No Peace Without Justice
Non c'è pace senza giustizia

DIFFERENZA DONNA
WOMEN AND GIRLS AGAINST VIOLENCE

La palabre

WOMEN SAFE INSTITUT en santé génésique

BEFORE

Best practices to Empower women against Female genital mutilation, Operating for Rights and legal Efficacy

PROTECTION, PREVENTION AND TREATMENT OF FGM

A training tool

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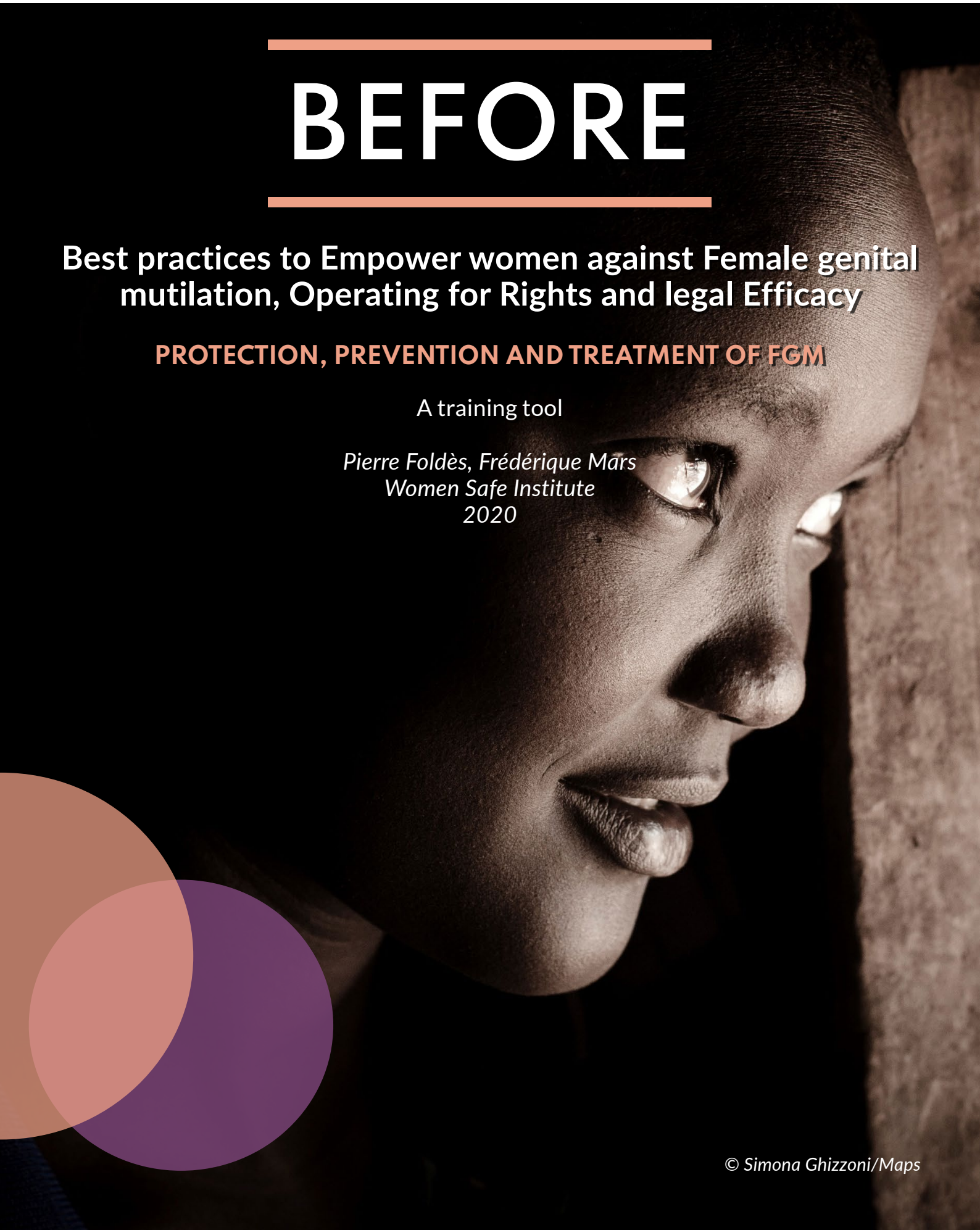
Women Safe Institute
2020



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Module I

Female genital mutilation – An introduction

Educational Goals

There are three types of skills to develop: Decide, Inform/Advise, Support. The specific skills depend on the type of role of the trainee.

Decide

- Build a case for the care and protection of the women who are victims of FGM
- Advocate for the care and protection of women at risk
- Develop public policy

Inform/Advise

- Identify victims or those at risk
- Describe/List risk factors
- Discuss the views of victims or those at risk

Support

- List the risk factors
- Categorize the types of FGM
- Review new academic contributions

Method:

The deductive method is used for this module. A combination of the affirmative and interrogative methods is the most appropriate. Active learning can be used at the end of the course after knowledge acquisition, e.g.: role-play an interview between two professionals.

This module is an introduction to the training.

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Definitions

Violence

The concept of violence is generally associated with physical force or physical abuse. However, it is more than that and violence can be defined as "the use of some type of force, coercion, or pressure" (UNFAP).

Physical violence

This is defined by the WHO is "the intentional use of physical force that has a likelihood of resulting in death, injury, or psychological harm". The United Nations High Commissioner for Refugees (UNHCR) describes physical violence more specifically as "beating, punching, kicking, burning, maiming or killing with or without a weapon".

Gender

The term sex refers to biologically determined characteristics while gender refers to socially constructed characteristics attributed to men and women. While sex characteristics are biological, social differences between men and women are acquired, vary over time and from one culture to another.

Examples of categorization based on biological sex:

- *Women menstruate*
- *Men have testicles*

Examples of categorization based on gender:

- *Women are better able to manage household chores than men,*
- *Women are sensitive, men don't cry.*

Gender-Based Violence (GBV)

This is a term used to describe any harmful act that is perpetrated against a person's will, and that is based on socially ascribed differences between genders.

Acts of GBV violate a number of universal human rights protected by international texts (the right to physical integrity, the right to life, the right to be free from torture and cruel, inhuman or degrading treatment, the right to equality and to non-discrimination, etc.).

