Support Services for survivors of female genital mutilation in Europe

END FGM EU POSITION PAPER

01 Introduction and background

End FGM European Network recognises the importance of the provision of support services for Survivors of female genital mutilation (FGM). It has been estimated by the European Union (EU) that around 600.000 women and girls are living with the lifelong physical and psychological consequences of FGM in Europe [1]. Moreover, United Nations High Commissioner for Refugees (UNHCR) estimates that every year approximately 20.000 female asylum seekers coming to Europe might be affected by FGM [2].

Over the past years, the focus of the EU and national governments on efforts to end FGM has been mostly on prevention and prosecution of FGM. Support services and care for girls and women who are living with the consequences of the practice often does not get the attention it deserves. Under the Victims' Rights Directive (VRD) and the Istanbul Convention (IC), Survivors of FGM have a right to access expert care, support and treatment. However, the level of support varies from country to country and there is considerable discrepancy between the existing support and health care services and Member States' obligations regarding availability, accessibility and quality.

In this position paper, we focus on the provision of support services aiming to provide health care, including counselling or access to health care, available to women and girls who are Survivors of FGM.

This position paper was developed by End FGM EU, in cooperation with the members who are part of the Network's Holistic Support Services Working Group [3], and thanks to the support of Middelburg Human Rights Law Consultancy. To assess the availability, accessibility and quality of health care and support services for Survivors of FGM, we jointly created a list of definitions and a questionnaire to be conducted among members of the Working Group covering the situation in Belgium, France, Germany, Portugal and Spain. Interviews were carried out by the Middelburg Human Rights Law Consultancy with End FGM EU members and looked at available primary healthcare, immediate medical care, gynaecological support, care during pregnancy/delivery/post-partum, deinfibulation, reconstructive surgery, psychological counselling, sexual healthcare, telephone helplines and multidisciplinary centres in the 5 countries. We used the answers from the interviews to extract the most relevant themes and promising practices to make recommendations on how Member States may better conform to their obligations in the Victims' Rights Directive and the Istanbul Convention and provide a more adequate support to FGM Survivors.

[1] European Parliament Resolution on an EU strategy to put an end to Female Genital Mutilation around the world (2019/2988(RSP)), 12 February 2020, available at https://www.europarl.europa.eu/doceo/document/TA-9-2020-0031_EN.html

[2] United Nations High Commissioner for Refugees, Too Much Pain: Female Genital Mutilation & Asylum in the European Union – A Statistical Overview, UNHCR, February 2013, available at https://www.unhcr.org/531880249.pdf [Last Accessed 25 January 2021].

[3] GAMS Belgique (Belgium), Excision, Parlons-en! (France), Terre des Femmes (Germany), Associação para o Planeamento da Família - APF (Portugal), Unión de Asociaciones Familiares - UNAF (Spain).

02 European standards: What **support services** should be available in Europe?

As victims of crime, Survivors of FGM are in principle covered by the VRD and are entitled to have access to support services prescribed by the VRD. For Survivors of FGM the most relevant provision in the VRD is art. 9(3)(b). It entitles Survivors of gender-based violence (GBV), including Survivors of FGM, to a targeted and integrated support, including trauma care and counselling. When we take a look at the IC, FGM is specifically mentioned in art. 38 IC, which means Survivors of FGM are specifically covered as victims by the provisions on support in the IC.

On the basis of art. 20 (2) IC, parties have an obligation to ensure that Survivors of FGM have access to healthcare and that these services are adequately resourced and professionals are trained to assist Survivors and refer them to the appropriate services. On the basis of art. 22 (1) IC parties must ensure that there are, in an adequate geographical distribution, immediate, short- and long-term specialist support services for Survivors of FGM. Specialist support services must be able to provide short and long-term psychological counselling and trauma care, and be able to refer Survivors to the correct type of service [4].

Art. 24 IC obligates parties to set-up state-wide round-the-clock (24/7) telephone helplines free of charge to provide advice to callers, confidentially or with due regard for their anonymity, in relation to all forms of violence. Therefor these helplines must also be available for Survivors of FGM, whether or not those helplines are specifically set-up for that purpose or for a broader scope of acts of GBV. The helplines must be manned by trained persons providing information and support, and where necessary be available in several relevant languages to ease the language barrier [5]. Art. 18(3) IC states that parties must ensure that support services must be available to vulnerable persons and address their specific needs, such as children, persons living in rural/remote areas, persons of national/ethnic minority background, and migrants, including undocumented migrants and refugees [6].

"Specialist support services must be able to provide short and long-term psychological counselling and trauma care."

[4] Explanatory report to the Istanbul Convention, p. 24, Par. 132
[5] Explanatory report to the Istanbul Convention, p. 25, Par. 137
[6] Explanatory report to the Istanbul Convention, p. 16,17, Par. 87

03 Challenges identified in relation to support services offered to FGM survivors

In all five EU countries where the members of the Working Group are based, several issues and challenges have emerged in relation to support services currently offered to FGM Survivors. An overview of these challenges and issues is provided below.

Lack of awareness around FGM among health professionals

In general, many health professionals are not aware of FGM and are not properly trained to treat women and girls living with FGM. Even though there are protocols and guidelines on (medical and clinical) support for survivors of FGM, only a few professionals are aware of these. In reality, this results in the situation where it depends on a few professionals who have a personal interest in the matter, if a survivor of FGM will receive the care and support she needs. This problem was most pronounced regarding General Practitioners (GPs), which is a very worrying and a significant obstacle since GPs are often the first contact women and girls have to access support and care.

