made clear is that there are several partnerships present in the UK, at the national, local and international levels. Some of the partnerships have developed formally (resulting in an established partnership) and others informally through networking and sharing similar interests (with the possibility of leading to joint collaborative work). Examples will be provided below of some of the partnerships in the UK.

Partnerships at the national level

Two partnerships have been mentioned at the national level: the government FGM Forum and the FGM special initiative. Both these partnerships have already been mentioned in the above sections. Another partnership that can also be considered as working at the national level is project Azure.

The FGM Forum

This government initiative is led by the Home Office and began during the period of the former FGM coordinator. Following the abolition of the post, the Home Office continued the forum, which is now coordinated by the lead person on FGM in the sexual violence team of the Home Office. Membership of the partnership is by invitation only. Currently there are 40 members in the forum, meeting once every 2 months. The actors involved include the different cross-government FGM leads, and representatives from NGOs, project Azure and some statutory agencies.

The aim of the partnership is to bring the different stakeholders together to discuss recent updates and share experiences with each other. It was also seen as an opportunity by the Home Office officials in hearing from the different stakeholders about the work being done at the grassroots level. The partnership is funded by the Home Office, but information on the budget allocated is not available. It is not clear what the role is of the FGM Forum in policy development and implementation or monitoring. It seems that it is a platform that links between the government and the different stakeholders from the other agencies (voluntary and statutory sector), but without it having further input into policy development.

FGM special initiative

As mentioned in the subsection about prevention, the FGM initiative evolved from three charity organisations. The initiative has allocated GBP 1 million to fund 14 organisations, which is a substantial amount. It is clear that the initiative is well thought through and also shows positive commitment on community engagement. It has also contracted an independent research consultancy (Options UK) to monitor and evaluate the work of the funded organisations. They have also set up an advisory group, which has undertaken a supportive role in the active projects. The initiative began providing funding in 2010, and
Study to map the current situation and trends of FGM

**Partnerships at the local level**

There are several partnerships currently working at the local level. These include the various partnerships which have been undertaken by the voluntary sector working together with the statutory sector, such as the local safeguarding children boards or the local NHS. Within the UK there have also been formed different FGM strategy groups, usually a partnership of the LSCB with community-based organisations as well as other stakeholders. One local partnership will be described below. It has been mentioned by a few of the respondents and has been highly commended.

**Community development approach in Bristol**

In 2009 Bristol implemented a multi-agency approach to FGM work. Part of its work has involved engaging with strategic partners and, as such, NHS Bristol commissioned the Bristol community development project (now in its fourth year). The project’s aim was to deliver a community-based prevention approach to FGM. It involves pioneering work with African FGM-practising communities living in Bristol to safeguard girls by empowering them to end FGM. The main underlying principal of the project is that women’s leadership and empowerment is central. Partnership working with individuals and community organisations is more sustainable, and training and capacity development are necessary. From the project, a community advisory group was developed (composed of NHS Bristol, Refugee Women of Bristol, project volunteer community health advocates, Platform 51 and Forward). The partnership group meets four times a year to review progress against a project logical framework, plan activities and address challenges. It is initiated, serviced and supported by Forward and coordinated by a ‘women’s coordinator’, a representative from the community who is responsible for coordinating the work between NHS Bristol, Forward and the health advocates. The post of the women’s coordinator is supported by Forward. The success of the partnership has been in engaging effectively with communities, having 12 community health advocates who now participate and assist in training courses held by Bristol LSCB, and including the community in the advisory group.

**Partnerships in the international campaign (EU)**

‘End FGM’ is a European campaign that is led by Amnesty International Ireland working in partnership with a number of organisations in several EU Member States. The campaign aims to put FGM high on the EU agenda and to echo the voices of women and girls living with FGM and those at risk of it. The ‘End FGM’ campaign is working with 14 key organisations in 12 Member States: Belgium, Ireland, France, Italy, Cyprus, Lithuania, the Netherlands, Austria, Portugal, Finland, Sweden and the United Kingdom. The campaign advocates for the recognition of human rights and lobbies EU institutions to ensure that the EU adopts a comprehensive and coherent approach towards ending FGM. For the UK, Forward is the partner organisation in the ‘End FGM EU campaign.

**Some of the success factors and challenges to partnerships**

The role of partnerships is seen as influential as it also involves collaboration between multiple agencies or stakeholders, thus allowing for the growth and development of the partnership as each partner brings its own skills and expertise to work together. It appears that the key success factors for the partnership include: the commitment of the different partners to the goals of the partnership; having a clear strategy for the partnership; the effective involvement and engagement of the different stakeholders. Other success factors include continuous monitoring of the progress of the partnership, as is occurring with the FGM special initiative and the Bristol partnership. Another success factor which the third respondent believes is important is the funding of the partnership.

