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FEMALE GENITAL MUTILATION AND EARLY AND FORCED MARRIAGES

A multi-agency intervention model for Mallow, Co Cork, Ireland

AkiDwA
AKINA DADA WA AFRICA

Co-funded by the European Union

Acknowledgements

To get this far in a task of this magnitude, groups need and rely on a large pool of people who with time, come to be viewed as family. This family was crucial for drawing the much-needed support and assistance, to produce this manual for training the Key Professionals. Networks formed in and out of Mallow, Co Cork and the community and most importantly the Key Professionals who were consulted during the writing of this manual as part of information gathering as to the best ways to bring about the Intervention Chains to fruition have been very important as a source of support. The sensitivity of the issues of Female Genital Mutilation (FGM) and Erly and Forced Marriages (EFM) cannot be lost to us and this is something we were reminded by the Community Trainers who reached out to the members of the affected community who were also a key cog in this participatory consultation.

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Introduction to AkiDwA

Akina Dada wa Africa (AkiDwA), Swahili for sisterhood, is a network of African and other migrant women living in Ireland that was founded in 2001. AkiDwA was established as a network of African women living in Ireland. The network swiftly grew to include African women of all nationalities, religious affiliations, and socioeconomic and legal statuses. Migrant women from other regions also wished to join the network and attend meetings and events. As a result, the network now serves all migrant women while staying true to its African roots. The organisation is acclaimed for its work in areas of gender-based violence (GBV). In the last 20 years, AkiDwA has spearheaded work on female genital mutilation and domestic violence from the perspective of migrant women. To advance its work on GBV, the organisation has begun looking into the many facets of this issue, and in 2002, AkiDwA conducted baseline research into the trafficking of migrant women in Ireland to help broaden awareness of the issue and to document its occurrence.

Female Genital Mutilation (FGM) and Early and Forced Marriages (EFM)

Looking into the twin issues of FGM and EFM and how to deal with them from multiple angles in Mallow, Co Cork, Ireland.

Definition

Female Genital Mutilation (FGM) is defined as the partial or total removal of the external female genitalia, or any practice that purposely alters or injures the female genital organs for non-medical reasons. The practice is internationally recognized as a severe human rights violation of women and girls.

The World Health Organisation (WHO) estimates that more than 230 million women and girls have undergone female genital mutilation globally.

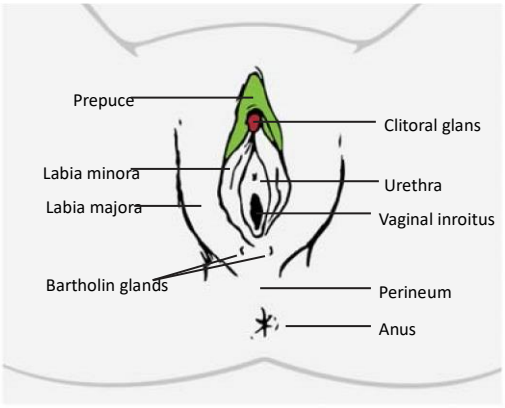
CLASSIFICATIONS OF FGM

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other potentially harmful non-medical procedures including pricking, piercing, incising or stretching the clitoris and/or labia, as well as scraping and cauterization (burning) of the clitoris and surrounding tissue, and using herbs or chemicals to cause bleeding or narrowing of the vagina.

NB: Women may not be able to correctly self-identify the specific type of FGM that they have experienced.

Type I

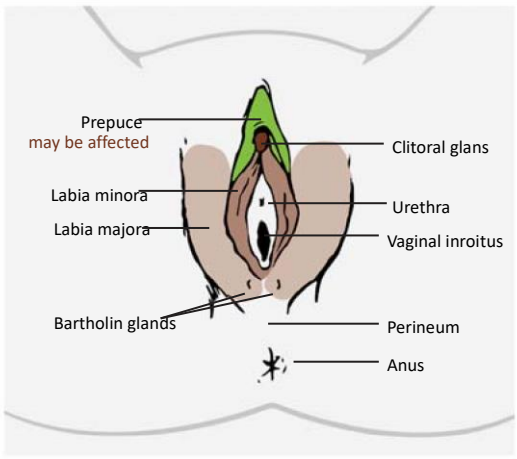
Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).



Type Ia removal of the prepuce/clitoral hood (circumcision)
Type Ib removal of the clitoral glans with the prepuce (clitoridectomy)

Type II

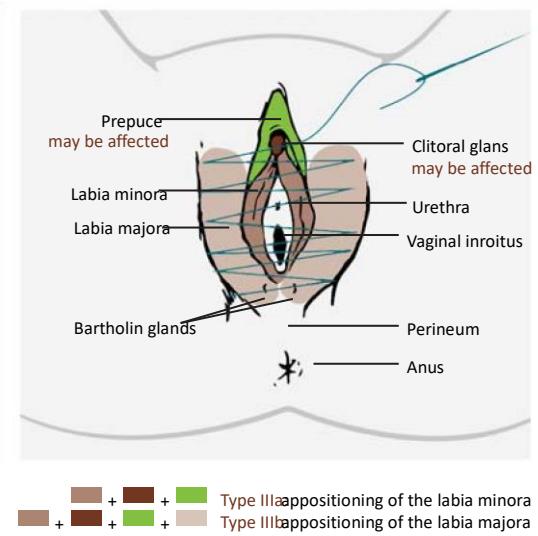
Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).



Type IIa removal of the labia minora only
Type IIb partial or total removal of the clitoral glans and the labia minora (prepuce may be affected)
Type IIc partial or total removal of the clitoral glans, the labia minora and labia majora (prepuce may be affected)

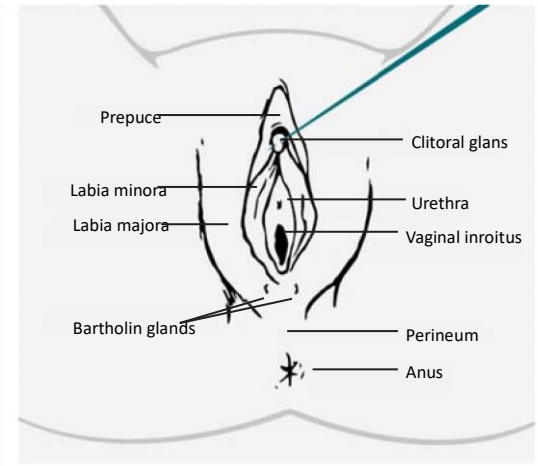
Type III

Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).



Type IV

All other potentially harmful non-medical procedures including pricking, piercing, incising or stretching the clitoris and/or labia, as well as scraping and cauterization (burning) of the clitoris and surrounding tissue, and using herbs or chemicals to cause bleeding or narrowing of the vagina.



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WHEN IS FGM PERFORMED?

The age at which girls undergo FGM varies by community. The most common age at which FGM is performed is between four and ten years, although this can vary from birth until pregnancy with first child (primagravida).

WHO PERFORMS FGM?

Typically, FGM is performed by an older woman in the community. Normally the practitioner would not have had any medical training. Others who are likely to perform FGM on girls are traditional birth attendants (TBAs). The use of anaesthetics and antiseptics is uncommon. Instruments used to perform FGM include razor blades, knives, pieces of glass, scissors, and scalpels. In some instances, several girls will be cut using the same instrument, heightening the risk of infections such as tetanus and HIV.

Justification for FGM, why it is carried out

- Cultural tradition
- Marriageability
- Rite of passage into womanhood
- Religion (although no religion includes FGM as a requirement)
- Preservation of virginity until marriage
- Social (and community) acceptance – among peers and very important for marriage
- Cultural/aesthetic reasons
- Health and hygiene
- Aesthetics

FGM Myths

- Male and female circumcision are the same
- Performing FGM in hospitals reduces the risk
- Some types of FGM of FGM are less harmful than others
- FGM is acceptable in some situations
- FGM is a religious requirement
- A woman who has undergone FGM is disempowered.
- FGM is a problem for women
- FGM is an African problem
- Women who have undergone FGM do not experience sexual pleasure
- FGM is barbaric and not performed by people who are sophisticated and/or educated

The origins of FGM are largely unknown, but the practice predates contemporary world religions. Local and cultural factors are likely to be some of the reasons for the development and continuation of the practice over time.

Three Feminine Sorrows

And if I may speak of my wedding night I had expected caresses. Sweet kisses. Hugging and love

No. Never.

Awaiting me was pain. Suffering and sadness.I lay on my wedding bed, groaning like a wounded animal, a victim of feminine pain. At dawn, ridicule awaited me. My mother announced. Yes, she is a virgin

*When fear gets hold of me. When anger seizes my body. When hate becomes my companion,then I get feminine advice, because it is only feminine pain.And I am told feminine pain perishes like all feminine thi*ngs. *The journey continues. Or the struggle continues.As modern historians say, as the good tie of marriage matures. As I submit and sorrow subsides, my belly becomes like a balloon.*

A glimpse of happiness shows, a hope. A new baby. A new life! But a new life endangers my life. A baby's birth is death and destruction for me! It is what my grandmother called the three feminine sorrows. She said the day of circumcision, the wedding night and the birth of a baby are the triple feminine sorrows. As the birth bursts, I cry for help, when the battered flesh tears.

No mercy. Push! They say. It is only feminine pain! And now I appeal: I appeal for love lost, for dreams broken, for the right to live as a whole human being. I appeal to all peace loving people to protect to support and give a hand to innocent little girls who have done no harm. Obedient to their parents and elders, all they know is only smiles. Initiate them to the world of love, not the world of feminine sorrows.

Poem by a woman of courage in Somalia Her name has been withheld to protect her privacy).

Justification for the continuation of FGM

It is important to look deeply into the reasons which cause the continuation of FGM. Some of the reasons advanced for the continuation of FGM are psychosexual, religious, sociological and for hygiene reasons.

Psychosexual

- A woman's virginity is an absolute prerequisite for marriage.
- In Egypt and Sudan, female circumcision is seen to increase male sexual pleasure during intercourse.
- The clitoris is seen as an aggressive organ that threatens the male penis.
- Presence of the clitoris endangers the baby during delivery.
- Alternatively, the clitoris is seen as central to sexual desire and its excision protects a woman from her over sexed nature and saves her from temptations and disgrace while preserving her virtue.

Religious

- Clitoridectomy is believed to have its origins in Africa and to have been adopted by Islam at the conquest of Egypt in 742 AD.
  Note: Female Genital Mutilation transcends religious boundaries and to be careful as this practice is not practiced in most Islamic countries as it is not in accordance with the Quran.

Social

- An institutional rite of passage into womanhood, becoming a mature.
- Socialization of female fertility
- The ceremony surrounding female circumcision is intended to teach young girls about her duties as a wife and a mother.

Aesthetic

- In some societies, the clitoris is considered unpleasant and ugly to the sight and touch.
- Removal of the 'unsighty' female genitalia is seen and deemed a sign of maturity.
- It is believed that female circumcision maintains a woman's physical and mental health.

FGM in Europe

In Europe, the foremost NGO to work to end the FGM was Terre Des Femmes (TDF) based in Berlin, Germany. TDF was founded in 1981. In France, Groupment Pour I'Abolition des Mutilations Sexualles (founded in 1982) was leading in the efforts to address and end the issue of FGM. The focus on NGOs and CBOs when working on FGM has been either focusing their work solely on ending FGM or is incorporated as part of their programming on other issues. This incorporation of FGM can be part of a wider programming in efforts to achieve gender equality, addressing women's health in an European context or as part of migrants or refugee health.

Working at different levels when addressing FGM has also been a focus of many actors. For example, some of the NGO activities are devoted to the prevention of FGM while other actors like the police, the media and schools are focused on addressing FGM at community level. NGOs focus on lobbying and advocating for an end to FGM, urging key government departments to avail resources to women and girls affected by FGM to cater for their diverse medical needs. These efforts of lobbying the government have also been incorporated into other international commitments to increase gender equality such as the Sustainable Development Goals where FGM has been explicitly mentioned as a threat to gender equality.

FGM in Ireland

According to the latest CSO figures, it is estimated that approximately 12,000 women and girls are living with the consequences of FGM in Ireland. Of these, Dublin, takes the bulk followed by Cork (which is Ireland's second largest city).

The Istanbul Convention has gone a step further and introduced the 5 Ps when dealing with addressing FGM in Europe.

