

Forced Migration Review mini-feature

FGM and asylum in Europe

The five articles in this FMR mini-feature address some of the issues relating to the practice of FGM in respect of asylum. The focus is on asylum in Europe in particular, and this mini-feature has been produced in collaboration with UNHCR's Bureau for Europe who are also generously funding the printing costs.

The mini-feature is online at www.fmreview.org/climatechange-disasters/FGM.pdf. Please feel free to circulate it, print it out, link to it, etc. To access it in French, Spanish and Arabic, or to access the individual articles in HTML, PDF and (for English) audio format, visit www.fmreview.org/climatechange-disasters. To request print copies, email fmr@qeh.ox.ac.uk.

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Female Genital Mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs, carried out for traditional, cultural or religious reasons. In other words, the procedure is for non-medical reasons.

All forms of FGM are considered harmful, although the consequences tend to be more severe the more extensive the procedure. Other factors, such as age and social situation, may also have an impact on the gravity of the consequences. FGM is mostly carried out on girls under the age of 15 years, although it is occasionally also performed on adult and married women. The procedure is often performed with rudimentary tools and without anaesthesia while the girl or woman is held down. Almost all those who are subjected to FGM experience extreme pain and bleeding. Other health complications include shock, psychological trauma, infections, urine retention, damage to the urethra and anus, and even death. The 'medicalisation' of FGM, whereby the procedure is performed by trained health professionals rather than traditional practitioners, does not necessarily make it less severe.

Taken from UNHCR (May 2009) *Guidance Note on Refugee Claims relating to Female Genital Mutilation*
www.refworld.org/docid/4a0c28492.html

FGM terminology

Initially the procedure was generally referred to as 'female circumcision' but the expression 'female genital mutilation' (FGM) gained support from the late 1970s in order to establish a clear distinction from male circumcision and to emphasise the gravity and harm of the procedure.

From the late 1990s, the terms 'female genital cutting' (FGC) and 'female genital mutilation/cutting' (FGM/C) have also been used, partly due to dissatisfaction with

the negative connotations of 'mutilation' for survivors and partly because there is some evidence that the use of the term 'mutilation' may alienate communities that practise FGM and thereby perhaps hinder the process of social change.

Abstracted from World Health Organization (2008) *Eliminating Female genital mutilation: An interagency statement*, p22. www.who.int/reproductivehealth/publications/fgm/97892141596442/en/

Female genital mutilation: a case for asylum in Europe

Fadela Novak-Irons

With some 71% of female EU asylum applicants from FGM-practising countries estimated to be survivors of this harmful traditional practice, it is time to accept that this subject demands greater scrutiny and a more dedicated response.

UNHCR has estimated that 18,500 of the 25,855 women and girls from FGM-practising countries seeking asylum in the EU in the first three quarters of 2014 may have been survivors of female genital mutilation (FGM), translating into an estimated 71% prevalence rate of FGM in EU asylum systems. The main countries of origin for these women and girls include Eritrea, Nigeria, Somalia, Guinea and Ethiopia, most of which have persistently high prevalence rates for FGM.¹ These numbers debunk the still all too common view that the practice is so insignificant in the asylum system as not to merit dedicated attention and specific responses.

There are a number of misconceptions relating to FGM that may create obstacles to meeting the specific protection needs and vulnerabilities of these women and girls. Many workers in the European asylum systems are not familiar with the practice and it is not uncommon to hear or read opinions that FGM is not a problem for these women because it is part of their culture; that educated parents should be able to protect their daughters from it; that 'intact' teenage girls and young women are too old to be at risk; that the increasingly medicalised practice of FGM is a minor procedure with no ill effects²; or that women should simply refuse to become 'cutters' and carry out this practice like their mothers.

Many of these misconceptions stem from a lack of awareness of the gender dimension in general and its role in this harmful traditional practice in particular, and from limited (or lack of) knowledge of the practice, its regional variations and its life-long consequences. This often leads to incorrect assumptions about the forms of persecution these women and girls may fear, the risks they may face if returned, the protection of which

they could avail themselves, the specific interventions they may need during the asylum procedure (and later when/if settling in Europe), and the prevention of the practice by the communities in exile in Europe.

