FEMALE GENITAL MUTILATION IN THE REFUGEE CONTEXT

Challenges and Recommended Actions

PLAN INTERNATIONAL

Bringing hearts and minds together for children

ACKNOWLEDGEMENTS

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Tel.: + 49 (0) 40 / 611 40-0
Fax: + 49 (0) 40 / 611 40-140
Email: info@plan.de
www.plan.de
www.facebook.com/PlanDeutschland
www.twitter.com/PlanGermany

Person Responsible
Maike Röttger, CEO

Coordinated by
Dr. Gwladys Awo

Authors
Dr. Gwladys Awo, Ibrahim Gueye, Dr. Dan mon O´Dey,
Dr. med. Christoph Zerm

Co-Authors
May Evers, Birgit Hüsing, Mohamed Maiga, Jens Raygrotzki

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German Original Version reviewed and proofread by
Annette Winkel

Present English Translation by
Marianne Gropp

Design and Layout by
hausgemacht. – Hedda Christians

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PREFACE

Dear readers,

world-wide, more than 200 million girls and women are affected by Female Genital Mutilation (FGM). This practice, which involves the removal of a girl's or woman's external genitals, is a grave human rights violation. It is a cruel practice that causes physical and mental distress in girls and women affected by FGM – often for life – and at times bears fatal consequences.

Female genital mutilation/cutting is mainly practiced in African countries and the Middle East. However, with global migration, this tradition has now arrived in Europe.
In Germany alone, around 60,000 girls and women are affected by FGM/C (female genital mutilation/cutting) and another 15,000 are considered at risk. Nowadays, FGM/C is an urgent matter in Germany, which presents us with major challenges.
We therefore see ourselves as being responsible to apply our many years of global expertise in Germany as well.

Moreover, affected families in refugee institutions face major challenges: Many of them barely speak the new language, cannot find work or have no secure residence status. Many of them - men and women - tend to hold on to old traditions, because it helps them feel at home in Germany. It is therefore important for us to involve all parties participating in FGM/C in our work against this practice, to stop social pressure and build trust. Only careful treatment can help to break the silence and lead to the sustainable abandonment of this tradition.

We launched a project against female genital mutilation/circumcision in Hamburg, as early as 2013, together with particularly committed members of African communities, in order to train key figures as multipliers. These women and men are well integrated in their communities and share their knowledge of the serious consequences of FGM/C within their communities. They are particularly engaged and culturally sensitive and clarify the consequences of female genital circumcision and therefore contribute to sustainably changing attitudes in the communities.

In the meantime, we have also used our expertise in refugee accommodation, initially in the frame of a pilot project in Hamburg. We follow a twofold approach: First, we are committed to protecting girls against any form of circumcision. Second, we are committed to giving support to all women and girls affected by FGM/C, as they need medical help, educational guidance, psychological support and legal education. The present material and information brochure developed at Plan International Deutschland, "Female Genital Mutilation in the Context of Refugees – Challenges and Recommended Actions" helps in the implementation of interdisciplinary work and is a milestone in educational work with affected women and girls.

Kindest regards,

Maike Röttger

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1. FUNDAMENTAL INFORMATIONS

1.1 RECOMMENDED LANGUAGE AND NEED FOR SENSITIVITY

The partial or total removal of the female genitals or other physical injuries to the female genital organs is referred to as Female Genital Mutilation/Cutting – FGM/C by the World Health Organization (WHO).[1]

World-wide, there is a variety of terms describing this practice. The respectively chosen designation usually reflects the speaker's view on Female Genital Mutilation/Cutting (cf. Table 1 and Annex). That is, the preference of one term over another one inevitably depends on the individual perspective, which ranges from supporting up to condemning the designated practice.

For example, the WHO, along with other international organisations, is raising awareness about female genital mutilation in order to emphasise the severity of the procedure and, at the same time, avoiding analogies to male circumcision. Whereas in practising communities, people tend to use terms which have a more positive connotation or are at least neutral-sounding. For example, according to Alice Behrendt[2], the designation used for FGM/C in some communities in Guinea, can be translated as "mutual help".

TABLE 1: FGM IN OTHER LANGUAGES THAN ENGLISH[3]

Country	Language	Description	Meaning
Colombia	Embera	Curación	Cure/healing/treatment
Egypt	Arabic	Khitan Khifad Thara	Circumcision Cutting Clean/pureness
Eritrea	Tigrinya Amharic	Mekhnishab Grazate	Circumcision/cutting Circumcision
Indonesia	Malaysian	Sunat Perempuan	Female circumcision Tradition
Malaysia	Malaysian	Wajib	Religious duty, ordered by Allah (God)
Yemen	Arabic	Al-takmeed	Compression

[1] WHO 2016 | [2] Behrendt 2011a, S. 5 | [3] Cf. Web. 10 Sept. 2018. http://nationalfgmcentre.org.uk/wp-content/uploads/2018/02/FGM-Terminology-for-Website.pdf

Choosing the appropriate term leads to a dilemma. On the one hand, the serious violation of human rights should be expressed, whereas on the other hand, a sensitive approach to the affected women is advisable. Sufferers may feel uncomfortable, attacked or stigmatised by the term “mutilation”. Organisations such as the United Nations International Children's Emergency Fund (UNICEF) and the United Nations Population Fund (UNFPA) are now using the combination of female genital mutilation/circumcision (FGM/C). This combination aims to underline the use of one or the other of the possible terms regarding the respective context within each situation in politics as well as in cooperation with the communities and those affected. Plan International Deutschland also follows this reasoning.

Recommendations for using a sensitive language
We recommend using the different terms depending on each context. Sensitive language is extremely important, especially when interacting with FGM/C affected girls and women.

RECOMMENDATIONS FOR CONTEXT-SENSITIVE USE OF TERMS

CONTEXT	PUBLIC AND OFFICIAL	APPROACH TOWARDS DEALING WITH THOSE AFFECTED	PERSPECTIVE OF THE PERSONS AFFECTED
APPLICATION	PUBLICATIONS, COMMUNICATION	ADVICE, GENERAL CONVERSATIONS	CONFIDENTIAL CONVERSATION
DESCRIPTION	FEMALE GENITAL MUTILATION/ CIRCUMCISION (FGM/C)	CIRCUMCISION, ECISION (EN) EXCISER (FR), BESCHNEIDUNG, EXZIDIEREN (DE)	ASK ABOUT: • Which term do you use to refer to this practice? • Should we use this term or another one?

1.2 DISSEMINATION

FGM/C has been practised for millennia. Today, 200 million girls and women are affected worldwide by it[4]. FGM/C is performed in all continents.

Europe

Female genital mutilation/circumcision is increasing due to migration in Europe. First of all, this development is attributed to emigration waves from countries with a high prevalence[5].

The 2009 European Parliament resolution on com-bating female genital mutilation estimated the number of women and girls with mutilated genitals living in Europe to be 500,000[6].

According to estimates by the United Nations High Commissioner for Refugees (UNHCR) between 2009 and 2012 about 20,000 of the girls and women who fled worldwide were from countries where female genital mutilation/circumcision is widespread. In 2013, their number increased to 25,000. Most of the women and girls came from Egypt, Ethiopia, Ivory Coast, Eritrea, Iraq, Mali, Nigeria and Somalia. Their numbers are likely to be much greater today due to increased migration flows.

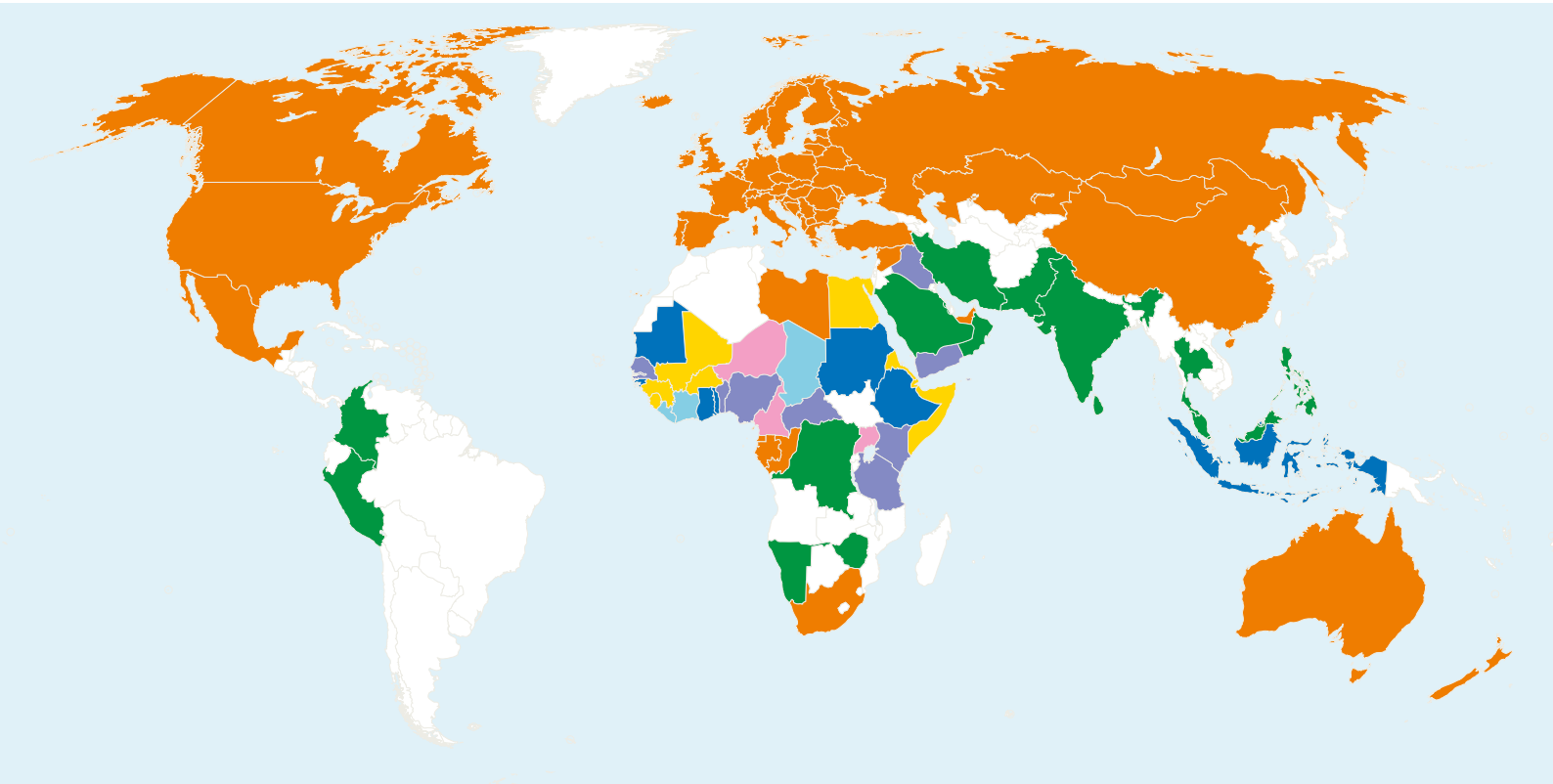
Germany

In 2017, more than 60,000 women living in Germany were affected by female genital mutilation/circumcision.

TABLE 2: SUSPECTED NUMBER OF WOMEN AFFECTED BY FGM/C IN GERMANY[8]

	February 2015*	May 2016*	June 2017*	December 2017*
Persons affected	35,715	48,770	58,093	64,812
At risk	5,956	9,322	13,320	15,540

* Reporting date from the Central Register of Foreign Nationals



PERCENTAGE OF WOMEN WHO LIVE WITH FGM/C

75 to < 100 % | 50 to < 75 % | 25 to < 50 % | 5 to < 25 % | < 5 % | Limited to communities
Reported cases among the migrant population | No data is available.

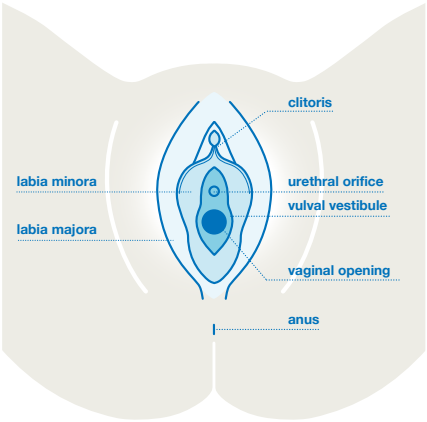
Data based on: UNICEF, G.A.M.S., Pharos

[4] UNICEF 2018 a | [5] UNICEF 2018 a | [6] European Parliament 2009 | [7] UNHCR 2014 | [8] Terre des Femmes 2018

1.3 FORMS

The WHO classification of female genital mutilation/circumcision is the most commonly used classification. It specifies four types, which in turn can be subdivided into subtypes[9].

TABLE 3: TYPES OF FGM/C ACCORDING TO THE WHO

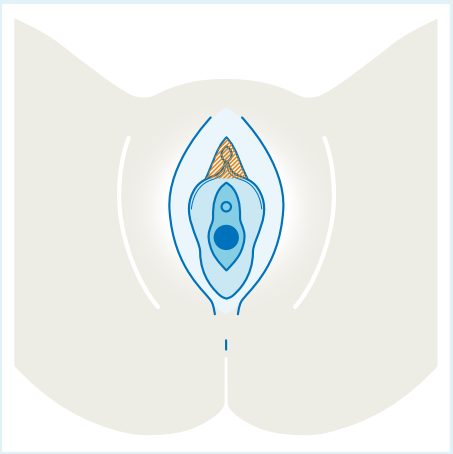


FGM TYPE I Clitoridectomy:

Partial or total removal of the clitoris and/or the prepuce

a Removal of the prepuce

b Removal of the clitoris and prepuce



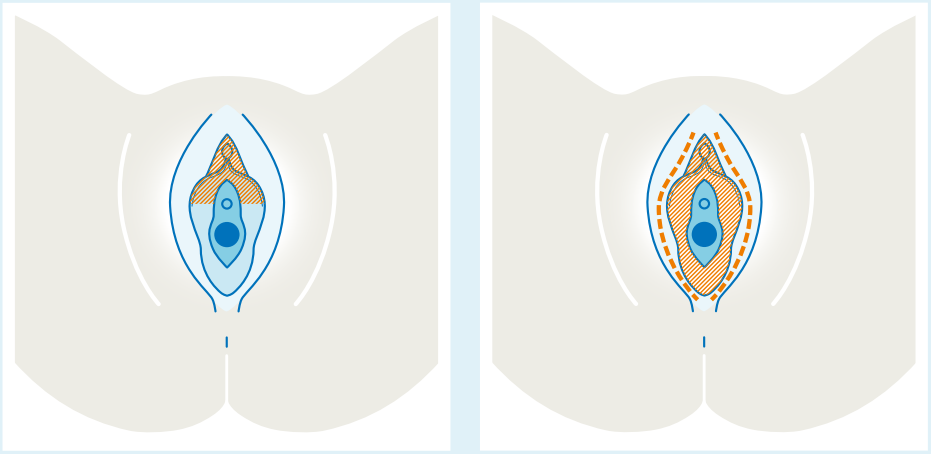
FGM TYPE II Excision:

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

a Removal of the labia minora

b Partial or complete removal of the external clitoris and the labia minora

c Partial or complete removal of the outer clitoris as well as the labia minora and labia majora

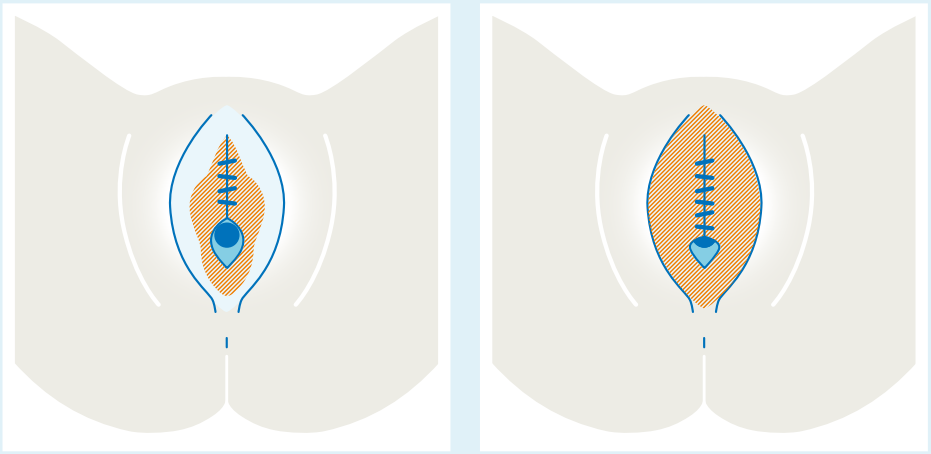


FGM TYPE III Infibulation

Narrowing of the vaginal orifice with a covering seal. The seal is formed by cutting and repositioning the labia minora and/or the labia majora. This can take place with or without removal of the clitoris

a Removal and stitching of the labia minora, with or without removal of the clitoris

b Removal and suturing of the labia minora, with or without removal of the clitoris



FGM TYPE IV All other harmful procedures, to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping or cauterisation

FGM type III is also referred to as pharaonic circumcision in current language.[10]
In addition to these four types defined by the WHO, there are many more forms of FGM/C worldwide, since genital mutilation/circumcision is done depending on the abilities and tools of the respective circumcisers.