This is the approach AkiDwA and Ireland has adopted and made the backbone to it's Towards a National Action Plan.

Strategic Theme 1: Prevention (engaging the community)

AIM: To promote effective prevention and victim support measures, through changing social norms as well as women's empowerment.

Community-based programmes play a key role in combating FGM. However, it takes time for both women and men to abandon a practice that they have personally regarded as positive. If Ireland is to prevent girls from being subjected to FGM, key programmes have to be implemented and measures put in place to cooperate with the affected communities, with women and men, with the young and the old. Education, training and awareness-raising about various aspects of the practice must also be considered for affected communities, for example to highlight the negative impacts of the practice, the legal prohibition on FGM and the fact that FGM is a danger to health and is not prescribed by any religion. 10 20 EU (2014) The Council of Europe Convention on preventing and combating violence against women and domestic violence, "A tool to end female genital mutilation. Some people believe that FGM is required by their religion, yet no religion demands that girls and women be genitally mutilated. Dialogue must be promoted with faith and community leaders who should be invited to help educate their members on the fact that FGM has no religious foundation and is harmful for its victims.

Such dialogue can be a valuable tool for improving understanding of different opinions and beliefs and thus for combating FGM. FGM is not only a grave violation of the rights of girls and women, it is also not an Islamic religious requirement. The ruling on FGM is not in the Holy Qur'an. There are a few narrations found in Hadith which include the topic of FGM, however Hadith experts and Jurists have considered these as weak and not to be taken into consideration." Shaykh Muhammad Umar Al-Qadri, Imam of Islamic Centre Ireland, February 2016. Communities are experts in their own lives, and their engagement on the issue is essential to enable them to actively end FGM. Community development and empowerment approaches are important. Creating a platform for young people to become advocates and to help change behaviour and attitudes towards FGM enables them to become key agents of change and can help in reaching out to their peers to raise awareness. Women need safe spaces to talk and to share their views and experiences as a first step towards protecting their daughters and ultimately towards developing the confidence to reach out to the wider community to campaign against FGM. Community engagement involving men, women, youth and faith groups is the most effective way to ensure commitment and a coordinated response to ending FGM. Efforts should also be made to raise awareness on the different forms of violence against women, including FGM, among the general public.

Strategic Theme 2: Protection (safeguard women and girls at risk of FGM)

AIM: To ensure women and girls are protected from FGM through effective identification of risk and provision of protective measures.

FGM is a harmful practice, inflicted mostly on young girls between infancy and age 15, causing short-term and longterm physical and psychological consequences. It is a violation of Article 19 of the UN Convention on the Rights of the Child (UNCRC)21. FGM is performed on children who are unable to give informed consent or to effectively resist the practice, which constitutes both physical and psychological child abuse. Efficient multidisciplinary cooperation is required to ensure the best interests of the child are a primary consideration in all actions undertaken in child protection. In 2013, the UN Committee on the Rights of the Child published General Comment No 14 (2013) on the rights of the child to have his or her best interests considered as a primary consideration in all actions or decisions that concern the child, in both the public and private sphere, as outlined in Article 3.1 of the Convention. Efforts should be made to ensure that girls living in Ireland from affected countries are protected from the harmful practice. Based on reports from other countries, the period of highest risk for girls is during holidays, as girls visiting their parents' country of origin may be at risk of being subjected to FGM22. Training and awareness-raising is essential. Establishing and developing risk assessment strategies and putting in place mechanisms to ensure that girls are fully protected are paramount. Under Section 3 of the 1991 Child Care Act, the Child and Family Agency Tusla has the responsibility for promoting the welfare of children who are not receiving adequate care and protection. On 1 January 2014 Tusla became an independent legal entity, comprising the HSE's Children and Family Services, the Family Support Agency and the National Educational Welfare Board, as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender-based violence. The Agency operates under the Child and Family Agency Act 201323 and is required to support and promote the development, welfare and protection of children, and support the best interests and views of the child. 11 21 Article 19 of the UNCRC relates to protection from abuse and neglect.
22 http://www.nhs.uk/conditions/female-genital-mutilation. 23

http://www.irishstatutebook.ie/eli/2013/act/40/enacted/en/pdf. Ireland signed and ratified the United Nations Convention on the Rights of the Child in 1992, which aims to ensure that children are safeguarded against all forms of abuse and neglect. Furthermore, the Department of Children and Youth Affairs' publication Children First: National Guidance for the Protection and Welfare of Children aims to promote the safety and well-being of children living in Ireland: "No childhood should be shattered by abuse. No young life should be lived in the shadow of fear. While it is not possible to prevent all violence, nor possible to guarantee that no child will ever be harmed by neglect or aggression or exploitation or predation, it is our duty to do everything in our power as a Government and as a society to prevent such harm24." The population of Ireland has changed over the last 20 years and encompasses a wide range of faiths, cultures and ethnic origins. This means that social workers must be acutely aware of the culturally sensitive approaches required to work with children and families from different backgrounds. It does not mean that cultural differences allow children to be abused25. The Children and Family Relationships Act 2015 was passed in 2015, and a number of its provisions came into force on 18 January 201626. The Act defines, for the first time, factors which a court can take into account in defining a child's best interests for the purposes of the Guardianship of Infants Act 1964, such as meaningful relationships and the physical, psychological and emotional needs of the child as well as issues such as family violence27. There are severe consequences to FGM, both psychological and emotional, and all cases where a risk of FGM is established must be referred to local child protection services and subjected to a child protection assessment by Tusla in consultation with other health professionals. Individuals and agencies need to be able to detect potential cases of FGM. Professionals working with children should be informed and trained to identify girls at risk. They should also be trained to recognise signs that indicate a girl may have previously been subjected to FGM. Such professionals include health professionals, teachers, Gardaí and social workers. The primary responsibility for protecting women and girls from FGM lies with each country. However, if a woman or girl under genuine fear of being subjected to FGM flees a country where such protection is not provided by the state and arrives in Ireland, it is vital that Ireland fulfils its legal obligations and provides adequate protection. In an update to the UNHCR publication Too Much Pain: Female Genital Mutilation & Asylum in the European Union - A Statistical Overview28, UNHCR estimates that in 2013, over 25,000 women and girls sought asylum from FGM-practising countries in the EU. That figure has increased steadily since 2008." Gender-based violence against women has been recognised as a form of violence amounting to gender-based persecution, and can be considered as grounds for claiming international protection29. In particular, the UNHCR recognises FGM as both a gender-based and child-specific form of persecution. In May 2009, the UNHCR established guidelines on how to treat claims for refugee status relating specifically to FGM, which state that: "a girl or woman seeking asylum because she has been compelled to undergo, or is likely to be subjected to FGM, can qualify for refugee status under the 1951 Convention relating to the Status of Refugees30." Women and girls applying for international protection in the state should be interviewed in a gender-sensitive manner to ensure they have an adequate opportunity to identify the types of harm they fear as relevant to the protection process31. The 2013 UNHCR report Beyond Proof, Credibility Assessment in EU Asylum Systems, also known as CREDO, notes that: "Gender roles affect male and female experiences of persecution and serious harm and, thus, their asylum claims. Females may be persecuted in ways that are different from those in which males are subjected32." Hence, gender-sensitive interviewing is essential to ensure the facts of the

claim are brought to light and can be properly assessed by the decision-maker. 12 24 Children First 2011. 25 Child Protection and Welfare Handbook 2011. 26 The Children and Family Relationships Act 2015 (Commencement of Certain Provisions) Order 2016 commenced specified provisions of Parts 1, 4, 5, 6, 7, 8, 12 and 13 of the Children and Family Relationships Act 2015. See: http://www.justice.ie/en/JELR/Pages/PR16000018. 27 Section 31. See: http://www.irishstatutebook.ie/eli/2015/act/9/enacted/en/print#sec45. 28 UN High Commissioner for Refugees (UNHCR), Too Much Pain: Female Genital Mutilation & Asylum in the European Union - A Statistical Update (March 2014), March 2014, available at:http://www.refworld.org/docid/5316e6db4.html 29 Istanbul Convention, Article 60. 30 See: UNHCR Guidance Note on Refugee Claims Relating to Female Genital Mutilation, May 2009, available at: http://www.refworld.org/docid/4a0c28492.html. 31 See UNHCR Guidelines no. 1, para 36(vii), available at: http://www.unhcr.org/3d58ddef4.html. 32 CREDO, p.69. Within the European Union, the Common European Asylum System provides for a system of laws designed to ensure that Member States incorporate similar standards and practices in reception conditions and procedures relating to international protection across the EU. However, unlike the majority of EU Member States, Ireland is not bound by European instruments adopted in the area of asylum that it has not specifically "opted into33". The EU Directives in relation to reception conditions for asylum seekers34 was recast in 2013 and now binds most EU Member States. It makes specific reference to gender sensitivities that must be taken into account in providing reception facilities for asylum-seekers. The recast Reception Conditions Directive of 2013 provides that Member States "shall take into consideration gender and age-specific concerns and the situation of vulnerable persons in relation to applicants within the premises and accommodation centres35." It must be noted, however, that Ireland has not opted into either the first Reception Conditions Directive of 2003 or the recast version36. A working group established in October 2014 by Minister for Justice and Equality Frances Fitzgerald and Minister of State Aodhán Ó Ríordáin, to report to Government on improvements to the protection process, including direct provision and supports to asylum seekers, made these recommendations in its final report of June 2015: l The State opt-in to all instruments of the Common European Asylum System, unless clear and objectively justifiable reasons can be advanced not to. l Where the State does not opt-in to an instrument for discrete reasons (as above), the State should give full effect to the remaining provisions in order to safeguard important common standards and to promote consistency in the application of protection procedures and standards across the EU37.

Strategic Theme 3: Provision, Support and Care (for women and girls who have undergone FGM)

AIM: To provide high-quality and accessible healthcare and support to survivors of FGM throughout Ireland.

Under the United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR), governments bear a duty to respect, protect and fulfil everyone's rights to the highest attainable standard of physical and mental health. Realisation of this requires provision of quality rights-based services that are available, acceptable and accessible38. Accessibility of services and information means that they need to be non-discriminatory, physically

accessible and affordable. Acceptability requires that all services and information are respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements. The issue of FGM is part of a set of wider issues in healthcare provision for women from minority ethnic backgrounds, particularly refugees and asylum seekers. A combination of barriers can prevent refugee women from accessing the healthcare they need39. These barriers include isolation of direct provision centres from the wider community and the requirement to have basic understanding of the services available and how they operate. Poor communication and language barriers are often reported by women seeking asylum and service providers as an obstacle to care. Lack of knowledge about FGM also inhibits women's informed consent in accessing health services generally. This is not compatible with women's rights to accessible and acceptable healthcare. It has broad implications for women's informed consent and trust in their healthcare providers, adherence to treatment and also for the right to refuse services, screening or treatment. During the consultation process for the setup of the IFPA specialist clinic for women who have undergone FGM, women reported feeling stressed and stigmatised in healthcare settings due to a lack of healthcare providers' knowledge around FGM and how to address it appropriately. 13 33 Protocol No. 21 annexed to the Treaty on the Functioning of the European Union, "on the position of the United Kingdom and Ireland in respect of the Area of Freedom, Security and Justice." 34 Reception Conditions Directive 2013/33/EU. 35 Article 17, Reception Conditions Directive 2013/33/EU. 36 Ireland has opted into the recast Dublin III Regulation (604/2013/EU) and the recast Eurodac Regulation (603/2013/EU). It continues to participate in the Qualification Directive (2004/83/EC) and the Procedures Directive (2005/85/EC) but did not opt into the Reception Conditions Directive (2003/9/EC). 37 Working Group Report to the Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, June 2015, p.101. 38 Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14. 39 UNHCR (2013) Towards a New Beginning. Awareness of FGM and preparedness to respond to it in a culturally appropriate manner is part of the requirement of acceptability. Adequately addressing the specific healthcare needs of women who have had FGM requires that services are delivered by healthcare professionals who are equipped with the knowledge and confidence to recognise and treat FGM-related problems comprehensively. To ensure this, FGM-related issues must be integrated into health policy, strategy and training. Evidence-based guidelines must be available to provide clear direction for healthcare professionals, including protocols for cross-sector cooperation and referral.