Some of the challenges to partnerships include dependence on funding (some have been kept going through support from Forward); time requirements (due to limited staff it is quite difficult to attend every time); and sometimes limited space to influence policymaking, such as via the government FGM Forum.

**VI. SUCCESSES AND CHALLENGES**

This section describes what are perceived as successes and challenges in the work on FGM in the UK. This will include the thoughts of the interviewees followed by a brief analysis of the successes and the success factors, the key challenges and how these could possibly be overcome.

Some of the successes that have been attributed to the work of FGM in the UK by the respondents can be found hereafter.

The African Well Woman Clinics were perceived to be a successful approach. This was agreed by the second and third respondents. The clinics were seen as being very strategic and have led the way as a very essential part of women’s well-being and health support. Provision of specialist health services, in particular to support women through the NHS system, allowed women to receive the best...
possible care. The UK was in fact the first country in Europe to provide a specialist service for women with FGM, and students travel from all over Europe to learn more about the clinics. But it seemed that provisioning would be ‘left to the well woman clinics only’ and nothing more would be done.

Having the law was deemed as a success in itself. This was mentioned by all the respondents as a positive development. The UK was the first country in Europe to introduce a law that criminalised FGM. But it was also perceived that despite the law no progression has been made in terms of prosecution and that there was still a lot to learn in this regard.

The UK now has robust multi-agency engagement, even within the different cities, for example, Birmingham against FGM and Bristol against FGM. This was described as a lot of hubs in the UK trying to work towards the same goal. She felt that it might not be strategic because you find that some of the hubs might not be engaging the communities effectively, but there is a structure that is being developed which can make this possible. It was pointed out by three of the respondents that there was good work being done by different people in different areas in the UK.

Another success was the special FGM initiative, which she believes has been a good model, with a number of agencies worked together in partnership, learning and supporting each other, as well as providing funding. It also supports voluntary sector organisations in working with communities, which she saw as something important and needed.

With regard to asylum protection, the sixth respondent believed that the ‘Fornah’ case was a success which has also been key to FGM and asylum. She felt that the strongest lesson from the case was that about strategic litigation, and the fact that a case and how it was dealt with (ending up in the Supreme Court) is still being used is very important to learn from.

Training courses and the education of professionals were mentioned by two respondents as being success factors for the work in the UK. Despite the fact that they have been ad hoc, they were seen as an effective preventive strategy. Again it was pointed out that there is a lot of good work being done, which the second respondent described as ‘pockets of good work’.

The prevalence study that was conducted by Forward in 2007 and the need to get data on the extent of the problem were perceived by the third respondent to be positive. Again she said that the UK was the first country in Europe to have a prevalence study to assess what the situation was. This was despite the fact that the figures were not accurate and only an estimate, but they have still been used widely as a basis of supporting evidence.

The multi-agency guidelines text was also seen as a good document that was believed to be successful in producing good guidelines but that there was still a lot of effort needed to make the guidelines be a really successful tool for professionals.

As for the challenges highlighted by the respondents, a summary of them is provided below.

One of the biggest challenges to the work of FGM in the UK is the lack of an overarching strategy and the obvious lack of support from the government. This was agreed by the majority of the respondents.

‘There isn’t a national action plan that actually determines what we can all buy into or all work from. Everybody is doing their own thing, and that does not help without some kind of guidance.’

This was also supported by the first respondent, who stressed that ‘there is no drive at the highest level, as without that people would not bother to do anything about FGM, when they have other “higher priorities to them”. Unless people make it a priority in the UK and it isn’t.’

Prosecution was perceived as a major challenge to all the respondents and it was felt that the UK still had a lot to learn in terms of its approach to prosecution and safeguarding children. It was also believed that some parts of Europe were making better models than the UK. It was perceived by the first respondent that ‘prosecution was not working as an approach’, explaining that there was still a lot of work to be done on it.

The issue of funding was said by the respondents to be a big challenge, in particular for working with communities and prevention work.

It was emphasised by the Home Office officials that ensuring that the multi-agency guidelines and tools developed were available and knowing which tools were working and effective was paramount.

‘So the review that we are going to conduct of the multi-agency guidelines, if we do not review that and actually people aren’t using it, people do not know how to access it or do not understand it, all that is our responsibility.’

For asylum protection and gender, it was pointed out that the major challenge was the issue of credibility. The Border Agency officials simply did not believe those women applying for asylum. She also mentioned that this was also found to be a challenge in the majority of the countries during the Gensen project.

Reflection on the successes and key success factors, the key challenges and how they can be overcome

Given all the different elements of success that have been highlighted on the work on FGM, it seems that the UK has set the precedent for and pioneered work on FGM. This can be seen in the following facts.

