



FEMALE GENITAL MUTILATION IN MALTA

A RESEARCH STUDY

This publication has been produced with the financial support of the PROGRESS Programme of the European Union. The contents of this publication are the sole responsibility of the National Commission for the Promotion of Equality and can in no way be taken to reflect the views of the European Commission.

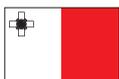
This publication is supported by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013).

This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe 2020 Strategy goals in these fields.

The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA-EEA and EU candidate and pre-candidate countries.

For more information see: <http://ec.europa.eu/progress>

The information contained in this publication does not necessarily reflect the position or opinion of the European Commission.



**FEMALE GENITAL
MUTILATION
IN MALTA**
A RESEARCH STUDY



CONTENTS

INTRODUCTION	7
LITERATURE REVIEW	8
The International Context	9
FGM in the European Union	11
FGM in Malta	13
FGM within a socio-cultural context	14
Health Implications of FGM	17
Different Complications per FGM Type	18
Immediate Complications	19
Long-term Complications	20
Pregnancy and Childbirth	20
Sexually Transmitted Diseases	21
Fertility	22
Sexual Impact	22
Cysts	22
Urinary Problems	23
Psychiatric Illnesses	23
Migrant Women: FGM in Western Healthcare	23
Training and Requirements for Healthcare Professionals	24
State of Knowledge and Research Gaps	27
THE LEGAL FRAMEWORK	29
THE INTERNATIONAL CONTEXT	29
NATIONAL LEGISLATION	30
Criminal Legislation	30
Victim Protection and Victims Rights	31
International Protection	31
RESEARCH RESULTS AND ANALYSIS	32
HEALTH CARE PROFESSIONALS	32
General Information	32
The training given related to FGM	33
Perception of FGM	34
Practical approach to FGM	36
Analysis and Discussion	40
PROTECTION PROFESSIONALS	41
General Information	41
Training given on FGM	41
Perception of FGM	42
Practical approach to FGM	43
ANALYSIS AND DISCUSSION	45
RESEARCHERS	45
General Information	45
Perception	46
Are girls at risk in Malta?	46
Who are the girls that would be most at risk in Malta?	47
How to deal with FGM in practice - The law	47
What can/needs to be done in Malta?	48
Analysis and Discussion	49

ASYLUM ENTITIES	50
General information	50
Types of gender based asylum claims in Malta	50
Asylum based on FGM in Malta	50
The concerns of people in the field with regards to FGM	51
Professional training on FGM	51
MIGRANT WOMEN	51
General information	51
Perceptions & Perspectives	52
The reasons for FGM	52
Should FGM be stopped?	53
Gender specific questions	54
Relations to demographic questions	54
MIGRANT MEN	54
General information	54
Perceptions & Perspectives	55
The reasons for FGM	55
The procedure of FGM	56
Role of education	57
Is FGM performed in Malta?	58
Should FGM be stopped?	58
Gender specific questions	59
Perceptions & Perspectives	59
Relations to demographic questions	60
PROMISING PRACTICES IN ADDRESSING FGM	61
PREVENTION	61
Female Genital Mutilation in Iraqi-Kurdistan	61
FGM-Free Communities Programme	61
Female Genital Mutilation Protection Orders	61
Igaddaa (We Do Not Want It Anymore)	61
Mapa de la Mutilación Genital Femenina en España	62
Petals	62
The Interdisciplinary Group for the Prevention and Study of Harmful Traditional Practices	62
Translation of National Laws and International Conventions	62
Vite in Cammino (Life on the move)	63
PROVISION OF SERVICE	63
Anti-FGM Training for Midwives	63
Anti-FGM Youth Champions	63
Female Genital Mutilation and its Management – Green-top Guideline No.53	64
Humanitarian Plastic Surgery	64
Hotline for FGM victims in the Middle East	64
Ketenaanpak (The Chain approach)	64
Mobile Women-Led Aid teams	65
Protocol for Personal Integrity	65
United to End Female Genital Mutilation (UEFGM)	65
PROSECUTION	66
Commission pour l’Abolition des Mutilations Sexuelles (Commission for the Abolition of Sexual Mutilations)	66

RECOMMEDATIONS	67
General Recommendations	67
Law Enforcement	67
Healthcare Professionals	67
Protection Professionals	68
Education Professionals	68
ANNEX 1 - REFERENCES	69
ANNEX 2 - INTERVIEWS – QUESTIONS KEY	72
INTERVIEW KEY 1: HEALTH CARE PROFESSIONALS	72
Demographic Questions	72
General Perceptions in Professions	73
Health and Professional Contact with FGM	73
National / Legal Context	73
Policy / Professional Policy	73
Education / Training	74
INTERVIEW KEY 2: ASYLUM ENTITIES	74
Perception of FGM in Asylum Claims	74
INTERVIEW KEY 3: MIGRANT MEN	74
Background Questions	74
Perceptions and Perspectives	75
Gender specific questions	75
INTERVIEW KEY 4: MIGRANT WOMEN	76
Background Questions	76
Perceptions and Perspectives	76
Gender specific questions	76
INTERVIEW KEY 5: EDUCATIONAL PROFESSIONALS	77
Demographic Questions	77
General Perceptions in Professions	77
Professional Contact with FGM	77
National / Legal Context	77
Policy / Professional Policy	77
Education / Training	78
INTERVIEW KEY 6: POLITICAL ENTITIES	78
INTERVIEW KEY 7: PROTECTION PROFESSIONALS	79
Demographic Questions	79
General Perceptions in Professions	79
Professional Contact with FGM	79
National / Legal Context	79
Policy / Professional Policy	79
Education / Training	80



INTRODUCTION

Female genital mutilation is a form of violence against women and a human rights violation. Combating it is a requirement under international law. At the international level much attention has been given to combating female genital mutilation at both the legal and policy level as well as on the practical level. In Malta little attention has been placed on the issue even if a number of important developments have indeed taken place.

Addressing FGM in Malta is relevant in a number of ways. First, individuals who have been cut are now in Malta and therefore use the Maltese health services. This means that doctors, nurses and other medical personnel frequently have to deal with the implications of and complications arising from FGM undertaken prior to the individual's arrival in Malta. Second, women and girls might be at risk of FGM whilst in Malta, and therefore the police and social services must be trained and prepared to deal with this situation when it arises whilst teachers and others should be aware of the issue in order to help identify individuals at risk. Over the last years Malta has come some way in this regard. Training has been offered to medical personnel by the migrant health unit, and criminal law provisions were introduced criminalising FGM as well as the willful failure to report it.

This is the first piece of research to provide in-depth analysis about the issue in Malta. Whilst the research aims to address a knowledge gap in the field, it must be taken into account that FGM is a multifaceted phenomenon that no one piece of research can fully address. The report also serves as an exploratory overview and identifies areas where further research is required. Some of these areas are outlined in the conclusions and recommendations section. The research also has a number of limitations including the short time frame in which it was carried out and the limitation as to the number of persons and entities that could be consulted. However, it goes a long way in providing a first analysis of the state of play, and a basis for further research on the issue. It also highlights some of the existing challenges in terms of awareness and knowledge of the issues that can be addressed through future measures including through training initiatives, sensitisation efforts and constructive engagement with communities at risk.

This report is structured as follows. Part I provides an overview of the literature on FGM. It focuses on the international, European and national context as well as on the health implications of FGM before reviewing the literature on the training of healthcare professionals. Finally, the review provides a number of country profiles focusing on countries of origin of migrants in Malta and in which FGM is a widespread phenomenon. Part II introduces the legal framework at the international, European and national level. It seeks to provide an introduction to the legal basis for action to combat FGM whilst at the same time acknowledging that the law is only a part of the framework in this regard. The relevant provisions from international and Maltese law are addressed with particular attention placed on the provisions in the Maltese criminal code introduced in 2014. Part III presents the findings from the qualitative research including both the focus group and interviews with stakeholders and communities at risk. Despite the small samples, a number of interesting observations emerge which provide insights into some of the challenges faced as well as opportunities for future measures to address FGM. Part IV presents promising practices from various countries on approaches to combat FGM. These practices could help inform the development, implementation and evaluation of measures in Malta. Part V concludes by identifying a number of running themes from the research and presenting a number of concrete and achievable recommendations.

LITERATURE REVIEW

FGM is a traditional practice having affected nearly 140 million women and girls worldwide¹. Considering the African continent alone, each year 3 million girls are at risk of the practice². The practice comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons³. It is generally performed when girls are between the age of 4 and 12, although in some cultures it is practised as early as a few days after birth or just prior to marriage. Typically, it is performed by traditional excisors, however in some countries it may be performed by professional doctors⁴.

The usage of the term 'Female Genital Mutilation' became a widely accepted reference to the practice from the late 1970's onwards by international institutions, human rights and women's health organisations as the variable 'mutilation' became seen as reflecting the 'gravity' of the practice as a violation of basic human rights⁵. Consequently, the term 'Female Genital Mutilation' remains in usage by the major international institutions such as the UN and its agencies, as well as by the EU^{6,7}.

The WHO has identified four main types of mutilation: clitoridectomy, excision, infibulation and "unclassified", the latter including all other kinds of harmful procedures realized for non-medical purposes as for example pricking, piercing, incising, scraping and cauterisation⁸. This kind of practice poses serious physical and mental health risks for women and young girls, especially for those who have undergone extreme forms of the procedure. They may experience long-term complications such as: problems urinating, cysts, infections, painful menstruation, infertility, sexual dysfunction, painful intercourse and blood-borne diseases (Hepatitis A, B, HIV/AIDS)⁹. Moreover, this kind of experience may lead women to avoid medical institutions and practitioners. According to a 2008 WHO study¹⁰, FGM can increase complications in childbirth and can also be linked to maternal deaths. The health complications of FGM will be discussed further in the third section of this paper.

- 1 Population Reference Bureau, Female Genital Mutilation/Cutting: Data and Trends Update 2014, 2. See <http://www.prb.org/pdf14/fgm-wallchart2014.pdf>
- 2 Feldman-Jacobs C. and Clifton D., Female Genital Mutilation/Cutting: data and trends, Population Reference Bureau, 2014, 2.
- 3 World Health Organization, (WHO), Eliminating female genital mutilation. An interagency statement, Geneva, 2008, 4.
- 4 UN Population Division, United Nations, World Population Prospects: The 2012 revision, Department of Economic and Social Affairs, Population Division, New York, 2013.
- 5 United Nations Populations Fund: Female Genital Mutilation (FGM) frequently asked questions, unfpa.org. Accessed September 22, 2015. http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#UNFPA_terminology.
- 6 Ibid.
- 7 When the practice first came to attention within the global scenario as a social phenomenon within its own right, the term 'female circumcision' was used to describe the act. However, the term became increasingly subject to criticism within the social sciences milieu as it was seen as 'obscuring' the physical and psychological consequences of partially or totally removing external female genitalia and/or causing other forms of injuries to the female genital organs for non-medical purposes. In the late 1990's, discourse on the practice also witnessed the mention of the term 'female genital cutting', as part of a movement to steer away from what was interpreted as 'demeaning' terminology towards the practising communities. However, as more states have outlawed the practice and an increased number of communities have expressed their commitment to do away with it, international attention has shifted again towards emphasizing the human rights dimension of the matter. See United Nations Economic and Social Council, (UNESCO), Ending female genital mutilation: Report of the Secretary-General, December 2011; World Health Organization, (WHO), Eliminating female genital mutilation. An interagency statement, Geneva, 2008, 3; United Nations Populations Fund: Female Genital Mutilation (FGM) frequently asked questions, unfpa.org. http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#UNFPA_terminology.
- 8 World Health Organization (WHO), Eliminating Female Genital Mutilation: An Interagency Statement, Geneva, 2008, 23:4.
- 9 Feldman-Jacobs C. and Clifton D., Female Genital Mutilation/Cutting: data and trends, Population Reference Bureau, 2014, 2.
- 10 World Health organization (WHO), "Female Genital Mutilation," Fact Sheet 241, Geneva, 2008.

THE INTERNATIONAL CONTEXT

FGM is reported to occur in all parts of the world but it is most practised in at least 28 countries in Africa and a few others in Asia and the Middle East. A study published by the Office of the United Nations High Commissioner for Refugees (UNHCR) enlisted the 28 African countries where FGM is practised, namely Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda and Yemen. The prevalence rate of FGM is almost universal (more than 85%) in seven countries, such as Djibouti, Egypt, Eritrea, Guinea, Mali, Sierra Leone, Somalia and Sudan, while a high prevalence rate (60 - 85%) of FGM practice is found in Burkina Faso, Ethiopia, Gambia and Mauritania. Countries such as Chad, Côte d'Ivoire, Guinea-Bissau, Liberia and Yemen are affected by a medium prevalence rate (30 - 40%) of FGM and a low prevalence rate (0.6 - 28.2%) has been found in Benin, Cameroon, Central African Republic, Ghana, Kenya, Niger, Nigeria, Senegal, Uganda, Tanzania and Togo. However, taking into consideration the FGM prevalence rate and the number of female applicants seeking asylum in Europe, it emerges that Somali, Eritrean and Guinea women and girls are likely to be the most affected by FGM.¹¹ The consequences for Europe will be discussed in the following subsection.

FGM is performed in all households regardless of social class, educational level or religious affiliation. Although the practice reflects deep-rooted inequality between sexes and constitutes an extreme form of discrimination against women, it also represents a form of social and cultural convention widely supported by both men and women. This is why it is usually difficult for the families to abandon the practice without having the support of the community. In fact, FGM is often performed even when it's known to inflict harm upon girls.¹²

It is believed that FGM is necessary in order to prepare a girl for her adulthood or marriage¹³ and that men will only marry girls who have undergone the procedure which is thought to preserve their virginity.¹⁴ In some cases FGM is performed as a ritual to allow girls to enter into women's secret societies; also, sometimes the girls themselves request to undergo the procedure as a result of social pressure and of fear of being marginalised. However, in most cases, FGM is thought to make girls "clean" and beautiful: the removal of the clitoris is thought of as the elimination of the "masculine" part, whereas infibulation is performed in order to achieve smoothness considered to be beautiful.¹⁵ Ultimately, some women believe that the practice can enhance men's sexual pleasure.¹⁶

11 UNHCR, "Female genital mutilation and asylum in the European Union", 27 February 2013.

12 UNICEF, "Female genital mutilation/female genital cutting: a statistical report", New York, 2005, p.14.

13 Cfr. Yoder P. S., *Female genital cutting and coming of age in Guinea*, Calverton, Macro International Inc., 1999; Ahmadu F., *Rites and wrongs: an insider/outsider reflects on power and excision*, in Shell-Duncan B., Hernlund Y., eds. *Female "circumcision" in Africa: culture, controversy and change*, Boulder, Colorado, Lynne Rienner, 2000, 283-312; Dellenborg L., *A reflection on the cultural meanings of female circumcision: experiences from fieldwork in Casamance, southern Senegal*, in Arnfred, S, ed., *Re-thinking sexualities in Africa*. Uppsala, Nordic Africa Institute, 2004, 79-98.

14 Cfr. Talle A., *Transforming women into "pure" agnates: aspects of female infibulation in Somalia*, in Broch- Due V., Rudie I., Bleie T., eds. *Carved flesh, cast selves: gender symbols and social practices*, Oxford, Berg, 1993, 83-106; Gruenbaum E., *Sexuality issues in the movement to abolish female genital cutting in Sudan*, *Medical Anthropology Quarterly*, Vol. 20, 2006, p. 121.

15 Cfr. Talle A., *Transforming women into "pure" agnates: aspects of female infibulation in Somalia*, in Broch- Due V., Rudie I., Bleie T., eds. *Carved flesh, cast selves: gender symbols and social practices*, Oxford, Berg, 1993, 83-106; Johansen R., *Experiencing sex in exile—can genitals change their gender?*, in Hernlund Y., Shell-Duncan B., eds. *Transcultural bodies: female genital cutting in global context.*, New Brunswick, Rutgers University Press, 2007, 248-277.

16 Almoth-Berggren V. et al., *Reinfibulation among women in a rural area in central Sudan*, *Health Care Women International*, Vol. 22, 2001, p. 711-721.

Although an ancient practice, it has gained attention from the governments, the NGOs, the international institutions and the national communities only recently.¹⁷ In 1979, in occasion of the WHO Seminar on Traditional Practices Affecting the Health of Women and Children, FGM appeared on the international agenda for the first time. In the same year the Hosken Report was released, which included the first ever estimates on FGM prevalence on a country-by-country basis, and the United Nations (UN) adopted the Convention on the Elimination of all forms of Discrimination against Women¹⁸ (CEDAW), which explicitly recognised practises harmful to women, such as FGM.

In 1990, the Organisation of the African Union (OAU) adopted the African Charter on the Rights and Welfare of the Child (ACRWC)¹⁹ which called upon the States to take appropriate measures to eliminate harmful social and cultural practices. However, only in 1993, during the World Conference on Human Rights held in Vienna, FGM has been classified as a form of violence against women and has been officially recognised as a health and human rights issue falling under the scope of international human rights law.²⁰ As a result global efforts have been made in legislation targeting excisors, medical professionals and families who perpetrate the practice.²¹

In 2002 the UN General Assembly, in its resolution on Traditional or Customary Practices affecting the Health of Women and Girls²², called upon all States to adopt national measures to prohibit practices such as FGM. This resolution was followed by the Maputo Protocol of the African Charter which called upon States to take measures to eliminate FGM and other traditional practices that are harmful to women. In 2008 the United Nations Children's Fund (UNICEF) launched the largest global programme on FGM and in 2012 the UN General Assembly passed the first resolution²³ calling on States to intensify efforts to eliminate FGM.

17 World Health Organization, (WHO), Female Genital Mutilation programmes to date: what works and what doesn't, Department of Reproductive Health and Research, Policy Brief, 2011, WHO/RHR/11.36

18 «For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field». UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, Art. 1. Available at: <http://www.refworld.org/docid/3ae6b3970.html>. Although the Convention did not make reference to FGM, the practice fits within the definition of discrimination against women as a practice exclusively directed towards women and girls with the effect of interfering with their enjoyment of their fundamental rights.

19 Organization of the African Union, "African Charter on the Rights and Welfare of the Child, Article 21, 1990. http://www.achpr.org/files/instruments/child/achpr_instr_charterchild_eng.pdf

20 Shell-Duncan B., "From Health to Human Rights", p. 227.

21 For different measures see for example: Chege JN, Askew I, Liku J. An assessment of the alternative rites approach for encouraging abandonment of female genital mutilation in Kenya: FRONTIERS final report. Washington, DC: Population Council, 2001. September, 2001: http://www.popcouncil.org/pdfs/frontiers/R_FinalReports/Kenya_FGC.pdf "The positive deviance approach in female genital mutilation eradication." Final end-of-project report for PROWID to the Center for Development and Population Activities. Cairo: CEDPA, 1999;

Diop NJ, Faye MM, Moreau A, et al. The TOSTAN program: evaluation of a community based education program in Senegal: FRONTIERS final report. Washington, DC: Population Council, 2004. August, 2004: http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Senegal_Tostan%20FGC.pdf;

Diop NJ, et al. "Experience from a community based education program in Burkina Faso: the Tostan program: FRONTIERS Final Report" Population Council, 2004: http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/BurkinaFaso_FGC.pdf

22 UN, General Assembly, "Traditional or Customary Practices affecting the Health of Women and Girls", A/RES/56/128. <http://daccess-dds-ny.un.org/doc>

23 UN, General Assembly, 'Intensifying global efforts for the elimination of female genital mutilations', A/C.3/67/L.21/Rev.1 <http://www.unfpa.org/webdav/site/global/shared/documents>

FGM IN THE EUROPEAN UNION

At European level the issue of FGM has been addressed by different institutions. In 2001 the European Parliament adopted its first FGM resolution²⁴ which strongly condemned the practice as a violation of human rights. It also highlighted the need for awareness raising and for the implementation of a comprehensive European strategy, urging Member States to draw up guidelines for health professionals and social workers about the subject. Moreover, it called on the European Commission to recognise the right to asylum to women or girls at risk of being subjected to FGM. Several other resolutions have been adopted between 2002 and 2009. The most recent is the resolution on Ending Female Genital Mutilation²⁵ adopted in 2012, which 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 March 2010 the Council of European Union adopted a Conclusion on the Eradication of Violence against Women in the EU²⁶ welcoming the European Commission's commitment to pursue a more active policy in the fight against FGM. In 2010 the Council of Europe adopted the Convention on preventing and combating violence against women and domestic violence (Istanbul Convention)²⁷ which requires the Member State to criminalise any type of conduct involving the practice of FGM²⁸. As a result, certain EU Member States²⁹ have recognised the practice of FGM as a criminal act and subsequently new laws against it have been drafted. Based on the legal principle of extraterritoriality, these laws make possible to prosecute the practice of FGM when it is committed outside the country's borders.³⁰ In fact, since cases of the practice involving girls living in the EU may occur in their countries of origin, or in the countries of their parents' origin, while they are on holidays or visits abroad, extraterritoriality is being increasingly recognised as the principle central to the criminalisation of FGM.³¹

24 European Parliament resolution on female genital mutilation (2001/2035(INI))
<http://www.europarl.europa.eu/sides/>

25 European Parliament, 'European Parliament resolution of 14 June 2012 on ending female genital mutilation', p.2 (2012/2684(RSP))
<http://www.europarl.europa.eu/sides>

26 Council of the European Union, 'Council conclusions on the Eradication of Violence Against Women in the European Union', <https://www.consilium.europa.eu/uedocs/>

27 Council of Europe, 'Convention on preventing and combating violence against women and domestic violence', <http://conventions.coe.int/Treaty/EN/Treaties/Html/210.htm>

28 Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalised: a) excising, infibulating or performing any other mutilation to the whole or any part of a woman's labia majora, labia minora or clitoris; b) coercing or procuring a woman to undergo any of the acts listed in point a; c) inciting, coercing or procuring a girl to undergo any of the acts listed in point a.

29 Austria, Belgium, Cyprus, Denmark, Ireland, Italy, Spain, Sweden and the UK.
European Institute for Gender Equality (EIGE), Female Genital Mutilation in the European Union and Croatia, Report, 2013, 28. <http://eige.europa.eu/sites/default/files/EIGE-Report-FGM-in-the-EU-and-Croatia.pdf>

30 With the exception of Bulgaria, Greece, Malta and Romania.

European Institute for Gender Equality (EIGE), Female Genital Mutilation in the European Union and Croatia, Report, 2013, 43.

31 "Eliminating female genital mutilation", European Commission, April 1, 2015. <http://ec.europa.eu/justice/gender-equality/>; "Female genital mutilation in the EU", UNHCR Malta, March 19, 2013. <http://www.unhcr.org/mt/female-genital-mutilation>; Balzan, Jurgen, "Labour MP to table draft law banning genital mutilation", Malta Today, 3 July 2013. Accessed June 30, 2015. <http://www.maltatoday.com.mt/news/national/>

The European Commission emphasized the need to adopt an EU-wide strategy for combating violence against women and eradicating FGM. The Daphne Programme has been the driving force for the development of many initiatives regarding the fighting of FGM at Member States level. In fact, FGM was specifically targeted allocating resources specifically to deal with this issue. Next to the Daphne Programme, the Lifelong Learning, the Youth in Action programme and the future Asylum and Migration fund supported activities to prevent FGM, raising awareness of the practice while empowering migrant women and girls, and training health professionals as well as those working with victims.³² During 2013, the European Commission distributed a total of €2.3 million to projects specifically fighting FGM. The funding was allocated to projects addressing the issue of FGM by, among others, Coventry University, Terre des Femmes, FORWARD, The National Commission for the Promotion of Equality for Men and Women in Malta, the UK Home Office and the French Women's Rights and Gender Equality Administration.³³ In addition, the European Commission emanated the Victims' Rights Directive³⁴ in 2012, establishing minimum standards on the rights, support and protection of victims of a crime.

With regards to international protection and asylum, article 33, par. 1) of the 1951 UN Convention Relating to the Status of Refugees (Refugee Convention) is of particular relevance to FGM. It 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». Furthermore, the UNHCR Guidance Note on Refugee Claims Relating to Female Genital Mutilation³⁵ provides information on the treatment of claims for refugee status relating to FGM, reaffirming that victims or potential victims of FGM can be considered as members of a particular social group, as described by Article I (A) (2) of the 1951 Convention on the Status of Refugees (Refugee Convention)³⁶. Besides, the evolving jurisprudence related to such claims has led to establish 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».³⁷

The 1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) provides an additional form of protection in this area. Article 3 of the Convention 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.³⁸

32 "Towards the elimination of female genital mutilation", European Commission, November 25, 2013.

33 "International day for elimination of violence against women: European Commission takes action to combat female genital mutilation", European Commission Press Release, November 25, 2013, pp 2.

34 COE, Council of Europe Convention on preventing and combating violence against women and domestic violence, art. 18. <http://www.coe.int/t/convention-violence/>

35 UNHCR, 'UNHCR Guidance Note on Refugee Claims Relating to Female Genital Mutilation', 2009. <http://www.refworld.org/docid/4a0c28492.html>

36 Ibid., «FGM-related claims not only involve applicants facing an imminent threat of being subjected to the practice, but also women and girls who have already suffered from it. While in general a person who has experienced past persecution will be assumed to have a well-founded fear of future persecution»; The term particular social group stems from Article I (A) (2) UN General Assembly, Convention Relating to the Status of Refugees, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137

37 Ibid., Cfr. European Institute for Gender Equality (EIGE), Female Genital Mutilation in the European Union and Croatia, Report, 2013, 34.