Strategic Theme 4: Prosecution

AIM: To provide protection, support and justice to women and girls.

The Istanbul Convention requires states to take the necessary legislative and other measures to ensure that investigations and judicial proceedings in relation to violence against women are carried out without undue delay. They should take into consideration the rights of the victim during all stages of criminal proceedings (Articles 49 and 50). Where suspicions arise that a girl or a woman is at risk of or is affected by violence against women, including FGM, protection systems that help with identification, reporting, referral and support are required to trigger a co-ordinated action that would prevent violence from taking place and protect the girl or woman in question (Articles 18, 49, 50, 51 and 53). On 16 November 2015 The EU Victims"

Directive came into effect in Ireland. The Directive establishes standards on the rights, support and protection of victims of crime. These rights include the right to information. This means that victims will now have a right to request a summary of reasons for a decision not to prosecute made by the Director of Public Prosecutions (DPP) and they will also have the right to ask for a review of a decision not to prosecute. Awareness of this Directive must be raised among community members, including FGM affected communities. In November 2015, Ireland signed the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, also known as the Istanbul Convention. The National Steering Committee will collaborate with other organisations working on GBV to encourage Ireland to ratify the Istanbul Convention. The Criminal Justice (Female Genital Mutilation) Act 2012 was signed into law on 2 April 2012. This law has been effective since 20 September 2012, and makes it a criminal offence for someone resident in Ireland to perform FGM. The maximum penalty under all sections of this new law is a fine or imprisonment for up to 14 years or both. It is also a criminal offence for someone resident in Ireland to take a girl to another country to undergo FGM. However, FGM does not have an Irish Crime Classification System (ICCS) code, making it difficult for FGM to be recorded as a specific crime. This also impacts on reporting and data collection; to date there have been no cases of female genital mutilation recorded by the crime and criminal justice section of the Central Statistics Office40. To make legislation that prohibits the practice of FGM effective, an ICCS code for FGM must be established. Individuals and agencies that are in a position to detect cases, such as health professionals, teachers, school liaison officers, Gardaí and social workers, should be informed and trained to be able to identify girls at risk or actual performed cases of FGM, to provide appropriate protection mechanisms and to prevent parents in future from subjecting their daughters to the practice. The Istanbul Convention foresees an obligation for state parties to ensure that law-enforcement agencies engage promptly and appropriately in the prevention and protection of a woman or a girl at risk, by taking preventive operational measures and ensuring the collection of evidence (Article 50). Investigation and prosecution procedures that are gender-, child- and culture-sensitive must always be applied; therefore, training and guidance on investigation and prosecution of FGM-related cases to the relevant professionals is vital. 14

40 EIGE (2015) Estimation of girls at risk of female genital mutilation in the European Union, p.51.

Strategic Theme 5: Promote the Eradication of FGM Globally

AIM: To promote the elimination of FGM worldwide and enhance protection for women and girls at risk.

FGM is well incorporated into the newly launched Sustainable Development Goals. Under Goal 5 (“Achieve gender equality and empower all women and girls”) lies target 5.3, to “Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.” Overall, there is a positive trend towards gradually abandoning FGM in the 28 countries most affected. To date, 42 countries have passed laws specifically condemning FGM. In 2013, the European Commission developed a Communication to the European Parliament and the Council, Towards the Elimination of Female Genital Mutilation, reiterating their commitment to combating violence against women and eliminating FGM both within and outside the EU, and acknowledging that the linkage between the communities affected in the

EU and their countries of origin needs to be taken into account41. In 2014, 11 organisations from across Europe formed the End FGM European Network. The aim of the network is to ensure that there is sustainable European action to end FGM. AkiDwA, the leading organisation on FGM work in Ireland, is a member of the network. In order to achieve the goal of preventing FGM in Ireland we must also contribute to the worldwide campaign to end FGM. FGM is a violation of girls' and women's rights and a key form of gender-based violence, which has serious impacts on girls' and women's health and well-being, even leading to death in some cases. Ireland's policy for international development, One World One Future, notes the need for us to both prevent and respond to GBV. Ireland should use its influence and leading role in international development to actively promote the eradication of FGM internationally and build bridges with stakeholders in this joint effort to combat FGM. 15 41 Communication from the Commission to the European Parliament and the Council: towards the elimination of female genital mutilation,

COM(2013) 833 final,
http://ec.europa.eu/justice/genderequality/files/gender_based_violence/131125_fgm_communication_en.pdf , p.12.

THE SHORT-TERM COMPLICA-TIONS OF FGM CAN INCLUDE	**INTERMEDIATE COMPLICATIONS OF FGM CAN INCLUDE**	**THE LONG-TERM COMPLICA-TIONSOF FGM CAN INCLUDE**
Death	Delayed healing	Decrease or loss of sexual sensation
Haemorrhage	Abscesses	Difficult and complicated childbirth
Infection and failure of the wound to heal	Scarring/keloid formation, dysmenorrhea and haematocolpos – obstruction to period flow	Dysmenorrhea, difficulties in menstruation including passing menses
Injury or trauma to adjoining areas such as the urethra and Anus	Pelvic infections	Dyspareunia (painful intercourse)
Surgical mishap	Obstruction to urinary flow	Incontinence and difficulty urinating
Tetanus	Urinary tract infections (UTIs)	Pelvic inflammatory disease (PID) and infertility
Transmission of HIV and other viruses	Absence from school due to painful menstruation and lack of menstrual hygiene support	Psychological trauma
	Increased risk of childbirth complications and new-born deaths	Scarring (with or without keloid formation) and hardening of the vaginal tissue, causing constant pain around the genital area

	The need for later surgeries because some procedures seal or narrow the vaginal opening e.g. infibulation. The vagina must be cut later to allow for sexual intercourse or/and childbirth. Sometimes it is stitched again several times including after childbirth, hence a woman goes through repeated opening and closing procedures, further increasing repeated both short-term and long-term complications.	Sebaceous cyst development

Respect for the culture of people who practice FGM has been called for by many groups for a long time. Most communities where people practice FGM observe a communal and collective way of life. However, when the same people migrate to western countries, there is an emphasis on individualism and self-sufficiency. This lack of communality and collectivity and the emphasis on individuality causes feelings of disorientation and bewilderment to the women and girls. This does cause a need to hold seek, and hold on to elements of their culture. Feelings of betrayal are experienced by the people coming from FGM and EFM practicing countries can and do make people to practice FGM and EFM as a way of maintaining loyalty to their culture and traditions. It is also important to note that this guilt associated with not wanting to give up the traditions and the culture the people left behind can be the reason for not wanting to change.

FGM in Ireland, figure, laws etc

Currently in Ireland, it is estimated that approximately (10,000) ten thousand women and girls are affected by FGM. This is according to the latest statistics from the CSO.

FGM and the Law in Ireland: WHAT LEGISLATION EXISTS AGAINST FGM?

Many nations around the world have passed specific legislation against the practice of FGM, including 26 African countries. The vast majority of European countries have legislation in place banning the practice of FGM, including, to name but a few Austria, Belgium, Spain, Ireland, and the UK. In some of the African countries that have passed anti-FGM legislation, there has been a trend toward the medicalisation of the practice instead of an overall decrease in prevalence. Several of the industrialised nations with anti-FGM legislation include the principle of extraterritoriality as a stipulation. That is, it is illegal to perform FGM on a resident of such a nation, even if it is done elsewhere. In Ireland, the Criminal Justice (Female Genital Mutilation) Act 2012 was signed into law on 2 April 2012. This law has been effective since 20 September 2012. It is now a criminal offence for someone resident in Ireland to perform

FGM. The maximum penalty under all sections of this new law is a fine or imprisonment for up to 14 years or both. While the principle of extraterritoriality is not included in the Act in order to conform to Constitutional and international law requirements, section 3 does make it an offence to remove a girl from the State for the purpose of FGM.

PREVALENCE: GLOBAL, EUROPEAN AND IRISH STATISTICS

The WHO estimates that around 200 million women and girls have undergone female genital mutilation (FGM), and 4.5 million girls are at risk of FGM in Africa annually. This equates to 7,500 women and girls undergoing FGM daily in the world. Prevalence often varies widely within countries, depending on region and cultural traditions.

PREVALENCE OF FGM IN PRACTISING COUNTRIES

Country	FGM prevalence among girls and women (%)		FGM prevalence among girls and women aged 15 to 49 years, by residence and wealth quintile (%)							Reference year	Data source
			Residence		Wealth quintile						
			Urban	Rural	Poorest	Second	Middle	Fourth	Richest		
Benin	9		5	13	16	14	10	7	2	2014	MICS
Burkina Faso	76		69	78	77	78	78	80	68	2010	DHS/MICS
Cameroon	1		1	2	1	4	1	1	1	2004	DHS
Central African Republic	24		18	29	34	31	26	17	15	2010	MICS
Chad	38		40	38	46	42	37	30	37	2014-15	DHS
Côte d'Ivoire	37		31	44	50	44	43	34	20	2016	MICS
Djibouti	94		94	98	97	96	94	95	93	2012	EDSF/PAPFAM
Egypt	87		77	93	94	93	92	87	70	2015	Health Issues Survey (DHS)
Eritrea	83		80	85	89	86	84	83	75	2010	Population and Health Survey
Ethiopia	65		54	68	65	69	69	69	57	2016	DHS
Gambia	76		77	72	68	78	85	81	67	2018	MICS
Ghana	4		3	5	13	4	3	1	1	2011	MICS
Guinea	95		95	94	95	94	93	96	95	2018	DHS
Guinea-Bissau	45		40	50	18	59	65	47	36	2014	MICS
Iraq	7		7	8	1	3	3	6	22	2018	MICS
Kenya	21		14	26	40	26	18	17	12	2014	DHS
Liberia	44		37	56	58	56	51	38	26	2013	DHS
Mali	89		89	88	86	86	90	90	90	2018	DHS
Maldives	13		14	12	14	12	12	15	12	2016-17	DHS
Mauritania	67		55	79	92	86	70	60	37	2015	MICS
Niger	2		1	2	2	2	2	3	1	2012	DHS
Nigeria	19		24	16	16	18	20	23	20	2018	DHS
Senegal	24		20	28	41	30	25	17	14	2017	DHS
Sierra Leone	86		80	92	93	93	90	85	74	2017	MICS
Somalia	98		97	98	98	99	98	97	96	2006	MICS
Sudan	87		85	87	88	82	81	90	92	2014	MICS
Togo	3		3	4	4	4	3	4	2	2017	MICS
Uganda	0		0	0	1	0	0	0	0	2016	DHS
United Republic of Tanzania	10		5	13	19	10	12	9	4	2015-16	DHS

Indicator definition: Percentage of girls and women aged 15 to 49 years who have undergone FGM.

Notes: In Liberia, only girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM, since it is performed during initiation into the society.

Source: UNICEF global databases 2020, based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys.
The Prevalence of FGM in Ireland was estimated using the Census statistics (CSO) on the number of women residents in Ireland from FGM practising countries. The statistics were synthesised with global prevalence data to ascertain an estimate for the number of women living in Ireland who have undergone FGM.

The data reveals that there is an increase in migrants coming to Ireland from countries where FGM is practiced. The table below shows an estimation of the number of women living with FGM in Ireland from the 2016 Census.

FGM Practising Country	Global Prevalence %	Total number of Women from FGM Practising countries aged 15-44 and Resident in Ireland	Estimated number of women in Ireland who have undergone FGM
1. Benin	*		
2. Burkina Faso	*		
3. Cameroon	1	519	5
4. Central African Republic	*		
5. Chad	*		
6. Cote d'Ivore	38	147	56
7. Democratic Republic of Congo	*		
8. Djibouti	*		
9. Egypt	91	675	614
10. Ethiopia	74	400	296
11. Eritrea	*		
12. Gambia	*		
13. Ghana	4	558	7
14.Guinea	*		
15. Guinea- Bissau	*		
16. Indonesia	*		
17. Iraq	8	818	65
18. Kenya	27	630	170
19. Liberia	66	90	59
20. Mali			
21. Mauritania	69	976	673
22. Niger			
23. Nigeria	27	8,606	2378
24. Senegal			

25. Sierra Leone	88	138	121
26. Somalia	98	747	732
27. Sudan	88	666	586
28. Tanzania	15	157	24
29. Togo	4	147	6
30. Uganda	1	276	3
31. Zambia			
TOTAL		**15,550**	**5795**
TOTAL PERCENTAGE			32.27%

Estimated prevalence of FGM in Ireland (Enumerated by 2016 CENSUS)

Note: It is important to point out that while several of the countries in the above table have been left blank, this does not mean that FGM is not prevalant there. Rather, the data from these countries has not been made available by the CSO. For example, in 2019 UNICEF estimated that almost 80% of women in Djibouti have undergone FGM.