GBV is based on social and cultural representations relating to the place given to each gender in a society. It reflects the inequalities in the distribution of power between men and women (decision-making power of men over women, subordination, social and economic devaluation, etc.). This type of violence particularly affects women, but it is important to recognize that children and men also suffer from GBV and that this is an even more difficult reality to grasp.

Victim or survivor

Victim and survivor are terms that are often used interchangeably and are used to refer to individuals who have experienced or are experiencing GBV. MdM prefers to use the term "survivor", as a victim of violence becomes a survivor when he/she no longer suffers this harm. The term survivor is thus used to underline the strength of the person and their refusal to be part of a victimization process. It therefore implies the notion of resilience. However, since the reconstruction process is not linear, a person who has experienced GBV may feel like a survivor at times, but a victim at other times.

Harmful traditional practices

These practices can take different forms of physical and sexual violence: selective and abortion and feminicide, Female Genital Mutilation, forced marriage, forced sexual initiation, etc. These practices must be considered as violence as such because they are harmful to health and physical and moral integrity. Furthermore, they pose real public health challenges.

Female genital mutilation (FGM)

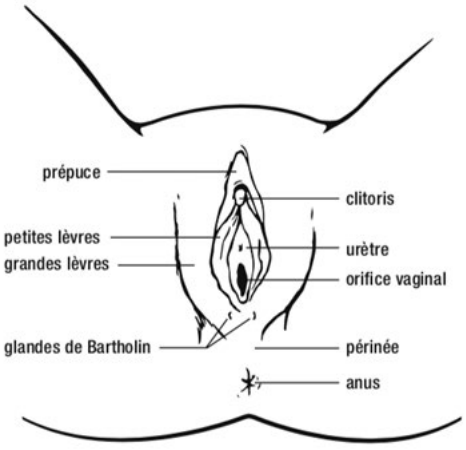
Definition

Female genital mutilation or Female Sexual Mutilation involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons[1]. Female genital mutilation is a procedure that intentionally alters or causes injury to a woman's external genitalia. The procedure is most often performed by traditional circumcisers, who often play a central role in communities, including as birth attendants. In many places, Female Genital Mutilation is performed by medical personnel because of the mistaken belief that the procedure is less dangerous when it is medicalized[2].

Types

The WHO defines four types of FGM. The first illustration shows the unaltered female genitalia for comparison.
Although the extent of genital tissue removal is generally greater when moving from Type I to Type III, there are exceptions.

Organes génitaux féminins non altérés



1 WHO guidelines on the management of health complications from Female Genital Mutilation. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.
2 https://www.who.int/fr/news-room/fact-sheets/detail/female-genital-mutilation

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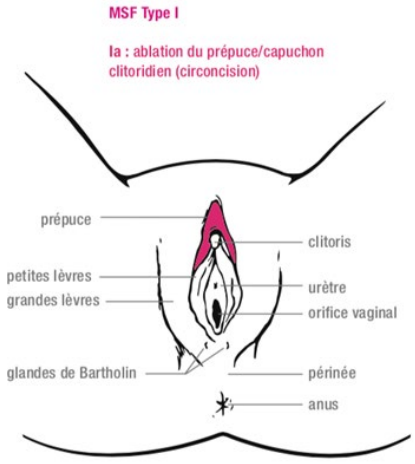
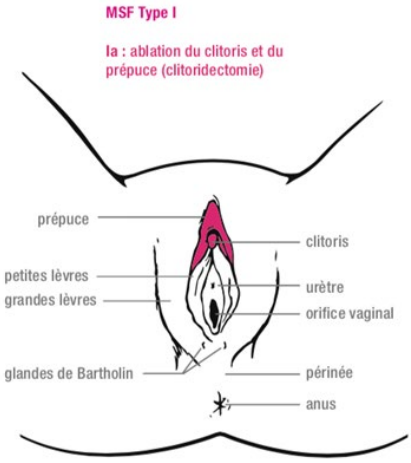
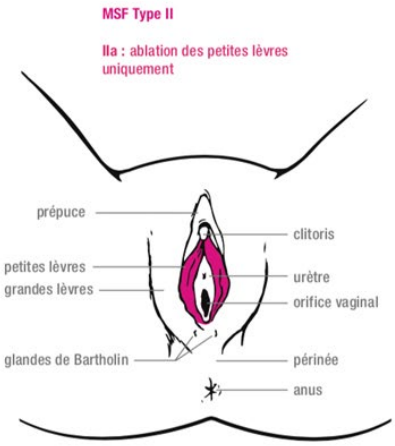
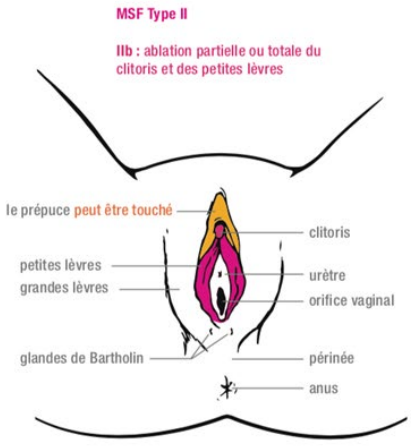
Type I Ablation partielle ou totale du clitoris (clitoridectomie) et/ou du prépuce

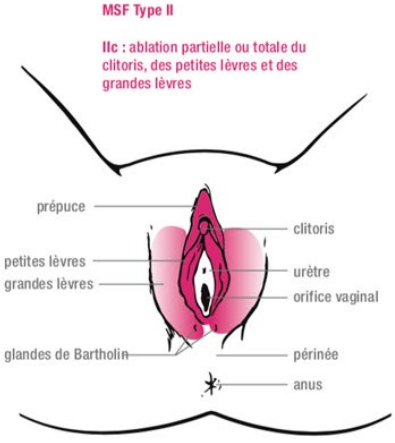




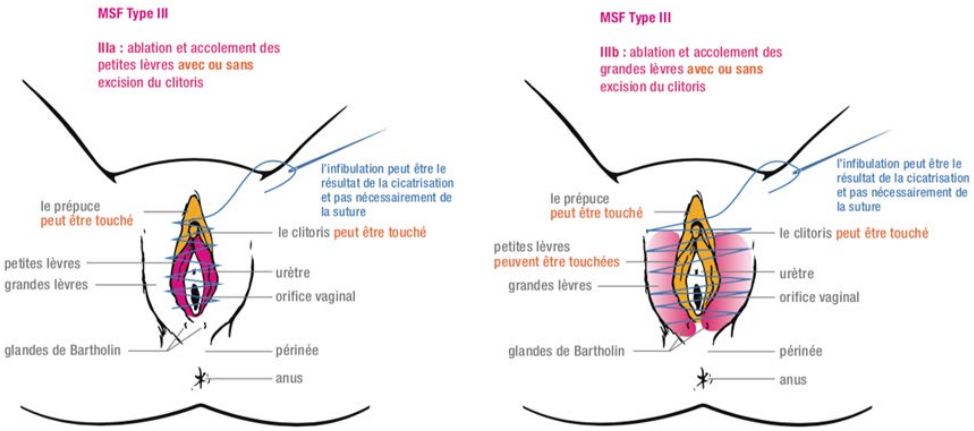
Type II Ablation partielle ou totale du clitoris et des petites lèvres, avec ou sans excision des grandes lèvres (excision)