38 UN General Assembly, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 10 December 1984, United Nations, Treaty Series, vol. 1465, 85. Available at <http://www.refworld.org/docid/3ae6b3a94.html>

However, no EU Member State has integrated specific provisions related to granting international protection and asylum on FGM grounds into its national legislation. Only Hungary mentions FGM in its explanation of possible forms of gender-based persecutions included in its general asylum law provision.³⁹

In general, asylum application on FGM grounds are most commonly based on fear of persecution or of being subjected to the practice again.⁴⁰ Most countries consider women submitting FGM-based asylum applications under the category of membership of a “particular social group”, whereas others, such as Belgium, Croatia and Greece, use the term “vulnerable groups” in order to include victims or potential victims of FGM. 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. Consequently, 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.⁴¹ Particularly in this regard, Cyprus, Greece, the Netherlands, and the UK refer to article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) which provides that «no one shall be subjected to torture or to inhuman or degrading treatment or punishment⁴²».

Nevertheless, it has to be noted that there is no harmonised approach to granting international protection on the ground of or fear of FGM. In some countries (Belgium, France, the Netherlands, Sweden and United Kingdom), there have been many asylum requests based on FGM and asylum has been frequently granted on this ground. However, in other countries like Italy, Latvia, Lithuania, Romania and Slovakia there have been only a few cases. In the remaining EU countries, although the general asylum provisions do leave room for interpretation for FGM claims, asylum has not been granted on such grounds yet.⁴³

FGM IN MALTA

Malta has ratified several international conventions condemning FGM, such as the Universal Declaration of Human Rights (UDHR), CEDAW, CAT, the Convention on the Rights of the Child (CRC), the ECHR, and the Charter of Fundamental Rights of the European Union. Recently, it has also deposited the ratification of the Istanbul Convention.⁴⁴

Currently there is no statistical data about the practice of FGM in Malta, mainly due to the fact that medical professionals are bound by confidentiality, and there are no estimates based on numbers of particularly vulnerable women on the basis of, for instance, countries of origin. To date, no cases of FGM in Malta have been officially reported or prosecuted.⁴⁵ Further research on FGM in Malta is therefore necessary, possibly with statistical modelling for understanding the size and needs of the concerned population.

39 Cfr. Asylum Act, Act 80 of 2007, Art. 60, par. 2 b).

40 “FGM Case Law and other Legal Documents”, International Refugee Rights Initiative. Accessed on July 1, 2015. <http://www.refugeelawinformation.org/fgmc-case-law-and-other-legal-documents>

41 Ibid.

42 Council of Europe, European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14, 4 November 1950, ETS 5, art. 3. <http://www.refworld.org/docid/3ae6b3b04.html>

43 Cfr. European Institute for Gender Equality (EIGE), Female Genital Mutilation in the European Union and Croatia, Report, 2013, 47.

44 Council of Europe Convention on preventing and combating violence against women and domestic violence 2011. <http://conventions.coe.int/Treaty/EN/Treaties/Html/210.htm>

45 Dalli Miriam, “Maltese doctors facing up to reality of female circumcision in pregnant refugees”, 28 July 2010. <http://www.maltatoday.com.mt/news/national>

FGM WITHIN A SOCIO-CULTURAL CONTEXT

In some EU countries such as Belgium, France, the Netherlands and Sweden, FGM has been considered as grounds for asylum due to the medical risks involved in the procedure. Such provisions are based on the possibility that women who have already undergone FGM could face a continued risk of repeated de-infibulation and re-infibulation following childbirth and risk of having daughters that would be subjected to FGM.⁴⁶ There is a record of one Ethiopian family requesting asylum on FGM grounds in Malta, but not granted.⁴⁷

However, despite having the highest number of female refugees coming from countries where FGM takes place, Malta has been one of the last EU member States to develop a specific criminal law against this practice.⁴⁸ In fact, until February 2014 there were no specific laws banning FGM.

According to UNHCR 2013 Statistical Overview about Female Genital Mutilation and Asylum in Europe, between 2008 and 2011 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%).⁴⁹ The study also estimated that, in 2011, more than 50% of all female applicants originating from FGM-practising countries who applied for asylum in Malta were potentially affected by FGM.⁵⁰

The European Institute for Gender Equality estimated that, until 2009, 242 women from countries where FGM is practised were living in Malta; it also assessed that between 2003 and 2007, there were 566 births in Malta by mothers of African nationality; 170 of these mothers came from sub-Saharan and Sahel regions.⁵¹

As explained by Professor Mark Brincat⁵², Director of the Department of Obstetrics and Gynaecology in Malta, dealing with FGM has proven to be rather challenging, without having neither a precise policy nor some kind of specific guidelines to follow. In case of expectant women, for example, all pregnancies had to be delivered by caesarean section but some of the women did not give their consent to the procedure and the doctors did not know how to proceed. All they could do was rely on the Royal British College guidelines. For this reason, a number of seminars have been organised in 2010. A midwife from abroad who was specialised in this field, provided training sessions for health care workers. These sessions included details about a procedure that reverses the genital mutilation through reconstructive surgery of the female genitals.⁵³

46 Cfr. Balzan, Jurgen. "Labour MP to table draft law banning genital mutilation", July 3, 2013. <http://www.maltatoday.com.mt/news/national/>

47 European Institute for Gender Equality (EIGE), Current situation of female genital mutilation in Malta, Report, 2013. <http://eige.europa.eu/sites/pdf>

48 Cfr. Times of Malta, "Mutilation needs more than law", January 15, 2014. <http://www.timesofmalta.com/Mutilation-needs-more-than-law>

49 UNHCR, Female genital mutilation and asylum in the European Union, 27 February 2013. http://www.endfgm.eu/content/assets/UNHCR_FGM_and_Asylum_in_Europe__an_statistical_overview_Ms_Fadela_Novak.pdf

50 Ibid.

51 See ft. 44.

52 Dalli Miriam, "Maltese doctors facing up to reality of female circumcision in pregnant refugees", 28 July 2010. <http://www.maltatoday.com.mt/news/national>

53 Ibid.

In the paper “We are going to fix your vagina, just the way we like it”: some reflections on the construction of [sub-Saharan] African female asylum seekers in Malta and their efforts to speak back’, Pisani adopts a cultural relativist view on FGM in Malta⁵⁴ and expresses the opinion that women in Malta have not been engaged in the debate concerning FGM. The author argues that procedures which reverse the genital mutilation through reconstructive surgery of the female genitals have been performed on women without their prior informed consent. The author adopts the view that the experiences of African women were ignored while, on the other hand, «the barbaric primitive practices conducted within primitive societies are discussed at length, almost fetishised⁵⁵». Pisani is also of the opinion that female asylum seekers were thought of as a «problem to be solved and managed through the strategies and the solutions imposed by the Western enlightened management⁵⁶». She further argues that decisions regarding the practice are usually taken based on the knowledge about women and FGM, rather than by the women themselves.⁵⁷

Cultural relativism *apropos* FGM has also been subject to criticism. In the paper ‘Slapping the Hand of Cultural Relativism: Female Genital Mutilation, Male Dominance and Health as a Human Rights Framework’, Mitchum sheds light on the relevance of the human rights dimension to the debate on FGM.⁵⁸ The author presents the argument that FGM exists in the context of male-dominated cultures characterised by submission of women and which leads to health and human rights contraventions.⁵⁹ Consequently, Mitchum concludes that cultural relativist views on FGM need to be re-assessed. The author argues that the only way to escape social alienation in FGM-practising cultures for women and children is to violate their own bodily integrity, which is in itself a breach of the “fundamental right to dignity, bodily integrity and security of their person”.⁶⁰ Whilst the author acknowledges the need for greater female participation in the debate on FGM; he further points out that as things stand, the current cultural and socio-political structures in FGM-practising cultures do not allow for this.⁶¹ Consequently, the paper suggests that whilst it is important not to simply disregard cultural practices as “wrong” on the basis that these do not fit within the Western notion of human rights, it is equally important to keep in mind that “universal human rights apply to all”.⁶²

54 In the paper ‘What is behind the tradition of FGM?’, Ashenafi argues that cultural relativists are those who “assert that the practices within any specific culture are unique to the values, systems and practices within that culture. For them, there are no universal standards and the morality and values of one national culture cannot be compared to that of another.” They deny the fact that tradition is dynamic. They refuse to accept the reality that old harmful traditions have been done away in many parts of the world. On Cultural Relativism and FGM see Ashenafi, M. ‘What is behind the tradition of FGM?’, 2013, p2. <http://www.african-women.org/documents/behind-FGM-tradition.pdf>; and Mitchum P. D. ‘Slapping the Hand of Cultural Relativism: Female Genital Mutilation, Male Dominance and Health as a Human Rights Framework’. William & Mary Journal of Women and the Law, Volume 19, Issue 3, pp.585-607.

55 Pisani M., “We are going to fix your vagina, just the way we like it.” Some reflections on the construction of [sub-saharan] African female asylum seekers in Malta and their efforts to speak back, *Postcolonial Directions in Education*, Volume 2, Issue 1, 2013, pp. 68-99, 82.

56 *Ibid.* p.86.

57 *Ibid.* p.86.

58 Mitchum P. D. ‘Slapping the Hand of Cultural Relativism: Female Genital Mutilation, Male Dominance and Health as a Human Rights Framework’, *William & Mary Journal of Women and the Law*, Volume 19, Issue 3, pp.585-607.

59 *Ibid.* p. 607.

60 *Ibid.*

61 *Ibid.*

62 *Ibid.*

In 2013, Labour MP Chris Fearne, supported by the Malta Confederation of Women's Organisations (MCWO), took the initiative to table a private member's Bill in Parliament proposing the introduction of a specific law banning FGM. The Bill aimed to outlaw the practice of FGM performed against Maltese citizens or permanent residents both in Malta and abroad, but also to criminalise the practice performed by Maltese citizens abroad⁶³; it included two clauses banning forced marriage and forced surgical sterilisation as well.⁶⁴

The Bill was unanimously approved in January 2014 and was included in the Criminal Code the following February.⁶⁵ According to previous Maltese criminal law, FGM could be considered as a type of bodily injury and be consequently punished as stated in article 214 of the Penal Code.⁶⁶ Physical mutilation, though, is punishable only if it causes death or seriously endangers health as stated in article 54D, par. b) of the Penal Code.

Since February 2014, Article 251 E (1-7) under title VIII 'Crimes against the Person' and subtitle IX 'Threats, Private Violence and Harassment' of the Maltese Criminal Code explicitly criminalises the practice of FGM.

The general provision included in article 251 E, par. 1) of the Criminal Code provides up to nine years of imprisonment for who commits the act, clearly stating that «whosoever, for non-medical reasons, performs an operation or carries out an intervention on a woman's genitalia that damages the genitalia or inflict upon them permanent changes, shall be guilty of enforced female genital mutilation and shall be liable for punishment of imprisonment for a term from three to nine years⁶⁷». Paragraph 2 a i) and ii) specify that in case of death of the victim, as a direct consequence of the procedure, the perpetrator shall be liable to imprisonment for a term from six to twenty years if death ensues within 40 days since the procedure has been performed, or for a term from three to nine years in case death occurs 40 days after the intervention.⁶⁸ Moreover, paragraph 2 b states that in case the death of the victim occurs as a result of a supervening accidental cause and not solely as a natural consequence of the procedure, the offender shall be liable to imprisonment for a term from three to nine years as well. Also, aiding and abetting FGM shall be considered a crime as stated in paragraph 6 of the same article.

This law states that anyone who fails to seek to forestall female genital mutilation, regardless of any kind of confidentiality duty, shall be chargeable to a fine of not less than 1,000 euro and not exceeding 5,000 euro, or to imprisonment for a term of six months to two years, or to both the fine and imprisonment.⁶⁹ Besides, it also establishes that exemption from punishment cannot be justified through consent from the person undergoing the operation.⁷⁰

63 Cfr. <http://www.maltatoday.com.mt/news/national/28095/mcwo-in-full-support-of-bill-proposing-ban-on-female-genital-mutilation-20130704#.VE4wkb6zQy5>

64 Cfr. <http://www.independent.com.mt/articles/2013-07-29/news/mp-to-propose-bill-to-ban-female-genital-mutilation-2193031168/>

65 Cfr. <http://www.timesofmalta.com/articles/view/20140115/local/-Mutilation-needs-more-than-law-.502677>

66 «Whosoever, without intent to kill or to put the life of any person in manifest jeopardy, shall cause harm to the health or the body of any other person, or shall cause to that other person a mental derangement, shall be guilty of bodily harm».

67 Criminal Code, Chapter 9, Art. 251 E, par. 1.

68 Criminal Code, Chapter 9, Art. 251 E, par. 2 i) and ii).

69 Criminal Code, Chapter 9, Art. 251 E, par. 4.

70 Criminal Code, Chapter 9, Art. 251 E, par. 3.

The MP Chris Fearne expressed the need for specific training and guidelines, together with a legal and regulatory framework. These should assist in addressing the issue of FGM, especially among migrants' communities. MP Fearne identified several groups that are in need of extra support; NGOs who work with refugees need backing because of language as well as cultural barriers. There is the need for cultural facilitators and interpreters in the field. Doctors and midwives require specific protocols and clear instructions because of their constant contact with expectant women who had been through FGM. Last, the members of the police force who deal with refugees also require guidance. Within these African communities there is pressure from relatives for FGM to be carried out, the authorities need to focus their attention.⁷¹

With regards to policy documents referring specifically to FGM, only the National Sexual Health Policy (2010) addresses the matter.⁷² The issue has been tackled in open centres through education by the Migrant Health Unit and the Jesuit Refugee Service, but no official policies have been identified so far.

HEALTH IMPLICATIONS OF FGM

Despite the fact that a large number of health complications have been associated with FGM; the current state of research on the subject matter is far from exhaustive. Whilst various studies have sought to provide extensive information on the immediate and long-term complications which women and girls go through; the findings of the studies have also served to shed light on a number of uncertainties and unanswered questions with regards to health implications and FGM.

This literature review draws an outline of leading research studies and their results as to the health implications of FGM on women, with the aim to identify consensus, disagreements and gaps in research; it starts with general immediate complications and general long-term complications and proceeds towards a number of specific health risks and trends in research. These include complications during pregnancy and childbirth, sexually transmitted diseases, problems related to fertility, an impact on sexual interaction, an increase in the development of cysts, urinary problems and psychological problems. Research on the subject has also focused on the difficulties health professionals in receiving countries face when coming in contact with patients who have undergone FGM in their country of origin. They do not have enough information or training regarding FGM and its implications. This section of the literature review will include an overview on the developments and gaps in training and education material for health professionals, both in countries where FGM is practised and in receiving countries without indigenous FGM practices.

⁷¹ Cfr. <http://www.timesofmalta.com/articles/view/20140115/local/-Mutilation-needs-more-than-law-.502677>

⁷² Ibid. «Female Genital Mutilation (FGM) is one of many realities arising around sexual health which needs to be addressed more comprehensively in Malta, as a result of an increase in the numbers of residents originating from societies where such practices are known to be prevalent. Government needs to establish a framework which will be responsible for the detection of the specific needs of minorities within the population of Malta».

DIFFERENT COMPLICATIONS PER FGM TYPE

FGM does not have any health benefits for girls and women. A number of studies review the severity of health complications depending on the type of FGM, in combination with professional healthcare and adequate facilities. A high risk of health complications with FGM type III was observed through a comprehensive study in Somalia.⁷³ In addition, there is agreement through various studies that FGM type III is extremely risky. These studies were conducted in different countries, including Burkina Faso, Mali, (Northern) Ghana, Kenya, Mali, Nigeria, Senegal, Sierra Leone, and (Northern) Sudan.⁷⁴ Risks of FGM type III manifest themselves especially once the woman is pregnant. Complications also arise during childbirth, due to scarring and a small introitus which makes de-infibulation necessary. This may lead to severe haemorrhage and carries a high infection risk.⁷⁵ However, health complications as a result of other types of FGM should not be underestimated as they can nonetheless be severe (for instance haemorrhage).⁷⁶ Kandil⁷⁷, however, concludes in his research that FGM may not be harmful if performed by experienced personnel and in suitable facilities where pain control and anaesthesia are used, and under the requirement that only FGM type I is undertaken. Whilst adequate facilities and treatment by professional healthcare personnel may limit health risks, this argument is generally reserved to the context of reducing risk in cases of FGM that has already been undertaken rather than for future FGM practices, whose elimination is explicitly demanded by the United Nations, amongst other international organisations and leading scholars, as the representation of the international community.⁷⁸

73 M.A. Dirie and G. Lindmark, "The Risk of Medical Complications after Female Circumcision", *East African Medical Journal*, Vol. 69, No. 9, 1992, pp. 479-482.

74 H. Jones, N. Diop, I. Askew, I. Kaboré, "Female Genital Cutting Practices in Burkina Faso and Mali" *Studies in Family Planning*, Vol. 30, Issue 3, 1999, pp. 219-230; World Health Organization "Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation", WHO/RHR/01.13, 2001; World Health Organization, "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries", *The Lancet*, 2006, 367, pp. 1835-1841; 28 Too Many, "Country report: Mali", September 2014.

75 WHO/RHR/01.13, p. 11.

76 WHO/RHR/01.13, p. 9.

77 M. Kandil, "Female circumcision: Limiting the harm", *F1000 Research*, 1:23, 2012.

78 General Assembly, Intensifying global efforts for the elimination of female genital mutilations : resolution / adopted by the General Assembly, 5 March 2013, A/RES/67/146.

One pertinent matter in research on health issues associated with FGM is that of underreporting by girls, women and doctors thereof. For this reason there is a high possibility that there are more health complications (in number and in severity) than research studies have found thus far.⁷⁹ For instance, while in a study undertaken in Sudan 73% of the girls were bedridden for a week after having undergone FGM, only 10% stated that there had been immediate complications.⁸⁰ These results draw attention to the possibility that there are more complications than are reported. It also points towards a need for careful consideration in the research methods utilised when asking questions about this practice, as perception and language, as well as issues of direct cause and effect are strongly associated with the ways in which people report about harmful practices. This is particularly the case if the related pain or other aspects are deemed to be an important part of their social belonging, experience, and identity. Even though it has been observed that respondents do not generally appear to have difficulties recalling immediate complications of FGM and were able to describe those in detail, there are a number of possible reasons for underreporting of such FGM related health issues. Some respondents felt shy or shame in speaking about a topic related to intimacy and genitals and were not able to describe complications.⁸¹ For instance, though urinary retention is a known immediate complication of FGM, this was often not admitted.⁸² A study conducted in Tanzania found that it was not only girls or women who reported health complications incorrectly, clinicians did this as well.⁸³ Reasons stated for underreporting included for example that the FGM procedure was seen to be “only” minor, or women and girl’s endured memory loss, due to the young age at which FGM was performed. Cultural reasons were also mentioned, such as objection of “modern” medicine and Western scholars, as well as the tradition to keep FGM a secret,⁸⁴ particularly in East Africa. Additionally, health complications are often not recognised as being related to the FGM, both by the sufferers themselves, as well as by healthcare personnel.⁸⁵

IMMEDIATE COMPLICATIONS

Most studies on FGM name the same or similar health complications⁸⁶: haemorrhage, severe pain, local infections, urinary retention, shock or even damage to surrounding organs. Haemorrhage was the most common immediate complication in a study with women who had undergone FGM type III (in Somalia) and was also reported in Kenya and Mali where type II is the most common form of FGM⁸⁷. However, it has been repeatedly demanded that more extensive research is needed on specific health complications, since a number of complications have been observed for which there is as yet no scientific proof of association with FGM.⁸⁸ For instance, morbidity from haemorrhage, infections or shock appear to be very common health complications but are poorly documented and do not allow for conclusive findings,⁸⁹ For some health issues a number of studies already exist. However, the findings of many have been neglected.

79 Also observed by Berg and Underland 2014.

80 L. Almroth, H. Bedri, El Musharaf, A. Satti, T. Idris, M.S. Hashim, G.I. Suliman, S. Bergström, “Urogenital complications among girls with genital mutilation: a hospital-based study in Khartoum”, *African Journal of Reproductive Health*, Vol. 9, Issue 2, 2005, pp. 118-124.

81 Dirie and Lindmark 1992.

82 Ibid.

83 E. Klouman, R. Manongi, K.I. Klepp, “Self-reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections”, *Tropical Medicine and International Health Journal*, Vol. 10, Issue 1, 2005, pp. 105-15, p. 111.

84 Ibid, p. 113.

85 28 Too Many, “Country report: Mali”, September 2014, p. 39, and “Country report: Sierra Leone”, June 2014, p. 38.

86 For comprehensive overviews, please see WHO publications on FGM, such as “A systematic review of the health complications of female genital mutilation including sequelae in childbirth”, WHO/FCH/WMH/00.2, 2000 as well as Berg and Underland “Gynaecological Consequences of Female Genital Mutilation/Cutting (FGM)”, Systematic Review No. 11, 2014 for a systematic review.

87 Dirie and Lindmark 1992; H. Jones, N. Diop, I. Askew, I. Kaboré 1999; 28 Too Many, “Country report: Mali”; 28 Too Many, “Country report: Kenya”, May 2013; WHO 2006, p. 3.

88 WHO/RHR/01.13 p. 4; Obermeyer 2013.

89 WHO/RHR/01.13, p. 4.

LONG-TERM COMPLICATIONS

Some of the immediate complications are also present as long-term complications. Haemorrhaging can occur either as an immediate complication due to the FGM procedure itself, or as a long-term complication within the context of de-infibulation (before sexual intercourse or childbirth) or re-infibulation (re-stitching).⁹⁰ Urinary problems are another health issue named both as an immediate and as a long-term complication. Whilst it may occur as a result of the procedure itself, symptoms may persist in the form of pain at micturition, poor urinary flow or dribbling urine incontinence.⁹¹ Other long-term complications which were reported are cysts, infertility, childbirth complications, difficulties with sexual intercourse, psychological illnesses, keloids and abscesses.⁹² Literature on the health complications of FGM has largely focused on the following issues:

PREGNANCY AND CHILDBIRTH

There are various complications that arise as a result of FGM during pregnancy and childbirth, all of which are very dangerous to mother and child; these complications have already gained considerable attention amongst scholars, though detailed documentation is missing thus far, especially on antenatal complications as well as long-term psychological effects.⁹³

The complications named as most common are haemorrhage, perineal tear, episiotomy, obstetric lacerations, prolonged labour, extended maternal hospital stay and the possibility of a caesarean section; foetal asphyxia, resuscitation of the infant or even stillbirth. Most of the complications related to extensive lacerations, haemorrhage or infections are found to occur during the postpartum period.⁹⁴

While it might be assumed that one of the complications of FGM in the context of childbirth is fistula resulting from obstructed labour, a correlation between the two cannot be established.⁹⁵ The injury that results in an obstetric fistula happens further up the birth canal when the baby's head gets stuck as it tries to pass through the pelvis. Complications during labour caused by FGM may include tearing of the skin, which can also result in infections and injuries. However, these complications need to be distinguished from obstetric fistula.⁹⁶

Scar tissue and a small introitus appear to cause most of the severe risks. De-infibulation is often necessary to deliver the child and may cause many of the complications named below, especially haemorrhage and perineal tear (severe pain). FGM type III causes the most damage to the genitals and is therefore a direct mechanical barrier for delivery, where de-infibulation becomes absolutely necessary.⁹⁷ De-infibulation is possible during pregnancy or in the first and second stage of labour, however, the ideal timing still has to be determined, based on more substantial evidence.⁹⁸ In any case, the timing is different for each woman, based on her individual circumstances.

90 WHO/FCH/WMH/00.2.

91 Dirie and Lindmark 1992.

92 Most comprehensive overview in WHO/FCH/WMH/00.2; Berg and Underland 2014 find the same complications in their systematic review.

93 I.a. WHO/RHR/01.13; WHO 2006; World Health Organization, "Effects of female genital mutilation on childbirth in Africa: Policy Brief", *The Lancet*, 2006, 267, pp. 1835-1841; Berg and Underland 2014; B. Essén, et al., "No Association Between Female Circumcision and Prolonged Labour: A Case Control Study of Immigrant Women Giving Birth in Sweden", *European Journal of Obstetrics & Gynecology & Reproductive Biology*, Vol. 121, Issue 2, 2005, pp. 182-185; A. Kaplan, et al., "Female Genital mutilation/cutting in The Gambia: long-term health consequences and complications during delivery and for the newborn", *International Journal of Women's Health*, Vol. 2013, Issue 5, 2013, pp. 323-331; further see 28 Too Many country reports.

94 WHO/RHR/01.13, p. 21.

95 A. Browning, J. Allworth and L. Wall, "The Relationship Between Female Genital Cutting and Obstetric Fistulas", *Obstetrics and Gynecology*, Vol. 15. Issue 3, 2010, pp. 578-583.