With this in mind, it is likely that the total number of women living in Ireland who have undergone FGM in Ireland could be three times higher than the above figures.

TRADITIONAL AND REGIONAL TERMS FOR FGM

	Country	**Term used for FGM**	**Language**	**Meaning**
	Egypt	Thara	Arabic	Deriving from the Arabic word ‘tahar’ meaning to clean, purify
		Khitan	Arabic	Circumcision – used for both FGM and male circumcision
		Khifad	Arabic	Derived from the Arabic word to lower (rarely used in everyday language)
	Ethiopia	Megrez	Amharic	Circumcision/Cutting
		Absum	Harrari	Name giving ritual
	Eritrea	Mekhnishab	Tigregna	Circumcision/cutting
	Kenya	Kutairi	Swahili	Used for both FGM and male circumcision

		Kutairi kwa wasichana	Swahili	Circumcision for girls
	Nigeria	Ibi/Ugwu	Igbo	The act of cutting – used for both FGM and Male circumcision
		Sunna	Mandingo	Believed to be a religious tradition
	Sierra Leone	Sunna	Soussou	Believed to be a religious tradition/obligation by some Muslims
		Bondo	Temenee/Mandingo/Limba	Integral part of an initiation rite into adulthood
		Bondo/Sonde	Mendee	Integral part of an initiation rite into adulthood
	Somalia	Gudiniin	Somali	Circumcision – used for both FGM and male circumcision
		Halalays	Somali	Deriving from the Arabic word 'halal' i.e 'sanctioned', implies purity. Used by Northern and Arabic speaking Somalis
		Qodin	Somali	Stitching/tightening/sewing – refers to infibulation
	Sudan	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
		Tahoor	Arabic	Deriving from the Arabic word 'Tahar' meaning to purify
	Chad – the Ngame	Bagne		Used by the Sara Madjingaye
	Sara Sub-group	Gadja		Adapted from 'ganza' used in the Cantral African Republic
	Guinea-Bissau	Fanadu di Mindjer	Kriolu	Circumcision of Girls
	Gambia	Niaka	Mandinka	Literally to cut/weed clean
		Kuyango	Mandinka	Meaning the affair but also the name for the shed built for the initiates

		Musolula Karoola	Mandinka	'The Women's side'/that which concerns women

For the World Health Organization's classification of FGM, please refer to: FGM – AN OVERVIEW

GLOSSARY

Angurya cuts	A form of (FGM Type IV) that involves scraping the tissue around the vaginal opening.
Deinfibulation	The medical procedure to open the vaginal area of a woman who has undergone FGM Type III.
Dry sex	The use of drying agents such as herbs, powders, and other substances to dry and tighten the vagina prior to sexual intercourse; may constitute FGM Type IV.
Gishiri cuts	A form of FGM Type IV that involves cutting the vagina

Medicalisation	Refers to trained health-care professionals performing FGM in public or private health-care facilities. This practice has been strongly denounced by WHO, UNFPA and other international medical and health organisations.
Pharaonic circumcision	Refers to FGM Type III.
Reinfibulation	A re-suturing of FGM Type III after childbirth.
Sunna	Signifies 'tradition' in Arabic and refers to a range of practices that follow the teachings of Islam; used mainly to refer to FGM Type I. References to the term 'Sunna' in the Koran are often used to justify FGM as being a religious obligation (UNFPA).

FGM GYNAECOLOGICAL AND HEALTH ISSUES

The exact incidence of morbidity and mortality associated with **FGM** is difficult to measure. Only a small percentage of complications ever come to the attention of health-care professionals. This may be due to the unavailability and inaccessibility of health-care, ignorance, or the fear of legal retribution. Since many women have undergone FGM as infants, they may not remember any immediate adverse effects. Complications arising during childbirth or later in life may not be linked by women to the 'surgery' they underwent as children, especially if the FGM occurred prior to menarche. FGM-related complications may be considered normal and natural to women, especially among populations in which FGM is prevalent. Complications may occur with all types of FGM but are most frequent with **FGM**

SHORT- TERM COMPLICATIONS OF FGM

AGONISING PAIN	Due to lack of anaesthesia or pain-relieving medication at the time of FGM procedure.
DEATH	Lack of access to first aid and immediate hospital access in acute situations.
HAEMORRHAGE	Amputation of the clitoris involves cutting across the clitoral artery vessel, which has a strong vascular flow and high pressure. Haemorrhage may also occur due to sloughing of the clot over the artery, usually because of infection. If bleeding is very severe and uncontrolled, it may lead to exsanguination.
INFECTION (due to use of unsterilised/ shared cutting instruments)	● death ● HIV and other blood-borne viruses (BBV) ● septicaemia ● tetanus (also due to lack of tetanus toxoid injection) ● UTI ● wound infection

INJURY	Fractures, dislocations, or other injuries due to restraining a struggling child. Injury to adjacent structures, such as the urethra, labia, and Bartholin's gland.
SHOCK	● haemorrhagic (bleeding) ● neurogenic (pain) ● septic (infection)
URINARY TRACT PROBLEMS	● acute urinary retention and labial adhesion (almost complete closure of the vaginal orifice), as in infibulation, nearly always occurs because of the following: ● incontinence due to urethral damage at time of procedure ● painful micturition/urophobia due to pain and burning sensation of urine ● on raw wound ● upper or lower UTI due to use of unsterilised equipment

INTERMEDIATE COMPLICATIONS OF FGM

Delayed healing	Absence from school due to painful menstruation and lack of menstrual hygiene support
Abscesses	Increased risk of childbirth complications and new-born deaths
Scarring (keloid formation) dysmenorrhea and haematocolpos – obstruction to period flow	The need for later surgeries because some procedures seal or narrow the vaginal opening e.g. infibulation. The vagina must be cut later to allow for sexual intercourse or/ and childbirth. Sometimes it is stitched again several times including after childbirth, hence a woman goes through repeated opening and closing procedures, further increasing repeated both short-term and long-term complications.

LONG-TERM COMPLICATIONS OF FGM

ANAEMIA	Due to profuse bleeding at time of FGM procedure.
CLITORAL NEUROMA	Develops on the dorsal nerve of the clitoris; can lead to genital hypersensitivity

CONTRACEPTION	Women who have undergone FGM will need a thorough and sensitive medical history taken. A vulvar examination is necessary to determine the type of FGM that a woman has undergone, as some contraceptive methods are not indicated. Women with FGM are at increased risk of recurrent vaginal and pelvic infections, therefore, avoid inserable contraceptive devices. Women who have undergone FGM Type III will have a reduced introital opening, which may contraindicate certain contraceptive methods. Hormonal contraceptive methods can be recommended with careful explanation to the woman. The WHO's Medical Eligibility Criteria for Contraceptive Use should be used as a reference guide. [8] For more information, please refer to: FGM – CONTRACEPTIVE TABLE
DYSMENORRHOEA	Difficulties in menstruation, including passing menses.
ENDOMETRIOSIS	May result from blocked menstrual flow
HAEMATOCOLPOS	Menstrual blood accumulates over many months in the vagina and uterus due to the closure of the vaginal opening by scar tissue; appears as a bluish bulging membrane on vaginal examination.
INFECTION	HIV and other blood-borne viruses (BBV) due to use of unsterilised/ shared cutting instruments, infertility due to tubal damage from infection, miscarriage from recurrent infections, recurrent pelvic and UTIs.
PAIN	● Chronic pelvic inflammatory disease (PID) ● Dysmenorrhea due to genital tract obstruction ● During procedures requiring speculum examination, e.g. smear-taking, insertion of intrauterine contraceptive devices (IUCD)
RETENTION CYSTS AND ABSCESSES	From damage to ducts, e.g. Bartholin's duct.
SCARRING (with or without keloid formation)	Formation of a keloid scar because of slow and incomplete healing of the wound and infection after procedure, leading to excessive connective tissue in scar and possible obstructed menstrual and urinary flow.
SEXUAL DIFFICULTIES	● Anal fissure, haemorrhoids, or faecal incontinence due to lack of easy access to introitus, leading to anal intercourse ● Dyspareunia (painful intercourse) ● Impaired sexual response and enjoyment ● Non-consummation due to obstruction, vaginismus, or painful scar tissue ● Trauma on deinfibulation by partner or traditional birth attendant (TBA) ● Vaginismus with or without introital scarring

URINARY TRACT PROBLEMS	● Bladder, urethral or kidney stones due to urinary stasis or obstruction ● Incontinence due to urethral damage or fistula formation and overdistended bladder ● Recurrent upper or lower UTIs ● Urinary retention and overdistension of bladder leading to neurogenic bladder ● Voiding difficulties due to urethral damage, scarring or obstruction, leading to prolonged bladder-emptying or altered direction of flow. ● Could be perceived as normal by the woman
VESICOVAGINAL OR RECTOVAGINAL FISTULA	Deinfibulation, reinfibulation or obstructed labour, leading to both faecal and urinary incontinence.

FGM

National Clinical Guide: Management of FGM

Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and the Clinical Strategy and Programmes Division, Health Service Executive

Key Recommendations

1. It is an offence to undertake FGM on a child or woman in Ireland, and it is also an offence to bring a child or woman out of the country for the purpose of undertaking FGM. Consent of the woman or her parents to the procedure is not a defense, nor is it a defense to say that it was required or permitted for customary or religious reasons.
2. Each hospital should have a designated consultant, senior midwifeor nurse with a special interest in FGM and expereince in its management and appropriate referral pathways. This healthcare provider should be familiar with the existing multidisciplinary services funded by the HSE, undertaken in the main by the Irish Family Planning Association (IFPA).
3. Obstetricians, gynaecologists, midwives, gynaecology nurses and GPs should receive formal training with regard to FGM, including on clinical care pathways and on the implications of the Criminal Justice (Female Genital Mutilation) Act 2012, and the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012. This training should be discipline appropriate. Training should also be updated regularly.
4. Women should be asked about FGM at their booking visit. The conversation should be supportive, patient focused and without value judgements. Translation should be used if required. Physical examination should be offered to ascertain the anatomical impact of FGM, and if indicated, deinfibulation explained and discussed.
5. Women identified as having undergone FGM at a booking visit, should be reviewed by a senior obstetrician or senior midwife. If FGM is identified in the index pregnancy but is not deemed to have a likely impact on delivery, then supported care may be an appropriate

option. If however, the type of FGM may impact on delivery, at least one antenatal consultation with an obstetrician is required to plan for birth, bearing in mind the woman's preferences. Assisted or specialised care may be more appropriate in this scenario. Women who have previously delivered vaginally, with a history of FGM, should be offered supported care unless they have additional risk factors or prefer assisted/specialised care.

National consensus recommends that deinfibulation should be offered to women intrapartum, however it may be undertaken in the late second or third trimester if preferred. Defibrillation may be offered preoperatively or post-caesarean delivery if appropriate, or women may be referred for deinfibulation postpartum.

6. Although postpartum reinfibulation is not specifically listed as an offence in Irish legislation, it is never clinically indicated and, consistent with best international practice, must never be carried out. Reinfibulation has no benefits, clinical or otherwise, and it may seriously affect the reproductive health of women and increase her risks for future birth/s. Reinfibulation violates the woman's human rights and bodily integrity. However, where clinically indicated, perineal tears must be sutured to achieve haemostasis using routine perineal repair techniques.
7. The type of FGM should be documented in the maternal healthcare record, and the midwifery discharge team, public health nurse and GP made aware. Be aware that FGM will not always fit into the defined sub-types, the anatomical impact should be clearly and accurately described.
8. Any concern with regard to female children of the woman and the risk of FGM should be assessed by a senior midwife or obstetrician - a referral to TUSLA should be made if appropriate as per Children First legislation. If there is no concern, this also must be documented in the maternal health record.
9. Deinfibulation should be offered to women who present to gynaecology services seeking this. HIPE data should be appropriately annotated on discharge.
10. Clitoral reconstruction is not currently recommended, and should be undertaken only as part of a research trial as there is insufficient evidence for its efficacy. To our knowledge, it is not currently offered in Ireland.