- It was the first country in Europe to have a law that criminalised FGM.
- It was the first country in Europe to establish African Well Woman Clinics specifically to cater for the needs of women with FGM in the UK.
- It was the first country in Europe to conduct a prevalence study to provide an estimate on the situation of FGM in the UK.
Despite the different successes that have been highlighted it seems that ‘we have become stuck’ and seem to not have moved forwards from that point.

There is clearly some good work that is being done and that is spread all over the UK through the provision of support by the African Well Woman Clinics, which have set the standard in the care that is provided. Within each clinic the work that is done has greatly helped the women who use the services. There is also an FGM national clinical group, an organisation set up to raise awareness regarding the clinical care of women with FGM and to provide further tools for health professionals to guide them in such care (such as a DVD on clinical defibulation). But there are also clear challenges for the African Well Woman Clinics.

• The number of clinics and their distribution in the UK is very limited, in particular with the increase in the number of migrant women coming to the country. So supply will soon be much less than demand.
• There appears to be no communication or coordination between the different clinics, thus there is no clear uniformly followed structure. In fact this is clear from how the different clinics have been opened and set up, i.e. mostly in an ad hoc manner and in most instances based on identification of the need either by the community or by a midwife working there.
• Funding is going to be particularly challenging for those clinics not situated in hospitals or coming under the umbrella of another establishment such as a larger clinic. Already some of the clinics operate during limited opening times (such as once a month). They are also short staffed, therefore, as in the second respondent’s situation, if she goes on holiday, or if she leaves, who will take her place in the clinic at St Thomas? Who will have the skills and expertise to cover the clinic and the work that is done? There is therefore also an issue of sustainability, which adds to the challenge.
• There is no clear method of outreach to raise the awareness of members of the community that such a clinic is available. This was raised by the women during the PEER research previously conducted by Forward. According to the second respondent, she used to do the outreach herself in the past, going personally to mosques and community gatherings to let them know of the services.

Prevention through awareness-raising initiatives and preventive strategies by the voluntary sector have progressed substantially due to the creative and innovative approaches to prevention. The work of the NGOs has been an essential and crucial success factor in raising the issue of FGM in the UK. But it seems like they are working on their own with the dedication and support of a few parliamentarians who have managed to provide their vocal support to the cause of the NGOs. However we have now reached a stage where this alone is not enough; without government support how long will the NGOs be able to hold the fort? How long will they be able to continue and persevere? Support should not only be financial, but also the policies should be supported in a way that eases their implementation.

‘The government sees civil society organisations as mainly responsible for challenging the practice and stopping FGM in their communities. At the same time, it provides a paltry sum of GBP 50 000 to support community engagement nationally per year. The highest sum a group could apply for from this fund is GBP 5 000.’

The fact is that GBP 5 000 is not even enough for 4 month’s salary for one member of staff.

Having the law is a success in being able to criminalise FGM as a means of protecting young girls at risk and setting a framework that will enable the voluntary and statutory sector to continue to work, but the approach of the government to prosecution has become an issue that has been and is still being criticised both by those working in the field and by onlookers. What is apparent is that there seems to be no progress at all with the law, and as such the issues that were spelt out during the APPG hearing in 2000 are still the issues which the UK is discussing and talking about in 2012. To illustrate this, below are extracts from some of the commentators during the hearing in 2000.

‘These documents do not specify any requirement for area child protection committees to include FGM within their local child protection guidance, policies and procedures. There is no government requirement for setting standards or auditing implementation … these documents are lost opportunities within this very important area of work’. (social worker, Harrow social services)

‘It would be good if we had government backing. NGOs seem to really work on their own, doing their own thing without proper support.’ (Faith Mwaangi-Powell, Forward)

‘I am aware that many teachers like me just do not know anything about FGM, yet we might have children sitting in our classrooms who have been subjected to it.’ (Hillary Pollard, Association of Teachers and Lecturers)

The issues that were discussed during the APPG hearing in 2000 are the same issues which are still discussed and stressed by those concerned in 2012. Why has there been no change in the current situation in the UK? Despite the UK being the country to set the precedent for a lot of the work on FGM, why are we still discussing what should now have become clear policies and guidelines that are fully structured and operable?

With regard to prevalence and data collection, despite the success of Forward conducting the prevalence study in 2007 there is still a need for information on what the current prevalence is in the UK. Although this has been called for, it seems that the underpinning of policies has mainly been reactions to what the media and the voluntary sector demand. As mentioned before there is no clear system for data collection and recording. It is as if the work on FGM is put aside and not prioritised. There is therefore a challenge in actually modifying the existing datasets in order to include information on FGM that can be used.
VII. POLICY LESSONS AND RECOMMENDATIONS

Below is a summary of the main lessons learnt regarding what works and what does not with regard to policy development and implementation.