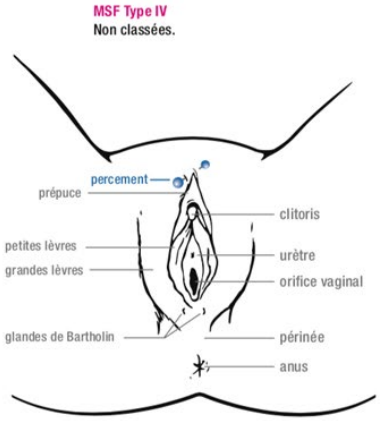


Type III Rétrécissement de l'orifice vaginal avec recouvrement par l'ablation et l'accolement des petites lèvres et/ou des grandes lèvres, avec ou sans excision du clitoris (infibulation)



Réinfibulation Procédure consistant à rétrécir l'orifice vaginal chez une femme après une désinfibulation (notamment après un accouchement) ; également appelée re-suture.

Type IV Toutes les autres interventions nocives pratiquées sur les organes génitaux féminins à des fins non thérapeutiques, telles que la ponction, le percement, l'incision, la scarification et la cautérisation



The severity and risks are closely related to the anatomical significance of the removal, including both the type and amount of tissue removed, which may vary from one type to another. For example, Type I generally includes the removal of the clitoris (Type Ib) and Type II mutilation involves the removal of both the clitoris and the labia minora (Type IIb). In this case, Type II would be more severe and associated with a greater risk. In some subtypes of Type II, however, only the labia minora are cut off and not the clitoris (Type IIa), in which case some risks, such as the risk of haemorrhage may be lower, while other risks, such as the risk of genital infection or scarring, may be the same or higher. Similarly, Type III FGM is mainly associated with more serious health risks than Type II FGM, such as complications when giving birth. However, with regard to infertility, an important factor is the anatomical extent of the removal, i.e. whether or not it includes the labia majora rather than the covering seal. As a result, Type II FGM that includes removal of the labia majora (Type IIc) is associated with greater risks of infertility than infibulation (Type IIIa) that is performed only on the labia minora (Almroth et al., 2005b). Since the clitoris is a very sensitive sexual organ, Type I FGM that

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includes the removal of the clitoris may decrease sexual sensitivity more than Type III FGM in which the clitoris is left intact while infibulation is performed (Nour et al., 2006)[3].

Classification issues

The questionnaire currently used in demographic and health surveys does not differentiate between Type I and Type II FGM, but only between whether a girl or woman has had her external genital organs removed, whether tissue has been removed and whether the tissue has been sutured. Most studies on types of Female Genital Mutilation, including demographic and health surveys, are based on self-reported statements made by women. Studies involving clinical assessment have found large discrepancies in the level of consistency between women's self-reported descriptions and clinically observed types of Female Genital Mutilation (Morison et al., 2001; Msuya et al., 2002; Snow et al., 2002; Klouman et al., 2005; Elmusharaf et al., 2006a). The most frequent discrepancy is that a high percentage of women in areas where Type III mutilation has traditionally been practiced report having undergone Type I or II FGM, even if clinical examination indicates Type III FGM (Elmusharaf et al., 2006a). In addition, the reliability of clinical observations may be limited by natural anatomical differences and the difficulty in assessing the amount of clitoral tissue present under infibulation.

Consequences/Risks

Female genital mutilation provides no health benefits and is harmful to girls and women in many ways. It involves the removal of or injury to normal, healthy genital tissue and interferes with the natural functioning of the female body. In general, the more extensive the procedure, the greater the risks.
There is no known health benefit. In addition, the removal and alteration of healthy genital tissue interferes with the natural functioning of the body and can have a variety of immediate and long-term health consequences. As a result, girls and women who have undergone these procedures are at risk of life-long complications[4].

3 Eliminate Female Genital Mutilation: inter-agency declaration OHCHR, WHO, UNAIDS, UNDP, UNCEA UNESCO, UNFPA, UN-HCR, UNICEF, NIFEM.
4 Idem

Summary table of FGM risks

Health risks related to FGM[5]
IMMEDIATE RISKS
Haemorrhages
Pain
Haemorrhagic, neurogenic or septic shock
Genital tissue oedema due to an inflammatory response or local infection
Infections: Acute local infections; abscess formation; sepsis; infections of the reproductive system; urinary tract infections; infections, such as tetanus
Fever
The direct association between FGM and HIV is unclear, but damage to the genital tissue may increase the risk of HIV transmission.
Urinary tract problems; acute retention of urine; difficulty urinating; lesion of the urethra
Damage to adjacent genital tissue
Healing problems
Death due to severe bleeding or sepsis
OBSTETRIC RISKS
Cesarean delivery
Postpartum bleeding of at least 500 ml blood loss after delivery
Episiotomy
Prolonged labour
Obstetric tears/lacerations
Instrumental delivery
Difficult labour / dystocia
Extended hospital stay for the mother
Neonatal intensive care
Newborn death

5 Idem

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RISKS RELATED TO SEXUAL FUNCTIONING
Dyspareunia (painful sexual intercourse: the risk of dyspareunia is higher for Type III FGM) for types I and II FGM (6)
Decreased sexual satisfaction
Decreased sexual desire and arousal
Decreased lubrication during intercourse
Decreased frequency of orgasms or anorgasmia
Health risks related to FGM (cont'd)
PSYCHOLOGICAL RISKS
Post-traumatic stress disorder (PTSD)
Anxiety disorders
Depression
LONG-TERM RISKS
Genital tissue damage resulting in chronic pain in the vulva and clitoris
Scarring and keloid issues
Vaginal discharge due to chronic infections
Vaginal itching
Menstrual problems; dysmenorrhea; irregular menstruation and menstrual blood flow difficulties
Reproductive system infections can cause chronic pelvic pain
Chronic genital infections including increased risk of bacterial vaginosis
Recurring urinary tract infections
Painful urination due to obstruction and recurrent urinary tract infections
Need for new surgical operations For example, when the FGM results in the closing or narrowing of the vaginal opening, the vaginal opening will have to be reopened to allow the woman to have sex and give birth (deinfibulation) The vaginal opening is sometimes closed several times, including after childbirth, which increases and multiplies the immediate and long-term risks

6

6 WHO guidelines on the management of health complications from Female Genital Mutilation. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Epidemiology

Female Genital Mutilation affects or could affect 200 million girls and women. Genital mutilation is mostly practised on young girls between childhood and adolescence and occasionally on adult women. More than 3 million young girls a year are threatened by these practices.