Complex asylum claims

For the first three quarters of 2014, the main countries of asylum for women and girls from FGM-practising countries were Germany, Sweden, France, Switzerland, UK, the Netherlands, Italy, Belgium, Norway and – a new entrant into the list – Denmark.

The fact that only a handful of states collect data on the grounds on which applications are made and decided limits our ability to better understand the extent of this phenomenon. Gathering better statistical data on FGM in European asylum systems should be a priority; data should include the number of FGM survivors assisted in European asylum centres as well as the number of asylum claims involving FGM issues. It is estimated, however, that asylum systems in the EU receive a few thousand applications every year relating directly to FGM, pointing again to the fact that this is not a negligible ground for asylum. In addition, these asylum claims are particularly complex and involve a variety of risk profiles.

"I fled my country because of the persecution I had been subjected to because of my activism against excision³ and my political engagement to promote the rights of women." (Halimatou Barry⁴)

In addition to the women and men activists persecuted for their opinions and commitment to end FGM in their countries of origin and/or their perceived threat to religious beliefs, European Member States have also been receiving claims from:

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- women and (unaccompanied and separated) girls who seek protection from being subjected to FGM whether they come directly from FGM-practising countries or have lived most of their lives in Europe and may be at risk of being cut upon return
- women and girls who have already been subjected to FGM and seek protection from re-excision, defibulation or reinfibulation⁵ upon marriage (including child marriage⁶) or at childbirth
- parents who claim international protection to protect their daughters from FGM
- women who are under pressure from their family and community but refuse to become 'cutters' in countries of origin
- women who had been subjected to FGM, have accessed reconstructive surgery (often while in Europe) and who fear being cut again upon return

When members of communities flee, they bring with them their customs and traditions, which may include harmful traditional practices such as FGM. Beyond the asylum system, we need to learn how to work with the FGM-practising communities in exile in Europe to prevent the practice of FGM in Europe. Lessons can be learned from the progress achieved in countries of origin, in particular how ending FGM has involved changing the

social norms of practising communities, the participation of the communities, and the empowerment of women and girls but also of men, young and old, to urge their respective communities to abandon the practice.

"It is horrible; it is painful, mentally, emotionally and physically; and I wished it had not happened to me. Whatever happened to me can never be turned back; it cannot disappear. The pain will remain forever." (Ifrah Ahmed⁷)

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1. See UNHCR (2014) *Too Much Pain: Female Genital Mutilation & Asylum in the European Union - A Statistical Update* www.refworld.org/pd/5316e6db4.pdf
See also www.unhcr.org/pages/5315def56.html

2. See Foldes article pp6-7.

3. Excision: a form of FGM (in French, used to denote FGM in general).

4. In UNHCR (2014) *Too Much Pain – the Voices of Refugee Women* www.youtube.com/watch?v=pW3TFcLIXiw

5. Infibulation: surgical removal of the external female genitalia and the suturing of the vulva. Defibulation: reconstructive surgery of the infibulated scar.

6. Child marriage is poorly understood in the asylum system, too often conflated with 'arranged' marriage (i.e. culturally acceptable), rather than a way of subjugating girls to a submissive gender role. In this sense, its purpose is closely allied to that of FGM. The practices of FGM and child marriage are generally prevalent in the same countries.

7. Anti-FGM activist, in UNHCR (2014) *Too Much Pain – the Voices of Refugee Women*

FGM: challenges for asylum applicants and officials

Christine Flamand

Asylum authorities in the European Union need to establish better procedures to help address the specific vulnerabilities and protection needs of women and girls who have undergone or are at risk of female genital mutilation.