96 Ibid.

97 WHO/RHR/01.13, p. 9.

98 J. Abdulcadir, et al. "Research Gaps in The Care of Women with Female Genital Mutilation: an Analysis", *BJOG: An International Journal of Obstetrics and Gynaecology*, Vol. 122: 3, 2015, pp. 294-303, p. 7.

The more extensive the FGM procedure, the more risky delivery is. For instance, a study conducted with women with type III FGM found a 70% higher risk of postpartum haemorrhage.⁹⁹ However, types I, II and IV may cause severe vaginal scarring and hence may cause similar risk of postpartum haemorrhage.¹⁰⁰ A study in The Gambia concurs with these findings, reiterating that if the mother had undergone FGM type I or II, there is a four times higher risk of complications during delivery as well as a four times higher risk of complications for the new-born. Complications for the newborn include fetal distress (with a fetal heart rate < 100–160 beats per minute), fractures, and the caput of the fetal head. A swelling can be formed under the presenting part of the scalp as a result of trauma during delivery.¹⁰¹

Though there have been studies questioning the association of obstetric complications with FGM, it appears that overall the health complications during delivery that have been named above, may be associated with FGM. However, there appears to be no sufficient proof for a higher risk of a caesarean section or an episiotomy. Uncertainty remains in regard to antenatal health complications, as mentioned above.

SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs) have been associated with FGM by a number of scholars. However, this issue is largely questioned and thus far there are no clear indications for a connection between STDs and FGM. There has been a study reporting that a girl in Malawi was HIV-positive, though she was not born with the virus and had not yet been sexually active. It was assumed that the razor used by the midwife for the girl's FGM was used for a number of children, without having the razor cleaned and disinfected.¹⁰² The FGM procedure may play a role in facilitating the spread of HIV as well as other diseases that may be spread through contact with contaminated blood, although conclusive findings are missing.¹⁰³ The WHO stated in 2001 that there was no known relation between FGM and the spread of HIV and Hepatitis.¹⁰⁴ A number of country-specific studies confirm that there is no indication of an association between FGM and STDs, including HIV; these studies were undertaken in Kenya, Lesotho, Sudan and Tanzania.¹⁰⁵ The only possible transmission was found through FGM-related blood exposures, i.e. as in the scenario described above where possibly one razor was used for several girls¹⁰⁶, one or more of whom may have already been infected with the virus and therefore transmission to subsequent girls occurred. There might be an association between FGM and vaginal infections (bacterial vaginosis), for which further research is required.¹⁰⁷

99 WHO 2006, p. 1835.

100 WHO/RHR/01.13, p. 9.

101 A. Kaplan, et al. 2013.

102 M.T. Post, "Female genital mutilation and the risk of HIV", Academy for Educational Development, Support for Analysis and Research in Africa, SARA Issues Paper, May 1995.

103 M. Brady, "Female Genital Mutilation: Complications and Risk of HIV Transmission", AIDS Patient Care and STDs, Vol. 13, Issue 12, 1999, pp. 709-716.

104 WHO/RHR/01.13, p. 19.

105 E. Klouman, R. Manongi, K.I. Klepp 2005, p. 112; S. Elmusharaf, I. Elkhidir, S. Hoffmann and L. Almroth, "A case-control study on the association between female genital mutilation and sexually transmitted infection in Sudan", BJOG: An International Journal of Obstetrics and Gynaecology, Vol. 113, Issue 4, 2006, pp. 469-474; D.D. Brewer, J.J. Potterat, J.M. Roberts and S. Brody, "Male and female circumcision associated with prevalent HIV infection in virgins and adolescents in Kenya, Lesotho and Tanzania", Ann Epidemiol, Vol. 17, Issue 3, 2007, pp. 217-226.

106 Also found by D.D. Brewer, J.J. Potterat, J.M. Roberts and S. Brody 2007.

107 WHO/RHR/01.13, p. 19; E. Klouman, R. Manongi, K.I. Klepp 2005, p. 112; also found in the systematic review Berg and Underland 2014.

FERTILITY

While initial studies have considered the possibility that FGM might have negative consequences for a woman's fertility, more recent studies state that there is no association, or that evidence is insufficient for this. It is suggested that infections that occur as a result of FGM may indeed lead to infertility.¹⁰⁸ Contrary to this a few studies state that there is no indication of association between FGM and infertility.¹⁰⁹ The WHO states, though, that the contribution of FGM to infertility remains unclear and that sufficient evidence must be gathered in order to reach a conclusive finding.¹¹⁰

SEXUAL IMPACT

A further health complication that has gained attention amongst scholars is the sexual impact of FGM. FGM may cause painful intercourse and a number of psychosexual problems.¹¹¹ Only a small number of studies have been undertaken regarding detailed scientific evidence on sexual impact. A detailed study in Egypt names dysmenorrhoea as the most common complication, which may lead to pain during intercourse. Other symptoms are vaginal dryness during intercourse, lack of sexual desire, less frequency of sexual desire, less initiative during sex, being less pleased by sex, experiencing less orgasms, and having difficulty reaching an orgasm.¹¹² Each type of FGM has complications for the sexual activity of women.¹¹³ Though the study in Egypt names difficulties in reaching an orgasm for women who have undergone FGM, it has also been found that it is possible to reach an orgasm for women with a type of FGM.¹¹⁴ Even though pain during intercourse is regularly reported as a consequence of FGM, final conclusions on the impact of sexual activities cannot be drawn as of now. Substantive research and scientific evidence on the health complications with regards to sexual activities is still lacking.¹¹⁵

CYSTS

The development of cysts has been named as a health complication of FGM.¹¹⁶ These epidermal inclusion cysts look like a swelling at the vulva, may reach a large size, may become infectious, may be painful and may in turn cause haemorrhage.¹¹⁷ They therefore often require removal, except for cases where the woman is already pregnant, in order to avoid haemorrhage.¹¹⁸ Such cysts have been observed to develop even years after the FGM has been carried out. Once again, further evidence for positive association between FGM and cysts is needed.¹¹⁹

108 Dirie and Lindmark 1992.

109 U. Larsen and S. Yan, "Does female circumcision affect infertility and fertility? A study of the Central African Republic, Côte d'Ivoire, and Tanzania", *Demography*, Vol. 37, Issue 3, 2000, pp. 313-321; E. Klouman, R. Manongi, K.I. Klepp 2005, p. 112.

110 WHO/RHR/01.13, p. 4, 22; an example for a start on gathering scientific evidence: L. Almroth, H. Bedri, El Musharaf, A. Satti, T. Idris, M.S. Hashim, G.I. Suliman, S. Bergström 2005.

111 WHO/RHR/01.13, p. 4, 22.

112 M.H. El-Defrawi, G. Lotfy, K.F. Dandash, A.H. Refaat and M. Eyada, "Female Genital Mutilation and its Psychosexual Impact", *Journal of Sex & Marital Therapy*, Vol. 27, Issue 5, 2001, pp.465-473.

113 S.A. Alsibiani and A.A. Rouzi, "Sexual function in women with female genital mutilation", *Fertility and Sterility*, Vol. 93, Issue 3, 2010, pp. 722-724.

114 L. Catania, O. Abdulcadir, V. Puppo, J.B. Verde, J. Abdulcadir and D. Abdulcadir, "Pleasure and orgasm in women with Female Genital Mutilation/Cutting (FGM)", *The Journal of Sexual Medicine*, Vol. 4, Issue 6, 2007, pp. 1666-78.

115 R.C. Berg and E. Denison, "Does Female Genital Mutilation/Cutting (FGM) Affect Women's Sexual Functioning? A Systematic Review of the Sexual Consequences of FGM", *Sexuality Research and Social Policy*, Vol. 9, No. 1, 2012, pp. 41-56.

116 Dirie and Lindmark 1992; WHO/RHR/01.13, p. 23; P.M. Moreira, I.V. Moreira, E.H.O. Faye, L. Cisse, V. Mendes and F. Diadhiou, "Three cases of epidermal cyst of vulva following female genital mutilation", *Gynécologie Obstétrique & Fertilité*, Vol. 30, Issue 12, 2002, pp. 958-960. Also mentioned in systematic review by Berg and Underland 2014.

117 Dirie and Lindmark 1992 also mention dermoid cysts at the site of the amputated clitoris.

118 WHO/RHR/01.13, p. 23.

119 Berg and Underland 2014.

URINARY PROBLEMS

As discussed above, urinary problems have been mentioned in research as immediate as well as long-term health complications of FGM. While urinary retention as a complication caused by FGM has been often documented, the long-term consequences are still uncertain and under-researched.¹²⁰ Especially urinary tract infections have been assumed to occur more often with women who have undergone FGM¹²¹; scientific proof is insufficient, though. Thus far it can only be said that a relation between FGM and a urinary tract infection is possible, however, a clear association has not yet been established.¹²²

PSYCHIATRIC ILLNESSES

A major research gap in health complications of FGM is that of mental health problems associated with the practice. Even though several studies mention mental health issues, there are no comprehensive and representative studies thus far. The WHO also mentions a clear lack of research on mental health issues suffered by women who have undergone FGM.¹²³ One study found that there is a higher prevalence of a posttraumatic stress disorder (PTSD) accompanied by memory loss, as well as a number of other psychiatric symptoms amongst women who have undergone FGM compared to those who have not.¹²⁴ However, even though this study suggests a clear indication of mental health issues following FGM, the authors of this study state that this finding may not be generalised and one has to be cautious with drawing conclusions, due to the relatively small size of the study group, the composition of the group and the geographic limitations.¹²⁵

MIGRANT WOMEN: FGM IN WESTERN HEALTHCARE

A new research area has opened up since migration flows are increasing and healthcare professionals in countries where FGM is not practised are facing cases of migrant women who have undergone FGM in their country of origin. The following section addresses the experiences of healthcare professionals with FGM, the established trainings on this topic and the identified requirements professionals should have.

120 WHO/RHR/01.13, p. 4.

121 L. Almroth, H. Bedri, S. El Musharaf, A. Satti, T. Idris, M. Sir K. Hashim, G. I. Suliman and S. Bergström, "Urogenital Complications among Girls with Genital Mutilation: A Hospital-Based Study in Khartoum", *African Journal of Reproductive Health*, Vol. 9, Issue 2, 2005, pp. 118-124.

122 This is also the finding of Berg and Underland 2014.

123 World Health Organization, "Mental health aspects of women's reproductive health: A global review of the literature", Department of Reproductive Health and Research, WHO, 2009, p. 152.

124 A. Behrendt and S. Moritz, "Posttraumatic Stress Disorder and Memory Problems After Female Genital Mutilation", *The American Journal of Psychiatry*, Vol. 162, Issue 5, 2005, pp. 1000-1002.

125 The study was conducted in Senegal, a country where relatively few FGMs are undertaken.

Studies on cases of FGM in Canada, Norway, Sweden, Switzerland and the UK have been reviewed. One interesting finding has been made regarding a health issue discussed above. While prolonged labour has been associated with FGM by a number of researchers (while the WHO states that no sufficient evidence thereof exists), a study in Sweden indicates that there is no such health risk where sufficient obstetric care is provided, i.e. in Sweden no indication of such a health risk was found.¹²⁶ Generally, there is a considerable knowledge gap as well as a lack of cultural sensitivity amongst health practitioners in host countries.¹²⁷ One named reason is that FGM is not (at all or not sufficiently) included in the curriculum in medical schools.¹²⁸

Yet, there have been a series of promising practices involving health care professional in the context of FGM. For example, in 2015 the Royal College of Obstetricians and Gynaecologists (RCOG) published the second edition of 'Female Genital Mutilation and its Management – Green-top Guideline No.53'.¹²⁹ This guideline provides for evidence-based guidance on the management of women that underwent or are at risk of FGM. Moreover, 'The Chain Approach' initiated by the Ministry of Health, Welfare and Sport in the Netherlands highlights the importance of enhanced collaboration between actors from different sector involved in the area of FGM, including preventive initiatives, psychological care and health care professionals.¹³⁰ 'The Protocol for Personal Integrity' under the auspices of the Spanish Ministry of Health, Social Services and Equality addresses the need for health professional to be more aware of the risk of trips for young females to undergo FGM and to provide families with more information on health and legal consequences of the practice.

TRAINING AND REQUIREMENTS FOR HEALTHCARE PROFESSIONALS

The large number of serious health complications for women who underwent FGM pose several challenges to healthcare personnel and require expertise as well as adequate facilities, not only in the countries where FGM is practised but also in countries of migration. There is an urgent need for improvement in healthcare services, both in countries of origin and countries of destination. The sectors in need of improvement differ per country though.

126 B. Essén, N.O. Sjöberg, S. Gudmundsson, P.O Ostergren and P.G. Lindqvist 2005.

127 A. Lalonde, "Clinical Management of Female Genital Mutilation must be handled with understanding, compassion", Canadian Medical Association Journal, Vol. 152, Issue 6, 1995, pp. 949-950; B. Chalmers and K.O. Hashi, "432 Somali women's birth experience in Canada after earlier female genital mutilation", Birth, Vol. 27, Issue 4, 2000, pp. 227-234; B. Ahmed, "Management of women who are circumcised especially during pregnancy and childbirth", Journal of Obstetrics and Gynaecology, Vol. 20, Issue 3, 2000, pp. 280-281; S. Vangen, R.E. Johansen, J. Sundby, B. Traeen, B. Stray-Pedersen, "Qualitative study of perinatal care experiences among Somali women and local healthcare professionals in Norway", European Journal of Obstetrics & Gynecology and Reproductive Biology, Vol. 112, Issue 1, 2004, pp. 29-35; N. Zaidi, A. Khalil, C. Roberts and M. Browne, "Knowledge of Female genital mutilation among healthcare professionals", Journal of Obstetrics and Gynaecology, Informa Healthcare, Vol. 27, Issue 2, 2007, pp. 162-164; S. Relph, R. Inamdar, H. Singh, W. Yoong, "Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London", European Journal of Obstetrics & Gynecology and Reproductive Biology, Vol.2, Issue 168, 2013, pp. 195-198.

128 J. Abdulcadir, C. Margairaz, M. Boulvain and O. Irion, "Care of women with female genital mutilation/cutting", Swiss Medical Weekly, Vol. 140:w13137, 2011.

129 Royal College of Obstetricians and Gynaecologists (RCOG) 2015

130 M. Exterkate, 2013

There are a number of training handbooks¹³¹ as well as studies researching the standard of healthcare which is provided. Several observations have to be made before going further into the content of the existing research and material: First, it appears that researchers fear a so-called medicalisation in countries where FGM is commonly practised. Medicalisation describes the situation where FGM is undertaken by healthcare providers; possibly due to the fact that FGM practised by untrained individuals was found to be risky to a girl's or woman's life, leading to individuals going to healthcare professionals and requesting the procedure.¹³² For example in a medical school in Egypt, where a study showed that the majority of students were in favour of the medicalisation of FGM while at the same time not being aware of the health implications of FGM¹³³. However, as the WHO stated, medicalisation is not the solution. In a joint technical consultation¹³⁴ on the medicalisation of FGM with UNICEF and UNFPA in 2009, they condemned the practice by medical professionals in any setting, FGM should be abolished completely.¹³⁵ Second, in migration countries there are strong indications that the vast majority of health professionals are not familiar with FGM health consequences on and lack cultural understanding and sensitivity.¹³⁶ Both these aspects constitute vital parts of the treatment and management that is required to both curb the practice as well as to allow for positive treatment for women who have been affected by the practice (physically or psychologically). Thirdly, in both countries where FGM is commonly practised as well as in migration countries there appears to be a lack of knowledge as to associating certain health complications with FGM. The last general observation to be made is that especially during pregnancy and delivery great caution must be paid and intensive healthcare must be given to women with FGM. This can be derived from the existing handbooks and teaching materials.¹³⁷

The WHO has acknowledged the urgent need for training material for healthcare professionals in order to offer women with FGM adequate care, and has published various handbooks and (policy) guidelines. While the handbook for frontline workers¹³⁸ from 2000 is still quite general and only gives an overview of the benefits of training for health care providers working at the frontline with communities that practice FGM as an important factor regarding the prevention of the practice others give detailed instructions on how to approach FGM cases. The policy guidelines for nurses and midwives on providing policy guidelines on de-infibulation, re-infibulation, the legal scope of practice, the documentation of FGM and its prevention are important for people working in the field.¹³⁹ Since it is a policy guide, it only states which skills and competences nurses and midwives must acquire, but it does not provide any details on the training itself. Another guide is particularly concerned with the management of pregnancy, which numbers all possible complications in the prenatal, delivery and postpartum period.¹⁴⁰ It gives rather broad instructions for the medical staff on how to proceed and outlines a number of research gaps and uncertainties.

131 The World Health Organization has published handbooks for different groups; for frontline workers, see WHO/FCH,WMH/005, 2000, nurses and midwives: WHO/RHR/01.13, 2001 and WHO/RHR/01.18, 2001, teachers of nurses and midwives: WHO/RHR/01.16, 2001, and a separate one for students of the nursing and midwifery profession: WHO/RHR/01.17, 2001.

132 World Health Organization, "Global strategy to stop health-care providers from performing female genital mutilation", WHO/RHR/10.9, 2010, p. 2 and 3.

133 S.R. Mostafa, N.A., El Zeiny, S.E. Tayel and E.I. Moubarak, "What do medical students in Alexandria know about female genital mutilation?", *East Mediterranean Health Journal*, Vol. 12, Suppl. 2, S78-92, 2006.

134 As mentioned in Serour, G.I. "The issue of reinfibulation." *International Journal of Gynecology & Obstetrics* 109, no. 2, 2010: 94.

135 *Ibid.*

136 See fn. 55.

137 Chalmers and Hash 2000; WHO/RHR/01.13; S. Vangen, R.E. Johansen, J. Sundby, B. Traeen, B. Stray-Pedersen 2004.

138 World Health Organization, "Female genital mutilation: a handbook for frontline workers", WHO, WHO/FCH,WMH/005.

139 World Health Organization, "Female genital mutilation: the prevention and the management of the health complications. Policy guidelines for nurses and midwives", WHO, WHO/RHR/01.18, 2001.

140 WHO/RHR/01.13.

Detailed training material is provided by the WHO teacher's and student's guide.¹⁴¹ Specifically designed for teachers and students respectively, these guides consist of modules addressing not only health complications and instructions for management thereof but also the necessary cultural background. The modules on cultural background delve into beliefs, values, attitudes as well as strategies for the prevention of FGM. The former modules teach the identification of health complications due to FGM, management of such health complications, counselling skills, the identification and management of psychosocial and sexual complications, the procedure for de-infibulation and one specific module addresses complications during pregnancy and childbirth. Furthermore, the guides include a number of case studies and checklists (on taking history, on physical examination, counselling and de-infibulation). All in all these guides provide a comprehensive source for the medical skills needed when dealing with FGM cases and may be used by both medical staff acquainted with FGM as well as medical staff confronted with this custom for the first time.

Other guides specifically address medical staff in countries where FGM is not commonly practised and where healthcare professionals lack the experience, knowledge and cultural sensitivity when dealing with women who have undergone FGM. One guide gives very detailed instructions on de-infibulation, re-infibulation and clitoral repair/restoration.¹⁴² In addition to the instruction on the operation itself, the manual reiterates the need for cultural sensitivity and psychological support for women who have undergone FGM. Such women may have fears or doubts and need specialised counselling. It has also been recommended that an interpreter be provided and that the terminology the woman uses be used by professionals.¹⁴³

Comprehensive practice guidelines have also been provided by the UK government.¹⁴⁴ These give instructions for health professionals, police officers, children's social care and schools, colleges and universities. Issues addressed are an introduction of the FGM procedure (explanation of its types, prevalence, cultural background), identification of women and girls at risk, good practices, the legal background and prevention.

141 World Health Organization, "Female genital mutilation: Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Teacher's Guide", WHO, WHO/RHR/01.16, 2001; World Health Organization, "Female genital mutilation: Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Student's Manual", WHO, WHO/RHR/01.17, 2001.

142 J. Abdulcadir, C. Margairaz, M. Boulvain and O. Irion 2011.

143 L. Perron, V. Senikas, M. Burnett and V. Davis, "Clinical Practice Guidelines No. 299: Female Genital Cutting", The Society of Obstetricians & Gynaecologists of Canada, Vol. 35, Issue 11, 2013, p.1-18.

144 Home Office and Department for Education, United Kingdom, "Multi-Agency Practice Guidelines: Female Genital Mutilation", first published 2011, updated 2014, part of: Female genital mutilation and violence against women and girls.

STATE OF KNOWLEDGE AND RESEARCH GAPS

In this literature review the current state of knowledge and research available as well as research gaps have been outlined and critiqued.

Internationally, millions of girls are affected by FGM practices as it remains supported by large parts of the societies they are part of. In 1979, the first global efforts were taken to form legislation targeting the excisors, practitioners and communities continuing the practice (WHO Seminar on traditional practices affecting health of women and children; UN adopted CEDAW). These efforts are continued ever since. However, there is still no comprehensive EU strategy in place. The Istanbul Convention has been adopted, combating and preventing violence against women and domestic violence, yet, FGM has not been recognised as a criminal act by all Member States. Today, there is also no harmonised approach to granting international protection and asylum on FGM grounds in the EU.

Malta has ratified several of the international conventions, including the UDHR, CEDAW, CAT, CRC, ECHR, and the Charter of Fundamental Rights of the European Union. Recently, the Maltese Government also adopted the Istanbul Convention. Nationally, a Bill was passed in 2014, to introduce a law specifically banning FGM in all forms, be it against Maltese citizens or permanent residents, both in Malta and abroad. Currently, there is no statistical data available, nor much knowledge about the practice since women are hardly involved, but it has been recognised that there is a need for specific training and guidelines, as well as a regulatory and legal framework.

A few important studies have identified a long list of health complications that are associated with FGM. Furthermore, efforts are undertaken to increase awareness, knowledge and response to FGM policies, health complications and patient interaction.

However, most of the studies undertaken do not provide sufficient proof for conclusive findings of the health complications, meaning that thus far no final statements can be concluded. Instead, the relation between a number of health complications and FGM remains an assumption in many cases, especially regarding long-term complications. Based on the review and evaluation of the available research, a number of research areas have been identified. While few appear to be rather “dead ends”, for the most part further research is urgently needed. The following topics are in need of further research: Mental health issues, as they are particularly under-researched; The association with urinary tract infections, (vaginal) infections and sexual impact, as these are rather assumed than proven; Health complications associated with pregnancy and childbirth. These have already gained considerable attention, particularly prolonged labour, need for caesarean section, episiotomy, prenatal complications and long-term psychological effects, but further research is vitally needed for verification/falsification of the claims. Furthermore, with growing migration flows further studies on the health care of migrant women who have undergone FGM in their home country and now live in a country where FGM is not practised, should be undertaken. Lastly, while training material for medical staff exists and include some crucial instructions, these guides depend on studies done on the health complications themselves and are therefore mostly lacking detailed and comprehensive instructions.



THE LEGAL FRAMEWORK

This section provides an overview of the key legal provisions related to Female Genital Mutilation at the international, regional and national level. Instruments calling for the elimination of the practice include both general and specialised international and regional instruments, as well as a number of soft law instruments many of which seek to interpret and / or expand the scope of the instrument they are issued under. This section is not intended to provide an exhaustive analysis of those provisions but rather to provide an overview of the legal basis for efforts to combat FGM in Malta.

THE INTERNATIONAL CONTEXT

As highlighted in the literature review section of this report female genital mutilation is recognised as a harmful practice and a human rights violation. Its prohibition is therefore based in several international and regional human rights treaties. These instruments include both general instruments and specialised instruments. Legal basis for abolishing FGM can be found in, amongst others, the Universal Declaration of Human Rights (hereinafter Universal Declaration)¹⁴⁵, the International Covenant on Civil and Political Rights (hereinafter Civil and Political Rights Covenant)¹⁴⁶ and the International Covenant on Economic, Social and Cultural Rights (hereinafter Economic, Social and Cultural Rights Covenant)¹⁴⁷. These instruments provide, amongst other things the prohibition of discrimination, the prohibition of torture, cruel and inhuman treatment and the protection of the right to life and physical integrity. These instruments have been supplemented by regional treaties, including the European Convention for the Protection of Human Rights and Fundamental Freedoms (hereinafter European Convention)¹⁴⁸, the European Charter of Fundamental Rights which contain provisions protecting the rights of women and girls and directly or indirectly requirement the prohibition of FGM. All of these instruments have been signed and ratified by Malta. Given the harm inherent in FGM, the Convention against Torture, Cruel and Inhumane Treatment is also relevant in this context.

More direct provisions are also found in more specialised treaties. The Convention on the Elimination of all Forms of Discrimination against Women (hereinafter CEDAW)¹⁴⁹ provides for the elimination of all forms of discrimination against women. The link between the Convention and FGM has been clearly articulated by the Committee on the Elimination of Discrimination against women in its General Comment Number 14 in which the committee recommends to States Parties to the Convention to take appropriate and effective measures with a view to eradicating the practice of female circumcision. Moreover, the Convention on the Rights of the Child (hereinafter Children's Rights Convention)¹⁵⁰ obliges States Parties to 'take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'. Both these instruments have also been signed and ratified by Malta.