[9] WHO 2016 | [10] Web. 04 Oct. 2018. <https://www.desertflowerfoundation.org/de/was-ist-fgm.html>

1.4 REASONS

In practising communities, female genital mutilation/ circumcision is a deeply rooted tradition based on a culturally influenced understanding of the roles of women, sexuality, family and marriage. Depending on the culture, the reasons for FGM/C vary.

Female genital mutilation/circumcision was practised before the spread of monotheistic religions[11]. However, no religion in the world explicitly suggests female genital mutilation/ circumcision.

The justifications for carrying out FGM vary according to the respective cultural context and background.[12]

TABLE 4: REASONS FOR FGM/C

MYSTICAL REASONS

- Vaginal secretions of uncircumcised women can kill sperm.
- The clitoris can hurt the partner during intercourse.
- The clitoris has male features and must therefore be removed for female development.
- The child dies when the child's head touches the clitoris at birth.
- An uncircumcised woman spoils the harvest when entering the field.

SOCIETY AND ROLE EXPECTATION

- High social pressure and obligation of the community
- Preservation of family honour
- Formation of identity and social acceptance as a member of the community/ strengthening of group membership
- Part of the rite of passage (transition ritual from girl to woman). Initiation is associated with positive events, such as gift giving, celebration, higher social status as a woman.

MARRIAGE, MATRIMONY AND FAMILY

- Better marriage prospects
- To preserve virginity before marriage
- Forced marriage and early marriage
- Preserve marital loyalty
- Ensure better fertility
- Increase male sexual satisfaction

RELIGION

- Religious duty
- Exercise of pressure by religious authorities

ECONOMIC EFFICIENCY

- Better marriage prospects => Prospect of bride price
- Higher bride price
- High prestige and high income for those practising circumcision
- Avoiding the economic isolation of the affected family

HYGIENE, HEALTH AND BODY

- Female genitalia are considered impure and the source of many illnesses.
- The circumcised vagina is considered beautiful and pure.
- Fears and ideas about the body: otherwise oversized growth of the clitoris and/or labia

OTHER REASONS FOR SEXUAL CONTROL

- After birth, the vagina which is defibrated for delivery is infibulated again (reinfibulation) in many cases, even with an upcoming trip of the husband.
- Following the detection of a first circumcision that was not properly carried out, re-excision (another genital mutilation) is used as a punitive measure for women returning from their escape.
- Prevent sexual development

MEDICALISATION

- In order to legitimise the practice, surgery is performed by physicians, doctors, midwives or nurses in some countries.

[11] Graf 2012 | [12] Behrendt 2011b, INTEGRA 2017, Graf 2012, Gruber 2005, Terre des Femmes 2017

1.5 CONSEQUENCES AND EFFECTS

Female genital mutilation/circumcision is painful and traumatic, as it is usually performed without anaesthesia. In addition, the removal or injury of the genital tissue compromises the natural functioning of the body and may have several immediate and/or long-term complications for the function of the urinary and genital organs. In addition, it can affect the psyche.

The WHO[13] lists a number of potential risks which are included in table 5.

TABLE 5: RISKS OF FGM/C

ACUTE RISKS[14]

Risks	Remarks
• Haemorrhage / Bleeding • Pain	• Heavy bleeding
• Shock	• Haemorrhagic, neurogenic or septic
• Swelling of the genital tissue	• Due to the inflammatory reaction or local infection
• Infections	• Acute local infections, abscess formation, sepsis • Abscess, genital and birth canal infections, ureteral infections • HIV risk • FGM/C can lead to HIV infection if non-sterile cutting tools are used
• Urination problems	• Urinary retention, pain • Greatly extended defecation • Urethral injury
• Wound healing problems	
• Death	• From bleeding, sepsis

RISKS WHEN GIVING BIRTH[15]

Risks	Remarks
• Prolonged labour	
• Difficult birth/disturbed birth process (caesarean section, forceps delivery, episiotomy)	
• Tears/wounds during childbirth	
• Stillbirth and death of premature babies	
• Resuscitation of the child at birth	
• Bleeding after birth	• Blood loss of 500 ml or more at birth
• Extended hospitalisation	

DISORDER OF SEXUAL FUNCTIONS[16]

Risks	Remarks
• Painful coitus (pain during sexual intercourse)	• In Type III, there is a greater risk of this pain in relation to Type I and II.
• Reduced sexual satisfaction • Reduced sexual desire and less stimulation • Reduced lubrication during sexual intercourse • Reduced frequency or absence of orgasms	• Isolation, pain, anxiety, marital conflict, lower self-esteem

PSYCHOLOGICAL RISKS[17]

Risks	Remarks
• Post-traumatic stress disorder (PTSD)	• Anxiety disorders, depression, aggression, irritability, diffuse identity, loss of one's identity

LONG-TERM RISKS[18]

Risks	Remarks
• Damage to the genital tissue	• With chronic clitoris pain
• Vaginal secretions	• Caused by chronic genital infections
• Vaginal itching	
• Menstrual problems	• Dysmenorrhoea (menstrual pain), irregular menstrual bleeding, • delayed discharge of menstrual secretion
• Chronic genital infections • Ascending genital infections	• On the vulva and vagina, bacterial vaginosis • Chronic abdominal pain
• Urethritis	• Frequently recurrent
• Painful urination	• Often because of obstruction of the ureter or urethra and more frequent ureteral infections

[13] WHO 2016 | [14] Berg 2014 a, Lavazzo 2013 | [15] Berg 2014 b, WHO 2006 | [16] Berg 2010, Vloeberghs 2012 | [17] Vloeberghs 2012 | [18] Berg 2014 a, Lavazzo 2013

1.6 LEGAL FRAMEWORK

International

Numerous conventions and resolutions of the United Nations (UN), the European Union (EU) and Germany classify female genital mutilation/circumcision as a serious human rights violation.

INTERNATIONAL RESOLUTIONS* AND CONVENTIONS**

United Nations Universal Declaration of Human Rights in 1948	Every woman and every girl has the right to live self-determined, free and dignified, and not to fall victim of cruel, inhuman or degrading treatment.
Convention on the Elimination of All Forms of Discrimination against Women (1981)	Article 2 requires States Parties to eliminate discrimination against women in all its forms; to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women; to take appropriate measures to ensure the effective protection of women.
Convention on the Rights of the Child (1989)	The Convention calls on all governments to take all effective and appropriate measures to abolish customs that are harmful to children's health.
UN Resolution "Declaration on the Elimination of Violence against Women" (1993)	Article 2 a lists female genital mutilation as a specific form of violence against women. "Violence against women shall be understood to encompass, but not be limited to, the following: [...] female genital mutilation and other traditional practices harmful to women [...]."
International Conference on Population and Development (Cairo 1994) – Programme of Action	See, inter alia, objective 4.22: "Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices."
World Conference on Women in Beijing 1995 – Platform for Action	See, inter alia, chapter 4.1 Human Rights of Women, section 232 h: "Prohibit female genital mutilation wherever it exists and give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices."
UN Resolution "Resolution on intensifying global efforts for the elimination of FGM" (2012)	Among other things, States are urged to condemn all harmful practices, to complement punitive measures, to enhance awareness-raising activities, and to develop information and awareness-raising programmes.

* United Nations decision-making: Except in the UN Security Council, UN decisions are generally not binding. However, they can have a not inconsiderable effect as so-called "soft laws".
**UN conventions are binding treaties under international law between all or some of the United Nations Member States, and are ratified in the respective national committees (Bundestag and Bundesrat being the respective committees in Germany).

Europe

EUROPEAN UNION

European Convention on Human Rights (ECHR) (1950)	Article 3: "Prohibition of torture" This article requires protection of physical integrity, among other things.
Convention on preventing and combating violence against women and domestic violence (2011) (Istanbul Convention)	Article 38: "Female genital mutilation" Any form of female genital mutilation is prohibited. Likewise, so is any behaviour by which a woman or a girl is enticed or coerced to undergo FGM.
Directive* 2011/95/EU of the European Parliament and Council (2011) – 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	In rectical 30, FGM/C is cited as a criterion for assigning persons to special social groups exposed to persecution or other threats in their country of origin.

EU Commission: COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT AND THE COUNCIL Towards the elimination of female genital mutilation (2013)	This communication includes the following points: • Reach a higher level of awareness among the population regarding the challenges of FGM in the EU • Promote sustainable social change to prevent FGM • Support Member States more effectively in the criminal prosecution of FGM cases • Ensure protection for vulnerable women on EU territory • Promote worldwide abolition of FGM
EU Parliament (February 2018) Resolution	Zero tolerance for female genital mutilation

*In EU law, only directives are legally binding. On the other hand, directives must be implemented by the Member States. They are therefore ultimately reflected in national law.

Germany

The Federal Republic of Germany has ratified all relevant international conventions and converted them into applicable national law: The Convention on the Elimination of All Forms of Discrimination against Women, and the Optional Protocol to this convention were transferred to German law in 1985 and in 2002 respectively.

The same applies to all European conventions.
In April 2017, the German Bundestag deliberated on the bill on the so-called Istanbul Convention and decided on ratification on 1 June 2017. The Convention entered into force in Germany on 1 February 2018.

Female genital mutilation/circumcision was included as a separate offence in Strafgesetzbuch (StGB, the German criminal code) in 2013 (section 226 a StGB) and is therefore considered a serious bodily injury, which can lead to the actor being liable to imprisonment not exceeding 15 years.

Since 2015, the action of bringing girls, who are registered in Germany, temporarily abroad to have them undergo female genital mutilation is considered a criminal offence according to German legislation (section 5 para. 9 a, b StGB).

In order to complicate such violations abroad, the Federal Government decided to amend the passport law in December 2016. People who want to travel abroad with girls or women to carry out genital mutilation or have genital mutilation carried out there are now threatened with the withdrawal of their passports (section 8 in conjunction with section 7 para. 1 No. 11 PassG). The passport can also be refused on this very basis right from the outset (section 7 para. 1 No. 11 PassG).

BASIC LAW FOR THE FEDERAL REPUBLIC OF GERMANY[19]

Article 2 Para. 2	"Every person shall have the right to life and physical integrity. Freedom of the person shall be inviolable. These rights may be interfered with only pursuant to a law."

LAWS APPLICABLE TO CRIMINAL PROSECUTION[20]

(StGB – German Criminal Code)

Section 5 para. 9 a, b StGB	Offences committed abroad against domestic legal interests "abortion (section 218), if the offender at the time of the offence is German and has his main livelihood in the territory of the Federal Republic of Germany"
Section 25 para. 2 StGB	"If more than one person commit the offence jointly, each shall be liable as a principal (joint principals)."
Section 26 StGB	"Any person who intentionally induces another to intentionally commit an unlawful act (abettor) shall be liable to be sentenced as if he were a principal."
Section 27 StGB	"Any person who intentionally assists another in the intentional commission of an unlawful act shall be convicted and sentenced as an aider."
Section 78 b StGB	"The limitation period shall be stayed 1. until the victim of an offence under section […] 226a has reached the age of 30 . […]"
Section 171 StGB	Violation of duties of care or education Whosoever grossly neglects his duty to provide care or education for a person under the age of sixteen and thereby creates a danger that the person's physical or mental development could be seriously damaged […], shall be liable to imprisonment not exceeding three years or a fine."

[19] Web. 05 Sept. 2018. <www.gesetze-im-internet.de/gg/art_2.html>. | [20] Web. 05 Sept. 2018. <www.gesetze-im-internet.de/stgb/> (Translator's note: English Version. Web. 02 July 2019 < https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html#p0148>).

Section 225 para. 1 StGB	Abuse of position of trust "Whosoever tortures or seriously abuses or by maliciously neglecting his duty of care for a person damages the health of a person under eighteen years of age […] shall be liable to imprisonment from six months to ten years."
Section 226 a StGB	Female genital mutilation as an offence "Whosoever mutilates the external genitalia of a female shall be liable to a term of imprisonment of no less than one year."
Section 228 StGB	Consent "Whosoever causes bodily harm with the consent of the victim shall be deemed to act lawfully unless the act violates public policy, the consent notwithstanding."

In the context of prosecution, the German Government replied to a so-called Kleine Anfrage (i.e. "brief enquiry") in April 2018 as follows: "Female genital mutilation has been recorded in police crime statistics since 2014. No cases were registered in the years 2014, 2015 and 2016". The Federal Government does not have any information regarding initiations of criminal investigations on female genital mutilation committed in countries other than Germany (section 5 para. 9 a, b StGB).

CIVIL LAW
(BGB – German Civil Code[22])

Section 1666 para. 1 Clause 1 BGB	Court measures in the case of endangerment of the best interests of the child "Where the physical, mental or psychological best interests of the child or its property are endangered and the parents do not wish or are not able to avert the danger, the family court must take the measures necessary to avert the danger."

In 2004, the German Federal Supreme Court[23] confirmed its decision to prevent a mother from travelling to Gambia with her child. She was deprived of the right to determine place of residence in accordance with section 1666 para.1 BGB, since there was the threat that she might have her daughter circumcised in Gambia.

The German Medical Association[24] explicitly points out that female genital mutilation/circumcision constitutes a criminal offence. What is more, female genital mutilation carried out by doctors in Germany is contrary to the professional code of conduct for German physicians.

(MODEL) PROFESSIONAL CODE OF CONDUCT FOR PHYSICIANS WORKING IN GERMANY
(As of 2018[25])

Section 2 para. 1 MBO-Ä	"Doctors practice their profession in accordance with their conscience, the dictates of medical ethics and humanity. They must not recognise any principles or observe any rules or instructions which are not compatible with their tasks nor do anything they cannot justify following."

1.7 ASPECTS RELATING TO ASYLUM

The European Commission and the European Parliament have repeatedly stressed the importance of the 2011 EU Qualification Directive. This Directive refers to the reasons for granting international protection (see 1.6 Europe).

DIRECTIVE 2011/95/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL
(2011)

Article 9, 2 a	Mental, physical or sexual violence is listed as a reason for granting international protection.

[21] Bundestag 2018 | [22] Web. 20 Sept. 2018. <www.gesetze-im-internet.de/bgb/index.html#BJNR001950896BJNE162701377>. | [23] Web. 21 Sept. 2018. <http://juris.bundesgerichtshof.de/cgi-bin/rechtsprechung/ document.py?Gericht=bgh&Art=en&nr=31519&pos=0&anz=1>. (Translator's note: content also available in English: Web. 4 July 2019. <https://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html>. | [24] Bundesärztekammer 2016. | [25] Web. 24 Sept. 2018. < ww.bundesaerztekammer.de/fileadmin/user_upload/down- loads/pdf-Ordner/MBO/MBO-AE.pdf>. (Translator's note: As of 2 August 2019, there is no official English translation of MBO-Ä.) | [26] European Commission 2013 | [27] European Parliament 2012; European Parliament 2018

Recital 30	It is required that aspects related to the applicant's gender, which may be related to certain legal traditions and customs, be properly considered. The directive explicitly includes female genital mutilation.
Recital 36	International protection is extended to parents who are exposed to real danger by refusing to allow their daughters undergo FGM.
Recitals 18, 19 and Article 20.5	This directive underlines the importance of the best interests of the child as a priority consideration for Member States, which is to be considered in various provisions.

Germany

The residence and entry of foreign nationals is regulated by the German Law on Aliens (Ausländerrecht in German). In January 2005, the new Immigration Act (Zuwanderungsgesetz in German) came into force and in August 2017 it was reformed. The reform's key aspect is the implementation of eleven EU directives regarding residence and asylum.

The so-called Residence Act (Aufenthaltsgesetz in German) stipulates that refugee status is also granted in case of non-state persecution in accordance with the EU Qualification Directive. Furthermore, the recognition of gender-based persecution has been introduced. A threat to life or physical integrity is therefore also given if persecution is solely linked a person's sex.