The asylum process examines whether an applicant has a well-founded fear of persecution based on one or more of the grounds in the 1951 Convention relating to the Status of Refugees or faces an actual risk of being subjected to serious harm. There are

a number of grounds on which female genital mutilation (FGM) can support a claim for asylum. It is a form of gender-based violence and a child-specific form of persecution. It also violates the principle of non-discrimination (as it only affects women and girls) and the right

of the girlchild to be protected against practices that are harmful for her health. FGM has short- and long-term health consequences and is therefore considered as a continuous form of persecution and also as a form of torture.¹

FGM constitutes a form of gender-related persecution under the 1951 Refugee Convention that can be related to the grounds of political opinion, membership of a particular social group or religious beliefs. FGM is mentioned as an example of persecution based on membership of a particular social group in the EU Qualification Directive,² and also constitutes 'serious harm' in the context of the qualification for subsidiary protection under Article 15 of the EU Qualification Directive.³ However, FGM survivors (or persons at risk) experience various procedural challenges in establishing the facts of their account and securing protection.⁴

Reception and information

EU Member States are required to identify vulnerable asylum seekers at an early stage but some vulnerabilities can be hard to identify. FGM is usually a taboo subject which many survivors do not want to speak about; in addition, sometimes they do not realise that it is a form of violence against women nor realise the impact of FGM on their mental and physical health.

It is standard practice in many EU member states that asylum seekers undergo a medical examination; this could be an opportunity to ask women coming from countries where the practice is prevalent specific FGM-related questions. However, this requires reception centre professionals to be trained on the issue and to be well informed about asylum seekers' country of origin and ethnic background.⁵ Some countries use special tools to detect indicators of vulnerability, such as the Protect Questionnaire which is currently used by some Member States such as France, Bulgaria and the Netherlands.⁶

It is essential to provide asylum seekers with information about the asylum process in a language that they can understand, as the

process is new to most of them and highly complex. They also need to be informed about specific aspects related to FGM, in particular its prohibition in the receiving country and the consequences of FGM on health. This can help women understand that they have been victims of violence that may give rise to a ground for asylum. It can also help prevent FGM for other family members. Understanding the asylum procedure will prepare them for having to tell their story and to talk about the violence they have undergone.

Establishing the facts and assessing credibility

The asylum authority will interview the asylum seeker to gather the relevant facts related to their testimony and assess the credibility of their claim but asylum seekers often lack knowledge about the aim of the interview. FGM survivors may face additional barriers to communication such as discomfort in discussing the subject and disclosing traumatic experience, the desire to hide shameful experiences and mistrust in authority figures. Trauma and/or lack of education can also hinder disclosure of information. Communicating with an applicant is done through the filter of language and culture, and often through interpreters whose presence may further impede disclosure.

Gathering evidence is not required if the testimony is generally coherent and consistent. However, many asylum authorities require material evidence and will cite a lack of cooperation if the asylum seeker is not able to substantiate his or her testimony.

In general, victims of gender-related persecution face major difficulty in providing evidence of past persecution. A medical examination or a psychological report can be useful to prove sexual violence or trauma but this evidence should not be a condition of qualifying as a refugee. The burden of proof is lighter if the asylum seeker has been a victim of past persecution and if he or she is considered as belonging to a vulnerable group. However, for women and girls who are survivors or at risk of FGM, the principle of the benefit of the doubt should be applied liberally.

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In assessing credibility, the decision maker must look into the individual and contextual circumstances of the asylum seeker. An asylum officer may conclude that a woman claimant should be able to protect her child from FGM in the event of return but this overlooks the fact that the girl belongs to the community and that her mother is not necessarily in a position to protect her child from such harmful traditional practices.

Country of Origin Information

The individual situation of the asylum seeker needs to be assessed against objective information about the country of origin. The prevalence rate of FGM in the asylum seeker's home country is a very important indicator; Country of Origin Information (COI) also includes information on access to state protection for women who fear that their daughter will be subjected to FGM. If a law prohibits the practice of FGM in the home country, the implementation of the law in practice needs to be assessed. Is it possible to file a complaint for a survivor of FGM? Will the police react diligently if a woman asks for protection for her daughter?

