GUIDELINES FOR THE EARLY IDENTIFICATION OF **VICTIMS OF FEMALE GENITAL MUTILATION OR OTHER HARMFUL PRACTICES**

For staff of **CPSA**
(first aid and reception centres),
CDA (reception centres) and **CARA**
(reception centres for asylum seekers)

Drawn up by

Associazione Parsec Ricerca e Interventi Sociali; Coop. Soc. Parsec; Università di Milano-Bicocca; A.O. San Camillo Forlanini; Nosotras Onlus e **Associazione Trama di Terre**

Presidenza del Consiglio dei Ministri
Dipartimento per le Pari Opportunità

ASSOCIAZIONE PARSEC
ricerca e interventi sociali

Parsec
COOPERATIVA SOCIALE

UNIVERSITÀ DEGLI STUDI DI MILANO
BICOCCA

SISTEMA SANITARIO REGIONALE
AZIENDA OSPEDALIERA
SAN CAMILLO FORLANINI

NOSOTRAS

trama di terre

Guidelines for the early identification of victims of Female Genital Mutilation or other harmful practices: for staff of Cpsa (first aid and reception centres), Cda (reception centres), and Cara (reception centres for asylum seekers)

drawn up by

Associazione Parsec Ricerca e Interventi Sociali; Coop. Soc. Parsec; Patrizia Farina (Università di Milano-Bicocca); San Camillo Forlanini Hospital; Nosotras Onlus; Associazione Trama di Terre

Objectives and Use of Guidelines

The overall aim of these guidelines is to provide direction for staff of CPSA (first aid and reception centres), CDA (reception centres), and CARA (reception centres for asylum seekers) working with male and female asylum seekers.

Specifically, the manual is intended to provide key practical indications about how to approach alleged victims of FGM, forced marriages or other harmful practices, and how to help them safely access resources that are appropriate to their needs, and international protection with respect to the violence to which they have been subjected.

Female genital mutilation and forced marriages are forms of gender-based violence against women. When undergone by female asylum seekers, they can constitute acts of persecution as defined under the United Nations' Geneva Convention of 1951 on the Status of Refugees and the Qualification Directive of the European Union.

The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) commits the parties to ensuring that gender-based violence against women, including female genital mutilation and forced marriage, be recognized as a form of persecution within the meaning of Article 1, A (2) of the 1951 Convention relating to the Status of Refugees and as a form of serious harm giving rise to complementary/subsidiary protection.

Female Genital Mutilation

The UN agencies with responsibility for promoting reproductive health and rights - the World Health Organization, UNICEF and UNFPA - state that:

"Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia for cultural or other non-medical reasons".

By implementing forms of sexual mutilation, the community signals to girls and women that their bodies are not their own. Thus, these practices are internationally recognized as a serious violation of human rights of women and girls, on a par with torture, and the victims required personalised care tailored to meet their specific needs.

Female genital mutilation is listed by the *Council of Europe Convention on preventing and combating violence against women and domestic violence* (Istanbul Convention) as a form of gender-based violence against women. Gender-based violence is understood as reflecting historically unequal power relations between the sexes, which have led to men dominating over and discriminating against women, thereby preventing full female emancipation. It may also be viewed as a key social mechanism forcing women into a subordinate position relative to men.

What is Female Genital Mutilation?

Female Genital Mutilation is the term adopted by the World Health Organization (WHO) in 1995 to refer to all procedures involving partial or total removal of the external female genitalia or injury to the female genital organs for cultural or other non-medical reasons.

There are several terms for FGM:

- **FC -** Female Circumcision
- **FGM -** Female Genital Mutilation (WHO, UNFPA, UNICEF)
- **FGC -** Female Genital Cutting (UNFPA, USAID)
- **FGM/C -** Female Genital Mutilation/Cutting (UNICEF)
- **E –** Excision
- **FGE -** Female Genital Excision

> Using the word "mutilation" to describe this practice emphasizes a negative interpretation of it as violating the rights of women and young people. This term is accepted and understood in the international community and by African women's associations, but can cause discomfort to those who believe in good faith that such practices are appropriate and a key part of growing up and gaining social acceptance that "good parents" need to ensure for their daughters.
>
> The term Female Genital Mutilation (FGM) is used throughout this manual, in keeping with the understandings of many women in the countries where these practices are widespread, albeit with respect for those who still follow tradition.

How many types of Female Genital Mutilation are there?

The World Health Organization has provided a detailed classification of the different types of FGM.

Type I. Clitoridectomy: Partial or total removal of the clitoris and/or the prepuce.

Type II. Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type III. Infibulation: 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.

Type IV: Other: All other harmful procedures to the female genitalia for non-medical purposes (pricking, piercing, incising, cauterization)

Why is Female Genital Mutilation practiced?

Many and varied are the reasons invoked to support the perpetuation of this practice: a collection of myths, beliefs, behavioural codes, and values, which for some are related to religious prescriptions, and for others to established traditions that have been handed down for centuries.

In the communities that practice it, FGM is viewed as a tradition of long standing that is important to keep up.

In immigrant groups, observing tradition can function to protect and maintain identity and belonging, and therefore FGM can be even more stringently interpreted and applied.

There are different kinds of justification for FGM, according to the country and community where it is practiced:

- Culture and tradition
- Religious requirement
- Family honour
- Requirement for respectability
- Hygiene (cleanliness) requirement
- Means of purification
- Protection of virginity
- Enhanced opportunities for marriage

Similarly, there are a range of false beliefs linked to the reproduction of these practices, according to which they may:

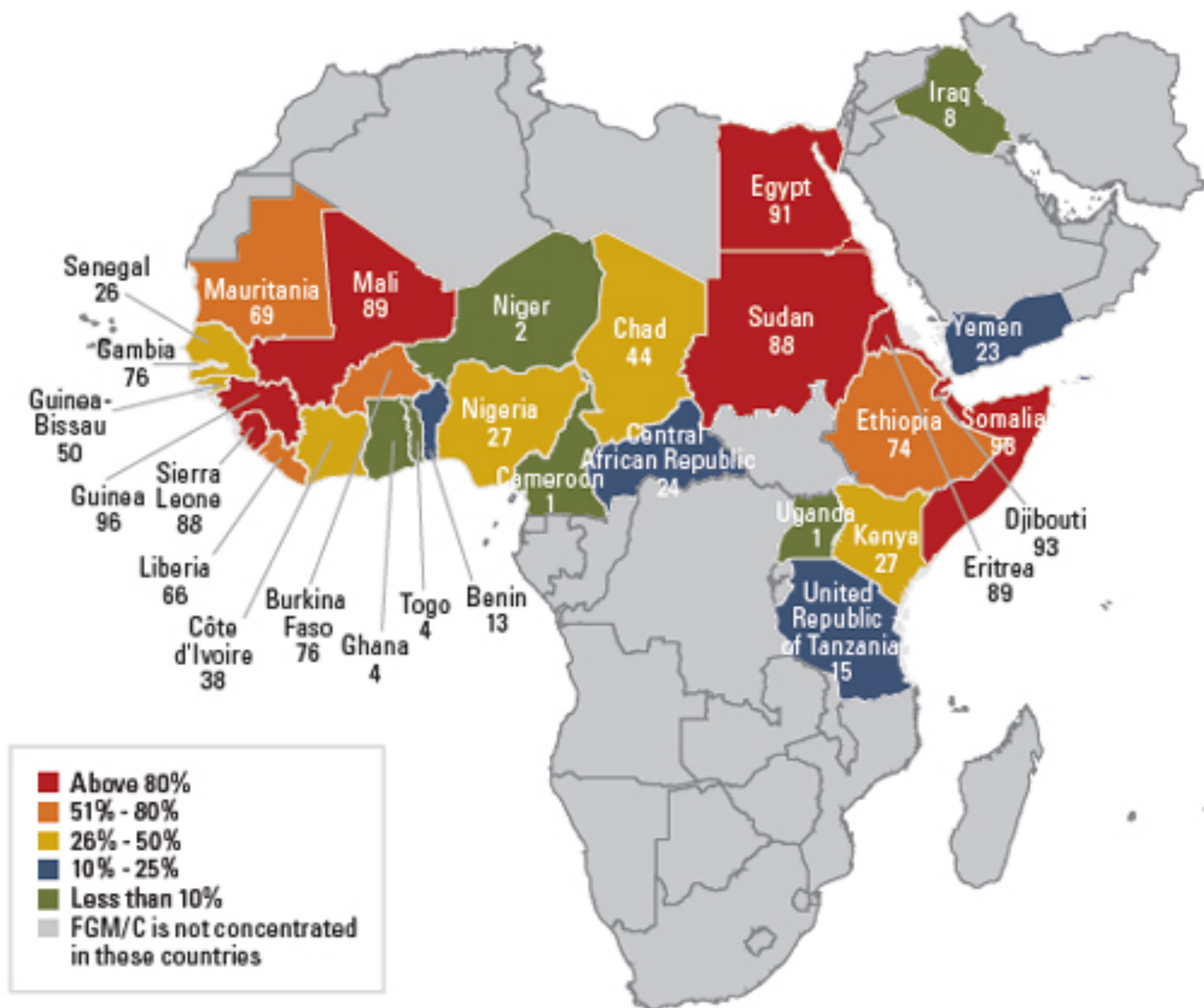
- Boost fertility
- Facilitate childbirth
- Prevent promiscuity
- Enhance the sexual pleasure of the woman's husband
- Prevent stillbirth
- Heal certain diseases and disorders

The incidence of FGM in Italy and the world

It is estimated that between 60,000 and 81,000 women currently resident in Italy were subjected to some form of genital mutilation as children. Nigerian women, followed by Egyptian women, are those most affected; together, these two national groups account for over half of the estimated victims.

The presence of such a high number of mutilated over-fifteens – a large proportion of whom are involved in humanitarian migration flows – suggests the need to implement measures of both assistance and prevention. The figures provided above[1] do not include girls who are at risk of being subjected to female genital mutilation in future.

[1]These estimates have been prepared by the research team led by Patrizia Farina under the auspices of the Daphne-funded FGM-Prev project coordinated by the University of Milan-Bicocca.



Given that significant numbers of refugees and asylum-seekers in Italy and the European Union are from countries in which FGM is practiced – including Nigeria (where FGM is undergone by an estimated 27 % of women aged 15-49 years, with peaks of 70-80% in some states), Eritrea (89%), Somalia (98%), The Gambia (76%), Guinea (96%), Ivory Coast (38%), Sudan (88%), Senegal (26%) and Mali (89%)[2] – it is reasonable to assume that survivors of FGM represent a large proportion of the women seeking protection.

In recent years, Italy has seen an increasing number of arrivals by sea, estimated at 181,500 people in 2016, and this has been accompanied by a sharp increase in asylum claims: in 2016, Italy became the third country of destination in the EU, with 123,000 new applications, compared to the 83,200 submitted in 2015. In 2016, asylum seekers' leading country of origin was Nigeria, with about 27,000 applicants. The four other main countries of origin were Pakistan (13,660), The Gambia (8,930), Senegal (7,610), and Ivory Coast.

In absolute terms, the largest group of women asylum seekers was from Nigeria, with over 7,000 applicants. However, the countries with the highest proportion of female asylum seekers were Cameroon and Somalia, with women representing 31% (600 of about 1,900 applicants) and 30% (700 out of 2,000 applicants), respectively. This outcome appears even more significant, if we take

[2] UNICEF Female Genital Mutilation/Cutting: What might the future hold?, 2013. http://data.unicef.org/resources/female-genital-mutilation-cutting-whatmight-the-future-hold-.html

into account that Cameroon and Somalia were not among the top 10 countries of origin for those seeking asylum in Italy.

Finally, we should note the case of Eritrea, with approximately 7,400 requests for asylum in 2016, a number that increased tenfold with respect to the slightly under 700 applications submitted in 2015[3]. The second largest group of female asylum seekers was from Eritrea, with women accounting for just over 27% of applicants (2,000 requests).

However, there is no data available on the number of women and girls who sought asylum because they had suffered, or feared being subjected to, FGM or who obtained protection on these grounds**.**

The Italian legislative framework

From the 1990s onwards, governments – both in the geographical areas where FGM is widespread and in areas where it has been introduced through immigrant populations – began to combat the practice using legal instruments.

The majority of European and non-European countries punish FGM, usually classifying it as an existing criminal offence such as grievous bodily harm, child abuse or child maltreatment. Italy, in contrast, has had a specific law against FGM since 2006: Law 9 January 2006 n. 7 "Provisions concerning the prevention and prohibition of female genital mutilation practices".

This piece of legislation is designed to prevent FGM from being carried out in Italy and to punish those who violate the law by practicing it:

Those convicted of voluntarily carrying out an FGM procedure or of pressurizing someone else to conduct one, face between 4 and 12 years' imprisonment.