Medicalization

The medicalization of FGM refers to situations in which such mutilation (including reinfibulation) is performed by health personnel, whether in a private or public clinic, at home or elsewhere, at any stage of a woman's life. FGM is a harmful and unethical practice that has no benefits and should not be performed under any circumstance[7].

Communities may also call upon caregivers to perform the procedure for a variety of reasons. An important factor is that FGM has been treated for years as a health problem, considered in terms of health risks. This approach involves locally recognized health specialists who express concerns about the health risks associated with FGM, in the form of fact-based educational messages (22). In several countries with a high prevalence of FGM, this approach unfortunately did not encourage individuals, families or communities to abandon the practice; however, they have begun to move away from traditional circumcisers as they turn to modern practitioners in the hope that this will reduce the risk of complications. This highlighted a problem: while providing information on the health risks associated with FGM is an important element to eliminate the practice, it is not enough to eradicate a practice that is essentially based on cultural beliefs and deeply rooted in social traditions.

Another side effect of this approach to FGM is that some professional organizations and governments are increasingly supporting less radical forms of mutilation (e.g. clitoral puncture), practised under hygienic conditions and medical supervision; these strategies are an attempt to reduce the risk of severe complications from the procedure when performed in unsafe conditions.

This situation - coupled with the fact that some providers still consider some forms of FGM to be harmless and many are unable or unwilling to speak out when faced with critical issues such as requests to perform FGM or reinfibulation - has contributed to the increased popularity of the medicalization of FGM in Africa and the Middle East. Moreover, the involvement of health personnel in FGM is likely to give some degree of legitimacy to the practice and may give the impression that it is good for women's health, or at least that it is harmless.

The WHO initiated an action to end this unintended consequence in 1979 at the First International Conference on FGM, held in Khartoum, Sudan, by stating that it was unacceptable to suggest that the practice of less invasive forms of FGM in medical facilities would reduce complications. Since then, this position has been adopted by a large number of medical professional associations, international institutions, non-governmental organizations (NGOs) and governments. The condemnation of the medicalization of FGM was reiterated in the 2008 interagency statement on the elimination of FGM. Stopping the medicalization of FGM was recognized as an essential element of the comprehensive, human rights-based approach to the elimination of the practice: when communities see that health-care providers take a position in favour of

7 WHO guidelines on the management of health complications from Female Genital Mutilation. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

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abandoning FGM and refraining from its practice, it will encourage local debate and challenge the practice.

The medicalization of Female Genital Mutilation is never acceptable. The practice violates medical ethics because 1) mutilation is a harmful practice; 2) medicalization perpetuates FGM; and 3) the risks of such procedures outweigh the perceived benefits[8].

Cultural and social factors

FGM is practised for a variety of socio-cultural reasons, which vary from region to region and ethnic group to ethnic group, the main one being that it is part of the community's history and cultural traditions. In many cultures, Female Genital Mutilation is a rite of passage to adulthood and is also practised to confer a sense of ethnic and cultural identity within the community. In many contexts, social acceptance is the main reason for perpetuating the practice. Other reasons include preserving virginity before marriage, promoting eligibility for marriage (i.e. increasing a girl's chances of finding a husband), ensuring fidelity after marriage, avoiding rape, providing a source of income for circumcisers as well as aesthetic reasons (cleanliness and beauty).

Whatever the reason, FGM reflects deep-rooted gender inequality and is a well-established socio-cultural practice, making its total elimination extremely difficult. For this reason, efforts must continue to prevent FGM worldwide and ultimately eradicate it while at the same time helping girls and women who are already living with the consequences of FGM and whose health needs are not fully met at present[9].

The reasons for Female Genital Mutilation vary from region to region and over time, and various socio-cultural factors within families and communities are involved. The most frequently cited reasons are:

- Where Female Genital Mutilation is part of a social convention, the social pressure to conform to what others are doing or have always done as well as the need for social recognition and the fear of rejection by the community, constitutes a strong motivation to perpetuate this practice In some communities, Female Genital Mutilation is an almost universal practice that is very rarely contested.
- Female genital mutilation is often seen as part of a girl's basic education and preparation for adulthood and marriage.
- Female genital mutilation is often motivated by beliefs about what is considered appropriate sexual behaviour. It is aimed at ensuring premarital virginity and marital fidelity. Many communities believe that Female Genital Mutilation is believed to reduce female libido, thus helping women to resist extramarital sexual acts. When a vaginal opening is blocked or narrowed (Type 3), the fear of pain if it is reopened and the fear that it will be discovered is also believed to discourage women from having sex outside marriage.
- Female genital mutilation is practised in communities where it is believed to help the girl's marriage.
- Female genital mutilation is associated with cultural ideals of femininity and modesty, according to which young girls are "clean" and "beautiful" after the removal of parts of their anatomy that are considered "unclean" and "not feminine or masculine".
- Although there is no religious text prescribing this procedure, practitioners often believe that it has a religious basis. Some communities believe that FGM is a religious obligation, although it is not mentioned in any major religious text, such as the Koran or the Bible. In fact, FGM predates Islam,and many Muslim countries do not practice FGM although it is practised in certain Christian communities.
- Religious authorities take varying positions with regard to Female Genital Mutilation: some advocate it,

8 Guiding Principles, Idem
9 Idem

others consider it foreign to religion and still others contribute to its elimination.

- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.
- In most societies, Female Genital Mutilation is considered a cultural tradition, an argument often put forward to perpetuate it.
- In some societies, the recent adoption of this practice is explained by the desire to copy the traditions of neighbouring groups. Sometimes there is a religious or traditional revival at the origin of the practice.

Geographic distribution

Widespread in 30 African countries and in a few countries in Asia and the Middle East, this practice is now present everywhere on the planet due to international migration[10]. Some forms of FGM have also been reported in other countries, including among certain ethnic groups in Central and South America[11].

Country	Year	Estimated prevalence of Female Genital Mutilation among girls and women aged 15-49 (%)
Benin	2001	16.8
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Côte d'Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea-Bissau	2005	44.5

10 Idem
11 Female genital mutilation/cutting: a global concern. Geneva: UNICEF; 2016 (http://data.unicef.org/ resources/female-genital-mutilation-cutting-a- global-concern.html, accessed 26 April 2016)

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Kenya	2003	32.2
Liberia*		45.0
Mali	2001	91.6
Mauritania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19.0
Uganda	2006	0.6
Central African Republic	2005	25.7
Tanzania	2004	14.6
Senegal	2005	28.2
Sierra Leone	2005	94.0
Somalia	2005	97.9
Sudan, north (around 80% of the total population surveyed)	2000	90.0
Chad	2004	44.9
Togo	2005	5.8
Yemen	1997	22.6

* The estimates come from various studies carried out at the local and sub-national levels (Yoder and Khan, 2007)[12]. In other countries, studies have reported Female Genital Mutilation, but no national estimates have been made. These countries are as follows: India, (Ghadially, 1992), Indonesia (Budiharsana, 2004), Iraq (Strobel and Van der Osten-Sacken, 2006), Israel (Asali et al., 1995), Malaysia (Isa et al., 1999), United Arab Emirates (Kvello and Sayed, 2002)

There is also anecdotal data on Female Genital Mutilation in several other countries, including Colombia, Oman, Peru, the Democratic Republic of the Congo and Sri Lanka. Countries in which Female Genital Mutilation is practised only by migrant populations are not included in the above lists.

12 Eliminate Female Genital Mutilation: inter-agency declaration OHCHR, WHO, UNAIDS, UNDP, UNCEA UNESCO, UNFPA, UNHCR, UNICEF, NIFEM.

FGM in France

The practice of Female Genital Mutilation (hereinafter FGM) appeared in France with African migration and entered the public debate in 1982, when a baby, Bobo Traoré, died as a result of FGM. The practice developed in the 1980s, then gradually declined from the 2000s onwards, particularly for FGM practised in France But the practice has not disappeared, and minors remain a population at risk, particularly teenage girls, especially during stays in their parents' country of origin.

According to a study by the United Nations High Commissioner for Refugees, France is the leading country of asylum for women and girls who are victims of Female Genital Mutilation. Between 2008 and 2011, more than 20% of women seeking asylum in France were from countries where FGM is practised. According to OFPRA's [French Office for the Protection of Refugees and Stateless Persons] 2014 activity report, the countries concerned by the issue of FGM stand out among the nationalities for which the admission rates for asylum applications have been the highest in recent years (until 2012). As of 31 December 2014, nearly 4,000 girls had been granted protection status in France against the risks of Female Genital Mutilation.

In the 1980s, it was estimated that 80% of mothers from countries where Female Genital Mutilation was practised underwent FGM and that 70% of girls from these same countries underwent FGM or at risk of FGM. Anthropologists, ethnologists and sociologists agree that in France between the 1980s and 2000, the majority of the practice concerned the Soninke, but today this should be extended to other populations since the practice is widespread throughout the world and therefore affects other continents and other populations[13].

In 2004, it was estimated that there were approximately 53,000 adult female circumcisers residing in the country. The ExH survey carried out between 2007 and 2009 estimated that 11% of girls with parents from countries practising FGM were excised, among them 3% were born in France and 45% in a country at risk (mainly West African countries, notably Mali, Senegal, Côte d'Ivoire, Guinea-Conakry and Mauritania). In addition, 3 out of 10 girls are reported to be at risk.

The data collected in the Maternal and Child Protection Centres (PMI) show that while the departments of the Paris region were originally the most affected; the rest of France is also concerned (particularly the regions of Normandie Auvergne-Rhône-Alpes, PACA, Nord-Pas-de-Calais-Picardie, Champagne-Ardenne-Lorraine, Centre-Poitou-Charente, Pays-de-la-Loire, Languedoc-Roussillon-Midi-Pyrénées and to a lesser extent Bretagne and Bourgogne-France-Comté).

More recent data is not available for France. Neither the national surveys on violence against women (ENVEFF in 2000), nor administrative and judicial statistics (reporting, filing of complaints, etc.) include FGM. The VIRAGE survey, currently underway, will include FGM among the typology of violence against women.

13 United to end FGM, country profile France 5 April 2016 final MAJ.pdf

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Annex 1
Training Evaluation form

1 - How many girls or women are exposed to the risk of FGM in the world?

❑ 20 million ❑ 100 million ❑ 200 million ❑ 800 million

2 - How many types of FGM are there?

❑ 4 ❑ 7 ❑ 8 ❑ 10

3 - List the five major risk categories survivors are exposed to

-
-
-
-
-

4 - The medicalization of FGM reduces the risks to women and girls

❑ True ❑ False

5 - The medicalization of FGM decreases the incidence of FGM

❑ True ❑ False

6 - FGM is only a problem on the African continent

❑ True ❑ False

7 - List at least two limits to studies carried out on FGM

-
-

8 - In France, young girls are not exposed to FGM

❑ True ❑ False

9 - List at least five countries where the estimated percentage of FGM survivors is greater than 90%

-
-
-
-
-

Module II
Legal protection against genital mutilation

Chapter I: International instruments banning FGM

Female genital mutilation of any kind is internationally recognized as a harmful practice and a triple violation of the human rights of girls and women, as human beings, women and girls. In particular, it violates the following rights:

- Right to physical and mental integrity
- Universal right to health
- Right not to be discriminated against on the basis of sex
- Children's rights (right to reach one's full potential, right to have one's opinion taken into account, etc.)
- Right not to be subjected to cruel, inhuman and degrading treatment;
- Right to life (when the practice results in death).