Specialised health professionals are in general more aware and better trained compared to GPs, however, not necessarily on a large scale. Gynaecologists, urologists and midwifes are usually more aware of FGM through their specific field of work compared to other health professionals, e.g. psychologist, whose expertise is not related to the female genitalia. However, FGM is usually not incorporated in the curricula of specialised health professionals.

In France, FGM is briefly mentioned in the curricula for gynaecologists, but this does not suffice. Not all universities have incorporated this curriculum yet, and older gynaecologists will generally not be aware of it. In Belgium, there are agreements with universities to include FGM and GBV in the curricula for nurses, midwifes, doctors and psychologists [7]: but this has not yet been implemented. In Germany, FGM is only included in the curricula for midwifes, but only since 2020. In Spain and Portugal, we did not have any reports of FGM being included in curricula.

The lack of awareness and training among most health professionals severely limits the accessibility and availability of health care, e.g. if a GP is not aware of FGM, he cannot recognise signs and symptoms and refer a patient to a specialised medical professional.

Lack of (cultural) sensitivity among health professionals

A lack of cultural sensitivity among health professionals and a general lack/shortage of interpreters or cultural mediators is also a recurring issue. In Portugal, some women have reported that the most traumatic day of their life was how the doctor reacted when they had a medical examination and the doctor noticed that she underwent FGM. From Belgium, we have received reports that health professionals are sometimes too eager with proscribing treatments, such as deinfibulation, scaring away women who are opening up about FGM for the first time in their life.

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In addition, it is important that interpreters or cultural mediators are available, currently this is not the case in any of the countries – apart from some exceptional situations at a very small scale and mostly facilitated by NGOs. For instance, in Belgium, a girl who did not understand her doctor correctly was deinfibulated without her informed consent, which was an incredibly traumatising experience for her, she felt like she had been raped. Barriers such as these dramatically limit the accessibility of care and support specifically for persons from different ethnic/national backgrounds and for migrants. Another unfortunately still too common barrier to access healthcare for Survivors of FGM is discriminatory, xenophobic and racist behaviour by professionals. This issue must be systematically addressed particularly through training and close cooperation of professionals with community members and cultural mediators.

[7] This is only for the French speaking community of Belgium (ARES Academy of Research and Superior Education), see https://www.ares-ac.be/fr/actualites/732-violences-faites-aux-femmes-resultats-du-processus-participatif-visant-a-l-integration-de-contenus-sur-les-violences-faites-aux-femmes-dans-l-enseignement-superieur

Lack of information for FGM survivors

The lack of information on support services and possible healthcare for Survivors of FGM is tied to the lack of awareness among health professionals. The distribution of leaflets and flyers is also dependent on whether professionals are interested in the matter. The information is there, but women will need to go and look for it themselves specifically and may not find it. For example, many Belgian women have gone to France to receive clitoral reconstructive surgery, while there are two centres in Belgium offering the surgery as well [8]. Moreover, linguistically, the information is usually only available in official national languages, which is a problem for the accessibility of the information because not all Survivors of FGM are so advanced in official languages as to read specialist medical advice and information.

Reconstructive surgery not available, fully covered or adequately accessible

Clitoral reconstructive surgery is offered in Belgium, France, Germany and Spain, but not in Portugal. However, there is a group of doctors in Portugal who are willing to get trained to perform the surgery, but due to COVID-19 this has not happened yet. In Spain, reconstructive surgery is offered in Barcelona, Valencia and Murcia, however not always free of charge and is offered without a comprehensive care for Survivors. In Germany, the surgery is available in Aachen and Berlin and at both hospitals it is fully covered by national health insurance. In countries the size of Germany and Spain, it is arguable that the service is not adequately geographically accessible.

"In France, there are multidisciplinary FGM units in certain public hospitals, but while covered by insurance, many of these units are underfunded and are run voluntarily by professionals who take an interest."

Only in Belgium and France, clitoral reconstructive surgery is offered in a multidisciplinary setting. In Belgium there are two centres employing a midwife, psychologist, sexologist and surgeon. Treatment at both centres is fully covered by insurance and patients/clients do not have to be solely interested in the surgery, they may also apply just for psychological care or make an appointment with the sexologist. In France, there are multidisciplinary FGM units in certain public hospitals, but while covered by insurance, many of these units are underfunded and are run voluntarily by professionals who take an interest [9]. Which is a recurring theme.

[8]GAMS, INTACT & End FGM EU, Shadow Report Belgium,
[9]GREVIO GREVIO Baseline Evaluation Report France p. 42, par. 143

Helplines do not meet the requirements

As it can be read in the definitions, this concerns helplines that offer counselling and (medical) advice to Survivors of FGM; helplines which for example offer legal advice or any services not related to health care and mental support were not included. In all five countries this service is either provided by NGOs or there are helplines available for Survivors of FGM [10], however only the German helpline 'Hilfetelefon Gewalt gegen Frauen' and the helpline 119 in France targeted at minors meet the requirements stated by the IC. Nevertheless, only the French helpline is also widely advertised. In relation to the accessibility of the helpline, the 119 helpline is only available in French, while the 'Hilfetelefon' is also available in some other 'relevant' languages.

Lack of funding for activities around support services

NGOs are often taking the responsibility for training professionals, increasing awareness among Survivors and are sometimes offering services. Although this is not contrary to the provisions of the VRD or the IC, NGOs often lack appropriate funding to offer these services, share information, increase awareness, and train professionals to the best of their ability. The same applies to public hospitals, for example the underfunded FGM units in French hospitals. While it is true that both the VRD and the IC affirm that States may ensure specialist support being offered through NGOs, it is also noted that states must then properly fund NGOs to take on this responsibility.