This penalty applies to all types of FGM (female genital mutilation, excision, infibulation).

If a woman's sexual function is damaged as a result of injury to her genitalia of a different type to those mentioned above, causing harm to her body or her mind, the penalty ranges from 3 to 7 years' imprisonment.

If the mutilation or injury is caused to a minor, or carried out for profit, that is to say, for monetary gain, these penalties are increased by a third.

The terms of the law continue to apply when the offence is committed outside of Italy by an Italian citizen or a foreigner resident in Italy or is committed abroad against an Italian citizen or a foreigner resident in Italy.

Penalties incurred by doctors who conduct an FGM procedure include suspension from the medical register for 3 to 10 years.

The social and health consequences of FGM

Female genital mutilation severely harms the psychological and physical health of girls and women, amongst other reasons due to the use of infected instruments and in general the poor sanitary conditions in which they are carried out.

Women with FGM experience problems during menstruation, given that the vaginal orifice may be partially or totally occluded by scars and secondary keloids caused by slow and incomplete healing

[3] Eurostat, Http://ec.europa.eu/eurostat/data/database.

of the wound, along with inflammation and post-surgical infections.

These women are often affected by recurrent endometritis, vaginitis, and cystitis. Urinary infections and kidney stones are also frequent and can compromise renal function. Fistulae are another common issue.

The gynaecological care of women with FGM

The gynaecological examination of women who have undergone FGM can be complicated, and is often perceived by the patient as invasive, especially in the case of women who have been infibulated. It is therefore crucial to fully explain to the patient in advance what the procedure consists of and how it will be performed. The doctor should only proceed with examination after the woman has given her consent, as is standard practice, and if the patient asks for the examination to interrupted, the doctor should comply with her request, especially if it is her first gynaecological check-up.

The examination can be difficult, painful, and sometimes even impossible to carry out; the doctor must proceed gently and sensitively, showing that he or she is familiar with and has respect for the woman's culture, including the practice of FMG. If the gynaecological inspection is causing excessive pain, the doctor should not insist on completing it. It is crucial to ensure that the woman fully understands what is being communicated to her at all times.

Obstetric and gynaecological clinicians report that women who have been infibulated can display feelings of shame and embarrassment, leading them to refuse gynaecological examination even during childbirth. This behaviour is frequently due, at least in part, to the attitude of curiosity and surprise displayed by reproductive healthcare practitioners themselves.

It is recommended that the medical interview with the woman takes place in the presence of an interpreter or cultural mediator. In any event, the healthcare practitioner should be aware of the possible ethical, psychological, and therapeutic implications of the consultation, and constantly strive to respect the principles of protecting personal autonomy and maximising therapeutic benefit.

Screening programs for the prevention of cervical, uterine and breast cancers should include specific strategies for involving women from communities with a tradition of FMG.

Deinfibulation

It is critical to offer women with Type III FGM access to deinfibulation procedures at a suitably specialized healthcare facility, while also seeking to involve their partners in this process.

Deinfibulation reduces the risk of urinary infections, menstrual pain, and pain during sexual intercourse. It facilitates gynaecological examination and reduces the incidence of caesarean delivery.

Deinfibulation is an uncomplicated, programmable outpatient procedure. However, the woman may require significant psychological and cultural support to prepare her for the intervention. Once all the relevant information has been provided, with the assistance where required of a linguistic and cultural mediator of the same ethnic origin as the patient, the practitioner must ensure that the woman has understood this information, before obtaining her informed, signed consent as legally required.

Ideally, women who are deinfibulated during pregnancy should be monitored throughout the entire prenatal period by the same healthcare team who conducted the deinfibulation procedure, in the interest of establishing a climate of trust and providing optimum assistance in the event that an episiotomy is performed to facilitate delivery.

FGM and pregnancy

In the case of infibulated women who are pregnant, in addition to the difficulty of performing gynaecological examination because it is impossible to introduce the speculum into the vagina, urinary and vaginal infections can develop, posing a risk to the pregnancy itself.

During childbirth, inelastic scar tissue can prevent dilation of the birth canal, causing serious issues for both mother and baby.

Specific precautions should adopted when assisting women with FGM during pregnancy and childbirth, given that they are at greater risk of complications. Of particular importance is the initial gynaecological consultation, which ideally should take place as soon as pregnancy has been confirmed.

At each prenatal check-up, the possibility of vaginal delivery should be thoroughly assessed in consultation with the infibulated patient, taking into account the degree of vaginal opening and other possible complications, and informing the woman that having recourse to deinfibulation during labour can be more problematic than getting it done in advance, because not all practitioners are skilled in this area.

If the woman is provided with detailed and exhaustive information about the gynaecological check-up, this can encourage her to ask for other gynaecological diagnostic tests for prevention and screening purposes or in preparation for childbirth (e.g., a Pap test, an abdominal-pelvic and/or transvaginal ultrasound scan, etc.).

From an educational point of view, if the foetus or new-born baby is female, during the medical check-ups, doctors must inform the parents that Italian law prohibits the practice of FGM, with a view to protecting the health of both mother and child.

In Italy, it is forbidden by law to carry out reinfibulation procedures, but any perineal tears occurring during delivery must of course be repaired.

Psychological aspects

It is difficult to comprehensively assess the psychological effects of FGM, given that the lived experience of the girls subjected to this practice can vary as a function of both cultural context and age.

Female genital mutilation can undermine psychological balance and give rise to trauma, upsetting a girl's existential equilibrium and compromising her emotional relationships for the rest of her life.

This practice is indirectly maintained by patriarchal logics, whose common thrust is to promote the mutilation not only of the girl's body but also of her psyche, consigning her to a subordinate social role characterized by psychological dependence and perpetuating unequal gender relations.

The relatively high age at which girls are subjected to genital cutting procedures, and the associated lack of preparation and explanation, increases their resentment towards their parents, seen as deceiving and betraying them, and in particular toward the mothers who failed to protect them. They often experience feelings of shame and embarrassment, humiliation, poor self-esteem, and a painful awareness of their disability/mutilation: *I am not whole, I am missing something*.

Their negative perception of what it means to be a woman is accompanied by a fear of the menstrual cycle, sexuality, and marriage, which is sometimes accentuated by the spread of the Western model of woman. Women who have undergone FGM may also display: repression of emotions such as anger and pain; a fear of being touched by strangers, a fear of sharp objects, surgical procedures, and doctors; recurring symbolic dreams and nightmares; emotional responses corresponding to the symptoms of post-traumatic stress disorder (PTSD - DSM4).