COI should be gathered from different sources (both governmental and non-governmental), be child-specific and include a gender dimension; the European Asylum Support Office has committed to improving these aspects and is also developing a training module on gender and interviewing techniques for vulnerable groups.

However, if no corroboration of facts is found in COI, this cannot in itself challenge the claimant's overall credibility. This is particularly relevant regarding the issue of re-excision (re-cutting at a later date); as this is an even more taboo subject than the initial FGM, no corroboration of the practice is found in COI – but the absence of supporting facts does not mean it is not a reality.

Some asylum authorities consider whether applicants could relocate to another part of their country, where the practice of FGM is less widespread. In those cases, it is necessary

to determine whether such an alternative is both safe, relevant, accessible and reasonable.⁷

Child-specific persecution and family unity

As previously mentioned, FGM is a child-specific form of persecution. If an unaccompanied child applies for asylum on this ground, the asylum authorities need to ensure that the procedure, the interviewing techniques and the credibility assessment are appropriate for a child.

In some countries (such as France), when a family applies for international protection due to fear of FGM being performed on a child, protection is only granted to the girl. In these cases, asylum authorities consider that the parents do not have legitimate reasons for claiming asylum for themselves, because their opposition to the practice will not lead to persecution or serious harm for them. However, family unity and the best interests of the child are fundamental principles in international and regional human rights and refugee law, and should be prioritised in asylum claims related to FGM where the overarching objective is to protect women and girls from persecution or serious harm.

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1. Manfred Nowak (15 January 2008) *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* www.refworld.org/pdfid/47c2c5452.pdf

2. Consideration no. 30 <http://tinyurl.com/EU-QualificationDirective>

3. A complementary form of protection against torture and inhuman and degrading treatment that is not linked to the five persecution grounds of the 1951 Refugee Convention.

4. A 2012 report of a comparative analysis of gender-related asylum claims in nine EU Member States includes a range of examples of good (and bad) practice. See <http://tinyurl.com/EU-Gender-asylum-claims-2012>

5. See, for example, the e-Learning course 'United to END FGM/C': www.uefgm.org/

6. <http://protect-able.eu/resources/>

7. See UNHCR (May 2009) *Guidance Note on Refugee Claims relating to Female Genital Mutilation*, section C. www.refworld.org/docid/4a0c28492.html

8. INTACT is a legal expertise centre in Belgium, working on the issues of FGM, forced marriage and honour-related crime.

The medicalisation of female genital mutilation

Pierre Foldes and Frédérique Martz

The ‘medicalisation’ of female genital mutilation should be denounced on two counts. Firstly, it is usually anatomically more damaging and, secondly, it goes against the ethical basis of the medical profession.

The ‘medicalisation’ of female genital mutilation/cutting (FGM/C) refers to the act being performed by doctors or other members of the health profession. The phenomenon is neither new nor unknown. The medical and paramedical professions have traditionally practised acts of mutilation in numerous countries in East Africa, primarily Egypt, Sudan, Eritrea and Somalia. It is a more recent, emerging phenomenon in West Africa where an increasing number of members of the nursing profession, midwives and *matrones* (traditional midwives) – and also doctors or surgeons – in Côte d’Ivoire, Mali and the rest of the sub-region are involved. Clinics that practise FGM/C have been identified in Kenya and Guinea.

Such acts of FGM/C are usually paid for, sometimes at a high price, on the pretext of ‘better quality’ or for safety reasons. Even in Europe, a few practitioners have offered ‘safe’ forms of FGM/C and even ‘minimal’ cutting to comply with tradition.

This practice is of growing relevance in asylum procedures where medicalisation tends to be viewed by non-medical experts (such as asylum officials) as a minor procedure and therefore not to be considered as persecution (unlike ‘more severe’, traditionally performed FGM/C). However, our experience over 25 years of treating and managing female genital mutilation and carrying out surgical repairs has given us a detailed understanding of the reality and impact of ‘medicalisation’, and we have no hesitation in denouncing these practices.