The need for a more holistic approach

FGM is not an issue for one stakeholder. Work on it requires the involvement of multiple layers of professionals in both the voluntary sector and the statutory sector. All work needs to be coordinated and monitored to ensure that it is implemented effectively and cohesively. Without the government’s commitment and support it will be difficult to include and involve all the different strands (health, education, LSCBs, the police, social services, specialist FGM clinics and NGOs). Currently there are multi-agency guidelines provided as a tool, but without front-line professionals knowing of their existence and using them they are of no use. These multi-agency guidelines can provide a structure with which all front-line professionals can become involved in the work on FGM.

Committed government

A government fully committed to the policy direction with a clear strategy on how to engage the issue. The government’s approach in steering towards the violence against women strategy is not working for FGM, as it is now even more side-lined in comparison to some of the other VAW issues such as domestic violence, rape, etc.

‘What has been made clear is that the incorporation of FGM into the VAWG strategy is inadequate and not working. There is a need to have a stand-alone strategy or policy that is specific to FGM. This will show the government’s commitment and will show the issue as a priority to be tackled.’

Even the recommendations of the APPG hearing of 2000 can be built on as a simple starting point from which a concise strategy or framework to work on can be developed. It is not enough to have guidelines or have a law without anything more done about them.

The need to strengthen the arm of the key front-line agencies

It is important that key front-line agencies learn how to work together and enable people in key positions to work together towards understanding and playing their role effectively. Currently, front-line professionals might not even have an idea about FGM, as such it would not be part of their priority (especially teachers, midwives, social workers, etc.). These are the people dealing with first contact, and unless they are able to understand FGM and its issues there will be a lot of missed opportunities in recognising and protecting girls.

The need to engage with communities effectively

According to the third respondent, the lack of strategic foresight in the government not engaging with communities in the UK has been very detrimental and has not allowed momentum to be created.

‘That momentum is actually being demonstrated in the work that is being done [by the NGO’s that are working at the grassroots with communities]. Just look at the amount of information, resources and energy that is coming out through the special initiative. The government only needs to add on, to actually inform and influence and shape it [to make use of the momentum that has already been created with the communities]. This is what the Dutch government did! The Dutch have actually made a tremendous achievement in community engagement because they were strategic, they worked in six cities providing resources, giving guidance, and they provided the enabling framework to make it happen. Now in Holland people talk about FGM more openly, so we do need to create that kind of space.’

The need to give comprehensive training to all front-line staff on FGM

Despite the work and efforts of the different organisations in providing training courses on FGM, there is a clear need for front-line staff to be provided with comprehensive training on FGM. This should include teachers, social workers, midwives (as FGM is not even in the midwifery curriculum), GPs and nurses, as they will usually be the first point of contact with young girls at risk of FGM. If they are not able to identify girls at risk, then there is a serious flaw in the system of child protection. It has been noted that teachers do not even attend the training courses that some of the local safeguarding children boards do on FGM, because they do not see it as a priority that affects them, and if any training is to be conducted it should be a mandatory requirement to attend.

Development of a system of early intervention and prevention

Suggestions of early intervention and prevention have been outlined by the person chosen for additional interview.

‘Once girls are identified as falling into an at-risk group, there is a range of preventive measures which could serve to reduce the future risk that they will be subjected to the practice. These include reminding parents about the physical and psychological damage that FGM can cause and the law forbidding FGM in the UK, and coordination with other professionals such as health visitors, GPs, nurse practitioners and public health specialists. Some young parents from FGM-practising communities are against FGM but come under pressure from older and extended family and community members to have FGM performed on their daughters. Engagement by health professionals could help provide them with the support they need to resist family and community pressures to subject their daughters to this practice. However, there is currently no mechanism to ensure that information gathered by one NHS body about a woman who has herself been subjected to FGM and has female children is communicated to any other part. For example, if a woman identified by a maternity unit as having undergone FGM gives birth to a daughter, there is no means by which that information can be passed to her GP and health visitor who have closer and longer contact with the woman, her family and the female children. Therefore, the opportunity for these key health professionals to take preventive action in relation to that family is lost. If education and child safeguarding measures are to be effective, the department
must ensure that information about the risk of occurrence of future FGM is communicated to those in a position to take action to safeguard girls at risk.’

Other measures could also be included so as to adopt a clear strategy on early detection and prevention, but if an initial approach is agreed upon, then key stakeholders could get together and explore further all the possibilities and provide recommendations for the government to follow up.

Measuring policy implementation performance
What has been occurring is that policy guidelines are developed but without any follow-up to ensure that they are being effectively implemented. Currently, at the local level, in some of the local safeguarding children boards that have developed FGM safeguarding working groups or groups working against FGM, they have developed a structure by means of which they monitor and follow its progress. Robust monitoring and follow-up is crucial to ensure that effective policies are in place, and this should be the strategy that the government adopts. It could be by developing an advisory board and a delivery group which will monitor the implementation. Such a structure is already available in the Home Office for the VAWG strategy, and should also be available specifically for the work on FGM if it is going to be taken to the next level.