145 UN General Assembly, Universal Declaration of Human Rights, 10 December 1948, 217 A (III), available at: <http://www.refworld.org/docid/3ae6b3712c.html> [accessed 5 May 2015]

146 UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171, available at: <http://www.refworld.org/docid/3ae6b3aa0.html> [accessed 5 May 2015].

147 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: <http://www.refworld.org/docid/3ae6b36c0.html> [accessed 5 May 2015].

148 Council of Europe, European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14, 4 November 1950, ETS 5, available at: <http://www.refworld.org/docid/3ae6b3b04.html> [accessed 5 May 2015].

149 UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, available at: <http://www.refworld.org/docid/3ae6b3970.html> [accessed 5 May 2015].

150 UN General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3, available at: <http://www.refworld.org/docid/3ae6b38f0.html> [accessed 5 May 2015]

Under The Istanbul Convention which Malta has signed, States parties are obliged to protect and support women affected by violence including FGM. The convention requires the provisions of services including legal assistance, shelters, medical assistance and counselling. Moreover, the Convention recognises the need for international protection for women and girls fleeing their countries from FGM would be able to seek international protection.

Whilst not legally binding declarations and resolutions have a significant impact on the understanding of international obligations. The Declaration on the Elimination of Violence Against Women¹⁵¹, which has been adopted by the General Assembly characterises FGM as a form of violence against women. The Programme of Action of the ICPD (hereinafter ICPD Programme of Action)¹⁵² and the Beijing Declaration and Platform for Action (hereinafter Beijing Platform for Action)¹⁵³, both call upon governments to take action against FGM.

As noted elsewhere, FGM violates a number of rights including the prohibition of discrimination, the right to life (in cases where it results in death), protection of physical integrity, the right to health, and the prohibition of cruel and inhuman treatment. As such, the provisions of these various conventions and instruments discussed above are directly relevant to the fight against FGM. Importantly, some of these obligations do not only include a negative obligation to prohibit certain things, but also positive obligations to work actively towards the elimination of such practices. Moreover, whilst the perpetrators of human rights violations in the context of FGM are rarely State actors, the responsibility of the State to ensure that human rights are respected even by non-State actors is critically important and creates a liability for the State.

NATIONAL LEGISLATION

CRIMINAL LEGISLATION

FGM has been a specific criminal offence in Malta since January 2014, with the amendment¹⁵⁴ to the Malta's Criminal Code¹⁵⁵. Prior to this amendment, FGM could be prosecuted under the broader offence of bodily harm. The provision, defines female genital mutilation as the performance, for non-medical reasons of an operation or the carrying out of any intervention on a woman's genitalia that damages the genitalia or inflicts upon them permanent changes¹⁵⁶. The act is punishable with imprisonment for a term from 3 to 9 years. The crime is considered as aggravated if committed by a family member, or against a child or other vulnerable person, if it is committed by two or more people or is preceded or accompanied by violence or with the use or threat of use of a weapon. Moreover, the crime is considered aggravated if it results in severe physical or psychological harm for the victim. Such aggravation results in an increase in the punishment of between one and two degrees. The consent of the victim does not exempt the perpetrator from punishment.

151 UN General Assembly, Declaration on the Elimination of Violence against Women, 20 December 1993, A/RES/48/104, available at: <http://www.refworld.org/docid/3b00f25d2c.html> [accessed 5 May 2015].

152 Programme of Action of the International Conference on Population and Development, Cairo, Egypt, September 5-13, 1994, U.N. Doc. A/CONF.171/13/Rev. 1 (1995).

153 United Nations, Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women, 27 October 1995, available at: <http://www.refworld.org/docid/3dde04324.html> [accessed 5 May 2015].

154 A BILL entitled AN ACT to further amend the Criminal Code, Cap. 9., 2014.

155 ACT No. 1 of 2014- Amending Criminal Code, Cap 9. Article 251E.

156 Article 251E of the Criminal Code, Cap 9 of the Laws of Malta

Moreover, the code criminalises individuals who willfully fail to seek to avert via formal complaint or in another manner, FGM. Such failure is punishable by a fine of between 1000 and 5000 Euros and / or imprisonment for between 6 months and 2 years. Moreover this duty to avert applies irrespective of any duty of confidentiality. Aiding, abetting counselling or procuring a female to excise, infibulate or otherwise mutilate the whole or any part of her own genitalia is also punishable under the same provisions.

Of particular importance and in line with good practices in the field, the Maltese criminal code provides for the extra territorial application of the provision in extending the jurisdiction of the Maltese court over the crime when only part of the crime took place in Malta, or when the offender or the victim is a Maltese national or a permanent resident in Malta. At the time of writing, no cases had been decided on the basis of this legal provision.

VICTIM PROTECTION AND VICTIMS RIGHTS

Beyond the criminal law provisions, a number of other national legal provisions are relevant including child protection laws and victim support laws. The Children and Young Persons (Care Orders) Act¹⁵⁷ provides the possibility of issuing care orders and in some cases taking a child away from her parents if she is at risk of harm. The act provides that if after listening to various representations the Minister is satisfied that that child or young person is in need of care, protection or control, it shall be the duty of the Minister by an order in writing under his hand to take such child or young person into his care. In practice this means that the custody of the parents is suspended for the purposes of ensuring the protection of the child. It is clear that protecting a child from FGM would meet the requirements set out in this provision.

Moreover, the victim's rights directive obliges member states to provide support services for victims during and after proceedings, provide training for practitioners (judiciary and police) and provide cooperation and coordination amongst services. Malta is currently in the process of transposing the provisions of the directive into national law. The enactment of the act will provide an important level of support for victims of crime generally including victims of FGM. There is no national provisions requiring training and awareness raising and therefore the criminal law provisions act as the primary preventive piece of legislation.

INTERNATIONAL PROTECTION

Moreover, international, European and Maltese asylum legislation provides the possibility for the granting of international protection to persons who have been subjected to FGM or who are at risk thereof. This is on the basis of the serious human rights violations associated with FGM and the fact that persons at risk have been characterised as a particular social group within the parameters of the Convention. Moreover, the European Asylum acquis, which national law also transposes, makes specific provisions regarding the reception conditions and procedural standards for vulnerable persons.

157 The Subsidiary Legislation 285.01, Children and Young Persons (Care Orders) Regulations, Legal Notice 49 of 1985, as amended by Legal Notices 43 of 1999 and 102 of 2005, Paragraph 10(1).

RESEARCH RESULTS AND ANALYSIS

This research consisted of a number of different methods utilised to develop a holistic view of FGM practice and perception in Malta. This section highlights the responses of stakeholders and their engagement with the issue. Over the past years a number of countries where the practice is common have banned FGM; others have worked to address the issue which presents primarily in migrant groups from particular countries. In Malta, the population affected or potentially affected by FGM is relatively small. Whilst being a positive factor, in terms of the provision of services, this is a key challenge as the provision of education, training and capacity building for those who may need to assist women who are affected by FGM would be relatively large compared to the service user population.

The sample of professionals was identified via a stakeholder mapping exercise. Of course, one could argue that all medical professionals, particularly those working with women and children, are stakeholders in this process, as indeed they are. However, given the small sample size, key individuals were selected to understand, in broad strokes, the policy and organizational level needs of addressing the issue rather than having a statistical compilation of a far wider representation of stakeholders.

The sample of migrants was one of convenience. It is interesting to note that two things affected this sample. The first is that in Malta there is a far higher population of men than women from countries in which FGM is practised; the second is that women were more reluctant to speak about the practice. This could present a significant challenge insofar as understanding women's own engagement with both the physical procedure itself as well as the socio-cultural understanding of the practice. It may also be the case that given that most migrants are aware of the illegality of the procedure, the migrants who were willing to speak to us were inclined towards this view and were therefore open to discussing this; whilst those who are in favour of the procedure may be more reluctant to discuss it.

The analysis of these interviews has been divided into professional or identity groupings, in order to extract key findings and develop stronger recommendations aimed at the different groups approached.

HEALTH CARE PROFESSIONALS

GENERAL INFORMATION

Four female health care professionals were interviewed for the purpose of this research and they were between the ages of 23 and 53, including a managerial level individual in the office within primary health care in Malta, a nurse and two midwives. Education levels ranged from Bachelor degree to Doctorate and all respondents received their undergraduate university education in Malta. Post-graduate studies were obtained in the United Kingdom.

THE TRAINING GIVEN RELATED TO FGM

The findings of this report highlight that health care professionals in Malta have limited exposure to transcultural health education and training, including FGM.¹⁵⁸ The primary resource for professional development training and education for health care professionals related to transcultural health is the Migrants Health Liaison Office. The Office was created in August 2008 as a response to the large influx of migrants arriving in Malta at the time. Operating under the auspices of the Department of Primary Health, the office seeks to bridge the cultural gap between the Maltese health care system and the needs of migrants, who come predominantly from sub-Saharan Africa and more recently from the Middle East, by engaging with both parties. While the health needs of the migrant population group include questions of access, meaning where, when and how to seek medical help – which are addressed during health education sessions specifically tailored and attended by members of the migrant community – health care professionals are in turn faced with new challenges related to different cultural understandings of the causes of diseases and the interpretation of symptoms. In other words, the increase in cultural diversity among the population of Malta led to the need for tools among health care professionals to manage complex differences in communications styles, attitudes, expectations, as well as language barriers. In response these needs, the Office provides training for health care workers, social workers and university students on the topic of cultural issues in health care, including FGM. For the benefit of health care professionals in Malta, the office furthermore participates in European Union (EU) programmes, seminars and workshops on the topic of migration and health.¹⁵⁹

However, the topic of FGM was only exclusively dealt with in one training session, namely “Addressing Female Genital Mutilation (FGM): Nurses/Midwives at Mater Dei Hospital” (July 2015) and one seminar “FGM – Like Mother, Like Daughter?: Exploring the health and socio-cultural dynamics of Female Genital Mutilation/Circumcision” (October 2010). In addition to this, the training session “EQUI – Health Training for Health Professionals: Migration and Associated Challenges” (November 2014) included one half an hour session specifically on FGM.¹⁶⁰ Health care professionals in Malta also attend professional development training on self-initiative in the country or abroad. The United Kingdom has been named as one of the most important locations for professional development training abroad¹⁶¹ together with conferences as well as workshops attended in Belgium and Ireland.¹⁶²

158 Conclusive finding as a result of interviews with P17 – Health Care Professional and P20 – Health Care Professional

159 Professional development training and seminar sessions for health care professionals in Malta held by the office to inform health professionals of the importance of cultural mediation amongst others, for the purpose of this report include “EQUI-Health Training for Health Professionals continued: EQUI-Health Training to Health Professionals continued” (Throughout 2015), “Training in Intercultural Competence in the Public Service” (March-April 2015), “EQUI-Health Training for Health Professionals: Migration and Associated Challenges” (November-December 2014), “Training for Health Professionals as part of the Mare Nostrum Project: Common Approach to upgrade asylum facilities in Italy and Malta” (March – April 2011), “Seminar: Migration, Culture and Health: An Anthropological View” (September 2010), Seminar: Cultural Issues: Beliefs, Values and Attitudes in Health Care” (May 2010) and “Seminar: Health Professionals in Primary Health – Addressing Migrant Health Issues” (December 2008).

160 Information provided by P2 – Health Care Professional

161 Interview with P17 – Health Care Professional

162 Interview with P2 – Health Care Professional

Concerns were raised that due to a lack of staff members in relation to the workload, it is often challenging to attend professional development training, even the one provided directly at the work place.¹⁶³ Moreover, training specifically related to FGM is not offered as frequently and consistently as it should be. One Health Care Professional working as a midwife recalled vaguely that she had heard of FGM during a training course;¹⁶⁴ yet later in the interview, the same respondent expressed having forgotten the details of the training and her wish for further training specifically related to FGM. A young midwife who works with female patients from African countries on a very frequent, sometimes daily basis, also expressed the wish to receive further training.¹⁶⁵ All health care professionals interviewed reported independently accessing information on FGM, predominantly via the internet.¹⁶⁶

Next to professional development training, the Office also offers transcultural training for future health care professionals studying at the University of Malta. In recent years the Transcultural Health module was incorporated in the curriculum of the BSc Community Nursing Students in April 2010 and May 2014. EQUI – Health Training for Health Professionals specifically addressed GP trainee specialists, BSc Nursing Students, BSc Community Nurses and Diploma Nursing Students.¹⁶⁷

PERCEPTION OF FGM

The perception of FGM among health care professionals cannot be described as homogenous or stable. Whereas all respondents were aware of the existence of the practice, the ability to elaborate on specifics of the practice in more detail, including knowledge on its typology or reasons for the practice, varied significantly among respondents. It is a widespread perception that girls are at risk in Malta and that those girls are the children of sub-Saharan migrants in Malta, with Somali girls being the ones most at risk. Despite the lack of evidence, respondents would not exclude that FGM has been or is practised in Malta.

A senior midwife, holding a Master in Midwifery from the University of Malta, while very much aware of the practice - drawing the various types seen from personal experience on a piece of paper - was neither able to elaborate in scientific or specific detail the different types of FGM nor confidently list practising countries. Interestingly, according to the same respondent, re-influbation used to be carried out in Malta by certain individuals “to help the women go back to their culture.”¹⁶⁸ These individuals were health care professionals or women from the same culture. While the respondent was sure that health care professionals stopped re-influbating women who requested it after birth, doubt remains when it comes to other migrant women:

“I’m not sure if it’s happening anymore but it used to be done by other women in the same culture who would re-suture her if we open her or if she had a baby. If someone had a baby and she was opened and then she comes back with another baby and she is closed, something is happening. So the other woman in the area in the same culture would re-suture them again.”¹⁶⁹

163 Interview with P17 – Health Care Professional

164 Ibid.

165 Interview with P20 – Health Care Professional

166 Interview with P 2, 4, 17 and 20 – Health Care Professional

167 Information provided by P2 – Health Care Professional

168 Interview with P17 – Health Care Professional

169 Ibid.

Another respondent, involved in health education and professional development training amongst others, identified three out of the four different types of FGM¹⁷⁰ in an assured and correct manner.¹⁷¹ Accordingly, it was clarified that the practice is not, contrary to the claim by some, related to religion but culture, tradition and social considerations, such as marriageability as well as social standing or fear from community exclusion, and that FGM is predominantly carried out in sub-Saharan African countries, including Eritrea, Somalia, Nigeria, Egypt and Ethiopia.¹⁷² When discussing FGM with individuals who have undergone the practice, the respondent was made aware that the practice was forced upon all women when they were very young. Furthermore, the decision whether a girl is being subjected to the practice is usually decided by the females in the family, mother or grandmother, and performed by female elders, usually of a certain social status, in (village) communities.¹⁷³

Although recognising the severe health consequences and risks, short and long term, and as a result not agreeing with the practice, all health professionals who participated in this research noted that the debate surrounding FGM is not a clear-cut issue. This is mainly due to the fact that the practice might carry a valuable cultural meaning for women from practising communities, which people outside these communities might not necessarily be able to fully comprehend. To challenge common, public Western perception and prejudice of the practice, two of the respondents¹⁷⁴ critically drew upon the comparison between FGM, specifically re-infibulation after birth, and Labiaplasty; thereby suggesting a certain contradiction arising out of the criminalisation of FGM in the Maltese context:

“Labiaplasty (...) Are we questioning that too? Okay, you’ll say it’s consensual. The only different thing here is that children don’t consent to having this done. Adults in the western world they have all the shapes, whatever range they are, they are consenting for that. But our law, if you read it well, it says that even if I decide to have that done now as an adult, if I consent to it and someone carries it out, it’s still against the law.”¹⁷⁵

170 As established in a Joint Statement by WHO/UNICEF/UNFPA Joint Statement classified female genital mutilation into four types.

171 Interview with P2 – Health Care Professional

172 Ibid.

173 Ibid.

174 Interview with P2 – Health Professional and P4 – Health Professional

175 Ibid.

PRACTICAL APPROACH TO FGM

Health complications that come with the practice have been identified by the health professionals to be short-term, long-term and psychological, the three categories not being mutually exclusive. Short terms consequences could be shock, meaning that the girls' most important organs would shut down because of bleeding, as well as tetanus as a result of the equipment, for example equipment used on several girls consecutively without proper cleaning, rusty material or broken glass.¹⁷⁶ The respondents named sepsis, a severe infection which can be lethal; other infections due to sluggish menstruation blood remaining inside the body and complications related thereto; pain in general; severe pain during sexual intercourse and incontinence as long term consequences.¹⁷⁷ Psychological consequences might arise in form of trauma due to stress to have been subjected to a sever human rights violation or depression resulting out of frustration not being able to enjoy sexual intercourse and feeling inferior to the other gender or person who has performed the practice without consent of the individual.¹⁷⁸ However, one response to the question of psychological consequences as a result of FGM distinctively stood out:

“That’s a very western kind of question, so that doesn’t really make sense. There could be psychological implications for us, because we look at it in a psychological kind of way, but not for them. (...) That question is tricky, because even with psychology, it’s a western thing, you can’t always import it, export it, whatever. It’s the same with post-traumatic stress disorder. Some cultures like to talk about that stress and some cultures don’t. So it doesn’t mean if it works for us, it works for them. What if being stopped from having the cutting causes them psychological trauma more than the opposite?”¹⁷⁹

It has been repeatedly stated that the manner in which the subject is tackled requires a high level of sensitivity from the side of the health care professionals.

The practical approach of health care professionals in Malta comes with a number of difficulties linked to limited, irregular education and professional training opportunities on the topic which results in a lack of knowledge, confidence and cultural understanding that would be necessary in order to offer the most considerate and tailored treatment to patients who experience health complications as a result of having undergone FGM.

176 Interview with P2 – Health Care Professional

177 Interview with P2, P17 and P4 – Health Care Professional

178 Interview with P2 – Health Care Professional

179 Interview with P4 – Health Care Professional

Firstly, limited education on transcultural health issues does not allow for health complications connected to FGM to be recognised as such and not in a timely manner. A recently graduated midwife stated that she has seen one case of FGM while caring for a woman during labour who had undergone the practice: “I was finding hard to catheterise her, we couldn’t even put the catheter through. So I think it was [FGM] because sometimes they tell me that it just an outer area, but I think she was completely.”¹⁸⁰ At the time the respondent was unsure whether it might be a case of FGM since she was only aware of type I and II. It was not until the senior midwife reassured her, that it was a case of FGM of type III, that she felt certain. This lack of professional confidence among young health care professionals could be counter-balanced by introducing transcultural health issues, including FGM, as an obligatory module among all health care professional degrees at the University of Malta. All respondents agreed to also introduce matters of transcultural health to teaching personnel and students at all level of schooling with the exception of primary school among students.

Secondly, the lack of regular professional training opportunities or temporal space for health care professionals to attend such training when provided affects the confidence and ability to professionally as well as ethically exercise the duty to care of senior health care professionals towards women who have undergone FGM. In this context, one of the respondents spoke of situations in which women, who were circumcised and in labour, had to be given anesthesia and deinfibulated without prior discussion regarding this action:

“There were times where you had to open without saying anything. At the moment the concern is the baby’s health and it’s very important.”¹⁸¹

The immediate situation of such cases was described as one in which communication and the lack thereof is a crucial concern among health care professionals. The women themselves neither wished to talk about potential health problems that might occur as a result of FGM nor the practice itself, in particularly not in front of their men or any men:

“When they were in labour, you would try to speak to her but mostly if the man is there it’s not a subject you speak about. (...) You’d say, ‘Listen, the baby won’t be able to come out. You might be opening a bit. Your health and the baby’s health.’ You would try and explain a bit. But again, there is bit of a language barrier. Unless you have an interpreter who’s another woman, if there is a language barrier then we have a problem.”¹⁸²

Cultural mediators, assisting health professionals and clients alike to overcome language and cultural barriers, seek to address this problem. Unless the cultural mediator is another woman, which usually is not the case, communication between health care professionals and patients is hindered by a variety of factors, namely lack of cultural understanding of the practice as well as medical implications thereof on side of the health care professionals in combination with language barriers and a reluctance of women who have undergone the practice to speak about the matter.

180 Interview with P4 – Health Care Professional

181 Interview with P17 – Health Care Professional

182 Interview with P17 – Health Care Professional

Thirdly, certain structures in place do not allow health care professionals to provide for preventive care. For example, a senior midwife in charge mentioned that it is hard from them to know whether FGM is still practised on young girls in Malta since after birth, midwives only care for their female patients for another six to eight weeks. However, “when it is being done, it is not being done in the first six or eight weeks.”¹⁸³

Respondents suggested various forms of models of care that have the potential to enhance both, the services available to women who have undergone the practice and the confidence of health care workers to tackle the matter. For example, one respondent suggested the establishment of a FGM clinic in Malta offering the option of deinfibulation and providing counseling that can address the physical and psychological suffering of the women:

“I think there should be a FGM clinic. I think they should have the option of deinfibulation that means to reverse. Of course, there needs to be a lot of counseling because if they have type three, it will take them about 15 minutes to pass water, whereas after the deinfibulation they would feel a pass of water coming out and that might shock them. Again for the man if there is deinfibulation, the sensation of sex intercourse will be different obviously for both of them, so you need to know beforehand. Also she would have a heavy period because before, it just used to trick in.”

Another respondent is not going as far as suggesting the establishment of a separate clinic but nonetheless is advocating for a more person-centered care and holistic approach:

“It is person-centred care, holistic approach, learning how to be sensitive, thinking what the person wants, what the person knows, you ask the person what do you think has caused the problem? (...) If some people come with FGM-related problems, I would ask what do you think is causing the problem? Then she might even say herself that, you know, it’s because I have been cut or I have been sewn or whatever. (...) So you’re giving the person a voice.”¹⁸⁴

The decision to take a step back, let the women themselves speak first has been mentioned by a number of respondents. This rather passive approach as a model of care from the side of the health care professionals might, in turn, provide for empowerment and open discussion in addition to care.

Most of the health care professionals interviewed for the purpose of this research are members of professional associations including the European Transcultural Nursing Association or Malta Midwives Association.¹⁸⁵ Yet, none of the associations cater a policy that specifically supports the respective health care professionals in dealing with individuals who have undergone the practice or are at risk of it. All respondents were of the opinion that professional policies need to be in place within the respective associations and their work places, including the hospital and health care centres.

183 Ibid.

184 Interview with P4 – Health Care Professional

185 Interview with P2, P17 and P20 – Health Care Professional

Despite the lack of specific education, professional development training and professional policy all respondents were aware of the change in law regarding FGM. From a health care professional's perspective, criminalisation is not necessarily the best way to address the matter since it might jeopardise individuals accessing certain services that are available to them because they know about the law in place. All of the respondents were aware of their legal obligation to report when becoming aware that someone has recently and in Malta undergone the practice. Nevertheless, none of the respondents opted to immediately report cases of FGM to the police and treating the matter as a criminal offence. Instead, health care professionals tend to consult with superiors in order to decide upon the next step on a case-by-case basis. Given the fact that health care professionals, next to social workers and other closely related stakeholders, are one of the most important sources to find out whether FGM is being practised in Malta, their tendency to not report the incident directly as criminal offence for reasons of cultural sensitivity and medical security, strongly questions the overall effectiveness of the law in place aside from it functioning as a deterrent.

Lastly, all health professionals interviewed for the purpose of this report agree with and are aware of the fact that their profession has a very decisive role to play in the treatment of individuals who have undergone the practice and those who might be of risk doing so. While the major concerns of professionals working in the field related to FGM are the language and cultural barriers, gender inequality, the severe bleeding and pain as well as infections and urination problems, the respondents clearly identified a couple of measures which might improve the ability of health care professionals to care for patients who have undergone the practice and those who are at risk of doing so. These suggestions include an increase in education and professional development training opportunities¹⁸⁶ as well as enhanced and timely communication between health care professionals and patients, for example increasing the cultural mediator training and starting incentives that make it particularly attractive for women to attend or addressing the issue with pregnant women who have undergone the practice early on in the pregnancy to be able sensitively and respectfully discuss the possibility of having to deinfibulate for the health of mother and baby at birth.¹⁸⁷

186 Interview with P4 – Health Care Professional

187 Interview with P20 – Health Care Professional

ANALYSIS AND DISCUSSION

It is evident from the information given by the health workers interviewed that information about FGM is only delivered sporadically and on the basis of singular or project-based events. Whilst some healthcare practitioners also have the opportunity to attend courses abroad, there is no prioritisation to take courses relating to FGM or gender based violence more broadly, and therefore there is no measure of how many individuals or teams have attended training events that have addressed the issue.

Yet the challenges faced by health professionals addressing FGM are not simply linked to the training time taken, but rather to a wider tasks burden which means that training and ongoing professional development are not sought as often as staff members would like to. The fact that the population of women affected by FGM is relatively small may mean that the issue is not deemed as a priority within the hierarchy of training needs, and that therefore although the procedure of FGM can have serious and even life-threatening implications, it may not be prioritised as other ailments which present more often in an emergency ward or indeed in routine check ups would be prioritised. This is indeed a challenge for the health system, both in terms of identifying risk as well as in adequately addressing the needs of a particular population within an already vulnerable population.