Clinical Guidelines on FGM in the Obstetric and Midwifery Setting

1.
   - ➢ All women should be asked about FGM at their booking visit, using the assistance of a formal translation service where required.
   - ➢ The use of partners or friends for the purposes of translation is not recommended.

- ➢ The booking midwife should enquire in a supportive and non-judgmental fashion with regard to FGM and may need to use the relevant colloquial term ('cutting' or 'circumcision').
- ➢ If the woman herself identifies as having undergone FGM, or is identified via direct questioning, then a chaperoned physical examination should be offered to ascertain the type of FGM.

2.

- ➢ If the urethral meatus can be easily identified and the urogenital hiatus is adequate, the woman can be reassured that, in the absence of other obstetric events, vaginal delivery without recourse to deinfibulation can be anticipated.
- ➢ If the urethral meatus cannot be identified, with extensive iatrogenic fusion of the labia, then deinfibulation may be offered. The timing of deinfibulation should be discussed with the women. The RCOG recommends discussing both antepartum and intrapartum deinfibulation.
- ➢ Clinical consensus based on enquiry (by a single clinician) from all 19 maternity units in Ireland was that intrapartum deinfibulation is generally preferred and offered over revision during the antenatal period but further research is required if one method is to be definitively endorsed over the other.

3.

- ➢ Most women who have undergone FGM will be suitable for the supported care pathway structure (National Maternity Strategy 2016-2026) unless they have other risk factors that may require the assisted or specialized care pathways.
- ➢ For women identified as having type 3 FGM, with significant labial fusion, assisted or specialized care may be recommended. If a woman with type 3 FGM has delivered vaginally in the past and prefers supported care, this pathway may be appropriate after discussion with a senior midwife and/or obstetrician.

4.

- ➢ A discussion should be documented at booking and a plan made with regard to the woman's preference for either antepartum or intrapartum deinfibulation.
- ➢ Additional socio-demographic complications may exist, some women will be living in direct provision accommodation, others may be late bookers and/or may have risk factors for preterm delivery and review by a senior clinician for the articulation of an agreed birth plan is important.

5.

- ➢ The preferred method of anaesthesia for the purposes of deinfibulation depends on patient preference and the clinical scenario.
- ➢ In general, during pregnancy and intrapartum, local, and regional anaesthesia is preferred over general anaesthetic.

- ➢ All obstetricians attending the labour ward should be familiar with intrapartum deinfibulation. Training should be offered and updated routinely. Relevant training and awareness raising should also be extended to midwifery and nursing staff and allied professionals (eg. medical social work) to ensure a broad understanding of FGM, among all staff providing a woman-centred service.

6.

- ➢ It is important to reassure a woman who has undergone FGM that she herself is not guilty of an offence, but it is important to hold a conversation around the woman's beliefs surrounding FGM to ensure that none of her children, or future children, are at risk. Care should be taken not to offend or alienate women.

7.

- ➢ A woman identified as having undergone FGM that does not require deinfibulation should be offered psychological support if she wishes, and a social work referral may be appropriate.
- ➢ If midwifery or medical staff have any concerns with regard to the female infant born to a woman with FGM, or any of her other female children, a referral to Tusla should be made (Children First Act 2015). If no such concerns exist, this should be documented in the maternal health care record.

8.

- ➢ Women who do not require deinfibulation, or who were deinfibulated in a previous pregnancy, can be offered midwifery-led care.
- ➢ If a woman planned for intrapartum deinfibulation undergoes caesarean section (CS), then deinfibulation may be offered after the CS (if elective), or if time allows in an emergency setting.

- ➢ If this is not possible, then arrangement should be made for elective postpartum deinfibulation (via postnatal or gynecology clinic, with appointment being provided prior to postnatal discharge).

Care of the women presenting to gynaecological services

Women may self-refer to services directly related to FGM treatment (via the IFPA) or may seek specialist referral via their GP for deinfibulation. They may also present and be diagnosed with FGM-associated complications at the gynaecology clinic, for example, during investigations for infertility, dyspareunia, apareunia, anorgasmia or urological omplications. Ideally, women should be encouraged to undergo deinfibulation prior to first sexual intercourse and in order to facilitate cervical screening.As per antenatal presentations, the legal framework should be sensitively outlined if indicated. Many women will already be fully aware of the legislation. Chaperoned examination should be undertaken to assess if surgical intervention is required. Dyspareunia may be improved by deinfibulation. We do not, however, currently have strong

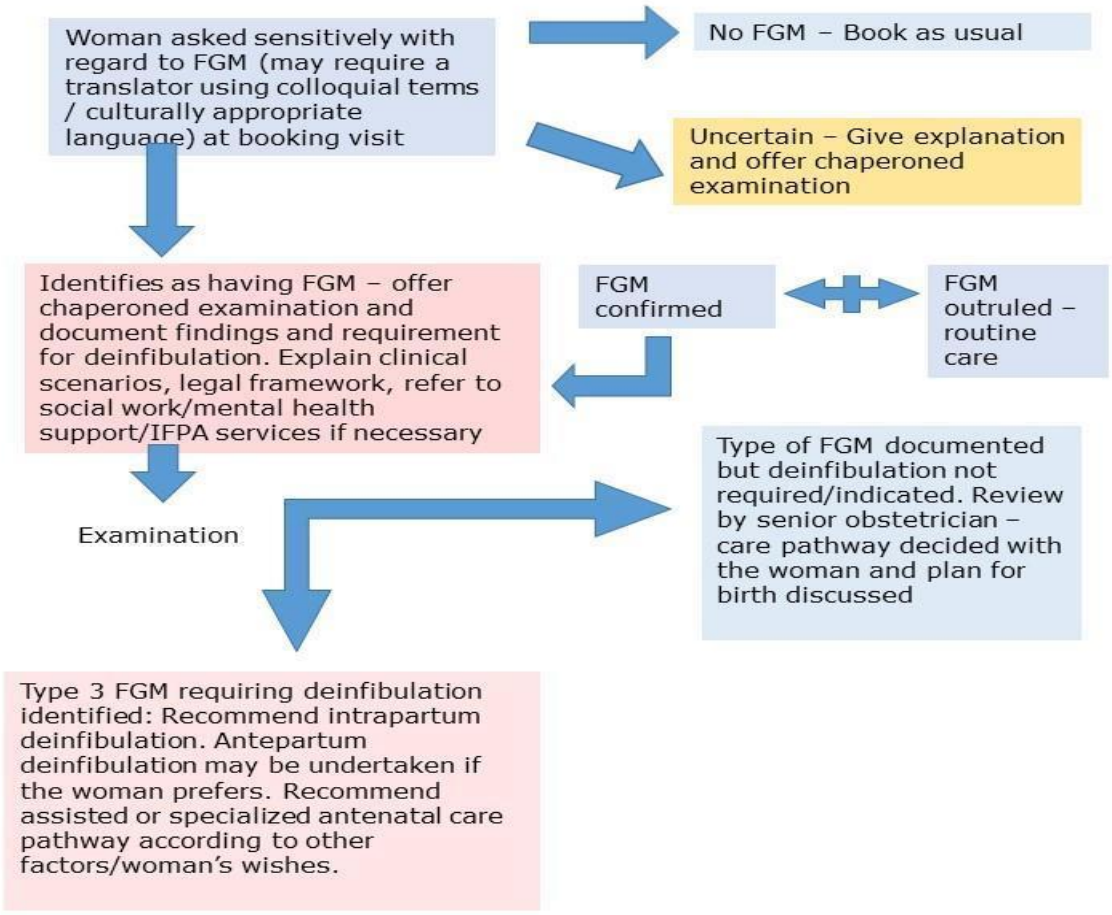
evidence to recommend clitoral reconstruction surgeries (Abdulcadir et al, 2015). Some work has been done demonstrating reduced dyspareunia and increased sexual satisfaction (Foldès et al, 2012), however, to our knowledge in Ireland, this surgery is not currently being undertaken, and should only be undertaken as part of a research trial.

Given the age profile at which FGM is generally undertaken (aged two to teenage years), it is likely that gynaecologists may not come into immediate contact with a child or young woman who has undergone FGM in Ireland; they may be called on to consult after the initial management. The basic tenets of resuscitation apply, and the patient may need surgical intervention to arrest bleeding if this has prompted the acute presentation.

A more likely scenario, perhaps, would be presentation of a child or young woman with complications related to FGM having been performed in another country. A high level of suspicion should be maintained when dealing with young women presenting with recurrent UTI, or frank perineal infection, or with newly onset psychological disturbance, who come from an area or community of high prevalence. The clinical presentation should be managed in the acute setting and then appropriate referral made for follow up and support if necessary.

FGM

Pathway for the care of a pregnant woman who may have undergone FGM – Booking Visit


Woman asked sensitively with regard to FGM (may require a translator using colloquial terms / culturally appropriate language) at booking visit
No FGM – Book as usual
Uncertain – Give explanation and offer chaperoned examination
Identifies as having FGM – offer chaperoned examination and document findings and requirement for deinfibulation. Explain clinical scenarios, legal framework, refer to social work/mental health support/IFPA services if necessary
FGM confirmed
FGM outruled – routine care
Examination
Type of FGM documented but deinfibulation not required/indicated. Review by senior obstetrician – care pathway decided with the woman and plan for birth discussed
Type 3 FGM requiring deinfibulation identified: Recommend intrapartum deinfibulation. Antepartum deinfibulation may be undertaken if the woman prefers. Recommend assisted or specialized antenatal care pathway according to other factors/woman's wishes.

FGM PSYCHOLOGICAL ISSUES

Research suggests that women who have undergone FGM are at an increased risk of developing psychological and emotional health problems. [12]

While research in this area is limited, one UK study has explored the psychological effects of FGM on 53 women. [4] It found that women who have had FGM Types I and II are less likely to experience the serious adverse psychological effects of FGM, compared with those who have had FGM Type III, which has been linked with post-traumatic stress disorder (PTSD).

EARLY AND FORCED MARRIAGES

A definition:

Early and forced marriages are under researched in Ireland, yet there is evidence that they are happening. This is from speaking to service providers and service users, reading news stories as well as from anecdotal evidence, it is clear EFM is taking place in Ireland and among Irish Citizens abroad.

Forced marriage

A forced marriage is one in which one or both participants enter the marriage without giving their consent. They are coerced into it, usually by their families or their community. 4 They are put under pressure to marry against their will, this pressure can be physical (including threats, actual physical violence, and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're disgracing their family). Sometimes, financial abuse can also be a factor (taking wages or not giving either party any money).

Early marriage

For the purposes of this report, early marriage is another term for child marriage. Early marriage refers to any formal marriage or informal union between a child under the age of 18 and an adult or another child.6 The practice is extremely prevalent. According to the UN, 37,000 girls under the age of 18 are married every day.

Arranged Marriage

An arranged marriage is intermediated by a third party, but both participants give their full consent and enter the marriage willingly. Crucially, what differentiates an arranged marriage and forced marriage is mutual consent. Sometimes, what starts as an 'arranged' marriage can escalate to a forced marriage. It is not uncommon for one of the participants to change their mind, even on the wedding day, only for their families to force them to go through with it.

Gender-based violence

Gender-based violence is any act of violence against women and girls based on their gender; an act "that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."9 Some examples of gender-based violence are FGM, domestic violence, sexual violence, and forced marriages when they are targeted toward women or girls.

Honour-based abuse

There is no statutory definition of honour-based abuse, but a common definition that has been adopted across the UK government and criminal justice agencies is: a crime or incident which has, or may have been, committed to protect or defend the honour of the family and/or community.

It can also be described as a collection of practices, which are used to control behaviour within families or other groups. This is done to protect perceived cultural and religious beliefs and or honour. Abuse and violence can happen when perpetrators think that a relative has "shamed" or "dishonoured" the family or community by breaking their "honour" code.11 Most victims of honour-based violence are women and girls, although it does affect men and boys too. There is often no singular perpetrator, and victims are often at risk from close or extended family or community members. Honour-based violence is sometimes under-recognised, as people feel it is part of cultures or religions. However, it is never justified and is a human rights issue.