A common issue in all concerned countries relating to psychological and trauma care is that there are long waiting lists, or the service is simply not available for Survivors of FGM.

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Moreover, NGOs and other institutions focussed on FGM do not have the funds to employ in-house psychologists or psychiatrists (and in general, mental health care is underfunded). [11] For example, in Spain local authorities are focussed on funding institutions targeted at domestic violence, "much-needed counselling and long-term psychological support and trauma care are thus unavailable for many of the forms of violence covered by the Istanbul Convention". [12] An additional problem is that in many countries psychological care is not covered by national health insurance. In Belgium for example, psychological counselling outside of public hospitals is not covered and can thus be very expensive, while support services for Survivors of violence should be available free of charge.

[10] However, it has to be noted that specifically in the case of FGM, affected women and girls do not seem to use much anonymous helplines and rather prefer to have a trusted person to whom they can talk to in case needed.
[11] Part of a larger systematic problem that does not only affect Survivors of FGM, waiting lists and waiting periods for almost all types of mental health care are very long
[12]GREVIO Baseline Evaluation Report Spain, p. 43-44, par. 156

Inaccessibility for all migrants, particularly undocumented

In France support services for migrants are covered by public funds, while in Portugal this is only true for sexual and reproductive health and rights. In Spain migrants have access to health care after three months of legally residing on Spanish territory.

In Spain, Germany and Belgium, undocumented migrants have in principle the right to basic medical care, but exercising this right is made more difficult by the risk of discovery by the immigration authorities and deportation, even if passing on data to the police or immigration authorities violates medical confidentiality. This is why many undocumented migrants are afraid to go to the doctor and prefer to turn to NGOs providing services, as they fear that their irregular status would otherwise be discovered. There are some initiatives that provide health advice and referral services for undocumented migrants, but the barrier to actively seeking help there is high.

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Lack of services for children and youth

In general, support services seem not to be available on a broad spectrum for children and youths, it seems only some paediatricians and health professionals specialised in youth are also aware of FGM, specifically Portugal and Spain reported this. Whether the service is available often depends on a personal professional network of referral. For example, in Belgium, gynaecologists who are aware of FGM and know a gynaecologist who is also aware of FGM and specialised in children, refer children to those specialised gynaecologists.

04 PROMISING PRACTICES

Several promising practices have also been highlighted in the five EU countries in relation to support services offered to FGM survivors.

1 MULTIDISCIPLINARY (HEALTH OR REFERRAL) CENTRES

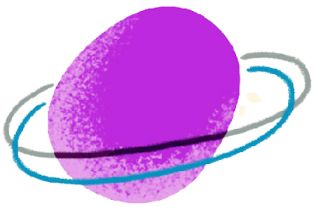
Multidisciplinary Health Centres are considered a particularly promising practice. FGM is a very specific form of violence which can have physical, psychological and sexual consequences during her lifetime. A multidisciplinary centre has the ability to focus on all these dimensions when providing care to FGM survivors by employing midwifes, psychologists, sexologists, gynaecologists/surgeons and social workers being able to offer tailor-made and survivor-centred care. Professionals working together while focussing on the same patient guarantee a targeted, integrated and holistic approach.

This type of care is best provided in Belgium, by i.a. Cemavie in St. Pierre's hospital in Brussels where a dedicated permanent team provides holistic care. We see that in France, while multidisciplinary care is available, more and more private clinics are offering the surgery but without a multidisciplinary approach, and we feel this may be a concerning development. Reconstructive surgery can be beneficial and efficient, but is not always necessary or the most appropriate type of care. Screening by a multidisciplinary team can prevent a woman from receiving surgery when treatment by a psychologists and sexologist would be a much better fit for a specific woman: a multidisciplinary centre would better guarantee this. Therefore, to better comply with art. 9(3)(b) VRD, art. 20(2) IC, and 22(1) IC, we recommend that authorities make funds available for multidisciplinary centres and units in public hospitals in relevant and strategic parts of the country, for sufficient geographical accessibility, employing as a minimum a psychologist, sexologist and a specialised gynaecologist.

Currently, Multidisciplinary Referral Centres are even less common, but they are a promising practice because these centres are efficient ways of concentrating knowledge, e.g. about specialised professionals, and resources, e.g. employing interpreters, while also being able to reach a wider scope of women, also specifically more vulnerable women, than e.g. a GP could.

In Portugal (Lisbon), the Office for Assistance to Victims of Domestic Violence and/or Harmful Traditional Practices, is incorporated inside a bigger service centre for migrants. The centre offers information and support, and functions as a professional referral mechanism helping women find the care and support they need, for example, psychological support, or a specialised gynaecologist. Moreover, multidisciplinary centres in France targeting all forms of gender-based violence and the interconnections between them, including FGM, such as Maison des Femmes de Saint Denis (Paris) or les Orchidées Rouges (Bordeaux), are also a good practice. These type of referral centres are more efficient at guaranteeing both emotional support and correct referral to the appropriate type of care needed, and are better qualified to provide these services, as prescribed by the IC. Therefore, to guarantee support and referral by trained professionals and to better comply with art. 20(2) IC, **we recommend that authorities also make funds available to set up multidisciplinary referral centres, if possible within structures addressing relevant overarching issues to be able to reach women and girls living with FGM.**

