

Female genital mutilation in the European Union and Croatia

Report



This report is based on the 'Study to map the current situation and trends of female genital mutilation in 27 EU Member States and Croatia'. It was commissioned by the European Institute for Gender Equality (EIGE) in 2012 and was carried out by a consortium of researchers from the International Centre for Reproductive Health (ICRH) and the Yellow Window Management Consultants. The study was carried out by a core team: Els Leye (project leader, ICRH), Lut Mergaert (project leader, Yellow Window) and Catarina Arnaut, with the support from Jessika Deblonde, Annemarie Middelburg, Siobán O'Brien Green, Anke Van Vossele and 31 national researchers. The researchers were supported by four advisors: Elise Johansen, Rianne Letschert, Christine Loudes and Naana Otoo-Oyorley.

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This report is accompanied by more publications related to EIGE's work on combating FGM. These resources can be found at: <http://eige.europa.eu/content/female-genital-mutilation>

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Female genital mutilation in the European Union and Croatia

The European Institute for Gender Equality (EIGE) is an autonomous body of the European Union, established to contribute to and strengthen the promotion of gender equality, including gender mainstreaming in all EU policies and the resulting national policies, and the fight against discrimination based on sex, as well as to raise EU citizens' awareness of gender equality. Further information can be found on the EIGE website (<http://www.eige.europa.eu>).

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Foreword

Female genital mutilation (FGM) is one of the most brutal human rights violations of our time, deeply rooted in gender inequalities, as well as deliberate physical and psychological dominance over girls and women. This cruel form of gender-based violence cuts deeply at the heart of the European Union's values and fundamental rights; thus, the EU's dedicated and tireless commitment towards putting an end to this phenomenon is of the utmost importance. Its commitment is affirmed in the European Parliament's resolutions, the Women's Charter and the European Commission's Strategy for Equality between Women and Men 2010–2015. The recently adopted Directive 2012/29/EU, which establishes the minimum standards on the rights, support and protection of victims of crime, is an important instrument in support of women and girls who are victims of and at risk of FGM. EIGE's research confirms that in the EU there is, unfortunately, a significant number of women and girls who are in jeopardy of becoming victims of FGM and/or have been subjected to FGM. Significant gaps in the area of data collection and support services, in the prevention of and fight against FGM point to the need for coherent and continuous measures.

This report aims to support policy makers and all relevant institutions by providing them with reliable and comparable data for evidence-based actions and policy improvement in the area of FGM. It also provides recommendations on how to protect girls, women and the European society from this destructive and devastating expression of power, and on how to give sufficient support to the girls and women who have fallen victim to this crime.

Despite a lack of prevalence data, EIGE's research mapped the current scale of female genital mutilation in the 27 EU Member States and Croatia, providing a thorough analysis of identified data; legislative and policy measures; support services; coordination and inter-sectoral cooperation. Our findings show that to effectively combat FGM, the EU needs a com-



prehensive strategy, based on a gender-sensitive and human rights-based approach, which empowers girls and women to be in control of their lives, and which balances protection, prevention and prosecution measures. Furthermore and equally important, attention is raised toward the need to intensify efforts on behavioural change among FGM-practising communities, decision makers and stakeholders in countries where FGM is practised.

On behalf of the European Institute for Gender Equality, I express my sincere gratitude to those who contributed in the compilation of this report, especially to the European Commission Directorate-General for Justice and EIGE's staff.

Today, it is still regrettably apparent that all of us need to unite our efforts in ensuring that girls and women victims of FGM in the EU receive sufficient support in order to prevent any girl or woman from having to face this traumatic, life-devastating expression of violence ever again.

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Abbreviations

| Country abbreviations | |
|-----------------------|----------------|
| AT | Austria |
| BE | Belgium |
| BU | Bulgaria |
| CY | Cyprus |
| CZ | Czech Republic |
| DE | Germany |
| DK | Denmark |
| EE | Estonia |
| ES | Spain |
| FI | Finland |
| FR | France |
| EL | Greece |
| HR | Croatia |
| HU | Hungary |
| IE | Ireland |
| IT | Italy |
| LT | Lithuania |
| LU | Luxembourg |
| LV | Latvia |
| MT | Malta |
| NL | Netherlands |
| PL | Poland |
| PT | Portugal |
| RO | Romania |
| SE | Sweden |
| SI | Slovenia |
| SK | Slovakia |
| UK | United Kingdom |
| EU-27 | the 27 EU MS |

| Frequently used abbreviations | |
|-------------------------------|--|
| CEDAW | Convention on the Elimination of all Forms of Discrimination against Women |
| CoE | Council of Europe |
| CSO | Civil society organisation |
| DHS | Demographic and Health Surveys |
| EIGE | European Institute for Gender Equality |
| EU | European Union |
| FGM | Female genital mutilation |
| FGM/C | Female genital mutilation/cutting |
| GAMS | Group for the abolition of FGM <i>Groupe pour l'Abolition des Mutilations Sexuelles</i> |
| GBV | Gender-based violence |
| ICRH | International Centre for Reproductive Health, Ghent University, Belgium |
| MICS | Multiple Indicator Cluster Survey |
| MS | Member State |
| NAP | National Action Plan |
| UN | United Nations |
| UNHCR | United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| WHO | World Health Organization |



Glossaryⁱ

Asylum seeker

A third-country national or a stateless person who has made an application for asylum in respect of which a final decision has not yet been taken (Article 2(c) of Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers).

Extraterritoriality (principle of)

The extraterritorial operation of laws; that is, their operation upon persons, rights or jural relations existing beyond the limits of the enacting state, but still amenable to its laws (Black's Law Dictionary).

Female genital mutilation, female genital cutting, female circumcision

Female genital mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2008). The practice has serious immediate and long-term consequences at multiple levels (WHO, 2010). The term 'mutilation', used *inter alia* by the European Parliament and the European Commission, gives weight to the severity and mutilating nature of any act of FGM.

Girls at risk (of FGM)

'Girls at risk (of FGM)' are minor girls (most commonly in the age range of 0–18) who have migrated from FGM risk countries, or were born to parents (or one parent) who originate from countries where FGM is practised.

Infibulation, de-infibulation, re-infibulation

Infibulation consists in narrowing the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without the removal of the clitoris (WHO, 2012). This is recognised as Type 3 of FGM, the most extensive form of FGM. De-infibulation can be defined as a surgical procedure to open up the closed vagina of FGM Type 3 (FORWARD, 2012). Re-infibulation refers to the practice of re-suturing and thereby recreating an infibulation following a procedure in which the infibulation has been partially or fully opened, most commonly to facilitate childbirth (WHO, 2010).

Medicalisation of FGM

'Medicalisation' of FGM refers to the situations in which FGM is practised by any category of healthcare provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of re-infibulation at any point in time in a woman's life (WHO, 2010).

Public policy

Public policy can be defined as a system of laws, regulatory measures, courses of action and funding priorities concerning a given topic promulgated by a governmental entity or its representatives (<http://www.musc.edu/vawprevention/policy/definition.shtml/>).

Refugee

Under the 1951 UN Convention Relating to the Status of Refugees, 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 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 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' (www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf).

Regional regulation

Policies or laws developed by decentralised governments.

Third-country national found to be illegally present

Synonyms: irregular migrant, insufficiently documented, undocumented, illegal, clandestine, unauthorised migrant.

In the EU context, a third-country national who does not fulfil or no longer fulfils the conditions of entry as set out in Article 5 of the Schengen Borders Code or other conditions for entry, stay or residence in that Member State (Regulation (EC) No 862/2007 of the European Parliament and of the Council of 11 July 2007 on Community statistics on migration and international protection).

In a global context, an irregular migrant is someone who, owing to illegal entry or the expiry of his or her legal basis for entering and residing, lacks legal status in a transit or host country (derived by EMN from the definition of 'illegal stay' in Directive 2008/115/EC and from UNESCO's Glossary of Migration-related Terms in European Migration Network).



Executive summary





Executive summary

Introduction

Female genital mutilation (FGM) refers to all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2008).

It is at heart an expression of gender inequalities, recognised as a serious form of gender-based violence against girls and women and a gross violation of their human rights (Ibid.). The term 'mutilation' is used deliberately, as it reflects the severity of harm done to girls, women and the community at-large in any act of FGM. Yet, approximately 100 to 140 million women and girls globally have experienced this appalling practice in their lives (Ibid.).

It is for these reasons that FGM has recently gained considerable international attention, engaging a range of actors and institutions to end this practice for good. The EU has expressed its will to address FGM, in recognition of the transnational nature of the phenomenon and the fact that women and girls who are affected by FGM live within the EU. It is in this context that Viviane Reding, Vice-President of the European Commission, responsible for Justice, Fundamental Rights and Citizenship, requested an assessment of the situation of FGM in the EU. The present report fulfils this request.

Objectives

The main objective of this report is to provide an analysis of the current situation of FGM in the EU-27 and Croatia. In particular, it intends to address prevalence, current policy

and legal frameworks, actors dealing with FGM and their approaches. The aim is to identify and fill the gaps in data collection and to support the development of strategies to combat FGM in the EU.

Reflecting international standards of discussing gender-based violence in a framework of human rights, this report uses a 'comprehensive approach', focusing on prevalence, prevention, protection, prosecution and provision of services. This report is based on the 'Study to map the current situation and trends of female genital mutilation in 27 EU Member States and Croatia', which was commissioned by the European Institute for Gender Equality (EIGE) and which mapped existing information and data on FGM in the EU-27 and Croatia. It is important to note that its in-depth component was only undertaken in nine EU Member States. Therefore, for countries where the in-depth phase of research did not occur, this report is less representative. Finally, it must be noted that any comprehensive approach to tackling FGM cannot be restricted to the borders of the EU-27 and Croatia. FGM is, by nature, a global, transnational phenomenon. That is why it needs to be addressed in bi- and multilateral discussions among authorities and stakeholders at a multitude of levels.

Prevalence

No hard evidence was identified on FGM being practised within the EU. Yet, girls and women living in the EU have been subjected to FGM in their countries of origin before moving to the EU, or are subjected to FGM while travelling outside the EU. Mapping the prevalence of this phenomenon within the EU is absolutely essential

for developing effective policies and legislation, allocating funding and evaluating the results of actions taken. However, no ongoing, systematic, representative surveys that use a harmonised approach to gather data on FGM prevalence within the EU-27 and Croatia are carried out for that purpose.

Some Member States and regions have used a variety of studies and information sources to collect data and to estimate the extent of FGM at national or regional levels. These methods include the ‘extrapolation-of-African-prevalence-data-method’, whereby researchers analyse: immigration records from African countries with high FGM prevalence; surveys among health professionals; studies among FGM-practising communities; surveys with asylum seekers; and compilations of various relevant data sets, such as registered births in families originating from FGM-practising countries. Due to a wide variety of methodologies, definitions and approaches these studies have not generated data that is comparable between EU Member States.

Where there is a lack or unavailability of national FGM prevalence figures, other information and data sets could be useful to produce estimates of FGM, such as hospital and/or medical records, child protection interventions, police cases, asylum records and FGM prosecution records. Unfortunately, these data sets are subject to a wide range of limitations and restrictions. They may not be systematically collected and collated across different regions, for example, or access to them may be restricted. Furthermore, despite the stated importance of accurate FGM prevalence data and figures, especially in relation to planning services, training and allocating resources in a targeted way, few authorities or states have taken initiatives to set aside resources to measure the extent of FGM.

To combat FGM, several Member States have developed policies and prevention programmes, which proved difficult to assess or measure in relation to their effectiveness because of insufficient information on FGM prevalence and shortage of baseline data.

Prevention

As part of efforts to combat violence against women, prevention work is, as laid out in the CEDAW, an international human rights obligation for every Member State. It can take

the shape of awareness-raising initiatives, the development of educational materials and the training of professionals. FGM prevention work needs to target deeply inherent social and cultural patterns of behaviour which are the root causes of FGM and should be tackled within the EU as well as in the countries in which the acts of FGM occur.

This study has identified and presented many examples of FGM prevention work in different Member States. Since this work is most often carried out by CSOs, strong partnerships between governmental bodies and institutions and CSOs are essential, as both types of actors are interdependent of one another.

The main focus so far of these initiatives has been on FGM-related advocacy activities, raising awareness of FGM among the general public, communities and professionals, and on providing training to professionals. Even though involving FGM-affected communities is considered necessary in prevention work, it seems it is not done most effectively. Targeted engagement with the women and girls directly affected by FGM, their families and wider communities should therefore be incorporated into future prevention initiatives.

Furthermore, prevention activities of continuous and coherent nature should focus on behaviour change in view of long-established practices. Unfortunately, limited support and scarce resources jeopardise these efforts, endangering long-term prevention projects. While a few Member States such as Sweden, the Netherlands and Italy have recognised the importance of this ongoing work and have prioritised funding for it, the majority of Member States has not. Serious commitments of Member States are needed to combat FGM, including support and funding provided to relevant institutions and CSOs.

Protection

In the area of criminal justice, the Victims’ Rights Directive, which explicitly refers to FGM as a form of gender-based violence, is also applicable to victims of FGM in the EU. It establishes minimum standards on the rights, support and protection of victims of crime, and creates obligations for Member States to train police officers and courts staff on the needs of victims. It also provides victims with the access to support services before, during and after criminal proceedings.



Child protection

The protection of children's human rights is extensively covered in international, European and domestic law. International discussions with all relevant stakeholders on the application of these international instruments are useful, especially when good practices on protecting women and girls from FGM are exchanged. At a domestic policy level, mechanisms and procedures should be established when dealing with girls who have undergone FGM, or who are at risk of FGM, to assess further risks and outline how to respond to different cases. It is essential for professionals who are confronted with FGM to know how to effectively deal with FGM cases, who to contact, how to determine risk factors and to know the legislative and protective mechanisms that are in place at national or regional levels.

Actors who come into contact with girls who are at risk of FGM or who have undergone FGM come from a wide field of professions, ranging from police and social workers to child protection officers and healthcare professionals. School teachers are those professionals that generally have the most consistent, regular and ongoing interaction with young people, and as such can notice behaviour changes which indicate that FGM has occurred or is about to occur. They can also act as confidantes for girls at riskⁱⁱ, at which point they can trigger support mechanisms. Even so, there seems to be a limited number of FGM protection policies targeting teachers across EU Member States. Furthermore, training on child protection specifically in relation to FGM appears random and does not seem to be conducted on a continuous, structured and nationwide basis.

Professional secrecy provisions

In a similar way as training of professionals on child protection with regard to FGM, training on professional secrecy provisions concerning FGM can also play a key role in protecting women and girls at risk. Professional secrecy, relating to the information gathered during the course of occupational duties, is generally superseded by the right or duty to report cases of impending harm. For FGM, it is essential that professionals like doctors, nurses, teachers and social workers can identify girls at risk, report their concerns to competent authorities and initiate protective measures. Failure to correctly understand, or breach when required, professional secrecy provisions can result in hindering the application of protective mechanisms and lost chances to prevent FGM.

In a majority of Member States, general provisions on the disclosure of information establish a right or duty to report FGM risk cases. However, in many Member States, health professionals cannot break their code of silence when the crime of FGM has already been performed, because FGM is not generally considered as a type of repetitive, recurrent child abuse.

International protection

International protection stems from the international legal principle of non-refoulement, as first established in the 1951 Convention Relating to the Status of Refugees. This principle was reiterated in the Convention against Torture, to which all EU Member States are signatories. Since then, the UNHCR and the ECtHR have stated that victims or potential victims of FGM can be considered as 'members of a particular social group' requiring international protection. Moreover, the fear of FGM, or having undergone FGM, can be considered justifiable grounds for seeking and being granted international protection in all EU-27 Member States and Croatia. The legal framework therefore sets clear standards regarding international protection and FGM.

It is unknown, however, how these international standards are implemented across the EU-27 Member States and Croatia. Currently no EU Member State has a specific provision on international protection and FGM in its national legislation. In addition to that, and despite the international legal framework in place, international protection is still deemed more difficult to obtain in cases where a woman or girl has already undergone FGM, as there seems to be no 'imminent risk'. Policy guidance, tools and resources for actors dealing with international protection in the context of FGM seem to be lacking as well, which seriously undermines efforts to tackle the issue of FGM effectively. Finally, any asylum records a country may have are often restricted in access and therefore not available for FGM research purposes.

In view of the Common European Asylum System, the absence of a harmonised approach to granting international protection on the ground of FGM is a problem that needs to be addressed in the transposition of the recast Qualification Directive. The lack of a gender-sensitive approach to asylum procedures and policies in general also contributes to this problem, leading to less protection and cases not always being fairly considered. In addressing the restrictions and limitations of current asylum systems in the EU with regard to protecting women's and girls' fundamental human rights and freedoms, the EU can complement the work of the Member States.

Prosecution

International framework

Prosecuting the crime of FGM forms an integral part of any human rights-based approach to combating violence against women. Prosecution is an acknowledgement of the harm done and an attempt to restore justice for the victims. All EU Member States and Croatia have signed and ratified several treaties of binding international law, which create a legal framework and set standards for EU Member States to adhere to with regard to FGM.

Member States

Currently, there are nine EU Member States which have specific criminal law provisions on FGM. In all Member States, however, FGM can be dealt with in criminal proceedings through a range of other provisions, such as those on bodily injury or mutilation. An important issue which has been recognised in the process of prosecuting FGM has been the legal principle of extraterritoriality, whereby courts can adjudicate on over cases outside the territory of their country. As FGM is usually performed outside the EU, it is important that criminal jurisdiction for domestic courts does not stop at its territorial border. The study has found that in the majority of countries the principle of extraterritoriality is applicable.

However, prosecution in FGM cases in the EU is still rare. This process comes with a multitude of obstacles, such as difficulties in detecting cases of FGM and gathering sufficient evidence, the lack of knowledge on FGM and the apparent tensions between prosecution and prevention as policy goals.

Provision of services

In addition to creating obligations for EU Member States with regard to the protection of FGM victims, the Victims' Rights Directive creates obligations for EU Member States to give victims of gender-based violence including those of FGM access to support services, including specialist support with particular attention to the specific services they need. The Directive also requires specialised training for professionals who provide services to support those affected by FGM.

The services currently provided range from awareness raising among communities and the general public to advo-

cacy initiatives, translation services, cultural mediation, and inter-agency referrals for women and girls affected by FGM. These services are mainly offered by health providers and CSOs, and they include training of different types of professionals on FGM.

A few countries have specialised health services for women and girls who have undergone FGM, which are usually set up in a multi-disciplinary fashion, provide translation services and are most often free of charge. While the establishment of these services is certainly a positive development to support victims of FGM, most of these specifically focus on providing gynaecological services. As a result, psychological care, psychosexual support and counselling by professionals skilled in post-traumatic stress disorder are often lacking. In recognition of the complex harms of FGM on its victims, the provision of specialised, holistic and gender-sensitive health services for women and girls who have undergone FGM needs to become the norm, rather than an exception.

Furthermore, the accessibility of specialised health services for women and girls who have undergone FGM emerged as a challenge in the study. Most of the few specialised health centres are concentrated in larger urban areas, which complicates access for rural women and girls who have to travel considerable distances to reach them. This is further aggravated by the ad hoc nature of FGM service provision, marked by a lack of continuous and accessible state-funded services.

Training professionals in how to deal with FGM is an important component of the provision of services relating to FGM. However, when it does occur, it seems to operate on an irregular basis, and specific tools for dissemination, content updates and complementary training are underfunded and are therefore not utilised to their full potential.

Overarching conclusions and recommendations

FGM constitutes a particularly brutal form of gender-based violence and a serious violation of human rights. Because of the immense suffering FGM inflicts on its victims and because of its transnational nature, it has been condemned by the international community at large, gaining momentum to ultimately stop this practice once and for all. Any such endeavour should comply with all principles of women's empowerment and universal human rights,



and include a range of actions focusing on prevalence data collection, prevention, protection, prosecution and the provision of services.

Any work or policy developed to combat FGM should start with reliable and rigorous data on the prevalence of FGM within the EU-27 and Croatia. It forms the basis for better insight into the complex scope of the problem and offers a solid baseline to measure the effectiveness of undertaken measures. The need for more robust data and knowledge on the practice of FGM in the EU-27 and Croatia therefore has to be addressed.

Prevention work is not evaluated and it is insufficiently funded. As a result, it cannot be organised in a structured or sustainable way and affects in this way the ability of responsible institutions and CSOs to impact sustainable behaviour change among targeted communities. The lack of support and funding for prevention work therefore needs to be addressed.

Protection work can only be effective when professionals dealing with FGM get the proper training, especially on child protection and professional secrecy laws. The system of international protection within the EU-27 and Croatia remains incoherent and unsystematic, putting at stake the human rights of the women and girls who apply for protection.

Prosecution in FGM cases remains extremely rare in the EU, even though existing legislation can be used for this purpose in all EU Member States. Too many obstacles are in the way of effective prosecution. It is crucial to strike a balance between prosecution, prevention and the provision of support services to respond to FGM.

Finally, the provision of services relating to FGM is currently hindered by a range of issues, most of which stem from the absence of a systematic approach to FGM, including a lack of dedicated funds, which needs to be addressed by all EU Member States.

It is only when the EU, its Member States and all stakeholders involved adopt a comprehensive, human rights-based approach to combating FGM that there is a chance of ending this practice.

Introduction





Introduction

The main objective of this report is to provide an analysis of the current situation of female genital mutilation (FGM) in the EU-27 and Croatia, most notably in relation to prevalence, current legal and policy frameworks, relevant actors and their approaches (methods and tools) in the work on FGM.

This report is based on the 'Study to map the current situation and trends of female genital mutilation in 27 EU Member States and Croatia'. It was commissioned by the European Institute for Gender Equality (EIGE) and was carried out by a consortium of researchers from the International Centre for Reproductive Health and the Yellow Window Management Consultants.

The study aimed at mapping existing information and data on FGM in the European Union and Croatia in order to identify gaps in data collection, as well as good practices in tackling FGM. An in-depth component of the research was undertaken in nine of the 28 countries: Germany, France, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the United Kingdom.

International standards put forward a human rights-based approach in the fight against gender-based violence. Such an approach takes into consideration prevention, protection

and prosecution. In order to fully consider the specificities of FGM and the particular needs of those affected by FGM, the following five focus areasⁱⁱⁱ have been identified for the study: prevalence, prevention, protection, prosecution and provision of services. Analyses on partnerships were integrated into several relevant focus areas.

Chapter 1 of the report introduces a definition and a typology, consequences and the context of FGM. Chapter 2 provides information about the prevalence of FGM in the EU-27 and Croatia; analyses different approaches to collecting data on FGM prevalence; and identifies administrative records that can serve as a source for such data. Chapter 3 of the report introduces international standards regarding FGM. Chapter 4 presents the legal and policy framework of the European Union related to FGM. Chapter 5 analyses the national legal frameworks relevant to FGM that are in place in EU-27 and Croatia, and addresses general and specific criminal legislation, child protection laws, asylum laws and professional secrecy provisions. Chapter 6 covers existing policies on FGM and their implementation, actors involved and the tools and methods deployed in the work against FGM. Finally, Chapter 7 summarises study results and formulates a number of recommendations for a comprehensive approach to FGM. Relevant statistical information, including graphs, boxes and tables, can be found in Annexes II–V.

1. Facts on female genital mutilation





1. Facts on female genital mutilation

The first chapter presents a definition of FGM, as well as a typology of FGM introduced by the WHO. Furthermore, it points out the multiple short- and long-term consequences of FGM, and provides insights into how FGM is rooted in gender inequalities, and embedded in cultural traditions of some communities.

1.1. Definition and typology of FGM

Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2008).

FGM is recognised as a violation of the rights of women and girls, and is a form of gender-based violence. Approximately 100 to 140 million women and girls globally have experienced FGM in their lives (Ibid.). The terms 'female circumcision' and 'female genital cutting' are also used to refer to FGM; however, the use of the word 'mutilation' gives weight to the severity and mutilating nature of any act of FGM, and distinguishes it from male circumcision. FGM is also the term used by the European Parliament and the European Commission.

FGM is performed on girls and women at varying ages. Depending on the community or ethnic group that practises it, the act can be carried out on a newborn baby girl, or on an adult woman later in her life. In some cultures, undergoing FGM is an important tradition and is required as a con-

dition for marriage, which is often used as a rationale for its continuation. The World Health Organization (WHO) states that FGM is mostly performed on girls between 0 and 15 years of age and, as a result, has particular implications on the protection of the girl child (Ibid.).

The WHO distinguishes four different types of FGM (WHO, 2012), illustrated in Figure 1.1. Knowledge of FGM typologies is important to enable appropriate healthcare, particularly during pregnancy and childbirth, where FGM can lead to complications during labour and higher rates of caesarean section (Ibid.).

Type I: **Clitoridectomy:** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

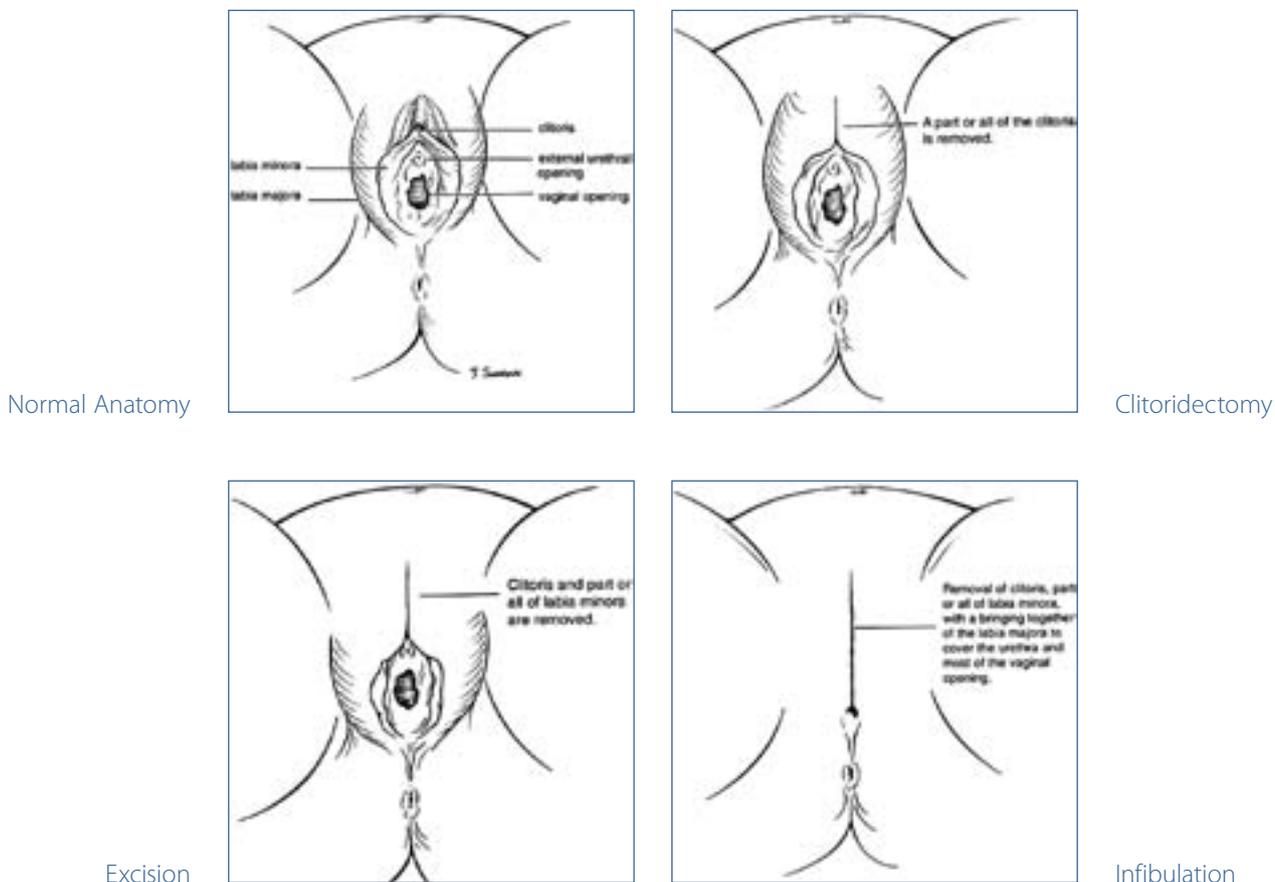
Type II: **Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina).