The Government of the Netherlands has listed the following as examples of honour-based violence:

- Physical abuse (kicking and beating)
- Psychological pressure (strict monitoring, humiliation, threats)
- Abandonment (leaving someone in their country of origin or sending them back there)
- Forced suicide
- Honour killing (murder)

They list refusal to cooperate with a forced marriage as a motive for honour-based violence and abuse.

Ireland - Legal Affairs

In 2016, the Department of Justice confirmed that they were introducing legislation which would make it an offence to force a person to marry where they do not consent to it. The proposed legislation would criminalise marriage where consent is given under emotional, physical, sexual or financial duress. The Department of Justice told the Journal.ie that "there have been investigations into 1-2 cases of forced marriage per year in Ireland in the past number of years, however, it is believed that more cases may be occurring."

The legislation brought in was section 38 of the Domestic Violence Act 2018, bringing in the offence of forced marriage: (1) A person commits an offence where he or she engages in relevant conduct for the purpose of causing another person to enter into a ceremony of marriage.

(2) A person commits an offence where he or she— (a) removes another person from the State, and

(b) intends the other person to be subject to relevant conduct outside the State for the purpose of causing that other person to enter into a ceremony of marriage.

(3) A person commits an offence where, in a place other than the State, the person engages in relevant conduct for the purpose of causing another person to enter into a ceremony of marriage and the first-mentioned person is, at the time he or she engages in that conduct.

A "ceremony of marriage" means any religious, civil or secular ceremony of marriage, whether legally binding or not. This legislation brings Ireland in line with the Istanbul Convention, a Council of Europe anti-domestic violence convention agreed upon in 2011, but which Ireland only signed up to in 2015.

Incidences of forced marriage in Ireland

Trying to collect data and statistics on the incidences of forced marriage in Ireland was extremely challenging. Women's Aid Ireland consulted with their team and reported that they do not have a lot of experience supporting women who have been subjected to forced marriages or at least it may not have been declared.

Cross care

Migrant Project, a Dublin-based NGO that provides information and advocacy support to Irish emigrants and people who have moved to Ireland reported that whilst none of the team had any cases of forced marriage in the last number of years, there have been cases they are aware of via Consular Services. The Department of Foreign Affairs has thus dealt with a handful of cases where an Irish citizen with dual citizenship has been forced into marriage abroad.

NASC Ireland, a migrant and refugee rights centre in Cork also reported having no cases of forced marriage.

It appears that forced marriage in Ireland is an entirely hidden problem, with few people contacting the relevant stakeholders who can support them.

I am from a South Asian family in Ireland, and I have heard anecdotal evidence of forced marriages occurring in Ireland. One that comes to mind is my mother telling me that a young girl, aged 17 or 18 was having an affair outside of marriage with an older man. When her parents found her in a hotel with this older man, they sent her to Pakistan to get married as punishment.

Various news outlets have reported cases of forced marriage in Ireland. For example, the Irish Central reported in 2020 about an Irish woman who escaped forced marriage in Bangladesh.24 They reported that at the age of 20, her family brought the unnamed 21-year-old woman from Dublin to Bangladesh under the guise of visiting her sick grandmother. When she arrived, however, her phone and passport were confiscated from her, and her family coerced her into a forced marriage. She was able to contact her partner in Dublin, who in turn called Britain's Forced Marriage Unit, as Ireland does not have such a unit.

British officials in Bangladesh waited until she was alone before escorting her out the back of her apartment building. She was picked up in a bulletproof car and driven to the airport. Her family went back to Ireland almost quickly after the wedding, leaving her trapped in Bangladesh with no passport and no way of getting back to Ireland.

She stated that she wished to aid other women who may be in similar situations and that there are undocumented occurrences of forced marriages occurring regularly in Ireland. The Irish Examiner also reported on a case in 2019 where Tusla, the Child and Family Agency, were investigating a case where a child's mother was suspected of being forced into a marriage.

I also spoke to service providers Ruhama and the Immigrant Council of Ireland about their experience of working with cases of forced marriage in Ireland.

Ruhama

Ruhama is a Dublin-based NGO that works on a national level with women affected by prostitution and other forms of commercial sexual exploitation. Ruhama explained that they work with cases of forced marriage because no organisation works specifically with forced marriage.

“We see forced marriages as an exchange of sex for safety in the family, e.g if you accept to have sex with me as a wife, then you will be kept safe in the family. You’re no longer at risk of being abandoned by the family or rejected by the community, making it a sort of exchange. That’s one of the reasons why we would work with women affected by forced marriage. From our point of view, it is sexual exploitation.

‘’I spoke to a caseworker/psychotherapist who estimated that 5-10% of the cases she deals with involve forced marriages. She didn’t know specific numbers but believed that “forced marriages are very prevalent.”

“Those who come to us are only those who realise that this should not be the norm and that their rights are not respected. I think that’s why it’s such a small percentage (of people that come forward about their situation).”

I asked about the typical victim/survivor profile. She explained that most are around 18-19 years old, in and around the first year they become an adult. When they become this age they can travel on their own.

“They’ve been told for the last 2-3 years before 18 that they will marry such-and-such and so there is quite an open conversation in the family about this… the future marriage. But they see it, of course, as part of the culture. So a lot of the time, the women that come into contact with us - they are 18/19.”

I asked about their ethnic backgrounds, and she reported that she’s noticed that her cases come from the Afghan community, Muslim communities, Indian communities, and wherever else arranged marriage is part of the culture.

The cases involved service users who are in school, who have lived in Ireland for several years and those who escaped their home country because of forced marriage. When I asked what the dynamics were at play in forced marriage cases she had worked with, she said the following:

“Usually the groom-to-be has financial potential, he can financially support the family that he’s marrying into…quite often he’s an older man, probably because older men have more financial stability. Sometimes it’s a man who is present in the family, usually, it doesn’t completely come out of the blue. It can be men who supported the family gradually, or over time with small amounts of money, food, or any other sort of good. Sometimes the family might feel that they owe it to the person to pay them back for all the support. The man also knows that if he keeps on giving and supporting the family, in the end, in three years when their daughter turns 18 and is ready to marry, then there are high chances she’ll be given to him because the family owes him.”

Immigrant Council of Ireland

The Immigrant Council of Ireland (ICI) is a national, independent non-governmental organisation that promotes the rights of migrants.

They noted that they do not typically come across cases of forced marriages in Ireland but noted a case that presented very recently. A third-party organisation was seeking some guidance from the ICI in assisting two individuals.

The third-party organisation was assisting two individuals who have alleged that they were brought outside Ireland for the purposes of forced marriages that didn't ultimately take place. They managed to engage with this third-party organisation who engaged with the relevant Irish authorities for them to be supported in coming back to Ireland.

This helps us shed light on how these cases are handled:

"*Rightly or wrongly, the intervention that appears to have been made is one of a human trafficking response, albeit imperfect and insufficient, I won't go into the details, because I'm not directly involved."*

The case followed the pattern of cases we have already seen in the UK, where it involved young people who had grown up living in Ireland:

"The case of the young person who's been living here for a long time, and whose parents may be planning to enter them into a marriage with somebody back from the 20 country of origin, you know, and they have grown up here in a completely different cultural context, for example.

Like that is what was kind of a play in that very recent case that I mentioned to you. I'm not directly involved, but it was about girls who have grown up here, both of whom were taken out of Ireland to enter into a marriage in a third country."

We see here that forced marriages may be taking place within immigrant communities in Ireland and still affecting second or third generations. The ICI also shared information about the protections for immigrants or refugees who have moved to Ireland from forced marriage.

The Immigration Angle

Section 4.7 of the Immigration Act of 2004 is wide enough for the Minister of Justice to change residence status depending on context and changes in circumstance. This means that if a victim of forced marriage has been brought to Ireland on a spousal visa, they could hypothetically apply to have an independent visa. Immigration law, therefore, has the potential to protect victims of forced marriage but there is no specific structure.

The ICI pointed out that this should be better publicised:

"*Does immigration law need to change? Perhaps not. But what does need to perhaps change is knowledge and understanding of forced marriages whether it is a frontline provider like our own or another third party civil society organisation or the state authority that's being asked to deal with the situation that there's knowledge and understanding of what are the relevant issues. So that cases can be appropriately submitted."*

The ICI was historically very involved in the introduction of the domestic violence concession. These are discretionary administrative arrangements within the Department of Justice that allow the Minister to look on a case-by-case basis at the facts of an individual case and to decide whether or not ongoing permission to remain will be granted in that particular case. So it's always a question of first notifying the minister of the changes in circumstance and then seeking ongoing permission to remain and how one does that is very factually dependent on the case.

Organisations including civil society groups and charities like Women's Aid lobbied the government to get the concession introduced because, at the time, there was nothing published on the Department of Justice's website to let a potential victim, who didn't happen to know about the concession, know that they could do this. They would regularly come across people who had gone to a lawyer who told them that there was nothing they could do or they'd be sent home (which was incorrect). Or they would be wrongfully told to apply for international protection, which depending on their nationality, they would not be a good candidate for.

The Department of Justice had never published any information about how to deal with relationship breakdown, that you need to notify the Department and apply for ongoing permission to remain. The whole point with the domestic violence concession was that the Department of Justice did this, but didn't state that they did this, so organisations wanted it formalised and published. This would allow people to find that information on their own website and not by happenstance.

The ICI noted that the same problem exists now with forced marriage:

"*I think that is exactly the same problem with something like forced marriage. There's possibly very little awareness, generally, about what constitutes a forced marriage, the fact that it is unlawful in Ireland. The legislation is relatively new, I don't know how many cases, if any, have been prosecuted under the Act, and there's then just no knowledge on the part of anybody who is the victim of forced marriage… what they would need to do, do they just go down the domestic violence concession route, or is there some other thing they need to do? There's just been no communication officially from the Department of Justice on its website that it falls under the broad umbrella of domestic violence or that there are specific things that a person needs to do."*

Refugees

In theory, being a victim of forced marriage is going to give rise to a granted protection status, but it's not as simple and as straightforward as that: 22 So looking at international protection, there will always be a question of whether or not like, what nationality is this person? Can they return safely to the country of origin? So some individuals of domestic violence might well have a strong case for being granted protection, particularly subsidiary protection or

humanitarian need to remain as opposed to refugee status itself. Not everybody would. For example, I think if you could show that a person came from a particular country, where the country of origin evidence documents could show that being a victim of domestic violence, you're not really going to have much support and security, your family are going to ostracise you, the political authorities won't support you either, and you would still be at risk if you were to return home - then you might be granted protection status.

This could work for some countries, Pakistan, for example, whereas if a person said they came from Brazil or the US; or somewhere where you could have access to supports such as women's refuges or the capacity to set up your life independently as a woman - then it might be completely different."

This means that it might be really difficult to get granted protection status depending upon the victim's country of origin, and it might be easier to simply change residence status instead.

Arranged marriages

The ICI also noted that it's important to distinguish arranged marriages from forced marriages and that it has caused trouble in some visa applications:

"*I think it's just a conversation that needs to be had, quite sensitively, so that everyone doesn't just come out with this kind of allergic reaction to like arranged marriages being completely inappropriate. They can be a very culturally appropriate way of entering into a marriage and very many parties to them are willing, voluntary, and end up happily married. Of course, over time relationships, just like anybody else, break down, or there may be domestic violence, but the marriage itself was not forced. And these are some of the things that are obviously important when it comes to training to have an appropriate cultural understanding of them.*

Because that was what our difficulty was, even sometimes in visa applications where everything was genuine, is the difficulty in convincing the visa officer that the arranged marriage was perfectly okay. And that they would like to expect someone to come from maybe the Irish perspective of like, moving in together and living together and having to live together before you decide to have a baby or decide to get married is just not going to be happening for very many people in other parts of the world. So like, you can't apply a Western understanding of relationship development to every visa application either."