Yet with training needs comes also the need to develop further protocols for addressing the needs of patients who have had FGM, that is, having clear guidelines that address both the psychosocial needs of women and girls, as well as the physical complications and remedies available. Closely linked to this is the child protection aspect which would require not only addressing the needs of an individual presenting with FGM, but also other female family members (particularly younger sisters or daughters) who are at higher risk of being affected by FGM.

On a physical level, more emphasis needs to be made on the detection of FGM. Those who were interviewed were not confident in describing the different types of FGM, and due to this lack of familiarity with the practice in its widest sense, would struggle to identify girls or women who have had scarring or pricking rather than, for instance, Type 3 FGM.

Beyond the remit of physical care, FGM must be addressed within a number of wider categories. The first is gender based violence; the second is child protection; and the third is intercultural healthcare. Whilst the first two are discussed in more length in other parts of this report, intercultural healthcare is a concern relating to both the short and long term needs of a diverse population. Whilst intercultural healthcare is challenging both philosophically as well as in practical terms is attested by the fact that some healthcare workers struggle with whether FGM should be allowed or not given that many women are strongly adamant that it is a necessity; despite being in wider (although not unanimous) agreement that this is a harmful and even cruel practice. At the same time, addressing and approaching FGM needs to be done in a culturally sensitive manner; in a form of discussion; so as to avoid both cultural clashes as well as reluctance to seek medical help should they require it. More familiarity with the topic through open discussion and training should also allow healthcare professionals to be able to have more confidence in addressing FGM within their professional groups as well as with patients, given the appropriate language intervention (most often in the form of translators or other linguistic aids).

At the same time, the questions asked about FGM may also be asked about Western practices such as labiaplasty, whereby an unnecessary surgery is carried out on the woman to enhance beauty or attractiveness. Whilst the latter is done on the basis of consent of the woman involved, it should be noted that FGM is illegal in Malta even if the woman on whom it is carried out is an adult and gives consent; yet in practice, FGM is almost invariably carried out on girls under the age of 15.

PROTECTION PROFESSIONALS

GENERAL INFORMATION

Three protection professionals were interviewed for the purpose of the research and they were between thirty-two and fifty-four years of age. Protection professionals interviewed for the purpose of this research consist of individuals associated with service providers for refugees, asylum seekers as well as migrants in addition to, more generally, children and women. All of the respondents in this category have obtained their undergraduate degree from the University of Malta and their Master degree abroad in the United Kingdom or Switzerland. Institutions attended were the University of East London, University of Manchester and Institut Universitaire Kurt Bösch.

TRAINING GIVEN ON FGM

In the case of protection professionals, knowledge on FGM has predominantly been obtained by own initiative and via the internet. None of the respondents received transcultural training including FGM in Malta. However, some of the respondents received specific training abroad, obtained at university level in the United Kingdom. Professional development training is attended on a regular basis between two and five times a year, mostly in Malta but also within the European Union. Some of the protection professionals do provide professional development training themselves for midwives, nurses and doctors with the aim to bring the voices of the migrant women and men on this topic across.¹⁸⁸ It is for reasons of personal experience and lack of specific university training as well as professional development training that all the protection profession respondents advocated for increasing inclusion of the topic in the curricula of students of all disciplines, which are vaguely related to their respective service providers, including law, international relations, midwifery, nursing and social work.¹⁸⁹

¹⁸⁸ Interview with P6 – Protection Professional

¹⁸⁹ Interview with P6 – Protection Professional

PERCEPTION OF FGM

Complementing the information provided in the previous section on health care professionals, the perception of FGM is naturally of a much more practical rather than medical nature, arising out of the fact that protection professionals deal with individuals who have undergone the practice or are at risk of doing so on a day-to-day, practical rather than medical basis. Yet, all of them knew about the practice and described the existence of three types¹⁹⁰ corresponding with various stages of severity. According to the protection professionals, FGM is an enforced¹⁹¹ form of violence against women¹⁹² and a human rights violation, particularly towards the young girl, since no consent was given prior to exercising the practice¹⁹³, which is not related to religion but to cultural beliefs and tradition and practised in sub-Saharan countries and Egypt, where the process of medicalisation of FGM is increasingly taking place¹⁹⁴. A protection professional working in the realm of children's rights identified FGM as part of their concern. According to the respondent, the practice does amount to child abuse which was defined as any action which violates the rights of the child and results in psychological or physical harm.¹⁹⁵ Another respondent described the practice as a manner of controlling women and an interference with the very essence of what it means to be a woman.¹⁹⁶ Alternatively, another respondent depicted FGM in the following way:

“It is barbaric. I don't believe in traditions or cultures, I just think that in today's age it is definitely against human rights and therefore should be illegal wherever.”¹⁹⁷

Contrary to this claim, the tradition, according to the respondents of this group, prescribes that community identity arises out of marriage which in turn depends on whether a girl has been cut and through this practice is in a healthy state and reached womanhood. Most of the respondents understood from interaction with their clients that women who have not undergone the practice are easily rejected by the community and perceived as dirty and unhealthy. Furthermore, the practice was perceived as an action “deeply engrained” in the culture of certain communities¹⁹⁸ which was passed one from generation to generation as a result of misinformation, lack of education and resistance against forced upon Western values¹⁹⁹. Albeit the absence of official confirmation, all the protection professionals fear that FGM could be carried out on young girls in Malta. Furthermore, it is suspected that young girls are taken to other places in Europe where the respective community is more established, particularly with respect to female elders.²⁰⁰

190 Leaving out type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

191 Interview with P3 – Protection Professional

192 Interview with P19 – Protection Professional

193 Interview with P3 – Protection Professional

194 Interview with P19 – Protection Professional

195 Interview with P3 – Protection Professional

196 Interview with P19 – Protection Professional

197 Interview with P3 – Protection Professional

198 Interview with P19 – Protection Professional

199 Interview with P6 – Protection Professional

200 Interview with P6 – Protection Professional; this information somewhat corresponds with information given by P21 – Migrant Woman, who confirmed that she knows of boys being brought to Italy

PRACTICAL APPROACH TO FGM

Especially referring to social workers, the practical approach of protection professional to individuals who have undergone the FGM or who are at risk of doing so is built on a relationship of trust rather than medical assistance which leads to an enhanced opportunity for social workers, next to their work which includes support in accessing available medical services in form of health clinics or hospitals, to initiate awareness-raising campaigns reaching affected individuals in a familiar, trusted environment. As a result of this, individuals experiencing health complications related to FGM seem to approach protection professionals before medical personnel:

“Initially, the presenting problem is medical. Many women, mostly Somali, complain of stomach problems, problems with their periods, problems with infections, and it often results to the FGM, because mostly they are completely sewn.”²⁰¹

Respectively, individuals who wish to be re-infibulated or for their daughters to be cut appear to, in the majority of cases, firstly turn to protection professionals rather than health care professionals. In both cases, individuals are met with information, awareness-raising and a referral to respective health care professionals:

“We have had a few requesting or asking recently where can I circumcise my daughter and that is (...) and we discussed with them not on the legality of it but the consequences of it. So over the years we have organised a lot of training and awareness-raising on this issue. What we do get is requests of women after giving birth to be re-sewn. There are a lot of discussions with the doctors and the midwives on this.”²⁰²

In this context, one protection professional called attention to the fact that Malta is lacking adequate university training and professional development training opportunities particularly for health care professionals to deal with the issue:

“We see many people on this level, but obviously in Malta even doctors, gynaecologists and midwives are still - now they’ve improved a lot and they’ve studied on it, but initially it was something that was completely alien to them.”²⁰³

Extraordinarily, a case of a woman was mentioned who had undergone the practice and due to the fact that she was in constant pain, she was, as a result of the efforts of the protection professional, brought to France for reconstructive surgery.²⁰⁴

201 Interview with P6 – Protection Professional

202 Interview with P6 – Protection Professional

203 Interview with P6 – Protection Professional

204 Interview with P6 – Protection Professional

Moreover, all protection professionals identified FGM as a predominant medical issue and see their work related to this matter as more of a secondary approach, which is tasked with referring individuals to more specialised channels. One social worker recalls:

“For example, we had a situation last year where two Nigerian women, who were friends and giving birth at the same time, really requested that their girls at a certain age will have FGM done on them. We worked a lot with them, we showed them videos, we had discussions, we alerted obviously the midwives and the social workers at hospital, because once we knew, we had to. Eventually they accepted and they were shocked at the videos, because they were young when it was done on them and many women that it happens to them, they have no recollection -very few have- of what actually happened and what the possible consequences are. So with discussion and awareness, many do change their mind and they do understand that it doesn't have to be that way.”²⁰⁵

Interestingly, the protection professional working in the realm of children's rights confirmed that there is not much of an interaction between their Office and children of migrants of sub-Saharan decent with the exception of open-centre visits. Further it was emphasised that FGM is a human rights violation which also constitutes a lacuna in the United Nations Convention on the Rights of the Child (UNCRC). Advocacy work and awareness-raising campaigns for individuals affected or at risk but also the general public are used as a tool to highlight the need for this gap in law to be filled.²⁰⁶

A speech given by the Office of the Child Commissioner in definite support and favour of Hon. MP. Dr. Christopher Fearne's efforts to explicitly criminalise FGM as well the inclusion of FGM²⁰⁷ as a stand-alone topic at the Commonwealth's Women's Forum²⁰⁸ are examples of the advocacy work directed at the general public and driven by protection professionals interviewed for the purpose of this research.

A divide among respondents of this category could be noticed when it comes to questions of dealing with individuals who have either undergone the practice or might be in danger or undergoing it as well as reporting. Two out of the three respondents were aware of the explicit criminalisation of FGM as of the beginning of 2014. Regardless, for one of them the issue was not one of legal concern primarily. Medical needs and cultural concerns overshadowed the legal character of the issue.²⁰⁹ The other two, one of them unaware of the change in law in 2014, acted in accordance with their perceived obligation to report individuals who have undergone the practice or are at risk of doing so to the police.²¹⁰

“I feel obligated as a citizen to do it, I know there is the law backing it, and yes I would do it, because I know about it and I feel we should protect people who are vulnerable.”²¹¹

205 Interview with P6 – Protection Professional

206 Interview with P3 – Protection professional

207 Interview with P3 – Protection professional

208 Interview with P19 – Protection professional

209 Interview with P6 – Protection Professional

210 P2 calls for inclusion of the FGM as a topic in the police academy curriculum and also as a professional development training for police men

211 Interview with P19 – Protection professional

ANALYSIS AND DISCUSSION

Within this study we were keen to address the protection needs of those who have been subjected to FGM as well as the preventive protection aspect for those who might be at risk. Whilst all those interviewed had obtained their first degree in Malta, their postgraduate training was obtained elsewhere. However, FGM was seldom discussed, and information about it was obtained largely via the internet. It is interesting to note that in some cases, protection professionals are tasked with providing training to health professionals, and that therefore their training in the social and cultural backgrounds and practices of populations has a wider impact beyond their own professional group.

There is a marked difference in the perception of FGM between health and protection professionals, since the latter view this in terms of the law and human rights, whilst the former are more concerned with the medical nature of the practice and how this relates to physical wellbeing. This could mean a number of things; the first is that we need a broader and more widely accepted definition and approach to FGM; the other that we need to bring different professionals together more often to discuss the issue. In this way they will be able to develop a coherent system of referral, treatment and assistance for women and girls affected by the practice. This link is particularly important in cases of prevention, as through referral one could explore issues that go beyond immediate health needs.

Another key difference in the perspective of protection professionals is that in many ways speaking to such an individual is a question of choice, whereas midwives, nurses and doctors are seen on the basis of necessity. Therefore, whilst medical professionals will be encountering women who would not otherwise have spoken about FGM and may be required to do so due to, for instance, pregnancy; less women will visit a protection professional unless there are other pressing issues for which the relationship of trust has already been built between the woman or girl concerned and the protection professional. It is this relationship of trust that often allows for a wider discussion on FGM and its causes. At the same time, trust has sometimes led to women asking protection professionals where they may have FGM done to their daughters. In this way, then, protection professionals are in an excellent position to prevent FGM, and indeed to discuss the implications (health, psychological and of course legal) of carrying out the procedure.

RESEARCHERS

GENERAL INFORMATION

Within the research field, two individuals were interviewed, a male working as a lawyer in Malta and a recent female law graduate. Neither of the respondents ever received any professional training on FGM. However, both have developed an express research interest in the topic.

PERCEPTION

Both researchers argue that FGM is socially bound, a norm, a custom, to which different cultures adhere. The fact that it happens across different countries and cultures, causes different perceptions of FGM. Even within the same culture individuals can have different reasons for performing FGM, says one of the interviewees.²¹² Both believe FGM practices should stop, especially when there is no informed consent. One of the two interviewees said a distinction should be made between children and adults, as minors are not mature enough to “give free and informed consent”.²¹³

The lawyer argues that the non-state actors that perform FGM should also be seen as agents of persecution, which would provide ground to persecute them under the 1951 Convention. FGM could be seen as an inhumane act of gravity, as it is a form of sexual violence which involves severe physical and mental harm. He sees a problem in the absence of state practice in those states where FGM is prevalent. Sometimes it is tolerated, or even approved, as higher governmental officers support the practice. The way ahead, when these states are unveiling or unable to prosecute or investigate, he argues, is jurisprudence on international level. However, for that to work, the “whole ICC regime”²¹⁴ has to work.

ARE GIRLS AT RISK IN MALTA?

Neither of the respondents had any direct knowledge or information about the risk that girls might be in here in Malta. They have not communicated with women or girls who have undergone FGM, be it here in Malta or anywhere else. However, they both heard rumors that FGM is being performed in Malta, in certain open centers and/or detention centers. The parliamentary debate leading up to the introducing of the Bill were based on these rumors, perceptions, feelings. P1 says, there might have been evidence, but he is not sure.

They do believe that girls are at risk in Malta though, as there is not yet a procedure of prevention. One respondent argues that “there is nothing implemented yet, nothing in force. It’s just the law that has entered into force.”²¹⁵ If a girl is at risk, this same respondent says she would rather speak to this girl first, before reporting immediately. Later on in the interview, she indicates that the first help she would seek would be that of NGOs, as their workers would have most experience with these matters. She argues that when dealing with deeply imbedded cultural traditions, it is important to be sensitive, rather than rigidly imposing the law on them.²¹⁶

212 Interview with P12 – Education Professional

213 Interview with P12 – Education Professional

214 Interview with P1 – Education Professional

215 Interview with P12 – Education Professional

216 Interview with P12 – Education Professional

WHO ARE THE GIRLS THAT WOULD BE MOST AT RISK IN MALTA?

Migrants are seen as the at-risk group in Malta by both the interviewees, coming from different countries including Somalia, Nigeria, Egypt, Eritrea. The first argues that they are between the age of 15 and 17 when they undergo FGM, the latter argues that it happens anywhere between birth and the age of 15. This probably depends on the state or country where they/their parents are from. However, she says, in some cultures it is also performed right after marriage, and often again after giving birth. One respondent sums up who he thinks are the girls most at risk in Malta; firstly, the unaccompanied minors, as they do not have a guardian who looks after and protects their rights and interests. The laws in Malta leave much to be desired also, regarding unaccompanied minors; secondly, girls whose parents adhere to this tradition; and lastly girls who are in a detention center or open center where these processes are undertaken. “Just simply being there physically might put these at risk if this is tolerated somehow or as it’s so latent and hidden and it’s done to others within that same space.”²¹⁷

HOW TO DEAL WITH FGM IN PRACTICE - THE LAW

One respondent argues that the law on FGM was not really introduced on its own, as it was collated with other crimes like forced marriage. So it was introduced as one of the many crimes and thus also criminalised together with other crimes - especially those of a sexual nature, or linked to crimes whereby sexual violence is *consummated* upon individuals.²¹⁸ Both interviewees argue that the introduction of forced marriage, female genital mutilation - following to the introduction of the Bill/law - started with the inflow of migrants, particularly those from certain countries as this urged the raising of “concern amongst the health professionals”²¹⁹ and reports were brought to the attention of the Parliamentary Secretary and the Minister showing that these are being practised in Malta.

The lawyer indicates that, according to his knowledge, there had never been a case brought forward relating a woman who had undergone FGM seeking asylum on these grounds. He contributes this to a combination of factors; firstly, the police being under-resourced, underpaid and focused on other - more serious - crimes that are considered more damaging to the Maltese society, like drug trafficking; secondly, the executive police might not want to prosecute individuals, as this bring to much attention on the matter and thereby the possibility of creating a stigma; lastly, it is concealed, hidden, from the public eye which makes it difficult to collect and preserve evidence to be able to prosecute. He also says that he is unaware if there has been any prosecution after the criminalisation of FGM with the introduction of the law. However, he argues, once it has been penalised, there is the prospect of prosecution, if there would be the evidence.

217 Interview with P1 – Education Professional

218 Interview with P1 – Education Professional

219 Interview with P12 – Education Professional

The student, having had contact with the Refugee Commission, says that she is aware of two or three - pretty recent - claims to asylum on the basis of FGM. However, none of these were given status, as the Refugee Commission argued that “there wasn’t enough evidence basically.”²²⁰ She argues that the law is “definitely not adequate” in its current form to tackle the issue and assigns this to the lack of a clear definition of FGM. She argues: “Basically, all procedures, even those which do not involve mutilation, they are all encompassed under FGM.”²²¹ She does argue however, that this is not just a problem in Malta, but can also be seen in other countries. Her solution would be to amend the law, so that it would cater for all the different forms of FGM, and include in it the procedures that are performed on intersex minors. She adds that she would also make changes to ultimately respect the “bodily autonomy of adults”, saying that she believes “people should be left free to decide what to do with their own bodies. As long as there is no form of external pressure or threat et cetera.”

Both of the respondents indicate that when asked, many of their colleagues, or fellow students, said not to know about FGM, or that the law had been passed. The lawyer argues that this is due to the fact that lawyers in Malta don’t think the topic is important to their profession, since it is not local, not domestic.

The fact that the population in Malta does not know about this is ascribed to a lack of education, according to the both of them.

WHAT CAN/NEEDS TO BE DONE IN MALTA?

What can be done in Malta is, first of all, the improvement of education to make the general population more aware, as well as specific educational training for the police force²²², medical professionals, health care professionals, teachers and other people who work with migrants, people coming from FGM practising societies. For medical professionals in Malta, “who are not fully aware of the risks and nature of the practice” according to one of the interviewees²²³, there should also be training on the identifying of those individuals “more prone, susceptible, subject”, those that are at the most risk.

One of the two respondents argues that NGOs can play a big role, but their main focus should not be on education. There should be a bigger focus on raising awareness among migrant communities about the health consequences of the intervention, and the fact that the law against FGM has entered in Malta into force.

²²⁰ Ibid.

²²¹ Ibid.

²²² One of the respondents says that she thinks that “the police force has to be educated on this issue as well. Because I heard a lot of things, that the police is not yet aware that FGM exists.” – Interview with P12 – Education Professional

²²³ Interview with P1 – Education Professional

This raising of awareness is also named by the other respondent as an important focus. Too many people do not know - or care - about FGM according to him. Teachers and school staff should be involved in this awareness raising, but, as far as the first respondent is aware, there is nothing implemented at the moment.²²⁴ Teachers would need more training though, as “First, the teachers need to be informed about the practice obviously alone, separately through seminars et cetera. There definitely should be seminars for teachers and then that is where they could develop this sort of programmes” like some sort of “check-ups for minors in school, in order to prevent the occurrence of FGM.”²²⁵

She argues that even males [children in primary school] should be informed on the issue, because they can prevent these occurrences.

The lawyer argues that Malta could also work together with Italy - as he considers them to be the two countries where FGM is practised most, vis-à-vis the other EU Member States - to urge the EU to put more (political) pressure on states that do not do enough. This could take various forms; “at African Union level, globally, internationally, media, economically”.²²⁶ He says that Malta could play a role in flagging the matter, showing that it has become more serious and more of a concern.

Another thing that can be done in Malta, according to this same respondent is the installation of a “commissioner for the prevention of sexual violence or other severe forms of harm on persons who are minors.”²²⁷ This person could issue complaints on behalf of the girls. He stresses the importance that this needs to be a person that is “very familiar with the practice and the persons who are most likely and susceptible to practice this on their daughters”.

ANALYSIS AND DISCUSSION

Very little has been written about FGM in Malta, and researchers were included in this study because of the usefulness of addressing scholarly work in the area, as well as of mapping out the contribution of academia to discussion on FGM.

As writing increases and there is potential for legal, health and social cases of FGM coming to the fore. It will be important to include these cases in tertiary curricula in order to start a discussion about FGM at the University level. Such a discussion would better prepare students who may come into direct contact, or need to refer, those who have queries or require assistance relating to FGM. At the time, it is important for academic writing to be based and anchored on both theoretical concepts as well as practical knowledge of the Maltese context. Leading on from this, academic discussion around FGM should be based around notions of human rights and women’s rights, and therefore should encourage a context that is open and conducive to intercultural openness, as well as to collaboration amongst different entities including NGOs, academia, law enforcement, international organisations and others.

224 Interview with P12 – Education Professional

225 Interview with P12 – Education Professional

226 Interview with P1 – Education Professional

227 Ibid.

ASYLUM ENTITIES

GENERAL INFORMATION

Two female officers working with refugees were interviewed; one Senior Case Worker and one Asylum Determination Officer. Both studied at the University of Malta and have been interviewing both male and female asylum seekers. Both mention that a high majority of the asylum seekers are male and from African countries. While they have not heard of it happen, they both believe FGM is practised in Malta. Both have ongoing training; profiling, interview techniques, interviews with children etc, yet nothing specifically focusing on FGM.

TYPES OF GENDER BASED ASYLUM CLAIMS IN MALTA

Both respondents mention that sexual orientation and gender-based violence have been used as asylum claims in Malta: “Yes. I know some of my colleagues have come across domestic type of gender-based violence but not FGM specifically. We’ve only had three cases of claims related to FGM.”²²⁸

ASYLUM BASED ON FGM IN MALTA

The respondents both indicate that there have been three cases of women seeking asylum based on FGM. All three female asylum seekers claimed that they would have FGM done on them (or their daughter in one case) if they had not left the country. According to one of the refugee officers, two of the women were from Ethiopia, while the other one claimed to be from the Ivory Coast (which she regarded a false statement). However, the other officer stated that the women were from Ivory Coast (she also stated that this was regarded a false statement), Ethiopia and Nigeria.

Both refugee commissioners state that the three female asylum seekers were rejected because their claims were not considered true: “[They were] rejected. None was credible. The one from Ivory Coast, we didn’t even believe that she is from Ivory Coast, she didn’t even substantiate that claim. The one from Nigeria was Christian, came from a Christian area, came from an area where FGM is illegal. (...) The other one, Ethiopian, she wasn’t credible and there wasn’t any grounds for believing that it could really happen to her, I don’t remember the details as such, but either she was Christian and —.”²²⁹

Both respondents state the Refugee Commissioner would consider asylum cases based on FGM.

228 Interview with P7 – Refugee Commissioner

229 Interview with P5 – Refugee Commissioner

THE CONCERNS OF PEOPLE IN THE FIELD WITH REGARDS TO FGM

One of the respondents mentions that she is concerned about the medical implications that an asylum seeker based on FGM might have:

“There can be concerns because that’s a medical thing, so we can also refer for the medical check-ups to test credibility. But how easy to do it we don’t know, it’s not something that you call the health centre, listen I have this woman, could you come and check. It’s not something that has ever been done so that can be concern if we can do it. That’s what I can think of.”²³⁰

However, the other respondent states a concern with regards to the lack of training they have received. Nevertheless, she states that because there have been few instances of FGM based asylum seekers, it has not yet been an issue though training would still be regarded as vital.

PROFESSIONAL TRAINING ON FGM

The two respondents both have not had professional training concerning FGM as it is not often brought up in their work. Nevertheless, both say it would be advisable to have training to raise awareness both for them as professionals, as well as for the public – for example, provide information to (migrant) children in schools:

“The public. Definitely! I have serious doubts of the level of awareness which the public has about it [FGM].”²³¹

MIGRANT WOMEN

GENERAL INFORMATION

Three women have been interviewed, their ages ranging between 22 and 25 years old. Two of them were born in Eritrea – one of them under the Tigrinya ethnic group – while the last respondent was born in Somalia. Two of them are single, while one is married to an Eritrean man. They have been in Malta for 1 to 3 years and their status differs from subsidiary protection, granted refugee status, and a rejected application for asylum. Most of them had some connection to the African community, via friends or church groups, but none of them felt particularly close to her own community here in Malta.

²³⁰ Ibid.

²³¹ Interview with P7 – Refugee Commissioner

PERCEPTIONS & PERSPECTIVES

In terms of their own perceptions and perspectives, women, compared to the male respondents, have a common response with regards to FGM; they all agreed on the physical consequences that this practice imposes on women. They say they are aware of the fact that women have a lot of problems during pregnancy, along with blood loss during the procedure: “Women also here in Tent Village are in pain, they are bloated because of blood inside their bodies, some have problems with urinating and infections. (...) They also have pain in their hips.”²³² In Somalia is more severe than in Eritrea or Ethiopia, both in women and men, they said.

None of the women’s opinions about FGM has changed; they are all against it and truly believe it should not be continued.