Data collection and prevalence data
There is a clear need to develop a more robust system of data collection and recording with regard to FGM. This would be very important particularly for the NHS, as women subjected to FGM will most likely be seen by GPs, as well as in maternity settings. There is also a significant need for the data to be streamlined to ensure that all front-line professionals concerned have access to this data. Unless there is a complete review and overhaul of the system of data collection, a lot of information will be missed. How could any effective policy or strategy be monitored if there is no original understanding of what the current situation is?

Analysis of the priorities in light of the ‘six Ps’ approach

Prevention
Prevention has been seen as work that is mainly done by the NGOs, and since the inception of Forward and BWHAFS in the 1980s has been their duty as well as that of other organisations that have joined the campaign over the years. Prevention methods adopted in the UK have included awareness-raising initiatives and the delivery of training courses (to both the voluntary and the statutory sector). Some of the hard-working organisations such as Forward also used to campaign and lobby extensively, but they tried and realised that they were not listened to, thus shifting their strategies and priorities to concentrating on the communities affected by FGM, the results of which have been rewarding to them. But it is interesting that the campaign on asylum and gender has been very successful, and in fact almost after all the research that has been conducted by Asylum Aid it seems that the UK Border Agency has carried out reviews and made changes. So the question is what is the ‘additional factor’ with regard to FGM that can be found to make it a priority and an issue that is part of the policy agenda? Currently it seems to be an issue for the NGOs to try to figure out and end the so-called ‘barbaric and abhorrent practice’.

Protection
With regard to child protection the issue of FGM still seems quite unclear and vague. It is spelt out as a safeguarding issue, and indeed recent policies have included it in their documents, but it is not treated like a safeguarding issue. As such, FGM falls outside the categories of safeguarding child abuse (neglect, physical abuse/injury, sexual abuse and emotional harm); as it stands FGM would be included in the line of sexual abuse, but even within that it would not be the first or even the second form of sexual abuse mentioned. Therefore, even within the local safeguarding children’s board’s not all of them include FGM as part of their programme. As an example, some boroughs do include FGM within their agenda, such as Haringey and Greenwich, but others do not see it even as being important enough to include, that it just is not an issue for them (23). In addition, there should be a duty for professionals to report, and it should be a legal duty, as currently there is no understanding of what they are expected to do.

As for asylum protection the issue is broader, as currently it is about asylum and gender policies. In terms of other countries in Europe the UK is considered to be progressive in having gender policy instructions for asylum. There have also been other clear victories such as the new training course on gender that is compulsory for all Border Agency staff. However, with regard to FGM there are also clear challenges to women and girls seeking asylum because of FGM, including not being believed by the UKBA case owners, and the UKBA selectively taking information on country of origin as well as the lack of understanding of the concept of a ‘particular social group’. There has been progress and good development, however.

Prosecution
Prosecution is an issue that has been exhaustively raised by the voluntary sector and the media, which has for the last 2 years been adding further pressure on the government. Having the law without carrying out any prosecutions has become the Achilles’ heel of the government. It is understandable that the issue of prosecution is not simple, but the government should take an attitude which does not seem like it is not doing anything, or not taking the issue of FGM seriously. It is still to be seen whether there will be any changes following the round-table meeting on 28 September 2012.

(23) Minutes of an LSCB meeting in February 2012 with regard to introducing a DVD on FGM for teachers, developed by Kids Taskforce with the Metropolitan Police.
**Provision of services**

The provision of services has been seen to be the most progressive issue, in terms of providing specialist services to cater to women with FGM. But the role of the AWWC can and should be further strengthened to service the needs of all target groups: young girls at risk, women and youth. The reality is that FGM does exist in the UK (so long as there are women from FGM-practising countries residing in the country). As such it should be part of the responsibility of the government to ensure that the clinics are all operating effectively and that there are enough clinics to service the women. In addition, midwives need to be trained on FGM; it is not acceptable that in 2012 there could be a midwife who might not know what to do if she sees a woman that has been subjected to FGM. It should be a recommendation that FGM be included within the curriculum for health professionals. Provision of services has also been concentrating on the surgical aspect mainly for women who are about to deliver, but the provision of services should incorporate a more holistic approach for these women, which could include other services such as psychological and counselling services, or awareness-raising initiatives and education.

**Partnership**

Partnership is important, as working together strengthens the input, and as the saying goes 'one hand does not clap by itself'. As such, working together strategically should be prioritised and encouraged. The FGM special initiative is one example of a partnership that is promising and effective. But the partnerships should also be clear about their goal and strategy. One success factor for it to work effectively would be to have an advisory group to support the work of the partnership.