ASYLUM ACT
(AsylG[28])

Section 1 Scope of application	"(1) This Act shall apply to foreigners applying for: […] 2. international protection under Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 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 (OJ EU L 337 of 20 December 2011, p. 9); international protection within the meaning of Directive 2011/95/EU comprises the protection against persecution under the Convention of 28 July 1951 on the legal status of refugees (Federal Law Gazette II pp. 559, 560) and subsidiary protection within the meaning of the Directive; international protection granted under Council Directive 2004/83/EC of 29 April 2004 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 (OJ EU L 304, p. 12) is equivalent to international protection as defined in Directive 2011/95/EU; Section 104 (9) of the Residence Act shall remain unaffected."
Section 3 a Acts of Persecution	"(1) Acts of persecution within the meaning of Section 3 (1) must 1. be sufficiently serious by their nature or repetition as to constitute a severe violation of basic human rights, in particular the rights from which derogation cannot be made under Article 15 (2) of the European Convention as of 4 November 1950 for the Protection of Human Rights and Fundamental Freedoms (BGBl. 1952 II p. 685, 953)." "(2) Acts of persecution as referred to in subsection 1 may among others take the form of: 1. acts of physical or mental violence, including acts of sexual violence; [...] 6. acts which are of a gender-specific nature or are directed against children."
Section 3 b Grounds for persecution	(1) 4. "[...] if a person is persecuted solely on account of their sex or sexual identity, this may also constitute persecution due to membership of a certain social group [...]."
Section 3 c Agents of persecution	3. "non-state agents, if the agents referred to under nos. 1 and 2, including international organizations, are demonstrably unable or unwilling to offer protection from the persecution within the meaning of Section 3d, irrespective of whether a power exercising state rule exists in the country."
Section 4 Subsidiary protection	"(1) A foreigner shall be eligible for subsidiary protection if he has shown substantial grounds for believing that he would face a real risk of suffering serious harm in his country of origin. Serious harm consists of: 1. death penalty or execution, 2. torture or inhuman or degrading treatment or punishment, or 3. serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of international or internal armed conflict."

[28] Web. 24 Sept. 2018. <ww.gesetze-im-internet.de/asylvfg_1992/index.html#BJNR111260992BJNE016300311>. (Translator's note: English version also available: Web. 4 July 2019. https://www.gesetze-im-internet.de/englisch_asylvfg/englisch_asylvfg.html#p0017>).

Numerous judgements recognising the asylum application due to the threat of female genital mutilation/circumcision have already been documented[29].

According to UNHCR estimates for 2011, a total of 1,962 asylum applications based on FGM/C were decided upon in EU countries, among them being Germany (184), France, Great Britain, Italy, the Netherlands and Sweden[30].

Further information and examples of judgements: www.netzwerk-integra.de/dokumente/recht-deutschland/

1.8 VICTIMS' RIGHTS

Protection by Criminal Law

According to section 226 a StGB, serious offences such as female genital mutilation/circumcision do not require a separate criminal complaint by the women concerned. Nevertheless, they can and should report such offences to the police or prosecutors so that proceedings can be initiated. Criminal prosecution of the case is thus achieved.

Crime Victims Compensation Act

Any person who has sustained a personal injury as a result of wilful, unlawful physical assault shall be entitled, upon application, to compensation as provided for by the Victims Compensation Act (Opferentschädigungsgesetz, OEG)[31]:

- Therapy and medical treatments (including psychotherapy)
- Pension benefits
- Welfare benefits
- Rehabilitation measures

Since 2009, law has enabled affected persons to claim benefits even if the act of violence occurred abroad.[32]

CRIME VICTIMS COMPENSATION (Opferschutzgesetz, OEG[33])

Section 1 para. 1 – Right to compensation	"Any person who [...] has sustained a personal injury as a result of willful, unlawful physical assault against himself or any other person or as a result of the lawful defense against such an assault, shall be entitled, upon application, to compensation on account of the resulting health damage and economic damage, as provided for by the Federal War Victims Compensation Act [...]."

Protection under Civil Law

In addition, compensation claims under tort law can be asserted before German civil courts against the perpetrator(s) or persons engaged in the act. The legal basis for such claims for damages are, in particular, section 823 para. 1 BGB and section 823 para. 2 BGB in conjunction with an individual protection standard provided by the StGB, e.g. in section 226 a StGB.

[29] Deutscher Bundestag 2018 b | [30] UNHCR 2013 | [31] Web. 08 Oct. 2018. <www.bmas.de/DE/Themen/Soziale-Sicherung/Soziale-Entschaedigung/Opferentschaedigungsrecht/oeg.html>. (Translator's note: Content also available in English: Web. 4 July 2019. <https://www.gesetze-im-internet.de/englisch_oeg/englisch_oeg.html#p0013>). | [32] Web. 08 Oct. 2018. <www.bmas.de/DE/Themen/Soziale-Sicherung/Soziale-Entschaedigung/Opferentschaedigungsrecht/oeg.html>. (Translator's note: Content also available in English: Web. 4 July 2019. <https://www.gesetze-im-internet.de/englisch_oeg/englisch_oeg.html#p0013>). | [33] Web. 21 Sept. 2018. <www.gesetze-im-internet.de/oeg/index.html>. (Translator's note: Content also available in English: Web. 2 August 2019. <http://www.gesetze-im-internet.de/englisch_oeg/index.html>.

1.9 VICTIM PROTECTION

The EU adopted the Victims Protection Directive on 15 November 2012[34]. In Germany, this directive was implemented in 2015 by the Law on strengthening victims' rights in criminal proceedings (3rd Reform of the Victim Protection Act[35]). The law seeks to better inform victims of crime about their rights in the proceeding. An important change is that it includes a separate law on psychosocial support during the criminal proceedings[36]. This law came into force in January 2017.

The 2013 EU Reception Directive[37] aims to ensure humane reception conditions (such as housing) for asylum seekers and to ensure respect for the fundamental rights of those concerned. This directive was not implemented into German domestic law by the deadline of July 2015. This is why it is currently not clear in which way this Directive is directly applicable in Germany.

EU DIRECTIVES

EU Victims' Rights Directive (2012)	Recital 17 Gender-based violence includes female genital mutilation. Article 8 This Article regulates the victim's right to free access to victim assistance. Article 9 This Article regulates the various measures for assistance through victim support services.
Reception Conditions Directive from 2013	Article 21 This Directive explicitly recognises those affected by FGM as in need of protection. Article 25.2 Staff in the reception centres should be trained, in particular to be enabled to assist vulnerable applicants such as victims of sexual violence.

LAW ON STRENGTHENING VICTIMS' RIGHTS IN CRIMINAL PROCEEDINGS

(3rd Reformed Victim Protection Act)

Law on psycho-social process monitoring (Strafprozess-ordnung, StPO section 406 g[38])	Para. 1 "Any Injured person has the right to psychosocial support during the criminal proceedings. The psychosocial support professional is allowed to be present at interrogations of the injured party and to accompany the injured party during the actual trial."

[34] Web. 09 Oct. 2018. https://eur-lex.europa.eu/legal-content/DE/TXT/PDF/?uri=CELEX:32012L0029&from=de. (Translator's note: You will find the English version here: Web. 20 June 2019. <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012L0029&from=fr>.). | [35] Web. 09 Oct. 2018. < <http://dipbt.bundestag.de/extrakt/ba/WP18/651/65145.html>. | [36] Web. 12 Sept. 2018. <www.bmjv.de/DE/Themen/OpferschutzUndGewaltpraevention/Prozessbegleitung/Prozessbegleitung_node.html>. | [37] Web. 14 Sept. 2018. https://eur-lex.europa.eu/LexUriS- erv/LexUriServ.do?uri=OJ:L:2013:180:0096:0116:DE:PDF. | [38] Web. 21 Sept. 2018. <www.gesetze-im-internet.de/stpo/ 406g.html>. (Translator's note: content translated by the translator of the present text)

1.10 CHILD PROTECTION

The EU Charter of Fundamental Rights establishes fundamental and human rights in the European Union. Article 24 deals with the rights of the child.

EU CHARTER OF FUNDAMENTAL RIGHTS OF THE EUROPEAN UNION

Art. 24 The rights of the child[39]	(1) "Children shall have the right to such protection and care as is necessary for their well-being. They may express their views freely. Such views shall be taken into consideration on matters which concern them in accordance with their age and maturity." (2) "In all actions relating to children, whether taken by public authorities or private institutions, the child's best interests must be a primary consideration." (3) "Every child shall have the right to maintain on a regular basis a personal relationship and direct contact with both, his or her parents, unless that is contrary to his or her interests."

Germany

A planned genital mutilation/circumcision in a girl requires immediate action in the context of child protection under section 8 a SGB VIII.

If genital mutilation/circumcision has already taken place, it is the responsibility of the youth welfare offices to support the girls and young women concerned in reducing the health and psychosocial consequences. In addition, the youth welfare offices accompany the girls or young women concerned during the criminal proceedings against their own parents and the assertion of claims in accordance with the Victims Compensation Act (OEG) or the general Civil Law.

As a rule, in order to protect the girls concerned, it is necessary to include the Family Court, which initiates family court measures, such as border closures (preventing the girls from moving abroad) or requirements for checking their physical integrity. If this is not sufficient to ensure the girls' protection, they may have to be taken into care.[40]

CHILD PROTECTION IN GERMAN LAW

Social Code (Sozialgesetzbuch, SGB) – Eighth Book (VIII) – Child and Youth Services / Civil Code (Bürgerliches Gesetzbuch, BGB) / KKG – Act on Cooperation and Information in Child Protection

Section 1 SGB VIII[41]	Right to education, parental responsibility, youth welfare
Section 8 SGB VIII[42]	Without the guardians' knowledge, children can be advised whenever counselling is required due to an emergency or conflict situation.
Section 8 a para. 1 SGB VIII[43]	"If the Youth Welfare Office publishes important indications for endangering the well-being of a child or adolescent, it must assess the risk of danger in the interaction of several skilled workers. […]."
Section 1631 para. 2 BGB[44]	Children's right to non-violent upbringing
Section 1666 para. 1 Clause 1 BGB	Court measures in the case of endangerment of the best interests of the child (see chapter 1.6)
Section 4 para. 1 KKG[45]	"If [...] members of a health profession [...] become aware of significant factors endangering the well-being of a child or adolescent in the course of their professional activity, they should discuss the situation [...] with the child or adolescent and the legal guardian [...]."

[39] Web. 23 Sept. 2018. <https://dejure.org/gesetze/GRCh/24.html>. | [40] Boldt et al. 2013 | [41] Web. 22 Sept. 2018. <www.gesetze-im-internet.de/sgb_8/ 1.html>. | [42] Web. 22 Sept. 2018. < www.gesetze-im-internet. de/sgb_8/ 8.html>. | [43] Web. 22 Sept. 2018. <www.gesetze-im-internet.de/sgb_8/ 8a.html>. | [44] Web. 22 Sept. 2018. <www.gesetze-im-internet.de/bgb/ 1631.html>. | [45] Web. 22 Sept. 2018. <www.gesetze-im-internet.de/kkg/ 4.html>.

2. CHALLENGES FOR THE AFFECTED WOMEN AND GIRLS

2.1 CHALLENGES IN THE ASYLUM PROCEDURES

Survivors of female genital mutilation/circumcision face various challenges in the asylum procedure.

They have to report on the taboo topic in detail and directly, even if this contradicts their cultural imprint. In that case, women are more likely to speak indirectly and superficially about their experiences and therefore run the risk of being considered untrustworthy in the asylum procedure.

The countries from which the affected girls and women originate may be characterised by cultural heterogeneity. Nevertheless, the role of women in their home countries is very different to the role adjusted to women in Germany.

As part of the asylum procedure, for example, during a hearing of the application, the woman or girl speaking might often happen to talk about her husband in the country of origin, without mentioning that the wedding was actually the result of a forced and/or early marriage. Sexual violence is and still remains an issue that is not talked about.

People react very differently to intense experiences of violence. Although memories cannot be erased from the mind, remembering those experiences can be so unbearable to the human consciousness that what ever happened to them can no longer be recalled for conscious experience.

Verbally reconstructed traumatic experiences are therefore often patchy and diffuse. In addition, reporting can lead to a renewed traumatisation, along with physical symptoms such as palpitations and panic attacks as well as anxiety.

During the whole asylum procedure, women have to learn to cope with an entirely different environment compared to the one they have known all their lives. What is more, they are missing their family and their well-known cultural and social surroundings. At the same time, they are looking into an uncertain future. Among other things, this state of uncertainty (negatively) affects their self-esteem and makes it even more complicated to openly treat their experiences of violence which is essential and necessary in this procedure.

The following table (table 6) shows the different challenges women are likely to face in the asylum procedure.

TABLE 6: CHALLENGES IN THE ASYLUM PROCEDURES

Break the taboo	Sexuality is a taboo topic for the affected girls and women; they are not used to talking about intimacy and intimate issues.
Be convincing	Persuasion is needed in order to be credible. However, the affected girls and women often do not succeed because they were not prepared for situations like these.
Managing pain: "Bravery is valued most highly"	In some countries of origin, bravery is considered a synonym of strength and wisdom. Bravery in this sense increases the woman's reputation.
Embarrassment when talking about sexual issues/ sexual violence	In most countries of origin, it is considered a disgrace and/or shameful to talk about such topics. Accordingly, this is usually avoided.
"Well educated woman"	Understanding the role of women: Only the woman who lets herself be subjected to political/ sexual violence and who nevertheless presents herself as strong to the outside is considered a "well educated woman".
Values	Values of affected women such as silence, bravery or strength are exposed in the asylum procedure and this affects the way they tell their stories.
Difficult to address	Difficult to address The topic is difficult to address due to differing cultural understandings of the role of women.
Blackouts	The narrated reports may appear diffuse; for example, the narrator may not know her age or year of birth.
Unstructured narrative	The FGM/C type may not be known and those acting in an advisory capacity may receive a different answer in this regard.
States of amnesia	Circumcision leads to amnesic states in some, whereas in others, it might lead to the elimination of the sensation of pain, to the loss of consciousness or those affected feel outside of their body. One consequence might be incoherent and diffuse reporting.
Lack of rhetoric skills	Many affected persons do not have a sufficiently pronounced language competence and therefore cannot communicate their experiences clearly.
Underestimating/not knowing about the importance their discourse might have	Women affected often tend to underestimate the value and impact their report does have regarding the current situation and the official decision on the residence permit for her child.
Post traumatic stress	Telling about/remembering the day of circumcision leads to post-traumatic stress.
Consequences of the conversation	Anxiety, palpitations, panic attacks, sweats, crying, urge to go to the bathroom or to vomit
States of shock	Experiences/violence during escape lead to states of shock
Grief over the loss of the family, loneliness, helplessness	These aspects lead to rejection of and withdrawal from the unknown.
Permanent transitional situation	Social connections are scare/hardly existing
Illnesses of a mental and physical nature	The permanent transitional situation often leads to mental and physical illnesses.
Lack of support	There is a lack of support from the familiar environment which leads to inner tensions and aggressive feelings which can be directed to the outside in the form of violence, but can also be destructively directed to one's self.
Language barrier	The new environment, the new language and the foreign culture represent barriers to the affected girls and women.
Low self-esteem	This complicates the necessary open handling of and narrating the experienced violence.
Disorders of sensory information	It poses a great challenge for mothers and children to talk about the aspects mentioned above. Affected women and mothers should always have in mind the importance of child protection according to German law. In case the asylum application were rejected, their daughters may be at risk of having to undergo FGM.

The challenges described above show that the affected women should prepare for the hearing – ideally supported by educationalists or psychologists.

2.2 CONSEQUENCES AND EFFECTS OF ASYLUM PROCEDURE

The credibility of the applicant's statement plays an important role in the asylum procedure. Taboos surrounding the issue, indirect communication, internalised role understanding, trauma, and/or low self-esteem are barriers to the applicant's credibility. If, for example, a woman's report during a hearing appears to be incomplete, or important information is only mentioned during the second hearing, doubts regarding the narrator's credibility might arise in the decision makers.

The introduction of the so-called accelerated asylum procedure aggravates these challenges. The time required to face the proceedings and the concomitant shortening of the preparation time often lead to unstructured statements which do not cover all the important and essential aspects of the situation. As a result, applications are often rejected.

Intercultural misunderstandings are not uncommon at a hearing. In some cultures, avoiding eye contact or crossing the arms is a sign of respect and courtesy, whereas in Germany, of all places, these behaviours will likely be interpreted as a negative or rejective attitude. In Germany, hesitant and evasive answers can likewise be regarded as an indication of untrue statement[46]. However, the reasons for this behaviour are often to be found in the applicant's insecure way of handling the respective taboo subject.