Anatomically more damaging

We have carried out reconstructive surgery on women who have been subjected to FGM/C and been able to compare the consequences of

so-called medicalised practices with cutting carried out by traditional practitioners.¹ The immediate and inevitable conclusion is that in the vast majority of cases, medicalisation is clearly an aggravating factor in mutilation.

Ritual cutting consists of cutting off a larger or smaller portion of the clitoral glans by a more or less clean cut that extends more or less towards the apex of the clitoral shaft. Traditional cutters are very well aware of how far they can go, particularly in terms of bleeding, and they understand that the death of young girls will neither serve their reputation nor help with recruiting new clients. As a result, the main nerve trunks are – paradoxically – avoided and thereby protected, as injuring them would also involve opening up blood vessels, resulting in an uncontrollable haemorrhage. The same applies to the *labia minora* and vulvar tissue, which are difficult to access on a terrified young girl.

However, the use of anaesthesia – whether local, locoregional or general – makes it possible to cut, unhindered, a body that is open and at rest. Worse, a doctor, surgeon or health-care professional knows how to prevent haemorrhage and is therefore much less constrained by the presence of major blood vessels – and can cut much more extensively, as we have observed. Moreover, the fact of being a surgeon or gynaecologist increases their ability to cut more, without risk, because of their greater knowledge of this part of the body. Medicalised cases performed by specialists have often been the ones that were most difficult to repair.

A breach of ethics

Medicine must not be used for harmful practices; furthermore, carrying out acts without a person’s consent or against their

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wishes is a crime. The medicalisation of FGM/C is an absolute breach of ethics that affects and tarnishes the entire health-care community. Historically, any other attitude has led to appalling practice, such as the experiments conducted during the Holocaust or assistance in prolonging torture sessions. The same applies to medical support for harmful practices such as FGM/C.

For the last 25 years, medicine has helped us understand the reality of FGM/C and its consequences. This new understanding must serve the needs of women. A doctor

or carer who carries out an act of mutilation commits a crime against the women who trust them, against the spirit and ethics of medicine, and against society.

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1. We have data from over 250 cases of medicalised FGM/C (some carried out in France). In addition, interviews with traditional female cutters have enabled us to gain a clearer understanding of their practices, while surgery on 4,500 cases (of all forms of FGM/C) has allowed us to understand the physiopathology of mutilation.

The Istanbul Convention: new treaty, new tool

Elise Petitpas and Johanna Nelles

The new Istanbul Convention provides a powerful tool for more effectively guaranteeing the protection of asylum seekers at risk of gender-based persecution and at risk of FGM in particular.

The Council of Europe Convention on preventing and combating violence against women and domestic violence, also known as the Istanbul Convention, is the first European treaty specifically devoted to addressing violence against women, including female genital mutilation. FGM is a threat to women and girls around the globe, including in Europe – a fact that has remained unacknowledged for too long.

With its entry into force in 2014, the Istanbul Convention legally obliges States Parties to accelerate preventive measures to protect and support FGM-affected women and girls, or those at risk, and to ensure effective and child-sensitive investigations and prosecution. These obligations include improvements in the area of refugee determination procedures for asylum seekers.

“What I remember from the interview is that the person who received me did not seem to believe me. It is true that some people leave their countries for economic reasons. But when you tell someone “I do not want my girls to be cut”, I want that this person’s vision changes.

In Europe, when a child falls and breaks her arm in the playground, everyone comes to help. I want to see the same reaction when we speak of a little girl at risk of FGM.” (FGM survivor Aissatou Diallo who fled Guinea to protect her two daughters from the practice and is now an anti-FGM activist in Belgium)

International protection under the Istanbul Convention

Building on existing international human rights law obligations, the Istanbul Convention clearly acknowledges that women and girls who suffer from gender-based violence can seek protection in another state when their own fails to prevent persecution or to offer adequate protection and effective remedies. The Istanbul Convention calls for more gender sensitivity in refugee determination procedures and obliges States Parties to take the necessary legislative and other measures to ensure that gender-based violence against women is recognised as a valid ground for claiming asylum.