**VIII. POTENTIAL GOOD PRACTICES**

This section will highlight the ‘good practices’ that have been highlighted by the interviewees. Altogether, four were described which were viewed as having the potential to be good practices.

**African Well Woman Clinics**

The African Well Woman Clinics or FGM specialist clinics were seen by the second and third respondents to have potential to be good practices. The Acton Well Woman Clinic in particular was a good model and example of a good practice that also provides a good model in terms of monitoring and evaluation of the service. The following is a description of the Acton Well Woman Clinic, specifically looking at its monitoring, integration, sustainability, efficiency and transferability.

The Acton African Well Woman Clinic was established in 2008 as a pilot project funding by Ealing Primary Care Trust in partnership with Queen Charlotte’s and Chelsea Hospital. It is in west London and is based at a local GP’s surgery. There is a large African community in Ealing; at the time of the 2001 census there were 11,075 Africans living in the borough. The African Well Woman Service had already been running since 2006 in the form of a signposting and referral service for women with FGM, but it was realised by the midwives providing the service that the women preferred not to go to the hospital to be operated on under local anaesthesia.

An audit was performed in 2006–07 at Queen Charlotte’s Hospital which identified a local need, in that 254 African women in the area had some type of FGM. Following that, the Well Woman Service began a preparation phase to set up a specialist clinic. Preparation involved:

- setting up a hospital community working party;
- observation and learning at Guy’s and St Thomas’ AWWC;
- attending the FGM module at King’s College;
- consulting with community groups in the area, including the Somali women’s network;
- forming a steering group;
- in 2006 a fast-track service for women to be referred to the hospital for defibulation was secured;
- the service began to be publicised, including an advert made for Somali TV;
- in November 2008 the clinic was officially opened.

The clinic provides the women with a range of services, including: surgical procedures; counselling and signposting to other services; referral to a specialist consultant for complicated cases; raising awareness of FGM; and providing training for healthcare professionals. The team in the clinic comprises two specialist midwives, a counsellor and a health advocate/interpreter who speaks both Somali and Arabic. The clinic is a midwife-led service.

Women contact the clinic by telephone, and then a face to face appointment is arranged. Based on the choice of defibulation it is either performed in the clinic within 2 weeks or the woman is referred to the hospital for the procedure. The women are then followed up for 6 weeks.

The clinic conducted an audit between October 2008 and October 2010, and in that time they defibulated 102 women. Further details in the audit included: the ages of the women attending the clinic; the reasons for attending the clinic; the age at time of circumcision; how the women heard of the service; and how long the women had lived in the UK.

The clinic uses a holistic approach, and works in partnership with Queen Charlotte’s Hospital as well as Ealing Primary Care Trust. The steering group also works with the clinic to ensure that key players are engaged and information is shared. Data is collected routinely from the women attending the service. The clinic also collaborates with Forward in providing training courses to health professionals. The clinic received the Guardian Public Services Award in 2011 for innovation and progress — diversity and equality.

**Community development approach in Bristol**

The community development approach in Bristol has already been mentioned above in Sections V.2. and V.6. (prevention and partnership). To avoid repetition the areas which will be discussed further will include responding to needs, integration in a wider strategy, and monitoring and evaluation.
The community development approach in Bristol was originally a 2-year project commissioned by NHS Bristol to develop a community-led prevention approach to ending FGM. The project has now been extended up to 2013. Forward provides management and capacity-building support to the project, including securing funding for the work.

Background to the project: The idea of a community development approach in Bristol was based on previous PEER research that Forward conducted with eight women from the community in Bristol. In Forward’s prevalence study, 612 women that used the maternity services in Bristol had experienced FGM. From the PEER study there was an identified need from the women for further support and awareness-raising for the community. The experience of the PEER research had already empowered the women, and it was clear to Forward that the principal route for any work in Bristol should be through the women leading the work. As such, women were selected from Bristol and were trained in leadership and other skills. As a result, 12 health advocates, who now lead the community development approach in Bristol, were trained up.

Aims and objectives: The main aim of the project is to improve the knowledge and awareness of women and girls affected by FGM, enabling them to make informed choices. Specific objectives include: improving access to information on sexual and reproductive health and rights; increased knowledge of FGM among communities; and creating a stronger voice for communities in tackling FGM.

The project’s activities are implemented by the health advocates, while the work is overseen by Forward staff, in particular the community programme coordinator. A logical framework including the aims, outcomes and outputs of the project was developed and is used to monitor the project closely. A community advisory group was developed, a multi-disciplinary group made up of representatives from NHS Bristol, Refugee Women of Bristol, project volunteer community health advocates, Platform 51 and Forward. The main aim of the advisory group is to review the progress of the work, plan activities and address any challenges. A women’s coordinator who coordinates the work in Bristol and reports directly to Forward was also appointed.