THE REASONS FOR FGM

The respondents all confirmed that tradition is the main reason for practising FGM. An Eritrean woman indicates that there is a division between elderly and young people in the community, as well as a difference between educated people and uneducated.²³³ In her case, her parents – a doctor and a teacher – did not want her to be circumcised, but her grandma had the tradition so deeply rooted, that she took her to get circumcised without her parents’ permission. However, she believes that this tradition is changing.

The other two women responded – with regards to the reason for FGM – that for some people this tradition means “to be clean and good for marriage,”²³⁴ and that “community says it is also for not being with boys from very young.”²³⁵

Traditional communities continue to follow this practice because it is a requirement that accompanies being part of the community, and limits their chances of being out-casted.

It is interesting to highlight that the Somali woman mentions that money has been seen as a justifying argument for FGM. According to her, the women who perform the circumcision make money off of the practice. It would be profitable for them to maintain the practice. However, tradition is seen as the main justification for FGM.²³⁶

All of them concur that being mutilated affects marriage, in particular females’ sexual pleasure is mentioned and the loss of sensibility:

“The man feels everything and wants to sleep with a woman but she does not feel anything and this is why women don’t want to sleep with men as often as they want. This can lead to problems.”²³⁷

232 Interview with P21 – Migrant Woman

233 Interview with P15 – Migrant Woman

234 Interview with P18 – Migrant Woman

235 Interview with P21 – Migrant Woman

236 Interview with P18 – Migrant Woman

237 Interview with P21 – Migrant Woman

SHOULD FGM BE STOPPED?

There is a disparity among the respondents about with whom do they discuss the issue; the Eritrean married woman discussed it with her family (the ones that were educated), the Eritrean single woman had no family but discussed it at the open centre, and the Somali woman said it is so accepted in her family and community that nobody talks about it.

Nevertheless, all women agree that FGM is not good for women and that it should be stopped for various reasons: “Women get infections, not all the instruments are clean and are used on several girls.”²³⁸ It is painful, and the long term consequence is that women feel nothing during intercourse: “It is hard and painful, this is why women suffer (...)”²³⁹ They all agree that FGM also provokes psychological and physical effects on women.

The responses to the question if they think FGM is performed on girls in Malta – or if they are being taken out of Malta to perform it – is unanimous; no. None of them have had any information since they arrived in Malta. Nor has their opinion changed; they have always been against it.

In terms of abolishing the practice in their countries of origin; the respondents mention that Eritrea has banned it, however; the practice has mainly subsided in the city, not so much in the villages. One of them also references Ethiopia where, according to her, the government has done more to ban the practice of FGM:

“I know that in Ethiopia, for example, the big sister can go to the police and report if you would like. That’s all I know. I have heard there are other countries too. It is starting to change things, but more in cities, no villages.”²⁴⁰

On the contrary, the Somali woman mentioned that Somalia has many NGOs and women’s organisations that work to ban the practice of FGM in the villages. Also the idea that schools should be involved in banning FGM is a common thought among the interviewees. Yet one respondent did not go to school and thinks FGM should not necessarily be tackled via school as it is more a family thing:

“I don’t know. It is more for the parents who are the ones making decision for their children without asking them. They need to be called.”²⁴¹

238 Interview with P15 – Migrant Woman

239 Ibid.

240 Interview with P21 – Migrant Woman

241 Interview with P21 – Migrant Woman

GENDER SPECIFIC QUESTIONS

All three women mentioned that FGM had affected them. One does not want to talk about it, yet she mentions that her family agreed with the practice being done on her. Another woman, who had been taken by her grandmother, states that it: “Feels like a violation, because I did not give consent nor my parents.”²⁴² Likewise, she says her husband “does not care so much, but I don’t think he would want it to continue.”²⁴³ The other woman had no family, nor knew their opinion but she was cut when she was very little.

RELATIONS TO DEMOGRAPHIC QUESTIONS

It is difficult to give relations to demographic questions as we merely interviewed three women; two from Eritrea and one from Somalia, all of them in the age range of 22 to 25, all but one single (one was married), and all of them had undergone the FGM practice. They have been in Malta for a maximum of 3 years, had a different status granted to them and had different forms of accommodation as well. All did not intend on staying in Malta, but wanted to leave for the United States.

All three women had different relations to the community; one just had some friends within the African community, one was involved in a Church community with other Africans, and one had no contact with her community.

The only thing the women have in common is that they have been cut, and agree on the necessity to stop the FGM practice. According to their point of view, FGM only brings pain – psychological and physical problems – as well as marital and sex-related issues. They also agree that it is a (cultural) tradition that is being amended by institutions such as the Eritrean government, the police authority in Ethiopia, and NGOs and women’s organisations in Somalia.

MIGRANT MEN

GENERAL INFORMATION

Eight men have been interviewed, all of them between the ages of 21 and 31. They were born in different African countries including Sudan, Somalia, Nigeria, Gambia and Eritrea. All but one of the men was single – the married male migrant had a wife who had remained in the country of origin. The men had been in Malta for some time, ranging from 10 months to over 10 years, their status differentiating between refugee, subsidiary protection, asylum seeker, temporary humanitarian protection, or still waiting for the application to go through. Most said they were in contact with many different people, from different nationalities. A couple of men said they preferred to be alone.

²⁴² Interview with P15 – Migrant Woman

²⁴³ Ibid.

PERCEPTIONS & PERSPECTIVES

There are of course many differences in perceptions and perspectives of the respondents based on their country of origin. Most men had heard about FGM being practised in their countries; in Sudan not everyone does it, but a majority does; in Somalia it happens; in Gambia it is considered “normal” and common (only the Wolof tribe does not practice circumcision, in the other tribes both males and females are cut); in Nigeria FGM is not common/considered getting less; in Eritrea it has been banned by the government 15 years ago, yet it is still a very common practice. The age at which girls were thought to undergo FGM ranged from a couple of days after birth to 7 years old.

THE REASONS FOR FGM

Different reasons were brought up with regards to the reasoning behind practising FGM. The main reason frequently mentioned is that FGM is part of a (cultural) tradition. Likewise, it is expected by the community that you circumcise your daughters. A Somalia migrant mentioned that you are better valued if you practice FGM and might not even get anything from anyone in your community if you refuse.²⁴⁴ A Nigerian migrant stated the following:

“They do it for many, many years and then there is a celebration. For the young girls and for the other people to see. They say: ‘look my daughter has it. It is ok.’”²⁴⁵

This quote shows that it is not only a cultural tradition, but a tradition that is required and highly valued by the community the people live in. A celebration is organised to show the community – particularly the elders – that the tradition is carried on for another generation. Another migrant, of Gambian descent, also mentions that FGM is a community ceremony: “They just arrange maybe every two or three years to do it because the oldest are big enough so they wait for the younger ones and they do it as a tribe and there is singing, dancing. It’s the culture.”²⁴⁶

For his community, a ceremony is arranged to circumcise all the young girls at the same time, as part of a shared celebration. In relation to the cultural community tradition, FGM is also practised because it is thought that it is harder for an uncut female to find a husband, and in some instances; FGM is thought to be ‘needed’ if women want to get married in the future. An Eritrean migrant mentions that females are better seen in the community when they are circumcised; FGM would thus better the change of females finding a future spouse in their community.²⁴⁷

244 Interview with P10 – Migrant Man

245 Interview with P22 – Migrant Man

246 Interview with P16 – Migrant Man

247 Interview with P14 – Migrant Man

Another reason for FGM that is frequently mentioned is in relation to the notion that FGM controls female hormones. Or, according to the following Gambian migrant: “They say that when you are not circumcised as a woman, you normally like men too much.”²⁴⁸ FGM is thought to calm hormones and limits the changes of young women leaving their homes to go meet boys and accidentally becoming pregnant. Instead, “Families want their daughters to grow good and not go and be with boys at a young age.”²⁴⁹ In addition, this latter particular Eritrean mentioned that FGM limits females’ sexual pleasure because “it is not good for girl to have sexual feelings.”²⁵⁰ Of the eight male migrants interviewed, six mentioned that controlling the female desires is one of the reasons FGM is practised.

Three out of the eight interviewees mentioned that FGM limits health issues. A Sudanese migrant shares that FGM originates in Egypt and “because of the sun it was very hot, and women smell if they have not done it [circumcision]. It is to control the heat inside the woman, also in warm weather.”²⁵¹ A Gambian migrant states similar health concerns and mentions that “if you are uncircumcised you normally bleed blood too much and you will be smelly at all times”²⁵² as the reason for FGM. According to these three interviewees, the reason for circumcision is for women to be healthier, calmer, and less ‘dirty’ or ‘smelly.’

Only one migrant, a 25 year old Gambian migrant, mentioned the reasoning for practising FGM is because of religious considerations. He stated his prophet said, in relation to daughters: “You teach her the Qur’an, to worship God, you circumcise her, and get her married. Then you’re finished. There is no judgment between (...) and the next world.”²⁵³ For him personally, he says he practises FGM “because our religion wants it and we believe in our religion.”²⁵⁴ Nevertheless, all other migrant men made a clear distinction between FGM being a cultural tradition, not a religious requirement.

THE PROCEDURE OF FGM

As aforementioned, some men indicated that the actual practice of FGM is organised communally, where girls from different age groups (from a few days old to about 7 years old) are gathered every couple of years and are all cut on the same day. There can be a ceremony afterwards, with singing, dancing and celebrations.

The procedure of FGM is not performed in the hospital but the migrants indicated that either special sort of midwives perform the cut, or elderly: “It does not happen in the hospital. Not anyone can do it, but there are women elderly or midwives to do the procedure.”²⁵⁵ Two men indicated that they have heard that they (used to or) use just one instrument on multiple women. Sometimes the instrument is not cleaned either resulting in infections amongst the young girls:

“Yes, I know girls can get sick when it is not clean. The knife or blade or whatever they use. They can use it on more than one person without proper cleaning it. This is a problem.”²⁵⁶

248 Interview with P16 – Migrant Man

249 Interview with P14 – Migrant Man

250 Ibid.

251 Interview with P13 – Migrant Man

252 Interview with P16 – Migrant Man

253 Ibid.

254 Ibid.

255 Interview with P13 – Migrant Man

256 Interview with P22 – Migrant Man

Another Eritrean man also mentions infection as a probably health risk:

“Health risks associated with FGM are infection because the materials they use are not clean and it does not happen in the hospital. The wound sometimes does not heal well. Women can also no longer control their pee because of FGM.”²⁵⁷

Nevertheless, many interviewees also mention they are not quite sure how the procedure is done because it is something talked about amongst women, not amongst men.

In general, the role of women is important with regards to whether or not the procedure is done for the young girls. Fathers and brothers generally do not have an opinion on the matter, nor do they have conversations about it amongst them. One Gambian man states that:

“Well, if your grandma is there normally she decides. Father has nothing to do with this because the girl is a woman, so father has nothing to do with it. If your grandma is there she is responsible, if your grandma is not there, it's your mum.”²⁵⁸ In multiple instances, the grandma has a deciding role as the elder female in the family.

ROLE OF EDUCATION

Education is considered a very important aspect, especially for the migrant men that believe the practice of FGM should be stopped. A Gambian man states the following: “Because the older people, the concept that they have is, they say that they are made by their parents to do this so the children will follow the steps of them, of their parents. This is the very wrong idea. Your parents are not educated; you are educated, so why would you follow them? If you are educated you know that it is bad and you know the advantages/ disadvantages. Your parents didn't learn about this in schools and they don't know the advantages/disadvantages, so why would you follow them?”²⁵⁹

The belief is that those who have not had schooling want FGM to be continued, while those who have had schooling are less in favour of the practice. Likewise, interviewees also indicate that education should be involved in awareness raising on FGM: “Yes, education is the most important thing”²⁶⁰

“Here I don't think they do it [circumcision], but in Africa a lot of negative people, even if they know that this is bad, you have to stop, they won't stop. Because of low education.”²⁶¹ And “Education can change everything but it will take a very long time.”²⁶²

257 Interview with P14 – Migrant Man

258 Interview with P10 – Migrant Man

259 Interview with P10 – Migrant Man

260 Interview with P14 – Migrant Man

261 Interview with P10 – Migrant Man

262 Interview with P22 – Migrant Man

IS FGM PERFORMED IN MALTA?

According to all respondents, circumcision of young females does not happen in Malta, nor are they taken to another place to have the procedure done either. The interviewees are aware that this practice is not considered to be part of Maltese culture or religion. One respondent did mention that young girls could be taken to Africa if the parents wanted to have her undergo FGM, but whether or not this is done depends on the parents' beliefs, culture, tradition; the way they live their life.

Some of the respondents mention that both boys and girls are circumcised in their country as part of their cultural tradition. However, we do not know whether or not the respondents themselves are circumcised. Nevertheless, this fact does not influence the respondents' knowledge on FGM as the practices of circumcision for boys and girls are very different from one another.

SHOULD FGM BE STOPPED?

An Eritrean man responded that FGM was banned by the Eritrean government about fifteen years ago, so it has been a decreasing tradition. He personally also agrees that it should be stopped. With regards to Gambia, one of the two respondents from this country mentioned that in some cities (e.g. the capital, Banjul, and Serekunda) they are making efforts to stop this practice. However, it mainly occurs in the rural areas, not the urban areas. No other respondents mentioned initiatives focused on stopping the practice of FGM.

In total, 5 out of 8 men argued that FGM should be stopped, of which one regarded it as a form of human torture: "My family is Christian and they are against any human torture and this I see it as a torture."²⁶³ Of the respondents, two thought it should be continued because they regarded it an important tradition and religious practice. Both also mention that FGM is practised in their families. One of the respondents was not sure whether or not the practice should be continued; for him it depended on the culture and religion. He argues that ideally people should be able to practice FGM if they want to, and that there should be respect for the culture and tradition. He considers it to be a Western idea that FGM is bad (for everyone). One of his ideas is that children should be able to decide for themselves once they are old enough if they want to be circumcised, instead of having their parents decide for them. His wife is of the opinion that it should be stopped.²⁶⁴

In most cases, when the man argues the practice should be stopped, he believes that his mother and/or sister would answer accordingly. With regards to the respondent unsure whether FGM should continue, his mom and sister believe it should be continued, while his wife believes it should be stopped. None of the male respondents has gotten information about FGM since their arrival in Malta.

²⁶³ Interview with P11 – Migrant Man

²⁶⁴ Interview with P22 – Migrant Man

GENDER SPECIFIC QUESTIONS

General perception is that girls are cut because they will be considered different from other girls if not cut, and not cutting will limit chances of getting married later on in life. The perception is that girls, when not cut, would want to be with males and are very ‘easy’ to have contact with. In this regard, ‘easy’ is referred to the desire to have sex with males as one respondent also argues that uncut girls have more sexual desire and pleasure.

One respondent expressed not wanting to marry a girl if she was not cut: “You ask me? If I see one girl, she didn’t cut, I wouldn’t marry. Yes, I wouldn’t. So you have to cut. It’s important.”²⁶⁵ All other men said it does not matter for them. One respondent even said he distinguishes between those cut and not – he prefers to have a girl who has not undergone FGM – since “those are happier and easier to connect with.”²⁶⁶

As aforementioned, it is important to notice that all men indicated that this topic is not something that is (frequently) discussed within families or amongst friends. This could be different for women, who might discuss FGM with their mother, sister(s) or grandmother(s). Likewise, none of the men knew the opinion of their father or brother(s): “It’s not something that people talk about. It’s just normal, no problem.”²⁶⁷

PERCEPTIONS & PERSPECTIVES

Many of the men indicated that they are unaware of the health consequences for women after FGM; in particular long-term complications (during sexual intercourse or when giving birth) are not known. As aforementioned, some men did know about infections that occur because of FGM due to unclean instruments or materials used on multiple women – without cleaning – during the procedure. Some of the respondents did indicate that they are aware that FGM causes women to not have any feelings during sex:

“Married women even can complain because troubles can last you know. I know also from my wife. It can hurt sometimes and women do not feel so much anymore. It is different with men anyways. But this is a real problem.”²⁶⁸

Likewise, one respondent indicated that he is aware of physical pain, infections, and psychological trauma that accompany FGM.²⁶⁹ Another recalls that young women can get sick for a couple of days, but that afterwards everything is fine and they do not have any complications.²⁷⁰ One respondent recalls having heard of women dying during pregnancy as a result of FGM.²⁷¹ One respondent states that FGM influences women’s ability to control their pee.

265 Interview with P8 – Migrant Man

266 Interview with P13 – Migrant Man

267 Interview with P16 – Migrant Man

268 Interview with P22 – Migrant Man

269 Interview with P11 – Migrant Man

270 Interview with P9 – Migrant Man

271 Interview with P13 – Migrant Man

One man argues that he has never seen a girl suffering from FGM; all young women are healthy and happy according to him. He says this is because they are no longer 'different' from the girls who had been cut: "Oh well it's normal, because for example if they cut this girl and this one didn't cut, she is different; it's normal." In addition, he says: "What I see is that girls who have got they are very healthy, I haven't seen any girl who is suffering from this."²⁷²

One man is very outspoken about no negative consequences of FGM on women, stating: "No, all positive [consequences of FGM]. No negatives. [And] it doesn't affect that [female body and sexual pleasure]. This is a long time tradition. Since we are (...). There is no problem with that and it is still existing."²⁷³

Again another does not think that there are any psychological effects from FGM as the women are very young when it happens:

"No, I do not think there are psychological effects because the women are young when it happens. I think girls might grow up not even knowing if they are cut or not."²⁷⁴

On the other hand, another respondent regards FGM as something that would be traumatising: "I think that cutting should be traumatising because they are probably scared."²⁷⁵

In short, three men say that it affects women's sexual pleasure because it either hurts or because she is unable to feel anything. However, one of the men argues that this is no problem as women are not supposed to have sexual feelings. Two men say that they do not know whether it affects women's sexual pleasure. One man says women are still able to have sexual pleasure.

RELATIONS TO DEMOGRAPHIC QUESTIONS

It is hard to see any patterns with regards to demographic questions, because while the males are all considerably within the same age cohort (20-30), they are from different countries, cultures and religions (in many cases their religion is not even known). As expected, the respondents' perceptions and knowledge on the topic of FGM differs.

272 Interview with P10 – Migrant Man

273 Interview with P16 – Migrant Man

274 Interview with P14 – Migrant Man

275 Interview with P11 – Migrant Man

PROMISING PRACTICES IN ADDRESSING FGM

This section was developed to address the lack of active projects in Malta addressing FGM in its holistic entirety and engaging with migrants on the topic in a conducive way. A number of initiatives have been undertaken both in countries where the practice is common as well as in others where it is practised by a minority (be this a migrant or ethnic group). Learning from both these contexts is useful as it requires and instills the importance of engaging with different entities as well as understanding the cultural sensitivities of FGM and its reasons. This section is divided into three – prevention, provision of service and prosecution.

PREVENTION

FEMALE GENITAL MUTILATION IN IRAQI-KURDISTAN

Location: Iraqi-Kurdistan

Organisation(s): Association for Crisis Assistance and Development Cooperation (WADI)

Timeframe: 2010

Description: The project consisted of a one-year and a half long empirical study underlining the dynamic of FGM in Iraq-Kurdistan. It also describes the failure of international organisations such as UNICEF and the World Health Organization in recognising the existence of the problem in Iraqi-Kurdistan

Strengths: The initiative raises awareness of the fact that FGM is a practice that happens in more places than expected

Focus: Awareness, information

Website: www.stopfgmkurdistan.org; www.wadinet.de

Address:
WADI e.V.
Herborner Str. 62
60439 Frankfurt am Main
Germany

Email: info@wadinet.de

Contact Germany:
Arvid Vormann: +49 1636128777
Anne Mollenhauer: +49 1797378426

Contact Northern Iraq:
Office Suleymaniah: +964 7701588173

FGM-FREE COMMUNITIES PROGRAMME

Location: Iraqi-Kurdistan

Organisation(s): Association for Crisis Assistance and Development

Cooperation (WADI)

Timeframe: 2003 - to date

Description: The purpose of the initiative is to inspire entire villages to commit themselves to ending the practice. In order to support change, the association provides free, small-scale community projects to the communities that decide to participate in the initiative. For instance some communities chose an electric generator, while others dedicated themselves to the construction of a community tent. Furthermore, different types of courses are provided to women of the participating communities. The courses range from literacy to sewing. Another service that is offered by the NGO is First Aid training, which is particularly important as medical service is often out of reach in rural areas. The majors of the participating villages are asked to sign a treaty and fully commit themselves to end the practice. In addition, a road sign that guarantees that the community promised to be FGM free is installed at in the village. Since the project started seven communities have joined and in none of them the practice was carried out anymore. The funds of the project are from the U.S. State Department.

Strengths: The initiative tackles the issue of FGM at a local level and with a multilateral approach.

Focus: Awareness, information, aid, rural areas, prevention and provision of service, education

Website: www.stopfgmkurdistan.org; www.wadinet.de

Address:
WADI e.V.
Herborner Str. 62
60439 Frankfurt am Main
Germany

Email: info@wadinet.de

Contact Germany:

Arvid Vormann: +49 1636128777
Anne Mollenhauer: +49 1797378426

Contact Northern Iraq:

Office Suleymaniah: +964 7701588173

FEMALE GENITAL MUTILATION PROTECTION ORDERS

Location: England

Organisation(s): HM Government

Publication: 2015

Description: The Serious Crime Act 2015 is the first ever FGM protection order banning travel for individuals who are believed to be at risk of leaving temporarily the country to undergo FGM. The Act contains a whole section on FGM, including subsection 73 on Female Genital Mutilation Protection Orders.

Strengths: The Act provides short-term protection to young female

Focus: Protection order

Website: www.legislation.gov.uk/ukpga/2015/9/contents/enacted

Address:
102 Petty France
London
SW1H 9AJ
England

Email: general.queries@justice.gsi.gov.uk

Telephone: +44 2033343555

IGADDAA (WE DO NOT WANT IT ANYMORE)

Location: Ethiopia

Organisation(s): Population Media Center

Timeframe: December 2007-November 2009 and October 2011-June 2014

Description: The project was part of the organisation's Female Genital Mutilation Whole Society Strategy 2007-2015. Igadaa was a weekly radio magazine and aired for a total of 206 episodes of 15 minutes each in Somali language on the National Service Radio of Ethiopia. The series included plays, interviews, narration and storytelling. The project included different segments which were aired regularly and included Gudayochachen (Our Concerns), Endenawk (For Our Awareness), Trunet (Having Good Values) and Misalewochachin (Our Models). Funds for the initiative were provided by Bayer and Save the Children

Strengths: The project Igadaa succeeded in spreading information and addressing misinformation, as health experts and other professionals answered vital questions raised by the community related to the practice.

Focus: Misinformation, radio magazine, professional guidance

Website: www.populationmedia.org

Address:
Population Media Center
30 Kimball Avenue, Suite 302
South Burlington, VT 05403
United States

Telephone: +1 802985-8156

Country Representative:
Dr. Negussie Teffera

MAPA DE LA MUTILACIÓN GENITAL FEMENINA EN ESPAÑA (MAP OF FEMALE GENITAL MUTILATION IN SPAIN)

Location: Spain

Organisation(s): Foundation Wassu UAB

Timeframe: 2002, 2006, 2010, 2013

Description: The Mapping of FGM seeks to inspire policies and actions to prevent the practice more effectively as well as to respond more specifically to the needs of women that underwent the practice in Spain. It studies the characteristics of the practising communities and their geographical distribution. The report is based on census data and it quantifies as well as localises the migrant female population hailing from countries where

FGM is a custom on the Spanish territory.

Strengths: The mapping of migrant females provides up-to-date and local data that inform policies and professionals.

Focus: Intercultural, mapping, awareness

Website: www.mgf.uab.es

Address:
Wassu Gambia Kafo
Fajara F Section
P.O. Box 339
Banjul
The Gambia

Email: wassukafo@gmail.com

Telephone: +220 7337583

PETALS

Location: United Kingdom

Organisation(s): University of Coventry

Timeframe: 2015

Description: Petals is a website app that provides guidance to girls at risk of FGM in the UK, and educates young people, boy and girls, about the practice. The app was launched before summer, which is, according to researchers from Coventry University, considered to be the period in which girls are most at risk of being sent abroad to undergo FGM. The project is funded by the Eleanor Rathbone Charitable Trust, the 1970 Trust, The Pamela Barlow Charitable Trust and Coventry University.

Strengths: The app provides guidance and protection to vulnerable girls, at the same time informing also young boys about the practice, who in turn are more likely to refuse to perform it on their children once they are grown-ups.

Focus: Youth, prevention, protection, information, app, web, technology, guidance, support

Website: www.petals.coventry.ac.uk

Address:
Coventry University
Priory Street
Coventry
CV1 5FB
United Kingdom

Telephone: +44 2477657688

THE INTERDISCIPLINARY GROUP FOR THE PREVENTION AND STUDY OF HARMFUL TRADITIONAL PRACTICES

Location: Spain

Organisation(s): Foundation Wassu UA, Department of Social and Cultural Anthropology in the Universitat Autònoma de Barcelona

Timeframe: 2003-ongoing

Description: The program is part of one of the research and training centres of the Transnational Observatory of Applied Research to New Strategies for the Prevention of Female Genital Mutilation. The team is composed of health professionals and social scientists that promote a preventive approach. The group does applied research and offer training activities.