A lack of knowledge in the environment, for example, among the advisers of a woman concerned, usually means that the challenges cannot be met professionally. This is because the required range of knowledge does not exclusively relate to female genital mutilation/circumcision.

In addition to female genital mutilation, many girls and women affected have also experienced other forms of gender-based violence. Many of the affected women have had various traumatising experiences at an early age (see case studies by Dr. med. Christoph Zerm, described in Chapter 3.4 of this publication). Therefore any decision maker should always consider female genital mutilation/ circumcision as being related to other forms of mental and physical violence. In addition, it is closely linked to gender discrimination in the respective political, cultural, religious and socio-economic structures.

In every stage of life and in every social life context, there are and will be different challenges, problems and risks. For example, the traumatising experience of female genital mutilation/ circumcision and the potential loss of trust in parents may pose an enormous challenge at an early age, while issues such as sexual intercourse, sexual violence, birth risks and forced marriage may be central challenges in the life of a married woman. In the home community, sexual abuse by relatives represents a typical risk, while escaping might lead to enslavement or rape.

The UNHCR Guidelines "Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons" (2013) examined the risks at each stage of life. The following table by the UNHCR[47] (Table 7) describes the forms of violence that girls and women can experience at each stage of life.

[46] Prechtel 2017 | [47] UNHCR 2013

TABLE 7: RISKS IN DIFFERENT STAGES OF LIFE

Stage	Type of violence
Before birth	Prenatal sex selection, i.e. abortion due to the supposedly "wrong" sex, assaults during pregnancy
During infancy	Killing of female infants, emotional and physical abuse, discrimination in supply with food and medical care
During childhood	Early marriage, female genital mutilation, sexual abuse by family members and strangers, deprivation of food, disadvantages in medical care services and access to education
During youth	Violence in relationships with men, economically motivated compulsion to sexual submissiveness (e.g. for school fees), sexual abuse (including in the workplace), rape, sexual harassment, arranged marriage, trafficking
During childbearing age	Physical, mental and sexual abuse by the male sexual partner and relatives, forced pregnancy by the partner, sexual abuse (including at work), sexual harassment, rape, abuse of widows, including removal of property and "sexual cleansing" practices (sexual intercourse supposedly having a "cleansing" effect, for example, a widow is forced to have sexual intercourse with her deceased husband's brother)
In old age	Abuse of widows, including the removal of property, accusation of witchcraft, physical and psychological violence by younger family members, disadvantages in supply with food and medical care services.

Women and children fleeing sexual and gender-based violence in their region of origin and seeking asylum are also at risk of becoming victims of violence during their escape. In addition, families are often separated on the escape route - a situation that increases the vulnerability of each family member.

The following table by the UNHCR[48] (table 8) describes the types of violence which can occur during the different phases of the escape.

TABLE 8: RISKS DURING THE FLIGHT

Stage	Type of violence
During the conflict, before the flight	Abuse by persons in positions of power; sexual barter with women; sexual assault, rape, kidnapping by armed members of the conflicting parties, including security forces; mass rape and forced pregnancies
During the flight	Sexual assaults by criminals, border guards, pirates, capture by traffickers and slave traders
In the country of asylum	Sexual assaults, coercion; blackmail by persons in authority, sexual abuse of unaccompanied children in foster homes/families, domestic violence, sexual assault in transit facilities, when fetching water or collecting wood, and so on; sex to survive/forced prostitution, sexual exploitation of individuals seeking legal status in the country of asylum or access to support and resources, re-establishing of harmful traditional practices
During the repatriation (retrieval)	Sexual abuse of women and children separated from their families, sexual abuse by persons in positions of power, sexual assault, rape by criminals and border guards, forced repatriation
During reintegration	Sexual abuse of returnees as a form of retaliation, sexual blackmail to regulate legal status, exclusion from decision-making processes, denial or blocking of access to resources, of the right to own personal documents and the right to property restitution or right to property

Many societies tend to unilaterally blame survivors of sexual and gender-based violence for the crime. This social rejection leads to emotional disturbances, such as self-hatred and depression. Because of their fear of social stigmatisation, most victims refrain from reporting the incident.

[48] UNHCR 2013

3. ASYLUM PROCEDURES: RECOMMENDATIONS FOR AFFECTED WOMEN

3.1 INTERPRETERS

The hearing at the German Federal Office for Migration and Refugees (BAMF) is at the heart of the asylum procedure. Any piece of information recorded during this interview is decisive for granting or rejecting the protection status. Since most of the interviews take place with an interpreter of either sex, these persons' influence on the course of the hearing should not be underestimated. Applicants have repeatedly reported on problems with BAMF interpreters during hearings. This may be due to the low quality of the offered interpretation service. There were also repeated cases of abuse of power and intimidation by interpreters.

The following points are important and serve as recommendations for any affected woman:

- The applicant has the right to have the hearing conducted in the language in which she personally can communicate best.
- She can apply for the use of an interpreter and has the right to bring an interpreter in whom she trusts to the hearing.
- The applicant has the right to be heard by a woman (in her role as individual decision maker, Einzelentscheiderin in German).
- BAMF explicitly points to these rights and endeavours to provide qualified training for employees.
- In order for the applicant to learn about these rights, the interpreter must inform her, before the hearing starts, for example, by reading the official BAMF information material (German original title: "Wichtige Informationen") to her.
- Unfortunately, it is very often the case that the applicant signs the information material form "Wichtige Informationen" but does not read it, although it was also provided in her mother tongue.
- The applicant has the right to ask questions before the hearing begins. The interpreter must inform her about this right.
- Whatever the title of the interpreter, that is, if he or she is a sworn or certified interpreter or not, he or she must be able to translate all medical and legal terms into both languages (not just general anatomical terms such as "clitoris" or "labia"). This is important in case the BAMF employees refer to a specialist medical opinion or the opinion of a lawyer, which allows them to ask exact questions and require exact answers in return.
- Only after the beginning of the hearing does the interpreter find out what has happened to the applicant. No preparation time is considered for this. The case studies of Dr. med. Christoph Zerm in chapter 3.4 are instructive in this regard.
- The more accurate the answers, the more credible the applicant is. In case BAMF appointed a male interpreter, we highly recommend to inform the applicant that she may require the service of a female interpreter because of the very intimate issues involved.
- Applicants are often impatient and want to be heard as soon as possible without preparation. The interpreters should explain to the applicant before the hearing that hurrying can be counter productive and it is advisable to stop and postpone the hearing in case of ambiguity or misunderstandings, even if it may then take several more weeks to the next hearing. BAMF does not have sufficiently trained employees at each branch. For this reason, the applicant could be heard in another city.

As a rule, it is advisable for the interpreter and the woman concerned to be from different communities. In this way, both parties avoid social pressure being exerted on them.

3.2 ADVICE IN REFUGEE ACCOMMODATIONS

Migrant women rarely explicitly seek to have a discussion about female genital mutilation/ circumcision. On the one hand, it is important to have sufficient knowledge of the circumstances and consequences of FGM/C as well as a transcultural understanding, and secondly, to look at a woman's overall situation without bias. The woman's individual point of view should be the focus of the consultation. Openness and sensitivity to the respective cultural background are important prerequisites for advising those affected.

The advisers are responsible for following these necessary steps to prepare the procedure:

- If necessary, use trained interpreters
- Exchange information on FGM/C with those affected
- Point out the global problem in order to avoid the feeling of being stigmatised (name possible case numbers)
- Show pictures of both, a non-genitally circumcised and a circumcised vagina for illustration
- Encourage those affected to talk about issues which concern them
- Explain the consequences of FGM/C
- Refer to the risk to the child's well-being
- In case of FGM/C involving a child, contact a youth welfare office immediately; find a trained paediatrician and a sex pedagogue; provide family supervision, and enhance communication between mother and daughter, if necessary
- Suggest support and therapy options in the neighbourhood, if available
- Visit a gynaecologist trained in FGM/C to obtain an appropriate opinion (see examples in chapter 3.4)
- When counselling pregnant women, FGM must be recorded in the maternity notes.
- Prepare a psychological report
- If possible, apply for a disability card (depending on the nature of the disability)
- Hand over all relevant reports and factual information of the persons concerned and inform the lawyer accordingly

Preparation of the hearing

The personal hearing at BAMF is the most important date for the applicants within the asylum procedure. The goal is to learn more about the individual causes of flight, to gain deeper insights and to identify potential contradictions. A good preparation of the hearing including the following aspects is therefore extremely important:

- Curriculum vitae and life circumstances
- Itinerary
- Persecution fate in the country of origin
- Assessment of risks for women and girls in the event of a possible return to their country of origin
- Assessment of risks to the child in case of return

The need for sensitive and targeted preparation is made clear in the light of the challenges for women in Chapter 2.

The preparation also includes the recording of physical and psychological traumatisation and their causes, among others, as the following:

- Early marriage
- Forced marriage
- Rape
- (Cases of) abuse
- Acute threat of genital mutilation/ circumcision of daughters
- Forced prostitution
- Death threats "in the name of honour"
- Human trafficking
- Persecution on return to the region of origin
- Experiencing violence on the flight route
- (Personal – physical and mental) situation after sexual exploitation (on the run, rape)

> Draw conclusion:
What is the overall psychological state of mind like?

Depending on the severity of the trauma, long-term transcultural psychotherapy is recommended.

For the decision-making at BAMF, the demonstration of a potential threat to life or physical integrity in the region of origin is crucial. For this purpose, BAMF requires an expert's report which should be brought to the first hearing (for more information see chapter 3.4.).

Trained Special Representative

If it makes the affected woman feel more comfortable, the hearing may be carried out or be continued by a woman and with an interpreter of the same sex, if needed. BAMF has specially trained decision-makers to deal with gender-based human rights violations, such as rape, other types of sexual abuse, threat of genital mutilation. This service also applies to victims of torture, trauma or victims of trafficking and unaccompanied minors. The German Federal Office has specially trained personnel for such cases, too.

Applicants should express their wish for an interpreter as early as possible before the hearing, preferably directly when handing in the application.[49]

[49] Web. 17 Oct 2018. <www.bamf.de/DE/Fluechtlingsschutz/AblaufAsylv/PersoenlicheAnhoerung/persoenliche-anhoerung-node.html> (translator's note: Site also available in English at: http://www.bamf.de/EN/Fluechtlingsschutz/AblaufAsylv/PersoenlicheAnhoerung/persoenliche-anhoerung-node.html [accessed on 27 Aug 2019])

3.3 LAWYERS

Legal representation and the associated legal support and advice should explicitly consider the individual human rights-relevant danger situation on the basis of the particular reasons for flight and, if necessary, traumas due to and/or during the flight.

3.4 GYNAECOLOGISTS

The Germany-based association *Frauengesundheit in der Entwicklungszusammenarbeit* (FIDE, "Women Health in Development Cooperation" in English) and the board of *Deutsche Gesellschaft für Geburtshilfe und Gynäkologie* ("German Society for Gynaecology and Obstetrics" in English) jointly advise the following aspects to be considered when contacting patients:

- The anamnesis is recommended to be carried out sensitively, and supported by a female interpreter if possible. Furthermore, the term "circumcision" is considered most appropriate when talking to affected women.
- Eliminate blood and urine flow obstructions
- Depending on the degree of genital mutilation/ circumcision, enable the affected woman to have sexual intercourse again (enable cohabitation act) by re-opening the vaginal opening under anaesthesia
- In pregnant circumcised women with a narrow vaginal discharge, dilated surgery may be medically indicated during pregnancy, especially if vaginal and/ or bladder infections occurred during pregnancy.
- Enable the woman to have a "normal" delivery by opening the infibulation, carrying out a controlled perineal tear or performing an episiotomy.

According to *Bundesärztekammer's* recommendations[50] an opening of the infibulation (so-called defibulation) may be medically indicated, especially in the case of corresponding complaints (such as recurrent urinary tract infections, menstrual disorders), sterility in connection with the impossibility of sexual intercourse and in case of sexual disorders (especially dyspareunia):

- Patient's wish
- Difficulties urinating
- Difficulties during sexual intercourse
- Keloid formation of the scar tissue
- Severe dysmenorrhoea (painful periods, menstrual cramps)
- Recurrent infections
- Inclusion cysts
- Birth

Before an intervention, a special consultation is considered necessary, taking into account medical aspects as well as the cultural background.
The procedure must be performed under anaesthesia to avoid any memory of a possible trauma coming up.[51]

Informative conversation

Many of the affected women believe that they have no serious health complications. They consider the (possibly repetitive) infections they suffer from to be a normal part of a woman's life and not as being related to the mutilation. As a result, affected women may not talk about their physical complaints on their own.

Schematic illustrations showing a woman's genital anatomy before and after changes through FGM/C provide a good basis for informative discussions.

The patient should be informed about the possibility of defibulation and its benefits (related to urine flow, menstruation, sexual intercourse). In particular, this intervention should be proposed in the case of severe dysmenorrhea (severe menstrual pain), difficult micturition (difficult bladder emptying), recurrent urinary tract infections or fear of sexual contact (before or after the first intercourse). Once a full clarification has been made to and understood by the affected woman, she will have the last word, as is the case with any other operation. However, obvious medical complications can help in the decision-making process.[52]

[50] Bundesärztekammer 2016 (German Medical Association translated to English) | [51] Bundesärztekammer 2016, Deutsche Gesellschaft für Gynäkologie und Geburtshilfe 2011 (German Society for Gynaecology and Obstetrics translated to English) | [52] Zerm 2007

Anamnesis and Expert's Report

For the decision-making at BAMF, the demonstration of a potential threat to life or physical integrity in the region of origin is crucial. For this purpose, BAMF requires an expert opinion. However, in practice, many physicians may not issue such a certificate due to uncertainties in dealing with FGM/C.

Anamnesis/case presentation and findings should be very sensitive, because they can be associated with severe psychological stress and renewed trauma for women. In individual cases, the results should therefore be documented with particular care in order to avoid repetition.

Based on the ideal structure of a report, six case analyses from the following countries are set out below:

CASE A – GUINEA
FGM/C, escape and forced marriage

CASE B – DAGESTAN/RUSSIA
FGM/C, escape and forced prostitution

CASE C – KURDISTAN/IRAQ
FGM/C, escape due to forced marriage and abuse

CASE D – NIGERIA
FGM/C, escape due to death threat by voodoo followers

CASE E – EGYPT
FGM/C, escape from death threat by family members and imminent FGM/C on her daughters

CASE F – SOMALIA
FGM/C, escape from imminent forced marriage and second circumcision/mutilation

For data protection reasons, no specific key data on the case studies may be mentioned.
The annex also contains a form for a special consultation session for refugee women regarding FGM/C and other human rights violations.

STRUCTURE OF A REPORT:

- **Personal details, date and place of consultation, accompanying person, language**
- **Diagnoses**
- **Anamnesis/Case presentation: Place(-es) of birth and childhood, (names of) parents and siblings**
- **School education, vocational training, living conditions**
- **When and how did the FGM/C take place?**
- **What reasons made her take the decision to flee? How was this plan taken into practice, who helped?**
- **Details of the escape, date of arrival in Germany**
- **Frequent problems: forced marriage, second circumcision, abuse, trafficking/ forced prostitution, protecting her daughter, post-traumatic stress disorder (PTSD)**
- **Meticulous findings of the external genitals**
- **Comprehensive assessment including a description of the dangers that would threaten her on return to the country of origin (human rights-infringing, "non-governmental, gender-specific, individual persecution" on the basis of facts/ relations to be explained in detail, including, where appropriate, revenge by human trafficking gangs); violation of codes of conduct for women in the society of origin**
- **Where applicable, risk, pregnancy, inability to travel for medical reasons**

SPECIALIST MEDICAL REPORT

Dr med. Christoph Zerm

A – GUINEA

Ms A, born on DD/MM/YYYY (document wrong in German: YYYY), appeared on DD/MM/YYYY for the specialist examination and assessment in my surgery in X, accompanied by X, advisor at X. The interview was conducted with X in her role as translator/interpreter in X language.