The community development approach has been strategic in engaging the different arms — engaging safeguarding, engaging the NHS and also, most importantly, engaging key communities. As an example, the training of professionals is led by the person responsible for safeguarding, but support is also provided by the community health advocates, who have a role in participating and also delivering some of the training courses.

The asylum policy instructions: gender issues in asylum claims

The asylum policy instructions are the government’s policy on asylum. They are followed by asylum case workers in the UK Border Agency. In 2004 the Home Office issued its guidance instruction on gender to provide further guidance on how the UK Border Agency’s responsibilities in considering asylum claims should be carried out with regard to gender. The guidance is targeted at asylum caseworkers. The aim of the guidance is to ensure that caseworkers are aware of additional issues related to women, including the introduction of gender-sensitive procedures, and are aware of issues of gender-based violence which might affect women. The UK is one of four countries in Europe that have gender guidelines.

The asylum policy instructions were revised in 2006, and again in 2010. During the last review a number of organisations were consulted, including Asylum Aid, UNHCR and the Immigration Law Practitioners Association (ILPA). By the end of the consultation process the UKBA included almost everything that the organisations had requested in the instructions. It is believed to be a very strong policy document.

The asylum instructions are accessible by all caseworkers, and they are all aware of it. It is also reviewed frequently to update it. The instructions document could be considered to be a good practice because the reviewing of the document also involves different key stakeholders in consultation. The UKBA also recently introduced gender training for all its staff, which is a positive move and will further add to knowledge of Border Agency staff on some of the gender issues. The UKBA also listens to organisations and the findings of research conducted by different organisations, including Asylum Aid, thus they are ready to improve and change. The instructions can be used effectively and can also be a tool for monitoring the progress of work of the UKBA.

Practice with potential

Female genital mutilation: Multi-agency practice guidelines was a joint publication produced by the Home Office, the Department of Health and the Foreign and Commonwealth Office. The main aim of the document is to provide advice and support to front-line practitioners who have responsibilities to safeguard children and protect adults from FGM. It is acknowledged in the document that no single agency will be able to meet all the needs of someone affected by FGM, as such it sets out a multi-agency response. Information in the guidelines relates to the following:

- identifying when a child or young person may be at risk of being subjected to FGM and responding appropriately to protect them;
- identifying when a child or young person has been subjected to FGM and responding appropriately to support them; and
- measures which can be implemented to prevent and ultimately eliminate the practice of FGM.

The document also clarifies that the guidelines are educational and provide advice; they are not a substitute for existing statutory guidance. The target group consists of all front-line professionals that work to safeguard children, young people and adults from abuse.

The guidelines were developed after consultation with members of the FGM Forum and with professional bodies such as the Royal College of Midwives, etc. The document was published in February 2011.
IX. FINAL CONSIDERATIONS AND RECOMMENDATIONS

The experience of the UK with regard to the work on FGM has in most cases been considered ground-breaking. Throughout the years the UK has set precedents in being the first to introduce a law to criminalise FGM in 1983, the first to establish a specialist service for women and girls with FGM in 1993 and the first to conduct a prevalence study to assess the magnitude of the situation with regard to women and girls with FGM in 2007. It is also one of only four countries in Europe to have asylum instructions on gender policies. The UK is also a good source of information on FGM, where academics, health professionals, sociologists and women’s rights activists have written extensively on the issue of FGM.

The guidelines have the potential to be considered a good practice, with regard to their forming a comprehensive document that it is useful to access and provides practical information. It has some points which might hinder it being a good practice, however:

- the guidelines were not widely disseminated and publicised to key front-line professionals despite the document being an important source of guidance for them;
- there was no plan set up to organise training courses to coincide with the guidelines, and as such a lot of front-line professionals might not know how to use it effectively;
- there seems to be no implementation strategy planned for the guidelines, which is a shame as they have good potential.

However, from the different interviews it is clear that there are still pertinent questions that remain to be answered with regard to the UK’s approach to the work of FGM. These include the following.

1. Why have there been no prosecutions for FGM despite the existence of a law in the UK since 1983?
2. Why is it not a statutory duty for professionals to report on FGM?
3. Why has there been no training for front-line professionals on FGM? It is not included in the curriculum for midwives, and teachers and social workers to not seem to have any idea about or interest in it.
4. Why is there no routine collection of data on FGM?
5. Why is it that since 2000, when the all-party parliamentary group convened the first hearing on FGM, the same questions are still being asked by concerned individuals.

These are some of the questions that have arisen, and it seems that there are still more that need to be answered to clarify why we have become ‘stuck’, as the third respondent describes it.