The extent to which European states currently recognise refugee status for women and

girls at risk of gender-based persecution varies significantly. Possible reasons for such variations include the lack of explicit laws and guidance nationally, and inadequate provision of legal support and other services. In addition, some states regard gender-based violence as a 'private' matter; when occurring in the private sphere, gender-based violence may be more difficult to prove, creating credibility issues for asylum seekers with gender-related claims.¹

The Convention provides a set of obligations for States Parties to better guarantee the protection of asylum seekers at risk of gender-based persecution and at risk of FGM in particular.² States Parties are required to:

Ensure a gender-sensitive interpretation of each of the 1951 Refugee Convention grounds (Article 60, paragraph 2): As is often the case in gender-based persecution, there is a trend to consider FGM as falling within the grounds of membership of a particular social group and to overlook other grounds. Parents who oppose FGM for their daughters may come under the grounds of political opinion. Similarly, where it is considered a religious practice, if a woman or a girl does not behave in accordance with the interpretation of her religion, such as by refusing to undergo FGM or to have it performed on her children, she may have a well-founded fear of being persecuted for reasons of religion.

Develop gender-sensitive reception conditions and support services for asylum seekers (Article 60, paragraph 3): The identification of and response to the gender-sensitive reception needs of women affected by FGM require measures to address legal and social barriers that may prevent women and girls from accessing vital health or other services. Restrictions on freedom of movement in detention can hinder women from accessing specialist health-care or counselling services. Barriers may include language, a lack of competent or non-judgmental interpreters, and different ways of understanding and viewing health issues. Some women asylum seekers may not be aware that they have undergone

FGM, particularly if it was performed at an early age and if their reason for fleeing their country of origin is unrelated to FGM. Women may come to health professionals with long-term complications resulting from FGM but may not know that these complications are associated with it. There is also a need to address its psychological consequences which may include fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss.³

Develop gender-sensitive procedures for asylum seekers (Article 60, paragraph 3): According to the Istanbul Convention, States Parties will need to put in place a refugee determination process that is respectful of cultural sensitivities, ensures that women and girls do not face further stigmatisation upon arrival in destination countries, and guarantees a supportive environment allowing women to disclose relevant information. In particular, gender-sensitive procedures should include:

- the provision of information on gender-specific aspects of the asylum procedure
- the opportunity to have a personal interview separately from their husband/partner and without the presence of family members (especially children)
- the opportunity for women to mention independent needs for protection and gender-specific grounds leading to a separate application for international protection
- gender-sensitive and child-sensitive interviews led by a trained interviewer, and assisted by a trained interpreter when necessary
- the possibility for the applicant to express a preference for the sex of their interviewer and interpreter
- the development of gender guidelines on the adjudication of asylum claims, and training to ensure their implementation.

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Respect the principle of *non-refoulement* (Article 61): The Convention creates the obligation to protect female victims of violence, regardless of their residence status. In this respect, states should guarantee that women in need of protection are not returned to any country where their life would be at risk or where they may be subjected to torture or inhumane or degrading treatment or punishment. Such obligation should extend to abuses by individuals who perpetrate FGM when the authorities in the country concerned are complicit, fail to exercise due diligence or are negligent in preventing or redressing the abuse.

Conclusion

The Istanbul Convention gives hope for real change in how women and girls are protected from gender-based violence. Official monitoring and evaluation of these new obligations by governments ratifying the treaty will help shed more light on what is being done to prevent and combat FGM, and will thus be an important element in ensuring that states live up to their responsibility to guarantee the physical, psychological and sexual integrity of all women.

The Istanbul Convention provides States Parties with a unique opportunity to lift the silence surrounding FGM in Europe. It is hoped that under the watchful eyes of civil society and national parliaments (both of which are allowed to contribute to the monitoring of the Convention), States

Parties will support women like Aissatou in realising their dream of being part of the last generation to have undergone the practice of female genital mutilation.

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The opinions expressed in this article are the responsibility of the authors and do not necessarily reflect the official policy of the Council of Europe.