Strengths: A group of health professionals and social scientists from different fields positively contribute to the work of the team, as they are able to offer a wider range of services and there is an enriching transfer of knowledge.

Focus: Prevention, health care, information, services

Website: www.mgf.uab.es

Address:
Wassu Gambia Kafo
Fajara F Section
P.O. Box 339
Banjul
The Gambia

Email: wassukafo@gmail.com
gr.gipe.ptp@uab.es

Telephone: +220 7337583

TRANSLATION OF NATIONAL LAWS AND INTERNATIONAL CONVENTIONS

Location: Uppsala, Sweden

Organisation(s): Kvinnointegritet (Female Integrity)

Timeframe: N/A

Description: Female Integrity is an association based in Uppsala that is part of the National Association RISK for ending the practice of FGM.

It is committed to the translation of national laws as well as international conventions that are relevant to FGM into Amharic language and plans to translate it into other African languages in the future.

Strengths: Awareness of existing national laws and international conventions can serve both to prosecute and prevent FGM practice. In fact, awareness of criminalisation of the practice may deter people from carrying out FGM, as well as informing victims of their rights and encourage them to speak up. The translation of laws and conventions is very important in the context of migrants that might not speak the language of the hosting country. However, criminalisation should also take external factors, such as culture, into account as fear of being prosecuted might, for instance, lead families to circumcise their daughters at a very young age in order to avoid organisations getting suspicious, or prevent women from speaking out of fear of being rejected by their national community.

Focus: Awareness of regulations, prevention and provision

Website: www.femaleintegrity.se

Email: femaleintegrity@telia.com

VITE IN CAMMINO (LIFE ON THE MOVE)

Location: Veneto, Friuli Venezia Giulia, Lazio (Italy)

Organisation(s): Associazione diritti umani sviluppo umano (Padova) e Associazione Culture Aperte (ADUSU)

Timeframe: 2008

Description: The documentary-fiction *Vite in Cammino* was one of the outcomes of a wider project financed by the Department for Equal Opportunities (Dipartimento per le Pari Opportunità). The wider project wanted to create a socio-cultural space that promotes the elimination of the practice. The project was explained in details and the association applied a comprehensive approach to the initiative by planning different activities. The documentary-fiction can be purchased

with a contribution of 17 euros, a shorter version is available free of charge.²⁷⁶

Strengths: The film-documentary comes with a guide to discussion. It has the potential to inform and educate. Due to the cost-factor, it is more likely that the documentary will be accessed mainly by the education sector, professionals or people interested in the matter rather than by the general public.

Focus: Discussion, informative, education

Website: www.aidos.it

Address:
Via dei Giubbonari 30
00186 Roma
Italy

Email: segreteria@aidos.it

Telephone: +39 066873214

PROVISION OF SERVICE

ANTI-FGM TRAINING FOR MIDWIVES

Location: Iraqi-Kurdistan

Organisation(s): Association for Crisis Assistance and Development Cooperation (WADI)

Timeframe: 2013 – to date

Description: The initiative is part of the wider WADI campaign “Stop FGM in Kurdistan”. The NGO seeks to provide midwives with an alternative to the FGM practice. The importance of addressing midwives specifically is rested in the fact that they are the ones that have much to lose from the abandonment of the practice as they have gained high status in their communities, and cutting is the source of their income. The midwives are also provided with an official certificate of the Ministry of Health, and, at the end of the medial training, they are requested to sign a declaration of refraining from practising FGM in the future.

Strengths: The project succeeds in considering the practice of FGM from different perspectives and

in tackling the issue at its roots, offering valid alternatives along with important information.

Focus: Awareness, information, training, prevention, provision of service

Website: www.stopfgmkurdistan.org; www.wadinet.de

Address:
WADI e.V.
Herborner Str. 62
60439 Frankfurt am Main
Germany

Email: info@wadinet.de

Contact Germany:
Arvid Vormann: +49 1636128777
Anne Mollenhauer: +49 1797378426

Contact Northern Iraq:
Office Suleymaniah: +964 7701588173

ANTI-FGM YOUTH CHAMPIONS

Location: Great Manchester, England

Organisation(s): Africans Unite Against Child Abuse (AFRUCA)

Timeframe: 2014- to date

Description: The Youth Champions project followed a qualitative research report exploring the practice of FGM among African communities in Greater Manchester. The Youth Champions project was launched at the end of March 2015 and appointed individuals between 16-21 years old to become Anti FGM Champions promoting the end of FGM within their communities and schools. These young people participated in training on the topic as well as public speaking session. The project is funded by the Department for Communities and Local Government.

Strengths: A role model may raise awareness and inspire other people to abandon FGM and create a chain reaction.

Focus: Youth, community

Website: www.afruca.org

Address:
AFRUCA Centre for Children and Families
Phoenix Mill
20 Piercy Street,
Ancoats
Manchester M4 7HY
United Kingdom

²⁷⁶ *Vite in cammino* di Cristina Mecci/AIDOS 2009, accessible at: www.youtube.com/watch?v=7zEQZHLH2s

Email: info@afruca.org

Telephone: +44 1612059274

Fax: +44 612052156

FEMALE GENITAL MUTILATION AND ITS MANAGEMENT – GREEN-TOP GUIDELINE NO.53

Location: England

Organisation(s): Royal College of Obstetricians & Gynaecologists (RCOG)

Timeframe: 2015

Description: This guideline published in 2015 is the second edition providing evidence-based guidance on the management of women that underwent or are at risk of FGM. It covers the clinical care of the patients before, during and after pregnancy. Furthermore it includes regulatory and legal responsibilities of health professionals. It focuses on the United Kingdoms, although the regulatory framework of Northern Ireland and Scotland differs to what is described in the guide itself.

Strengths: It gives clear and up-to-date directions to obstetrics and gynaecologists and it improves the standard of care delivered to women who underwent FGM.

Focus: Guidelines, regulations, assistance, health, pregnancy

Website: www.rcog.org.uk

Address:

Royal College of Obstetricians & Gynaecologists
27 Sussex Place,
Regent's Park,
London, NW1 4RG
England

Telephone: +44 2077726200

HUMANITARIAN PLASTIC SURGERY

Location: Switzerland

Organisation(s): Swiss & Love

Timeframe: 2005

Description: The NGO offers treatment to women who underwent FGM. Surgeries

are carried out by the plastic and aesthetic surgery centre La Colline. If the FGM reparative work is covered by the insurance, the sum is reimbursed to the non-governmental organisation. If it is not, the surgeons provide their service on a voluntary basis, while the NGO might cover minor costs.

Strengths: organisational, reparative surgery

Focus: Assistance, health, surgery

Website: www.swiss-and-love.ch;
www.lacollinechirurgieplastique.ch

Address:

THE SWISS & LOVE ORGANIZATION
76 A, Avenue de la Roseraie
1205 Geneva
Switzerland

Email: info@swiss-and-love.ch

Telephone: +41 227029700

HOTLINE FOR FGM VICTIMS IN THE MIDDLE EAST

Location: Iraqi-Kurdistan

Organisation(s): Association for Crisis Assistance and Development Cooperation (WADI)

Timeframe: 2012 – to date

Description: The hotline is the first of its kind in the Iraqi-Kurdistan region and it links individuals with trained social workers who are experts in the field and familiar with the practice at local level. The service offers information, assistance and it also refers the person to other professionals such as doctors or lawyers. Furthermore, the public may also contact the staff to receive information regarding FGM. The project is funded by the Clifford Chance Foundation.

Strengths: The project is not only a mean to provide information to women affected by FGM practices but also to reach out and give information to people in rural areas or that are illiterate. People interested are able to ask questions and receive clarifications for them.

Focus: Proximity, technology,

Website: www.stopfgmkurdistan.org; www.wadinet.de

Address:

WADI e.V.
Herborner Str. 62
60439 Frankfurt am Main
Germany

Email: info@wadinet.de

Contact Germany:

Arvid Vormann: +49 1636128777
Anne Mollenhauer: +49 1797378426

Contact Northern Iraq:

Office Suleymaniah: +964 7701588173

KETENANPAK (THE CHAIN APPROACH)

Location: Netherlands

Organisation(s): Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and

Sport, the Netherlands) in cooperation with GGD, FSAN and Pharos

Timeframe: 2006 – to date

Description: The Chain approach seeks to facilitate the collaboration between actors from different sectors involved in the area of FGM. It recognises that FGM is a sensitive issue that encompasses multiple services and actions, such as preventive initiatives, psychological care or healthcare. Therefore, the responsibility are spread among different actors and a protocol for each sector guides the work of the multiple actors.

Strengths: A better coordination between different actors could facilitate success and accelerate the process of ending FGM and providing service of those affected.

Focus: Coordination, de-fragmented, inclusion, collaboration

Website: www.huiselijkgeweld.nl

Address:

Ministerie van Volksgezondheid, Welzijn en Sport
Postbus 19129
3501DC Utrecht
Netherlands

Email: huiselijkgeweld@movisie.nl

Telephone: +31 307892000

Fax: +31 307892111

MOBILE WOMEN-LED AID TEAMS

Location: Iraqi-Kurdistan

Organisation(s): Association for Crisis Assistance and Development Cooperation (WADI)

Timeframe: 2003 - to date

Description: The Association for Crisis Assistance and Development Cooperation supports mobile teams of local medical staff, social workers as well as psychologists that operate in remote areas. These units offer ambulant treatment as well as psycho-social aid in the regions of Arbil, Garman, Halabja, Mosul, Pishder, Qandil and Sulemaniyah. Furthermore, a lawyer sometimes accompanies mobile teams to offer information and legal consultation. The teams work in close collaboration with rescue shelters and local centres, which became very active in the field of anti-FGM awareness training. Additionally, the teams provide also information through the display of certain TV-spots and films and encourage participants to join FGM-Free Community Programme.

Strengths: TV-spots containing information about the health risks of FGM is regularly shown on Kurdish channels.

Focus: Awareness, information, aid, rural areas

Website: www.stopfgmkurdistan.org; www.wadinet.de

Address:
WADI e.V.
Herborner Str. 62
60439 Frankfurt am Main
Germany

Email: info@wadinet.de

Contact Germany:
Arvid Vormann: +9 1636128777
Anne Mollenhauer: +49 1797378426

Contact Northern Iraq:
Office Suleymaniah: + 964 7701588173

PROTOCOL FOR PERSONAL INTEGRITY

Location: Spain

Organisation(s): Consejo Interterritorial

del Sistema Nacional de Salud (Ministerio de Sanidad, Servicios Sociales e Igualdad)

Timeframe: 2015

Description: The protocol states that health care professionals should be more aware of the risk of trips for young females to undergo FGM and to enhance preventive activities. Families are provided with information on health and legal consequences of the practice and are then asked to sign a commitment to refrain from cutting their daughter.

If parents are not willing to sign, the medical staff has the choice to communicate the case to the public authorities for the protections of minors, as well as to the public prosecutor, who will state the process for the adoption of different precautionary measures to avoid the risk that the girl will undergo FGM. Preventive engagement is voluntary and does not guarantee that mutilation will not be performed, however, experts consider it useful.

Strengths: Preventive actions by health care professionals

Focus: Prevention, health, legal obligations

Website: www.msssi.gob.es

Address:
Paseo del Prado 18-20
Planta baja
Esquina con Lope de Vega
28014 Madrid
Spain

Email: oiac@msssi.es

Telephone: +34 901400100

UNITED TO END FEMALE GENITAL MUTILATION (UEFGM)

Location: Europe

Organisation(s): Mediterranean Institute of Gender Studies (AKIDWA), Italian Association for Women in Development (AIDOS), Family Planning Association Portugal (APF)

Timeframe: 2012 – to date

Description: The United to End Female Genital Mutilation campaign is a free e-learning tool that offers information

as well as practical advices about FGM. The transnational project is directed primarily to health and asylum service staff in Europe, in addition to women's organisations and shelters. The primary aim of the campaign is to raise awareness and improve knowledge about FGM.

Firstly, the initiative aims to improve the quality of the services offered to victims or individuals at risk of FGM in Europe by promoting a gender- and culture-sensitive approach. The second objective of UEFGM is to strengthen skills necessary to achieve and maintain a high standard of services provided to women affected or at risk of FGM. Thirdly, the project wants to promote harmonisation of the Common European Asylum System (CEAS) by raising awareness on relevant treaties and legislations in regard to the topic of Female Genital Mutilation. The course is composed of six modules and is designed as virtual seminars.

Strengths: As a result of the course, participants can distinguish different types of FGM, possible consequences of the practice and recognise FGM as a human rights violation. They will also be able to identify European and international asylum regulations and treaty provisions relevant to the subject, implement a gender, culture-sensitive, trans-cultural approach.

Focus: Education

Website: www.uefgm.org; www.medinstgenderstudies.org

Address:
Contact point Mediterranean Institute of Gender Studies (MIGS)
46 Makedonitissas Avenue
PO Box 24005
Nicosia 1703
Cyprus

Email: info@medinstgenderstudies.org

Telephone: +357 22352311

Fax: +357 22353682

PROSECUTION

COMMISSION POUR L'ABOLITION DES MUTILATIONS SEXUELLES (COMMISSION FOR THE ABOLITION OF SEXUAL MUTILATIONS)

Location: France

Organisation(s): Commission pour l'abolition de mutilations sexuelles (CAMS)

Timeframe: 1982 to date

Description: CAMS was founded by the Senegalese Awa Thiam in March 1982 and is nowadays directed by Linda Weil-Curiel,

a lawyer who has been involved with the majority FGM cases in France. More specifically, the organisation is active in the judicial area and has until now taken part in over forty trials at the French Court "Cour d'Assises". In France, criminal procedures have to be initiated by public prosecutors, while a civil society organisation such as CAMS may take the role of civil party during the trial for the purpose of defending the victims of FGM.

Strengths: In France the number of mutilations has decreased over the last five decades. Prosecution, criminal trials and the work of CAMS have contributed to this success. In fact, prosecution has an important potential in raising

awareness of the FGM practice.

Focus: Implementation of law, awareness

Website: www.populationmedia.org

Contact details:

Address:

Commission pour l'abolition des mutilations sexuelles
6, place Saint-Germain des Prés
75006 Paris
France

E-mail: contact@cams-fgm.com

Telephone: +33 145490400

Fax: +33 145491671

Contact person: Linda Weil-Curiel



RECOMMENDATIONS

This research project has brought to the fore a number of issues relating to both needs around the issue of FGM generally as well as the need to address FGM from a number of particular disciplines. This section builds on the data collected, literature reviewed and legal analysis, and addresses the key areas requiring intervention.

GENERAL RECOMMENDATIONS

- Engaging further with communities that are at risk of FGM to understand their perspectives and aspects that may facilitate discouraging the practice. Such constructive engagement needs to be predicated on mutual respect.
- Organisations involved in addressing the issue should consider joining international and European networks focusing on the issue in order to extend opportunities to learn from peers who have worked on the issue elsewhere, to share their own experiences and to exchange promising practices.
- Conduct further research, including surveys as well as needs analyses particularly with health care professionals and protection professionals as well as with communities at risk of FGM.

LAW ENFORCEMENT

- Provide training to law enforcement officials, women and men, on how to deal with the issue of FGM in order to ensure effective prosecution of the crime whilst at the same time respecting the rights and dignity of victims thereof.
- Ensure that specially trained police officers, women and men, are available to investigate and prosecute cases of FGM.

HEALTHCARE PROFESSIONALS

- Expand and develop opportunities for training on intercultural health issues at both pre-service and in-service level.
 - Develop further training on FGM, with a focus on different types of FGM, recognising risks and recognising the effects of FGM.
 - Raise awareness and foster an open discussion on FGM that includes healthcare workers, women and men.
 - Develop and implement protocols and procedures that may be followed in situations where FGM or the risk thereof is identified. Such protocols and procedures should be developed by the Ministry of Health together with professional bodies in Malta.
 - Develop a small specialist service that has specific expertise on FGM and its implications and to which cases can be referred to when identified.
 - Implement a proactive approach to addressing FGM in women who are pregnant, to reduce the risk on both mother and child particularly during childbirth.
 - Foster greater dialogue between health professionals and child protection and protection professionals, particularly social workers and psychologists, to address FGM in a multi-disciplinary way.
-

**PROTECTION
PROFESSIONALS**

- Develop (further) training opportunities on intercultural issues at undergraduate level so as to ensure that protection professionals are well equipped to perform their duties.
- Foster greater interaction between different professionals working on this issue, to raise awareness and open up referral pathways for issues related to FGM.
- Widen the services offered so that there is more outreach from mainstream services to populations at risk of FGM.
- Develop and implement guidelines for protection professionals on both addressing FGM as well as, if and when necessary, reporting it to law enforcement

**EDUCATION
PROFESSIONALS**

- Raise awareness amongst teachers of FGM and the risk factors empowering them to identify and report children at risk.
 - Inclusion of FGM in curricula and/or reading lists for law, medical, nursing, social work, midwifery students at the various levels of education studies in Malta.
-

ANNEX 1 - REFERENCES

- R.C. Berg and V. Underland 2013**
R.C. Berg and V. Underland, "The Obstetric Consequences of Female Genital Mutilation/Cutting: A Systematic Review and meta-analysis", *Obstetrics and Gynecology International*, 2013, 496564
- R.C. Berg, J. Odgaard-Jensen, A. Fretheim, V. Underland and G. Vist 2014**
R.C. Berg, J. Odgaard-Jensen, A. Fretheim, V. Underland and G. Vist, "An Updated Systematic Review and Meta-Analysis of the Obstetric Consequences of Female Genital Mutilation/Cutting", *Obstetrics and Gynecology International*, 2014, 542859
- R.C. Berg and V. Underland 2014**
R.C. Berg and V. Underland, "Gynaecological consequences of female genital mutilation/cutting (FGM)", *Report from Kunnskapsenteret (The Norwegian Knowledge Centre for Health Services), Systematic Review No. 11, 2014*
- M. Brady 1999**
M. Brady, "Female Genital Mutilation: Complications and Risk of HIV Transmission", *AIDS Patient Care and STDs*, Vol. 13, No. 12, 1999, pp. 709-716
- D.D. Brewer, J.J. Potterat, J.M. Roberts and S. Brody 2007**
D.D. Brewer, J.J. Potterat, J.M. Roberts and S. Brody, "Male and female circumcision associated with prevalent HIV infection in virgins and adolescents in Kenya, Lesotho and Tanzania", *Ann Epidemiol*, Vol. 17, Issue 3, 2007, pp. 217-226
- L. Catania, O. Abdulcadir, V. Puppo, J.B. Verde, J. Abdulcadir and D. Abdulcadir 2007**
L. Catania, O. Abdulcadir, V. Puppo, J.B. Verde, J. Abdulcadir and D. Abdulcadir, "Pleasure and orgasm in women with Female Genital Mutilation/Cutting (FGM)", *The Journal of Sexual Medicine*, Vol. 4, Issue 6, 2007, pp. 1666-78
- Centre for Development and Population Activities 1999**
CEDPA, "The positive deviance approach in female genital mutilation eradication. Final end-of-project report for PROWID to the Center for Development and Population Activities". Cairo: CEDPA, 1999.
- B. Chalmers and K.O. Hashi 2000**
B. Chalmers and K.O. Hashi, "432 Somali women's birth experience in Canada after earlier female genital mutilation", *Birth*, Vol. 27, Issue 4, 2000, pp. 227-234
- J.N. Chege, Askew I, Liku J. 2001**
Chege JN, Askew I, Liku J. "An assessment of the alternative rites approach for encouraging abandonment of female genital mutilation in Kenya: FRONTIERS final report", Washington, DC: Population Council, 2001
- N.J. Diop, Faye M.M., Moreau A, et al. 2004**
Diop NJ, Faye MM, Moreau A, et al. "The TOSTAN program: evaluation of a community based education program in Senegal: FRONTIERS final report", Washington, DC: Population Council, 2004
- N.J. Diop, Djingri O, Zakari C, et al. 2004**
Diop NJ, Djingri O, Zakari C, et al. "Experience from a community based education program in Burkina Faso: the Tostan program: FRONTIERS Final Report", Washington, DC: Population Council, 2004
- M.A. Dirie and G. Lindmark 1992**
M.A. Dirie and G. Lindmark, "The Risk of Medical Complications after Female Circumcision", *East African Medical Journal*, Vol. 69, No. 9, 1992, pp. 479-482.
- M.H. El-Defrawi, G. Lotfy, K.F. Dandash, A.H. Refaat and M. Eyada 2001**
M.H. El-Defrawi, G. Lotfy, K.F. Dandash, A.H. Refaat and M. Eyada, "Female Genital Mutilation and its Psychosexual Impact", *Journal of Sex & Marital Therapy*, Vol. 27, Issue 5, 2001, pp.465-473
- S. Elmusharaf, I. Elkhidir, S. Hoffmann and L. Almroth 2006**
S. Elmusharaf, I. Elkhidir, S. Hoffmann and L. Almroth, "A case-control study on the association between female genital mutilation and sexually transmitted infection in Sudan", *BJOG: An International Journal of Obstetrics and Gynaecology*, Vol. 113, Issue 4, 2006, pp. 469-474
- B. Essén, N. Sjöberg, S. Gudmundsson, P.O. Östergren, P.G. Lindqvist 2005**
B. Essén, N. Sjöberg, S. Gudmundsson, P.O. Östergren, P.G. Lindqvist, "No association between female circumcision and prolonged labour: a case control study of immigrant women giving birth in Sweden", *European Journal of Obstetrics & Gynecology & Reproductive Biology*, Vol. 121, Issue 2, 2005, pp. 182-185
- M. Exterkate 2013**
M. Exterkate, "Female Genital Mutilation in the Netherlands Prevalence, incidence and determinants", Pharos Centre of Expertise on Health for Migrants and Refugees, 2013
- Home Office and Department for Education, United Kingdom 2014**
Home Office and Department for Education, United Kingdom, "Multi-Agency Practice Guidelines: Female Genital Mutilation", first published 2011, updated 2014, part of: Female genital mutilation and violence against women and girls
- H. Jones, N. Diop, I. Askew, I. Kaboré 1999**
H. Jones, N. Diop, I. Askew, I. Kaboré, "Female Genital Cutting Practices in Burkina Faso and Mali", *Studies in Family Planning*, Vol. 30, Issue 3, 1999, pp. 219-230
- M. Kandil 2012**
M. Kandil, "Female circumcision: Limiting the harm", *F1000 Research*, 1:23, 2012
- A. Kaplan, M. Forbes, I. Bonhoure, M. Utzet, M. Martín, M. Menneh and H. Ceesay 2013**
A. Kaplan, M. Forbes, I. Bonhoure, M. Utzet, M. Martín, M. Menneh and H. Ceesay, "Female genital mutilation/cutting in The Gambia: long-term health consequences and complications during delivery and for the newborn", *International Journal of Women's Health*, Vol. 2013:5, pp. 323-331
- E. Klouman, R. Manongi, K.I. Klepp 2005**
E. Klouman, R. Manongi, K.I. Klepp, "Self-reported and observed female genital

cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections”, *Tropical Medicine and International Health Journal*, Vol. 10, Issue 1, 2005, pp. 105-115, p. 111.

A. Lalonde 1995

A. Lalonde, “Clinical Management of Female Genital Mutilation must be handled with understanding, compassion”, *Canadian Medical Association Journal*, Vol. 152, Issue 6, 1995, pp. 949-950

U. Larsen and S. Yan 2000

U. Larsen and S. Yan, “Does female circumcision affect infertility and fertility? A study of the Central African Republic, Côte d’Ivoire, and Tanzania”, *Demography*, Vol. 37, Issue 3, 2000, pp. 313-321

O. Meirik, E. Banks, T. Farley, O. Akande, H. Bathija and M. Ali 2014

O. Meirik, E. Banks, T. Farley, O. Akande, H. Bathija and M. Ali, “Female Genital Mutilation and Obstetric Outcomes: Flawed Systematic Review and Meta-Analysis does not accurately reflect the available evidence”, *Obstetrics and Gynecology International*, 2014, 205230

P.M. Moreira, I.V. Moreira, E.H.O. Faye, L. Cisse, V. Mendes and F. Diadiou 2002

P.M. Moreira, I.V. Moreira, E.H.O. Faye, L. Cisse, V. Mendes and F. Diadiou, “Three cases of epidermal cyst of vulva following female genital mutilation”, *Gynécologie Obstétrique & Fertilité*, Vol. 30, Issue 12, 2002, pp. 958-960

S.R. Mostafa, N.A., El Zeiny, S.E. Tayel and E.I. Moubarak 2006

S.R. Mostafa, N.A., El Zeiny, S.E. Tayel and E.I. Moubarak, “What do medical students in Alexandria know about female genital mutilation?”, *East Mediterranean Health Journal*, Vol. 12, Suppl. 2, S78-92, 2006

C.M. Obermeyer 2005

C.M. Obermeyer, “The Consequences of Female Circumcision for Health and Sexuality: An Update on the Evidence”, *Culture, Health & Sexuality*, Vol. 7, No. 5, 2005, pp. 443-461

Organization of the African Union 1990
Organization of the African Union,

“African Charter on the Rights and Welfare of the Child”, 1990.