The trauma associated with genital cutting can also be expressed through the body, and the international scientific literature reports that women subjected to mutilation are more prone to psychosomatic disorders than women who have not undergone cutting. The wound gives rise to a trauma, altering the woman's relationship with her body and causing disturbance both in the sexual sphere, and in her intimate and social relations in general.

When women migrate, the issue of female genital cutting heightens the tension between the maintenance of traditional customs and dynamics of change. On arrival in the destination countries, female migrants from regions where FGM is a widespread practice experience conflict between remaining faithful to the customs of their own culture and complying with the rules of the host country. Their emotional experience is situated in a boundary zone that is already culturally conflictual, although it abounds in opportunities to modify harmful traditional practices.

Migrant woman can experience their mutilation in an ambivalent manner: on the one hand as a normal characteristic that acts to mark their cultural identity, keeping them anchored to their own cultural traditions, on the other hand as providing the impetus to clearly oppose what they may perceive as a violation of their right to psychophysical integrity and self-determination.

Younger women's awareness of their disability is accentuated by comparisons with their peers in the host countries and increases their anger about feeling different, in turn triggering anxiety, phobias, a sense of betrayal and a loss of trust in their own mothers. Over the long term, compromised self-esteem may give rise to phobic neuroses, panic attacks, and psychosomatic disorders, seriously compromising the woman's reproductive health and sex life.

Ethno-systemic narrative psychotherapy can be helpful in treating these negative outcomes.

FORCED MARRIAGES

What is forced marriage?

Forced marriage is defined in the Istanbul Convention as "intentional conduct of forcing an adult or a child to enter into a marriage... [or] intentional conduct of luring an adult or a child to the territory of a Party or State other than the one she or he resides in with the purpose of forcing this adult or child to enter into a marriage" (Art. 37).

Forced marriage is a practice that is not limited to specific religious or cultural groups, or even to specific social classes or castes, and it affects both young women and girls. Most victims are aged between 13 and 30 years. The suffering caused to girls and young women, both in their countries of origin and on Italian territory, can take the form of domestic violence: physical, sexual, and verbal abuse, segregation, psychological and social pressure starting with emotional blackmail; restrictions on daily life that affect their freedom of movement or of dress, or choices concerning education and employment.

The victims may be subjected to abuse by close family members, relatives of their own or of their husband's, or their imposed marriage partners. The pressure can come both from the victim's own family and from the entire "community" to which the family feels that it belongs and to which it is accountable, whether in Italy or in another country. This mainly involves subtle forms of conditioning that amount to emotional and social coercion, with the result that the victims live in a state of alarm with constant feelings of guilt. The family's "honour" and at times that of the entire community appears to rest entirely on their shoulders. Sometimes these women are made to marry by proxy or on payment of a dowry, as part of an exchange of money/property. Young women and girls may be forced to marry men who are much older than them, or in any case unsuitable marriage partners, in order to enhance the family's social status or, in some cases, so the family can get rid of girls deemed to be rebellious. Family honour can even be invoked to justify the commissioning of crimes against those who do not wish to accept the treatment being imposed on them.

There are no official statistics on the extent of forced marriage in Italy. Even when data concerning domestic violence or child abuse is collected, cases of forced marriage or other harmful or discriminatory practices are rarely identified and in any case, are not recorded as a category in their own right. Yet many of these events arise in the context of problematic situations coming to the attention of both educational and healthcare institutions.

The Italian legislative framework

Italian law does not contain explicit references to "forced marriage". However, it may be addressed using other legal instruments, in particular the classification of domestic maltreatment as a criminal offence (Art. 572 of the Penal Code).

It should also be pointed out that Italy ratified the Istanbul Convention in on 27 June 2013 (via Italian Law n. 77). Article 42 of the Istanbul Convention is entitled *Unacceptable justifications for crimes, including crimes committed in the name of so-called "honour"* and reads as follows: "in criminal proceedings initiated following the commission of any of the acts of violence covered by the scope of this Convention, culture, custom, religion, tradition or so-called 'honour' shall not be regarded as justification for such acts. This covers, in particular, claims that the victim has transgressed cultural, religious, social or traditional norms or customs of appropriate behaviour."

Also crucial is Article 5 of the Convention, concerning a state's responsibility to intervene in cases of forced marriages or other harmful and discriminatory practices committed in the name of "honour": this article binds all the relevant institutions to develop professional standards and procedures for prioritizing women's safety and protecting their personal identity; respect the victim's wishes concerning whether or not to initiate civil or criminal legal proceedings; and ensure gender equality as well as impartiality and non-discrimination with respect to ethnic identity or other characteristics relating to the victim's country of origin.

HARMFUL TRADITIONAL PRATICES

In some communities, illness is viewed as resulting from the breakdown of an equilibrium that is either internal to the individual, or between the individual and the real or imaginary environment in which he/she lives. Thus, traditional medicine is relied on to prevent and treat disease.

Traditional practices are customary behaviours of a person, group or community that are based on tradition. Many of these practices are **useless** and **harmful** to health.

Brief Explanatory Glossary[4]

Ablation of the uvula: Many different motives are offered as justifications for the practice, from the treatment of fatigue in adults to the prevention of illness in new-born babies. It may be undergone at any age.

Early marriage and motherhood: The numerous justifications for early marriages, that is to say, marriages entered into before the age of eighteen, vary from country to country, and from culture to culture.

Force-feeding: Force-feeding is adopted to ensure that a woman puts on weight, which is perceived as a sign of beauty and wellbeing. The reported consequences include stress and diabetes.

Nutritional taboos: Some foods are prohibited while others may be imposed, based on popular beliefs. For example, curdled milk may be offered to favour closely-spaced pregnancies, or eggs may be withheld from children to ensure that they do not become thieves.

Extraction of milk teeth and dental alveoli: Believed to protect the child and especially the family from poverty.

Touching with fire: A practice mainly carried out on children, which consists of tapping the victim's forehead, stomach, chest, and back with a red-hot iron. This is done to prevent diarrhoea, malnutrition, or asthma. The consequences can include infections or the formation of keloids.

Bleeding: A practice that consists in the stripping away of flesh with traditional materials such as animal horns, or awls. It may be practiced as a means of tribal identification, or to treat headaches, lumbago, or dizziness. It can potentially lead to serious consequences such as haemorrhaging, anaemia, and infection.

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[4]These definitions have been prepared by Nosotras Onlus in collaboration with the Niger non-governmental organization CONIPRAT, which seeks to eradicate ritual practices that are harmful to the health of women, girls, and children in general. CONIPRAT also works to promote changes in the national legislative framework, through dialogue with government and local institutions.