2 Awareness campaigns and training for currently practicing professionals



In all five Member States there are NGOs and other institutions who provide training and spread awareness of and information on FGM to relevant health professionals such as GPs and gynaecologists. This is a good practice, however it is not sufficient. Awareness and knowledge of FGM is lacking among most health professionals with only an isolated few being invested out of their own volition and interest. This makes a woman or girl living with FGM dependent on whether or not a professional has taken a personal interest in FGM for her to find the support and care she needs. Moreover, non-discrimination, cultural sensitivity and anti-racism must be at the core of any support provided to FGM survivors to truly ensure its adequacy and accessibility. To guarantee access to health care by trained professionals and to better comply with art. 20(2) IC, **we recommend authorities to collaborate with NGOs and other relevant institutions to create a systematic and compulsory training on FGM, sexual health, gender and cultural sensitivity, as well as non-discrimination for relevant health professionals and to make funds available to set up larger scale awareness campaigns for professionals, to guarantee that survivors of FGM have access to health care by trained professionals who can treat them with respect and discretion. Furthermore, we recommend that in these trainings special attention is given to support and care for minors and youth, and that paediatricians receive this training as well.**

3 FGM integrated in university curricula of professionals

In the French-speaking part of Belgium there are agreements with universities to include FGM in the curriculum for nurses, midwifes, doctors, psychologists and for a post-graduate diploma on GBV, including FGM. To us, this would be the most effective way of tackling the lack of awareness and knowledge for future generations of professionals. In Spain and Portugal no such developments have taken place, but in Portugal there is a non-mandatory 'postgraduate' on sexual and reproductive health and FGM available. The postgraduate is followed by about 30 different health and medical professionals per year. While in France and Germany steps have been made towards the inclusion of FGM in curricula, those steps do not seem sufficient; In France it varies from university to university whether FGM is mentioned and in Germany FGM is only included in curricula for midwifes. To better comply with art. 20(2) and 22(1), **we recommend authorities to promote the inclusion of gender sensitisation, scientifically based knowledge [13] around gender power structures, GBV, including FGM, and multicultural literacy in a systematic and compulsory way in the curriculum of relevant courses at universities and other educational institutions. These should be addressed to professional groups in the fields of health, social work, education, youth-welfare, asylum, media, etc.**

4 Community health workers, interpreters and cultural mediators

Linguistic and cultural differences form a significant barrier for many women and girls living with FGM to access health care or get the correct type of health care in all 5 countries. Sometimes NGOs work with trained interpreters, cultural mediators, or community health workers to accompany women to appointments with health professionals, but not on a large enough scale. Community health workers in general are a promising practice that we witness globally [14]. They are members of the community who are appointed to form a bridge between the community and relevant institutions, and assist members of the community in accessing health care: they know which problems there are in the community and how health services can help. Furthermore, community health workers can be key in providing information on health care to the survivor which at the moment is considerably lacking.

[13] Such as the Value-Centred Approach (VCA), see here.
[14] World Health Organization, Community-Based Health Workers: WHO Guidelines on health policy and system support to optimize community based health worker programmes, WHO, available at https://www.who.int/hrh/community/en/ [Last Accessed 26 January 2021].

In Portugal the 'health centres' which are closer to the communities than the public hospital to some degree take on this role, however specific knowledge of FGM is lacking among the professionals working in these health centres. To make health care more accessible and to better comply with art. 18(3) IC and art. 20(2) IC, **we recommend authorities to collaborate with NGOs and other relevant institutions to set up programs for training and introducing community health workers as an officially recognised part of the national health system, and make more funds available for either NGOs or health care institutions to employ interpreters and cultural mediators, so that these may be more readily available to assist women and girls who are survivors of FGM in overcoming the linguistic and cultural barriers they experience in accessing health care.**

5 Telephone helplines and (online) counselling

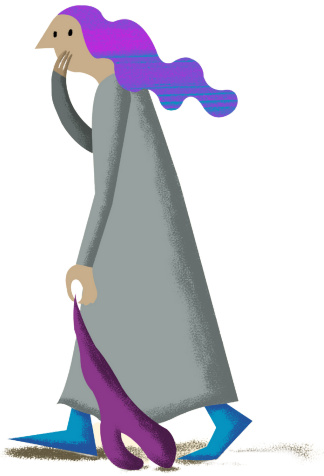
The IC requires 24/7 telephone helplines and States parties are obliged to facilitate them. The explanatory report makes clear that the helplines must be available state-wide, round the clock, free of charge, widely advertised, and available in several (relevant) languages where necessary [15]. The helplines must provide their services confidentially or anonymously, with trained personnel giving counselling, information and support. To comply with art. 24 IC, **we recommend authorities to make funds available to set-up such helplines for the broader issue of Gender-Based Violence and Violence against Women, explicitly clarifying this includes FGM and other harmful traditional practices, and that funds are made available for a state-wide advertisement campaign.**

In France, not a telephone helpline, but a chat for support has been set up targeting specifically the youth, called 'Comment on s'aime'. The chat is run by the NGO En avant toutes! and currently available only in French. The chat is meant to provide counselling and information, or just a virtual 'listening ear' for younger women and girls who are confronted with any form of violence from either a partner or family member. It was reported to us that FGM is also covered. Although still on a small scale, we have been told that the chat is working well, most likely because the younger demographic is more used to textual communication: it lowers the barrier to start the conversation. A significant benefit of the chat, compared to a phone line, is that it is discrete, it is not necessary to speak, making it easier for girls still living at home to seek help and support, guaranteeing that needs of vulnerable persons such as children are more adequately met.