1. Asylum Aid (UK) *et al* (2012) *Gender related asylum claims in Europe: A comparative analysis of law, policies and practice focusing on women in nine EU Member States*, p41. <http://tinyurl.com/EU-Gender-asylum-claims-2012>
2. For detailed guidance on what the obligations of the Istanbul Convention in relation to FGM mean in practice, and how they can be put into practice, see Council of Europe and Amnesty International (2014) *The Council of Europe Convention on preventing and combating violence against women. A tool to end female genital mutilation*, Strasbourg. See box below re 'Promising practice'. <http://tinyurl.com/CoE-AI-2014-Istanbul-Conv-tool>
3. Irish Family Planning Association (2011) *Sexual health and asylum. Handbook for people working with women seeking asylum in Ireland*. <http://tinyurl.com/IFPA-2011-Asylum-handbook>
4. The End FGM European Network (END FGM) is a European umbrella organisation set up by eleven national non-governmental organisations to ensure sustainable, coordinated and comprehensive action by European decision-makers to end FGM and other forms of violence against women and girls. Its vision is of a world where women and girls are empowered and free from all forms of gender-based violence, in particular female genital mutilation, where their voices are heard, and where they can enjoy their rights and make informed choices about their lives. The principles of respect and promotion of human rights and gender equality are at the core of this work.

Promising practice

The Netherlands: In 2011, the Dutch government developed an official document – *Statement opposing female circumcision* – to help parents withstand pressure when visiting their families in their country of origin. This document outlines the health consequences of FGM and explains relevant Dutch legislation. Parents are given a copy by children's health-care centres and school doctors. www.pharos.nl/documents/doc/pp5056-verklaring-uk-2011_definitief.pdf

Germany: In 2013, the German government set up a national, free telephone helpline 08000 116 016 offering victims of all forms of violence against women – including FGM – advice on demand; around 60 trained counsellors provide confidential

support in 15 languages, around the clock, 365 days a year. www.hilfetelefon.de/en/about-us.html

United Kingdom: In 2008, London's Metropolitan Police issued standard operating procedures on FGM which provide police with an overview of FGM and describe the procedures to be adopted when a girl is at risk of FGM or a girl or an adult woman has already been subjected to the practice. The objective is to ensure that those at risk are protected and supported, and to achieve best evidence for prosecution and protection orders. www.londonscb.gov.uk/fgm/

For more examples, see <http://tinyurl.com/CoE-AI-2014-Istanbul-Conv-tool>

Changing attitudes in Finland towards FGM

Saido Mohamed and Solomie Teshome

Former refugee women are now working as professional educators among immigrant and refugee communities in Finland to tackle ignorance of the impact and extent of female genital mutilation/cutting.

The objective of the Finnish League for Human Rights' Whole Woman Project¹ is that no girl living in Finland be cut in Finland or taken abroad to be cut. Talking about female genital mutilation/cutting (FGM/C) from the perspective of human rights, equality and health, we concentrate on changing attitudes in the affected communities and on educating immigrants as well as professionals and students in areas such as health care, child welfare and daycare.

Nowadays FGM/C is globally recognised as a practice that violates human rights and, like other forms of violence, is an attack on the dignity, equality and integrity of girls and women. In addition to violating many international human rights conventions, the practice has been criminalised in many countries. We achieved one of our earlier objectives in 2012 when Finland published a National Action Plan on the Prevention of Circumcision of Women and Girls 2012-2016; we were involved in preparing the contents of the Action Plan and today we monitor its implementation and lobby the authorities to meet their responsibilities.

Two of our advisors were themselves refugees – from Somalia and Ethiopia – and are now professional educators.

Saido

My name is Saido Mohamed. I came to Finland as an asylum seeker from Somalia in 1992. In 2001 while working as a nurse, I attended a training-of-trainers course for immigrant women and men organised by the Whole Woman project. The topic of training was FGM/C – more precisely, its consequences for health and its relation to women's rights and human rights. Despite the fact that I was not unaware of the phenomenon, the course

gave me new tools to approach the issue and I began volunteering in my own community, spreading information about FGM/C.