Diagnose:

- Condition after female genital mutilation (FGM, identical to FGC, C = cutting) Type II according to the WHO with radical resection of the clitoris as well as the labia minora at the age of X in the hospital in X
- Escape from forced marriage
- Condition after psychological terror by her family (due to FGM) and severe abuse
- Condition after human trafficking and repeated rape
- acute danger to life and limb if returning to Guinea
- severe mental and physical trauma with PTSD and urgent need for therapy
- Suspected kraurosis/LSA of vulvar scars

Anamnesis:

Ms A has been in Germany since DD/MM/YYYY. She grew up with her Muslim family in X, a small town in Guinea. Her mother was Christian and saved her daughters from FGM as long as she lived. Ms A is the youngest of three sisters. The family belongs to the ethnicity of the X and was rather poor. With difficulty, Ms A was able to attend school for about 10 years. She would have liked to become a teacher, but that was not possible due to lack of financial resources. She had to contribute to the family income accepting occasional jobs. She had a childhood friend whom she wanted to marry, but her father had already selected another man who was more than ten years older than her. She had to be his first wife. Even on his deathbed, he died around YYYY due to illness, he made her promise to marry this man, "if you love me, you will obey this". For four years she refused, also supported by her mother. However, the future family in law harassed her until she finally gave up her resistance to FGM/C in YYYY [four years later]. During this time, the second-oldest sister gave birth to a boy and the birth made her so ill that she died about 3 months later. Ms A's mother made sure that the boy was adopted by Ms A. He later got the her husband's (X) last name like her two biological children. Shortly thereafter, her mother suddenly died under unclear circumstances, it is believed that the younger brother of the deceased father was behind it. He wanted to inherit the house.

Her father's family was now able to exert massive pressure on Ms A to be circumcised at last. The relation between her Christian mother and the greater family had been rather cold anyway. Her two older sisters had been circumcised after their mother's death according to her family's wish. Ms A initially refused. However, when she was in hospital X to deliver her first child, in YYYY, family members found that the treating doctors mutilated her genitals while she was giving birth. However, another doctor came and had the circumcision stopped, thereby stopping the resection of the left labium. However, she had bled heavily for a long time and she felt very bad, aside from the terrible pain. When giving birth to her 2nd child in YYYY, she went to another hospital in the capital, where the "rest" was not cut. As a result of the "incomplete" FGM, her family in law began to pressure Ms A to be "properly and completely" circumcised. After some time, under this (unsuccessful) pressure, the forced husband distanced himself from her and left her at the end of YYYY [about 1 year after delivery]. He went to X [another country in Africa].

The house in X in which Ms A lived belonged to an imam who was well acquainted with the parents-in-law. When he heard about the "incorrect" circumcision and Ms A's resistance, he threw her out of the house (certainly also under her in-laws' influence). For Ms A, the situation was literally life-threatening. So in YYYY [about a year after her husband's leaving], she travelled with the children to X to her parents' house, which her younger uncle had now acquired with his family. It was not long before this uncle and his children brutally forced Ms A and her children out of the house (which actually had belonged to her).

In her distress she fled to a friend in a village "on the other side of the river," probably in the village X south of X. She had lived with this friend of hers a little less than one year. Since she could not stay permanently, she was looking for ways to escape from the country. She had inherited a property from her parents and offered it for sale or, in other words, used the value to pay the traffickers. This "buyer" from X [Country in Africa] organised all the necessary papers, claiming, however, that the delivered money was not enough to take the daughter who was born in YYYY. So she desperately had to leave her 3 children with her girl friend in the village.

In 2016, the "buyer" from X flew with Ms A from X to Paris, where he disappeared along with her luggage and her papers. After hours of waiting in vain at the airport, she approached a man from X [Country in Africa] who pretended to offer some help. He took her to an apartment, but locked her in there and raped her for days. She only managed to escape after about 2 weeks. Once again she stood helpless and penniless in the street. She met some Africans who were on their way to Belgium and they took her with them. In Belgium (presumably X), she happened to meet a Guinean man whom she had met during the flight. He took her to Germany, where she climbed aimlessly into a train, where she was picked up by a police patrol. So she finally arrived at a refugee accommodation in Germany. At this very moment, she lives in X.

Menarche at about 15/16 years, irregular cycle with amenorrhoea lasting up to 4-5 months, often dysmenorrhea. LP around October 2017. Gravida 2, Para 2, both partus by section in Guinea: 1st on Sat, DD/MM/YYYY, a boy, 2nd on DD/MM/YYYY, a girl. No abortions, no further operations. She has lower abdominal pain every day, and the external genital is very sensitive to touch.

Findings:
Small, stocky, adipose stature, about 159 cm tall; vaginal examination: sparse pubes, obesity. Strongly retracted lower abdomen median scar, a little bulging cranially adjacent, about 1 cm diameter large, soft, compressible umbilical hernia. Labia majora relatively normal on both sides. The clitoris is completely absent, it has been radically removed. Instead, there is a 20 – 25 mm (in cc-line) long, narrow, coarse scar tissue in the form of a string of pearls, and course, nodular, keloidal growths. On and between these nodes, there are several, about 2-3 mm large whitish, non-wipeable coverings that look like Kraurosis/LSA. In the middle of this scar tissue, the median parts of the labia majora gather tightly together on both sides. Cranially, the scar turns into a flat and very narrow median ridge, under which the slight cranial clitoris remainder can be palpated. On the right, there is a thin, bridged caudal connection to the almost completely removed labium minus, of which there are only about 2 mm wide left. However, the left labium minus is intact and is almost 3 cm wide in the middle section. The external urethral orifice is orthotopically visible and unremarkable. More dorsally, the inconspicuous, just under 3 cm large introitus vaginae follows, as far as visible, inconspicuous vaginal walls. Wall and perineum are also unremarkable. A further gynaecological examination is currently rejected.

During the conversation, the severe psychological trauma is manifested by frequent painful weeping at the mention of traumatic events. In addition, Ms A gets lost in long descriptions of small details, and also expresses an apparently traumatic flight of ideas (the other, more frequent extreme is speechlessness).

Conclusion:
Condition after FGM type II as radical as described above; Condition after forced marriage and abuse. Suspected severe mental trauma with PTSD.

Ms A grew up in very traditional, rural conditions. The economic conditions were not sufficient to implement her career aspiration to be a teacher. Her father died when she was about 20 years old, not without emotionally obliging her to accept a forced marriage prearranged by him. Her Christian mother died approximately 4 years later. Presumably, her mother somewhat protected her daughters as long as she was living, among other things, from FGM. However her family was regarded as a nuclear family by the rest of the larger family and as unwanted outsiders. This larger family, however, wanted to acquire their modest possessions as soon as possible after Ms A's father's death. Actually, it seems they accelerated the inheritance process by eliminating her mother. This same family branch inexorably and brutally ensured that her older sister was circumcised (another sister had died when giving birth) and, taking advantage of the maternity hospital stay in the capital (presumably by bribery), also made sure Ms A, aged X [25 - 29 years], was being cut!

A dissenting physician prevented the completion of this mutilation, which made the life of Ms A even more unbearable. Because the extended family who were informed about this would not rest until Ms A were completely mutilated.

After this controversy, her forced husband finally left Ms A, thereby indirectly making her homeless. Her ancestral parental housing in the village was contested by her paternal family. She had been forced out after physical abuse. Even her nephews and nieces had been animated to beat her. In dire need she used the remainder of her remaining inheritance to finance the traffickers who were to take her out of the country, because she had to fear for her life in the long term, especially because of the blind rage of the extended family, but also materially through the withdrawal of her livelihood. To her great despair, the traffickers took advantage in such a way that they claimed that the proceeds would not be enough to take the children with her. Since then, this insatiable worry has burdened her with additional traumatisation. The rapes and fears during the escape are other components.

A dismissal to Guinea would have catastrophic consequences for Ms A: Not only would she be left with nothing, but she would have to reckon with the fury and persecution she had exacerbated from her extended family because she had often violated the unrelenting, oppressive rules of traditional patriarchal society in Guinea and they would severely punish her, whereby killing her would not be out of the ordinary. Ms A would not be the first victim to pay with her life. A woman's life does not count for very much in these very traditional areas. Government agencies in Guinea and all of West Africa are unwilling and unable to protect citizens in this regard. She is currently away from these human rights violations and should be saved from this gender-based, non-state and individual persecution by granting her permanent residence in Germany.

Even her little daughter, born in YYYY, is at imminent risk of being circumcised as well (which, hopefully, has not happened yet) and she should, therefore, be protected as soon as possible by family reunion.

In addition, there is an urgent need for long-term psychotherapy, including accompanying measures, to be substantiated in terms of psychology. Especially with this clinical picture, sustainable therapy is only possible if the entire environment and the living conditions ensure safety and security, for which a permanent residence permit is a decisive contribution. A high probability of deterioration would be expected in Guinea.

Furthermore, for Ms A, there is an urgent medical indication for a reconstructive operation of at least the clitoris, as offered, for example, in the Centre for Reconstructive Surgery of Female Sexual Characteristics, Luisenhospital at Aachen (German name: Zentrum für Rekonstruktive chirurgie weiblicher Geschlechtsmerkmale im Luisenhospital in Aachen).

B – DAGESTAN/RUSSIA

Ms B, born on DD/MM/YYYY [structure as case A] [in her early 20s]

Diagnose:
- Subjective anamnestic condition after female genital mutilation (FGM, identical to FGC, C = cutting) Type ? as an infant in Dagestan
- Anamnestic condition after abuse and forced prostitution by her husband

Anamnesis:
The medical history is interpreted (translated) by the accompanying interpreter (translator). Ms B grew up in X, Dagestan, in a Muslim family. She has 6 brothers and 2 sisters.
She attended school up to class 9. After that, she trained as a nurse.
She has been married for 4 years (around YYYY). In YYYY [1 year later] she spontaneously gave birth to a son. Soon after she became pregnant again, this pregnancy was terminated by abruption; she was told that was necessary because the pregnancy had occurred less than a year after the birth. Her husband continued to severely abuse her, and eventually forced her into prostitution. She had also been genitally injured in these cases of rape, and once she bled so severely that she had to be surgically treated at hospital. Because of all this, in YYYY [approx. 3 years after she gave birth to her son], she fled from her husband. She has been in Germany since DD/MM/YYYY [4 months later].

She reports being circumcised at the age of about 2 or 3 years. This was done at her grandmother's request and was carried out by a man. According to her, FGM is not widespread in Dagestan. She did now know why it happened to her.

Further anamnesis:
Menarche 12 years, regular cycle 4 weeks/5 days, eumenorrhea.
In the summer of 2012, she had a partial resection of the ovary, probably because of cysts. So far no gynaecological examination in Germany.

Findings:
Sturdy, but not obese, tall stature. Unobtrusive pubes, vulva unremarkable. Labia majora normal on both sides. The well-developed clitoris is complete with prepuce. The labia minora are also intact on both sides, however, they are of different depths on both sides (right > left) due to scarred indents set off from the clitoris. This could be caused by the tears described in the case presentation. The vaginal introitus and the external urethral orifice are inconspicuous, neither the visible vaginal portion shows gross abnormalities, nor does the perineum/anus area. A further gynaecological examination is currently not carried out by mutual agreement.

Conclusion:
No condition after FGM. Suspected forced prostitution and sexual abuse/mistreatment.

Ms B has escaped a human rights-abusive, degrading and possibly life-threatening situation in her country of origin, she is most likely to have suffered severe mental and physical trauma. Therefore, she urgently needs protection (and therapy) here in Germany to protect herself and her child from this non governmental gender-based persecution. Fortunately, the offence of FGM can be excluded. It may take some time until she will have this information integrated into her self-image. How this "memory" came about and what actually happened, would be subject of a pycho-traumatological treatment.

C – KURDISTAN/IRAQ

Ms C, born on DD/MM/YYYY [structure as case A], [in her early 20s]

Diagnose:
- Condition after female genital mutilation (FGM, identical to FGC, C = cutting) type I according to WHO with partial resection of the prepuce clitoridis and the glans clitoridis
- Escape due to forced marriage and abuse
- Recurrence pain after nephrolithiasis

Anamnesis:
Ms C is Kurdish and grew up in X in Kurdistan/Iraq near the Iranian border with her Muslim family, who comes from a rural background, from X village in the region of X. Ms C is the third child of nine siblings: she has 4 brothers and 4 sisters. One brother and one sister live in the UK, the rest of the family lives in X. Ms C attended school until she successfully graduated from high school after 12 years of school. She wanted to study economics, but her father and eldest brother were against this plan. They wanted her to stay at home. So she involuntarily spent at least 10 years at home, without further vocational training, until she was about 29 or 30. Her father since decided that she should become the second wife of a man at least 12 years older than her (possibly much older). He has lived in Germany for about 17 years and is married to a German woman who he has a 15-year-old son with. After about one year "engagement time", the marriage took place in YYYY. 3 weeks later, this man took her to Germany, where she lived with him and his existing family for about 2 months. This man was very violent and often beat and abused her. She tried to escape from his apartment, and succeeded on DD/MM/YYYY. She then came into the care of the women's shelter X. She has had no contact with her "husband" since the escape.

FGM is still widespread in Kurdistan, especially in the rural-conservative areas, with a prevalence of 60-80%. This assessment is confirmed by Ms C. Usually, the act is completed in the first 3 years of life, but depending on the situation and circumstances, this can also be at the end of the first decade of life. Ms C was circumcised at the age of about 9 years.

Menarche about 12 years, cycle is regular, 4 weeks/5, eumenorrhea, dysmenorrhoea only in the first years. Nulligravida; According to her statement, she was still a virgin. Approximately in YYYY thyroidectomy, including tonsillectomy. Years ago, she had had nephrolithiasis, the stones were non-invasively removed, but she still has recurrent pain.

Findings:
Large, medium-lean stature. Vaginal examination: Vulva/pubes unremarkable. Labia majora normal on both sides. The clitoris is cranial at about 2 cm long median bulge, which ends caudal with the approach of prepuce clitoridis, the prepuce itself appears shortened, thereby exposing the view of a rudimentary, otherwise smooth glans clitoridis. From here, there are two thin flanks on both sides of the labia minora, each of which is present in full width of up to 6 - 7 mm. The external urethral orifice is orthotopically visible and inconspicuous, as well as the visible parts of the vaginal walls. The vaginal introitus appears juvenile, and can be sufficiently opened. There are no visible scars. A further gynaecological examination will not take place in agreement with the patient. The findings indicate a partial resection of the prepuce and the glans clitoridis.

Conclusion:
Condition after FGM type I according to WHO as stated above. This underlines Ms C's origin from a conservative-traditional environment. The prohibition to study or otherwise take up a profession, and finally the forced marriage with an already married older man point in the same direction. The fact that she attended school until graduation is rather surprising in this context, but cannot be counted as counter evidence in times of rapid change towards modern times. Ms C should be available as a second wife to the Kurdish "husband" predominantly living in Germany, a condition which, taken in isolation, already blatantly violates German law. In addition, she has freed herself from this violent relationship at great risk to her life and limb, in turn violating traditional rules and laws and offending family honour. This puts her in mortal danger, as tragically honour killings among Kurds occur even in Germany.

She can only be protected against this illegal gender-based non-state persecution by a protected stay in Germany.

D – NIGERIA

Ms D, born on DD/MM/YYYY [in her early 20s], appeared together with her husband and daughter for the specialist examination and assessment in my surgery in X accompanied by X at Health Department X. The interview was conducted in English. Furthermore, the minutes of the hearing at BAMF on DD/MM/YYYY are available.

Diagnose:
- Condition after female genital mutilation (FGM, identical to FGC, C = cutting) Type I according to WHO with scarred overgrowth of the partially dissected clitoris from baby age in Nigeria
- Escape from the threat of death by voodoo followers in her home town
- acute danger to life and limb when returning to Nigeria
- Need to protect her daughter from FGM

Anamnesis:
Ms D grew up in Greater X, capital of X, with her Christian family of X people. Her mother still lives there, together with 4 younger sisters and 2 brothers, one of them is older than her. Her father was shot dead around YYYY. She attended school up to the 12th year with a “small” degree (probably equivalent to a secondary school diploma) and then did an unpaid apprenticeship as a hairdresser. In addition, she worked in restaurants to provide for herself and her family. Despite their Christian beliefs, many Voodoo-type social structures still have great influence on many Nigerians. Many people belong to such tight-knit communities. In the centre of such a community, there is usually an "oracle" (a kind of temple facility, usually in a village). Ancient, traditional rules are strictly followed there. This includes the fact that from each family the eldest daughter, a virgin, must be delivered to this temple service (rarely sons). Those who resist are ultimately killed.

The members of the community (led by the village elders) see this as fully justified. People act likewise because they are afraid of the spirits' revenge. For example, Ms D was chosen as the eldest daughter by this oracle clan to serve as a slave for the rest of her life. She did not want that destiny and was supported by her father. Soon after he was killed by these people. Ms D also received death threats. The murder of her father left no doubt about the seriousness of these threats. When her paternal uncle from X (city in Nigeria) came to her father's funeral, he took her to X (city in Nigeria) and organised her departure to X (European country). In the month of X in YYYY, she told us, she left Nigeria and flew to X (European country) due to a real threat to life. A friend accompanied her. In X (European country) she learned that her uncle had been killed in the meantime by the followers of the “oracle”. This shows that these fanatical people can track down anyone to whom they want to do something in Nigeria.