[15] Explanatory Report to the Istanbul Convention, p. 25, par. 137

In Belgium, the NGO GAMS has also set-up a chat during the COVID-19 pandemic, with community representatives to chat in their mother tongue with affected women and girls at specific times in the week. Following this promising practice, **we recommend authorities test it on a larger scale and enable relevant actors, particularly NGOs, to provide for such chat functions in addition to the helplines and direct support to survivors they already offer, and that funds are made available for a state-wide advertisement campaign for such services.**

THE HELPLINES MUST PROVIDE THEIR SERVICES CONFIDENTIALLY OR ANONYMOUSLY, WITH TRAINED PERSONNEL GIVING COUNSELLING, INFORMATION AND SUPPORT.



6 ACCESSIBILITY FOR MIGRANTS

In France, and to a more limited extent in Spain and Portugal, migrants have (universal) access to health care through public funds which is a very good practice. In Belgium, Spain and Germany, there are still considerable barriers for undocumented migrants to access healthcare. Victims of the forms of violence covered by the Istanbul Convention have a right to support and healthcare to recover from that violence, regardless of their nationality, status or residence permit. Art. 18(3) IC explicitly specifies that the needs of vulnerable persons must be addressed. To better comply with art. 18(3) IC and 20(2) IC, we recommend authorities to ensure universal health coverage for migrants regardless of status. Until this is achieved, we urge governments to set up alternative forms of public funds to help all migrants living with FGM to access the necessary support and health care services.

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05 End FGM EU position statement

End FGM EU affirms its commitment to ensure that adequate holistic support services for FGM survivors are available and accessible in Europe, and that all European countries provide services that are in compliance with European standards.

In order to do so, End FGM EU assessed the availability, accessibility and quality of health care and support services for survivors of FGM in 5 European countries, as well as the existing challenges, trends and potential gaps of the current service provision in light of the obligations enshrined in the Istanbul Convention and the Victims' Rights Directive.

End FGM EU identified the following promising practices which need to be taken into consideration for an adequate health care service provision to FGM survivors in Europe:

- Multidisciplinary centres
- Community health workers, interpreters and cultural mediators
- Telephone helplines and (online) counseling
- Relevant university curricula integrating the subject of FGM, GBV & gender sensitisation
- Universal health coverage and healthcare accessibility for all migrants
- Awareness campaigns & training for relevant professionals

06 RECOMMENDATIONS

END FGM EU RECOMMENDS TO THE *EUROPEAN UNION* TO:

Ensure that its Member States have adequately transposed the **Victims' Rights Directive** and comply with obligations enshrined in it, particularly in terms of support services for survivors of FGM.

Support transnational programmes and **mutual learning exchanges among Member States** to promote promising practices and ensure all survivors of FGM have access to adequate support services, regardless from where they live.

END FGM EU RECOMMENDS TO THE *COUNCIL OF EUROPE* TO:

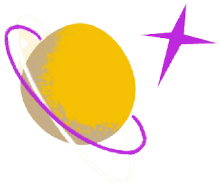
Ensure that its States Party are adequately implementing the **Istanbul Convention** and comply with obligations enshrined in it, particularly in terms of support services for survivors of FGM.

END FGM EU RECOMMENDS TO *EUROPEAN COUNTRIES* TO:

Ensure that reconstructive surgery is offered free of charge and is integrated within **multidisciplinary holistic care**.

Increase **funding** to offer all range of support services for FGM survivors, including provision of adequate information to them, and awareness and training activities for professionals.

Introduce **community health workers** as an officially recognised part of the national health system, and make more funds available for either NGOs or health care institutions to employ interpreters and cultural mediators



Make funds available for **helplines** around GBV as well as direct support provided by NGOs around this, explicitly clarifying this includes FGM and other harmful traditional practices, and for a state-wide advertisement campaign.

Ensure **universal health coverage** for all migrants regardless of status, and until then, set up alternative forms of public funds to help migrants living with FGM to access the necessary support and health care services.

Enable relevant actors to provide for **direct counselling to survivors**, including through chat functions, in addition to the required 24/7 helplines on GBV, and make more funds available for a state-wide advertisement campaign

Increase the funding for provision of long-term adequate psychosocial counselling and trauma care, to **prioritise the mental wellbeing** of FGM survivors.

Ensure that adequate and **accessible support services** are available for girls and young women survivors of FGM.

Promote the mandatory inclusion of GBV, including FGM, and multicultural literacy in the curriculum of **relevant courses** at universities and other educational institutions.

Create a **systematic and compulsory training** on FGM, sexual health, gender, non-discrimination and cultural sensitivity for relevant health professionals and to make funds available to set up larger scale awareness campaigns for professionals, with special attention to train professionals, including paediatricians, on support and care for minors and youth.

Invest in **outreach activities** towards FGM-affected communities and in adequate information campaigns and material around available support services for FGM survivors, that are linguistically and culturally accessible, gender- and age-sensitive and non-discriminatory.

Make funds available for **multidisciplinary centres** and units in public hospitals as well as **community-based initiatives** providing support services for survivors in relevant and strategic parts of the country, for sufficient geographical accessibility, employing as a minimum a psychologist, sexologist, a specialised gynaecologist, as well as a social worker(s) and cultural/community mediator(s).

ANNEX 1 - DEFINITIONS

PRIMARY HEALTH CARE

Refers to the medical care offered by General Practitioners (GPs) or family doctors such as health checks, managing symptoms as pain, and referral to the correct type of care to further diagnose or treat complaints. Also encompasses general medical advice offered in walk in consultation hours of public health services.

"Adequate training" for GPs would entail technical knowledge about FGM, and what type of care is best suited for any complaints, and the ability to be age-sensitive, gender-sensitive, culturally sensitive and to treat patients with respect i.e. without stigmatisation or racist remarks.