In the early 2000s, talking about FGM/C was still very difficult in the Finnish Somali community but there has been a tremendous change in attitudes since then. Today men and women are willing to discuss FGM/C openly and most of them are strongly against it. They do not want their daughters to go through the practice, and young men are willing to marry uncut women. A male participant in one of our seminars said that FGM/C violates not only women's rights but men's rights as well.

Those girls and women who have themselves undergone FGM/C find themselves in a completely new situation when they move to Finland or elsewhere in Europe, where it is not practised. What had been culturally normal in their country of origin suddenly becomes abnormal; encounters with professionals such as Finnish health-care workers may not only cause stress and fear but also humiliation. Many cut women try to avoid gynaecological examinations. One woman who had experienced the most severe form of FGM/C² told the following story when asked about gynaecological examinations:

"It was the worst experience I've ever had. The doctor asked, horrified, what the hell has happened to you? That was my first and last visit to a gynaecologist!"

Solomie

My name is Solomie Teshome. I came to Finland as a refugee in 1995. Unaware of the prevalence of FGM/C in my own country, Ethiopia, I was shocked and saddened when I saw a documentary about it on Finnish TV. I had known about its existence but I hadn't

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known how many girls and women were dying because of it. During my next visit home, I decided to investigate and discovered not only that it had always been considered as a normal practice and was part of Ethiopian culture but also that the phenomenon was closer than I had realised – my neighbours, relatives and friends were also victims of it. The truth changed my life and since then I have been working against FGM/C.

Since working at the Whole Woman project I have come to realise that:

- people who have suffered the procedure or have themselves performed the procedure are victims of a harmful tradition and their awareness of the topic may be minimal
- FGM/C is a traumatic personal experience which needs handling with utmost care and confidentiality
- establishing personal trust with individuals and groups is the first step to getting rid of the practice
- each case needs to be approached individually, bearing in mind, for example, people's cultural and educational backgrounds
- the role of 'key persons' is essential – individuals who participate in our groups and then commit to talking about the negative impacts of FGM/C in their communities and family networks.

In groups one can see and measure changes in attitudes towards FGM/C. After a series of individual discussions to build trust, we organise separate groups for women and men. Then when we feel that the participants are ready, we bring women and men of the same origin together; we also organise groups with people from different ethnic, cultural and religious backgrounds. Our aim is to change attitudes through discussion, step by step.

Through one of our 'key persons', I met a recently arrived Ethiopian refugee whose

wife and daughters were still in Ethiopia. When he learned that the procedure was still routinely practised in urban settings in Ethiopia, he talked to his wife who told him that her mother was planning to perform FGM/C on their youngest daughter. The man shared his new-found knowledge of FGM/C with his wife, who then convinced her mother to give up the idea of cutting the girl. Nowadays the whole family lives in Finland and the daughter has not been cut.

Conclusion

As professionals with long experience in working against FGM/C and as women with first-hand experience in forced migration, we strongly believe that systematic training on the disadvantages of FGM/C as well as on related rights should be offered to all refugees waiting to be relocated. Some people who have come to Finland as refugees told us that they deliberately had their daughters cut in the refugee camps because they were aware that the practice would not be accepted in their new home country. This can and should be prevented. Furthermore, training should also take place in the receiving country, soon after arriving, in the newcomers' own languages.

In both situations, there should be discussion groups for refugees, and programmes to change attitudes at the grassroots, as well as one-to-one counselling. By receiving information and having the opportunity to reflect on their experiences in a peer group, people become empowered, even in difficult circumstances. And when empowered, they will continue to make a change in their own communities.

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1. The Whole Woman project was chosen as an example of good participatory practice by UNHCR. See UNHCR (2014) *Speaking for Ourselves. Hearing Refugee Voices - a Journey towards Empowerment* www.refworld.org/docid/537afd9e4.html

2. Type III, also known as infibulation or pharaonic FGM/C.



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