Type III: **Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

Type IV: **All other harmful procedures** to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping or cauterising the genital area.

The WHO estimates that globally, approximately 90% of FGM cases are Types I, II or IV and the remaining 10% are Type III.

Figure 1.1. Anatomy of the female genitals before and after FGM



Source: Committee on Bioethics, 2010.

FGM is usually performed in a girl’s home in unhygienic conditions, without anaesthesia and by a traditional birth attendant or circumciser. However, there is an increasing trend to ‘medicalise’ FGM, i.e., to have FGM performed by health professionals (WHO, 2010). This medicalisation goes against the non-maleficence principle of medical ethics, and has prompted a number of professional organisations^{iv} to speak out against FGM carried out by health professionals. The WHO published a global strategy to stop healthcare providers from performing FGM (WHO, 2010). The World Health Assembly Resolution WHA61.16 of 2008 equally rejected the performance of the procedure by health professionals.

1.2. Consequences of FGM

Depending on the type of FGM, the circumstances in which it was performed, and the general health condition of the woman or girl, FGM has multiple effects on the physical and psychological health and sexuality of women and girls who suffer from it. It also has consequences on the society at large.

Although FGM is generally a one-off act, some women and girls who have been subjected to Type III FGM may undergo repeated de-infibulation (opening up of Type III FGM) and re-infibulation (re-suturing or re-closing of Type III FGM) and endure the health and gynaecological consequences that this entails (WHO, 2010).



The health consequences of FGM are usually divided into short- and long-term effects. The short-term consequences include pain, haemorrhage, infections (such as tetanus), shock and injury or trauma to the genital area and body. The long-term consequences of FGM include chronic pain, painful menstruation, painful sexual intercourse, infections such as frequent urinary tract infections, pelvic infections, cysts and abscesses, scar tissue formation, infertility and possible increased susceptibility to HIV infection and other sexually transmitted infections (RCOG, 2009). The most serious consequence of FGM is death.

FGM can also lead to anxiety, depression, flashbacks, nightmares and post-traumatic stress disorder (AkiDWA, 2008). It can have a lasting impact on the sexual health of a woman and her intimate relationships. The removal of the genital tissue and the subsequent formation of scar tissue can make sexual intercourse painful, traumatic or impossible. The psychosexual repercussions of FGM, including traumatic memories of the act, can lead to a decrease in sexual pleasure and inability to climax. It should be noted that these psychological and sexual consequences of FGM can also have negative effects on a woman's partner. Consequences of FGM are particularly severe in relation to reproductive health and childbirth (Vloeberghs, 2011; AkiDWA, 2008). A major WHO multi-country study of 28 obstetric centres in six African countries found that obstetric complications were particularly frequent among women who had undergone FGM. The study revealed that childbirth by victims of FGM is more likely to be complicated by caesarean section, postpartum haemorrhage and extended hospital stay when compared to women who have not undergone FGM. FGM is also associated with higher rates of infant death. A WHO study estimated that an additional one to two babies per 100 deliveries die as a result of FGM (WHO study group on female genital mutilation and obstetric outcome, 2006).

The social consequences and ramifications of FGM are also significant. Women and girls who do not conform to their community norms and remain uncut may be shunned, excluded from their communities and viewed as unsuitable for marriage. The health repercussions associated with FGM, such as medical costs and being unable to attend school or work due to poor health, also entail a significant burden on women and communities (END FGM, 2010).

1.3. Context of the practice of FGM

The practice of FGM is an expression of deeply entrenched gender inequalities, grounded in a mix of cultural, religious and social factors inherent within patriarchal families and communities. FGM is not merely maintained by these inequalities, but gender inequalities are indeed sustained by the practice of FGM. It maintains power structures based on gender in a society where women and their 'honour' are valued as the objects and properties of men.

This is reflected in FGM often being considered as a necessary part of raising a girl 'properly', and a way to prepare her for adulthood and marriage. FGM can be driven by beliefs about what is accepted as a proper sexual behaviour, linking procedures to the requirements of premarital virginity or marital fidelity as a yardstick for measuring honour. Many communities believe that FGM reduces women's libido and therefore helps them resist 'illicit' sexual acts. When a vaginal opening is covered or narrowed (Type III), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage 'illicit' sexual intercourse by women who have undergone this type of FGM (WHO, 2012). Furthermore, FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are 'clean' and 'beautiful' after the removal of body parts that are considered 'male' or 'unclean'. It should therefore be clear that FGM acts as an instrument for sustaining patriarchal hegemony, which is why any remedies to this issue must take a gender approach into account.

Though no religious texts prescribe the practice, practitioners often believe FGM has religious grounds. Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, others contribute to its elimination. Local structures of power and authority, such as community leaders, religious leaders, circumcisers and even some medical personnel, can contribute to upholding the practice. In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation, while in others the recent adoption of the practice is linked to copying the traditions of neighbouring groups. Some groups have recently started practising FGM as part of a wider religious or traditional revival movement, or because they moved into areas where the local population practises FGM (WHO, 2012).

2. Measuring the extent of FGM in the EU-27 and Croatia





2. Measuring the extent of FGM in the EU-27 and Croatia

Chapter 2 presents methods of data collection which are used for FGM prevalence estimates due to the absence of a harmonised, systematic approach to measuring the extent of FGM in the EU and Croatia, and presents data and prevalence estimates from selected studies. Finally, this chapter points out the major shortcomings and challenges regarding data collection on FGM, which may be a first step towards the development of an effective approach towards measuring FGM prevalence in the EU and Croatia.

2.1. Prevalence estimates

UNICEF defines prevalence of FGM as the percentage of women aged 15 to 49 who have undergone some form of FGM (UNICEF, 2005). Although challenging to determine, the collection of data on FGM prevalence is vital to understand the extent of FGM within countries and populations; it can be utilised to track progress on FGM prevention; and it can and should inform decision making and resource allocation.

About 140 million girls and women worldwide are currently living with the consequences of FGM. FGM has been documented in 28 African countries and is practised in Yemen, Northern Iraq and Indonesia, and has been reported, to a lesser extent, in various other countries. In Africa, an estimated 92 million girls aged 10 and above have undergone FGM, and annually about three million girls are at risk of FGM (WHO, 2012).

In the EU-27 and Croatia, there are no ongoing, systematic, representative surveys that use a harmonised approach to gather data on FGM prevalence. The European

Parliament Resolution of 24 March 2009 on female genital mutilation indicates that an estimated 500,000 women living in the EU have been subjected to FGM, and that 180,000 girls and women are at risk of undergoing FGM every year (European Parliament, 2009). However, the methods used for this estimate are not clear.

Generally, FGM is not practised in the EU, but women and girls have undergone FGM in their countries of origin before moving to the EU, or are subjected to FGM while travelling outside the EU. That is why estimate studies on the prevalence of FGM in the EU have utilised the 'extrapolation-of-African-prevalence-data-method', whereby statistical data from the general population census and national statistical offices are used, containing the number of female migrants from FGM-practising countries residing in an EU country. This method consists of using prevalence data from the DHS and MICS – or, in some cases, prevalence data from the WHO or UNICEF – and extrapolating these prevalence rates onto data of the female population living in a given EU country and originating from FGM-practising countries in Africa and Yemen. In order to take into account the female migrant population from FGM risk countries, other data sources may be also required; for example, it may be necessary to include asylum seekers, refugees, undocumented migrants and second/third generations of girls and women.

A recently published statistical study using this method is the UNHCR study on 'Female Genital Mutilation and Asylum in the European Union' (UNHCR, 2012), which calculated estimates of the prevalence of FGM among female asylum seekers in the EU, disaggregating data by the applicants' countries of origin and their countries of asylum. According to this study, the EU Member States with the high-

est number of female asylum applicants originating from FGM-practising countries were, in 2011, France (4,210), Italy (3,095), Sweden (2,610), the United Kingdom (2,410), Belgium (1,930), Germany (1,720) and the Netherlands (1,545) (UNHCR, 2012). Compared to 2008, these figures increased in all but two (the Netherlands and Sweden) countries. The proportion of female applicants from FGM-practising countries out of the total number of female applicants was the highest in Malta (more than 90 %) and Italy (around 66 %). As the UNHCR study points out, women from FGM-practising countries who applied for asylum in the EU came mostly from Nigeria, Somalia, Eritrea, Guinea and Cote d'Ivoire, and their distribution differed across the EU.

For 2011, the study calculated that an estimated 8,809 female asylum applicants aged 14 to 64 were likely to be affected by FGM in the EU, which constitutes 61 % of the total number of female applicants of this age group (see Annex II). The EU Member States with the highest estimated number of female applicants aged 14 to 64 who may

have been affected by FGM before their arrival in the EU were Sweden (1,716), France (1,597), Italy (1,092), the United Kingdom (1,085), Belgium (945), the Netherlands (798) and Germany (733). The study estimates that in 2011, more than 50 % of all female applicants originating from FGM-practising countries who applied for asylum in Austria, Malta, Belgium, France, Germany and the United Kingdom were potentially affected by FGM (UNHCR, 2012).

In addition to prevalence estimates obtained through the 'extrapolation-of-African-prevalence-data-method', some EU-27 Member States and regions have used a variety of other studies and information sources to collate data and to formulate national or regional FGM estimates to calculate the extent of FGM. Studies to date have included: surveys among health professionals; research with FGM-practising communities; surveys with asylum seekers; compiling various relevant data sets such as registered births in families originating from FGM-practising countries; and counting numbers of women resident in a given EU coun-

Table 2.1. Figures of the most recent FGM prevalence studies in the EU

| Country | Title of study | Year of publication | Number of women and girls victims of FGM | Number of women and girls at risk of FGM |
|---------|--|---------------------|--|--|
| Belgium | Estimating the number of women with FGM in Belgium ^v | 2011 | 6,260 | 1,975 |
| France | Quantitative chapter of the 'FGM and disability' project ^{vi} | 2007 | 61,000 | Not available |
| Germany | Statement of Terre Des Femmes e.V. – Human Rights of Women at the Public Hearing of the Committee on Family Affairs, Senior Citizens, Women and Youth on the subject 'Fighting FGM' ^{vii} | 2007 | 19,000 | 4,000 |
| Hungary | FGM prevalence in Hungary, estimation | 2012 | Between 170 and 350 women affected | |
| Ireland | International Day of Zero Tolerance to FGM ^{viii} | 2011 | 3,170 | Not available |
| Italy | Quantitative and Qualitative Evaluation of the FGM phenomenon ^{ix} | 2009 | 35,000 | 1,000 |
| UK | A statistical study to estimate the prevalence of FGM in England and Wales ^x | 2007 | 65,790 | 30,000 |



try and originating from an FGM-practising country. However, these have not generated data that is comparable between the EU Member States due to the wide variety of methodologies, definitions and approaches utilised.

This report has collated thirteen studies (including pending studies) in eight EU Member States (Belgium (2), France (1), Germany (1), Hungary (1), Ireland (3), Italy (3), the Netherlands (1), and the UK (1)) that can be referred to as FGM prevalence estimation studies. The actors that performed these studies included research institutes (Belgium, France and Italy), CSOs (Germany, Hungary and Ireland) or a combination of these two (Italy, the Netherlands and the UK), as well as a Ministry of Health (Italy). Prevalence studies were commissioned by Ministries of Health (Belgium, France, Italy and the Netherlands), equal opportunities departments (Italy), research institutes (Belgium) and CSOs (Ireland, Germany and the UK).

Five of these studies – two done in Belgium, one each in Hungary, Ireland and Italy in addition to the number of female migrants derived from the national statistics offices – also included other administrative records to estimate more accurately the prevalence of FGM. Two of the extrapolation studies, in Italy and the Netherlands, utilise a mixed method approach to take into consideration the influence of migration on the practice of FGM. (See Annex II for more details.)

Table 2.1 presents the main findings of the most recent studies in terms of the estimated number of victims of FGM, as well as of women and girls at risk of FGM living in the above-mentioned seven EU Member States (the Dutch study is pending).

2.2. Administrative records

In the absence or unavailability of national FGM prevalence figures, other surveys, studies and data sets have been used to begin to estimate the prevalence of FGM, often by collating information from administrative records. The administrative records that could be used to provide information on FGM include hospital and/or medical records, child protection records, asylum records and prosecution records. Data from these records could act as a proxy indicator of prevalence and incidence of FGM at both regional and national levels, and also indicate whether states have adequately responded to the practice.

2.2.1. Hospital and medical records

Existing hospital and/or medical records that have the potential to collect data on FGM consist of patient registers, maternity registers, child health registers and school health registers. In some countries (e.g., Belgium, France, Ireland, the Netherlands, Portugal, Sweden and the UK), hospital and/or medical records contain information about FGM. Some data collection tools for these records are relatively new and will need to be evaluated in time. Limitations exist especially with the potential under-recording of FGM due to the lack of knowledge of FGM among health professionals to adequately register the varied types of FGM. Limitations also exist due to the lack of (adequate) nomenclature or codes for recording FGM incidence and types. The general lack of availability of administrative recording systems for outpatients in medical and hospital records, and the lack of data from primary care settings or by general practitioners, restrict the possibility of a comprehensive picture. When women or girls are asked to self-disclose FGM to a health professional, this can entail further challenges such as: women and girls not wanting to disclose their status, women and girls not recognising the terms used by healthcare professionals to describe FGM and/or typologies, health professionals not having the skills to adequately ask women and girls about FGM, and insufficient training for health professionals focussing on FGM and cultural competence.

Health records have a particular role to play in terms of care and treatment for women who have undergone FGM. Rigorous data collection on healthcare and complications related to FGM – including maternal and neonatal deaths, de-infibulation, surgical repair and reconstruction and postnatal care in patients with FGM – should allow for both FGM prevalence data collection and insights into recommended clinical care pathways and patient outcomes.

2.2.2. Child protection records

In the EU-27 and Croatia, child protection systems, registers and processes are in place to protect children from child abuse and neglect. These systems could also be used for collating numbers of girls at risk and of girls who have already been subjected to FGM. Currently, the Dutch 'Advice and Reporting Points for Child Abuse' have included FGM in their registration system, and there is a small number of court cases regarding child protection measures in cases of FGM in Germany, Spain, Denmark and Italy. Even so, there is no conclusive data available on the number of cases reported, the number of subsequent investigations or outcomes of investigations across all EU Member States.

Given the nature of FGM and the importance of child protection mechanisms and responses, this suggests a concern for Member States in terms of a lack of data and of data collection tools.

2.2.3. International protection records

There is limited data available across Member States on the number of cases where international protection or asylum was requested, granted or rejected in relation to FGM.

The lack of data on asylum and FGM is problematic. Most EU countries have a responsible agency or government department for collecting data on international protection in their country, but nevertheless, Bulgaria, Croatia, the Czech Republic, Denmark, Estonia, Finland, Hungary, Ireland, Latvia, Slovenia, Spain, Sweden and the UK state that there is no record of the grounds on which asylum was requested, denied or accepted. Furthermore, very few countries provide access to the information contained in such records. As a result, the number of FGM-related international protection claims is, in most cases, not registered or not accessible and remains unknown.

Only Belgium, France, Italy (through regional commissions) and Luxembourg have some mechanisms to collate this data, and only Belgium has a department that monitors asylum applications based on fear of FGM.

2.2.4. Police and criminal justice records

Nine EU countries (Austria, Belgium, Cyprus, Denmark, Ireland, Italy, Spain, Sweden and the UK) have specific legislation with regard to FGM. However, it still remains challenging to obtain data on numbers of reports of suspected and/or performed FGM to police, numbers of investigations, outcomes of investigations and numbers of court cases, as there are no central registration systems to provide such information. France prosecutes FGM under a non-specific criminal law provision (harm to bodily integrity causing permanent mutilations), and more than 40 court cases relating to FGM have occurred, most of them before criminal jurisdictions. The opportunity for other countries to learn from France's experience in the area is possible but has not been fully realised yet, due to the lack of collation, analysis and publication of respective data.

In conclusion, despite the potential of various administrative records to assist and enhance FGM prevalence data across EU Member States, there remain considerable shortcomings and barriers. Many of the records are not systematically used, existing data are not collated centrally, and

access to data from such records is often restricted or extremely limited. In order to develop these records for FGM data collection, considerable training will be needed for the professionals involved. Enhanced data compilation systems, software and tools may also be required, and specific relevant codes or nomenclatures identified and developed.

2.3. Challenges and trends in data collection on FGM

Despite the absence of accurate FGM prevalence data in the EU, several Member States have developed policies, prevention programmes and fund work to combat FGM. Nonetheless, it is hard to document the long term overall effectiveness of these measures without the initial FGM prevalence data and information. Performing accurate FGM prevalence studies poses significant challenges and requires commitment and adequate resources.

Despite the efforts of Member States, CSOs, academics, professionals and research institutes to formulate and calculate FGM prevalence estimates and develop data collection tools and methodologies, the key concerns persist.

2.3.1. Prevalence estimates and data collection on girls at risk of FGM

One of the critical data gaps with prevalence estimates and data collection to date in the EU-27 and Croatia is the lack of information and numbers of girls at risk of FGM and girls who have undergone FGM (both within the EU and in countries of origin prior to arriving in the EU). The approximation of FGM prevalence among girls aged less than 18, as well as among second and third generation girls remains particularly problematic; only Belgium, Italy and the UK have attempted to estimate it. Registered live births of girls to women from FGM risk countries are considered a first indication of risk but are not systematically noted in hospital records. Girls at risk are defined as: 'Minor girls (age range 0–18 years) that migrated from FGM risk countries or who are born to parents (or one parent) who originate(s) from countries where FGM is practised'.

There are a number of challenges that should be recognised regarding this definition, including that girls who have already undergone FGM are included in the 'at risk' group. Moreover, second and third generation girls are not necessarily 'at risk', and girls with an irregular status are not taken into account. However, in the absence of a working



definition and a realisation that data on girls at risk of FGM is critical to develop appropriate support and response, it is unlikely that their needs will be acknowledged and met, nor that their protection will be prioritised, unless steps towards calculating their numbers in the EU are taken. Attempts to calculate numbers of second and third generation girls who may be at risk of FGM should be made in future FGM prevalence studies.

2.3.2. Limitations of census data

There is a number of limitations to the use of the 'extrapolation-of-African-prevalence-data-method' drawing on census figures to calculate FGM prevalence in EU Member States.

- There is no reliable global FGM prevalence data for girls aged 0–15 years available through the DHS and MICS, and these two surveys do not provide data on FGM for Asian countries where FGM is practised (like Indonesia) (P. S. Yoder, Khan, S., 2008).
- FGM prevalence rates from African countries change over time and these changes are often not reflected in figures used by the EU countries to calculate FGM prevalence.
- Census data may not be recent and may not reflect changes in migrant populations in a country.
- Female asylum seekers, refugees and undocumented migrants may not appear in national census figures.
- Census data sometimes lack disaggregation by country of origin, by country of birth and by length of stay in a country.
- Ethnicity is not routinely included in census data figures, although it is often a more useful indicator of FGM than nationality. In some Member States accessing and utilising data on the basis of ethnicity is not possible for legal and ethical reasons.
- The definitions of concepts underlying the calculation of FGM data like 'at risk' and 'prevalence' vary across countries and studies.

In order to assess changes over time, FGM prevalence estimation studies need to be repeated on a regular basis, using the same methodology. This is currently not the case.

In addition, census data do not take into consideration the influence of migration on the practice of FGM. The length of stay of migrants in a country, the reasons for migration (possibly to avoid FGM), ethnicity and inter-generational repetition of cultural norms such as FGM are not present in census data. As a result, mixed research methods to assess the influence of migration on FGM are required. But this needs further elaboration to clarify an appropriate research

design suitable for application in many Member States, including tools and methodologies, as well as cognisance of ethical and potential legal considerations. Whilst the current FGM prevalence estimates from the Member States using census data should be commended as initial data on the issue, further work is required to develop, refine and enhance the 'extrapolation-of-African-prevalence-data-method' using census figures.

2.3.3. Lack of comprehensive data collection and collation

The lack of systematic data collection is one of the main challenges with regard to the development of prevalence estimates. If data collection is not required by policies, protocols, guidelines, professional standards, hospital or school policies, etc., then systematic, routine, ongoing data collection is not viable. The lack of aggregations of existing records presents another challenge. A number of records or potential data sources are dispersed in a variety of databases across various sectors and departments; at a national level, few, if any, efforts are made to collate and examine the data to provide a more accurate picture of the prevalence of FGM. Multi-sectorial and multi-agency collaborative efforts are required to gather the most comprehensive records and data on a country-by-country basis in relation to FGM. However, the use of different software platforms and tools by services and professionals to collate patient and client data is a challenge as well. There may be variations between data gathering systems in relation to technical, privacy and security (data protection) issues, as well as settings which make it difficult to integrate existing databases and merge data.

During the consultation process organised by EIGE, experts representing EU Member States and international organisations indicated the relevance of distinguishing between a baseline and an enhanced FGM prevalence estimate, meaning a more detailed estimate to be used by relevant stakeholders. The proposed baseline definition of a prevalence estimate of FGM in an EU Member State is:

Prevalence of FGM in any of the EU-27 Member States and Croatia refers to the number of women and girls in that country who have undergone FGM at a certain point in time, expressed as the proportion of the total number of women living in the country and originating from countries where FGM is practised.

In order to estimate this baseline prevalence, census data from national statistical offices can be used. These data

should, as a minimum, be disaggregated by country of origin, sex and age. Other datasets to be used to calculate and extrapolate the baseline prevalence include the DHS and MICS prevalence rates for African countries and Yemen. It is important to use the most recent and up to date DHS and MICS data for these calculations.

For some EU countries, possible additional indicators can be utilised in order to calculate an enhanced FGM prevalence estimate and to generate more precise data on FGM and the population affected. In addition to country of origin, sex and age, elements of the following data could be collated:

- place of birth;
- place of residence;
- age of arrival to the EU country;
- age when FGM was performed;
- type of FGM;
- country of birth;
- country of origin of mother and father;
- age when FGM is usually performed in the country of origin;
- length of residence in an EU country;
- ethnicity.

However, these indicators will need further discussion and examination, as well as a robust and transferrable definition and methodology to produce an enhanced prevalence FGM estimate model at a national level.

2.3.4. Insufficient funding and monitoring

Despite the stated importance of accurate FGM prevalence data and figures, especially in relation to planning services and training and targeting resources, few authorities or states have taken the initiative to set aside resources to measure the extent of FGM. The EU countries that have done this are Belgium, France, Italy and the Netherlands. Adequate resources are also required to update data collection systems to include FGM codes and nomenclature, in particular in medical and hospital settings. Currently several countries such as Spain (in Catalonia) and the Netherlands are improving their data collection systems regarding child protection data, and Ireland and the UK regarding maternity data. Surveillance and monitoring of data collection is also important to reaffirm the importance of correct and consistent data entry and collection. When there is no authority to monitor the data collection on a regular basis, it may not be given the priority needed, and data gaps or inaccurate data could emerge. In the absence of ongoing monitoring and quality control checks, staff may not be motivated to enter and collect data as required to achieve robust statistics and comparable findings.

2.4. Concluding remarks

The absence of information on FGM prevalence appears to be a conspicuous gap. The data collated differs from country to country, making comparisons between countries highly problematic. Additionally, FGM figures are not collated or recorded by the national statistical offices in the EU-27 Member States and Croatia.

The main reasons for this gap are the lack of studies on the subject, the non-use of administrative datasets and the complexity of calculating accurate, up-to-date FGM prevalence figures. Insufficient funding, a lack of expertise and the absence of a consensus on working definitions and common methodologies may also be influencing factors. In spite of these difficulties, the eagerness of governments, researchers and CSOs to develop FGM prevalence figures should be considered a recently growing trend.

National statistical offices could play an important role in contributing to the knowledge on FGM in the Member States by utilising and sharing the collected data, in particular population census data. This census data needs to be disaggregated by country of origin, sex and age, and needs to be collected on a regular basis. Eurostat has a role in supporting the development and piloting of data collection tools, and common methodologies and approaches across the EU Member States in terms of FGM data. Based on the collated data from the Member States, it could also calculate FGM prevalence estimates among the asylum seeking population in the EU, an exercise most recently undertaken by UNHCR (UNHCR, 2012). Newer forms of data collation, analysis and mapping such as Geographic Information Systems (GIS) tools could also be explored for their relevance and possible application to the issue of FGM.^{xi}

The willingness of countries to learn from each other and share data collection tools, methodologies and expertise should be harnessed. It is important to note that experience exchange among countries preceded the development of some data collection tools, for example in Ireland with the Ethnic Identifier^{xii} and the Irish FGM prevalence studies, which were based on the UK prevalence study. The current Dutch FGM situation analysis^{xiii} is based on a broad consultation with experts from Europe and abroad. This underlines the importance of facilitating experience exchange meetings, sharing research and findings through online databases and web portals, and perhaps initiating regular online multilingual forums to share learning between the Member States and national experts.



Finally, a possibility exists to use the results of FGM prevalence estimates for varied political or ideological purposes, including racist and anti-immigrant campaigns and movements. Thus, methodologies for research on FGM, any FGM prevalence estimates produced, as well as the public presentation of any research findings on FGM, should be carefully considered taking into account ethical concerns and possible ulterior motives in the use of data.

3. International standards related to FGM





3. International standards related to FGM

This chapter lays out the international legal and policy frameworks relating to FGM in the contexts of the United Nations (UN) and the Council of Europe (CoE). Focusing on the major milestones and jurisprudence, it tracks the devel-

opment of FGM as a matter of international concern. This development also serves to highlight that FGM is a transnational issue which does not merely concern the EU and must be dealt with multilaterally.