In X (European country) she had applied for asylum, this was rejected in YYYY. However, she had seen no other option than to continue to stay there illegally. She had kept herself alive by begging.

Shortly before fleeing Nigeria, she married her current husband, Mr X, born on DD/MM/YYYY [now in his early 30s]. He left Nigeria in YYYY and came to Germany via the land route, the Mediterranean and X (European country). From this he managed to get his wife from X (European country) to join him in Germany, entry on DD/MM/YYYY.

Ms D was circumcised as a baby according to tradition.

Menarche at 18 years, regular cycle 4 weeks/5 days, eumenorrhea. 1 spontaneous labour on DD/MM/YYYY in the X Clinic in the 33rd week of pregnancy (1.200 g), suffering from SGA and rupture of the membranes with gestational diabetes, girl, the newborn was treated in the paediatric department for some time. No operations.

Findings:
Medium-sized, sturdy stature, around 166 cm; vaginal examination: normal pubes, labia majora et minora largely normal on both sides, in the cranial section, the labia minora, however, “stick” to each other over a length of about 1 cm and therefore conceal the at least partially palpable clitoris or glans. This is probably due to the removal of the prepuce, and possibly also parts of the glans clitoridis were removed. Cranially joins a peculiar medial groove over 7 – 8 mm in length, cranial of this, the further subcutaneous clitoris course can be palpated as a medial ridge. The external urethral orifice is orthotopically visible and inconspicuous, as is the normal vaginal introitus, including the visible parts of the non-irritating vaginal walls. Wall and perineum unremarkable, no conspicuous scars. A further gynaecological examination is currently rejected.

Otherwise, it is noticeable during the anamnesis survey that Ms D is severely traumatised by the events of her years-long escape and, above all, by the continuing threat to her life from the local voodoo oracle, tragically proven by the murder of her father and uncle. Besides all this, the situation is now culminating in the worry over her daughter. The psychopathological suspicion of PTSD or other psychological trauma should be clarified and treated, if necessary, in this case.

Conclusion:
Condition after FGM (at least) type I according to the WHO. Escape from enslavement in a voodoo oracle temple and threat to life due to her refusal. Need to protect her daughter from imminent FGM.

Ms D first grew up in average conditions in X, but she had to contribute to the family income at an early age, as the family of 7 was rather poor. Their life-threatening problem began when the local voodoo community or their village's elder appointed her as the eldest daughter according to the tradition of a lifelong slave-like ritual service in the oracle temple (for this, the front door or hut is marked with an unmistakable sign). Those who resist are killed. The answer to the crucial question on page 5 of the BAMF hearing that Ms D was afraid of: either the traditional voodoo spirit or the people in the village, is based on an intercultural misunderstanding. For people who grew up with such traditional ideas, this difference, which is logical for Europeans, does not exist! Because the overpoweringly experienced or respected traditional voodoo spirit acts through the people who have dedicated themselves to its service, and in this sense it is the real people who kill those people who resist the will of "the oracle". Therefore, the life-threatening danger for Ms D is quite real (and not just "spiritual"), because her father and uncle were killed in real life, and it would be just as threatening to Ms D, since it was just about her; and this problem is not changed.

On her return to Nigeria she would be threatened immediately and existentially, and she would be found anywhere in the country and killed. Rule of law conditions cannot be assumed, and neither local family nor state bodies want to or can protect vulnerable women from it. Moreover, her then unborn daughter, born here, would also be threatened by FGM, as FGM is still widely practised in many parts of Nigeria across religions, as the findings in Ms D underline.

Therefore, only by remaining in Germany can Ms D and her daughter be protected from these human rights-inhibiting threats. Finally, it should be clarified by a transcultural, psychophysical examination, whether Ms D needs a psychotherapeutic therapy, because she has undergone significant traumatic experiences.

E – EGYPT

Ms E, born on DD/MM/YYYY, appeared on DD/MM/YYYY for the specialist examination and assessment in my surgery in X accompanied by her partner X and her two daughters. The conversation took place in German, in which Mr X is fluent.

Diagnose:
- Condition after female genital mutilation (FGM, identical to FGC, C = cutting) Type II according to WHO with almost total resection of the labia minora on both sides of the right half of the prepuce clitoridis at the age of about X years in Egypt
- Condition after forced marriage with permanent abuse
- Escape from death threat by the family "in the name of honour"
- Necessary protection of daughters from FGM in Egypt
- Suspected mental trauma (PTSD?), specialist medical need for clarification

Anamnesis:
Ms E has been in Germany since MM/YYYY. She comes from an Evangelical Christian (?) Family in X, where she grew up. She is the youngest of three children, the two older ones are boys. Her parents and brothers still live in Egypt, now in the village of X. Ms E was only allowed to attend school until the 11th year. After that she had to help the family. Her parents have a shop that sells spices, smoked goods, etc. When she was about 19 years old, she was forcibly married to a man twice her age. Life with him was hell, he beat her constantly. However, she was unable to escape right away, and only after about 3 years did she succeed. She had fled to a friend in X to hide there. This friend then took her to another place to live in X on the Red Sea. She spent a while in this resort and eventually met an Egyptian who was friendly at first, who told her that he lived in Germany. Later, it turned out that he had a business in France. But at first, he suggested her to live with him in X. He soon realised that Ms E was wanted and threatened by her family. Therefore, he got her papers and a visa to Germany, and they flew to X in 2012. She met a woman there and made friends with her. She had continued to take care of her, since the Egyptian disappeared after some time. She then made it possible for Ms E to return to Egypt after she had been in Germany for around 3 months.

Back in Egypt, however, Ms E quickly learned that her family was looking for her to kill her. The escape from forced marriage, and, presumably an even worse fate, the trip with a "foreign" man to Germany had hurt the family honour so much that this could only be atoned for by her death. She therefore could not stay in Egypt without risking her life, as she would have been found wherever she was at some point. So she had to flee again. In this situation, her friend in X helped her again, and with her help she came to Germany for the second time in April YYYY. In an asylum shelter in X, she met a fellow countryman living there (in Germany since 2009), who was supposed to translate for her. They became friends and he is her daughters' father who were born in Germany. Ms E was circumcised at the age of about 12/13 years.

Menarche at about 14/15 years, cycle is usually regular 4 weeks/4 – 5. 2 partus: DD/MM/YYYY in X, girl, at full-term, but previously about 2 months inpatient treatment because of premature cervical shortening; as well as on DD/MM/YYYY by section in the 25th week of pregnancy in X, girl. Breastfeeding was not possible with either of her girls. No other surgery or serious illness.

There are signs of latent traumatisation in both the history and the examination, most likely due to prolonged abuse in forced marriage and the threatening events following her escape. This suspicion should be clarified by specialist psychiatrists and, if necessary, treated thereafter.

Findings:
Short, medium sized (162 cm), slightly adipose stature. Vaginal examination: Irritable Pfannenstiel incision, total shaving. Labia majora normal on both sides. The clitoris is present and without conspicuous defects, but the right wing of the prepuce clitoridis is completely absent. It cannot be

clarified with certainty whether the glans clitoridis was minimally resected with this cut. After the caudal, thin strands follow on both sides as extensions of the labia minora, right labia minora completely missing and the left one has a rudimentary width of about 2 mm. Inconspicuous vaginal introitus with orthotopic external urethral orifice, further posterior follows with normal width and, as far as visible, inconspicuous vagina. On the left of the wall there is a left mediolat. scar as a suspected consequence of an intrapartum episiotomy (or tear). No further gynaecological examination is required.

Conclusion:
Condition after FGM type II according to WHO as stated above. Condition after 2 partus in short succession. There is no indication for the surgical correction of the external genitals in Ms E.

Ms E grew up in a rather rural-traditional environment in Egypt. She was only allowed to attend school until the 11th year, then the traditional fate of a young girl awaited her: a forced marriage to a much older man. In this "marriage" she experienced continued violence from which she eventually escaped. She stayed with a friend, finally on the Red Sea, where at some point through the acquaintance with a helpful and compassionate fellow countryman, she seemed to find a solution to her life situation that was difficult to sustain. He offered her a life together first in X and then allegedly in Germany when X turned out to be too dangerous for Ms E because of the family reprisals. Probably with a tourist visa, she followed her friend to Germany, where he disappeared for unknown reasons after a short time. She found the support of a woman in X whom she made friends with. This woman allowed her first return to Egypt and the re-entry into Germany, as it turned out, that she had to fear for her life in Egypt. Her circumcision and forced marriage underline the rigidly conservative and traditional attitude of her ancestral society, from which her family obviously does not differ.

On her return to Egypt, Ms E would be in mortal danger, because family honour is paramount in such traditional societies. In contrast, the life of a woman is not only worth nothing, on the contrary, her death is a pledge for restoring the “honour”. So-called internal exile is illusory, and the Egyptian authorities are obviously unwilling or unable to protect women and girls from such threats to human rights. In the same sense, the daughters born in Germany would be threatened by FGM. Therefore, Ms E and her daughters must be sustainably protected against this non-governmental, gender-specific persecution through permanent right of residence in Germany.

F – SOMALIA

Ms F, born on DD/MM/YYYY, appeared unaccompanied on DD/MM/YYYY for specialist examination and assessment in my surgery at Pro Familia in X. The interview took place in Somali with the help of Ms X. The report is also based on the minutes of the BAMF hearing on DD/MM/YYYY in X.

Diagnose (including all relevant factors):
- Defibulated condition after female genital mutilation (FGM, identical to FGC, C = cutting) Type III/infibulation according to WHO with radical clitoral and labia resection at age X in Somalia
- Individual persecution and abuse as a result of ethnicity to X
- Escape from the threat of forced marriage
- Threat of second circumcision (due to “incomplete” infibulation)
- Condition after month-long escape through X, X and X as well as life-threatening sea crossing, etc. with suspected traumatisation
- Vaginal prolapse

Anamnesis:
Ms F has been in Germany since DD/MM/YYYY. She comes from Somalia and belongs to X clan, she was born in X village in the province of X, near X (about 370 km south of the capital of X) and grew up there with her Muslim nomad family. The X, who consider themselves descendants of the indigenous people, are subject to multifaceted social exclusion and repression in Somalia, similar to the fate of the Dalits in India.

Ms F has a sister who is one year younger than her, and one older sister. When she was X, she was infibulated with her younger sister and experienced unforgettable pain. Her younger sister bled to death. She herself walked around “too early” after this torture, and therefore the stitching of the infibulation opened at least partially. However, her mother wanted to have her completely closed, at the latest by marriage. Therefore, Ms F was always afraid to be infibulated again as soon as her “condition” became known or she got married. Ms F could never attend school as a nomad’s daughter. (Therefore, unlike Europeans, she is not accustomed to making exact dates, and the dates below must be taken as approximate indications, which as well might refer to dates a few months earlier!)

The following dates are therefore subject to change. Her father died of a snakebite in August YYYY. His death deprived the mother and her 2 remaining daughters of the breadwinner. Tragically, this stroke of fate caused the mother to die about 2 months later. She is believed to have starved to death. The daughters could certainly not continue the nomadic life, and so they went on a trip to the next city X which lasted 1.5 days.
The older sister had already set off before her. When Ms F arrived at X, she could not find her sister, she stayed lost. Ms F worked as a domestic helper in a family. After maybe a month, a man began to pressurise her to marry him. Ms F was a kind of “fair game” in two respects: As a member of the X and as a completely single young woman. The man, who had at least three wives, became more threatening every now and then, pointing out that he belonged to one of the local clans who could choose what they wanted, and if she refused, he would kill her. At the same time, his influence went so far that the family she worked for dismissed Ms F at his request, because otherwise they had to fear reprisals. So Ms F had to flee from place X after about 2 months. She boarded a minibus, which brought her (after about a week's drive) across the southern border to X, where she was housed as a refugee, probably in camp X. In the logic of the specified timeline, this is most likely to have happened in January YYYY. After some time she met a young man there, also X, who ran a small grocery shop. They quickly became friends and married in the camp. Soon after, Ms F became pregnant, but the pregnancy ended in abortion. Both decided to leave behind the miserable life in the camp and flee to the north. Her husband organised everything. They travelled through X to X. In X, they arrived at the infamous camp X. One night it was time to board one of these precarious boats to Europe with many other escapees.

Her husband told Ms F to get in, he was about to follow her. They lost each other in the darkness, because the next morning at sea, her husband was

not on board, and she has not had news from him ever since. This crossing was extremely traumatic, there was nothing to drink nor to eat, the sea was very high, and another refugee boat capsized and many people drowned. Her boat was also at risk from sinking when, at the last moment, a lifeboat took her and her co-escapees. She stayed with a group of other Somalis in X, who then took her on the onward journey to Germany after 2 days and also paid for her ticket.

Menarche about 15 years, regularly monthly cycle/7 (for a few months up to 14 days), dysmenorrhea.

1 Pregnancy that ended as an abortion or stillbirth (in X). No operations.

Findings:
Medium-sized, about 163 cm, slender stature. Vaginal examination: Sparse pubes, labia majora on both sides only lateral and flat. The clitoris is completely absent, instead there is a discretely tight, wider scar with an extension of about 15 mm, cranial, the subcutaneous clitoris portion is a median, flat ridge of about 1 cm in length with only very light palpation. On the scar surface, there are some millimetre-small papilloma-like scar growths. The caudal scar is bounded by a tight, very pressure-sensitive, cranio-convex scar, followed by the thin, sometimes stringy, partly saw-tooth-like, scarred edges of defibulation or dehiscence which are present instead of the labia minora and the medial parts of the labia majora. The external urethral orifice is orthotopic and unremarkable, visible below the scar sheets, the introitus gapes slightly, an arching of approx. 10 - 13 mm large cystocele bulges, the CUW has partially passed. Wall and perineum are largely unremarkable. A further gynaecological examination is not planned.

The finding represents the medical indication at least for clitoris remobilisation surgery and for the elimination of the painful scar tissue, for example, as is offered at the Center for Reconstructive Surgery of the External Female Genital in the German city of Aachen (hospital name in German: Zentrum für Wiederherstellende Chirurgie des äußeren weiblichen Genitales).

Conclusion:
Condition after defibulation or dehiscence of FGM type III/infibulation according to WHO as above (for further information, see above)

Ms F grew up in a poor, illiterate nomad family in a rural setting in southern X, where terrorist al-Shabab militias are exercising their tyranny still today. One of her sisters bled to death due to infibulation as a child. As a member of the X minority, she and her family have only experienced marginalisation, persecution and physical and psychological abuse throughout their lives (see above). When her father died from a snake bite, the family's livelihood was lost, her mother allegedly starved to death soon afterwards, and the two daughters had to head to the next town, where Ms F also lost sight of her older sister. No sooner had she got a precarious job with a family, did she come into the focus of an influential man who wanted to force her to become the latest of his so many wives. Ms F cannot say for sure whether he "only" had the closest ties to the local ruling clan or whether he was an al-Shabab member. Anyway, a life-threatening situation developed for her after a few weeks because she did not want to become his additional wife. She did not really believe his affirmations of love she reported during the hearing at BAMF. What is more, he caused her to stay without work (and therefore without at least a low income). She knew that she had to escape if she wanted to carry on living. So she got into a refugee camp in X, when being asked whether it was camp X, she affirmed. There she met a young man belonging to the ethnicity of X, whom she made friends with and whom she married in the camp.

Shortly after the marriage, she became pregnant, but had a miscarriage. Here it remains open, which timeline has actually taken place. If it was an early abortion, the dates described above regarding the arrival in X, the marriage and the onward journey to Europe fit reasonably. However, if the claim was that it was a stillbirth in the last trimester of pregnancy, with a corresponding obstetric vaginal intervention in the refugee camp, then all information on the death of the parents and the flight to X must be backdated at least 6 – 7 months. So, for example, the statement made to me that her father had died in February YYYY is quite conclusive. Because then the mother would have died around April YYYY, her stay in X would have followed these events until about June/July YYYY and she would already have arrived in X, would have met her husband, e.g. would have become pregnant in August and had the stillbirth in February YYYY, all of course as vague estimates. These incomprehensible contradictions of the given information are immediately understandable for European mentality if one considers the completely different way of life of nomads in X (and other culturally similar countries).

Exact dates hardly play a role in their lives, not even birthdays (e.g.: ... I was born that year when the big rain came …). How can someone who first, does not know any calendar system of the European style, and second, is illiterate come to remember the month in which a particular event took place? Therefore, it would be malicious to accuse Ms F of not properly clarifying the circumstances of her escape. Both versions are possible, and the inconclusive nature of the version is trivial in the face of Ms F's traumas and threats (even on return to Somalia!).