Join our CHAIN Model in Mallow, Cork, Ireland

Intervention CHAIN, definition

The intervention chain can be defined as a model to guide the work on FGM and EFM in Mallow, Cork, through the involvement of various stakeholders. In Mallow, the important stakeholders who have been identified to work to end the harmful cultural practices of FGM and EFM are:

- The affected communities
- Service providers such as schools, law enforcers, medical /health personnel such as nurses and midwives, social workers of all cadres, housing etc
- The political class
- Organisations working in the area of sexual and gender based violence
- Community based organisations working in Mallow and beyond
- The Community Trainers

As evidenced above, it is clear that the intervention chain model is going to involve sectors who are in contact with the affected communities, where they seek services and most importantly, are familiar with them. For this to be effective, there is need for education on FGM and EFM so that the identified sectors can be aware of what FGM and EFM are. Familiarising themselves with the subject matter will make it possible for the service providers to communicate well about the matters and more importantly, in a culturally sensitive manner which is very important. In the past, we have had situations, where, due to lack of knowledge on what these issues are, there is miscommunication at service provision level. This has led to people coming from affected groups feeling misunderstood and disrespected and as a result, not wanting to seek services when they need them.

he same misunderstandings have been aired by service providers and a need to understand has been communicated. To meet this need, there is going to be education. This issue of miscommunication and misunderstanding was also expressed during the Kick off Meeting (KoM) of the Join our CHAIN Project in Cork in September 2023.

The Community Trainers, who are part of the Join our CHAIN Project, are going to train the different stakeholders on what FGM and EFM are. These service providers are based in Mallow as well the wider Cork area where a vast majority of people coming from FGM and EFM affected communities are residing. It is important to state that the Community Trainers are from the FGM and EFM affected communities. The advantage of having these trainers drawn from the affected offer the following advantages:

9. Knowledge and familiarity of the members of the affected community
10. Knowledge and familiarity of the issue of FGM and EFM
11. Familiarity with service providers as the Community Trainers are leaders in the community.
12. Where language barriers exist, the Community Trainers are there acting as a bridge between the community and key stakeholders, to create a deeper understanding on both sides on the importance of the other and how to work together to end FGM and EFM.
13. The Community Trainers are also going to act as geniuses of emulation in Mallow area as one of the key identifiers for the Community Trainers when they were being identified was to be exemplary, to be people who lead by example.
14. Lived experience of being a migrant in Mallow is also benefitting the Join our CHAIN Project as the Community Trainers will be able to communicate some of their experiences to the service providers who are Key Professionals and what they would like to see done, where they would like change etc.
15. Communicating and interacting with the key professionals will also benefit the community as there is going to be a double pronged kind of communication where the two, will be able to do advocacy work on behalf of the affected groups.

How the Intervention CHAIN works

Defining what needs to be done by different stakeholders is key to the success of the intervention chain model to achieving behaviour change.

As stipulated in the earlier section, there are different people who are involved Join our CHAIN in Mallow. Clarity as to what each is going to do is very important. This will enable the message on how to end FGM and EFM to reach as many people as possible, at different levels of society.

Starting with the end in mind: How will success look like?

For the Intervention Chain model to be well structured in Mallow, it is important to start with the end in mind. The end in mind according to all stakeholders involved is to bring and end to the harmful practices of FGM and EFM and to ensure that there are sufficient services to cater for the complex social, physical and psychological needs of the affected women and girls. Supports, should go beyond the women and girls who are directly affected by the practices of FGM and EFM but also the wider community who must deal with the effects of change in behaviours which have been esteemed and held highly for generations by members of the affected groups. It is important to note these practices are important aspects of the cultural heritage of those who practice FGM and EFM and hence the need for active sensitivity should be emphasized when dealing with these issues.

Redefining success of the Join our CHAIN is very important as we go on with these very important engagements and interactions with various stakeholders. Hence, in this section, we want to look at the numbers which will have been reached by the end of the Join our CHAIN project and more importantly, the impact and especially on the lives of the affected groups.

Training for Key Professionals to end FGM and EFM

The need to work with key professionals based in Mallow and surrounding areas is being seen as an effective method of ending the practices of FGM and EFM. This way of working towards eliminating these issues has been tried and tested in Milan, Italy and it was found to be effective.

Training for key professionals is premised on the fact that members of the community practicing FGM and EFM are in contact with professionals such as teachers, police, social workers, nurses and midwives, and organisations working on issues such as domestic violence, sexual and gender-based violence and those providing housing, mental health services and many others. Working with these stakeholders and training them to know and understand what FGM and EFM is, why these practices thrive, how to recognise them and most importantly support affected women and girls. Knowing what wrap around supports to offer to these groups to relieve the physical and psychological harm occasioned by these practices is crucial for the success of the Join our CHAIN Project in Mallow. More importantly, it is important to factor that prevention is better than a cure and ensure that preventative strategies which are culturally sensitive and appropriate are put in place to ensure that no girl or woman goes though FGM and EFM in Mallow.

How it is going to work in Mallow

Engaging key professionals to appreciate FGM and EFM and to have a one stop shop where it will be possible to offer supports to women and girls affected by FGM and EFM as well as those who are at risk of these harmful practices is the starting point.

In the middle we have Community Trainers who are the link between the Key Professional and members of the practicing community.

The community and role models in the practicing community are key to completing the targets of those who are going to be trained.

The benefits of this method of creating change, and ensuring an end to the harmful practices of FGM and EFM are many as shown below:

- The migrant community has a suspicious relationship with stakeholders such as social workers and the latter are viewed as people who only come to homes to take away children from their parents. This way of working with key professionals will go a long way in breaking these barriers as the community will be able to interact freely during various events and understand the key professionals' way of doing things. On the other hand, the key professionals are going to benefit from understanding the community and the cultural reasons behind practices such as FGM and EFM. This kind of

understanding will ensure that there will be no judgement on those who are affected by FGM and EFM and most importantly, they will be handled with utmost dignity when seeking services.

- On the other hand, service providers are afraid of being called racists, or interferers with other people's cultural practices and this has made practices such as FGM and EFM to go underground, and to be practices without anything being raised. Only coming to the fore when something goes wrong as in the case of the 21-month-old girl who was subjected to FGM in Ireland in 2016 and had to be taken to hospital because she was bleeding heavily.
- When it comes to FGM especially, the fact that it is a woman's genitalia which is affected makes it very difficult to address as it a taboo in many cultures to touch on issues affecting a woman genitalia, leave alone looking at what could be happening to that area of the body. The same goes for early and forced marriages as it is looked at as something that happens or is supposed to happen to girls and women.

- Increase in services and also quality of services in Mallow: as a result, it is envisaged that the key professionals will become advocates who will talk to policy makers and government on behalf of the community about what the needs to avail services for women and girls affected by FGM and EFM. This will make it possible to centralise provision of wrap around services to affected groups and will greatly improve quality of life for the affected groups.

- Other benefits which the approach is going to have on the community is trust. Trust between the key professionals and the community, as earlier mentioned, has always been at the lowest ebb in Mallow, and thus this way of working, will help the community and the key stakeholders in not only dealing with FGM and EFM but also other issues which are affecting members of the community in Mallow.

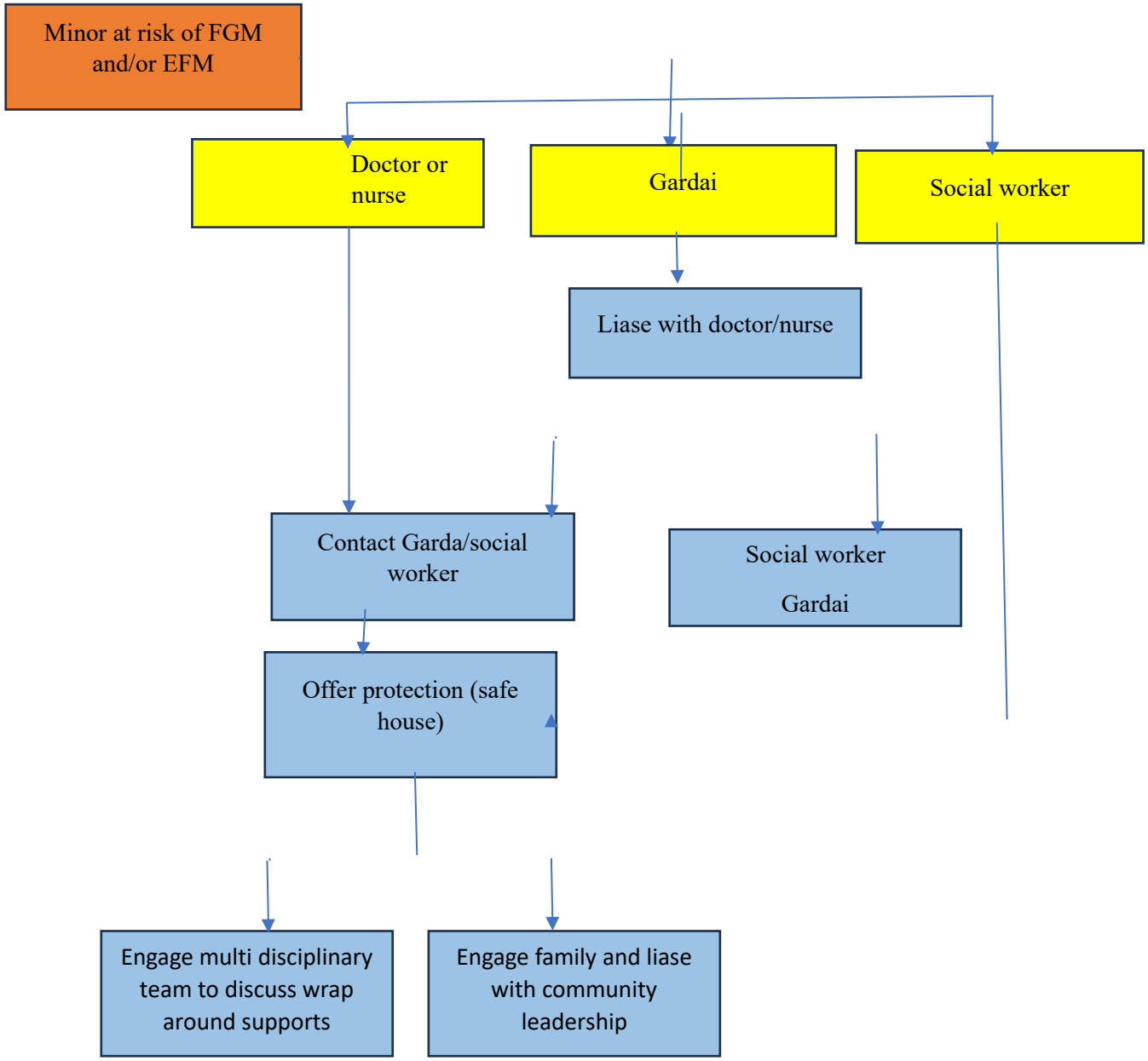
  In Mallow and wider Cork, the focus is providing a one stop shop where women and girls affected by FGM and EFM can be catered for in one place. This will require equipping the Key Professionals with skills on how to work with affected with the affected groups as these issues of FGM and EFM are very sensitive.