Box 3.1. Human rights violated by FGM

The right to life

- Art. 3 of the Universal Declaration of Human Rights
- Art. 6 of the International Covenant on Civil and Political Rights

Human dignity

- Art. 22 of the Universal Declaration of Human Rights

The right to be free from discrimination (on the basis of sex)

- Art. 2 of the Universal Declaration of Human Rights
- Art. 2 of the International Covenant on Economic, Social and Cultural Rights
- Art. 2 and 26 of the International Covenant on Civil and Political Rights
- All Articles of the Convention on the Elimination of all Forms of Discrimination against Women

Equality between men and women

- Art. 3 of the International Covenant on Economic, Social and Cultural Rights
- Art. 3 of the International Covenant on Civil and Political Rights

- All Articles of the Convention on the Elimination of all Forms of Discrimination against Women

The right of the child

- Art. 2, 3, 6, 19, 24 and 37 of the Convention on the Rights of the Child

The right to the highest attainable standard of health

- Art. 25 of the Universal Declaration of Human Rights
- Art. 12 of the International Covenant on Economic, Social and Cultural Rights
- Art. 12 of the Convention on the Elimination of all Forms of Discrimination against Women

The right to be free from torture, cruel, inhuman and degrading treatment or punishment

- Art. 5 of the Universal Declaration of Human Rights
- Art. 7 of the International Covenant on Civil and Political Rights
- All Articles of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

3.1. United Nations legal and policy framework

The UN started its work on FGM in the late seventies and early eighties, when FGM was still considered solely a health issue. This view then later expanded, as a recognition grew of the multi-faceted approach required to tackle FGM effectively. Now the international human rights framework of the UN provides a very broad approach for the Member States to tackle FGM, as it includes the right to non-discrimination of women, the rights of the child, the right to health, and the right to freedom from torture, cruel, inhuman and degrading treatment. International recognition of FGM as a form of discriminatory violence entails an acknowledgement of women and children's rights and also the fact that those affected by FGM are provided access to protection, prosecution and services.

The UN treaties form a part of binding international law that creates a legal framework and sets standards for the EU Member States with regard to FGM. Core obligations distilled from the main human rights treaties include the obligation to: prosecute with due diligence; protect and assist victims; prevent violence by addressing the underlying causes; and provide adequate resources for advocacy, advice, support and counselling (European Commission, 2010).

In 1990, the first UN policy that specifically dealt with FGM was developed, the General Recommendation No. 14 of the UN Committee on the Elimination of Discrimination Against Women (CEDAW) on Female Circumcision. The Committee was concerned about the 'continuation of the practice of female circumcision and other traditional practices harmful to the health of women'. It called on states to 'take appropriate and effective measures with a view to eradicating the practice of female circumcision'. In 1992, the word 'mutilation' appeared in CEDAW General Recommendation No. 19 on Violence Against Women. This Recommendation focused on a health perspective, but it also featured gender inequality and discrimination as factors of FGM.

In the earlier years of recognising FGM as a concern, various UN agencies (the WHO, UNFPA and UNICEF) worked separately on the issue of FGM, based on their respective mandates. The first Joint Statement on Female Genital Mutilation was issued in 1997.^{xiv} UNHCR issued a policy in 1997 on harmful cultural practices, including FGM, in which the Joint Statement of WHO, UNFPA and UNICEF was fully endorsed. In February 2008, a new joint statement (WHO, 2008) with wider United Nations support was issued to

support increased advocacy for the abandonment of FGM. This statement by the Office of the High Commissioner for Human Rights (OHCHR), the Joint United Nations Programme on HIV and AIDS (UNAIDS), the United Nations Development Programme (UNDP), the United Nations Economic Commission for Africa (UNECA), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the United Nations Development Fund for Women (UNIFEM) and the WHO highlighted the cross-sectorial and human rights-based approach required for the abolishment of the practice, replacing the earlier statement of 1997.

Since then, FGM has also featured in the Universal Periodic Review Working Group of the UN Human Rights Council. In total, FGM has been noted as an area of concern by Members of the Human Rights Council fifty-five times since its inception in 2006, covering more than eleven countries under review.

The principle of non-refoulement as related to FGM

With regard to international protection or asylum, the 1951 UN Convention Relating to the Status of Refugees is of particular relevance to FGM. Article 33 (1) constitutes one of the core articles of this Convention, to which no reservations are permitted. This article establishes the international legal principle of non-refoulement, by stating that 'no Contracting State shall expel or return ('refouler') a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion'.

The UNHCR Guidance Note on Refugee Claims Relating to Female Genital Mutilation (UN High Commissioner for Refugees, 2009) provides information on the treatment of claims for refugee status relating to FGM, and reaffirms that there is a well established understanding that victims or potential victims of FGM can be considered as members of a particular social group, as described by the Convention on the Status of Refugees. Based on the evolving jurisprudence regarding such claims, the Note establishes that a girl or woman seeking asylum because she has been compelled to undergo FGM, or is likely to be subjected to it, can qualify for refugee status under the 1951 Convention relating to the Status of Refugees. Under certain circumstances, a parent could also establish a well founded fear of persecution within the scope of the 1951 Convention because of the risk of FGM for his or her child.



The 1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment provides an additional form of protection in this area. Its Article 3 reiterates states' obligations with regard to non-refoulement, for which the Committee Against Torture specified that the feared danger must be assessed not just for the initial receiving state, but also for states to which the person may be subsequently expelled, returned or extradited.

UN General Assembly Resolution concerning FGM

In December 2012, the UN General Assembly (GA) unanimously passed the long-awaited Resolution banning the practice of FGM. This resolution urges countries to condemn FGM and all other harmful practices that affect women and girls, and to take all necessary measures – including enforcing legislation, raising awareness and allocating sufficient resources – to protect women and girls from this form of violence. It calls for special protection and support to women and girls who have been subjected to FGM and to those at risk, including refugees and migrants (UN Women, 2012). This resolution reflects the rise in recognition of the issue of FGM and the increased willingness to take action at the international level.

3.2. Council of Europe legal and policy framework

FGM appeared on the agenda of the CoE^{xv} – of which all EU-27 and Croatia are now Member States – as early as 1994. The trend that can be recognised with regard to FGM at CoE level is an increasing awareness among the Member States of FGM. One of the main policy goals of the CoE regarding FGM is to ensure that FGM can be considered a justification for granting international protection or asylum in CoE Member States. The CoE moved from policy-based, non-binding measures to legally binding measures in 15 years.

Most notable in this development was Resolution 1247 (2001) on Female Genital Mutilation, adopted in 2001, whereby the CoE acknowledged that FGM had become increasingly common in CoE Member States, especially among immigrant communities. The CoE argued that FGM should be regarded as inhuman and degrading treatment within the meaning of Article 3 of the European Convention on Human Rights (ECHR). Article 3 of the ECHR states that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'. The European Court

of Human Rights (ECtHR) has interpreted this article as implicitly prohibiting the returning of refugees to a place where they would face a 'real and substantiated' risk of ill-treatment.

By February 2012, the ECtHR had handled five cases related to asylum on FGM grounds, with the first case appearing in 2007. In all cases, applicants who feared being subjected to FGM if they were expelled to their country of origin based their claims on Article 3 of the ECHR. While the Court in the above-mentioned cases clearly stated that subjecting a woman to FGM leads to ill-treatment, as meant by Article 3 of the ECHR, it nevertheless rejected all complaints, as the credibility of the claims were called into question. Even though the Court rejected all the claims, it constituted an important step for the protection of women and girls from undergoing FGM, as the Court has clearly recognised the fear of FGM to be a justifiable ground for non-refoulement.

In April 2009, the CoE Resolution 1662 (2009) on Action to Combat Gender-Based Human Rights Violations, Including the Abduction of Women and Girls, reaffirmed that concrete actions must be taken to combat FGM. It reiterated that under existing international instruments, and in particular the ECHR, all CoE Member States have an obligation to act with due diligence to prevent and combat FGM. Member States should act both at a national level, developing policies to protect victims, prevent violations and punish perpetrators, and at an international level, promoting women's rights and action against gender-based violence.

This Resolution led to the CoE's adoption, on 7 April 2011, of the landmark Convention on preventing and combating violence against women and domestic violence (Convention CETS No. 210). This Convention, also known as the Istanbul Convention, will be, once ratified, the first legally binding instrument in Europe to prevent and combat violence against women as well as the most far-reaching international treaty to tackle serious violations of human rights. The Istanbul Convention has not entered into force yet, as the condition of 10 ratifications including eight Member States is not yet fulfilled^{xvi}. Article 38 of the Convention deals specifically with FGM, and all general provisions in the Convention (i.e., preventive measures, prosecution measures, protection measures and comprehensive and co-ordinated policies) also apply to FGM.

All these developments reflect the importance of discussing FGM in international fora with the input of multiple stakeholders as a transnational issue.

4. European Union legal and policy framework





4. European Union legal and policy framework

This chapter presents the legal and policy framework on FGM at the EU level, focusing on the milestones of legal and policy developments at the EU level, including measures on international protection. It also highlights the importance of the European Commission's Daphne Programme, one of the most recent and successful attempts at the EU level to deal with FGM.

4.1. Important European Union legislation and policies

The most fundamental EU legislation with regard to FGM is the Charter of Fundamental Rights of the European Union, as it lays out the human rights approach required to tackle such a multi-faceted issue. Similarly to the international human rights treaties it is inspired by, this Charter establishes for fundamental rights and freedoms, such as the right to life and human dignity, the rights of the child and of women, the right to be free from discrimination, torture and inhuman treatment and the right of men and women to be treated equally. These rights provide the building blocks for all EU legislation and policies, including those combating FGM. As such, the Charter forms the ultimate cornerstone laying out why the EU should combat FGM and on what principles its methods may rely.

The second major treaty with FGM relevance at the EU level is the Treaty of Amsterdam, which entered into force in 1999 and set an agenda for the enactment of a common European asylum legal order. Based on the full and inclusive application of the 1951 Geneva Convention relating to the Status of Refugees, it aimed to affirm the principle of

non-refoulement, ensuring that no individual is sent back to their persecutor. With the rise of the number of asylum applications within the EU during the 1990s, political will grew to agree on a common EU approach to asylum. The Treaty of Amsterdam set the agenda for harmonisation and identified the building blocks of a common EU asylum system. Article 63 of the Treaty required EU Member States to adopt measures, criteria, mechanisms and minimum standards regarding the reception and qualification of asylum seekers, refugees, and displaced persons within five years. This treaty lays the groundwork for establishing not only a common European asylum order, but also a common policy on FGM-based asylum applications. As explained in Chapter 2, this can be vital to approaching more accurate prevalence models, as well as creating a very necessary exchange of information about FGM among the Member States themselves and with external stakeholders.

The aims pursued in the recent stage of the EU asylum process are to achieve both higher common standards of protection and greater equality in protection across the EU, as well as to ensure a higher degree of solidarity between EU Member States. The European Commission Policy Plan on Asylum, issued in 2008, laid out the roadmap for completing the second phase of the Common European Asylum System (CEAS). Higher protection standards combined with fair and effective procedures capable of preventing abuses and allowing for rapid examination of asylum applications in order to ensure the sustainability of the system are desirable for all asylum seekers in the EU, including girls and women who base their asylum claims on FGM grounds.

The redistribution of competences in the area of justice and home affairs undertaken by the Lisbon Treaty is of par-

ticular relevance for EU level policy making on FGM. With the entry into force of the Lisbon Treaty in December 2009, the former ‘third pillar’ of the EU which was based on intergovernmental cooperation has been integrated into EU competences, which means that the EU now has certain competences in all the fields of the Area of Freedom, Security and Justice.

Thus, Article 82 (2) TFEU lays down that the European Parliament and the Council may establish minimum rules concerning, amongst others, the rights of victims of crime, which has paved the way for the Victims’ Rights Directive (see below). And according to Article 83 (1) TFEU, the European Parliament and the Council may ‘establish minimum rules concerning the definition of criminal offences and sanctions in the areas of particularly serious crime with a cross-border dimension’.

4.2. European Parliament

The European Parliament adopted its first Resolution on Female Genital Mutilation in 2001 (2001/2035(INI)). In this Resolution, the European Parliament strongly condemned FGM as a violation of fundamental human rights for the first time. The Resolution tackled legislative aspects, prevalence of FGM in the EU, the lack of data on FGM in the EU and the need for a comprehensive strategy. It also highlighted the need for an awareness-raising campaign directed at legislators, with a view to maximising the impact of existing legislation and to assist in the formulation and adoption of new legislation. Member States were also urged to draw up guidelines for health professionals, teachers and social workers, aimed at informing and educating parents. With regard to asylum, the European Parliament called on the European Commission and the Council to ‘recognise the right to asylum of women and girls at risk of being subjected to FGM.’

Since then, the European Parliament has repeatedly called for action in the field of FGM. From 2002 until 2007, several Resolutions and a Regulation were adopted by the European Parliament, dealing with sexual and reproductive health (2001/2128 (INI) and Regulation No. 1567/2003); the situation of women from minority groups (2003/2109(INI)); population and development (2003/2133(INI)); violence against women (2004/2220(INI)), and the rights of the child (COM(2006) 367 final), each including FGM in their body of work.

In January 2008, the European Parliament adopted the Resolution Towards an EU Strategy on the Rights of the Child

(2007/2093(INI)). In this Resolution, the European Parliament called for Community legislation that prohibits all forms of violence and harmful traditional practices, including FGM. The European Parliament also called on Member States ‘either to implement specific legal provisions on female genital mutilation or to adopt laws under which any person who carries out genital mutilation may be prosecuted’ and drew attention to the role of education on FGM. The European Commission was urged to allocate the resources needed to prevent FGM, by setting up programmes for education and awareness-raising on FGM.

In March 2009, the European Parliament adopted the Resolution on Combating FGM in the EU (2008/2071(INI)). This was the second Resolution at the EU level that specifically dealt with FGM. A number of issues that were dealt with in the first Resolution of 2001 were reiterated; however, the second Resolution marked the first time that the European Parliament addressed asylum as it pertains to FGM.

Since then, the European Parliament has remained firmly committed to the issue of FGM. It has included FGM in countless of its policy measures, reflecting the recognition of the multi-faceted and transnational nature of the issue. The European Parliament has, for example, expressed the need for coherence in the EU internal and external policies regarding FGM and has urged for the integration of FGM into political and policy dialogues with partner countries and relevant stakeholders. It actually insisted on women’s rights, especially concerning FGM, being addressed in all external human rights dialogues. It has also recognised the need for improved data collection efforts regarding FGM, in order to identify the extent of the problem and to provide a basis for a change towards the eradication of this problem. Finally, the European Parliament has recognised the fact that FGM is a highly contextualised form of violence against women and an expression of unequal power relations at its heart. These actions reflect the deep understanding of FGM and demonstrate the European Parliament’s commitment to combating this phenomenon fervently.

The most recent resolution on FGM, the European Parliament resolution of 14 June 2012 on ending female genital mutilation, can be considered a further landmark in the fight against FGM. It clearly stipulates that ‘any form of female genital mutilation is a harmful traditional practice that cannot be considered part of a religion, but is an act of violence against women and girls which constitutes a violation of their fundamental rights’. In this resolution, the European Parliament also called on the Member States to take firm action to combat this illegal practice.



4.3. Council of the European Union

In March 2010, the Council of the EU adopted the Council conclusions on the Eradication of Violence Against Women in the European Union. In these conclusions, the Council welcomed the European Commission's commitment to pursue a more active policy in the fight against FGM. The Council urged Member States to identify and remedy shortcomings in the protection of women who are victims of FGM. In addition, the Council called on the Member States to take appropriate measures to stop FGM and 'urged the Commission to establish a clear legal basis for combating all forms of violence against women; and called on the Commission to draw up a more coherent EU policy plan to combat all forms of violence against women'. The Council took into account that an international approach in the exchange of knowledge, policies and best practices, within the EU and with non-EU countries that have experience in fighting FGM, is essential, as this can contribute to the prevention and eradication of FGM in Europe.

Furthermore, FGM has been explicitly addressed in the EU Strategic Framework and Action Plan on Human Rights and Democracy, the first unified framework of the EU on human rights policies that was adopted by the Foreign Affairs Council in June 2012. FGM is integrated into the section 'Protection of the rights of women, and protection against gender-based violence', and the action plan states that the EEAS and the Member States are supposed to take actions to support relevant initiatives against harmful traditional practices, in particular FGM by 2014.

In the Council conclusions on Combating Violence Against Women, and the Provision of Support Services for Victims of Domestic Violence of 6 December 2012, the Council reaffirmed that 'neither custom, tradition, culture, privacy, religion nor so-called honour can be invoked to justify [violence against women] or to avoid the obligations of the Member States with respect to its prevention and elimination and the prosecution of perpetrators'. It specifically mentioned FGM by referring to the Trio Presidency programme in which Poland, Denmark and Cyprus announced to support initiatives tackling FGM, in particular its cross-border aspects. Furthermore, the Council called on the Member States to 'ensure that support services for victims of violence are in adequate supply and apply a gender equality perspective in particular with a view to protecting and empowering women and children', and stressed the need of 'long-term awareness-

raising activities including through education and training programmes to combat discriminatory traditional, cultural and social norms'.

The 'Stockholm Programme – an open and secure Europe serving and protecting citizens' (2010/C 115/01), adopted under the Swedish Presidency in December 2009, establishes priorities for developing the European area of freedom, security and justice for the years 2010–2014. It can be considered a landmark policy in the EU's battle against FGM, as it is the first time FGM is noted in an EU Programme for Action. The Stockholm Programme states that: 'Vulnerable groups in particularly exposed situations, such as women who are the victims of violence or of genital mutilation (...), are in need of greater protection, including legal protection. Appropriate financial support will be provided, through the available financing programmes.'

Finally, with regard to setting the legal framework relating to international protection, the following EU policy documents are applicable in FGM cases concerning asylum provisions:

- EU Council Directive laying down minimum standards for the reception of asylum seekers (2003/9/EC);
- EU Council Directive 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 (2004/83/EC);
- EU Council Directive on minimum standards on procedures in Member States for granting and withdrawing refugee status (2005/85/EC);
- Directive of the European Parliament and of the Council on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection; for a uniform status for refugees or for persons eligible for subsidiary protection; and for the content of the protection granted (2011/95/EU (recast of the 2004 Qualification Directive (2004/83/EC)).

4.4. European Commission

The European Commission has contributed to the fight against FGM by adopting the Action Plan Implementing the Stockholm Programme COM(2010) 171. This Action Plan included provisions establishing that 'all policy instruments available will be deployed to provide a robust European response to violence against women and children, including domestic violence and female genital mutilation'.

Furthermore, in 2010, the European Commission adopted two other Communications that can be considered an expression of the commitment of the European Commission to take action against FGM, namely, A Strengthened Commitment to Equality between Women and Men – A Women’s Charter (COM/2010/0078) and the Strategy for equality between women and men 2010–2015 (COM(2010) 491).

In all three policy documents, the European Commission emphasised the need to adopt an EU-wide strategy for combating violence against women and eradicating FGM by using all appropriate instruments, including criminal law, within the limits of the EU’s powers.

In February 2011, the Vice-President of the European Commission, Viviane Reding, issued a Joint Statement with the High Representative Catherine Ashton on the International Day against Female Genital Mutilation (MEMO/11/73). In this statement, they pointed out that FGM violates women’s and girls’ rights to equal opportunities and freedom from violence, and that the EU condemns FGM. Both reaffirmed their commitment to work toward the eradication of FGM, as well as gender-based violence in general, in the EU and in external relations.

Finally, the Victims’ Rights Directive (2012/29/EU), which establishes minimum standards on the rights, support and protection of victims of crime, is of particular importance regarding the support and protection of girls and women affected by FGM. The proposal to this Directive was adopted by the European Commission, together with a Communication on ‘Strengthening victims’ rights in the EU’ and a Regulation on mutual recognition of protection measures in civil matters.

The definition of gender-based violence used in the Directive includes women and girls affected by FGM. The Directive states that children are considered vulnerable, which entails their particular rights to protection. The Directive, adopted by the Council of Ministers on 25 October 2012, requires Member States to ensure that:

- victims are recognised and receive respectful treatment;
- victims get information on their rights and their case in a way they understand;
- victim support exists in all Member States, including specialist support, in accordance with victims’ needs;
- victims can participate in court proceedings if they want to and are helped to attend the trial;
- victims are protected during criminal proceedings based on an individual assessment of their protection needs;

- victims (including children) who are particularly vulnerable to further victimisation during the criminal proceedings will benefit from special protection measures;
- victims’ families also benefit from rights under the Directive;
- police, prosecutors and judges are trained to address victims’ needs.

The provision in the Directive on the setting up and development of specialised support services is particularly relevant to girls and women who have been subjected to FGM. The expected cooperation between Member States, whereby they are encouraged to exchange good practices, and to provide consultation on individual cases, is especially important. The Directive also pushed for Member States to take actions such as information, research and education programmes that aim at raising awareness about the rights contained in the Directive, which also implies actions on gender-based violence.

4.5. The Daphne Programme

The European Commission, through its I, II and III Daphne programmes^{xvii}, has been the driving force for the development of many initiatives with regard to FGM at Member States level.

Since 1997, 21 projects dealing with FGM in Europe were implemented, contributing to an increased understanding of the nature and extent of FGM in the EU-27 and Croatia. In the 2004 Daphne II programme and the 2007 Daphne III Programme, in particular, FGM was specifically targeted, allocating resources specifically to deal with FGM, among other issues. The total amount spent on FGM-related projects under the three Daphne Programmes (until summer 2012) ranges between EUR 15 and 20 million.^{xviii}

Daphne support was vital in the early efforts to create a European network to stop FGM, and to assure co-operation between academic and research institutions and grassroots organisations. In the course of various Daphne projects, a number of tools were developed, including kits for training health professionals on FGM-related issues and guidelines for the care of women who have undergone FGM. A research agenda on FGM in Europe was developed as well. As part of the Daphne projects, several seminars and workshops have been organised with the overall aim to guarantee that women from affected communities were closely involved in FGM-related work. Several Daphne pro-



jects were instrumental in putting the issue of FGM on the agenda in a number of EU countries (e.g., Ireland, Portugal).

Box 4.5.1. Daphne programme: a vehicle for cooperation in the prevention of FGM

Many international partnerships were created and supported through Daphne projects, such as the project Establishing a European Network for the prevention of FGM, which continued its activities after the programme ended as the network EuroNet FGM based in Brussels. EuroNet-FGM joins over 30 organisations working in 15 European countries in order to fight harmful traditional practices affecting the health of women and children. Several new Daphne projects were coordinated by EuroNet-FGM.

Box 4.5.2. Training kit aiming at behaviour change (Austria)

The training kit and information brochure to prevent and eliminate female genital mutilation for migrants in Europe was produced in 2005 by the African Women's Organisation (Afrikanische Frauenorganisation) with the support from the EU Daphne Programme, the city of Vienna and the Ministry of Social Affairs. This digital free kit is targeted at migrants and aims to change the values, norms and behaviour of migrants in relation to FGM. It consists of three modules, each with seven learning units.

All Daphne programmes have been evaluated and an ex-post evaluation of Daphne III will take place in 2014. However, the evaluations mainly focused on the management of the programmes, assessing for example the geographical reach of the activities and the number of beneficiaries reached, and did not include indicators to measure their content. Therefore it is not possible to measure the impact of the Daphne projects on gender-based violence, including the practice of FGM.

4.6. Concluding remarks

References to FGM are found in many legislative and policy documents of the EU. The EU Charter of Fundamental Rights and Freedoms provides the basis for EU policy makers and legislators to strongly condemn FGM as a violation of fundamental human rights, and numerous EU institutions have taken subsequent measures to address the issue of FGM.

Recently, the need to address FGM in external relations has emerged in political and policy dialogues with partner countries and stakeholders, and when calling for coherence in the EU internal and external policies regarding FGM. Also, the need for exchanging experiences when dealing with FGM has been addressed repeatedly in policy documents, highlighting the recognition of the complex and multi-faceted approach needed to deal with the issue of FGM.

5. Legislation at Member State level





5. Legislation at Member State level

This chapter examines the situation in EU Member States and Croatia in relation to FGM legislation, including both general and specific criminal laws; child protection laws; asylum laws; and provisions regarding professional secrecy. This chapter also analyses the key challenges and trends regarding these laws.

5.1. General and specific criminal laws on FGM

Across EU Member States, there has been a trend to recognise FGM as a criminal act and, subsequently, to draft and enact new laws or enhance and augment existing legislation to effectively respond to FGM. In all EU Member States, legal provisions dealing with bodily injury, mutilation and removal of organs or body tissue, are applicable to the practice of FGM and may be used for criminal prosecution.

However, in some countries, a specific criminal law has been introduced to address the issue of FGM. Such is the

case in Austria, Belgium, Cyprus, Denmark, Ireland, Italy, Spain, Sweden and the UK. Sweden was the first European country to adopt specific legislation on FGM in 1982, followed by the UK in 1985. Ireland and Croatia have the most recent specific criminal law provisions concerning FGM.

The legal principle of extraterritoriality has increasingly been recognised as important in terms of FGM, as cases of FGM involving girls living in the EU may occur in their countries of origin, or in countries of their parents' origin, while on holidays or visits abroad. This principle makes it possible to prosecute the practice of FGM when it is committed outside of a country's borders. The large majority of EU Member States include this principle in their general criminal law and, furthermore, all EU Member States with specific criminal legislation on FGM foresee the principle of extraterritoriality within their respective laws. Only Bulgaria, Greece, Malta and Romania do not include the principle of extraterritoriality in their general criminal laws. Conditions for the application of this principle differ from country to country. Frequently, either the offender or victim, and sometimes both, must be a citizen or, at least, a resident of the European country concerned.

Table 5.1.1. Countries with specific and general criminal laws to address FGM in the EU-27 and Croatia

| Specific criminal law provisions | General criminal law provisions |
|--|--|
| AT, BE, CY, DK, IE, IT, ES, HR, SE, UK | BG, CZ, DE, EE, FI, FR, EL, HU, LT, LV, LU, MT, NL, PL, PT, RO, SK, SI |

The Female Circumcision Act in the United Kingdom was introduced in 1985, and has been strengthened in 2003 including a change of terminology from circumcision to mutilation, to reflect the terminology used in international law and forums. The UK Female Genital Mutilation Act 2003 introduced the principle of extraterritoriality, including even countries where the practice is not considered illegal. The revised act also increased the length of possible imprisonment to up to 14 years following prosecution and conviction.

In the Netherlands, changes to laws in 2006 removing the principle of double incrimination allowed for FGM to be punishable even if committed in countries where it is not considered illegal.

In the recent FGM Act in Ireland, the drafters of the Act included a clause in Section 3 of the Act, which criminalises the actual removal of a girl from Ireland for the purpose of conducting FGM. Consequently, the removal of a girl with the intent of her undergoing FGM abroad is now actually a crime in itself and the principle of double incrimination is circumvented.

There is no substantial evidence that specific criminal law provisions are more effective in prosecuting and punishing acts of FGM. A limited number of criminal cases on FGM have been brought to courts in Denmark, France, Italy, the Netherlands, Spain and Sweden. Notably, the majority of these court cases took place in France, where FGM is liable under general criminal law. In the Netherlands, a re-emerging debate regarding the enactment of a specific FGM criminal law has deemed the Dutch legal framework on child abuse as sufficiently robust to respond to FGM. In Portugal, an ongoing legislative discussion considers specific FGM laws as potentially stigmatising and discriminatory to migrant communities, while useful for applying standard criminal procedures and assisting with police interventions in cases of FGM.