Indeed, in her entire life story, starting with the lifelong degradations, terrorisation and certainly physical violence because she belongs to X, the threatening situation after her parents' deaths and the threatened forced marriage, the subsequent escape into the unknown, vegetating in a crowded mass refugee camp, shock of miscarriage and the traumas suffered (thousands of times also from other refugees), especially in X and on the Mediterranean, and finally the loss of the protective husband on the escape, assuming that Ms F has suffered the most severe mental trauma, the extent of which should be urgently diagnosed psychologically and then treated appropriately. The creation of beneficial concomitant circumstances is also indispensable for the success of therapy, in particular, building the existential security of being allowed to stay in Germany and to be protected from human rights violations and individual, gender-specific persecution.

A return to X would represent a renewed danger to life and limb for Ms F by the influential man who wanted to force her to marry him, possibly in conjunction with the al-Shabab militias. She would be tracked down everywhere in X. So-called internal exile is therefore completely illusory. Her "open" genital condition would make her face reinfibulation and forced marriage at any time. State bodies in X are unwilling and unable to protect women from these threats. For human rights reasons, this only leaves the conclusion that Ms F should be granted a permanent residence in Germany.

The recent declaration of the European Council and the EU Council of Ministers of DD/MM/YYYY regarding "FGM and Forced Marriage" underlines the determination of the European institutions, to support and protect women and girls in particular who are affected by these crimes, including the associated psychological trauma.

PREGNANCY, CHILDBIRTH AND POST-NATAL CARE

Pregnancy and pre-natal care

Informative discussion

Some affected women may not be familiar with the German health care system. Therefore, we recommend to provide them with explanations and information about the type of care in the German system. For example, some women might not understand the reasons for rather frequent, repetitive pre-natal medical check-ups and tests.[53]

Likewise, migrant women are usually unfamiliar with the importance of the maternity notes. Each patient should therefore be advised by her gynaecologist that this document contains important health-related data so that an emergency can be responded to quickly and appropriately. An important piece of information in this context is the type of female genital mutilation/circumcision. Therefore, the professional association of gynaecologists recommend pregnant women to always carry their maternity notes during pregnancy54. This document also provides important information for future pregnancies.

Furthermore, migrant women may have little knowledge of the anatomical and physiological nature of their body and need appropriate information. Based on a drawing, both the “normal” anatomy and physiology of the sexual organs can be explained as well as the changes associated with mutilation or circumcision. Girls and women often do not see the connection between FGM/C and occurring health problems they face. Clear and descriptive information is a prerequisite to explain and make the affected women understand the reasons for a deinfibulation and/or a birth without subsequent reinfibulation.[55]

Provision (pregnancy complications and preliminary examinations)

In obstetrics, complications occur predominantly in women who have an infibulation. It is often not possible to perform vaginal examinations through the remaining opening in the vaginal area. Catheterisation, if necessary, is difficult to carry out, or not possible at all. The Pap smear may not be feasible during pregnancy. Cysts and vulvar abscesses are other complications which might occur, as might do urinary tract infections at an increased risk level. Some of the affected women from certain regions tend to be under-nourished during pregnancy to avoid the birth of a "big" baby and the associated complications. In this case, insufficient weight gain or anaemia is observed during pregnancy.[56]

Pregnancy may be psychologically problematic for affected women due to[57]:

- Fear of the nurse's reaction
- Fear of gynaecological examination
- Fear of pain during or after birth
- Fear of a caesarean section

[53] Richter 2001 | [54] www.frauenaerzte-im-netz.de/schwangerschaft-geburt/schwangerenvorsorge/ (retrieved: 27.09.2018) | [55] Kuckert et al. 2008 | [56] Zerm 2007, Kuckert et al. 2008 | [57] Zerm 2007, Kuckert et al. 2008

Birth

Risks during delivery

Without medical help, the following complications may occur during delivery due to scars obstructing the birth canal:

- Hypertonia (labour spasm) of the uterus
- Atony of the uterus
- Uterine rupture (i.e. muscular wall of the uterus tears during childbirth)
- Delayed progress in the birth with impairment of the foetus and risk of developing a vaginal fistula due to pressure necrosis (if the child's head remains in the birth canal for too long)
- Perineal tears (cracks in the area of the anus) or other maternal complications that can be fatal

In the countries of origin the risk mother and newborn might die is greatly increased. In Germany, a birth that has been adequately overseen should not pose a specific risk to neither mother nor child. Ideally, patients with infibulation should be referred to medical teams or midwives who are well-experienced with FGM-affected women and might, in addition to that, have access to high quality translation (interpretation) services[58].

Birth process

Due to the hardened and hardly extensible circumcision scar in the vaginal area, the child's head coming down cannot adequately dilate the birth canal. The consequences are a slowed and extremely painful birth and, if the scar tissue is not opened, it can result in an uncontrollable tearing of the tissue with injury to the vessels and the urethra and irreversible damage to the nerves. The prolonged labour is also very dangerous for the child due to the consequent lack of oxygen.[59]

In order to make the birth as painless as possible, the examinations of the vagina should be limited to what is necessary. Normal birth is assumed if the patient has previously undergone defibulation. The usual indications apply for a medio-lateral episiotomy. If the patient has not previously received defibulation, the first phase of the delivery can be normal. During the second birth phase, an incision of the infibulated area must be made under peridural anaesthesia. Local anaesthesia might also be considered.[60]

Defibulation

Defibulation is a controversial issue in midwifery. Some authors recommend a systematic defibulation during pregnancy, generally during the second and third trimesters (three-month period). The goal is to avoid the problems that occur during childbirth, especially for inexperienced medical teams. Studies[61] have shown that this approach does not affect the duration of birth, the number of episiotomies or vaginal tears, blood loss, the Apgar score or duration of hospital stay. Studies[62] from countries such as Great Britain in which a defibulation in the second trimester is generally recommended, have shown that the women are opposed to this approach. The same is reported from Switzerland[63]. It is critically questioned why an additional, painful procedure should be carried out during pregnancy if the entire intervention can (also) take place in connection with giving birth. In any case, a defibulation during pregnancy should be considered whenever vaginal examination or catheterisation are necessary to check uricult, proteinuria (pathological protein excretion), etc., which – without defibulation – would not be possible at all. It is crucial to discuss the question of defibulation with the pregnant woman in advance and, if possible, involving her partner. The first consultation must take place as early as possible during pregnancy. If a patient is confronted with the question of defibulation in the delivery room for the first time, she will probably find it much more difficult to accept a procedure that is strange to her and contrary to her traditions.

After-care

The follow-up visit to affected women should take place earlier than usual (three to four weeks after birth). The patient should have the opportunity to ask questions about her altered anatomy and physiology. In particular, the patient must get used to the much shorter times for micturition (urination) and menstruation. The follow-up visit is also an opportunity for health workers to clarify the positive aspects of change and to have a prevention discussion in case a girl is born (illegality of circumcision in Germany, negative consequences for physical and mental health). In some cases, providing psychological support over a longer period of time might be helpful.[64]

[58] Zerm 2007 | [59] Kuckert et al. 2008 | [60] Zerm 2007 | [61] Zerm 2007 | [62] Zerm 2007 | [63] Zerm 2007 | [64] Zerm 2007

Ethics and the legal situation[65]

According to law, there is a distinction between the different forms of (primary) genital cutting and wound care. While the former is a serious bodily injury, the second is a medically necessary measure. Wound care after delivery aims to take care of the opened scars as well as the perineal tear or cut.

If women with infibulation require the restoration of their physical condition as before birth, still after being sensitised by professionals, the doctor must refuse the treatment, since reinfibulation (restoration of infibulation) is also a serious crime according to section 226 a StGB and section 228 StGB.

The primary care objective must always be to avoid re-traumatisation and to support self-care of girls and women after operations to prevent blood and urine drainage obstruction and restore the ability to have sexual intercourse.[66]

3.5 PAEDIATRICIANS

The age at which girls are mutilated or circumcised varies from case to case.

During screening examination a doctor should therefore check the integrity of the genitals or detect any existing genital mutilation/circumcision. The interviews with parents should sensitively but unambiguously point out the importance of physical integrity for the general development of the child and the criminal liability of female genital mutilation/circumcision.

With girls from regions affected by FGM/C, it should be a matter of course for every study to include the genital area in the medical examination as well as to show that paediatricians explicitly pay attention to continued integrity. Ideally, FGM/C should be discussed again in the course of further family medical examinations. It may be useful to ask about the mother's and the father's attitude regarding FGM/C, possibly also individually.[67]

[65] German Society for Gynaecology and Obstetrics 2011 | [66] Kuckert et al. 2008 | [67] stop mutilation 2013

4. RECONSTRUCTION OF THE OUTER FEMALE GENITAL THROUGH PLASTIC SURGERY

An article by Priv.-Doz. Dr. med. Dan mon O'Dey, FEBOPRAS

Reconstruction of a cut/mutilated vagina is a curative and medically necessary measure if considered whigh grave consequences FGM/C (see Chapter 1.5) has in a woman. The form in which such a reconstruction might be carried out strongly depends on the severity of circumcision in each individual case.

4.1 CONDITIONS

The reconstruction of the mutilated outer female genital after ritual circumcision is characterised by both, the clear medical indication and the affected women's will to self-determination. The technical-operational measures are complex and, in addition to a complex form, must take into account a complex function in order to meet the gender-specific psychophysical significance of this part of the female body.

Desire to have children before reconstruction

If the affected woman wishes to have children before the reconstruction, it is recommendable to carry out a medical examination at a department for plastic-reconstructive surgery and gynaecology to check whether inner and outer genitals meet the requirements for pregnancy and birth. During these examinations, health-related aspects have to be considered as well as whether conception and birth via naturalis (vaginal delivery) are possible without complications. If some of these prerequisites do not apply, it is important to talk about it and make appropriate recommendations and offer a solution.

Pregnancy before reconstruction

In the case of a pregnancy before reconstruction, a check-up should be carried out as part of a medical examination in the plastic-reconstructive surgery or gynaecology department to determine whether there is a birth defect. In case of confirmation of an obstacle to birth (such as scarred narrowed vestibulum in FGM type III), it should be considered whether a simple opening under local anaesthesia could effectively remedy the situation outside of the vulnerable phase or if a precautionary caesarean section should be planned as a measure in both, the mother's and the unborn child's interest. Further reconstruction plans can be resumed after pregnancy.

Financing and combining of health insurance funds

Due to the special significance and value of the genital area, its reconstruction should particularly take into account effective and, as it were, specialised surgical procedures in order to provide the patients with the best conditions possible for anatomical normalisation[68]. Such a normalisation will have not only physically, but also psychologically beneficial effects. The surgical reconstruction therefore fulfils all criteria of curative medicine and is by no means an aesthetic indication. Therefore, FGM/C is also listed and firmly established in the ICD system (ICD: International Classification of Diseases) as physical suffering. Therefore, in Germany, the costs of an operative reconstruction are covered by both, the public and the private health insurers with existing insurance coverage. After the reconstruction, the patients usually feel like starting a new life. They feel like a real woman and might be free from any symptoms. These extremely positive effects exert a great influence on the psychological and physical well-being.

[68] O'Dey 2010

4.2 PREPARATION

Patients who would like to present themselves for reconstruction after having undergone FGM/C should either have the linguistic prerequisites to communicate in German or a world language, especially English, or ask someone familiar to accompany them to translate important conversations that serve as operational preparation. In addition to this individual linguistic requirement and/or support, internal interpreters can guarantee effective communication. They should be trained appropriately and be culturally open-minded.

The medical consultation

As part of the medical consultation, the patient's history, current complaints, existing problems and findings are recorded, and the operative planning and further procedures are discussed and defined in detail with the patient. It is very important that the patient becomes aware of the content of the operation, its potential for healing, risks and the necessary pre- and postoperative behaviours.

Role of the specialist

Due to the complex anatomy of the external female genitals and the individual local conditions regarding FGM/C, an in-depth anatomical knowledge of the genital region, a special operative-reconstructive knowledge, microsurgical skills and cultural empathy are indispensable. The consultation of a specialist experienced in this respect therefore represents the greatest possible certainty of an anatomically more normal vulva.

Particularly in the case of atypical findings, such as those frequently found with FGM Type IV, and/or unexpected countries of origin of the affected women, profound professional experience and expertise are important prerequisites for recognising even non-obvious genital damage, presenting reconstructive therapy options and alleviating the patients' complaints accordingly. In this context, curious past histories can also unfold, such as that of a woman from Afghanistan who was violently torn off the labia minora for intimidation, after she wanted to save her two daughters from a planned circumcision.

4.3 RECONSTRUCTION PROCEDURE

Amputation findings on the vulva, particularly FGM/C type III, require complex shape and function reconstructions to achieve anatomical normalisation. The latter includes the reopening and tissue reshaping of the vulva and vaginal vestibule, the recovery and scar removal of the clitoris, usually located at the level of the corpora clitoridis, the microsurgical reconstruction and resection of a glans clitoridis and the embedding of the latter in a newly formed clitoral prepuce (praeputium clitoridis). Although these reconstructive procedures are complex, they enable the affected women and girls to achieve a medically optimal restoration and therefore to regain the form and function of their external genitals.

After female genital circumcision type I - III according to WHO, there is usually a partial amputation of the clitoris at the level of the corpora clitoridis. A surgical technique called OD flap (Omega Domed Flap) developed by O'Dey, the author of this article, reconstructs the prepuce and at the same time ensures clear access to the clitoral organ[69]. After recovery of the scarred clitoris stump, it can be microsurgically reconstructed by means of a further surgical technique, also invented by O'Dey and called NMCS procedure (NMCS: Neurotising and Molding of the Clitoral Stump)[70]. For this, the nervi clitoridis are reintegrated into the newly formed glans clitoridis. The newly formed glans clitoridis is thereby centrally neurotised. The result is a reliably targeted re-innervation and therefore a functional reconstruction of a glans clitoridis.

FGM/C type III according to WHO reflects the most organically severe form of ritual female genital cutting. Anatomically, the main problem is a massive tissue loss. In order to achieve normalisation, it is therefore necessary to add correspondingly similar tissue. Using a new surgical technique called the aOAP flap (aOAP: anterior Obturator Artery Perforator), a versatile reconstructive application is possible, especially for pronounced soft tissue defects of the vulva and vaginal entrance, while ensuring a very tissue-authentic and therefore beneficial for reconstruction of a more anatomically normal vulva[71]. As part of wound closure, the scar at the donor site is positioned almost invisibly, restoring the suculus genitofemoralis. This results in a natural and anatomically correct picture in the area of the flap removal point.

[69] O'Dey 2017 | [70] O'Dey 2017 | [71] O'Dey 2017

4.4 INPATIENT AND OUT-PATIENT TREATMENT

A hospital stay is recommended due to the complexity of the FGM/C surgical reconstructive procedure, the necessary preparations and the complex post-operative support patients will need. This way, ambiguity or uncertainty in dealing with the recovered genital form and function can be adequately resolved without fears or problems or mistakes in handling arise.

4.5 FOLLOW-UP AND SUPPORT

Given the fact that after form and functions have been reconstructed, women usually experience a new, normalised feeling for her body, providing support to the patient is an important issue. During regular visits in the first year following the operation, counselling services are: checking the findings and giving guidance on scar care, provide explanations regarding sensitivity to touch of the clitoris organ, give advice regarding behaviour in everyday life and sexual intercourse, as well as estimates regarding possible vaginal birth/delivery.

4.6 DESIRE TO HAVE CHILDREN AFTER RECONSTRUCTION

In the case of a desire for children after the external female genitals reconstruction, it is strongly recommended to await maturation of scarring. Pregnancy is therefore not recommended earlier than one year after the reconstruction operation took place.

This is especially true against the background of the complex reconstructive measures which often only lay the basis for vaginal delivery. As part of a medical examination, especially at a department of plastic-reconstructive surgery or gynaecology, professionals should check whether the organic conditions of the internal and external genitals are met.

A solution to this problem can only be implemented for the expectant mother with the greatest possible certainty when the decision is made jointly.

In this context too, it should be considered that, in addition to health aspects, it must be weighed up whether a conception is possible without hesitation and/or birth via naturalis (vaginal delivery) can take place without restrictions.

Any deviations should be discussed and doctors should give corresponding recommendations or offer alternatives.