These rights are protected by a set of international and regional legal instruments for the protection of human rights, as well as by texts adopted by consensus. Some of these can be cited here:

- International Bill of Human Rights
- International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- International Convention on the Rights of the Child
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- African Charter on Human and Peoples' Rights (Banjul Charter) and its Protocol on the Rights of Women in Africa
- Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention)
- Beijing Declaration and Platform for Action of the Fourth World Conference on Women
- Programme of Action of the International Conference on Population and Development (ICPD).

The French Senate's Delegation for Women's Rights worked on Female Genital Mutilation, following which a report was submitted on the subject in 2018.
At the completion of its analysis, the delegation presented its findings and points of vigilance in this area, and more particularly on the excision of minors.
<u>The points below concerning international efforts to combat Female Genital Mutilation are taken from the information contained in the report:</u>
Female genital mutilation is now considered by the international community to be a violation not only of the rights of girls and women but also of the rights of children.
As noted, however, in an above-mentioned INED study published in 2016, international mobilization only really began to take off in the 1990s: "*Within the United Nations, the recognition of universal women's rights and respect for their integrity has long come up against the principles of respect for the sovereignty of Member States, on the one hand, and respect for family traditions and transmissions, on the other.*".

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The growing importance of international mobilization

The subject of excision was first presented in 1958 by a resolution of the United Nations Economic and Social Council as a problem for the international community; the text also addressed the harm caused by the practice, but without calling for strong condemnation by the Member States.
The WHO's viewpoint warrants particular mention. In 1959, the WHO did not consider itself competent to deal with such matters, considering this to be a social and cultural, rather than a medical, problem. The WHO began to reflect on the consequences of excision on the health of women and girls at the end of the 1970s: in 1977, a working group on "traditional practices affecting the health of women and children" was set up; two years later, work was begun on an inventory of the medical consequences of this practice.
There was also a gradual change of perspective within the World Conference on Women. In 1980, at the Copenhagen conference, a clear opposition was expressed between two points of view: to see the practice as a rite of passage to adulthood or to consider it as a harmful practice. In Nairobi, in 1985, a "*broader consensus*" began to emerge on the problem of Female Genital Mutilation. Then in Beijing in 1995 a "*real international consensus in favour of the abolition of FGM*" emerged.

The commitment of the United Nations since the 1990s

As early as 1990, the Committee on the Elimination of Discrimination Against Women adopted a recommendation on female excision, expressing its concern "*to note that certain traditional practices prejudicial to the health of women, such as female circumcision, remain in use*", and which highlights the serious consequences of excision, "*particularly in terms of health, for women and children*". The text calls on governments to "*take appropriate and effective measures to abolish the practice of excision*". Among the means of combating these practices, the recommendation mentions the need for statistical data, support for women's organizations working against Female Genital Mutilation, mobilization of the education sector and action in the framework of public health policies, emphasizing "*the special responsibility of health personnel, including traditional birth attendants, to explain the harmful effects of excision*". The UN committee also urges Member States to involve political personnel, "*religious leaders and community leaders at all levels*" in raising awareness of the need to abolish excision.

In February 1994, a United Nations General Assembly resolution included "*genital mutilation and other traditional practices harmful to women*" (Article 2) and called on Member States to "*not invoke considerations of custom, tradition or religion to avoid their obligation to eliminate it*" (Article 4).

Other resolutions, in 1998 and 2001, complemented these positions, as well as resolutions of the Commission on the Rights of Women adopted in 2007, 2008 and 2010.
The Programme of Action adopted at the end of the United Nations International Conference on Population and Development, held in Cairo in 1994, refers to the goal of abolishing Female Genital Mutilation and calls on governments to support NGOs and religious institutions working to eliminate this practice.

In 1997, Unicef, WHO and the United Nations Population Fund (UNFPA) adopted a joint declaration on the prevention and abandonment of Female Genital Mutilation.
It should be stressed that the adoption of international positions calling on States to

combat Female Genital Mutilation has only been possible thanks to the mobilisation of the countries concerned.

Article 5 of the Maputo Protocol, adopted in 2003 within the framework of the African Charter on Human Rights by the Heads of State of the African Union, explicitly prohibits and condemns Female Genital Mutilation.
It should be noted that this text has been ratified by 36 Member States and signed by 15 others. In the same vein, it should be noted that the African Inter-Parliamentary Union, in 2005, called for the adoption of legislation to abandon these practices.

The strengthening of international mobilization with the establishment of the International Day of Zero Tolerance for Female Genital Mutilation

In 2003, the United Nations strengthened international mobilization against the practice by establishing the International Day of Zero Tolerance for Female Genital Mutilation, held annually on 6 February.
The desire to accelerate a process that has remained relatively slow was strengthened in 2007-2008, along with a growing awareness of the global nature of the practice that has long been misunderstood as being primarily African in nature, while recent studies highlight its existence in countries such as Malaysia and Indonesia, as previously noted.
Since 2007, a global programme has been conducted jointly by the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) to "*accelerate the abandonment of Female Genital Mutilation*".
During the first phase of implementation of this project, between 2008 and 2013, efforts focused on training some 100,000 health professionals in prevention and care. According to the presentation of the programme on the UNFPA website, more than 20,000 religious or traditional leaders made public statements during the same period "*disavowing religious precepts imposing the practice of Female Genital Mutilation/cutting*".
In February 2008, 10 UN agencies, including the Office of the High Commissioner for Human Rights, issued a joint statement calling Female Genital Mutilation a human rights violation and calling for "*accelerated change*" to end the practice.

In 2012, a General Assembly resolution expressed concern about the persistence of Female Genital Mutilation "*in all regions of the world*", reaffirmed the health threats to girls and women caused by genital mutilation, "*including psychological, sexual and reproductive health*", and recalled its "adverse obstetric and neonatal consequences", expressed "*concern at the documented increase in the number of cases of Female Genital Mutilation performed by medical personnel in all regions where the practice occurs*" and urged Member States to intensify their efforts to end the practice, including through information campaigns "*systematically targeting the general public, relevant professionals and communities*".

On 6 February 2015, the International Day of Zero Tolerance for Female Genital Mutilation, the UN Secretary-General said "*if everyone takes action - women, men and young people - it will be possible, within a generation, to put an end to a practice that affects some 130 million girls and women in the 29 countries for which we have statistics*".
Among the 17 sustainable development goals (SDGs) adopted in September 2015, target 5-3 specifically aims to "*eliminate all harmful practices, such as child marriage, early or forced marriage and Female Genital Mutilation*".
Two years later, on February 6, 2017, the UN Secretary General set out a clear vision: "to put an end to these practices by 2030".