Sectors involved in the Intervention Chains

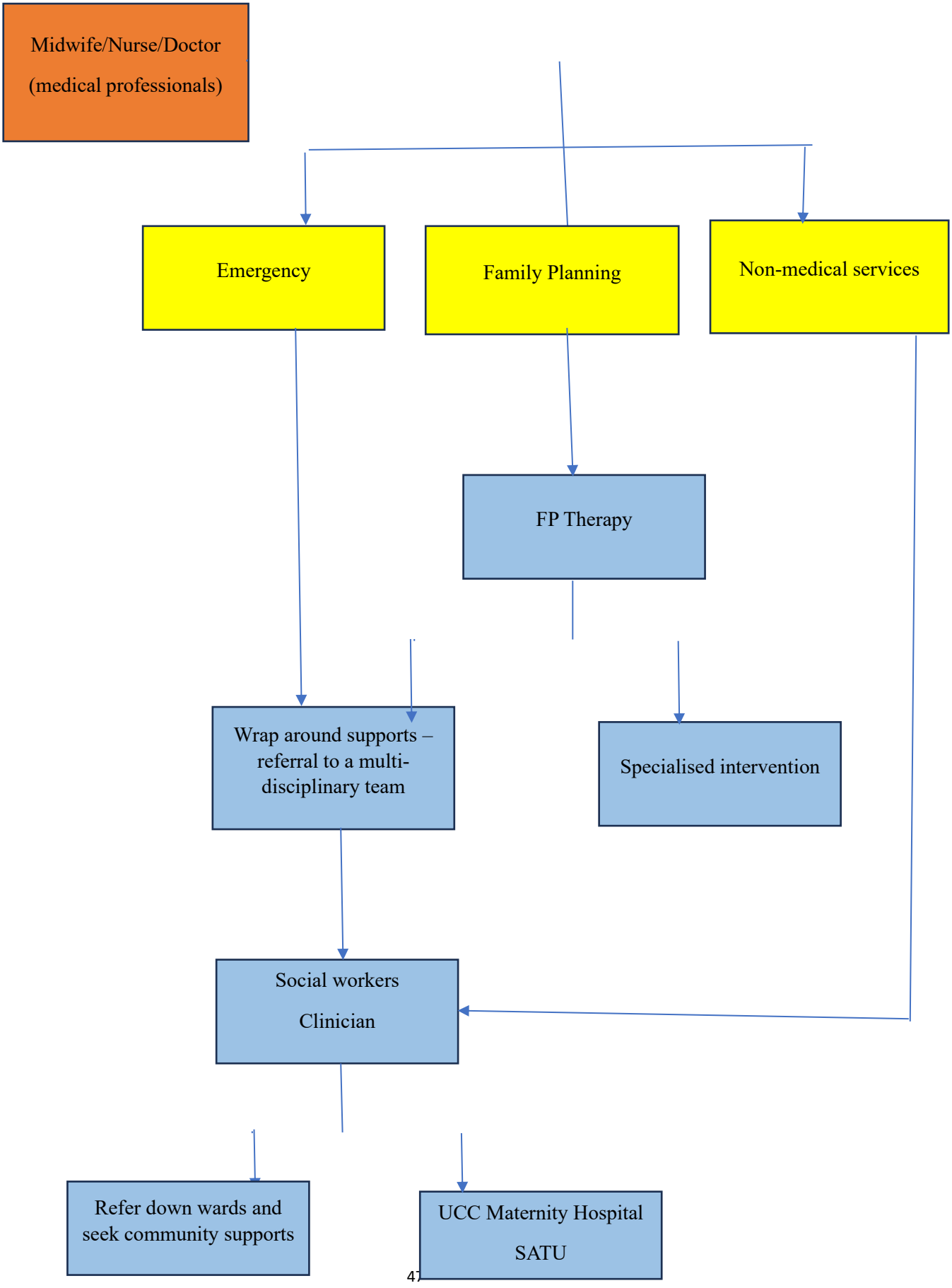
Health	**Education**	**Law and law enforcement**	**Social/cultural/religious**
Doctors	Teachers	Garda Siochana	Social workers
Nurses	Principals	Legal professionals	Local councillors
Midwives	Community education workers	Magistrate	
Social care workers	Health Service Executive	Judge	Social care workers
Psychologists	School social workers	Migrant lawyers and other legal experts	TUSLA

Therapists	3rd level education workers	Guardians	Religious leaders
General practitioners	Third level educationists	Adoption and vulnerable children placement workers	Interpreters
Anaesthetists	Schools of nursing and midwifery		Workers at Sexual and gender-based violence centres
	Early years education		Community mediators
	Counsellors		Peer support workers
			Community Trainers

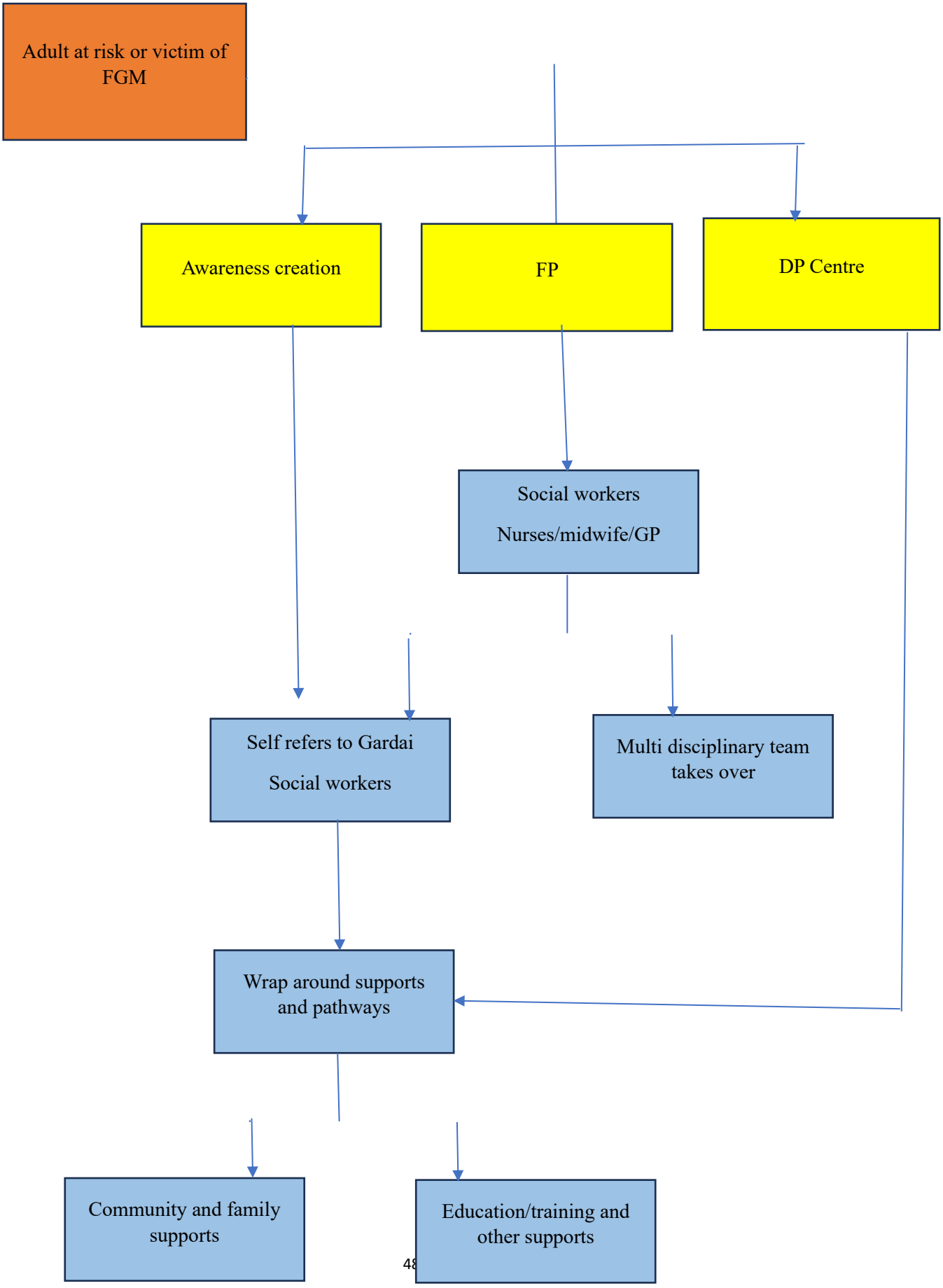
1. Minor at risk of FGM and/or FGM

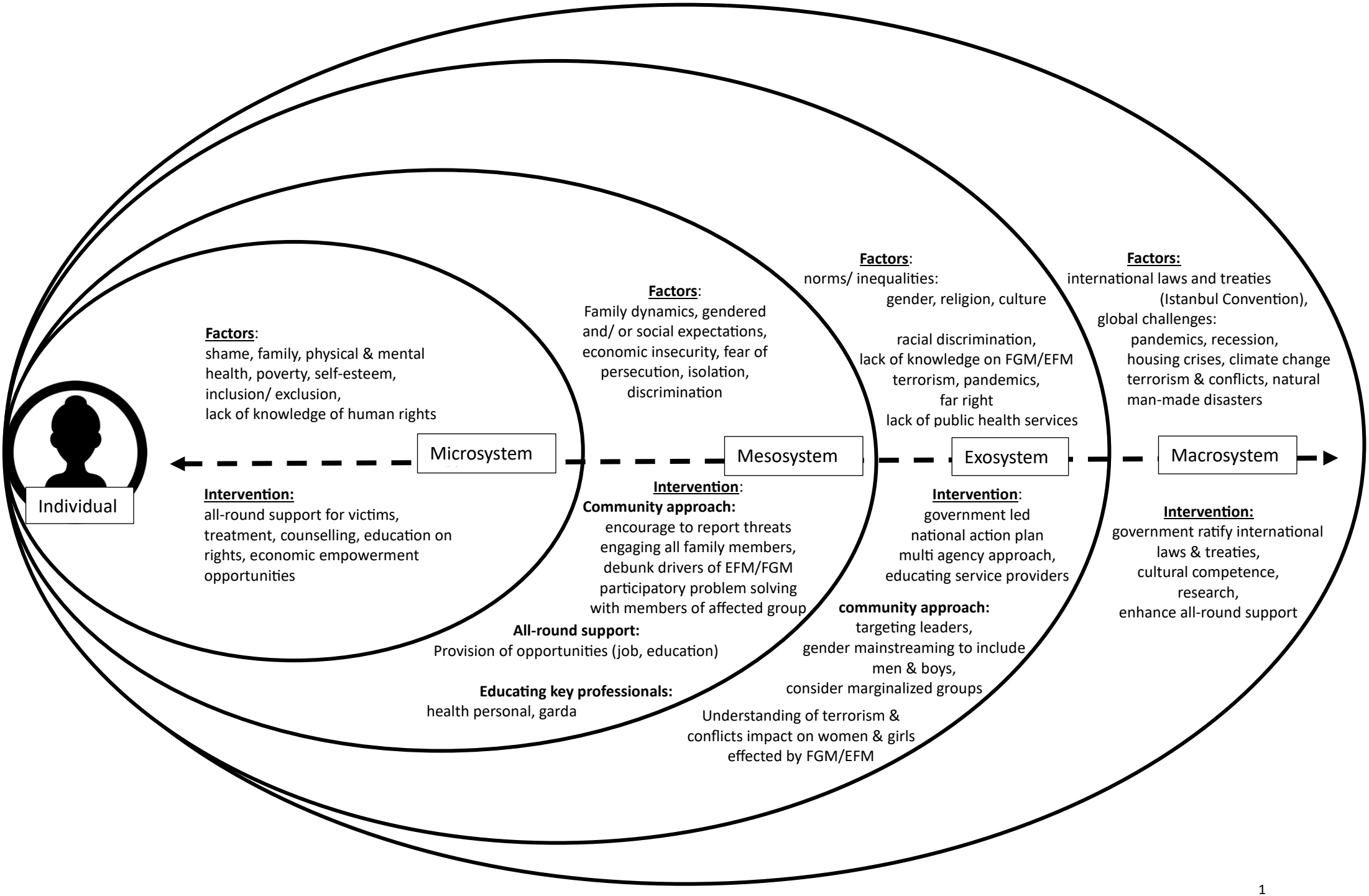


2. Adult with FGM



3. Adult at risk of Early and Forced Marriage




Individual
Microsystem
Mesosystem
Exosystem
Macrosystem
Factors:
shame, family, physical & mental health, poverty, self-esteem, inclusion/ exclusion, lack of knowledge of human rights
Intervention:
all-round support for victims, treatment, counselling, education on rights, economic empowerment opportunities
Factors:
Family dynamics, gendered and/ or social expectations, economic insecurity, fear of persecution, isolation, discrimination
Intervention:
Community approach:
encourage to report threats
engaging all family members,
debunk drivers of EFM/FGM
participatory problem solving
with members of affected group
All-round support:
Provision of opportunities (job, education)
Educating key professionals:
health personal, garda
Factors:
norms/ inequalities:
gender, religion, culture
racial discrimination,
lack of knowledge on FGM/EFM
terrorism, pandemics,
far right
lack of public health services
Intervention:
government led
national action plan
multi agency approach,
educating service providers
community approach:
targeting leaders,
gender mainstreaming to include men & boys,
consider marginalized groups
Understanding of terrorism & conflicts impact on women & girls effected by FGM/EFM
Factors:
international laws and treaties (Istanbul Convention),
global challenges:
pandemics, recession,
housing crises, climate change
terrorism & conflicts, natural
man-made disasters
Intervention:
government ratify international laws & treaties,
cultural competence,
research,
enhance all-round support

TERRE DES FEMMES

AkiDwA
AKINA DADA WA AFRICA

actionaid
REALIZZA IL CAMBIAMENTO

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