Early weaning: Interruption of breastfeeding at a very early stage, in order to prevent the new-born girl from getting pregnant before marriage in the future. The consequences are generally serious and can even include the death of the new-born baby.

Tattoos: Parts of the body are marked with materials that colour the skin. This is done for aesthetic reasons or to mark cultural identity, but can cause infection and fever.

It is crucially important to distinguish between harmful traditional practices and **beneficial traditional practices (BTP)**. All communities engage in practices such as those just described, which are negative, alongside others that are positive. Positive practices include some that are shared across cultures, such as the promotion of social cohesion, solidarity, development, and societal wellbeing in the broad sense.

Beneficial practices that are part of the traditions of many African countries include the following:

- **Breastfeeding**
- **Mothers carrying their babies on their backs**
- **The practice of taking 40 days' rest (or "quarantine") following childbirth**

RECOMMENDATIONS FOR PRACTITIONERS

It is recommended that practitioners working in reception centres for asylum seekers:

- be able to identify and assess the risk factors for FGM and forced marriages in the countries of origin of women and young girls arriving in Italy;
- be able to provide information about the victims' right to file an asylum application based on gender, given that violence against women is recognized as a form of persecution;
- be aware that, in keeping with the principle of *non-refoulement*, there are measures in place to "prevent victims of violence against women who are in need of protection, regardless of their status or residence, from being returned to any country where their life would be at risk or where they might be subjected to torture or inhuman or degrading treatment or punishment" (Art. 61, Istanbul Convention).

Women must be guaranteed regular and timely access to information and training in their rights, in a language that they understand.

Practitioners must be aware that having suffered, or fearing being subjected to, female genital mutilation or a forced marriage may constitute grounds for obtaining international protection (See: *FGM and forced marriages as grounds for the granting of international protection*).

The reception of women who are potential victims of FGM

Every girl and every woman, regardless of traditions and conventions, bears the right to health and personal integrity.

Familiarity with the traditions and typical practices of other cultures is a key prerequisite to building an equal relationship between staff and guests at the reception centre, without losing sight of universal principles of protection for the human rights of women, children, and young girls.

Knowing these traditions and being able to put them into context, without stigmatizing and/or criminalizing them, helps to prepare the ground for a dialogue that is accepting of the women who have been victim to such practices.

Practitioners involved in the reception of women asylum seekers need to be prepared to address these issues, informed about the existence of these traditions, and competent in offering women with FGM the assistance that they require.

When interviewing female asylum seekers, practitioners should: be aware of what is potentially at stake ethically, psychologically, and therapeutically; avail of cultural mediation; and strive to respect the principles of benefiting the interviewee and protecting her personal autonomy.

During an interview with a woman who may have been subjected to FGM, the practitioner should maintain a balanced attitude, without displaying prejudice towards or judging either the phenomenon of genital mutilation or the interviewee's culture of origin, and avoiding taking for granted that all women, even those from the countries with the highest percentage of FGM, have been subjected to the practice.

The interviewers' in-depth knowledge of the phenomenon should also lead them to consider the possibility that many women may not be aware of having been mutilated (especially those with Type I FGM).

Taking into account the fact that sexuality remains a taboo in many communities, exploring the interviewee's reproductive health and wellbeing can provide indications as to whether or not she has undergone FGM.

Hence, at first interview, practitioners are recommended to:

- Verify the woman's geographical origin and her tribal and cultural identity;
- Verify whether she has a minimum level of education and basic knowledge of her own body.

Once these two aspects have been explored, it is possible to introduce the topic of traditional practices connected with rites of passage and/or purification that may be present in the woman's culture. This will enable the practitioner to discover what terminology the woman herself uses to identify the phenomenon, facilitating a dialogue with her to establish what type of FMG she has undergone, if any.

When the interviewer has established a relationship of trust, more specific questions may be asked, concerning, for example, the regularity of woman's menstrual cycle, pain experienced during menstruation and/or during sexual intercourse, issues experienced during pregnancies and childbirth.

To enhance their ability to identify potential victims of FGM, practitioners are recommended to use the risk assessment chart provided in this manual (See: *How to identify victims of FGM*).

"Do's"

- inform the woman about her rights and about how the interview will be conducted;
- use simple clear language, avoiding adjectives that might seem judgmental of the woman's culture of origin;
- conduct the interview in a safe place and in the presence of a female staff member (this can include the linguistic-cultural mediator, who should be adequately trained in the topic).

"Don'ts"

- do not assume anything about the interviewee's understanding of FGM or that she views it as a negative practice;
- do not use language that is aggressive and/or stigmatizing;
- do not have more than one interviewer, or conduct the interview without the presence of another woman;
- do not involve a male mediator.

The reception of women who are potential victims of forced marriages

All interviews with the woman must take place in a private setting, and the utmost confidentiality must be ensured. It is crucial in this kind of interview to avoid involving relatives, friends, or mediators from the woman's own community as interpreters, because this would prevent her from freely speaking about any situation of violence that she has undergone and would prevent her from openly asking for help.

The interview must always be conducted in a place that the woman perceives as safe. All possible risk factors must be taken into consideration and evaluated in the course of the interview.

The practitioner must briefly and clearly explain to the woman the forms of help that are available to her and possible legal solutions for her situation.

Women who have become pregnant as the result of a forced marriage

When a woman has chosen to keep the child of an unwanted marriage, in addition to protection she will require mothering support. Loneliness, a sense of guilt, and missing her own "familiar" community, even if it is violent and disrespectful, can have devastating effects on a woman's mental and physical health.

It is important to bear in mind the need to keep tight security measures in place until the child is six months old, given that up to this time, a father who entered Italy illegally might have a vested interest in tracking down and recognizing the minor in order to obtain regular immigrant status.

To enhance their ability to identify potential victims of forced marriages, practitioners are recommended to use the risk assessment chart provided in this manual (See: *How to identify victims of forced marriages*).

HOW TO IDENTIFY VICTIMS OF FGM

The risk of FGM may be evaluated using the assessment chart provided in this manual, which provides indications for differentiating between women who have already undergone mutilation and young girls at risk of mutilation in the future. This categorization is based on the girl's or woman's current age, in conjunction with the age at which FGM is usually practiced in her country of origin.