IMMEDIATE MEDICAL SUPPORT

Refers to the care provided by hospitals in dealing with the immediate consequences and later possible severe complications of recently FGM such as open wounds, excessive blood loss, infections, shock, urinary or menstrual problems, etc.

"Adequate training" for providers of immediate medical support would entail primarily technical knowledge of FGM and technical medical knowledge in treating any consequences. Ideally they would also receive training in soft skills such as age, gender and culture-sensitivity and treating patients with respect without stigmatization or racist remarks.

GYNAECOLOGICAL AND UROGYNECOLOGICAL CARE

Refers to the services of gynaecologists, urogynecologists and urologists in diagnosing FGM and dealing with possible long-term complications of FGM such as vulvar pain, clitoral neuroma, reproductive tract infections, menstrual difficulties, urinary tract infections, painful or difficult urination, epidermal inclusion cysts and keloids in the genital area.

"Adequate training" for providers of gynaecological and urogynecological care would entail technical knowledge of FGM and technical medical knowledge in treating the long-term complications of FGM, as well as training in soft skills such as age, gender and culture-sensitivity and treating patients with respect, i.e. without stigmatisation or racist remarks.

Care during pregnancy, delivery and postpartum

Referring to the services of obstetricians, midwives and other health professionals specialised in female reproduction, dealing with complications of FGM regarding reproduction. During pregnancy FGM may cause complications such as reproductive tract infections, vulvar adhesions, urinary tract infections, vulvar abscesses, and epidermal inclusion cysts and keloids. There are increased obstetric risks as postpartum haemorrhage, episiotomy, prolonged or difficult labour, obstetric tears and lacerations, instrumental child birth, and extended maternal hospital stay. There are also increased risks to infants born to women who have undergone FGM as stillbirth and neonatal death, asphyxia and resuscitation of the infant at birth.

"Adequate training" for providers of care during pregnancy, delivery and postpartum would entail technical knowledge of FGM and technical medical knowledge in treating the complications which FGM may arise during pregnancy, delivery and postpartum, as well as training in soft skills such as age, gender and culture-sensitivity and treating patients with respect, i.e. without stigmatization or racist remarks.

Deinfibulation

Refers to the surgical procedure to undo infibulation by opening up the closed genital scar tissue of a woman or girl who has undergone FGM type III.

Clitoral Reconstructive Surgery

Refers to the surgical procedure to reveal the still existing part of the clitoris, partly/visually undoing the physical consequences of excision. Some surgeons propose to also include labial reconstruction at the same time of the clitoral reconstruction where necessary.

Psychological counselling

Refers to the services of counsellors, psychologists and psychiatrists. In the direct aftermath of crime, helping survivors process what happened to them, dealing with shock. On the long- and short-term treating survivors for mental health problems and mental health disorders, such as depressions and anxiety, caused by FGM. Any mental health issues will be influenced by a number of factors, that is why health care providers must take into account a survivor's background, beliefs and social context to find the best way to discuss FGM and help, advise and support the survivor i.e. a targeted and integrated approach.

This may also refer to such activities as group workshops or other communal activities which have a therapeutic effect and purpose.

TRAUMA SUPPORT

Refers to services of counsellor, psychologists and psychiatrists in helping women to process the trauma caused by FGM and treating them for PTSS where necessary.

"Adequate training" for counsellors, psychologists and psychiatrists would entail technical knowledge of FGM and technical knowledge of the connection between FGM and consequences for mental health and how to best treat those consequences, as well as training in soft skills such as age, gender and culture-sensitivity and treating patients with respect, i.e. without stigmatization or racist remarks.

SEXUAL HEALTH (MENTALLY AND PHYSICALLY)

Refers to services by sexologists and both physicians and counsellors/psychologists or combined dealing with both the mental and physical consequences of FGM on female sexuality. Treating the mental effects of FGM on women's sexual health such as feelings of inferiority, lack of understanding of their own sexuality and sexuality in general. Treating the physical complications of FGM on sexual health such as dyspareunia and pelvic pain. Addressing sexuality as a series of changes that take place in a woman's brain and body during sexual arousal and activity: an integration of biological and psychological factors. Reduced sexual satisfaction and sexual desire can both be results of FGM, but may be caused mentally, physically or by a combination of the mental and physical.

"Adequate training" for providers of sexual health services would entail technical knowledge of FGM and technical knowledge of the connection between FGM and consequences for sexuality, both mentally and physically, and how to best treat complaints, as well as training in soft skills such as age, gender and culture-sensitivity and treating patients with respect, i.e. without stigmatization or racist remarks.

TELEPHONE HOTLINES/HELPLINES

Offering support and advice, referring to the appropriate entities and services where survivors can receive further care and support.

Professionals must be trained to have technical knowledge of FGM, to have sensitive conversations about this subject, and to be aware of and sensitive to the circumstances FGM-affected women and girls may find themselves in.

Telephone Hotlines/helplines

Refers to centres employing/or with ready access to professionals from different fields and disciplines such as psychologists, gynaecologists, midwives, sexologists, surgeons, social workers and other professionals, possibly integrated in Hospitals or at least at the same premises, which can offer a so called 'holistic approach', to see which type of treatment would best suit the recovery/wishes of an FGM-affected woman or girl.

Multidisciplinary Cooperative Networks

Refers to networks of professionals or institutions from different fields and disciplines who can refer patients to one another, discuss best treatment plans and access each other's knowledge.