In some EU Member States or regions, the process of adding a specific reference to FGM to the existing legislation has proven to be effective. For example, in Spain, six regions (Catalonia, Aragon, Murcia, Madrid, Cantabria, and the Canary Islands) have approved laws concerning gender-based violence that explicitly include FGM. This secured the legal right to protection, to specialised medical care, to receive financial assistance and to access free legal advice. In Scotland, an FGM-specific act was introduced in 2005 since the UK Female Genital Mutilation Act 2003 did

Table 5.1.2. Criminal court cases related to FGM

| | | | | | |
|----|---|----|----|----|---|
| DK | 1 | FR | 29 | NL | 1 |
| ES | 6 | IT | 2 | SE | 2 |

not extend to Scotland. The Scottish Prohibition of Female Genital Mutilation (Scotland) Act 2005 contains similar penalties to the ones included in the UK Female Genital Mutilation Act. It also includes the principle of extraterritoriality. In France, where a specific criminal law on FGM is not deemed necessary, the possibility for CSOs to be able to sue perpetrators in FGM cases is considered vital. This will also serve to ensure that FGM cases will receive their appropriate legal qualification as crimes and not mere offences in order to be judged before higher jurisdictions. As a result, a key CSO (CAMS France) has been instrumental in bringing FGM cases before the French courts.

Trends and challenges

A gradual trend across EU Member States is the introduction of FGM-specific criminal legislation. Where this has not yet occurred, a more general debate on signing the Istanbul Convention may stimulate discussions on the merits of establishing FGM-specific national legislation and accelerate the development of respective legislative reform. The practice of consulting with other Member States and relevant stakeholders prior to the introduction of legislation also emerges as a trend in some Member States and this should be a common practice.

Box 5.1.1. The importance of consultations for the drafting of legal acts on FGM

Consultation was an important aspect in the process of drafting the new Irish FGM Act. It took place with CSOs and professionals, such as the police. A similar consultation with experts and CSOs also guided the drafting of the Law 7/2006 on Female Genital Mutilation in Italy^{xix}, where the aim was to strike a balance between prosecution, prevention and protection measures, and to provide resources through assigning budgets.



With regard to prosecution, the main challenges noted in countries such as Ireland, Italy, the Netherlands, Spain, Sweden and the UK include the difficulties with detecting and reporting cases and finding sufficient evidence to bring a case to court. The lack of willingness of family and community members to report cases of girls at risk is a concern expressed in Italy, Ireland and the UK. The tension between prosecution and prevention is also a concern as prevention policies entail a collaborative dimension involving families as part of the solution whereas prosecution seeks to impose penalties on situations where the law is breached. What is more, those working in FGM prevention sectors may be very reluctant to report suspected cases of FGM, because that could lead to prosecution and prosecution is considered as incriminating families. This is regarded as incompatible with preventive work, interaction and involvement of migrant communities. An over-emphasis on efforts to take FGM cases to court may influence finding the right balance between prevention, protection and prosecution. An additional issue arose when Sweden and the Netherlands removed the principle of double incrimination from the national legislation as it was challenging to assess whether FGM was performed before or after the adoption of the new law.

Despite the legislative structures to prosecute cases of FGM, gathering sufficient evidence to bring FGM cases to court has proven to be difficult across EU Member States. Some of the additional barriers and complications noted are: finding evidence when a girl has been genitally mutilated in her country of origin; gathering criminal evidence to prosecute when non-family members have performed FGM; the onus on girls who have undergone FGM to testify against their parents and/or families in court; and the absence of implementation of the principle of extraterritoriality.

Box 5.1.2. Learning from the case of France

As France has the highest number of cases brought to court within EU Member States for FGM, these experiences and observed challenges are of particular relevance. In France, the reluctance of magistrates to prosecute FGM perpetrators or facilitators and to address FGM as a criminal offence, due to the status of the legislation, but also due to deeply rooted personal or cultural prejudices, was raised as an important issue.

Additional issues related to prosecution include: the comparison of FGM with male circumcision (which denies FGM its mutilating effect); cultural relativism as a lens through which the understanding of potentially harmful traditional practices are viewed; and the presence or absence of provisions allowing CSOs to act in law in cases of FGM. For instance, in France, there is a legal possibility for CSOs to act in law under specific conditions. However, legal proceedings have to be initiated by prosecutors who represent the interests of society and should not be initiated by individuals (in these cases, CSOs).

As part of the evidence-gathering for criminal cases involving FGM, gynaecological examinations may be requested. In fact, gynaecological screenings of girls to detect FGM cases or as a protection mechanism have been suggested repeatedly as a method to increase the number of detected cases, and consequently, the number of prosecutions. However, critics of this method point out the many ethical challenges and the potential ethnic discrimination that such a measure would entail, as well as practical obstacles to this approach. Some of these control measures may harm the intimacy and dignity of the minors. It would require substantial training of health professionals to be able to assess all forms of FGM, in particular Type I, and would require profound knowledge about the female anatomy. While legislation could never replace prevention, protection and provision of FGM-related services, it nonetheless must be part of a range of measures that support and enhance women's rights.

5.2. Child protection laws

It is not enough to address FGM with only criminal laws and prosecution, as they only apply when a crime has been committed. Child protection measures, on the other hand, are put in place to protect a girl at risk of FGM in the future. There is no EU Member State that has developed child protection laws solely and specifically dealing with FGM. However, general laws regarding child protection exist in all EU-27 and Croatia and can be used in cases of FGM. In situations where a girl is at risk of FGM, child protection laws can be leveraged to safeguard the girl. A range of measures can be applied, from removing the girl from her family and suspending parental authority to withholding passports or travel documents and issuing a non-authorisation to leave the country. These measures

are subject to court permission (Leye & Sabbe, 2009). Interventions to protect girls from FGM have taken place in Denmark, Finland, France, Germany, Italy, the Netherlands, Spain, Sweden and the UK. Denmark, Germany, Italy and Spain have had court cases regarding child protection measures against FGM.

5.3. International laws related to protection

As explained earlier, the policy framework on international protection has been set out by the EU directives on international protection (see Section 4.3), while the UNHCR protection guidance notes provided useful information on FGM-based asylum applications (see Section 3.1). The directives are legally binding for EU Member States (excluding Denmark, Ireland and the UK).

Consequently, all Member States have a legal framework in place that could be used to grant international protection in cases of FGM. However, there is no EU Member State that has integrated specific provisions on international protection and FGM into its national legislation. Only Hungary specifically mentions FGM in its explanation of the general asylum law provision (Article 60 (2) b) within the Act 80 of 2007 (Asylum Act). In this explanation, a list is provided of possible forms of gender-based persecution, including FGM.

Usually, women submitting an FGM-based asylum application are considered under the category of membership of a 'particular social group'. However, Member States have different definitions of a 'particular social group'.

FGM is considered gender-based persecution, which also includes physical or psychological violence and sexual violence. Belgium, Bulgaria, Estonia, Italy, Portugal, and Slovakia have included gender-based persecution in their asylum legislation. Gender- or child-specific acts of persecution are also frequently referred to as a ground for protection, namely in Belgium, the Czech Republic, Estonia, Greece, Hungary, Italy, Luxembourg, Portugal, Slovakia and Sweden. Spain also established that persecution based on gender and sexual orientation could be considered grounds for persecution as defined by Article 1 of the Geneva Convention. Finally, some countries (Belgium, Croatia and Greece) use the term 'vulnerable groups' in their legislation, which may include victims or potential victims of FGM. This does not refer to the criteria qualifying for asylum, but to the type of procedure and reception conditions that asylum seekers can access.

Several countries also provide alternative systems of protection in case a person is not deemed eligible as a refugee under the terms of the Refugee Convention, but nevertheless is in danger of being submitted to torture, and other cruel, inhuman or degrading treatment or punishment. As a consequence, women at risk of FGM can receive subsidiary protection, temporary protection, or protection on humanitarian grounds in Austria, Belgium, Croatia, Czech Republic, Denmark, France, Ireland, Luxembourg, Slovenia and Spain. Cyprus, Greece, the Netherlands, and the UK refer to Article 3 of the European Convention on Human Rights in this regard, which provides that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'.

Asylum applications regarding FGM are most commonly based on fear of persecution, namely the pending threat of being subjected to FGM. However, there are some countries (Belgium, Hungary, Italy and the UK) which take into account certain additional future circumstances linked to past persecution in the form of FGM. In view of the UNHCR Guidance Note on Refugee Claims relating to Female Genital Mutilation (UNHCR, 2009), this should be the case in all countries. This may include cases where a woman has already undergone FGM, but who may be at continued risk of repeated de-infibulation and re-infibulation following giving birth, future forced marriage and the risk if she has daughters that they will be subjected to FGM.

In some of these countries, there have been many asylum requests based on FGM and asylum has been frequently granted on this ground, e.g., in Belgium, France, the Netherlands and Sweden. However, in other countries (e.g. Italy, Latvia, Lithuania, Malta, Romania and Slovakia) there were only a few exemplary cases. In the remaining European countries, asylum has yet not been granted on the grounds of FGM, although the general asylum provisions do leave room for interpretation for FGM claims. Table 5.3.1 lists the countries where FGM-based asylum applications have been submitted. Table 5.3.2 provides an overview of the European countries where asylum has been granted to women in FGM cases, and the countries where asylum has not been granted.

Trends and Challenges

There is no harmonised approach to granting international protection on the ground of FGM or fear of FGM. This is problematic in view of the development of the Common European Asylum System and needs to be addressed in the transposition of the recast Qualification Directive.



Furthermore, asylum procedures are not gender sensitive. This leads to less protection and cases not always being fairly considered because of a lack of evidence, and to cases being dismissed for a lack of credibility of asylum seekers.

Due to the lack of data on the number of cases where international protection is requested, granted or rejected on the basis of FGM, it is hard to assess the implications of international law regarding protection in relation to FGM.

5.4. Professional secrecy provisions

The role of professionals (doctors, nurses, teachers, social workers, etc.) in identifying girls at risk of FGM, reporting concerns to competent authorities and initiating a series of protective measures is critical. Professionals also have a role in cases where FGM has already been performed by ensuring that appropriate care and measures are mobilised if the girl has (a) younger sister(s) or other family members that might be at risk. In these cases, professional secrecy as to information gathered in the course of occupational duties, is generally superseded by the right or duty to report cases of possible harm, particularly in relation to children. Disclosure regulations regarding professional secrecy underpinned by potential sanctions are therefore important mechanisms to ensure the implementation of FGM laws and the protection of girls at risk of FGM.

Although most countries do not have specific legal regulations with regard to reporting cases of performed or planned FGM, general provisions covering professional secrecy and situations requiring disclosure may apply. Conditions for disclosing information differ greatly across countries, ranging from a suspicion of a pending criminal offence to a crime that is already committed. In more than half of the EU-27 and Croatia, information either can or must be disclosed when an under-age child is severely endangered. In this way, general professional secrecy provisions can be applied to report cases of FGM or to protect girls at risk of FGM. Only in Belgium and Sweden is there a specific legal provision with regard to reporting cases of performed or planned FGM.

There are differences across countries with regard to the professional categories envisaged. In most countries health professionals are included, as well as social workers and teachers. In a few countries, the professional secrecy provisions are extended to personnel of public bodies or services.

There is no consensus about whether these professionals have a 'duty to report', or merely are offered a 'right to report'. Three countries – Belgium, Germany and the Netherlands – have only a right to report for all professional categories. Other countries established a duty to report for, at least, one of the key professional categories (see Annex IV). The majority of these countries have established criminal, administrative or disciplinary sanctions in case of non-reporting.

Table 5.3.1. FGM-related asylum requests in the EU-27 and Croatia

| | Asylum requested | Asylum not requested | No information about asylum cases |
|------------------|--|----------------------|-----------------------------------|
| Countries | AT, BE, CY, DK, FR, DE, HU, IE, IT, LV, LT, LU, MT, NL, PO, PT, RO, SK, SE, UK | BG, HR, EE, SI | CZ, ES, EL, FI |

Table 5.3.2. Asylum granted on FGM-related grounds in the EU-27 and Croatia

| | Asylum granted | Asylum not granted |
|------------------|--|--|
| Countries | AT, BE, FR, DE, HU, IE, IT, LV, LT, NL, RO, SK, SE, UK | BG, HR, CY, CZ, DK, EE, FI, EL, LU, MT, PL, PT, SI, ES |

Box 5.4. Swedish legislation for the prosecution of FGM

In Sweden, the Secrecy Act established that cases of FGM always constitute valid grounds for lifting the obligation of professional secrecy. Furthermore, the Act Regarding Special Representative for a Child has been introduced, enabling genital examinations to be made without parents' or caregivers' consent. The principle of double incrimination^{xx} has also been removed, which means that all FGM cases performed on Swedish girls after 1999 (when the principle was removed) can be brought before the Swedish court even if performed in the countries where FGM is not criminalised. Finally, the period of limitation^{xxi} has been prolonged: the period of limitation is now 10 years starting from the day the child turns 18, or should have turned 18.

However, in many countries, health professionals cannot break their code of silence if the crime of FGM has already been performed, because FGM is not generally considered as a type of repetitive, recurrent child abuse. In several countries, there are sanctions for non-reporting of FGM already performed; these sanctions may be criminal, administrative or disciplinary.

Trends and Challenges

Clear policies on professional secrecy and conditions for disclosure are crucial for the initial implementation of protection policies and measures in cases of suspected FGM and for the introduction of FGM-related criminal proceedings. Failure to correctly understand, and, when required, lift professional secrecy provisions can result in FGM taking place without protective mechanisms enabled. Disclosure regulations and potential sanctions are important mechanisms to ensure both the implementation of FGM laws and the protection of girls at risk of FGM. Such regulations require clear signposting for relevant professionals in terms of FGM risk indicators; procedures to be followed; relevant referrals to be made; time frames for these referrals to take place; and professional sanctions and penalties in cases of non-reporting.

5.5. Concluding remarks

In the last decade, there has been significant progress and momentum regarding legislation and policy development on FGM across the EU. This progress appears to have been stimulated in some countries by a better understanding of the phenomenon. Legislative developments to tackle FGM began as early as 1982 in Sweden and have continued to develop, with the most recent FGM legislation having occurred in Ireland in April 2012; Malta and Croatia are discussing the adoption of a specific law. The re-assessment of the suitability of current legislation to prosecute and protect in cases of FGM, as well as the need for specific FGM laws is also ongoing. The introduction of the principle of extraterritoriality and the responses to concerns about double incrimination aim at providing as much protection as possible to EU residents when travelling abroad. These also reflect the recognition of FGM as a transnational crime, which can only be tackled when action is taken within and outside the EU. However, concerns still remain about the lack of FGM prosecution in some countries, and regarding the challenges in gathering adequate evidence of FGM cases. There have been few court cases on FGM to date, which is related to the lack of reports and barriers in finding sufficient evidence. The lack of reports might be related to the insufficient knowledge of professionals who are confronted with FGM; their inability to deal with the issue and the absence of mechanisms to properly address FGM cases.

In all EU Member States and Croatia (except for Bulgaria), fear of FGM could be a ground for international protection, even if none of these countries have developed specific asylum provisions on FGM in national legislation. In these countries, the general asylum provisions do leave room for interpretation for FGM-related claims. Most countries assess applications based on future persecution (legitimate fear of being subjected to FGM). Fourteen countries granted asylum based on fear of being subjected to FGM, including countries with few migrants from countries with high FGM prevalence such as Latvia, Lithuania, Romania, Slovakia and Hungary.



6. Policy development, implementation and actors at Member State level





6. Policy development, implementation and actors at Member State level

This chapter begins with a focus on overall integrated and coordinated policies, such as national action plans, then examines in more detail actors, tools, challenges and trends within various categories. The analysis in this chapter is organised following the categories identified previously: prevention, protection, prosecution and provision of services, focusing on FGM at Member State level. It is important to note that there is an overlap between sectors, actors and policy areas in relation to FGM. As a result of an in-depth research conducted in nine Member States (France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the UK) this chapter features more data and information coming from these countries than from others.

6.1. Overview of policies and policy makers

The range of policy documents relating to FGM that were identified includes action plans, strategies, circulars, proposals, guidelines, recommendations and reports. The role of policy makers and activists is crucial in relation to FGM.

6.1.1. National action plans on FGM

National action plan development and implementation, a key policy development on FGM at Member State level, has gathered momentum in the past decade.

Eight Member States have developed national actions plans (NAPs) on FGM: Austria, Denmark, Finland, Germany, Greece, Ireland, Portugal and Sweden. Sweden was the first country to develop a NAP in 2003; the most recent NAP is from Finland

and was launched in August 2012. Six of these NAPs (in Austria, Denmark, Germany, Greece, Ireland and Portugal) were developed under the framework of a Daphne programme project^{xvii} and began in 2008. The NAPs were developed and released by CSOs, government bodies or a combination of the two. Portugal is the only country that has renewed its NAP on FGM. The first Portuguese NAP was concluded in 2010, and a second NAP was launched in 2011 and will conclude in 2013. None of the action plans specified a budget for implementing the proposed measures contained in the NAP, except for Sweden, which allocated approximately EUR 328,000 to its NAP. Only in Portugal and Sweden were responsible agencies designated for NAP implementation: the Commission for Citizenship and Gender Equality in Portugal, and the National Board of Health and Welfare in Sweden.

The range of actions and recommendations contained in each of the NAPs varies. Many of them set out strategies, target groups and actors to deal with FGM at national level. They may call for specific legislation in relation to FGM (as is the case in the German and Irish draft NAPs) or for more research on the issue.

Although not consistent throughout Member States, NAPs do seem to provide a focus for work on FGM across sectors, a rationale for collaboration and partnership; and publicity and awareness of the issue. Further evaluation and assessment of the role of NAPs in policy making and policy progression is required. Many of the NAPs were developed through the formation of working groups, committees and partnerships, the development of which should be considered a positive step in terms of networking and interagency working relations on FGM. Involving representatives from FGM-practising communities (or relevant representative CSOs) in the NAP development can be considered of particular importance.

Box 6.1.1. The Finnish National Action Plan on FGM

The Finnish Action Plan for the prevention of circumcision of girls and women 2012–2016 (FGM), set up by the Ministry of Social Affairs and Health, was developed by a working group including representatives from multiple government Ministries and African women’s organisations. The purpose of this NAP is to create permanent Finnish national and regional structures to prevent the circumcision of girls and women. Other goals of the Action Plan include more effective collaboration, clearer division of work and better coordination between different authorities and other actors. The NAP outlines how to protect girls through legislation, including the duty, which applies to professionals, to report cases of a child at risk or face criminal sanctions. The NAP also states the objective of monitoring and evaluation of the actions foreseen in the NAP.

6.1.2. Broader national strategies covering FGM

In 10 Member States (Austria, Belgium, Croatia, Finland, France, Greece, Ireland, the Netherlands, Portugal and the UK), FGM is included and discussed in strategies and action plans addressing: children’s rights (Austria); integration (Austria and Portugal); gender equality (Croatia and the Netherlands); sexual and reproductive health (Finland and Greece); violence against women/intimate partner violence/domestic violence (Belgium, Finland, France, Ireland, the Netherlands, Portugal and the UK); internal security (Finland); and intercultural health (Ireland). These documents have all been issued by ministries or other government bodies. In particular, the fact that FGM appears in NAPs concerning violence against women/gender-based violence in six Member States (Belgium, Finland, France, Netherlands, Portugal, the UK) indicates that the framing of FGM is a broader issue for Member States and not solely linked to immigration, ethnic minorities and overseas aid. Some of these strategies had a budget assigned to them, as is the case in France with EUR 290,000 attached to the work on violence against women. Sweden uniquely assigned funds to work on FGM prior to its NAP and not necessarily in conjunction with other strategies and policies. In 1993, the Goteborg Project focusing

on FGM was initiated by the National Board of Health and Welfare (NBHW) and received approximately EUR 280,500 between 1993 and 2001. In 1998 the Swedish government allocated approximately EUR 295,000 to the NBHW for further preventive work on violence against women, including FGM. The potential for embedding the issue of FGM in more encompassing national policy frameworks is potentially enhanced by its inclusion into broader policy documents. However, it is not possible to fully assess this impact yet, especially as some of the policies and strategies are relatively recent.

6.1.3. The role of partnerships

Partnerships at a city or regional level appears an established practice across some of the EU countries with city ‘roundtables’ (Runde Tische) functioning in six city areas in Germany, and up to 70 Local Networks on FGM (Xarxas Locals de Prevenció de la Mutilació Genital Femenina) across Catalonia in Spain. While this approach can lead to the development of good inter-agency partnerships in areas of most need, it can also lead to a disparity of support across a country and a lack of professionals, structures and CSOs who are equipped and ready to deal with cases of FGM on a nationwide basis.

Box 6.1.3. Regional partnerships on FGM in France

One of the earliest partnerships to emerge was the Working Group of the Women’s Rights and Equality Directorate (Délégation Régionale aux Droits des Femmes et à l’Egalité) in Île-de-France, France during 1992^{xxiii}. This Group began to hold annual conferences on FGM prevention in order to share experiences related to work on FGM, and this led to the establishment of similar regional partnerships in France.

Partnerships have been developed at national level in some countries in response to the development of NAPs, including those in Finland, Germany, Greece, Ireland, Portugal and Sweden. Involvement of statutory bodies and staff, migrant organisations, representatives and CSOs in such partnerships seems to be important to progress the implementation of NAPs on FGM. This is particularly apparent in Portugal where the Inter-Sectorial Working Group has produced two concurrent Programmes of



Action for the Elimination of FGM in Portugal since 2007, coordinated by the Portuguese Commission for Citizenship and Gender Equality (CIG). Part of the perceived success of this approach is the diverse composition of the group that brings together experience and experts from multiple sectors. However, the group is united by strong coordination and a shared aim to combat FGM and work together on the specific tasks that are outlined in the Programme. A similar partnership was formed in Ireland for the National Steering Committee for Ireland's National Plan of Action to Address FGM 2008–2011. The mix of statutory and voluntary sector actors on the Committee made united and concerted efforts possible to successfully lobby for policy changes and the introduction of specific FGM criminal legislation in Ireland. The importance of including migrants' organisations and both statutory and non-statutory actors appears to be a crucial element of productive partnerships. In Germany, the INTEGRA-Network founded in 2000 by the Federal Government brings the partnership approach to an international level by including CSOs and statutory organisations as well as individuals that work on abolishing FGM in Germany and in African countries.

6.1.4. Regional action plans

In Spain, there is a number of regional action plans which include references to FGM. The plans address violence against women, gender-based violence, women's policies, and gender equality. These plans were developed by the Department of Employment and Women (Community of Madrid – 2002), Women's Institutes (Canary Islands – 2002, Catalonia – 2008, Aragon – 2009, and Andalusia – 2010) and the Department of Social Well-Being (Valencian Community – 2006). Information on budgets assigned to the regional plans and progress to date is not available.

6.1.5. Other relevant policies

Some Member States have developed and utilised other policy tools than NAPs to support work in the area. In Italy, the Law 7/2006 on FGM sets out a number of initiatives and strategies in order to deal with FGM in the country. The Law also appointed responsible actors and assigned a budget (EUR 8.2 million) for FGM-related work in Italy and in some African countries. The Law was not re-financed and no evaluation results have been made public about the impact of the measures taken as a result of Law 7/2006. An announcement, however, was made on 18 October 2012 that a budget of 3 million euro would be made available to regions as of January 2013.

In France, a number of annotated policy documents refer to the 'Action Plan on FGM' which consists of a set of preventive and educational measures taken up at regional and national level within the social, educational and health sectors to address the issue of FGM. These policy documents emerged after the 2006 Act No. 2006–399 was passed, strengthening the prevention and punishment of violence perpetrated within a couple and against children.

The utilisation of relevant legislation, policy documents and government policy briefs appears to have been effective in progressing the work on FGM in France, Italy and the Netherlands.

6.1.6. Policy makers and catalysts

FGM policy making appears to be a reactive response to a number of events such as FGM-related court cases, for example. The media have played a role in highlighting FGM as a concern related to 'new communities'. Responses to media queries and reports by politicians and policy makers have also been used to develop policies tackling FGM in a number of Member States. An example of such media reporting is the 2002 journalistic investigation in Portugal on potentially performed FGM (Branco, 2002) conducted by Sofia Branco. Media appear to have a catalyst role in some Member States in terms of initiating a public dialogue on FGM. This happens through undercover reporting to reveal covert FGM cases within a country or acting as a forum to debate issues related to FGM, including a lack of prosecution, which recently occurred in the UK. However, media reporting on FGM does not appear to be influenced by media guidelines or policies with the exception of guidelines developed in Austria in 2008 – titled 'Sensitive reporting on Violence against Women' ('Sensible Berichterstattung zum Thema Gewalt an Frauen') (Frauenabteilung der Stadt Wien, 2008) – which contains a chapter specifically devoted to FGM.

Parliamentary debates, parliamentary questions and letters to government ministers also act as policy initiators. For example, the public and parliamentary debate in the Netherlands was triggered by Ayaan Hirsi Ali, a member of the Dutch Parliament from 2003 to 2006. Research and FGM prevalence data can also lead to policy responses, as was the case in Ireland. Court cases on FGM have acted as policy drivers where legislation or policies have followed from high-profile FGM court proceedings, as it has happened in France and Spain. The role of committed activists (notably, but not always, from FGM-practising communities) and CSOs also contributes to debate, media coverage, policy instigation and policy development at Member State level.

At a government level, Ministries of Health, Justice, Equality and Education appear to be most involved in developing and producing policies on FGM. Health and child protection agencies as well as police forces have also developed policies that include FGM. The Multi-Agency Guidelines produced by the Home Office in the UK deserve a special attention with regard to targeting multiple key actors in FGM prevention, prosecution and care for women and girls who have undergone FGM in one combined government publication.

6.1.7. Challenges and trends in policy making

Any policy development in relation to FGM should be based on sound data, such as prevalence estimates. In this way, the impact of any interventions can be monitored and evaluated, and can better steer future policy development and budget allocations. It is remarkable that a number of policies and NAPs have been operating and were developed in the absence of prevalence data and related research. Ideally, NAPs should be developed and endorsed with the involvement of state or regional authorities and assigned to a responsible agency to ensure progress. Moreover, specifying a budget to each proposed measure or area of work would help ensure implementation, adequate monitoring and evaluation throughout and would help assess the NAPs' impact.

Despite the development of policies and NAPs across many EU Member States, there is a lack of similar initiatives in some Member States. There are no specific FGM policies in Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia. In other places, including Croatia, Cyprus and Luxembourg, policies are limited. However, these countries do have policies in place regarding the protection of women and children from violence, gender equality and crime prevention; these may also cover FGM in the context of gender-based violence or can be applied to cases of FGM. In general, FGM is not a policy concern in the countries with a small number of people coming from FGM-practising communities. Cyprus and Malta, being Member States that process a substantial inflow of migrants from Africa, became engaged with the issue of FGM quite recently.

In some Member States significant differences in the level of policy development and implementation were noted. This is particularly the case in France, Italy and Spain. While policy tools and networks to implement these policies may be very robust and efficient at a regional level, this may not be uniform across the whole country. Naturally, FGM policy development will reflect the local needs, as reflected in regional variations of population. Larger cities, for instance, have tended to attract greater numbers of migrants. But the possibility of local or regional staff changes exists, which implies that in the absence of coherent national policies, regional progress may regress over time. Strong national coordination of a NAP by a central authority driving national FGM policy implementation seems useful in developing a coherent country-wide policy response to FGM.