While the chart is not intended to provide a sure indication of whether a woman or a girl has been subjected to FGM, it indicates how strong a possibility this is, with a view to informing the practitioner's approach to the interview. Furthermore, identifying the age at which the risk of mutilation comes into play facilitates the provision of appropriate assistance for those who have already undergone a form of FGM and working with families to prevent it in the case of younger girls.

Women with FGM

The set of the indicators used to rate the probability that the interviewee has been subjected to FGM – with scores ranging from 1 to 6 that may be further grouped into high, medium, and low risk categories – are based on data sourced in the countries of origin concerning:

- The estimated incidence of FGM, defined as the ratio between the number of women aged 15-49 years who have undergone forms of genital mutilation and the total population of women in this age group (%).
- Trends in the incidence of FGM over time. The indicator of decline (strong, moderate, or none) has been calculated by comparing, for each country of origin, the incidence of FGM among older women (45-49 years) with the incidence among very young women (15-19 years) who in any case are past the age for potentially undergoing mutilation. This indicator has the function of reinforcing or mitigating the risk value attributed. If there is a pattern of strong decline in the country of origin and the woman is under 30 years of age, incidence may be reduced by a quarter (strong decrease), between 10-20% (moderate), or to an insignificant extent (no decrease). The combined results of the data gathered are reported in the table below.

Incidence of FGM among women aged 15-49 by country of origin, risk assessment

Origin	FGM (%)	TENDENCY TO DECLINE	RISK	
Somalia	98	NONE	6	HIGH
Guinea	97	NONE		
Djibouti	93	NONE		
Sierra Leone	90	MODERATE		
Mali	89	NONE	5	
Egypt	87	MODERATE		
Sudan	87	MODERATE		
Eritrea	83	MODERATE		
Nigeria* states: Imo, Ebonyi, Osun, Oyo	70-80			
Senegal* areas of the south	70-80			
Burkina Faso	76	STRONG		
Gambia	75	NONE	4	MEDIUM HIGH
Senegal* ethnic groups: Mandingue, Soninke	70	n/a		
Ethiopia	74	MODERATE		
Ghana* areas: northern regions	75	n/a		
Iraqi Kurds	70	STRONG		
Mauritania	69	MODERATE		
Liberia	50	STRONG	3	
Benin* ethnic groups: Bariba, Peul; areas: Borgou	50	STRONG		
Senegal* ethnic groups: Diola, Poular	40-50			
Guinea-Bissau	45	NONE		
Nigeria* states: Edo (Benin City); Lagos, Ondo, Delta, Kano; Kwara, Enugu	30-50			
Nigeria* ethnic groups: Ekoi, Igbo, Yoruba	30-50			
Chad	44	MODERATE		
Ivory Coast	38	MODERATE		
Nigeria	25	STRONG	2	MEDIUM LOW
Senegal	25	MODERATE		
Central African Republic	24	STRONG		
Kenya	21	STRONG		
Yemen	19	MODERATE		
Tanzania	15	STRONG		
Benin	9	NON-SIGNIFICANT	1	
Iraq	8			
Togo	5			
Ghana	4			
Niger	2			
Cameroon	1			
Uganda	1			

The asterisk * indicates specific variations within countries, otherwise the data refers to the whole country.

Some countries are listed more than once because the internal situation varies significantly by ethnic group or geographical area (which often coincide).

At-risk girls

A small number of countries, albeit with a generally high incidence of FGM, mutilate their girl children before they reach the age of five years, not infrequently in the first year of life. In contrast, FGM is most rarely practiced on girls of 10 years and over, with the exception of women from the Central African Republic and some women from Egypt. In fact, most girls are mutilated by 9 years of age, and knowing this helps staff involved in the reception and care of women migrants and asylum seekers to implement appropriate information and prevention actions.

Knowing the age at which genital cutting is commonly practiced in the country of origin enables practitioners to work effectively with girls, and above all with their parents, to prevent FGM.

Percentage of mutilated women by age at mutilation and country of origin

Very early		Early		Late	
Age at mutilation	**<5 years**	**Age at mutilation**	**By 9 years***	**Age at mutilation**	**10-14 years.**
Country of origin	**%**	**Origin**	**%**	**Origin**	**%**
Yemen	100	Burkina Faso	91	Central African Republic	52
Mali	89	Somalia	88	Sierra Leone	37
Ghana	83	Ethiopia	86	Kenya	30
Nigeria	82	Djibouti	84	Egypt	29
Mauritania	81	Benin	83	Tanzania	21
Niger	76	Ivory Coast	83		
Senegal	74	The Gambia	83		
		Niger	83		
		Guinea	82		
		Sudan	74		
		Egypt	71		
		Chad	71		
		Togo	68		
		Tanzania	68		
		Eritrea	68		
		Iraq	67		
		Guinea-Bissau	62		
		Kenya	52		

**This excludes countries where over 74% of mutilations are conducted before age 5 years (left-hand column)*

Early or forced marriage

The risk of forced marriages is less quantifiable than that of FGM and therefore does not lend itself to numerical scoring. There is a lack of official statistics on the practice in the countries of origin, while the motives leading parents to marry off daughters against their will are complex, defying statistical analysis.

However, the United Nations data on early marriage can act as a proxy indicator for the practice of forced marriage in a given country population.

Hence, the practitioner can construct a sort of "risk profile" based on the age of the girl/young woman, who – if anyone – is accompanying her, the incidence of early marriages and official fertility rates for younger women and girls in her country of origin, and contingent factors affecting living conditions in the region from which she has migrated (natural disasters, conflict, other).

The combination of several of the above risk factors will correspond to an overall higher risk profile.

The official United Nations ranking (UNFPA) reveals that the proportion of child brides (under 15 years) in some countries is over 20%, and that two thirds to three quarters of all women are married by age 18 years, which still qualifies as early marriage.

Another indirect indicator of early marriage is the fertility rate of young people aged 15-19 years. This supplementary indicator shows, as might be expected, that in countries with large percentages of girls entering marriage before 15 years of age, the fertility rate is very high, but also that the early motherhood is frequently among women marrying before age 18.