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The international treaties whose signatories undertake to put an end to these practices and to punish their perpetrators are recent since they date from the 21st century.
For example, the 1989 International Convention on the Rights of the Child does not address Female Genital Mutilation as such, even though it commits Member States, in Article 24 (3), to "*take all appropriate effective measures with a view to abolishing traditional practices harmful to the health of children*".
In contrast, the Convention on Preventing and Combating Violence Against Women and Domestic Violence, known as the Istanbul Convention, which was adopted by the Committee of Ministers of the Council of Europe on 7 April 2011 and entered into force on 1 August 2014, includes an article specifically concerning Female Genital Mutilation: "*Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalised:*

- *excising, infibulating or performing any other mutilation to the whole or any part of a woman's labia majora, labia minora or clitoris;*
- *coercing or procuring a woman to undergo any of the acts listed in point a;*
- *inciting, coercing or procuring a girl to undergo any of the acts listed in point a" (Article 38).*

European laws and directives

In order to protect the human rights of women and the girl child, the National Consultative Commission on Human Rights (CNCDH) was called upon to rule on the issue of Female Genital Mutilation (MSF).
The points below concerning the fight against violence and Female Genital Mutilation on the European level, are taken from the opinion of the plenary assembly of the CNCDH, on Female Genital Mutilation of December 11, 2013

At the European Parliament level

European Parliament resolution of 24 March 2009 on combating Female Genital Mutilation in the EU: "*Calls on the Member States to:*

- *regard any form of FGM as a crime, irrespective of whether or not the woman concerned has given any form of consent, and to punish anybody who helps, encourages, advises or procures support for anybody to carry out any of these acts on the body of a woman or girl;*
- *pursue, prosecute and punish any resident who has committed the crime of FGM, even if the offence was committed outside their borders (extraterritoriality);*
- *adopt legislative measures to allow judges or public prosecutors to take precautionary and preventive measures if they are aware of cases of women or girls at risk of being mutilated;*

Calls on the Member States to implement a preventive strategy of social action aimed at protecting minors without stigmatising immigrant communities, through public programmes and social services aimed at both preventing these practices (training, education and awareness-raising among the communities at risk) and assisting the victims who have been subjected to them (psychological and medical support including, where possible, free medical treatment to repair the damage); calls also on the Member States to consider, in accordance with child protection legislation, that the threat or risk of being subjected to FGM may justify intervention by the authorities; Calls on the Member States to draw up guidelines for health professionals, teachers and social workers aimed at informing and educating parents, in a respectful manner and with the assistance of interpreters if necessary, about the enormous risks of FGM and the fact that such practices are considered as a crime in the Member States, and also to cooperate with and fund the activities of the networks and NGOs that are working to educate, raise awareness and mediate in the sphere of FGM, in close contact with families and communities".

The June 2012 resolution called for an end to FGM in Europe and abroad through prevention, protective measures and legislation. Parliament reminded the European Commission of its commitment to develop a strategy to combat violence against women, including Female Genital Mutilation.
Nearly 400 MEP candidates signed a pledge to prioritise the elimination of Female Genital Mutilation if elected in 2014. 93 of these candidates were elected as MEPs.
The February 2014 resolution welcomed the Commission's communication called "Towards the elimination of Female Genital Mutilation", which calls for EU funding to be used to prevent Female Genital Mutilation, improve support for victims, strengthen international dialogue and encourage research to clearly identify women and girls at risk and to facilitate the exchange of experience and good practices on FGM issues between Member States, NGOs and experts.
Among actions undertaken at the EP there are:

- Oral Question without resolution of January 2015 posed by the Chair of the FEMM Committee, MEP Iraxte Garcia Perez, during the plenary session of the European Parliament, on progresses on the Commission's Communication "Towards the elimination of Female Genital Mutilation".
- Written Question of December 2017 posed by MEP Cécile Kyenge during the 34th session of the ACP-EU Joint Parliamentary Assembly on actions between States within the EU and the African Caribbean and Pacific region on prevention, protection, prosecution and integrated policies to end FGM.
- Oral Question with debate of February 2018 posed by the Chair of the FEMM Committee, MEP Vilija Blinkevičiūtė, during the plenary session of the European Parliament on the progress made to mainstream FGM into all relevant policy and legislative frameworks of various Commission's Directorates-General in order to ensure that the issue is tackled within all sectors.
- Resolution of February 2018 on zero tolerance against FGM called for increased efforts from the Commission and Member States to build bridges, strengthen community engagement, mainstream FGM and ensure the highest standards of international protection for FGM survivors coming to Europe.

At the European Commission level

The European Commission published its first ever Action Plan "Towards the Elimination of Female Genital Mutilation" on the occasion of the International Day for the Elimination of Violence against Women (25 November 2013).
A high-level round table on Female Genital Mutilation was organised by the European Commission on 6 February 2009, at which the End FGM campaign's request for support for EU action was supported. On that day, the Commission launched a consultation with civil society on combating Female Genital Mutilation in the European Union.
On 6 February 2013, on the occasion of the tenth anniversary of the International Day of Zero Tolerance for FGM, six European Commissioners confirmed the EU's commitment to ending FGM.
On the occasion of International Women's Day 2010, each Commissioner pledged to support the Women's Charter by taking stronger action against FGM.
In September 2010, the proposal for a Gender Equality Strategy recognised the need for a strategy to combat Female Genital Mutilation; however, this proposal has not yet been adopted.
The 2009 Stockholm Programme Action Plan included provisions to combat Female Genital Mutilation among its initiatives on the problem of gender-based violence.
The European External Action Service (EEAS) adopted the EU Action Plan on Human Rights and Democracy 2015-2019, which contains a commitment to end FGM in external relations in Action14b;
In 2015, the European Commission published a document entitled "10 principles for integrated child

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protection systems" to guide Member States in the field of child protection, with a special focus on girls affected by or at risk for FGM.
The European Commission adopted the EU Action Plan for Gender Equality in External Relations 2016-2020, which has as its first priority "ensuring the physical and psychological integrity of girls and women", including through the fight against FGM.