6.2. Prevention of FGM

Prevention involves measures to promote changes in the social and cultural patterns of behaviour of women and men of all ages. It includes FGM awareness-raising initiatives, the development of educational materials and the training of professionals. There has been ongoing work in relation to FGM prevention in many of the countries analysed in this study. CSOs are the main actors working on FGM prevention, and partnerships between CSOs and statutory organisations are sometimes formed to address issues related to FGM prevention in Member States. The majority of prevention activities have focused on raising awareness of FGM among the general public, communities and professionals, and on providing training to professionals and FGM-related advocacy activities. FGM prevention initiatives often have a broad target audience, such as the general public, and a broad aim, such as awareness raising, whilst engaging with the women, girls and communities that are most at risk of FGM through prevention activities appears less pronounced. Targeted messaging and audience segmentation in relation to developing lasting behaviour change seems somewhat insufficient in FGM prevention. Therefore, key targets – men from FGM-practising communities, young girls at risk of FGM, religious leaders, and the professionals that interact with these targets (for instance, teachers and integration or community workers) – may not be fully reached and engaged.



Box 6.2.1. Danish resources for the prevention of FGM

The document 'Prevention of FGM' contains comprehensive recommendations produced by the National Board of Health. Furthermore, this document provides information on FGM for legal and health professionals, as well as guidelines for teachers. The aim of the document is to prevent the mutilation of girls living in Denmark, and to ensure that women who have undergone FGM receive the best treatment and care.

There appear to be limited tools and prevention activities specifically targeted at FGM-practising communities in Europe. Involving FGM-affected communities in the development, roll-out and delivery of FGM prevention work is very important and has occurred in some Member States (e.g. in Ireland, the Netherlands, Sweden and the UK). Taking an inclusive stakeholder approach provides the possibility for inputs by FGM-affected communities, helps to overcome cultural barriers and stereotypes; and often provides appropriate language, interpretation and cultural mediation input into prevention activities.

Much of the prevention work on FGM in the EU is undertaken in the absence of accurate FGM prevalence estimates and baseline data pertinent to assessing behaviour change and the abandonment of FGM over time. Very few of the projects or resources identified in this study have been evaluated to assess success factors and areas in need of more work. Prevention activities are aimed at changing deeply rooted, culturally-acceptable and long-established practices such as FGM. Yet, the support and resources available to CSOs can be limited; they may operate on a year-to-year basis in relation to their funding. In Sweden, the Netherlands and Italy the importance of prioritising FGM prevention with budgets assigned for the work has been critical; in these countries policy and government commitment to FGM prevention has been demonstrated by the support and finances attached to the work and allocated to CSOs.

Box 6.2.2. Prevention of FGM in France

In France, the state and regional or local authorities provide the framework and funding for prevention work, but delegate it to CSOs such as GAMS. One of the most enduring prevention projects in France was the production, in 1993, of the booklet called, 'Let's protect our little girls' (Protégeons nos petites filles). This booklet aimed to prevent FGM through the provision of information and presented the legal grounds of FGM criminalisation in France. It was designed by experts from GAMS, family planning clinics and doctors from the Maternal and Infantile Protection service (PMI). The booklet is still in use, and has been customised and relaunched in the Haute Normandie and Loire Atlantique regions. It has also been used as a template to produce similar FGM prevention materials and has been adapted for publication and dissemination in Belgium, Germany and Luxembourg.

Box 6.2.3. FGM prevention tool from Italy

The Italian Association for Women in Development (Associazione Italiana di Donne per lo Sviluppo, AIDOS) produced a docu-fiction film entitled 'Lives in Motion' (2009) and a handbook that was funded by law 7/2006. The aim of the film is to influence the behaviour of FGM-practising communities, and to sensitise and train organisations, social and healthcare services, educational institutions, citizens and policy makers about the social and cultural aspects of FGM. The film shows the relationship between migration and cultural change in relation to FGM and uses images, symbols and languages familiar to viewers. The film is accompanied by a 30-page handbook that suggests discussion topics and themes to raise awareness.

Box 6.2.4. The Dutch ‘Chain Approach’

In the Netherlands, a number of briefs issued by the Minister of Justice (2001) and the Minister for Health (2005 and 2007) outlined and detailed the national policy regarding FGM. The 2005 brief recommended the initiation of a FGM prevention project in six Dutch cities, the ‘Pilot Projects’^{xxiv}, where most of the migrants from practising communities live (Amsterdam, the Hague, Eindhoven, Rotterdam, Tilburg and Utrecht). Subsequently, a budget of €4 million was invested. The ‘Pilot Projects’, which ran from 2006 until 2010, can be considered a meaningful initiative to involve communities in FGM prevention work,^{xxv} and a landmark in the prevention of FGM in the Netherlands. A crucial feature in the ‘Pilot Projects’ was the ‘Chain Approach’, involving relevant actors that are or might be confronted with FGM. In this approach, trained peer educators and members of FGM-practising communities play an important role as ‘Key Persons’ (Sleutelpersonen). ‘Key Persons’ provide peer interventions and do home visits in cases of fear of FGM. The ‘Pilot Projects’ were evaluated and discussed at national level, and subsequently measures for the prevention of FGM were integrated at municipal level.

Box 6.2.5. Toolkit aimed at behaviour change (UK)

The toolkit named ‘Replace: Pilot Toolkit for Replacing Approaches to Ending FGM in the EU: Implementing Behaviour Change with Practising Communities (2011)’ is designed to promote changes amongst FGM-practising communities in the EU. It constitutes a guide to conducting Participatory Action Research and presents a behaviour change cyclic framework to ending FGM. It focuses on identifying problematic behaviour with regard to FGM and specifically targeting that behaviour to instil core changes. This approach replaces the dominant approaches to eliminating FGM which focus on raising awareness of the health and human rights issues associated with the practice, and then expecting individuals to change their behaviour accordingly. It was developed by Coventry University staff, FSAN and FORWARD UK, and received financial support from the EU Daphne Programme.

Box 6.2.6. Teaching toolkit (the Netherlands)

The ‘Prevention Girls’ Circumcision (FGM) teaching toolkit’ (2009) was developed at the request of the Dutch Ministry of Health (VWS) by Rutgers Nisso Groep and Pharos (Pharos Centre of Expertise on Health for Migrants and Refugees). It provides lesson plans, background information on FGM for both primary and secondary schools, tips on how to integrate FGM into school curricula, as well as referral and support services information. It also lists risk indicators for girls at risk of FGM or those who have undergone it.

6.3. Protection against FGM

Protection comprises cooperative actions to protect victims who have undergone FGM and girls and women at risk of being subjected to it; focusing on the safety of victims and addressing specific needs of this target group. Protection within the EU is firstly achieved by recognising the transnational nature of FGM and that it mainly occurs outside of the EU. Hence, having protection policies in place within the countries where FGM mainly occurs is crucial, even though few seem to be in place currently. It also includes reporting the occurrence of FGM or anticipated acts of FGM, under appropriate conditions, by any person or professional. The study distinguishes between two types of protection most relevant to FGM: child protection and international or asylum protection. Regarding international protection, special attention is given to the recognition of gender-based violence, and in particular FGM, as a form of persecution and serious harm requiring protection.

6.3.1. Child protection

Policies used when dealing with girls at risk of FGM usually contain procedures to assess risks and outlines on how to respond to cases of potential or earlier FGM in accordance with national laws. These policies are important for professionals to know how to effectively deal with cases of FGM, who to contact, how to determine risk factors, and the legislative and protective mechanisms that are in place at a country or regional level. Some Member States (Denmark, France, the Netherlands and the UK) have developed specific policies on FGM and others (such as Ireland and Sweden) may have mainstreamed FGM into the existing child protection frameworks.



In countries such as France, designated policies simply outline who should be contacted in suspected cases of FGM.^{xxvi}

The main role for the protection of girls at risk lies with statutory agencies and staff such as police, social workers, child protection officers and healthcare workers. School teachers also have a crucial role to play in protecting girls at risk and triggering support for girls who have undergone FGM. There appear to be a limited number of policies for teachers regarding FGM across EU Member States. While many of the child protection guidelines and policies would potentially cover the teaching profession, the important role of teachers to identify girls at risk of FGM and to instigate protective mechanisms for such girls – and possibly other family members – should not be ignored. Teachers are generally the professionals who have the most consistent, regular and ongoing interaction with young people and as such can be important confidantes for girls at risk. Teachers can also notice behavioural changes that indicate the fact that FGM has occurred or is about to occur.

Multi-agency cooperation and protection resources are an increasing trend to respond to FGM in EU Member States. The UK 'FGM Multi-Agency Practice Guidelines', the 'Chain Approach' (Ketenaanpak) in the Netherlands and the 'Roundtables' (Runde Tische gegen weibliche Genitalverstümmelung) in Germany are all examples of collaborative responses to FGM. Training on child protection in relation to FGM is very important to ensure effective implementation of protocols, guidelines and policies and to build the awareness and capacities of professionals working within child protection. However, training for child protection staff on FGM appears random and does not seem to be conducted on a continual, structured and nationwide basis. When parents or family do not constitute a safe place for a girl, interventions must be rapid and follow policies and guidelines so as not to jeopardise a girl's safety nor to appear to make discriminatory judgements based on ethnic background.

6.3.2. International protection

In relation to international protection, the main actors are ministries and state agencies who monitor and grant international protection. Judicial actors may also be involved in the case of appeals to international protection decisions. CSOs and refugee or immigrant support organisations provide counselling, information, advice and translation services in relation to international protection.

There appears to be little impetus to develop or produce policy guidance in relation to FGM and international protection across Member States. In some Member States, such as

Box 6.3.1. Dutch tools to protect girls travelling to FGM-practising countries

In the Netherlands, a 'contract' is signed between the Youth Health Care and parents from FGM-practising communities who intend to travel. The contract aims to help parents resist the pressure concerning FGM in their countries of origin.

The 'Statement Opposing Female Circumcision', developed by the Dutch Secretary of State for Health, Welfare and Sport and the Ministry for Security and Justice, launched in 2011, is a similar tool. This Statement declares that FGM is illegal in the Netherlands, outlines the penalties for it and provides a portable document signed by Ministers, medical association directors, directors of immigrant organisations, etc., to help parents resist family pressure related to FGM. It has been translated in several languages and also provides a space for the parents' signatures.

Hungary and the UK, gender guidelines have been produced in relation to processing and assessing asylum applications.

In Belgium, the 2011 'Guideline asylum policy for women and girls in Belgium' (Richtlijn Asielbeleid voor Vrouwen en Meisjes in België) from the Office of the General Commissariat for Refugees and Asylum Seekers outlines the asylum policy in Belgium and how FGM is considered a form of persecution of women, girls and their parents and therefore recognised as a ground on which to grant refugee status.

Tools to address FGM in the international protection sector appear limited. Training on gender and gender-based violence has taken place for staff in the UK Border Agency. Training for staff processing and managing FGM-related asylum cases has been initiated in Belgium (in addition to general gender training). In 2010, the Mediterranean Institute of Gender Studies (MIGS) and the END FGM European Campaign, in cooperation with the UNHCR Cyprus held a professional development training workshop for all staff involved in the decision making on asylum cases, entitled: 'Women and Refugee Status Determination: Developing Quality Asylum Procedures'. The workshop aimed to examine and improve asylum procedures and the quality and efficiency of the decision making in relation to gender specific claims of international protection. Professionals attending the workshop were given the opportunity to discuss challenges in the area of women and refugee status determination, as well as to share best practices and lessons learned.

Box 6.3.2.1. UK's Asylum Policy Instruction

In 2004, the Home Office in the UK launched 'The Asylum Policy Instruction: Gender Issues in the Asylum Claim'. This Instruction was revised and updated in 2006 and in 2010. The 'Asylum Policy Instruction' is the UK Government's policy on asylum and is followed by asylum caseworkers within the UK Border Agency (UKBA). The aim of the Instruction is to ensure that all caseworkers are aware of gender-specific issues related to women seeking asylum, including gender-based violence and FGM, which is specifically mentioned numerous times within the Instruction. The Instruction also contains guidance on how caseworkers should deal with asylum applications by women, and the need to utilise gender-sensitive procedures.

Box 6.3.2.2. Information leaflet about asylum application in Belgium

The leaflet 'Women, girls and asylum in Belgium. Information for women and girls applying for asylum' was produced by the Office of the Commissioner General for Refugees and Stateless Persons and funded by the European Refugee Fund in 2011. The leaflet is specifically aimed at female asylum seekers in Belgium and contains information on the asylum procedure, in addition to content on family violence, FGM and human trafficking. This leaflet is distributed to all female asylum seekers aged 16 and older when they register at the Belgian Immigration Department. It was translated in nine languages: Albanian, English, Arabic, French, Dutch, Pashto, Peul, Russian and Serbian.

Another tool to assess and monitor whether to grant international protection based on the fear of FGM is a medical examination and/or medical certification to prove that a girl/woman has not undergone FGM. These examinations may also take place to ensure that once refugee status or subsidiary protection has been granted, FGM does not occur. This tool is utilised in France, where the 2003 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 now limited to a one-year status that is renewable upon proof of the integrity (absence of FGM) of the girl through an annual medical check-up. A similar process takes place in Belgium and the Netherlands.

The lack of specific training and tools emerges as a key challenge regarding FGM and international protection. In the absence of both, international protection granted or refused in full cognisance of facts and information on FGM and using a gender-sensitive approach is jeopardised. Decisions regarding international protection do not always take the situation in the country of origin into account and tend to look only at the existence of legislation against FGM without considering whether it is adequately implemented.

6.4. Prosecution

Prosecution covers not only the legal proceedings against those suspected of having subjected a girl or woman to FGM, but also the related investigative measures and judicial proceedings, including court cases.

It is a welcome trend that the EU Member States and Croatia are examining their legislative structures and mechanisms; enhancing the possibility of prosecuting cases of FGM by enacting specific legislation; and improving existing legislation (or in some countries producing guidelines or policies to assist with prosecution). However, FGM prosecution cases are rare. Across Member States, specific prosecution policies on FGM only exist in Ireland, the Netherlands and the UK. In some cases, FGM may be incorporated into broader investigative and prosecution policies, as is the case in Ireland.

The Irish police policy 'Garda Síochána Policy on the Investigation of Sexual Crime, Crimes against Children, Child Welfare in Ireland' from 2010 provides practical guidance to members of the police force on the investigative and welfare responsibilities associated with such crimes. It sets out the main legal and human rights provisions – necessary when



conducting such investigations – and contains information on FGM. The ‘Domestic Violence Policy’ (2007), also issued by the Irish National Police (Garda Síochána), outlines how all police should respond to domestic violence incidences. It contains a specific mention of FGM in the section on Cultural Issues. This Domestic Violence Policy is currently being updated. In the Netherlands, a proactive approach was initiated due to the perceived lack of prosecutions on FGM. The aim was to put in place an adequate system to enhance signalling, detection and enforcement related to FGM. The Dutch government appointed a special commission to provide information on, in addition to other concerns, the issue of prosecution and implementation of the law.

A very broad range of actors are implicated in the prosecution of FGM, including health and child protection professionals, teachers, police, state prosecutors, the judiciary and at times CSOs who provide legal advice, support and, in the case of France, may initiate law suits. Although the range of actors potentially involved in prosecution is high, the number of overall tools available to these actors appears very low.

Training in relation to prosecution appears to be rare. Often training does not accompany policies or guidelines for the police and judicial sectors. Training seems to be essential in order to provide information on FGM, to counter racism and prejudicial attitudes and to learn how to manage cases in a culturally sensitive way. Training is paramount for the sectors and actors dealing with FGM and prosecution but appears distinctly lacking in EU Member States and Croatia.

Prosecution requires a number of fundamental steps: reporting of suspected FGM cases; investigation of FGM, including evidence-gathering; utilising a legislative framework that allows for prosecution in cases of FGM and bringing cases before a court. Each of these steps requires knowledge, information and procedures to ensure that FGM cases are adequately responded to and subsequent steps can be followed. It is important to emphasise the barriers to reaching a reported case: a lack of knowledge by relevant professional interacting with a girl who has undergone FGM and as a result a lack of reporting. There may also be reluctance to report due to concerns regarding separating girls from the family or that the parents may be sent to jail, as this is not perceived as being in the best interest of the girl. Finally, professional secrecy provisions may impact reporting cases of FGM. The barriers for girls themselves to report to police or authorities include fear of rejection from their community, fear of reprisal from their community, fear of separation from their family and language barriers, amongst many others.

Box 6.4.1. The UK’s tools for investigation in cases of (risk of) FGM

In 2008, the London Metropolitan Police (LMP) issued Standard Operating Procedures (SOP) on FGM titled ‘Female Genital Mutilation – A Guide to Investigation’, within the Project Azure of the Child Abuse Investigation Command. These guidelines target the LMP force, and the procedures are advised to be utilised in conjunction with The London Safeguarding Children Board document ‘Safeguarding Children at Risk of Abuse through Female Genital Mutilation’, and the current London Child Protection Procedures.

The SOP provide an overview of FGM, describe risk groups and give step-by-step instructions for police working on FGM cases. They describe the procedures to be taken into consideration with regard to a girl at risk of FGM, a girl already subjected to FGM and an adult woman that has undergone FGM.

The Police Service of Northern Ireland (PSNI) recently launched their ‘Service Procedure: Police Response to Female Genital Mutilation’ (2011), which provides the policies and procedures in relation to the PSNI response to FGM and refers to the 2003 UK Female Genital Mutilation Act.

Finally, as briefly discussed earlier, the issue of gynaecological check-ups for girls and women, which are a key method for finding evidence and prosecuting offenders, needs a thorough ethical and legal debate. Routine gynaecological/medical screenings of girls to detect FGM cases are controversial, but have been proposed in some countries as a tool to increase the number of detected FGM cases, and consequently, the number of prosecutions.

If a case of suspected FGM has been reported, then evidence and statements must be gathered in order to advance a criminal investigation. The gynaecological/medical screenings of girls to detect FGM requires training and is contentious. If a case can then proceed, many steps must be taken: interviewing witnesses (if required); gathering evidence that can precisely indicate when and where the FGM took place (in jurisdictions with the principle of double incrimination or where extraterritoriality measures need to be applied) and finally persuading a girl to testify against her family and her community.

6.5. Provision of services

Provision of services refers to the services offered to women and girls who have undergone FGM as well as to women and girls at risk of FGM and their families. It also covers 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.

CSOs and health professionals are the leading actors involved with the provision of services across all EU Member States. Services provided by CSOs include awareness-raising among communities and the general public, advocacy initiatives and broad service delivery in relation to FGM. CSOs may also offer translation services, cultural mediation, and inter-agency referrals and are often involved in training a range of professionals on FGM.

Specialised health centres for women who have undergone FGM have been created in a few countries, such as Belgium, Italy, Sweden and the UK. These centres are usually multi-disciplinary, free of charge and may offer translation services. In France, several hospitals have set up multi-disciplinary teams to provide surgical repair of the clitoris and psychosexual counselling for victims of FGM. The focus of many of the specialised services is de-infibulation procedures for women victims of Type III FGM.

Overall, the main focus of service provision appears to be on gynaecological services often related to childbirth and de-infibulation. There is a lack of services providing psychological care, psycho-sexual support and counselling by professionals skilled in post-traumatic stress disorder, sexual trauma and sexual violence. Specialised, holistic health services for women and girls victims of FGM, which provide healthcare as well as psycho-social and sexual care, are not common. Most FGM medical services across EU Member States are provided through general medical care systems. Services may be only concentrated in larger urban centres leading to accessibility problems for some patients who may need to travel considerable distances for appropriate, knowledgeable care. The *ad hoc* nature of service provision and a lack of mainstreaming and institutionalisation of services for victims of FGM were noted in this study. Careful assessment and consideration is needed as to whether specialised health centres for FGM are necessary, cost effective and provide best care outcomes or whether it is preferable to train key professionals who can serve as treatment reference points in a country to provide adequate care within and across general health systems. This assessment will have to consider issues such as the preferences of women and girls affected by FGM (for example, some are reluctant to visit specialised centres because of fear of being identified), costs, patient outcomes, staff turnover, resources and training available.

Box 6.5.1. Manual for professionals (Belgium)

The manual 'Female Genital Mutilation (FGM): Manual for relevant professionals' (2011) was published by the Belgian federal authorities responsible for health, protection, food and environment, and was developed by a committee of experts including doctors, gynaecologists, psychologists, midwives, nurses, researchers, lawyers, etc. The development was coordinated by GAMS Belgium, a CSO which works with communities where FGM is practised and advocates ending FGM. The manual targets all professionals in Belgium that may be confronted with victims of FGM. It aims to help professionals understand the socio-cultural context of FGM, to better support families, to offer medical and psychological support to women who have undergone FGM and to contribute to the development of measures to prevent FGM.

Box 6.5.2. Children's House (*Barnhusen*) (Sweden)

The Swedish Children's House (*Barnhusen*) provides services for children and teenagers under the age of 18 who have been subjected to sexual assault, violence and/or abuse, including FGM. They consist of a comprehensive partnership between the Swedish prosecuting authorities, health care and social services and provide facilitation of police investigation and prosecution, as well as medical examinations. There are 22 Children's Houses currently operating in Sweden in several cities, including Malmö, Linköping, Stockholm, Göteborg, Uppsala, Umeå and Sundsvall. Children's Houses pursue the aim of providing to child victims help and support from all relevant professional groups simultaneously and in the same institutional setting.

**Box 6.5.3. INTEGRA: an international partnership working against FGM**

The INTEGRA-Network was founded by the German Society for International Cooperation GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH) in 2000. The INTEGRA-Network currently has 30 members, including organisations and individuals working to eradicate FGM in Germany and in African countries. The aim of the Network is to bring together actors working against FGM to enhance impacts of the work, learn from each other and to act as a reference point for the state when it plans measures or policies on FGM. Members of the Network meet twice a year in different locations in Germany.

Training for professionals is an important aspect of the provision of services. Training on FGM and its legal and health implications for women and girls is necessary for all sectors, but especially for health, social work, child protection, immigration and judicial sectors and the police.

Training, when it does occur, is usually by request and not on an ongoing or regular basis. The non-inclusion of FGM in the formal education curricula of health and other relevant professionals was noted in this study. A substantial number of guidelines, teaching tools, handbooks and manuals on FGM have been developed by a range of actors, sometimes working in collaboration to support service provision. However, proper assessment of the quality and effectiveness of these tools is missing.

As CSOs are a major service provider in relation to FGM, their lack of multi-annual funding, the often *ad hoc* nature of their service provision implementation and the constraints on the financial and human resources available to them are very problematic. CSOs are often exceptionally well-positioned to provide a link between community needs and services, such as healthcare, and to deliver the relevant training required for professionals to meet these needs. However, they may lack the resources to adequately do this.

Multi-agency partnerships also exist to provide services and to respond to protection concerns relating to FGM. These partnerships are usually made up of professionals employed by the state such as police, social workers, paediatricians and psychologists.

6.6. Actors, methods and tools

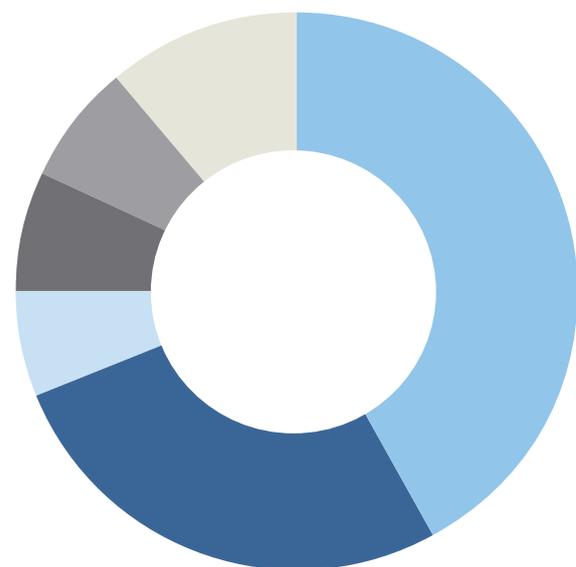
6.6.1. Number and profile of actors

Across the EU Member States and Croatia, the total number of identified actors who are working or have at some point taken action in their country on FGM is 507, and varies from zero (Estonia, Latvia and Slovenia) to 68 (the UK).

Looking at the type of actors, the largest category consists of civil society organisations (CSOs): 215 were identified, representing 42% of all listed actors. Considering the countries with a large number of actors, the share of civil society organisations is highest in Spain, where 22 of 33 actors are a CSO, and in Austria (18 of 32). The lowest number is in the Netherlands (seven of 43) and in Sweden (also seven of 28).

CSOs are followed by government bodies or departments including: ministries, agencies, regional government bodies, public health bodies, gender equality bodies and police, among others. Research institutes, professional as-

Graph 6.6.1. Type of actors working on FGM in the EU-27 and Croatia



Source: Data collected through the desk research until 5 February 2012

sociations and individual experts on FGM are other types of actors emerging in the study but in considerably lower numbers than CSOs and governmental bodies.

6.6.2. Approach to the work on FGM

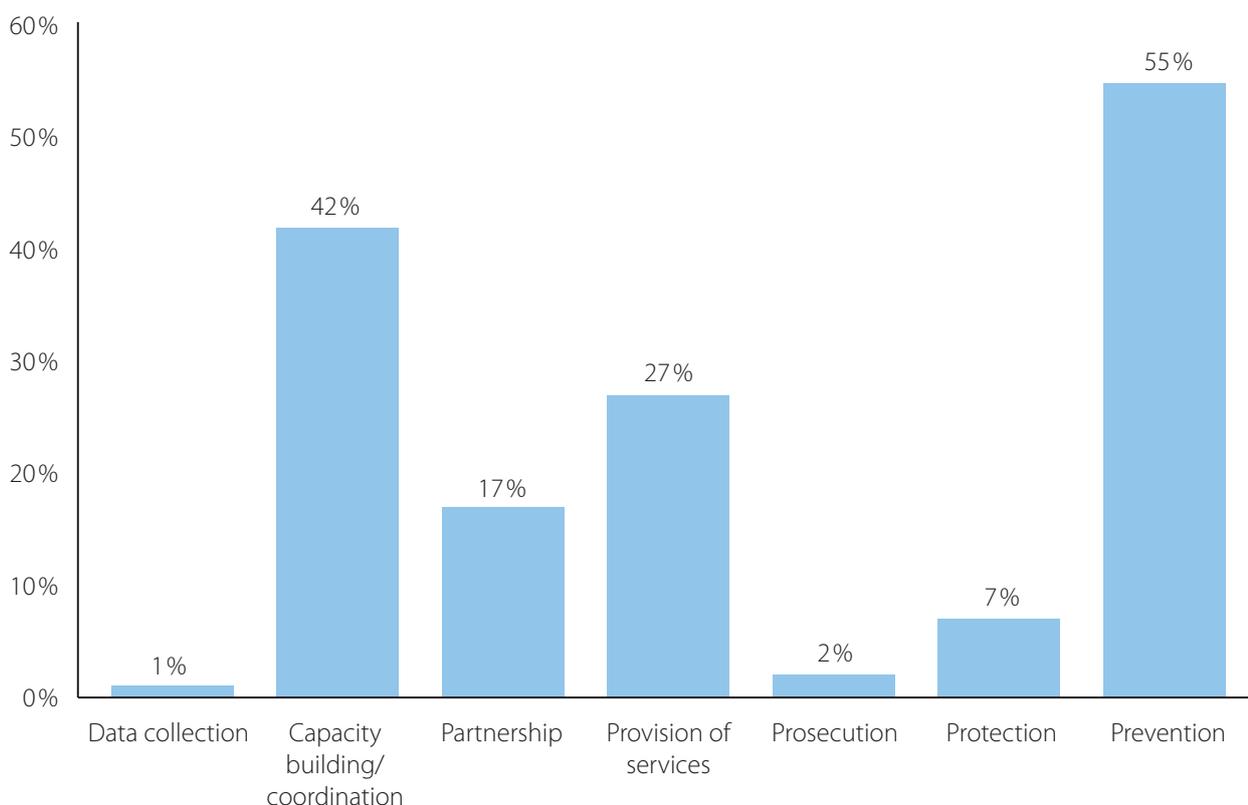
For nine per cent of the actors identified, work on FGM is their complete focus – either working towards the abandonment of the practice or towards the provision of healthcare for women and girls who have undergone FGM. Such organisations were found in ten countries (Austria, Belgium, Denmark, France, Germany, Italy, the Netherlands, Spain, Sweden and the UK).