Community Health Workers

Refers to members of a community appointed to address problems in (overlooked/harder to reach) communities and connect community members to the right type of care within the existing public health systems and assist them in accessing this care, and address gaps in the public health system.

Community health workers should receive a basic training in healthcare, primarily focussed on enabling them to provide information and to assist community in accessing support, e.g. by joining them in consultations.

Protocols or guidelines

Refers to any relevant protocol or guideline or relevant parts of protocols or guidelines on the support, i.e. the types of care mentioned in the definitions, for FGM-affected women and girls.

ANNEX 2 - QUESTIONNAIRE

QUESTION 1: PRIMARY HEALTH CARE

1. Are GPs adequately trained to recognise possible signs/symptoms of FGM, able to offer information on/refer to the correct type of care and support that is needed;
2. And, are they trained to treat FGM-affected women and girls in a culturally sensitive and respectful manner without judgment nor stigmatisation?
3. Are there consultation hours by public health services available for or specifically targeted at FGM-affected women and girls?
4. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
5. Is information widely accessible (including linguistically) on support for FGM-affected women and girls through GPs and consultation hours?

6. Is this care geographically accessible? (COVID-19, tele-medicine)
7. Is this service free of charge and fully covered by the basic health insurance?
8. Are there interpreters and cultural mediators available when accessing general medical care?
9. Is this service available for FGM-affected women and girls regardless of their citizenship, residence or migration status?

QUESTION 2: IMMEDIATE MEDICAL SUPPORT/CARE

1. Are providers of immediate medical care adequately trained to be able to offer care to FGM-affected women and girls who need immediate medical attention?
   a. E.g. is the topic of care for FGM-affected women and girls included in the curricula of professional education?
2. Are providers also adequately trained to offer care to children and youth who have undergone FGM and need immediate medical attention?
3. Is this type of care adequately geographically distributed?
4. Is this type of care free of charge covered by basic insurance?
5. Is this service available for FGM-affected women and girls regardless of their citizenship, residence or migration status?

Question 3: Gynaecological and Uro-gynaecological support/care

1. Are gynaecologists and urologists adequately trained to provide care to FGM-affected women and girls?
a. E.g. is the topic of care for FGM-affected women included in the curricula of professional education?
2. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
3. Is information widely accessible (including linguistically) on support for FGM-affected women and girls though gynaecological or uro-gynecological services, or are adequate referral systems in place?
4. Is gynaecological care geographically accessible for FGM-affected women and girls?
5. Is this service free of charge and fully covered by the basic health insurance?
6. Are there interpreters and cultural mediators available when accessing gynaecological care?
7. Is this service available for FGM-affected women and girls regardless of their citizenship, residence or migration status?
8. Are gynaecologists and urologists adequately trained to provide care to children and youth who have undergone FGM, or are specialised gynaecologists and urologists available?
a. E.g. is the topic of care for FGM-affected girls included in the curricula of professional education?
9. If so, are those specialised gynaecologists and urologists equally or at least adequately available and accessible?

Question 4: Care during pregnancy, delivery and postpartum?

1. Are obstetricians, postpartum and other professionals adequately trained to provide care to FGM-affected women during pregnancy, delivery and postpartum?
a. E.g. is the topic of care for FGM-affected women included in the curricula of professional education?
2. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
3. Is information widely accessible (including linguistically) on support and care for FGM-affected women during pregnancy, delivery and postpartum by obstetricians, postpartum and other professionals, or are adequate referral systems in place?
4. Is support and care for FGM-affected women during pregnancy, delivery and postpartum adequately geographically distributed?

5. Is this service free of charge and fully covered by the basic health insurance?
6. Are there interpreters and cultural mediators available when accessing care during pregnancy, delivery and postpartum?
7. Is this service available for FGM-affected women regardless of their citizenship, residence or migration status?

Question 5: Deinfibulation

1. Is Deinfibulation available in your country for women (and girls if medically necessary) affected by FGM type III?
2. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
3. Is information widely accessible (including linguistically) on deinfibulation for women and girls affected by FGM type III or are adequate referral systems in place?
4. Is long-term postoperative care available? Does this include psychological care?
5. What is the age of consent for the surgery: can minors affected by FGM type III who have started menstruating choose to undergo deinfibulation without consent of the parents?
6. Are services for deinfibulation adequately geographically accessible throughout the national territory?
7. Are services for deinfibulation free of charge and fully covered by the basic health insurance?
Are there interpreters and cultural mediators available when accessing services for deinfibulation?
8. Are FGM-affected women (and girls) eligible for deinfibulation regardless of their citizenship, residence or migration status?

Question 6: Reconstructive Surgery

1. Is Reconstructive Surgery available in your country for FGM-affected women?
2. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
3. Is information widely accessible (including linguistically) on reconstructive surgery for FGM-affected women or are adequate referral systems in place?
4. Is long-term postoperative care available? Does this include psychological care?
5. Is reconstructive surgery adequately geographically accessible throughout the national territory?
6.Is this service free of charge and fully covered by the basic health insurance?
7.Are there interpreters and cultural mediators available when accessing services for reconstructive surgery?
8. Are FGM-affected women and girls eligible for reconstructive surgery regardless of their citizenship, residence or migration status?