5. RECOMMENDED ACTIONS

	International level	National level	Regional level	Local level	Community level
Establish multidisciplinary cooperation (international networks, Federal Ministries, EU Institutions)	●	●			
Establish multidisciplinary cooperation (networking round tables, nationwide) with INTEGRA		●			
Establish multidisciplinary cooperation (round table, in cities and rural areas)			●		
Establish multidisciplinary cooperation (round table Hamburg)				●	
Offer vocational training opportunities in the health sector to affected women (with lower qualifications)	●	●	●	●	●

	International level	National level	Regional level	Local level	Community level
Introduce a quota for women affected by FGM/C in the education or vocational training system	●	●	●		
A hearing consultation should definitely take place before the hearing at BAMF (at best, before submitting the asylum application)	●	●	●	●	
Hearing consultation		●	●	●	●
Psychological therapy as primary care	●	●	●	●	
Psychological, educational and gynaecological professionals should offer trainings at BAMF		●			
Expand trainings in the area of FGM/C for interpreters and provide a higher number of interpreters	●	●	●	●	●
Establish information centres (counselling services lead by migrant women and men) in the field of FGM/C	●	●	●	●	●
Capacity building in the respective communities to ensure immediate counselling opportunities for those affected	●	●	●	●	●
Create a network of multipliers who transfer knowledge at regional, national and international level	●	●	●	●	●
Empower those affected in the communities	●	●	●	●	●
Legitimate trainings for multipliers in the field of FGM/C	●	●	●	●	
Networking of doctors against FGM/C	●	●	●	●	●
Offer trainings on FGM/C for paediatricians	●	●	●	●	
Offer trainings for refugee helpers	●	●	●	●	●
Offer trainings in the health sector		●			
Document re-excision cases	●	●	●	●	●
Establish counselling centres for outpatient psychological help to provide opportunities for support		●	●	●	
Create a national database of trained interpreters closely cooperating with health insurance offices		●			
Provide cost coverage of health insurance for medical certificates		●			
Create a pool of experts: Consensus on forensic report	●	●	●	●	
Provide a long-term transcultural therapy	●	●	●	●	●
Increase actions against social racism and occupational discrimination, as both lead to the communities being isolated and to making awareness-raising with those affected even more difficult.	●	●	●	●	●

MEDICAL GLOSSARY

Ability to have sexual inter-course	In the narrower, traditional sense of hetero-sexual intercourse with insertion of the penis into the vagina
Abortion	Intentionally induced termination of pregnancy
Abortion/ Miscarriage	Termination of pregnancy before the 24th week of pregnancy
Amenorrhoea	Cycle disorder with no menstruation
Anaemia	Reduction of erythrocyte count, haemoglobin concentration and/or hematocrit
Anaesthesia	Total insensitivity to pain, temperature and touch stimuli. The term is also commonly used for performing anaesthesia.
Anamnesis	Medical history of a patient
Apgar Score/ Apgar Index	Point scheme for assessing child-related well-being after birth
Atony	Flaccidity, relaxation due to lack of tissue tension
Caudal	Directed toward the tail, towards the foot end, lying downwards
Circumcision	Cutting, mutilation
Circumcision scar	Scar as a result of circumcision
Clitoral prepuce	Clitoral hood, prepuce of clitoris
Clitoral tip	Female erectile genitals at the front end of the labia minora
Conception	Fertilisation by the fusion of semen and egg
Corpus clitoridis	Clitoris shaft containing part of the corpus cavernosum clitoridis. It is located between the crus clitoridis and the glans clitoridis
Cranial/cranialis	Belonging to the head or towards the head
Defibulation	In the context of genital mutilation, surgical opening of the ostium vaginae which was closed by infibulation
Dysmenorrhea	Primary (since the menarche) or second-ary painful menstruation (partly colicky or labour-like)
Dyspareunia	Constant or very frequent pain of differ-ent origin in women or men for at least 6 months during coitus in the genital area and in the pelvis
Episiotomy	Obstetric surgery for enlargement of the pelvic outlet (cut to vagina in childbirth)
Eumenorrhea	Normal flow menstruation which lasts 3 to 7 days
Genitofemoral nerve	Mixed nerve of the lumbar plexus (plexus in the area of the lumbar spine)
Gestational diabetes	Disturbed glucose tolerance of the mother occurring in pregnancy for the first time
Glans clitoridis	Small mass of highly sensitized erectile tissue capping the body of the clitoris.
Hypertension	Tension or pressure increase beyond the physiological value, e.g. of the muscles, the intracranial pressure or the pressure in blood vessels
Incision	Separation of the body's own tissue or opening of a pathological cavity, e.g. for the treatment of an abscess
Infibulation	Genital mutilation with partial closure of the vaginal entrance by rings or staples or by scarring after mutilation and suture
Introitus vaginae	External entrance to the vagina, located in the vulval vestibule (vestibulum vaginae)
Keloid	Rough, flat or shaped like a cord, sometimes itchy connective tissue growth
Kraurosis	Obsolete name for atrophic-sclerosing dystrophy (state of shrinkage) of the transi-tional mucous membranes, especially in the genital area (craurosis vulvae or craurosis penis). This leads to severe itching
Labia majora/ Labia majora pudendi	Outer lips
Labia minora/ Labia minora pudendi	Inner lips
Labium minus/ Labium minus pudendi	Paired skin folds, as part of the vulva count-ing to the outer genital
LSA	Liebowitz Social Anxiety: External assess-ment procedure for detecting social anxiety
Lubrication	Transudation of a mucoid substance (lubricating substance) through the vaginal epithelium during the sexual arousal phase
Mediolateral episiotomy	The medio-lateral episiotomy is performed from the midpoint at a 45° angle and can be guided longer because of the lack of boundary through the anus, resulting in a higher space gain
Menarche	First appearance of menstruation in puberty between the ages of 9 and 16 in Western industrialised countries
Micturition	Urination or emptying of the urinary bladder

Nervi clitoridis	Bundles of nerve fibres surrounded by connective tissue that serve the saltatory conduction
Neurotisation	Regeneration, formation of a severed nerve
Nulligravida	Latin term describing that a woman has never been pregnant
Obese	Fatty, adipose
Obesity	Increase in body fat above the normal extent
Orificium externum urethrae	Outer urethral opening
Orthotopic	Locally consistent, e.g. orthotopic transplantation of an organ
Palpable	Touchable under the skin (e.g. of organs), tangible, can be felt
Palpate	Examine by touching
Pap smear	Papanicolaou smear / gynaecological smear followed by special staining (papanicolaou staining) for cytodiagnosis
Partial ovariotomy	Surgical removal of a female gonad (ovary)
Peridural anesthesia	PDA, central spinal cord anaesthesia
perineal tear	The rupture of the perineum, often also of the anterior third of the vagina
Perineum	Structure of muscle fibres and connective tissue tracts between the anus and scrotum (man) or vagina (woman)
Pressure necrosis	Necrotic tissue area due to the effect of pressure
Proteinuria	Excretion of proteins in the urine
Pubes	Pubic hair, pubic region
Reinervation	The restoration of conduction of neural signals by nerve regeneration
Reinfibulation	Repeated genital mutilation with partial closure of the prepuce of the vaginal entrance by rings or staples or by scarring after mutilation and suture
Resection	Operative removal of a (diseased) organ part
Sepsis	Complex systemic inflammatory response to infection with endangerment of vital functions (blood poisoning)
SGA	Small for Gestational Age, that is, deficient, below-average size growth
Spontaneous labour	spontaneous birth, childbirth, miscarriage
Subcutaneous	Under the skin
Sulcus	Groove or channel, e.g. the limitation of the cerebral convolutions at the surface of the brain
Trimester	Period of 3 months. Pregnancy is divided into 3 trimesters: first trimester 1st to 12th week of pregnancy, second trimester from 13th to 28th week of pregnancy, third trimester from 29th week of pregnancy until birth (40th week of pregnancy)
Umbilical hernia	Congenital or acquired, often painless, hernia that passes through the umbilical ring (umbilical hernia)
Uricult	Bacteriological diagnosis of urinary tract infections
Uterine rupture	Tear of the musculature of the uterus, occurs during pregnancy (rarely) or during childbirth
Vestibulum	Entrance area, atrium of a structure or body cavity, e. g. vestibulum vaginae (vulval vestibule)
Virgo	Virgin
Week of pregnancy	Actual duration of pregnancy (gestational age)

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ANNEX

FEMALE GENITAL MUTILATION/CIRCUMCISION IN OTHER LANGUAGES[72]

Country	Language	Description	Meaning
Benin	French	**Excision**	Excision
Burkina Faso	French	**Excision**	Excision
Burundi	French	**Excision**	Excision
	Swahili	**Tohara kwa wanawake**	Circumcision of women
Central African Republic	French/Sango	**Ganza**	Circumcision
Chad	Nilo-Saharan languages (sara-bongo-bagirmi)	**Bagne** **Gadja**	Traditional female initiation Derived from “ganza”, used in the Central African Republic
Colombia	Embera	**Curación**	Cure/healing/treatment
Democratic Republic Congo	Swahili Swahili	**Kukeketwa**	Female circumcision
		Tohara kwa wanawake	Circumcision of women
Djibouti	French	**Excision**	Excision
	Swahili	**Gudnin**	Circumcision
Egypt	Arabic	**Khitan**	Circumcision
		Khifad	From the arabic word „khafad“, that means „to lower“ (rarely used)
		Thara	To clean/purify
Eritrea	Tigregna	**Mekhnishab**	Circumcision/cutting
	Amharic	**Grazate**	Circumcision
Ethiopia	Amharic	**Megrez**	Circumcision/cutting
	Harrari	**Absum**	Name giving ritual
Gambia	Mandinka	**Niaka**	Literally to cut/weed clean
		Kuyungo	The affair/hut where the initiation rite takes place
		Musolula Karoola	The women’s front side / what defines a woman
Ghana	English	**Female circumcision**	Female circumcision
Guinea	English	**Female circumcision, excision**	Female circumcision, excision
	French	**Excision**	Excision
Guinea-Bissau	Creole	**Fanado**	Circumcision
		Fanadu di mindjer	circumcision of girls
India	Lisan ud-Dawat (dialect of Gujarati)	**Khatnauracion**	Circumcision
Indonesia	Bahasa Indonesia	**Sunat perempuan**	Female sunnah or tradition
		Sunat	Circumcision
Iran	Kurdish (Sorani dialect)	**Khatana (خەتنە)**	Circumcision
	Farsi	**Sunat**	Circumcision
Iraq Kurdistan		**Khatana (خە تە نە)**	Circumcision
Ivory Coast	French	**Excision**	Excision
	English	**Excision**	Excision
Java	Javanese	**Kres** **Tetesan**	Hatching/Pricking

[72] cf. National FGM Centre; FORWARD 2012

Country	Language	Description	Meaning
Kenya	Swahili	**Kutairi**	Circumcision
		Kutairi was ichana	Circumcision of girls
		Kukeketwa	Female Circumcision
		Tohara kwa wanawake	Circumcision of women
Malawi	English	**Initiation**	Step into adulthood
Malaysia	Malay	**Wajib**	Any religious duty commanded by Allah (God)
		Sunnah	Religious tradition/obligation (for Muslims)
Maldives	Divehi	**Sunnah**	Religious tradition/duty (for Muslims)
Mali	French/Bambara	**Selidjili**	Ritual for purity, ablution (religious washing)
		Bolokoli	To wash your hands
		Sunnah	Religious tradition/duty (for Muslims)
	French	**Excision**	Excision
Mozambique	Swahili	**Tohara kwa wanawake**	Circumcision of women
		Kukeketwa	Female Circumcision
Niger	Hausa	**Kaciyar mata**	Female Circumcision
Nigeria	Igbo Yoruba	**Ibi/Ugwu**	The act of cutting Female circumcision
		Dida abè fun omo-birin	Bathing before delivery
	Ibo Mandingo	**Isa aru Sunnah**	Religious tradition/duty (for Muslims)
Oman	Arabic	**Khifad (خفاد)**	Circumcision
		Badhr (بضر)	Clitoris
Pakistan	Urdu	**Khatna**	Circumcision
Panama	Embera	**Curación**	Cure/treatment
Peru	Embera	**Curación**	Cure/treatment
Philippines	Filipino	**Pag-islam/tuli**	Circumcision
		Sunnah	Religious tradition/duty (for Muslims)
Rwanda	Kinyarwanda	**Bukgukuna imishino Guca imyeyo**	Stretching of the labia
Saudi Arabia	Arabic	**Sunnah**	Religious tradition/duty (for Muslims)
Sierra Leone	Soussou	**Sunna**	Religious tradition/duty (for Muslims)
	Mendee	**Bondo/sonde**	Integral part of the initiation rite into adulthood (for non-Muslims)
	Mandinka	**Halalays**	Sanctioned – implies purity
	Mandingo, Limba, Temenee	**Bondo**	Integral part of an initiation rite into adulthood (for non-Muslims)
Singapore	Malay	**Sunat perempuan**	Female Sunnah/circumcision or tradition
		Sunat	Circumcision
		Khitan perempuan	Female Circumcision
Somalia	Somali	**Gudiniin**	Circumcision
		Halalays	From the Arabic “halal”, means sanctioned – implies purity (used in the northern part)
		Qodiin	Stitching/tightening/sewing – referring to infibulation

Country	Language	Description	Meaning
Sri Lanka	Tamil	**Sunnah**	Religious tradition/duty (for Muslims)
Sudan	Arabic	**Khifad**	Lowering
		Tahoor	Purification/Pureness/circumcision
		Takhor	Purification/Pureness/circumcision
Tanzania	Swahili	**Kukeketwa**	Female Circumcision
		Tohara kwa wanawake	Circumcision of women
	Malay	**Sunat perempuan**	Female sunnah or tradition
		Sunat	Circumcision
Togo	English	**Female circumcision**	Female Circumcision
	French	**Excision**	Excision (to cut out)
Turkey	Turkish	**Kadin sunneti**	Circumcision of women
Uganda	Swahili	**Sunnah**	Religious tradition/duty (for Muslims)
		Kukeketwa	Female Circumcision
		Tohara kwa wanawake	Circumcision of women
Yemen	Arabic	**Al-takmeed (التكميد)**	Compression
Zimbabwe	Arabic	**U kwevha**	Elongation of the labia minora
		Sunnah	Religious tradition/duty (for Muslims)

Note: Translations generally tend to be ambiguous and might therefore also be interpretative. This is also true in this case.

TEMPLATE: QUESTIONNAIRE
SPECIAL CONSULTATION FOR REFUGEE WOMEN IN THE CONTEXT OF FGM AND OTHER HUMAN RIGHTS VIOLATIONS

by Dr med. Christoph Zerm

German/Englisch/French/...../Translator:

Questionnaire: Special Consultation for Refugee Women in the Context of FGM and other Human Rights Violations

Date: **Time:** City/town:

Last name: **First name:**

Date of birth: **Ethnicity:**

Country of origin: **Religious:**

Born/raised in (city/region):

Family/siblings (number, who is (still) alive and where do they live): Sisters: Brothers:

Mother what is her position [in the family] like?

Father

Education (School until class/graduation from: /Vocational training)

Date of leaving her home country: Means of transport: **Has been in Germany since:**

Overland route/ Flight/

Reason for emigration: continue on next page, if necessary!

(risk of) **forced marriage** (...) when:

FGM at the age of:

Human trafficking/forced prostitution (...)
(Raped (several times?) – when, where)

Operations, serious illnesses:

not recalled
Menarche: Y.; Menstruation: ir-/regular monthly/; **Eu-/Dys-Menorrhoe;** **LP:**
Pregnancy: **Sp.-/partus by section:**
Miscarriage:

Children (some?) living with her in Germany?
Physique: slim / medium / strong / obese (approx. ..... cm / lt. ID) **Suspected PTSD (...)**
stocky

Already legally represented? Name/address of the lawyer:

Who should the report be sent to? Email address? To whom is the bill to be sent?

Current address:
Phone:
Interpreter:
Will come alone/accompanied by **advisor**:

Supervising organisation:

How did you hear about us?

PLAN INTERNATIONAL

Plan International is an independent organization, with no religious, political or governmental affiliations. We stand up for children's rights worldwide and strive to be open, accountable and honest in what we do. We have been working for over 80 years to tackle poverty, violence and injustice. In more than 70 countries, girls and boys are encouraged to actively shape their future. Our main objective is to achieve sustainable change and to enhance the living conditions of the people in our partner countries. When disasters or conflicts threaten their lives and well-being, we are quick to respond. The United Nations Sustainable Development Goals encourage us to continue to strengthen girls and women and promoting gender equality. Our ambition is to transform the lives of 100 million girls so that they can learn, lead, decide and thrive.

PLAN INTERNATIONAL

Bringing hearts and minds together for children

Plan International Deutschland e.V.
Bramfelder Straße 70
D-22305 Hamburg

Tel.: +49 (0) 40 61140 - 0
Fax: +49 (0) 40 611 40 - 140
E-Mail: info@plan.de

www.plan.de

Bundesministerium für Familie, Senioren, Frauen und Jugend

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