As can be seen in the chart below, prevention of FGM appears to be the most common approach utilised by actors

in their work on FGM with more than half (55%) of actors identified as working on prevention. A capacity-building and coordination role emerged as the second largest focus of actors (42%) and this was usually seen as an activity of ministries and government bodies. Service provision was the third largest area of work for actors (27%) followed by partnership activities. Partnership structures that are formally organised and operate at a national level to work on FGM have been documented in Finland, Germany, Greece, Ireland, Portugal and Sweden. Partnerships are also formed between actors to enhance responses to cases of FGM, such as girls at risk of FGM, and these partnerships may be between CSOs and public bodies.

For only seven per cent of the actors, their FGM-related activities include the active protection of women and girls at

Graph 6.6.2. Areas of intervention of actors working on FGM in the EU-27 and Croatia*



* Each of these percentages is calculated out of the total number of actors working on FGM-related issues in the EU-27 and Croatia. One actor might be working on more than one area of intervention.

Source: Data collected through the desk research until 5 February 2012



risk (these organisations were most common in the Netherlands, France and Germany). Two per cent of the actors' work is related to prosecution and one per cent was identified as collating relevant data.

Finally, at EU and international level, a number of actors were identified. These include the EU, the European Commission, the European Parliament, EU agencies and the Parliamentary Assembly of the CoE and CoE Committees. International CSOs and UN organisations and committees, including the WHO, were also identified as actors, some of which are located in the EU.

Most FGM prevention work is done by CSOs and the task of changing deeply-rooted, long-established practices such as FGM is vast. Yet the supports and resources available to CSOs are very limited. To point out positive examples, Sweden, the Netherlands and Italy not only prioritised FGM prevention with budgets assigned, but also shared the work and finances with CSOs.

Partnerships have been developed at national level in some countries in response to the development of a NAP such as in: Finland, Germany, Greece, Ireland, Portugal and Sweden. Involvement of statutory bodies, migrant organisations and CSOs in such partnerships seems to be important to advance the implementation of NAPs on FGM.

Partnerships would benefit from an increased involvement of academic and research institutes studying FGM and research instruments and methods to evaluate their work and measure progress.

Some challenges noted in the study include the high turnover of people and organisations within partnerships. Consequently, institutional knowledge gaps can emerge due to a member or organisation leaving. This phenomenon also requires subsequent training for new members or even recruitment attempts to fill gaps in a partnership.

International partnerships also exist to respond to FGM and to act as experience exchange forums. Many of these were created and supported through Daphne projects, such as Euro-Net FGM based in Brussels. The END FGM European Campaign run by Amnesty International Ireland works with partner organisations in 14 EU countries.

6.6.3. Methods and tools

In this study, methods and tools were defined as manuals, toolkits, protocols, awareness-raising campaigns and materials, guidelines, conferences and seminars focused on FGM. Overall, 592 tools and instruments were documented in the study across 27 EU Member States and Croatia. The first trend that emerged is that the regions or countries with a longer history and larger number of migrants from Africa are those who have developed more tools on FGM. In general, the methods and tools collated appear to focus on FGM prevention and building the capacity of professionals to provide services for victims. Learning materials (170), public awareness-raising campaigns (125) and research (117) are the largest categories of methods and tools emerging in the study. Tools specifically targeted at communities that practise FGM, and at women and girls at risk of FGM are very limited. Graph 6.6.3.1 provides an overview of the number of methods and tools found relevant in each country.

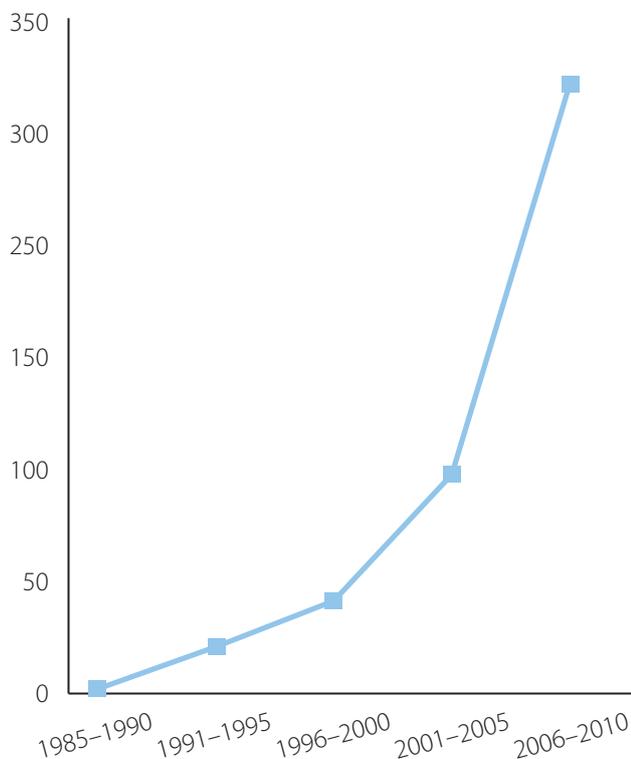
Secondly, and in consonance with the first finding, there was a notable boom of methods and tools issued in the period of 2006–2010 (more than 300 methods and tools were issued in this period) (see graph 6.6.3.1).

Thirdly, there seems to be a tendency across the majority of countries to intensify the development and publication of tools (except for Denmark and Sweden). The substantial growth of methods and tools issued in Austria, Finland, France, Ireland, Italy, the Netherlands, Portugal, Spain and the UK from 2001–2005 to 2006–2010 is particularly noteworthy; the number of tools released or published from one period to the next doubled.

Regarding the target groups addressed by the identified methods and tools, there are essentially 13 target groups, namely the general population, health professionals, other professionals, the scientific community, policy makers, ethnic groups with a tradition of FGM, migrants, asylum seekers, women and girls at risk of FGM, parents and families of groups at risk, FGM experts, university students, and young people.

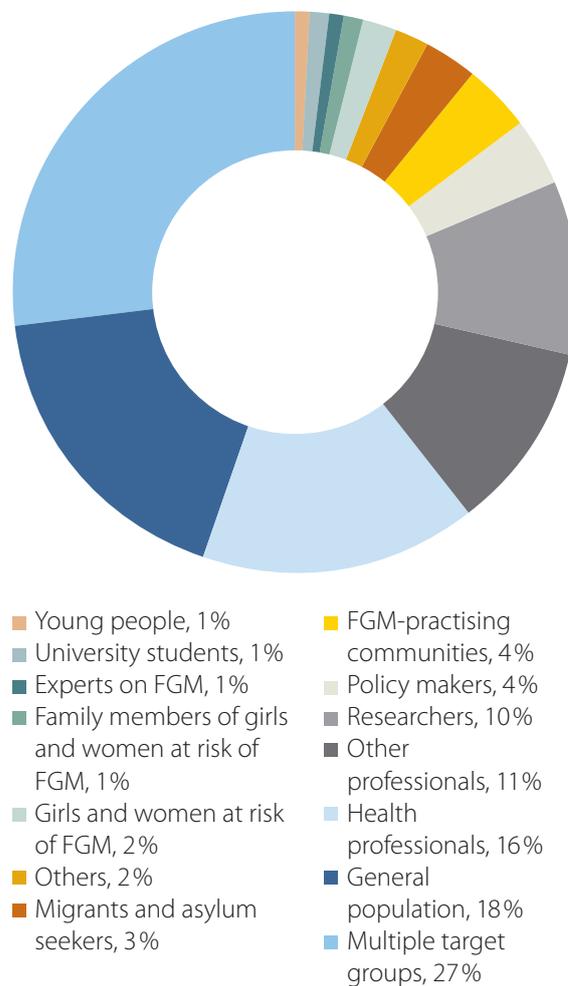
Approximately one-quarter of the methods and tools are aimed at multiple target groups. Nearly 20% of the methods and tools are targeted at the general population. The

Graph 6.6.3.1. Number of methods and tools on FGM in the EU-27 and Croatia (1985–2010)



Source: Data collected through the desk research until 5 February 2012

Graph 6.6.3.2. Target groups of FGM-related activities in the EU-27 and Croatia



health professionals are a significant target group of the sample of methods and tools. It is important to highlight the limited percentage of methods and tools developed to target FGM-specific groups, such as ethnic groups with a tradition of FGM (4%) and women and girls at risk and victims of FGM (2%). The countries that have developed methods and tools for these target groups are Austria, Belgium, Denmark, Finland, France, Italy, Malta, the Netherlands, Portugal, Sweden and the UK.

Methods and tools dealing with FGM that are most common in the EU-27 and Croatia are related to prevention, i.e. awareness-raising initiatives. Methods and tools aiming at prosecution and protection are more rare.

Tools to initiate, support, guide and evaluate partnerships in relation to FGM appear to be lacking. This is an issue that requires attention to optimise, support and enhance the growth of partnerships across EU Member States.



6.6.4. Academic literature

As part of the study, academic literature on FGM in the EU-27 and Croatia was collated and analysed.

The academic publications on FGM from Member States and Croatia take different approaches to FGM. The predominant theme of the literature collated discusses medical aspects of FGM, with a focus on reproductive health. Publications discussing socio-cultural, anthropological or ethnicity aspects of FGM are the second most common approach. These include academic papers providing background information on the practice of FGM and examine some of the following topics: types of FGM; prevalence; motives for the practice of FGM (such as religious, health, cultural, etc.); and consequences of FGM. These papers describe FGM as a traditional practice or provide information on customs, traditions and ethnicity. The third-largest category focuses on FGM from a legal perspective, describing national court cases; elaborating on the criminalisation of FGM; enumerating the pros and cons of either a general or specific criminal law approach to combat FGM; and discussing the implementation of legal provisions. Finally, the fourth-largest category approaches FGM from a human rights perspective, describing FGM as a violation of the right to physical and mental integrity, or considers FGM within the framework of violence against women. Overall, little empirical research, be it quantitative or qualitative, exists at EU Member State level. Academia could play an enhanced role in informing, supporting and evaluating work on FGM across the EU and in providing robust and comparable FGM longitudinal prevalence data.

been pointed out and appears to be essential to NAPs when it comes to ensuring leadership, funding and, ultimately, implementation at both a statutory level and a community level.

Multi-agency and multi-sectoral collaboration is to be encouraged as FGM involves and requires a range of actors, tools and skills for effective responses. Sharing knowledge and experiences and developing rapid inter-agency referral routes are other benefits of such partnerships.

It is important that training, resource allocation and promotion are part of any policy introduction and implementation package. Only then can the knowledge, familiarity and commitment of key actors and professionals be ensured. A lack of policies linked to child protection and international protection emerged in this study. A number of issues have been identified with regard to policy making, including to the lack of coordination within countries where relevant policies belong to the competencies of regional authorities and not the national authorities. This needs further examination, as it could create policy gaps whereby different regions within a single Member State offer unequal treatment, and girls in certain areas may be more at risk than others.

6.7. Concluding remarks

The development of a range of policies across multiple sectors in relation to FGM should be noted as a positive change. When developing national or regional policies, it is necessary to involve governmental agencies or bodies inside and outside of the EU, and to foster participation among migrant communities. Such collaboration has

7. Conclusions and recommendations: a comprehensive approach to FGM in the EU





7. Conclusions and recommendations: a comprehensive approach to FGM in the EU

EIGE's findings show that despite the EU's increasing commitment to combat female genital mutilation, significant gaps remain in the areas of data collection and monitoring; legislative and policy measures; support services; coordination; and intersectoral cooperation in the EU-27 and Croatia.

The European Commission's Daphne Programme has been instrumental for the development of a number of policies in the area of FGM, including NAPs in several Member States, as well as the creation of the European Network for the Prevention of FGM. The recently adopted Directive establishing the minimum standards on the rights, support and protection of victims of crime is an important instrument to support women and girls who are victims or who are at risk of FGM.

Thus, even though important steps have been taken, legislative measures and actions to combat FGM and support women and girls victims and at risk of FGM need to be strengthened. Research shows that to effectively combat FGM, the EU needs a more comprehensive approach which balances protection, prevention and prosecution. Furthermore, it is also important to work towards long-term behaviour change, involving FGM-practising communities, decision makers and stakeholders in their countries of origin.

This chapter presents the key recommendations in the area of data collection and monitoring; legislative and policy measures; support services and coordination; and intersectoral cooperation in the area of FGM. It also provides suggestions for further research.

Data collection and monitoring

EIGE recommends developing a common definition of FGM prevalence, ensuring its consistent use at national, regional, European and international levels and guaranteeing regular administrative and population-based data collection.

At present, information and data on FGM in the EU-27 and Croatia are fragmented and scattered. There are no EU-wide FGM prevalence estimates, and the existing national prevalence studies are not comparable. Administrative data relevant to FGM is neither systematically collected nor centrally stored.

The collection of data to estimate the prevalence of FGM is fundamental to targeted and evidence-based policy making and measures. Only accurate data can ensure that developed policies are relevant, proportionate and respond to the existing needs by mobilising adequate resources. Prevalence estimates are also necessary to assess progress made in tackling FGM. EIGE recommends also improving the collection of primary data and introducing further quantitative and qualitative analyses to better estimate the risk of FGM for second- and third-generation women and girls originating from FGM-practising countries, and to have better knowledge on how integration processes affect FGM practices in the EU.

EIGE's report also shows that data and information on the implementation, monitoring and evaluation of the effectiveness, adequacy and quality of policies aimed

at preventing and combating FGM are, to a large extent, non-existent or not accessible. To improve the effectiveness and implementation of legislative and policy measures, reliable mechanisms to monitor and evaluate policies need to be introduced at EU and Member State levels.

Specifically, possible measures at EU level would include: developing common, comparable indicators and reliable mechanisms to monitor and evaluate the implementation of policies and the support services provided to victims; developing common methodological tools and minimum standards for prevalence estimates and administrative data collection; and developing a 'country of origin information database', possibly through the European Asylum Support Office and in conjunction with other international organisations. Such a database should include information on the prevalence of FGM and threats towards and/or persecution of persons who oppose FGM.

Member States could contribute to a sound collection of data on FGM by including information related to FGM into national censuses, and by adapting administrative information systems to enable an effective and systematic collection of data on FGM. This might include the development of specific codes on FGM and of a central recording system of cases of asylum requested, granted and denied in relation to FGM. Finally, it is recommended that the statistical services are involved in centralising the collection and dissemination of data on FGM, and that access restrictions to data on FGM are assessed and removed where possible and necessary.

Legislative and policy measures

EIGE stresses the need for comprehensive and effective policies on FGM which should follow a gender-sensitive, human rights-based approach.

At EU level, the development of a strategic framework on violence against women, including FGM, could contribute to coherent and effective policy making on FGM. Within this framework, an EU action plan on FGM could be developed in order to earmark FGM-specific measures addressing issues of prevention, protection, prosecution, provision of services and partnership, in particular with community-based organisations.

At national level, strategies that address FGM as a form of gender-based violence and a violation of human rights, and point out clear objectives, milestones, actions, financial and human resources and responsible agencies for

tackling FGM, can provide a sound ground for the development of sustainable measures. EIGE recommends explicitly addressing FGM in national laws. At present, nine EU Member States have specific criminal laws on FGM. Other countries apply general national laws dealing with (serious) bodily injury, mutilation and removal of organs or body parts in cases of reported FGM. Better enforcement of the existing laws and policies is necessary to avoid impunity; currently only a marginal number of FGM cases are effectively brought to court.

In order to facilitate prosecution of FGM perpetrators, it is recommendable to remove the principle of double incrimination from national criminal laws. This would enable FGM to be punishable even when committed in the countries where it is not considered illegal. Furthermore, all EU Member States are recommended to recognise the principle of extraterritoriality.

In order to make prevention efforts effective, measures should aim at behaviour change, including those that ensure sustainability once the prevention scheme or projects ends. To date, however, most of the policies and measures aiming at the prevention of FGM focus on awareness-raising, rarely target FGM-practising communities and do not support long-term change.

Support services

EIGE recommends ensuring that the needs of women and girls victims and at risk of FGM are appropriately addressed within the framework of specialised services such as health services, women's and girls' shelters, helplines and counselling services, and guaranteeing sustainable funding for them. Barriers that may hinder women and girls who have undergone FGM from accessing these services should be removed.

General social and health systems should be adequately prepared to treat and assist victims of FGM. Specialised services which implement a gender-sensitive approach are especially well-suited to meet the specific needs of women and girls who are victims of violence, including FGM, and to support their recovery from trauma effectively. The specialised support services should provide safe accommodation, protection, healthcare, legal, psychological and employment counselling and social and financial support. Psychological support and counselling is of particular importance and should be available to all women and girls victims and at risk of FGM. It is also important to involve FGM-practising communities and build bridges between FGM-practising communities and specialised service providers.



At present, specialised services are insufficient and unequally distributed in and among the Member States. Funding to ensure access to services is similarly inconsistent. EIGE's study identified that healthcare systems must adequately address specific gynaecological and obstetric needs of women and girls victims of FGM.

Professionals who are in contact with girls and women at risk of FGM do not possess sufficient knowledge on FGM. They often fail to identify risks and fail to respond in an adequate, culturally sensitive manner. They are also not acquainted with legal provisions related to FGM. Making specialised training and awareness-raising on FGM for professionals mandatory and systematic is one of EIGE's key recommendations. Funds for this should be ensured.

It is of key importance that the effective implementation of the Directive establishing minimum standards on the rights, support and protection of victims of crime is ensured, especially with regard to the right to access victim support services and the training of professionals from various institutions that are in contact with FGM victims on the issue of FGM as a form of gender-based violence.

Coordination and intersectoral cooperation

EIGE's key recommendation in the area of coordination and intersectoral cooperation is implementing comprehensive and multiagency action plans on FGM addressing prevention, protection and prosecution, with a special focus on countries of origin and behaviour change within FGM-practising communities. At present, cooperation between stakeholders is insufficient and not coordinated effectively at the regional, national and international levels. Moreover, many actors, including FGM-affected communities living in the EU and countries of origin, are not actively involved in dialogues on FGM.

The collection, evaluation and exchange of good practices in data collection, protection, prosecution and service provision in relation to FGM in Member States can further support the development and implementation of more effective policy measures and instruments on FGM across the EU. The establishment of a network of experts and key actors on gender-based violence, including FGM, could contribute to coordinated and well-informed decision making on FGM.

EIGE also recommends recognising and supporting financially the role of CSOs as crucial actors in awareness-raising, exchange of good practices and advocacy for the eradi-

tion of FGM. To ensure this, it is recommended to acknowledge the need for projects in the area of FGM within a framework of specific funding specifically for initiatives which tackle violence against women and girls, among others, in the Fundamental Rights and Citizenship Programme, as stated in the Commission's actions to implement the Strategy for Equality between Women and Men.

At present, awareness-raising campaigns on FGM often face difficulties in reaching migrant groups. Including information on FGM in a broader framework of education on gender equality and gender-based violence to be introduced in formal education can be a promising way of reaching children and their parents from FGM-practising communities.

Further research and public debate needed

In order to develop appropriate and effective policy measures on FGM, further debates still need to be conducted on a number of issues. These debates should involve all types of stakeholders, including FGM-practising communities and CSOs working on FGM. Additionally, some questions require further research.

As FGM is such a nuanced, multifaceted issue, it is important to carefully consider how FGM data and initiatives may be used and misused for a variety of political or ideological purposes, including racist and anti-immigrant discourse. Such abuse of information should be prevented.

Further research is needed in order to assess the extent and circumstances of FGM practised on girls and women living in the EU during trips to their or their parents' country of origin. Such assessment requires a sound analysis of the situation related to FGM in the respective countries of origin.

As pointed out above, combating FGM and protecting girls and women at risk of FGM who reside in the EU require international and transnational cooperation. Forms of dialogue and cooperation with governments of countries where FGM is practised, as well as with stakeholders within these countries, should be evaluated and further developed. The cooperation with these stakeholders may involve, amongst others, the development of instruments to protect women and girls at risk of FGM.

An issue of particular controversy are the routine gynaecological screenings of girls supposedly at risk of FGM. Such

screenings have been proposed, and in some countries introduced, as a means to increase the reporting of FGM; to gather evidence for prosecution; and to protect girls at risk of FGM. A comprehensive debate should be conducted with FGM-practising communities, CSOs and professionals dealing with FGM on the potential harm to the intimacy and dignity of the girls, as well as the potential ethnic discrimination that these screenings may entail. In addition, questions related to the practicability of such screenings need to be discussed. A thorough debate involving experts and communities affected by FGM is needed on how to handle asylum requests based on the fear of FGM in a gender-, culture- and child-sensitive manner. Determining procedures to assess the credibility of claims is crucial.

With its assessment of the situation regarding FGM in the EU-27 and Croatia, providing an analysis of effective measures and remaining challenges, this report has contributed to filling the gaps in knowledge about FGM in Europe, and can support the development of a comprehensive approach to combating FGM in the EU.



Annexes





Annexes

Annex I: Methodology of the study

In the framework of this study, six aspects that are highly relevant to FGM were researched: the prevalence of FGM in the EU-27 and Croatia^{xxvii}; the prevention of FGM; the protection of girls and women at risk; the prosecution of persons found guilty of practising FGM; the provision of services to victims of FGM; and partnerships between actors involved in the fight against FGM.

The methodological approach followed in this study consisted of a desk study and an in-depth phase.

The first part of the study, the desk study, started in December 2011 and ran until April 2012. A pool of native-speaking researchers performed the national desk research in the 27 EU Member States and Croatia (in 24 different languages), searching academic databases and institutional websites for material relating to prevalence data, the legal and policy framework on FGM, relevant actors and methods and tools on FGM. The researchers also contacted key institutions and individuals to confirm the collected data and to get more detailed information.

In order to ensure the consistency of the approach across the countries, the researchers were provided with templates for the compilation of data and for the country reports, as well as with comprehensive guidelines for the national data collection. These guidelines featured, amongst others, a detailed checklist and a description of inclusion and exclusion criteria clarifying the type of data and information considered to be relevant for the scope of this study.

Inclusion criteria

The researchers were recommended to collect material relevant to FGM in each country (in English and local language), including:

- data and information available from 1980 onwards;
- reports, presentations and articles by civil society organisations, the health sector, the social sector, government agencies and others;
- texts of law on FGM, resolutions, protocols;
- codes of conduct;
- manuals for professionals;
- toolkits;
- guidelines for professionals by professional organisations or other agencies;
- national action plans;
- national surveys and studies;
- papers by academics.

Exclusion criteria

The following documents were recommended to be excluded from national research:

- documents on sexual and gender-based violence in general (except when these refer explicitly to FGM);
- studies that do not concern Europe or a specific European country (EU-27 and Croatia);
- documents published before 1980;
- newspaper and magazine articles.

In line with the inclusion and exclusion criteria, two types of information were accepted as exceptions:

- In case of inexistence of academic literature in a country, newspaper and magazine articles were accepted.

- Comparative studies between countries which were not the focus of the researchers' search could be included in the database of methods, tools and resources on FGM.

Following the experience of telephone briefings scheduled with each national researcher, the core team prepared a document with frequently asked questions that was then provided to the pool of researchers. In addition, a helpdesk function was established in order to assist the national researchers during the desk research.

Based on the results obtained during the desk research, the researchers issued analytical reports of their desk studies, resulting in 28 country reports that provided detailed insights into the situation of FGM in the respective country. Furthermore, a country fact sheet was developed for each EU Member State and Croatia.

In addition to the national research, a desk study mapping the existing international and European information and data on FGM was performed. This desk study addressed the same themes as the national data collection, consisting mostly of Web-based desk research performed by the core team following the same guidelines as the national researchers and by using the same templates to compile the collected information. The research focused on material written in the past three decades (in order to assess trends) and relevant to FGM in Europe. Material focusing on only one European country was excluded from the international analysis, as this was covered by the national desk studies.

After mapping, collecting and analysing the national data identified in the EU-27 and Croatia, nine countries – France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the UK – were selected for a qualitative in-depth study which was undertaken between the end of May 2012 and mid-September 2012. The in-depth study aimed at assessing successes and challenges in the work on FGM in these nine countries and at EU level, and at establishing past and present good practices in relation to prevention, protection, prosecution, provision of services and partnerships.

The countries for the in-depth study were selected based on indicators developed by the core team. These indicators included the existence of prevalence studies; a national action plan on FGM; and specific criminal law provisions

in a country. Additional criteria included the existence of a high number of actors working on FGM and FGM-related methods, tools and academic publications, as well as good practices on FGM that were identified in the respective country during the desk research.

The EU level perspective was also included in this in-depth study phase.

This in-depth phase consisted of at least six in-depth semi-structured interviews in each of the nine countries conducted by native-speaking researchers, and five in-depth interviews at European/international level performed by a member of the core team. Comprehensive guidelines instructed the researchers about their fieldwork, and were adapted after a pilot was performed in France to test the methodological approach. All national researchers attended a central briefing on the methodology that took place on 23 June 2012 in Antwerp, Belgium, and were provided with a provisional list of most of the potential key informants.

The majority of the key informants were governmental officials and members of CSOs. Several other representatives of different public institutions departments (in the areas of health, child and youth protection, equality, victims' protection, sexual violence, justice and immigration) also participated in the in-depth study phase. For the interviews conducted at European and international level, the European Commission, the Council of Europe, the United Nations and international CSOs collaborated in the study.

Based on a standard set of questions to all the interviewees, and taking into account the specificities of each interview, the national researchers drafted a customised questionnaire for each interview which was reviewed by the core team.

Key informants in all interviews were asked to describe key actions on FGM in their country. Using the criteria outlined in EIGE's action plan of good practices, the national researchers then selected the most promising practices and outlined them in the country reports.

The interviews were conducted from June to August 2012 at national and European level. On average, the total interview time was 76 minutes. After each interview, the researchers were required to produce a detailed summary based on recordings and their notes.

**Table 1.1. Overview of the key informants' profiles at national level**

| Profile of key informants | Total | Countries |
|---|-------|--------------------------------|
| CSO representatives | 13 | DE, FR, IE, IT, NL, PT, SE, UK |
| Governmental officials and representatives | 7 | ES, FR, IE, IT, NL, PT |
| Child and youth protection department representatives | 5 | ES, FR, NL |
| Health public department representatives | 5 | IE, NL, PT, SE |
| FGM network representatives | 4 | DE, IT, NL, SE |
| Justice officials (lawyers and judges) | 3 | DE, FR, IT |
| Academic professors | 3 | ES, IT, SE |
| Police department or school representatives | 3 | PT, SE, UK |
| Victims' protection department representatives | 2 | DE, ES |
| Sexual violence public department representatives | 2 | UK |
| Medical doctors with expertise on FGM | 2 | IT, UK |
| Research institute representatives | 2 | ES |
| Immigration public department representatives | 1 | SE |
| Justice public department representatives | 1 | NL |
| Equality body representatives | 1 | PT |
| Individual activists | 1 | IE |
| Journalists | 1 | PT |

After conducting the interviews, analytical reports were drafted by the researchers based on the information collected during the fieldwork and other sources of information (e.g., the country reports produced in the desk research phase, as well as Web-based research). In these reports, milestones in policy development related to FGM were highlighted; the key actors involved were identified; successes and challenges of the policy approaches were examined; good practices were highlighted; and policy lessons and recommendations were developed. A quality control of all analytical reports was undertaken by the core team, and subsequently a comparative analysis was done of the nine country reports and the EU/international report.