Percentage of women married before ages 15 and 18 and adolescent fertility rates by country (%)				
	Percentage of women married at <15 years	Percentage of women married at <18 years	Percentage of women who gave birth before age 19	
Country/Unit of Measurement	**%**	**%**	**‰**	**Risk**
Central African Republic	**29**	**68**	**229**	**VERY HIGH: AT LEAST 21% OF GIRLS**
Chad	**29**	**68**	**203**	
Niger	**28**	**76**	**206**	
Guinea	**21**	**52**	**146**	
India	**18**	**47**	**28**	**HIGH: 10-20% OF GIRLS**
Bangladesh	**18**	**59**	**113**	
Nigeria	**17**	**43**	**122**	
Ethiopia	**16**	**41**	**71**	
Mali	**15**	**55**	**172**	
Mauritania	**14**	**34**	**71**	
Sierra Leone	**13**	**39**	**125**	
Eritrea	**13**	**41**	**76**	
Cameroon	**13**	**38**	**119**	
Madagascar	**12**	**41**	**145**	
Benin	**11**	**26**	**94**	
Uganda	**10**	**40**	**140**	
Ivory Coast	**10**	**33**	**129**	
Burkina Faso	**10**	**52**	**132**	
Yemen	**9**	**32**	**67**	**LOW: 6-9% OF GIRLS**
Senegal	**9**	**32**	**80**	
Malawi	**9**	**46**	**136**	
Liberia	**9**	**36**	**149**	
The Gambia	**9**	**30**	**88**	

Somalia	**8**	**45**	**n/a**	
Afghanistan	**8**	**35**	**78**	
Tanzania	**7**	**37**	**95**	
Sudan	**7**	**33**	**87**	
Guinea-Bissau	**7**	**22**	**106**	
Togo	**6**	**22**	**85**	
Iraq	**5**	**24**	**82**	**VERY LOW: 1-5% OF GIRLS**
Ghana	**5**	**21**	**65**	
Kenya	**4**	**23**	**96**	
Syria	**3**	**13**	**54**	
Pakistan	**3**	**21**	**44**	
Egypt	**2**	**17**	**56**	
Djibouti	**2**	**5**	**21**	

The two risk assessment charts feature different lists of countries of origin, because – although both are harmful practices – there is no correlation between FGM and early marriage.

In addition, the nationalities listed are not restricted to those making up the current population of asylum seekers, because in the future humanitarian flows might arrive from other countries in which one or both phenomena is strongly present.

Statistical Data Sources

DHS Program Demographic and Health Survey: https://dhsprogram.com/

UNICEF: https://data.unicef.org/resources/female-genital-mutilation-cutting-country-profiles/

UNFPA: http://www.unfpa.org/data/world-population-dashboard

Girls not brides: https://www.girlsnotbrides.org/where-does-it-happen/

Italian Ministry of the Interior: http://www.interno.gov.it/it/sala-stampa/dati-e-statistiche/sbarchi-e-accoglienza-dei-migranti-tutti-i-dati

FGM AND FORCED MARRIAGES AS GROUNDS FOR THE GRANTING OF INTERNATIONAL PROTECTION

The Geneva Convention and UNHCR documents

The definition provided in Article 1, A (2), of the Geneva Convention as well as in its 1967 Protocol states that a refugee is a person who has a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it".

In order to guide interpretation and application of Article 1, A (2) of the 1951 Convention and the 1967 Protocol, the Office of the United Nations High Commissioner for Refugees (UNHCR) has issued over the years a series of guideline documents and guidance notes on different aspects of international protection, and these are key tools for governments, legal professionals, decision-makers and the judiciary.

Of particular relevance to the granting of international protection to victims of FGM and forced marriages are the following documents:

- Guidelines on International Protection No. 1: Gender-Related Persecution within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees (May 2002).
- Guidelines No. 2: "Membership of a Particular Social Group' within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees (May 2002).
- Guidelines No. 9: Claims to Refugee Status based on Sexual Orientation and/or Gender Identity within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of. Refugees (October 2012).
- Guidance Note on refugee claims relating to female genital mutilation (May 2009).

The United Nations High Commissioner for Refugees (UNHCR) defines "gender-related persecution" as any form of persecution in which gender is a key consideration in determining refugee status. It can be caused by laws, policies and state activities that discriminate against women and violate their human rights, but also by actions of non-state subjects which the state is unable to prevent or effectively prohibit[5].

Women who often face persecution related to their sex or gender, may also represent a "particular social group" for the purposes of obtaining refugee status. "A particular social group" is defined by UNHCR as "a group of persons who share a common characteristic other than their risk of being persecuted, or who are perceived as a group by society. The characteristic will often be one which is innate, unchangeable, or which is otherwise fundamental to identity, conscience or the exercise of one's human rights. […] This definition includes characteristics which are historical and therefore cannot be changed, and those which, though it is possible to change them, ought not to be required to be changed because they are so closely linked to the identity of the person or are an expression of fundamental human rights. It follows that sex can properly be within the ambit of the social group

[5]Guidelines on International Protection No. 1: *Gender-Related Persecution within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees* (May 2002).

category, with women being a clear example of a social subset defined by innate and immutable characteristics, and who are frequently treated differently to men."[6]

Specifically concerning FGM, UNHCR has declared 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 Refugees. Under certain circumstances, a parent could also establish a well-founded fear of persecution, within the scope of the 1951 Convention refugee definition, in connection with the exposure of his or her child to the risk of FGM"[7].

Finally, the guidelines on sexual orientation and gender identity refer to forced marriage as a violation of the UN Convention on the Elimination of All Forms of Discrimination against Women (1979), which in Art.16 calls on the signatory States to ensure that men and women enjoy "the same right to freely choose a spouse and to enter into marriage only with their free and full consent".

The Qualification Directive

In the context of European asylum legislation, the Qualification Directive[8] establishes that women with the well-founded fear of being persecuted or at the risk of being subjected to FGM are eligible for international protection. This rule also protects parents who fear being persecuted or run a real risk of suffering serious harm because they refuse to allow their daughter to undergo FGM.

The recast Qualification Directive[9] offers greater protection to those who fear being subjected to FGM, explicitly recognizing that aspects related to the sex of the applicant must be taken into consideration to the extent that they are related to the person's well-founded fear of persecution. The directive specifies that the sex of the applicant is linked to characteristics such as gender identity and sexual orientation, which may be implicated in certain customs and legal traditions involving for example genital mutilation.

Article 7 (concerning "acts of persecution") of Italian Decree n. 251 of 19 November 2007, which implements Directive 2004/83/EC (amended pursuant to Legislative Decree n. 18 of 21 February 2014, which implements Directive 2011/95/EU) states that refugee status may be granted to persons who can prove that they have been (or have the well-founded fear of being) victims of acts of violence, whether physical, mental, or sexual (subparagraph 2(a)) or acts specifically targeted at a given gender or at children (subparagraph 2(f)).