Question 7: Psychological counselling and trauma support

1. Are psychologists and psychiatrists adequately trained to provide care/treatment for FGM-affected women and girls or are specialist institutions providing such care available?
2. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
3. Is information widely accessible (including linguistically) on psychological counselling and trauma support for FGM-affected women and girls or are adequate referral systems in place?
4. Is (in general) a targeted and individual approach taken when offering psychological counselling and/or trauma support to FGM-affected women and girls?
a. E.g. are cultural, social and socio-economic circumstances taken into account or addressed when creating and applying a treatment plan?
i. Can you mention a specific example of when did this not happen and that had negative consequences for the treatment of the patient?
5. Does this type of support also include communal activities such as group workshops with a therapeutic effect and purpose?
a. Can you give examples of such initiatives?
6. Is psychological counselling and trauma support available to FGM-affected women and girls both on the short- and long term?
7. Is support for mental health problems caused by FGM equally available as support for mental health disorders caused by FGM?
a. E.g. how many sessions are reimbursed for mental health problems and have survivors indicated whether that number is insufficient?
8. Are psychological counselling and trauma support adequately geographically distributed? E.g. through the availability of tele-counselling or online sessions?
9.Is this service free of charge and fully covered by the basic health insurance?
10. Are there interpreters and cultural mediators available when accessing services for psychological counselling and trauma support?
11. Are FGM-affected women and girls eligible for psychological counselling and trauma support regardless of their citizenship, residence or migration status?

Question 8: Sexual Health (mentally and physically)

1. Is support from sexologists/psychologists and physicians available for FGM-affected women regarding their sexual health or are professionals in this fields adequately trained to provide care for the sexual health of FGM-affected women?

2. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
3. Is information widely accessible (including linguistically) on the support FGM-affected women can receive for their sexual health (mentally and physically) from sexologists/psychologists and physicians or are adequate referral systems in place?
4. Is (in general) a targeted and integrated approach taken when providing care for the sexual health of FGM-affected women?
a. E.g. are cultural, social and socio-economic circumstances taken into account or addressed when creating and applying a treatment plan?
i. Can you mention a specific example of when did this not happen which had negative consequences for the treatment of the patient?
b. Do sexologists/psychologists and physicians cooperate or consult with each other when offering care or do they work in isolation of each other?
i. Can you mention a specific example of when sexologists/psychologists and physicians worked in isolation of each other which had negative consequences for the treatment of the patient?
5. Is support for sexual health (mentally and physically) adequately geographically distributed? E.g. regarding mental sexual health through the availability of tele-counselling or online sessions?
6. Is this service free of charge and fully covered by the basic health insurance?
7. Are there interpreters and cultural mediators available when accessing services for sexual health (mentally and physically)?
8. Are FGM-affected women eligible for sexual health services regardless of their citizenship, residence or migration status?

Question 9: Telephone helplines/hotlines

1. Do telephone helplines on FGM, or GBV in general specifically mentioning FGM, exist?
2. Does the helpline offer counselling by trained professionals?
3. What kind of services or support does the helpline provide? E.g.:
a. General emotional support
b. Tele-counselling
c. Medical advise
d. Referral to correct entities
4. Is the helpline state-wide available, or a variation available in every region of the country?
5. Is the helpline available 24/7?
6. Is the helpline free of charge?
7. Is the helpline widely advertised, or is information widely and easily accessible?
8. Is the helpline available in languages, other than the official languages, which are necessary and relevant?
9. Are the services offered confidentially and/or is it possible for callers to remain anonymous?

Question 10: Multidisciplinary (reference) centres

1. Are there multidisciplinary centres specialised in FGM, or available for and i.a. targeted at FGM-affected women (and girls) in your country?
2. What services are offered at those multidisciplinary centres? For example, what kind of professionals to they employ/have access to? Psychologists, sexologists, psychiatrists, gynaecologists, midwives, surgeons, etc.
3. By which type of institution are these services offered? Public hospitals or other public services, NGOs, private practices?
4. Is information widely accessible (including linguistically) on multidisciplinary centres or are adequate referral systems in place?
5. Are multidisciplinary centres geographically accessible throughout the national territory? Or only at capital level? Please include reference to where this service is available and under which conditions; provide links if possible.
6. Do multidisciplinary centres also provide long-term care?
7. Is this service free of charge and fully covered by the basic health insurance?
8. Are there interpreters and cultural mediators available when accessing multidisciplinary centres?
9. Are those multidisciplinary centres adequately equipped/trained to also provide care for children and youth (where that would be appropriate) or are there multidisciplinary centres specialised in children and youth with FGM?

a. Is multidisciplinary care for children and youth affected by FGM equally available and accessible as general multidisciplinary care?

10. Are FGM-affected women and girls eligible for care by multidisciplinary centres regardless of their citizenship, residence or migration status?

Question 11: Multidisciplinary cooperative networks

1. In lieu of multidisciplinary centres, are there multidisciplinary cooperative networks specialised in FGM, or available for and i.a. targeted at FGM-affected women (and girls) active in your country?
2. What types of professionals or institutions are affiliated with those networks?
3. Does the level of cooperation within those networks actually amount to a multidisciplinary approach offering FGM-affected women and girls more tailored and targeted treatment?
4. Do those networks also provide care for children and youth or does a separate specialised network for children and youth exist?

Question 12: Community health workers

1. Are there Community health worker programmes or initiatives in your country?
2. Are these programmes run by public services or by NGOs/civil society?
3. What are the purposes/tasks of those community health workers?
4. Are community health workers sufficiently available?
5. Are community health workers adequately trained?
6. Do programmes, if not public, receive adequate funding?

Question 13: Protocols

1. Are there relevant protocols or guidelines in place on support for FGM-affected women and girls or is support included in any other relevant protocols or guidelines on FGM or GBV?
Are professionals for which these protocols or guidelines, or parts of, are in place aware of these protocols or guidelines, or parts of, and do they comply with their provisions?

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