In the course of the study, two experience exchange meetings were organised.

The first experience exchange meeting took place in Paris on 1 June 2012 and focused on measuring the prevalence of FGM. This meeting aimed at exchanging experiences regarding estimations of prevalence of FGM in the EU, and at discussing a common framework for estimating prevalence in the EU.

The second experience exchange meeting took place in London on 13 September 2012 and focused on selecting good practices in prevention, protection, prosecution, provision of services and partnership from the practices with potential outlined in the country reports. This meeting was designed to debate and share ideas about how to best

fight against FGM in the EU; present examples of approaches relating to the five areas mentioned above; explore the transferability of certain approaches across countries or contexts; and promote policy learning and networking.

Both meetings brought together a significant number of experts and representatives from different Member States (13 and 25, respectively, excluding EIGE's staff and research team members of the study) in order to exchange experiences and foster discussion about the six areas addressed within the framework of this study.

Challenges

Due to the limited time that was available, the national data collected during the desk study may not be fully exhaustive, particularly for countries where the volume of data and information on FGM is very significant (Austria, Belgium, Germany, Spain, France, Italy, the Netherlands, Sweden and the UK). Similar restrictions were experienced by the researchers during the in-depth study phase.

Since the scope of the study was defined as comprising the 27 Member States and Croatia, publications, actors, methods and tools dealing with FGM outside these countries, notably in relation to the countries where FGM is commonly practiced, were excluded from the mapping exercise. This exclusion limits the possibility to analyse how external policies, especially development policy, have influenced or are influencing the policy agenda on FGM inside the EU and Croatia.



Annex II: Tables for Chapter 2

Table 2.1. Estimated number of female applicants aged 14–64 potentially affected by FGM in EU–27 Member States (2011)

| EU Member State | Total female applicants aged 14 to 64 from FGM-risk countries | Estimated number of female applicants aged 14 to 64 affected by FGM | Estimated % of female applicants aged 14–64 affected by FGM out of the total female applicants from FGM-risk countries to each EU MS | Estimated % of female applicants aged 14–64 affected by FGM out of the total female applicants from FGM-risk countries to the EU |
|-----------------|---|---|--|--|
| Belgium | 1,380 | 945 | 68.5 % | 6.54 % |
| Bulgaria | 5 | 5 | 100.0 % | 0.03 % |
| Czech Republic | 10 | 6 | 60.0 % | 0.04 % |
| Denmark | 55 | 29 | 52.7 % | 0.20 % |
| Germany | 1,250 | 733 | 58.6 % | 5.08 % |
| Estonia | 0 | 0 | 0.0 % | 0.00 % |
| Ireland | 65 | 29 | 44.6 % | 0.20 % |
| Greece | 395 | 156 | 39.5 % | 1.08 % |
| Spain | 190 | 65 | 34.2 % | 0.45 % |
| France | 2,820 | 1,597 | 56.6 % | 11.06 % |
| Italy | 2,665 | 1,092 | 41.0 % | 7.56 % |
| Cyprus | 40 | 27 | 67.5 % | 0.19 % |
| Latvia | 10 | 2 | 20.0 % | 0.01 % |
| Lithuania | 0 | 0 | 0.0 % | 0.00 % |
| Luxembourg | 10 | 4 | 40.0 % | 0.03 % |

| EU Member State | Total female applicants aged 14 to 64 from FGM-risk countries | Estimated number of female applicants aged 14 to 64 affected by FGM | Estimated % of female applicants aged 14–64 affected by FGM out of the total female applicants from FGM-risk countries to each EU MS | Estimated % of female applicants aged 14–64 affected by FGM out of the total female applicants from FGM-risk countries to the EU |
|-----------------|---|---|--|--|
| *Hungary | 15 | 15 | 100.0% | 0.10% |
| Malta | 285 | 207 | 72.6% | 1.43% |
| Netherlands | 990 | 798 | 80.6% | 5.53% |
| *Austria | 235 | 176 | 74.9% | 1.22% |
| Poland | 15 | 1 | 6.7% | 0.01% |
| *Portugal | 30 | 19 | 63.3% | 0.13% |
| Romania | 5 | 1 | 20.0% | 0.01% |
| Slovenia | 5 | 5 | 100.0% | 0.03% |
| *Slovakia | 15 | 15 | 100.0% | 0.10% |
| *Finland | 110 | 81 | 73.6% | 0.56% |
| Sweden | 2,010 | 1,716 | 85.4% | 11.88% |
| UK | 1,830 | 1,085 | 59.3% | 7.51% |
| EU TOTAL | 14,440 | 8,809 | | |

* Data for these countries is based on 'Asylum Applicant' not 'New Asylum Applicant' as this information was not available in Eurostat

Source: UNHCR (2012) *Female Genital Mutilation and Asylum in the European Union: A Statistical Overview (provisional)*



Table 2.2. Overview of prevalence studies in the EU (2004–2012)

| Country | Title of the study | Data sources used | Year of publication | Disaggregation of data | Commissioned by | Performed by |
|----------------|--|---|---------------------|---|--------------------|--------------------|
| Belgium | Belgian legislation regarding female genital mutilation and the implementation of the law in Belgium | <ol style="list-style-type: none"> 1) Foreign female population in population register of National Office of Statistics on 1 January 2002 (includes foreigners who obtained Belgian nationality) 2) Female population in the foreigners register on 1 January 2002 (foreigners who received permission to reside in Belgium for more than 3 months, but who did not obtain Belgian nationality) 3) WHO prevalence figures of 2001 (WHO (2001) Female Genital Mutilation. A Teacher's Guide) | 2004 | Age, country of origin and 5 most affected cities | Research institute | Research institute |
| | Estimating the number of women with FGM in Belgium | <ol style="list-style-type: none"> 1) Registered births in families from FGM risk countries in the registers of Child & Family from the French-Speaking Community (French Community) (children aged 0–5 years born between 1998 and 2007 to women from countries from FGM-practising countries; includes only live births) 2) Registered births in families from FGM risk countries in the registers of Child & Family from the Dutch-speaking Community (Flemish Community) 3) Foreign female population in population register of National Office of Statistics (includes foreigners who obtained Belgian nationality) on 1 January 2008 4) Study from Federal Agency for the Reception of Asylum Seekers of 2009 (female asylum seekers from FGM-practising countries, excluding all girls born after 1 January 2008) 5) DHS and MICS published 31 May 2010 | 2011 | Age, country of origin and most affected cities/regions | Ministry of Health | Research institute |

| Country | Title of the study | Data sources used | Year of publication | Disaggregation of data | Commissioned by | Performed by |
|----------------|---|--|--------------------------------|---|--------------------|--------------------|
| Germany | Statement of Terre des Femmes e.V. – 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' on 19 September, 2007 | 1) Population census data, year not specified 2) DHS and WHO prevalence data, year not specified | 2007 | Not specified | Not specified | CSO |
| Ireland | FGM: Information for Health-Care Professionals Working in Ireland | 1) 2006 population census (female migrant population from FGM-practising countries) 2) Most recent DHS, MICS and WHO prevalence studies | 2008 | Age, country of origin | AkiDwA | AkiDwA |
| Ireland | Press release: International Day of Zero Tolerance to FGM 2011 | 1) 2006 Population Census (female migrant population from FGM-practising countries) 2) Data from Office of Refugee Applications Commissioner (asylum seeking women from FGM-practising countries from April 2006 to August 2010) 3) Most recent DHS, MICS and WHO prevalence studies | 2011 | Country of origin | AkiDwA | AkiDwA |
| Ireland | Not yet available | 1) 2011 Population Census (female migrant population from FGM-practising countries) 2) Most recent DHS, MICS and WHO prevalence studies | 2013 (forthcoming publication) | Not yet available | AkiDwA | AkiDwA |
| France | Quantitative chapter of the 'FGM and disability' project, and evaluation of the needs in surgical repair | 1) Study of Family Trajectories (supplement to population census 2004) 2) DHS surveys (year not specified) | 2007 | Age, country of origin, educational level, professional background, date of arrival in France | Ministry of Health | Research institute |



| | | | | | | |
|----------------|--|--|------|---|--|---|
| Italy | Guidelines Ministry of Health | 1) 2006 Population Census (female migrant population from FGM-practising countries) 2) DHS and UNICEF data (year not specified) | 2007 | Age, country of origin (only for Veneto region) b) Country of origin, province and municipality of residence | Ministry of Health | Ministry of Health |
| Italy | a) FGM and Human Rights in migrant communities. Report of the Research in the Veneto and Friuli Venezia Giulia Regions b) FGM in the Lazio Region. Experiences by and knowledge of professionals, women and migrant communities | a) 2006 Population Census (female migrant population from FGM-practising countries) for two regions: Veneto region and Friuli Venezia Giulia region (country of origin prevalence data, source not specified) b) 2006 Population Census (female migrant population from FGM-practising countries) in Lazio Region (country of origin prevalence data, source not specified) | 2009 | Department of Equal Opportunities | a) CSOs b) Consortium of research institutes, CSOs and others | Research institute |
| Italy | Quantitative and Qualitative Evaluation of the FGM Phenomenon | 1) 2008 Population Census (female migrant population from FGM-practising countries) 2) Female population with residence permits from FGM-practising countries on 1 January 2008 3) DHS and WHO prevalence data (year not specified) | 2009 | Age | Department of Equal Opportunities | Research institute |
| Hungary | FGM prevalence in Hungary – estimation | 1) Number of persons residing in Hungary with a residence permit from countries where FGM is practised as of 31 December 2008 (by Institute for Ethnic and National Minority Studies of the Hungarian Academy of Sciences and ICCR-Budapest) 2) Number of female refugees between 2001 and 2011 with the citizenship of countries where FGM is prevalent (Office of Immigration and Nationality) 3) Number of women granted temporarily protected status in the past five years from countries where FGM is practised (Hungarian Helsinki Committee) | 2012 | None | MONA Foundation for the Women of Hungary | Lea Kőszeghy (independent researcher) and MONA Foundation |

| Country | Title of the study | Data sources used | Year of publication | Disaggregation of data | Commissioned by | Performed by |
|-----------------------|--|---|---------------------|------------------------|--------------------|--------------------------------------|
| | | 4) Number of women from countries where FGM is practised residing at one of the reception centres (at the time of the study, 2011, the Office of Immigration and Nationality and the Békés county police) 5) WHO | | | | |
| Netherlands | Not specified yet | 1) Population Census data (year not specified) 2) Country of origin prevalence (not specified) | 2012 | Not specified yet | Ministry of Health | Research institute – Focal point FGM |
| United Kingdom | A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales | 1) 2001 Population Census (female migrant population from FGM-practising countries) 2) DHS and MICS data; other sources for countries where no DHS is available | 2007 | Country of origin | CSO | CSO and research institutes |

Source: Data collected through the desk research, January 2012



Table 2.3. Overview of other studies and assessments of the practice of FGM in the EU-27 and Croatia (2000–2012)

| Country | Type of study | Title of the study | Methodological approach of the study | Disaggregation of data | Performed by | Commissioned by | Year of publication |
|-----------------|--|--|--|-------------------------------|--|--|---------------------|
| Belgium | Survey among health professionals | Female genital mutilations, better understand them to better respond to them | Survey among 132 midwives and gynaecologists to assess experiences with FGM among their patients (response rate 42%) | None provided | Institut St Julienne Liège (Ms Thesis Midwifery) | Research institute | 2003 |
| Belgium | Survey among health professionals | Female genital mutilation: Knowledge, attitudes, and practices of Flemish gynaecologists | Questionnaire survey was sent to 724 Flemish gynaecologists and trainees to assess their knowledge, attitudes and practices with regard to FGM (response rate 46%) | Country of origin of patients | Research institute | Research institute | 2008 |
| Belgium | Assessment of registered births | Data on registered births in the French Community | Counting registered births in families originating from FGM-practising countries in French Community | None provided | Office de la Naissance et de l'Enfance | Office de la Naissance et de l'Enfance | 2007 |
| Belgium | Survey among health professionals | Beliefs, traditions and deliveries of medical care | Survey among 254 members of the GGOLFB (gynaecologists and obstetricians) to assess their experiences with FGM among their patients | None provided | Groupement des gynécologues obstétriciens de langue française de Belgique (GGOLFB) | Groupement des gynécologues obstétriciens de langue française de Belgique (GGOLFB) | 2007 |
| Belgium | Assessment of prevalence of FGM in reception centres | Excised women or women at risk of excision in the Belgian reception structure | Extrapolation of prevalence rates of countries where FGM is practised to female population in reception centres originating from those countries | Country of origin | Federal Agency for the Reception of Asylum Seekers | Federal Agency for the Reception of Asylum Seekers | 2009 |
| Bulgaria | Not applicable | | | | | | |

| Country | Type of study | Title of the study | Methodological approach of the study | Disaggregation of data | Performed by | Commissioned by | Year of publication |
|-----------------------|---|--|--|---|---|---------------------|---------------------|
| Czech Republic | Not applicable | | | | | | |
| Denmark | Counting numbers of women | Female immigrants and descendants in Denmark originating from countries where FGM is performed, disaggregated by country of origin and age | Counting number of female migrants from countries where FGM is practised, disaggregated by country of origin and age | Country of origin, age | National researcher | National researcher | 2011 |
| Denmark | Counting numbers of girls at risk | Female migrants at risk from FGM countries | Counting numbers of females at risk of FGM, disaggregated by country of origin and age | Country of origin, age | National researcher | National researcher | 2011 |
| Denmark | Counting numbers of female asylum seekers | Female asylum seekers from FGM risk countries | Counting numbers of female asylum seekers from countries where FGM is practised | Country of origin | National researcher | National researcher | 2011 |
| Germany | Counting female population | Survey on FGM | Counting numbers of women and girls at risk (< 15 years) in Germany from FGM-practising countries | Country of origin, age | Terre Des Femmes | Terre Des Femmes | 2005 |
| Germany | Survey among health professionals | Cuts in Body and Soul: A Survey on the Situation of Circumcised Girls and Women in Germany | Survey among gynaecologists in Germany on their experiences in working with women who have undergone FGM | FGM among patients (type, requests for performance) | UNICEF, Terre des Femmes, Berufsverband Frauenärzte | Not specified | 2005 |



| | | | | | | | |
|----------------|---|---|--|---|--|--|------|
| Germany | Survey among FGM-practising communities | Listening to African Voices: Female Genital Mutilation/Cutting among Immigrants in Hamburg: Knowledge, Attitudes and Practice | Literature review and three-month field study targeting immigrants from sub-Saharan Africa residing in Hamburg; interview based on a questionnaire with 685 women and 1082 men originating from 26 sub-Saharan Countries | Country of origin, age and support for practice | Plan International Germany | Not specified | 2011 |
| Estonia | Not applicable | | | | | | |
| Ireland | Not applicable | | | | | | |
| Greece | Not applicable | | | | | | |
| Spain | Counting numbers of women | Building a map of female genital mutilation in Spain | Counting numbers of female population in Spain originating from 28 countries where FGM is practised; data from three sources: the Ministry of the Interior, the Yearbook on Migrations 2000 and the Institute of Statistics of Catalonia | Country of origin, age, autonomous region | Universidad Autónoma de Barcelona – Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices | Universidad Autónoma de Barcelona – Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices | 2002 |
| Spain | Counting numbers of women | Map of Female Genital Mutilation in Spain 2006 | Counting numbers of female population in Spain originating from 29 countries where FGM is practised; data from the Padrón (Spanish register of population per municipality) | Country of origin, age, autonomous region | Universidad Autónoma de Barcelona – Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices | Universidad Autónoma de Barcelona – Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices | 2006 |

| Country | Type of study | Title of the study | Methodological approach of the study | Disaggregation of data | Performed by | Commissioned by | Year of publication |
|---------------|-----------------------------------|---|--|---|--|--|---------------------|
| Spain | Counting numbers of women | Map of Female Genital Mutilation in Spain 2009 | Counting numbers of female population in Spain originating from 29 countries where FGM is practised; data from the Padrón (Spanish register of population per municipality) | Country of origin, age, autonomous region | Universidad Autónoma de Barcelona – Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices | Universidad Autónoma de Barcelona – Interdisciplinary Research Group for the Prevention and Study of Harmful Traditional Practices | 2010 |
| Spain | Counting numbers of women | Female Genital Mutilation in Andalusia: Analysis and Proposals | Counting female population in Andalusia originating from 29 countries where FGM is practised; data from the National Statistics Institute and the Permanent Andalusian Observatory of Migrations | Country of origin, age | María Luisa Grande and María Hernández | María Luisa Grande and María Hernández | 2011 |
| France | Survey among health professionals | Preventive actions and medical screening of FGM and their potential medical complications in general practice | Quantitative survey among 152 general practitioners in eastern districts of Paris to assess prevention, screening, examination, diagnosis and abuse-reporting practices with regard to FGM (response rate: 32 %) | Gender of general practitioners | Doctoral thesis in general medicine | Doctoral thesis in general medicine | 2007 |



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|---------------|---|--|--|--|---|--|------------------------------------|
| France | Survey among health professionals | Evaluation of the needs in surgical repair (part of the prevalence study 'Quantitative chapter of the FGM and disability project') | For the evaluation of FGM consequences and needs in surgical repair, collection of data in 74 public medical centres in Paris region and 4 other regions with highest rates of populations at risk; 2,882 valid questionnaires collected during gynaecology consultations in day care centres and hospitals (714 mutilated women over 18 and 2,168 non-mutilated women over 18 from FGM risk countries); interviews lasted 60 min on average | Country of origin in relation with age at which FGM was performed | Research Institute | Ministry of Health | 2007 |
| France | Survey among health professionals | Regional survey on violence against women in the Pays de la Loire region | Over a period of one month, previously trained obstetricians and midwives in 24 selected maternity wards in the Pays de la Loire region filled out on a daily basis a database indicating: number of births/number of parturients from FGM risk countries/number of mutilated parturients/types of FGM | Country of origin, type of FGM and educational level of health professionals | Gynécologie sans frontières | Groupement régional de santé publique des Pays de la Loire | 2009 |
| France | Counting cases of asylum granted | OFPPRA Annual Activity Report, 2009 | Counting numbers of female asylum seekers, stateless persons and refugees from FGM-practising countries; claiming subsidiary protection in France on grounds of FGM | Country of origin | Office Français de Protection des Réfugiés et Apatrides | Office Français de Protection des Réfugiés et Apatrides | 2009 |
| France | Counting cases of asylum granted | OFPPRA Annual Activity Report, 2010 | Counting numbers of female asylum seekers, stateless persons and refugees from FGM-practising countries, claiming subsidiary protection in France on grounds of FGM | Country of origin | Office Français de Protection des Réfugiés et Apatrides | Office Français de Protection des Réfugiés et Apatrides | 2010 |
| France | Counting female population originating from FGM countries | National Census data | Counting numbers of migrants residing in France (born as foreigners in a foreign country, including people who became French citizens since) and foreigners (people holding another citizenship than the French one, except multiple citizenships) | Country of origin | Institut National de la Statistique | Institut National de la Statistique | 2004, 2005, 2007, 2008, 2010, 2012 |

| Country | Type of study | Title of the study | Methodological approach of the study | Disaggregation of data | Performed by | Commissioned by | Year of publication |
|----------------|------------------------------------|--|---|------------------------|---|-----------------------------------|---------------------|
| Croatia | Not applicable | | | | | | |
| Italy | Survey among various professionals | a) FGM and Human Rights in migrant communities. Report of the Research in the Veneto and Friuli-Venezia Giulia Regions | a) Semi-structured interviews and focus groups with 21 professionals to assess attitudes regarding gender roles, opinions about FGM, opinions about Law 7/2006 and its implementation, and professional experiences with (potential) victims of FGM | Not specified | a) CSOs | Department of Equal Opportunities | 2007 |
| Italy | Survey among various professionals | b) FGM in the Lazio Region. Experiences by and knowledge of professionals, women and migrant communities | b) Questionnaire sent to 420 Healthcare and 702 sociocultural professionals and cultural mediators in 8 regions to assess knowledge of FGM and the Law 7/2006, experiences with FGM; 33 opinion leaders from migrants' CSOs and cultural mediators to assess persistence of FGM among migrant communities in the Lazio Region | | b) Consortium of research institutes, CSOs and others | | |
| Italy | Survey among various professionals | Quantitative and Qualitative Evaluation of the FGM Phenomenon | In-depth interviews with medical doctors; cultural mediators and women's CSOs' activists | Not specified | Research institute | Department of Equal Opportunities | 2008 |
| Cyprus | Not applicable | | | | | | |
| Latvia | Not applicable | | | | | | |



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|--------------------|------------------------------------|---|--|---------------|-------------------------|--------------------|------|--|
| Lithuania | Not applicable | | | | | | | |
| Luxembourg | Not applicable | | | | | | | |
| Hungary | Not applicable | | | | | | | |
| Malta | Not applicable | | | | | | | |
| Netherlands | Survey among various professionals | 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 | Written questionnaire to 807 respondents (professionals/schools/organisations) in Amsterdam and 173 in Tilburg | Not specified | Commission Fighting FGM | Ministry of Health | 2005 | |
| Netherlands | Survey among health professionals | Retrospective survey on the prevalence of FGM or female circumcision among mid-wives in 2008 | Retrospective survey by sending questionnaire to 478 respondents in midwifery practice. Respondents were asked about the number of circumcised women they had dealt with in 2008 (response rate 93%) | Not specified | TNO | Ministry of Health | 2009 | |

| Country | Type of study | Title of the study | Methodological approach of the study | Disaggregation of data | Performed by | Commissioned by | Year of publication |
|--------------------|---|--|--|------------------------|-----------------|---|---------------------|
| Netherlands | Counting numbers of women | FGM/C situation analysis in European countries. Discussion paper for expert meeting. The Hague, the Netherlands, 12 and 13 September 2011; personal e-mail from M. Exterkate on 24 January with an update for 2011 | Counting numbers of women from FGM-practising countries, from website of National Bureau of Statistics | Country of origin, age | FGM Focal Point | FGM Focal Point | 2011 |
| Austria | Survey among FGM-practising communities | A study of female genital mutilation in Austria: the use of FGM among migrants in Austria | Qualitative and descriptive cross-sectional study: The study is based on an anonymous questionnaire with closed and open questions, sent to 250 African migrants (130 female and 120 male) from Burkina Faso, Somalia, Sudan, Ethiopia, Egypt, Kenya, Nigeria, Mali, Senegal, Ghana and Sierra Leone | Country of origin | Not specified | Federal Ministry for Health and Women, Austrian Medical Association, UNICEF | 2000 |
| Austria | Survey among health professionals | Genital mutilation in Austria: A survey among gynaecologists, paediatricians and hospital staff | 250 questionnaires were sent to 130 public hospitals with departments of gynaecology and obstetrics and/or departments of children and adolescent medicine, collecting information on FGM among patients of 415 gynaecologists and paediatricians (response rate 52%) | Country of origin | Not specified | Federal Ministry for Health and Women, Austrian Medical Association, UNICEF | 2006 |



| | | | | | | | |
|-----------------|---|--|---|------------------------------------|--|--|------|
| Austria | Survey among health professionals | Female genital mutilation: What knowledge do doctors have about it? | Study among gynaecologists, paediatricians and midwives to assess their experiences with FGM (response rate 13%) | Country of origin, age of patients | Austrian Institute for Child Rights and Parent Education | Austrian Platform against FGM, Vienna Women's Health Programme | 2006 |
| Austria | Assessment of number of asylum requests | Asylum Statistics 2011 | Counting of number of asylum applications from female population of FGM countries; data sources were Foreigner Information System (FIS) and Asylum Information System (AIS) | None provided | Ministry for Internal Affairs | Ministry for Internal Affairs | 2011 |
| Poland | Not applicable | | | | | | |
| Portugal | Not applicable | | | | | | |
| Romania | Not applicable | | | | | | |
| Slovenia | Not applicable | | | | | | |
| Slovakia | Not applicable | | | | | | |
| Finland | Not applicable | | | | | | |
| Sweden | Survey among health professionals | Prevalence of female genital mutilation among African women resident in the Swedish county of Ostergötland | Questionnaire and clinical examination of African women in Ostergötland | Not specified | Kangoum, A.A.; Flodin et al. | Not specified | 2004 |
| Sweden | Survey among health professionals | Female genital mutilation – an exported medical hazard | Questionnaire and clinical examination in an African immigrants organisation | Not specified | Elgaali, M.; Strevens, H.; Mårdh, P.A. | Not specified | 2005 |

| Country | Type of study | Title of the study | Methodological approach of the study | Disaggregation of data | Performed by | Commissioned by | Year of publication |
|-----------------------|---|--|--|------------------------|-----------------|-----------------|---------------------|
| Sweden | Survey among health professionals | Swedish healthcare providers' experience and knowledge of female genital cutting | Questionnaire to professionals in the healthcare sector (gynaecologists, midwives, paediatricians, school nurses, school physicians) | Not specified | Tamaddon et al. | Not specified | 2006 |
| United Kingdom | Survey among FGM-practising communities | Not specified yet | Quantitative method: online survey for males and females from FGM-practising communities between 16–25 years of age; qualitative method: focus group discussions | Forthcoming | FORWARD | FORWARD | 2012 |

Source: Data collected through the desk research, January 2012



Annex III: Tables for Chapter 4

Table 4.1. Overview of Daphne projects concerning FGM

| Year | Project leader | Title |
|------|---|---|
| 1997 | International Centre for Reproductive Health (ICRH) | Towards a consensus in Europe regarding FGM. Inventory and international workshop on legal, medical and socio-cultural aspects surrounding traditional female circumcision practices as applied in the European Union |
| 1999 | International Centre for Reproductive Health (ICRH) | Establishing a European Network for the prevention of FGM |
| 2000 | Consorzio Aurora | Female Genital Mutilation (FGM) – Awareness-raising, training and information for General Practitioners – None touches Eve |
| 2001 | Finnish Red Cross | Development of community methods in order to prevent the mutilation of Somali girls' and women's sexual organs |
| 2001 | GAMS France | FGM in Europe – Seminar, training, guide |
| 2001 | Centro Piemontese di Studi Africani | Instruments to Develop the Integrity of Lasses |
| 2002 | African Women's Organisation in Vienna | Development and production of a FGM teaching kit and the training of community/religious leaders, women and other communicators on its use |
| 2002 | International Centre for Reproductive Health (ICRH) | Evaluating the impact of existing legislation in Europe with regard to FGM |
| 2002 | Municipality of Rome | Stop all FGM: a European strategy |
| 2003 | International Centre for Reproductive Health (ICRH) | FGM – Building on experiences and results from the early past – Basic IEC tool |
| 2003 | GAMS Belgium | Female genital mutilation (FGM) and forced marriage – A comic for young people |
| 2004 | Somali Women's Organisation Denmark | FGM – Empower ethnic women through new creative & artistic ways |
| 2006 | International Centre for Reproductive Health (ICRH) | Towards an improved enforcement of FGM legislation in Europe: dissemination of lessons learned and capacity building of actors in the legal and paralegal field |
| 2006 | European Network for the Prevention and Eradication of Harmful Traditional Practices, in particular female genital mutilation (EuroNet-FGM) | Developing national plans of action to eliminate FGM |
| 2008 | Coventry University | Researching FGM: Intervention Programme linked to African Communities in the EU |