During the final conclusion to this report, I will provide a brief summary of the main discussions and an analysis based on the previous sections.

Interest in the issue of FGM arose with the increase in migrant populations from FGM-practising communities coming to the UK during the 1970s and 1980s. The first point of contact was with health professionals, as women with FGM required their services during pregnancy and the delivery of their children. A series of events in the early 1980s, including evidence being found of FGM being conducted in the UK, resulted in the birth of the FGM campaign through the establishment of the two leading organisations working with perseverance towards ending FGM, Forward and BWHAFS. Public outrage and the vigorous campaigning of these two new organisations led to discussions in parliament and the introduction of a law to prohibit the practice.

Following on through the next two decades, the issue of FGM arose constantly, with both policies and tools developed to include it as part of the agenda. In addition, academics, researchers, health professionals, sociologists and psychologists, along with women’s rights activists, wrote extensively about the issue. The first of several African Well Woman Clinics was established in 1993 with the aim of providing adequate healthcare to women and girls with FGM. The main actors working in the field were the NGOs, in particular Forward, which was and still is considered to be the leading organisation working on FGM in the UK, and interested politicians and individuals. The most important driving forces behind policy development throughout the campaign have been those interested individuals who had the individual drive and interest in the issue; the pressure from the NGO sector through their constant campaigning and lobbying and continuous research; and perhaps quite importantly the media, which has raised the public’s attention to the issue, resulting in ‘knee jerk reflexes by policymakers’.

During that same period FGM became framed as a safeguarding issue and a form of child abuse, resulting in it being included specifically in some policy documents. One crucial event during 2000 was the 2-day hearing on FGM convened by the All-Party Parliamentary Group on Population and Reproductive Health, which invited key persons from the UK and the international arena to discuss and share experiences on the issue. The hearing resulted in the production of 47 recommendations, of which only the amendment of the Prohibition of Female Circumcision Act was acted upon, resulting in the FGM Act 2004.

The law was welcomed by activists and NGOs as they believed it provided an environment for their work on the ground. In 2007 Forward published the findings of its prevalence study, the figures from which, although only estimates, have been used as a reference by many people. Since 2009, the focus on FGM has shifted to reframe it within the wider VAWG strategy, as a result of which any
government action concerning FGM is currently included in the action plan of the VAWG strategy.

Other than the prevalence study on FGM by Forward in 2007, there have been no studies aiming to understand the magnitude and extent of the problem in the UK. It is clear that no policies on FGM have been underpinned by any actual hard facts, but have relied more on the reactions of the public and other driving forces.

Currently there is no data collection specific to FGM. Some hospitals collect information during maternity healthcare, but it is inconsistent and not part of the routine data. The only place where data on FGM is currently available is the African Well Woman Clinics, and this also is not uniform data as such, as each clinic collects its own data and is entirely independent of the other clinics. It is evident that data collection on FGM is important, however.

Overall in the approach to FGM in the UK there seems to be more emphasis on policies of prevention, protection and provision of services.

Prevention has been seen to be the role that has been undertaken by NGOs working against the practice. The work has involved awareness-raising campaigns, development of materials and resources, and the provision of training courses. What is evident is that everyone is doing their own thing, and there seems to be a lot of good work being done, but what has been made clear is that there is no government backing to the work. As for protection, despite FGM being included in the safeguarding agenda it is still not clear to professionals what they are supposed to be doing. Crucial front-line professionals (such as teachers and social workers) have no idea about FGM, raising the pertinent question of how FGM can be a form of child abuse if front-line professionals are not able to even recognise or prioritise it. It is seen as being important for professionals dealing with FGM to have a duty to report, as currently there is no such clear guidance.

Provision of services has been highlighted as having a lot of emphasis through the availability of the African Well Woman Clinics, but there are currently only 15 clinics which are definitely operating. Given the fact that the majority have irregular opening times, are understaffed and underfunded, are 15 clinics enough to serve the large numbers of migrant women currently resident in the UK? In addition, the data collected from the different clinics is not even collated to understand how many people have actually accessed the clinics, etc.

Prosecution has become the Achilles’ heel, in particular with the existence of but lack of action regarding the available law. There is a huge call for the government to take action about this issue, as not only have there been no prosecutions, but also most recently in 2012 two doctors were arrested following an undercover report that they were willing to perform FGM on girls. This is in addition to claims that FGM is being performed inside the UK. These are serious issues against which the government needs to take a more positive stance.

Finally, FGM is a form of child abuse which needs to be recognised as such and acted upon in that way. Unless there is a proper discussion with all stakeholders, including developing a specific action plan regarding working on FGM, we will continue in this vicious circle. An effective strategy needs to be put in place, including effective implementation, clear policies and proper engagement with communities to result in a more conducive and enabling environment that protects women and girls.