Article 8 of the same decree specifies what is meant by persecution due to membership of "a particular social group", defined as a group whose "members share an innate characteristic or a common history that cannot be changed, or share a characteristic or a faith system that is so fundamental to identity or conscience that a person should not be forced to give it up", that is to say, a group that has a "distinct identity in the country of origin, because it is perceived as being different from the rest of society". This article also specifies that "for the purposes of establishing

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[6]Guidelines on International Protection No. 2: *"Membership of a Particular Social Group' within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the status of refugees* (May 2002).

[7]*Guidance Note on refugee claims relating to female genital mutilation* (May 2009).

[8] Directive 2004/83/EC on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted.

[9]Directive 2011/95/EU on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted.

membership of a particular social group or identifying the characteristics of this group, due account shall be taken of gender-related factors, including gender identity".

See also the Reception Conditions Directive 2013/33/EU and Asylum Procedures Directive 2013/32/EU, which contain specific provisions for meeting the special needs of vulnerable female asylum seekers, whether women or children. These provisions apply to those who have undergone or are at risk of undergoing FGM and forced marriages.

Indications for referral

Identifying the victims of FGM or forced marriages is essential to ensuring that they can access their rights and may be referred to the relevant specialized services. This means that the victims will receive appropriate assistance, be fully informed about their future options, and be put in touch with one or more organizations that can provide them with the support they need going forward.

For girls and young women who are identified as victims of gender-related persecution, including forced marriages, the main local resources are anti-violence centres, and the services provided by local networks of anti-violence centres. In order to obtain a first response to their needs, useful information, and direction to the nearest anti-violence centres and both public and private social and healthcare services, women may call the national freephone number 1522[10].

Women victims of FGM, who have been identified based on the criteria outlined above, should be referred - in accordance with the level of urgency reported by the doctors at the reception centre - to specialized public health facilities with the necessary expertise to provide them with ongoing care.

These healthcare facilities can recruit the support of associations and other local institutions with competence and experience in the field of services for migrants, and especially in intervention with female victims of gender-based violence and in the implementation of protection programs for victims of trafficking.

Italian Law 7 of 9 January 2006 laying down "provisions concerning the prevention and prohibition of female genital mutilation practices"[11] called for an inventory to be made of all the services offered at the regional level to women and girls who have been subjected to FGM. The following list, while not exhaustive, presents a selection of the hospitals and healthcare facilities currently providing specialized medical and psychological support, and a range of associations offering social support, linguistic-cultural mediation, and referral to specialized healthcare institutions[12].

Abruzzo

Associazione Focolare Maria Regina onlus, Piazza Don Silvio De Annuntiis, Scerne di Pineto (TE), tel. 085 9461127, focolare@ibambini.it, www.mgfabruzzo.it

Basilicata

Associazione Tolbà (doctors who provide voluntary assistance to foreign workers), Recinto I D'Addozio 1, Matera, tel. 083 5333522, http://www.associazionetolba.org

Emilia Romagna

Bologna Health Board (USL), Obstetrics and Gynaecology Unit at the Ospedale Maggiore – Counselling service specializing in deinfibulation

[10] The multilingual helpline service contactable at the telephone number 1522 is active 24 hours a day, 365 days a year, providing victims with an immediate first response and contributing to larger numbers of women asking for help by guaranteeing complete anonymity. Operators provide victims with psychological and legal support, as well as recommending local public and private healthcare institutions for them to contact.

[11] http://www.salute.gov.it/imgs/C_17_pubblicazioni_769_allegato.pdf

[12] This list has been drawn from http://www.aidos.it/wp-content/uploads/2017/02/COUNTRY-INFO-PAGES_ITALY_ITALIAN-FINAL.pdf

Bologna Health Board (USL). Medical clinic for foreign women and their children, Via Antonio Zanolini 2, Bologna

Modena Health Board (USL) has trained female practitioners in reception, support and the prevention of FGM at the following clinics:

Centre for Families and Migrant Women, via Don G. Minzoni 121, Modena.

Centre for Families and Youth, Viale Molza 3, Modena.

Friuli Venezia Giulia

IRCCS Burlo Garofolo (maternity and paediatric hospital), Trieste, via dell'Istria 65, tel. 040 378 5111

Lazio

Regional centre for healthcare and surgical treatment of medical complications arising from FGM. Department of Women's and Children's Health, Ospedale San Camillo - Forlanini Circonvallazione Gianicolense 87, Roma, tel. 06 58704617/4641/3677, gscassellati@scamilloforlanini.rm.it

INMP – National Institute for Health, Migration and Poverty, Via di S. Gallicano 25, Roma, tel. 06 5855 8505

Lombardy

Ospedale San Paolo (hospital), via di Rudinì 8, Milano - Blocco D, Piano 2, Stanza 15 bis Opening hours: Tuesday 9.00/12.00; Thursday 13.30/17.00; Friday 9.00/12.30.

Ospedale San Carlo Borromeo (hospital), via Pio II 3, Milano – Piano 3, Settore B.

Crinali Cooperativa Sociale Onlus (social cooperative), Corso di Porta Nuova 32 – 20121 Milano, tel. 02 62690932

Cooperativa Sociale KANTA RA (social cooperative), Via Angera 3, Milano, tel. 02 67075398 kantara@tiscalinet.it,

Piedmont

Ospedale Sant'Anna (hospital), Corso Spezia 60, Turin. Direct-access service at Centro S VS (sexual violence centre) or by appointment, 011 3131869

Two dedicated FGM clinics: Lungo Dora Savona 24, Turin, Dr. Mira D'Ercole, tel. 011 2403681; via Maddalene 35A, Turin, Dr. Mortara, tel. 011 284738

Sicily

INMPS Sicilia, c/o Ospedale Civico–Benefratelli (hospital). Gynaecology, Obstetrics, and FGM Clinic. Service provided by the ARNAS Obstetrics and Gynaecology Unit. P.zza Nicola Leotta, 4, Palermo.

ANLAIDS, Largo Giuliana 2, Palermo

CEF PAS, Centre for the Continuing Professional Development of Medical and Healthcare

Personnel, Via G. Mulè 1, Caltanissetta, www.cefpas.it

Tuscany

Regional Centre for the Prevention and Treatment of Medical Complications arising from FGM at the Department of Mothers' and Childrens' Health (DAI), Careggi, Largo Brambilla 3, Firenze.

NOSOTRAS Onlus, via Faenza 103, Firenze, mgf@nosotras.it

Umbria

Regional Centre for the Study and Prevention of FGM, c/o Angelo Celli Foundation, strada Ponte d'Oddi, 13 Perugia.