L. Perron, V. Senikas, M. Burnett and V. Davis 2013

L. Perron, V. Senikas, M. Burnett and V. Davis, “Clinical Practice Guidelines No. 299: Female Genital Cutting”, *The Society of Obstetricians & Gynaecologists of Canada*, Vol. 35, Issue 11: e 1-e 18, 2013

Population Reference Bureau 2014

Population Reference Bureau, “Female Genital Mutilation/Cutting: Data and Trends Update 2014” 2014

M.T. Post 1995

M.T. Post, “Female genital mutilation and the risk of HIV”, *Academy for Educational Development, Support for Analysis and Research in Africa, SARA Issues Paper*, May 1995

S. Relph, R. Inamdar, H. Singh, W. Yoong 2013

S. Relph, R. Inamdar, H. Singh, W. Yoong, “Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London”, *European Journal of Obstetrics & Gynecology and Reproductive Biology*, Vol. 2, Issue 168, 2013, pp. 195-198

Royal College of Obstetricians and Gynaecologists

Royal College of Obstetricians and Gynaecologists (RCOG) ‘Female Genital Mutilation and its Management Green-top Guideline’ No. 53, July 2015

Parliamentary and Legal Material

Malta, Ministry for Justice, Culture and Local Government, Act VII of 2003, as amended by Legal Notice 427 of 2007. <http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=8928&l=1>

Malta, Ministry for Justice, Culture and Local Government, Act XX, 2005. <http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=8947&l=1>

Malta. Ministry for Justice, Culture and Local Government Children and Young Persons (Care Orders) Regulations’ (Legal Notice 49 of 1985, as amended by

Legal Notices 43 of 1999 and 102 of 2005. <http://www.justiceservices.gov.mt/>

United Nations General Assembly

General Assembly, *Intensifying global efforts for the elimination of female genital mutilations: resolution*, adopted by the General Assembly, 5 March 2013, A/RES/67/146

G.I. Serour 2004

Serour, Gamal I. “The issue of reinfibulation.” *International Journal of Gynecology & Obstetrics*, 109:2, 2010, pp. 93-96.

S. Vangen, R.E. Johansen, J. Sundby, B. Traeen, B. Stray-Pedersen 2004

S. Vangen, R.E. Johansen, J. Sundby, B. Traeen, B. Stray-Pedersen, “Qualitative study of perinatal care experiences among Somali women and local healthcare professionals in Norway”, *European Journal of Obstetrics & Gynecology and Reproductive Biology*, Vol. 112, Issue 1, 2004, pp. 29-35

WHO

World Health Organization, “A systematic review of the health complications of female genital mutilation including sequelae in childbirth”, WHO/FCH/WMH/00.2, 2000

World Health Organization, “Female genital mutilation: a handbook for frontline workers”, WHO, WHO/FCH/WMH/005, 2000

World Health Organization “Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation”, WHO/RHR/01.13, 2001

World Health Organization, “Female genital mutilation: the prevention and the management of the health complications. Policy guidelines for nurses and midwives”, WHO, WHO/RHR/01.18, 2001

World Health Organization, “Female genital mutilation: Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Teacher’s Guide”, WHO, WHO/RHR/01.16, 2001

World Health Organization, “Female

genital mutilation: Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Student's Manual", WHO, WHO/RHR/01.17, 2001

World Health Organization, "Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries", *The Lancet*, 2006, 367, pp. 1835-1841

World Health Organization, "Effects of female genital mutilation on childbirth in Africa: Policy Brief", *The Lancet*, 2006, 267, pp. 1835-1841

World Health Organization, "Mental health aspects of women's reproductive health: A global review of the literature", Department of Reproductive Health and Research, WHO, 2009

World Health Organization, "Global strategy to stop health-care providers from performing female genital mutilation", WHO/RHR/10.9, 2010

World Health Organization, "Female Genital Mutilation programmes to date: what works and what doesn't", Department of Reproductive Health and Research, Policy Brief, WHO, WHO/RHR/11.36, 2011

N. Zaidi, A. Khalil, C. Roberts and M. Browne 2007

N. Zaidi, A. Khalil, C. Roberts and M. Browne, "Knowledge of Female genital mutilation among healthcare professionals", *Journal of Obstetrics and Gynaecology*, Informa Healthcare, Vol. 27, Issue 2, 2007, pp. 162-164

28 Too Many

Country report: Kenya, May 2013

Country report: Uganda, July 2013

Country report: Ethiopia, October 2013

Country report: Tanzania, December 2013

Country report: Sierre Leone, June 2014

Country report: Mali, September 2014

Country report: Liberia, December 2014

Center for Reproductive Rights, 2006. Female Genital Mutilation A Matter of Human Rights An Advocate's Guide to Action.

European Institute for Gender

Equality, Current situation of female genital mutilation in Malta.

Rahman Anika, Toubia Nahid, 2000. Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies.

UNHCR, 2009. Guidance Note on Refugee Claims Relating to Female Genital Mutilation.

UNICEF, 2010. Legislative Reform to Support the Abandonment of Female Genital Mutilation /Cutting.

The Advocates for Human Rights, 2011. Developing Legislation on Violence against Women and Girls.

WHO, 1997. Female Genital Mutilation: A joint WHO, UNICEF, UNFPA Statement.

WHO, 2008. Eliminating Female Genital Mutilation: An Interagency Statement. OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO.

WHO, 2010. Global strategy to stop health-care providers from performing female genital mutilation UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA.

ANNEX 2 - INTERVIEWS - QUESTIONS KEY

These questions have been developed for the particular stakeholders to which they will be addressed.

- The groups covered are:
 - Health care professionals
 - Asylum entities
 - Education professionals
 - Political entities
 - Protection professionals
 - Migrant women
 - Migrant men
-

INTERVIEW KEY 1: HEALTH CARE PROFESSIONALS

Aims and objectives for health care professionals interview questions:

- An understanding of training given to health care professionals on cultural aspects of their practice particularly FGM – both university training and in continuing professional development
 - An understanding of their perception of FGM
 - An understanding of their practical approach to FGM
 - An understanding of how often FGM is seen by health professionals
-

DEMOGRAPHIC QUESTIONS

- 1 Age
 - 2 Gender
 - 3 What is your profession?
 - 4 When did you finish your training in this profession?
 - 5 What academic qualifications do you hold?
 - 6 Which institutions did you achieve them from?
 - 7 Do you take any Professional Development training? How often?
 - 8 How often do you see female patients in your job?
 - 9 How often do you see migrant women from Arab and African countries in your job?
-

GENERAL PERCEPTIONS IN PROFESSIONS

- 1 Have you heard of “Female Genital Mutilation”?
 - 2 What is FGM?
 - 3 What types of FGM exist?
 - 4 What is your opinion on FGM?
 - 5 Which countries do you think practice FGM?
 - 6 Do you think FGM is carried out in Malta and to what extent?
 - 7 Are girls at risk in Malta? Who are the girls most at risk Malta?
 - 8 Have you come across a woman or girl who has undergone female genital mutilation? If so, how often? How did you know?
 - 9 Have you heard any stories of FGM being practised in Malta? Please elaborate...
 - 10 What do you know about when and how FGM is carried out? {Age of the girl, location, severity of FGM, who encourages it, etc}
 - 11 What are the cultural, social and religious factors that victims of FGM have alluded to when discussing the issue?
 - 12 Have you discussed the reasons or root causes of FGM with any such individuals? What were these reasons?
 - 13 Have you ever discussed the issue of FGM with other individuals? Who? {Colleagues, patients, tutors, students} What were their views/reactions?
 - 14 What are the concerns of people in your field regarding FGM?
 - 15 What role do you think your profession should play on this issue?
-

HEALTH AND PROFESSIONAL CONTACT WITH FGM

- 1 Are there short or long term health consequences relating to FGM?
 - 2 What is your knowledge of these consequences?
 - 3 Are you aware of any psychological issues related to FGM?
 - 4 What is your knowledge of these consequences?
 - 5 Do you carry out any gynaecological or urological health check-ups on African or North African women?
 - 6 If a woman comes in and you think she may have had FGM, how would you broach the subject with her?
 - 7 If a woman comes in with a complication related to FGM, do you know how to ask her about it and/or deal with this? If no, what do you need to feel that you are able to tackle the subject?
 - 8 What do you think would be a good model of care for women who have experienced FGM?
 - 9 In Malta deinfibulation is not currently carried out. What is your opinion of this?
-

NATIONAL / LEGAL CONTEXT

- 1 If an adult woman came to you and you noticed / she told you that she has undergone FGM, do you think you have any particular legal obligations?
 - 2 Would you do anything to address the wider issues relating to, for instance, any of her children who may be at risk?
-

POLICY / PROFESSIONAL POLICY

- 1 Are you a member of a professional association?
 - 2 Is there a policy in your professional association on dealing with individuals who have undergone or are at risk of undergoing FGM?
 - 3 Do you feel that this policy is adequate?
 - 4 Is there a policy in your department on dealing with individuals who have undergone or are at risk of undergoing FGM?
 - 5 Do you feel that this policy is adequate?
 - 6 What services do you currently offer to people who have experienced FGM, or girls who are at risk of FGM?
 - 7 What internal regulation do you think should be in place to enable those in the medical professions to deal with cases of FGM?
-

EDUCATION / TRAINING

- 1 Did you receive any training on different cultural aspects of your profession at University / Medical School / Nursing School?
 - 2 How did this take place, when and by who?
 - 3 Did you receive any training on FGM at University / Medical School / Nursing School?
 - 4 Do you receive any further professional training as part of your job?
 - 5 Did any of this professional training relate to intercultural aspects of your profession?
 - a If so, by who, when, how?
 - 6 Have you independently accessed information about FGM? Where from?
 - 7 Should there be more awareness on FGM? If so, what should awareness-raising campaigns on FGM include?
-

INTERVIEW KEY 2: ASYLUM ENTITIES

PERCEPTION OF FGM IN ASYLUM CLAIMS

- What types of gender based asylum claims have there been in Malta?
 Has asylum ever been sought in Malta on the basis of FGM?
 If yes –
 How many such cases have there been?
 Were the claims assessed on the basis of FGM having happened or the risk of it happening in the future?
 How would such a ‘risk’ be ascertained?
 Where were the women from?
 What was the reasoning behind accepting or rejecting such claims?
 What social groups would be considered in order to grant asylum to women on the basis of FGM?
- If no –
 Would RefCom consider an asylum claim on the basis of FGM?
 If yes – how so
 If no – why not
- What are the concerns of people in your field with regards to FGM?
 Have you ever received any professional training on FGM?
 a If so, by who, when and how?
 b If not, how do you access information on FGM?
-

INTERVIEW KEY 3: MIGRANT MEN

BACKGROUND QUESTIONS

- 1 Age
 - 2 Gender
 - 3 Country of Origin
 - 4 Ethnic Group
 - 5 Marital Status
 - a If married or has a partner: National origin and ethnicity of husband/wife
 - 6 When did you arrive in Malta?
 - 7 Do you live in an open centre or privately owned/rented accommodation?
 - 8 What is your status in Malta?
 - 9 Do you plan to stay in Malta / move to another European country / move to another country (USA etc) / go back to country of origin?
 - 10 Have you lived in any countries other than your own and Malta?
 - 11 Are you a member of a migrant community organisation here in Malta?
 - 12 How close do you feel to the community that’s from the same country/ethnic group as yourself here in Malta?
-

PERCEPTIONS AND PERSPECTIVES

- 1 What do you know about FGM?
 - a Types
 - b Reasons for practice
- 2 Since arriving in Malta, has your view of FGM changed? How so?
- 3 Is FGM common in your culture? If yes, can you tell me more about the way it is practised?
- 4 Do you think FGM is required by your culture / tradition?
- 5 Do you think FGM is required by your religion?
- 6 Are you aware of any health risks associated with FGM?
- 7 What do you think are the reasons families choose to practice FGM on their daughters?
- 8 Are there any benefits of performing FGM on girls?
- 9 Do girls have any inconveniences or negative consequences of having FGM?being genitally mutilated?
- 10 Does FGM affect a girl's marriage?
- 11 Does FGM affect a girl's sexual pleasure?
- 12 Is FGM discussed in your family and close circle of friends?
- 13 Have you ever encountered arguments justifying FGM?
- 14 Do you think FGM should continue to be carried out? Why?
- 15 Do you think FGM is performed on girls in Malta? What do you think about this?
- 16 Do you think girls are taken outside of Malta to be genitally mutilated? What do you think about this?
- 17 Do you think there are any psychological effects on girls when FGM is carried out?
- 18 Prior to arriving in Malta, what was your source of knowledge on FGM?
- 19 Following your arrival in Malta, what has been your source of knowledge on FGM?
 - a Have you received any information from a government entity, NGO or other organization about FGM?
- 20 Has your opinion about FGM changed since your arrival in Malta?
- 21 Are you aware of any efforts to ban FGM?
 - a What do you think about these efforts?
 - b What do you think about the motivation behind these efforts?
 - c Do you think such efforts have an impact on social perception of FGM?
- 22 Do you think schools should be involved in awareness raising on FGM?

GENDER SPECIFIC QUESTIONS

- 1 Does FGM affect the way you perceive women?
 - 2 Would you marry a woman who has not had FGM?
 - 3 Does your wife / mother / sister / daughter think the practice of FGM should be continued or stopped? Why?
 - 4 Does your son / father / brother think the practice of FGM should be continued or stopped? Why?
-

INTERVIEW KEY 4: MIGRANT WOMEN

BACKGROUND QUESTIONS

- 1 Age
 - 2 Gender
 - 3 Country of Origin
 - 4 Ethnic Group
 - 5 Marital Status
 - a If married or has a partner: National origin and ethnicity of husband/wife
 - 6 When did you arrive in Malta?
 - 7 Do you live in an open centre or privately owned/rented accommodation?
 - 8 What is your status in Malta?
 - 9 Do you plan to stay Malta / move to another European country / move to another country (USA etc) / go back to country of origin?
 - 10 Have you lived in any countries other than your own and Malta?
 - 11 Are you a member of a migrant community organisation here in Malta?
 - 12 How close do you feel to the community that's from the same country/ethnic group as yourself here in Malta?
-

PERCEPTIONS AND PERSPECTIVES

- 1 What do you know about the different types of FGM?
 - 2 What are the reasons for the practice of FGM?
 - 3 Since arriving in Malta, has your view of FGM changed? How so?
 - 4 Do you think FGM is required by your culture / tradition?
 - 5 Is FGM common in your culture? If yes, can you tell me more about the way it is practised?
 - 6 Do you think FGM is required by your religion?
 - 7 Are you aware of any health risks associated with FGM?
 - 8 What do you think are the reasons families choose to practice FGM on their daughters?
 - 10 Are there any benefits of performing FGM on girls?
 - 11 Do girls have any inconveniences or negative consequences following FGM?
 - 12 Does FGM affect a girl's marriage?
 - 13 Does FGM affect a girl's sexual pleasure?
 - 14 Is FGM discussed in your family and close circle of friends?
 - 15 Have you ever encountered arguments justifying FGM?
 - 16 Do you think FGM should continue to be carried out? Why?
 - 17 Do you think FGM is performed on girls in Malta? What do you think about this?
 - 18 Do you think girls are taken outside of Malta to have FGM? What do you think about this?
 - 19 Do you think there are any psychological effects on girls when FGM is carried out?
 - 20 Prior to arriving in Malta, what was your source of knowledge on FGM?
 - 21 Following your arrival in Malta, what has been your source of knowledge on FGM?
 - a Have you received any information from a government entity, NGO or other organization about FGM?
 - 22 Has your opinion about FGM changed since your arrival in Malta?
 - 23 Are you aware of any efforts to ban FGM?
 - a What do you think about these efforts?
 - b What do you think about the motivation behind these efforts?
 - c Do you think such efforts have an impact on social perception of FGM?
 - 24 Do you think schools should be involved in awareness raising on FGM?
-

GENDER SPECIFIC QUESTIONS

- 1 How did/does FGM affect you?
 - 2 Does your husband / father / brother / son think the practice of FGM should be continued or stopped? Why?
 - 3 Does your mother / sister / daughter think the practice of FGM should be continued or stopped? Why?
 - 4 Have your relatives ever tried to influence your personal view on FGM?
-

INTERVIEW KEY 5: EDUCATIONAL PROFESSIONALS

DEMOGRAPHIC QUESTIONS

- 1 Age
 - 2 Gender
 - 3 What is your profession?
 - 4 When did you finish your training in this profession?
 - 5 What academic qualifications do you hold?
 - 6 Which institutions did you achieve them from?
 - 7 Do you take any Professional Development training? How often?
 - 8 What is the gender distribution of your students?
 - 9 How many of the students that you teach are from Arab and African countries?
 - 10 Which countries are they from?
-

GENERAL PERCEPTIONS IN PROFESSIONS

- 1 Have you heard of “Female Genital Mutilation”?
 - 2 What is FGM?
 - 3 What types of FGM exist?
 - 4 What is your opinion on FGM?
 - 5 Which countries do you think practice FGM?
 - 6 Are girls at risk in Malta? Who are the girls most at risk Malta?
 - 7 Have you come across a woman or girl who has undergone female genital mutilation? If so, how often? How did you know?
 - 8 What do you know about when and how FGM is carried out? {Age of the girl, location, severity of FGM, who encourages it, etc}
 - 9 Have you discussed the reasons or root causes of FGM with any such individuals? What were these reasons?
 - 10 Have you ever discussed the issue of FGM with other individuals? Who? {Colleagues, school admin, school leadership, students}
 - a What were their views/reactions?
 - 12 What role do you think your profession should play on this issue?
-

PROFESSIONAL CONTACT WITH FGM

- 1 Have you ever conducted formal / informal research on FGM?
 - 2 Are you aware of any physical or psychological issues related to FGM?
 - 3 What is your knowledge of these consequences?
 - 4 Are there any girls that you teach that may be at risk of FGM?
 - 5 What are the risk factors?
 - 6 If you thought that a girl was at risk, what would you do?
 - 7 Do you think teachers and school staff should be involved in awareness raising on FGM?
 - 8 Do you think teachers and school staff should be involved in preventing FGM?
-

NATIONAL / LEGAL CONTEXT

- 1 Do you think you have any legal obligations relating to possible cases of FGM?
 - 2 If a girl came to you and told you that she has undergone FGM, what would you do?
 - 3 If a girl came to you and told you that she will undergo FGM, what would you do?
-

POLICY / PROFESSIONAL POLICY

- 1 Are you a member of a professional association?
 - 2 Is there a policy in your professional association on addressing the issue of FGM?
 - 3 If yes, do you feel that this policy is adequate?
 - 4 Is there a policy in your school or college on dealing with individuals who have undergone or are at risk of undergoing FGM?
 - 5 If yes, do you feel that this policy is adequate?
 - 6 What internal regulation do you think should be in place to enable those in the education sector to deal with cases of FGM?
-

EDUCATION / TRAINING

- 1 Did you receive any training on different cultural aspects of your profession at University?
 - 2 How did this take place, when and by who?
 - 3 Did you receive any training on FGM at University?
 - 4 Do you receive any further professional training as part of your job?
 - 5 Did any of this professional training relate to intercultural aspects of your profession?
 - 6 Did you receive any training on FGM?
 - a If so, by who, when, how?
 - b If not, how do you access information regarding FGM?
 - c If not, what aspects do you think should have been covered?
-

INTERVIEW KEY 6: POLITICAL ENTITIES

- 1 How did the law on FGM come about?
 - 2 Why was the previous legal regime not adequate?
 - 3 Have you come across women and girls who have undergone FGM in Malta?
 - 4 What do you think are the biggest risk factors in Malta?
 - 5 Which girls are more at risk?
 - 6 Do you think the law in its current format is adequate?
 - 7 It has been argued that the issue of harm is not adequately addressed and instead the legislation encompasses forms of surgery that are unrelated to FGM and carried out for non-medical reasons? What are your views on this?
 - 8 A case of FGM has never been brought forward in Malta. Why do you think this is?
 - 9 FGM is not only a legal issue. What do you think needs to be done to address the issue outside of the law on FGM, and by whom?
 - 10 What prevention mechanisms need to be in place?
 - 11 What protection mechanisms need to be in place?
 - 12 Are you aware of any promising practices from other countries that we may look towards to improve our current approach to FGM?
 - 13 What awareness-raising initiatives are required on FGM, if any? Should the awareness-raising campaigns target:
 - 14 Prior to arriving in Malta, what was your source of knowledge on FGM?
 - 15 Following your arrival in Malta, what has been your source of knowledge on FGM?
 - a Have you received any information from a government entity, NGO or other organization about FGM?
 - 16 Has your opinion about FGM changed since your arrival in Malta?
 - 17 Are you aware of any efforts to ban FGM?
 - a What do you think about these efforts?
 - b What do you think about the motivation behind these efforts?
 - c Do you think such efforts have an impact on social perception of FGM?
 - 18 Do you think schools should be involved in awareness raising on FGM?
 - 19 Do you think further training on FGM for medical, educational and protection professionals is required?
 - 20 Do you think sensitisation and awareness on FGM should be a topic covered in schools?
 - 21 Have you ever received training on FGM?
 - 22 Prior to arriving in Malta, what was your source of knowledge on FGM?
 - 23 Following your arrival in Malta, what has been your source of knowledge on FGM?
 - a Have you received any information from a government entity, NGO or other organization about FGM?
 - 24 Has your opinion about FGM changed since your arrival in Malta?
 - 25 Are you aware of any efforts to ban FGM?
 - a What do you think about these efforts?
 - b What do you think about the motivation behind these efforts?
 - c Do you think such efforts have an impact on social perception of FGM?
 - 26 Do you think schools should be involved in awareness raising on FGM?
-

INTERVIEW KEY 7: PROTECTION PROFESSIONALS

DEMOGRAPHIC QUESTIONS

- 1 Age
 - 2 Gender
 - 3 What is your profession?
 - 4 When did you finish your training in this profession?
 - 5 What academic qualifications do you hold?
 - 6 Which institutions did you achieve them from?
 - 7 Do you take any Professional Development training? How often?
 - 8 What is the gender distribution of your client group?
 - 9 How many of your clients are from Arab and African countries?
 - 10 Which countries are they from?
-

GENERAL PERCEPTIONS IN PROFESSIONS

- 1 Have you heard of “Female Genital Mutilation”?
 - 2 What is FGM?
 - 3 What types of FGM exist?
 - 4 What is your opinion on FGM?
 - 5 Which countries do you think practice FGM?
 - 6 Do you think FGM is carried out in Malta? To what extent?
 - 7 Are girls at risk in Malta? Who are the girls most at risk in Malta?
 - 8 Have you come across a woman or girl who has undergone FGM? If so, how often? How did you know?
 - 9 What do you know about when and how FGM is carried out? {Age of the girl, location, severity of FGM, who encourages it, etc}
 - 10 Have you discussed the reasons or root causes of FGM with any such individuals? What were these reasons?
 - 11 Have you ever discussed the issue of FGM with other individuals? Who? {Colleagues, clients, supervisors} What feedback did you receive?
 - 12 What role do you think your profession should play in this issue?
-

PROFESSIONAL CONTACT WITH FGM

- 1 Are you aware of any physical or psychological issues related to FGM?
 - 2 What is your knowledge of these consequences?
 - 3 What are the risk factors?
 - 4 If you thought that a girl was at risk, what would you do?
-

NATIONAL / LEGAL CONTEXT

- 1 Do you think you have any legal obligations relating to possible cases of FGM?
 - 2 If a girl came to you and told you that she has undergone FGM, what would you do?
 - 3 If a girl came to you and told you that she will undergo FGM, what would you do?
-

POLICY / PROFESSIONAL POLICY

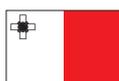
- 1 Are you a member of a professional association?
 - 2 Is there a policy in your professional association on addressing the issue of FGM?
 - 3 If yes, do you feel that this policy is adequate?
 - 4 Is there a policy in your organization on dealing with individuals who have undergone or are at risk of undergoing FGM?
 - 5 If yes, do you feel that this policy is adequate?
 - 6 What internal regulation do you think should be in place to enable those in the protection sector to deal with cases of FGM?
-

**EDUCATION /
TRAINING**

- 1 Did you receive any training on different cultural aspects of your profession at University?
- 2 How did this take place, when and by who?
- 3 Did you receive any training on FGM at University?
- 4 Do you receive any further professional training as part of your job?
- 5 Did any of this professional training relate to intercultural aspects of your profession?
- 6 Did you receive any training on FGM?
- 7 If so, by who, when, how?
- 8 If no, how did you access information regarding FGM?

- 1 Do you think there needs to be further awareness raising on FGM? What type, and with who?
 - 2 Do you think there are girls and women who have had or are at risk of having FGM, who are not being captured by the system and are therefore unaware of their rights?
 - 3 Do you think FGM should be a topic covered in schools?
 - 4 Are you aware of any promising practices from other countries that we may look towards to improve our current approach to FGM?
-

**NATIONAL COMMISSION
FOR THE PROMOTION OF EQUALITY**
T: 2590 3850 E: EQUALITY@GOV.MT
WWW.EQUALITY.GOV.MT
f FIND US ON FACEBOOK



This project is supported by the European Union Programme for Employment and Social Solidarity – PROGRESS (32007-2013). This programme is implemented by the European Commission.