Source: Data collected through the desk research, January 2012

Annex IV: Tables for Chapter 5

Table 5.1. Overview of criminal laws to prosecute FGM in the EU-27 and Croatia

| LEGAL PROVISIONS | Total | BE | BG | CZ | DK | DE | EE | IE | EL | ES | FR | IT | CY |
|--|-------|----|----|----|----|----|----|----|----|----|----|----|----|
| Criminal law to prosecute FGM: | | | | | | | | | | | | | |
| * specific | 10 | 1 | | | 2 | | | 3 | | 4 | | 5 | 6 |
| * general | 18 | | | | | | | | | | | | |
| Principle of extraterritoriality foreseen: | 23 | | | | | | | | | | | | |
| * victim is a citizen or a resident in the country | 11 | | | | | | | | | | | | |
| * offender is a citizen or a resident in the country | 13 | | | | | | | | | | | | |
| * offender is a foreigner | 1 | | | | | | | | | | | | |
| * victim is a minor | 3 | | | | | | | | | | | | |
| * offender found on the territory | 8 | | | | | | | | | | | | |
| * competence of the court | 1 | | | | | | | | | | | | 13 |
| * categorised offence ¹⁴ | 1 | | | | | | | | | | | | |
| * double incrimination | 8 | | | | | | | | | | | | |
| * depending on bilateral agreements | 1 | | | | | | | | | | | | |
| Implementation of the law | 6 | | | | | | | | | | | | |
| No of court cases | 41 | | | | 1 | | | | | 6 | 29 | 2 | |

Source: Data collected through the desk research, January 2012

- 1 In 2001, a specific criminal law provision on FGM was adopted. Article 409 of the Penal Code prohibits all forms of FGM, ranging from clitoridectomy to infibulation. The criminal offence consists of the performance of FGM, the participation, the facilitation and the attempt to perform it. The consent of the victim does not affect the legal qualification of the act. The commitment of the offence against a minor is considered as an aggravating circumstance that increases the penalty. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country.
- 2 Since 2003, there has been a specific criminal law provision concerning FGM, namely section 245a of the Penal Code. The law is applicable to any procedure that involves removing parts of the female external genital organs (clitoridectomy, excision, infibulations) whether or not this happens voluntarily or by force. 'Attempt to' and 'participation in' are covered by the general provisions of the Danish Code of Criminal Law whereas 'performance' is inscribed in the specific law. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country.
- 3 Since April 2012, there has been a specific criminal law provision concerning FGM, namely the Criminal Justice (Female Genital Mutilation) Act 2012. Any defence of customary of ritual reasons for FGM is not acceptable under this Act; neither can a girl ever consent to FGM. The penalties under the Act are up to 14 years in prison and/or a fine of EUR 10.000. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country. The offences of aiding, abetting, counselling or procuring for the commission of FGM are provided for in the Irish general criminal law acts.
- 4 Since 2003, Spain has had a specific criminal law provision on FGM. The Organic Act 11/2003 on concrete measures in the field of citizens' security, domestic violence and social integration of aliens amended article 149 of the Penal Code, now stating that: 'Anyone who causes another person to suffer any form of genital mutilation shall be punishable by imprisonment between six and twelve years. In case the victim is a minor or an incapable, it will be applicable the withdrawal of parental authority, custody or foster care for a period from four to ten years' if the judge deems it appropriate to the best interest of the minor or incapable. The consent of an adult woman to the mutilation of her genitalia does not affect the legal qualification of the act, however it reduces penalties. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country.
- 5 Since 2006, there has been a specific criminal law provision concerning FGM (Law No 7/2006). Articles 583 bis and 583 ter of the Penal Code prohibit the performance of all forms of FGM, including clitoridectomy, excision, infibulation and any other practice causing effects of the same kind, or causing mental or physical illness. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country.
- 6 In 2003, a specific criminal law provision on FGM was adopted. Article 233A of the Penal Code prohibits FGM, being defined as the cutting or any other mutilation of the major lip (labia majora), the minor lip (labia minora) or the clitoris of a woman's genitalia. The consent of the victim does not affect the legal qualification of the act. Upon court decision, the principle of extraterritoriality may be applicable, making FGM punishable even if it is committed outside the borders of the country.
- 7 In 2001, a specific criminal law provision was adopted through Article 90 of the Penal Code, declaring that nobody can agree to a mutilation of her/his genitals causing a lasting impairment of sexual sensation. The criminal offence consists of the performance, the participation and the attempt to perform the mutilation. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country.
- 8 Since 1982, FGM has been specifically prohibited in Sweden. This rule is primarily contained in the Act Prohibiting the Genital Mutilation of Women (1982:316). According to the wording of the Act, an operation may not be carried out on the outer female sexual organs in order to mutilate them or bring about some other permanent change in them, regardless of whether consent has been given for the operation. Those attempting to perform or preparing/conspiring to commit the offence of female genital mutilation are punishable, as is a party who fails to report female genital mutilation. The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country.
- 9 Since 1985, FGM has been specifically prohibited in the United Kingdom. The rules were set out in the Prohibition of Female Circumcision Act which was replaced in 2003 by the Female Genital Mutilation Act. According to this Act, it is prohibited to carry out, aid or abet any form of FGM, including excision, infibulation or mutilation in relation to the whole or any part of the labia majora, labia minora, prepuce of the clitoris, the clitoris or vagina. In Scotland, similar prohibitions are set out in the Prohibition of Female Genital Mutilation Act (2005). The principle of extraterritoriality is applicable, making FGM punishable even if it is committed outside the borders of the country.
- 10 The specific criminal law entered into force on 1 January 2013.
- 11 The principle of extraterritoriality also applies if the victim has been a resident in Sweden.
- 12 The principle of extraterritoriality also applies if the offender has been a resident in Sweden.
- 13 Decision pertaining to court's competence.
- 14 The offence is categorised as 'inhuman and cruel treatment' or 'discrimination against specific groups' or 'persecution'.
- 15 Double incrimination applies if the offender is a foreigner.
- 16 Double incrimination applies if the offender is Polish.



Table 5.2. Duty to report per country and according to professional category in the EU-27 and Croatia

| Country | Doctors | Social workers | Teachers |
|----------------|---------------------------------|---------------------------------|---------------------------------|
| Belgium | | | |
| Bulgaria | X | X | X |
| Czech Republic | X | | |
| Denmark | X | X | X |
| Germany | | | |
| Estonia | X | X | X |
| Ireland | X (if working with children) | X (if working with children) | X (if working with children) |
| Greece | X | | X |
| Spain | X | X | X |
| France | X | X | X |
| Croatia | X | X | X |
| Italy | X | X (public body) | X (public body) |
| Cyprus | | | |
| Latvia | X | | X (state inspectors) |
| Lithuania | X | | |
| Luxembourg | | | |
| Hungary | X | X | X |
| Malta | | | |
| Netherlands | | | |
| Austria | X | (X) | |
| Poland | X | X | X |
| Portugal | X | X | X |
| Romania | X (legal medicine) | | |
| Slovenia | X | X | X |
| Slovakia | X | X | X |
| Finland | X | X | X |
| Sweden | X | X | X |
| United Kingdom | X | X | X |

X indicates a duty to report

Source: Data collected through the desk research, January 2012

Annex V: Tables for Chapter 6

Table 6.1. National action plans on FGM

| Country | Title (English) | Title (original) | Period covered | Issued by | Agency responsible for implementing the NAP | Budget specified |
|----------------|---|---|-------------------------|---|---|------------------|
| Denmark | The Danish Action Plan Against FGM | Den Danske Handlingsplan imod Omskaering af Kvinder | 2009–2010 | Somali Women's Organisation in Denmark | No | No |
| Germany | National Action Plan to Ameliorate the Situation of Women, victims of FGM and to Protect Girls at Risk in the Federal Republic of Germany | Nationaler Aktionsplan Zur Verbesserung der Situation von Frauen, die von weiblicher Genitalverstümmelung betroffen sind und zum Schutz gefährdeter Mädchen in der Bundesrepublik Deutschland | 2008 | Forward Germany, Terre Des Femmes, INTEGRA e.V. Network | No | No |
| Finland | Action Plan | Toimintaohjelma | To be published in 2012 | Ministry for Social Affairs and Health, in collaboration with Finnish League for Human Rights, National Institute for Health and Welfare and others | No | No |
| Ireland | Ireland's National Plan of Action to Address Female Genital Mutilation | Ireland's National Plan of Action to Address Female Genital Mutilation | 2008–2011 | CSOs and statutory agencies from various sectors gathered in the National Steering Committee | No | No |



| | | | | | | |
|-----------------|---|--|---------------|---|--|-------------------------|
| Greece | Greece National Plan of Action to Prevent and Eliminate FGM | Greece National Plan of Action to Prevent and Eliminate FGM | 2009 | Hellenic Sudanese Friendship League, Institute of Child Health, Greek Forum for Immigrants, United African Women Organisation, One Earth, Amnesty International, Advisor to the Mayor's Office on Immigration | No | No |
| Austria | National Action Plan for the Prevention and Elimination of FGM in Austria | Nationaler Aktionsplan zur Vorbeugung und Eliminierung von FGM in Österreich | 2009–2011 | African Women's Organisation | No | No |
| Portugal | I Programme of Action for the Elimination of FGM | I Programa de Acção para a Eliminação da Mutilação Genital Feminina | 2009–2010 | Secretary of State of the Presidency of the Council of Ministers – Jorge Lacão | Commission for Citizenship and Gender Equality | Not specified in report |
| Portugal | II Programme of Action for the Elimination of FGM | II Programa de Acção Para a Eliminação da Mutilação Genital Feminina | 2011–2013 | Council of Ministers | Commission for Citizenship and Gender Equality | Not specified in report |
| Sweden | National Action Plan Against FGM | Nationell handlingsplan mot kvinnlig könsstympning | 2003–on-going | | | |

Source: Data collected through the desk research, January 2012

Table 6.2. National action plans that address FGM among other issues

| Country | Title (English) | Title (original) | Period covered | Issued by | Responsible implementing agency(-ies) | Budget allocated | Reference to FGM |
|----------------|--|--|----------------|---|--|------------------------------------|--|
| Belgium | National Action Plan to fight Partner Violence and other forms of Interfamilial Violence 2010–2014 | Nationaal Actieplan ter Bestrijding van partnergeweld en andere vormen van intrafamiliaal geweld 2010–2014 | 2010–2014 | Ministry of Equal Opportunities | Institute for the Equality between Women and Men, representatives of federal and regional administrations and ministers and the expert group | No | FGM is specifically dealt with in a separate chapter with a set of measures to be taken |
| Ireland | National Intercultural Health Strategy 2007–2012 | National Intercultural Health Strategy 2007–2012 | 2007–2012 | Health Service Executive | No information currently available | No information currently available | It acknowledges the need for special care of women who have undergone FGM who are pregnant or in labour, and the need for training of staff; prioritises the roll-out of ethnic identifier |
| Greece | National Action Plan for Sexual and Reproductive Health 2008–2012 | Εθνικό Σχέδιο Δράσης για την Αναπαραγωγική και Σεξουαλική Υγεία 2008–2012 | 2008–2012 | Ministry of Health | No information currently available | No information currently available | Protection from FGM is recognised as one of the twelve sexual and reproductive rights in Greece |
| France | Twelve goals to achieve in fighting violence against women: Second global triennial action plan, 2008–2010 | Douze objectifs pour combattre les violences faites aux femmes. Deuxième plan global triennial, 2008–2010 | 2008–2010 | Ministry of Employment, Social Relationships and Solidarity | No information currently available | No information currently available | FGM is listed as a priority to tackle |



| | | | | | | | |
|--------------------|---|--|-------------|--|---|------------------------------------|--|
| France | Interministerial Plan to Fight Violence Against Women, 2011–2013 | Plan Interministériel de lutte contre les violences faites aux femmes, 2011–2013 | 2011–2013 | Ministry of Social Cohesion and Solidarity | National Committee for Fight Against Violence Women | EUR 288.500 | FGM is addressed under a specific chapter with a set of proposed measures |
| Croatia | National Policy for the Promotion of Gender Equality 2006–2010 | National politika za promicanje ravnopravnosti spolova 2006–2010 | (2003–2006) | Government Office for Gender Equality | Office for Gender Equality, Office for National Minorities, Ministry of Health and Social Welfare, CSOs | No information currently available | FGM is mentioned in the chapter on violence against women |
| Croatia | National Policy for Gender Equality 2011–2015 | Nacionalna politika za ravnopravnost spolova 2011–2015 | 2011–2015 | Government Office for Gender Equality | Office for Gender Equality, Office for National Minorities, Ministry of Health and Social Welfare, CSOs | Not specified | FGM is mentioned in the chapter on violence against women |
| Netherlands | Private Violence – Public Issue. A brief concerning the coordinated approach towards domestic violence; 2002–2008 | Privé Geweld – Publieke Zaak. Een nota over de gezamenlijke aanpak van huiselijk geweld; 2002–2008 | 2002–2008 | National Government | No information currently available | No | FGM is referred to as a form of domestic violence that needs specific policy |
| Netherlands | Note More Opportunities for Women. Emancipation Policy 2008–2011 | Nota Meer kansen voor Vrouwen. Emancipatiebeleid 2008–2011 | 2008–2011 | National government | No information currently available | No | FGM is referred to as a specific objective within equal opportunities policy, but detailed policy on FGM is referred to Ministry of Health |

| Country | Title (English) | Title (original) | Period covered | Issued by | Responsible implementing agency(-ies) | Budget allocated | Reference to FGM |
|-----------------|---|--|----------------|--|---------------------------------------|------------------------------------|--|
| Austria | National Action Plan on Children's Rights | Nationaler Aktionsplan für die Rechte von Kindern und Jugendlichen in Österreich | 2003 | Ministry for Social Security, Generations and Consumer Protection (BMSG) | No information currently available | No information currently available | FGM is specifically mentioned |
| Austria | National Action Plan for Integration | Nationaler Aktionsplan für Integration | Not specified | Not specified | Ministry for Internal Affairs | No information currently available | FGM is mentioned |
| Portugal | II National Plan Against Domestic Violence (2003–2006) | II Plano Nacional Contra a Violência Doméstica (2003–2006) | 2003–2006 | Presidency of the Council Ministers | No information currently available | No information currently available | FGM is referred to in the chapter on immigrant women, where it is stated that FGM will not be condoned by the government |
| Portugal | III National Plan for Equality – Citizenship and Gender (2007–2010) | III Plano Nacional para a Igualdade - Cidadania e Género (2007–2010) | 2007–2010 | Presidency of the Council of Ministers | No information currently available | No information currently available | FGM is mentioned in the chapter on gender-based violence, and the chapter on development cooperation |
| Portugal | I Plan for Immigrant Integration (2007) | I Plano Para a Integração dos Imigrantes | 2007–2009 | Presidency of the Council of Ministers | No information currently available | No information currently available | FGM is mentioned in the chapter on gender equality measures and the vulnerability of female immigrants |



| | | | | | | | |
|-----------------|---|---|-----------|--|------------------------------------|------------------------------------|---|
| Portugal | II Plan for Immigrant Integration (2010–2013) | II Plano Para a Integração dos Imigrantes (2010–2013) | 2010–2013 | Presidency of the Council of Ministers | No information currently available | No information currently available | FGM is mentioned in the chapter on preventing domestic violence and gender violence among immigrant men and women |
| Finland | Promotion of sexual and reproductive health. Action programme 2007–2011 | Seksuaali- ja lisääntymisterveyden edistäminen. Toimintaohjelma 2007–2011 | 2007–2011 | Ministry of Social Affairs and Health | No information currently available | No information currently available | FGM is mentioned and the NAP recommends counselling and care for victims |
| Finland | Action Plan to reduce Violence against Women | Action Plan to reduce Violence against Women | 2010–2015 | Ministry of Social Affairs and Health | No information currently available | No information currently available | FGM is mentioned in the chapter on Violence against ethnic minorities; a plan to develop a specific NAP on FGM is mentioned |
| Finland | Programme for Internal Security | Sisäisen turvallisuuden ohjelma | 2008 | Ministry of Internal Affairs | No information currently available | No information currently available | This programme specified that there is no need for special criminalisation of FGM, and recommends to focus on prevention of FGM in schools and healthcare |

| Country | Title (English) | Title (original) | Period covered | Issued by | Responsible implementing agency(-ies) | Budget allocated | Reference to FGM |
|-----------------------|---|---|----------------|-------------|---------------------------------------|------------------------------------|--|
| United Kingdom | Action Plan: Call to End Violence Against Women and Girls 2011–2015 | Action Plan: Call to End Violence Against Women and Girls 2011–2015 | 2011–2015 | Home Office | No information currently available | No information currently available | The action plan mentions FGM in sections on prevention, intervention and prosecution |

Source: Data collected through the desk research, January 2012



Table 6.3. International academic literature on FGM in the EU-27 and Croatia

| First author | Year | First author's country | Topics addressed |
|-----------------|------|------------------------|---|
| Elchalal | 1997 | Israel | <ul style="list-style-type: none"> ▪ Historical background ▪ Migrants in Europe (and US, other Western countries) ▪ Description of types of FGM ▪ Consequences |
| Richards | 2000 | US | <ul style="list-style-type: none"> ▪ Migrants in Europe (and US, Canada, Australia) ▪ Health professional confronted with FGM ▪ FGM as a multicultural issue ▪ Medical and cultural information |
| Oboler | 2001 | US | <ul style="list-style-type: none"> ▪ Migrants in Europe (and US) ▪ Programme approaches to eliminate FGM |
| Sala | 2001 | Italy | <ul style="list-style-type: none"> ▪ FGM as a multicultural issue ▪ Cultural rights versus human rights ▪ Nurses confronted with FGM |
| Morrone | 2002 | Italy | <ul style="list-style-type: none"> ▪ FGM as a form of violence ▪ Description of types of FGM ▪ Migrants in Europe ▪ Health professionals confronted with FGM ▪ Health education programmes |
| Essen | 2003 | Sweden | <ul style="list-style-type: none"> ▪ FGM as an illegal act in Nordic countries ▪ Studies done among Somali immigrants ▪ Intervention and information campaigns about providing care to women who have undergone FGM |
| Essen | 2003 | Sweden | <ul style="list-style-type: none"> ▪ Migrants in Europe ▪ FGM and its consequences ▪ Pregnancy complications ▪ Need for practice guidelines |
| Essen | 2004 | Sweden | <ul style="list-style-type: none"> ▪ Legislation applicable to FGM in Scandinavian countries ▪ Cosmetic genital surgery in Western countries ▪ Double morality in public discussions |
| Momoh | 2004 | UK | <ul style="list-style-type: none"> ▪ Migrants in Europe (and US, Canada, Australia) ▪ Health and social care professionals confronted with FGM ▪ Professionals feel ill-prepared to deal with the complex health needs and challenges related to FGM |

| First author | Year | First author's country | Topics addressed |
|--------------------|------|------------------------|--|
| Powell | 2004 | UK | <ul style="list-style-type: none"> ▪ Migrants in Europe as a heterogeneous group ▪ Specific health needs of women and girls who have undergone FGM ▪ Variation in responses to FGM across the EU (legislation, research, interventions) ▪ Need for a common agenda |
| Elgaali | 2005 | Sweden | <ul style="list-style-type: none"> ▪ Migrants in Europe (and other Western countries) ▪ Types of FGM found among migrant women in Scandinavia ▪ Complications encountered ▪ Attitudes concerning FGM |
| Momoh | 2005 | UK | <ul style="list-style-type: none"> ▪ Health professional confronted with FGM ▪ Advice for midwives to improve reproductive health and childbirth experiences of women subjected to FGM |
| Conroy | 2006 | UK | <ul style="list-style-type: none"> ▪ FGM as a traditional cultural practice ▪ Cosmetic genital surgery in Western countries |
| Leye | 2006 | Belgium | <ul style="list-style-type: none"> ▪ Migrants in Europe ▪ Healthcare response to FGM ▪ Need for a coordinated approach |
| Guine | 2007 | France | <ul style="list-style-type: none"> ▪ Migrants in Europe and other Western countries ▪ Policies and practices to fight FGM in France and the UK |
| Leye | 2007 | Belgium | <ul style="list-style-type: none"> ▪ Legislation applicable to FGM ▪ Implementation of legislation |
| Utz-Billing | 2008 | Germany | <ul style="list-style-type: none"> ▪ Description of types and geographical distribution of FGM ▪ Reasons for and consequences of FGM ▪ Medicalisation of FGM ▪ Specific laws that ban FGM in Europe (and other countries) |
| Jaeger | 2009 | Switzerland | <ul style="list-style-type: none"> ▪ FGM as an injury of external female genitalia for cultural reasons ▪ Migrants in Europe (and other Western countries) ▪ Description of types of FGM ▪ Possible complications ▪ Role of paediatricians in prevention |
| Leye | 2009 | Belgium | <ul style="list-style-type: none"> ▪ Migrants in Europe ▪ Legislation applicable to FGM ▪ Implementation of legislation on FGM |



| First author | Year | First author's country | Topics addressed |
|----------------------------|------|------------------------|---|
| Rogowska-Szadkowska | 2009 | Poland | <ul style="list-style-type: none">▪ Migrants in Europe▪ Health professionals confronted with FGM▪ Medical information |
| Johnsdotter | 2010 | Sweden | <ul style="list-style-type: none">▪ FGM as a traditional cultural practice▪ Cosmetic genital surgery in Western countries▪ Discrepancy in social attitudes |
| Kontoyannis | 2010 | Greece | <ul style="list-style-type: none">▪ Migrants in Europe▪ Health professionals confronted with FGM▪ Information on FGM |
| Krasa | 2010 | Germany | <ul style="list-style-type: none">▪ Migrants in Europe▪ Differences in the number of women affected by FGM across countries▪ Variation in legislative approaches |
| Abdulcadir | 2011 | Switzerland | <ul style="list-style-type: none">▪ Migrants in Europe▪ Health professionals confronted with FGM▪ Lack of knowledge▪ Information on FGM▪ Specific care needs▪ Pricking/nicking |

Source: Data collected through the desk research, January 2012

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Endnotes

- i Unless otherwise mentioned, the definitions provided below have been developed by the core team for the purpose of this study.
- ii The definition of 'girls at risk (of FGM)' as developed for the purpose of the study refers to minor girls (most commonly in the age range of 0–18 years) who have migrated from FGM risk countries, or were born to parents (or one parent) who originate from countries where FGM is practised.
- iii This is in line with the framework proposed by the European Parliament in its resolution of 5 April 2011 on priorities and outline of a new EU policy framework to fight violence against women (2010/2209(INI)), in which it identifies the following focus areas: policy, prevention, protection, prosecution, provision and partnership.
- iv The practice of medicalisation was condemned by the World Medical Association in 1993, and numerous other medical professional associations, including the International Federation of Gynaecology and Obstetrics (FIGO), as well as by international agencies, CSOs and governments (WHO, 2010).
- v Dubourg D, Richard F, Leye E, Ndame S, Rommens T, Maes S. (2011) Estimating the number of women with female genital mutilation in Belgium. *The European Journal of Contraception and Reproductive Health Care*.
- vi Andro A, Lesclingand M. (2007) Les mutilations sexuelles féminines: le point sur la situation en Afrique et en France. *Population & Société*, No 438.
- vii Terre des Femmes (2007) Statement of Terre des Femmes e.V. Human rights of women at the public hearing of the Committee on Family Affairs, Senior Citizens, Women and Youth on the subject "Fighting FGM" on 19 September 2007.
- viii Patel S. (2011) Press release: International Day of Zero Tolerance to FGM, Dublin.
- ix Istituto Piepoli S.p.A, Innovazione nelle Ricerche di Marketing (2009) Valutazione quantitative e qualitativa del fenomeno delle mutilazioni genitali in Italia (Quantitative and Qualitative Evaluation of the FGM phenomenon).
- x Dorkenoo E, Morison L, Macfarlane A. (2007) A statistical study to estimate the prevalence of female genital mutilation in England and Wales. Summary Report.
- xi Geographical Information Systems (GIS) integrate hardware, software and data for capturing, managing, analysing and displaying all forms of geographically referenced information, data and statistics. GIS allows the user to map quantities, map densities, analyse spatial relationships and visualise data and statistics in ways that reveal interactions and patterns. For more information see: http://epp.eurostat.ec.europa.eu/portal/page/portal/gisco_Geographical_information_maps/introduction.
- xii The Ethnic Identifier is a data collection tool used by the Irish Health Service Executive to collect information on patient ethnicity in various health care settings through its use on patient charts and admission forms. It is based on ethnicity questions from the 2006 and 2011 Irish censuses.
- xiii This is an FGM prevalence study based on the 'extrapolation-of-African-prevalence-data-method' but with additional qualitative research to assess the influence of migration on FGM.
- xiv See http://www.childinfo.org/files/fgmc_WHO-NICEFJointdeclaration1997.pdf.
- xv The Council of Europe policy documents include Reports, Recommendations, Resolutions and Opinions.



- xvi By 29 January 2013, only Turkey had signed and ratified the Council of Europe Convention, and there were 25 other signatures not followed by ratification. See <http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=210&CM=8&DF=14/01/2013&CL=ENG>.
- xvii See the website of the Daphne Programme for more detailed information: http://ec.europa.eu/justice/grants/programmes/daphne/index_en.htm.
- xviii Source: Interviews conducted in the framework of this study with European Commission officials.
- xix Disposizioni concernenti la prevenzione e il divieto delle pratiche di mutilazione genitale femminile.
- xx Offence considered as such in both States.
- xxi FGM is usually performed on minors, so that by the time the girls reach the age of majority, the crime (FGM) has already been time-barred.
- xxii European Network for the Prevention and Eradication of Harmful Traditional Practices (<http://www.euronetfgm.org/index.php>).
- xxiii In 1992, the Women's Rights and Equality Directorate at the Region Île-de-France (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, the PMI, health services, educational communities (rectorats), police officers of the Brigade de protection des mineurs, as well as individual experts. In the Île-de-France region, this built quite a functional policy network, which is coordinated by a public agency, and associates CSOs, State services and regional agencies.
- xxiv Position of the Cabinet regarding the advice on FGM from the RVZ, Letter P6/062.594.902, 2005.
- xxv Protected and able-bodied, inventory of care, aid and assistance for violence in dependent relationships – Kamerstukken II, vergaderjaar 2007–2008, 28345&22894, n°51.
- xxvi Cellules départementales de recueil et de traitement des informations préoccupante (CRIP) were established by the act No 2007-293 of 5 March 2007, reforming children's protection provisions. The CRIP implement an inclusive notion of "endangered children" which includes girls at risk of FGM.
- xxvii With regard to the prevalence of FGM, it is important to underline that the national researchers were instructed to collect secondary data. The timeframe and budget established for this study, along with ethical and methodological discussions around prevalence data collection on FGM, did not allow collecting primary data.

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