At the level of the European Institute for Gender Equality (EIGE)

The European Institute for Gender Equality has published the results of the "Study on the situation and trends in Female Genital Mutilation in 27 EU Member States and Croatia", prepared at the request of Commissioner Viviane Reding. The study found no consistency in terms of literature and data already collected on the prevalence of FGM and the number of girls at risk, with some countries having no data at all.
In 2015, EIGE launched a common methodological framework for collecting data on FGM in the "Step-by-Step Guide: Estimating the number of girls at risk of genital mutilation in the European Union".
In the same year, EIGE published the results of the first study "Estimating the number of girls at risk of Female Genital Mutilation in the European Union" using the new methodology, focusing on 3 EU countries: Ireland, Sweden and Portugal.
EIGE published in 2018 the results of the second study entitled "Estimating the number of girls at risk of Female Genital Mutilation in the European Union" in six EU countries: Belgium, Cyprus, France, Greece, Italy and Malta.

At the European Council level

On 22 May 2001, the Parliamentary Assembly of the Council of Europe met to draw up Resolution 1247 on combating Female Genital Mutilation:
"*Genital mutilation should be regarded as inhuman and degrading treatment within the meaning of Article 3 of the European Convention on Human Rights, even if carried out under hygienic conditions by competent personnel. (Paragraph 4)*
The Assembly underlines the serious consequences for the victims, in particular the direct impact on their physical health of infections caused by lack of hygiene leading to diseases such as Aids, and serious psychological complications. (Paragraph 8)
It condemns the increase in the number of forced marriages, which make girls even more vulnerable, and virginity tests. (Paragraph 9)
In this connection, non-governmental organisations (NGOs) will have a key role to play in combating genital mutilation by enabling girls and young women to become involved in local communities and helping to devise prevention programmes and information campaigns aimed at eradicating the practice." (Paragraph 10)

In June 2014, the Justice and Home Affairs Council adopted conclusions on preventing and combating all forms of violence against women and girls, including Female Genital Mutilation.
In March 2010, the Committee for Employment and Social Affairs Ministers in the Employment and Social Affairs Council (EPSCO) called for the creation of tools and the exchange of knowledge and practices to end violence against women, including FGM, by setting up a European observatory.

Subsequently on 13 October 2016, the Parliamentary Assembly of the European Council met following a discussion on Female Genital Mutilation in Europe decreed:
"*The Assembly underlines the fact that Female Genital Mutilation is an act of violence against women and children*

and a flagrant violation of human rights. It causes serious physical and mental harm, and is a violation of the prohibition of cruel, inhuman or degrading treatment and of the right to health. As mutilation is practised in most cases during childhood, it also constitutes a violation of children's rights. (Paragraph 3)
The Assembly is convinced that prevention must lie at the heart of all efforts to eradicate Female Genital Mutilation and must involve all those concerned, whether the practising communities, grass-roots organisations, social and education services, the police, the justice system or health-care professionals. Awareness-raising, information and education campaigns must include both women and men from the communities concerned and work to dissociate these practices from religion, gender stereotypes and the cultural beliefs which perpetuate discrimination against women." (Paragraph 4)

Directives adopted by the EU

The Victim's Rights Directive adopted in October 2012 requires the provision of support services for victims of violence, including FGM.
The Directive on Reception Conditions for Asylum Seekers, endorsed by the European Council in October 2012, specifically mentions victims of FGM among the vulnerable persons who should receive appropriate health care during their asylum procedure.
The Asylum Qualification Directive adopted at the end of 2011 included FGM as a ground for consideration for international protection.
The Asylum Procedures Directive adopted in 2013, describes adequate procedures adapted to women and children and targeting vulnerable groups, including survivors of Female Genital Mutilation. As part of the reform of the Common European Asylum System (CEAS) launched by the European Commission in 2016, the three asylum directives are currently being revised.
Recently the European Union (EU) and the United Nations (UN) have embarked on a new multi-year global initiative to eliminate all forms of violence against women and girls: the Spotlight Initiative.
The initiative is called the Spotlight Initiative because it draws attention to this problem, bringing it into the spotlight and placing it at the heart of efforts to achieve gender equality and empower women, in line with the 2030 Agenda for Sustainable Development.
An initial investment of around €500 million will be made, with the EU as the main contributor. Other donors and partners will be invited to join the initiative in order to broaden its scope and scale. The implementation modality will consist of an EU multi-partner trust fund, administered by the Multi-Partner Trust Fund Office, with the support of the lead agencies, UNDP, UNFPA and UN-Women, and supervised by the Executive Office of the UN Secretary General.

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Chapter II: National instruments banning FGM in France

The Legal Framework in France

There is no specific legal definition in French law for the acts of genital mutilation. Such a definition is inappropriate since Female Genital Mutilation is an indisputable violation of physical integrity, which is punishable under the Criminal Code.

These practices are currently prosecuted and punished as criminal offences under either:

- violence resulting in mutilation or permanent disability, an offence punishable by 10 years in prison and a fine of €150,000 (Article 222-9 of the French Criminal Code). The penalties incurred, when the offence is committed against a minor under 15 years of age, are 15 years in prison (Art. 222-10, paragraph 1, of the French Criminal Code) or 20 years in prison if committed by an ascendant or any person having authority over the minor (Art. 222-10, penultimate paragraph, of the French Criminal Code);
- violence resulting in death without intent to cause it, an offence punishable by 15 years in prison (Art. 222-7 of the Criminal Code), or 20 years in prison if committed against a minor under 15 years of age (Art. 222-8, paragraph 1, of the French Criminal Code) or 30 years if committed by an ascendant or any person having authority over the minor (Art. 222-8, last paragraph, of the French Criminal Code);
- torture or acts of barbarism punishable by 15 years in prison (Art. 222-1 of the French Criminal Code), or by 20 years in prison if committed against a minor under 15 years of age or on a person who is particularly vulnerable because of his or her age (Art. 222-3, paragraph 2, of the French Criminal Code).

French law obviously applies to foreigners when the mutilation is committed in France, but also when it is committed abroad. In such cases, the perpetrator, whether French or foreign, may be prosecuted in France, provided that the victim is of French nationality (Art. 113-7 of the French Criminal Code) or, if the victim is a foreigner, is habitually resident in France (Art. 222-16-2 of the French Criminal Code). Parents may be prosecuted as accomplices, subject to the restrictive conditions of Article 113-5 of the French Criminal Code.

In 2013, the criminal penalties were extended to two new offences:

- It is punishable by 5 years in prison and a fine of €75,000 for inciting a minor to undergo genital mutilation through offers, promises or by exerting pressure or coercion of any kind.
- The same penalties apply when inciting others to commit mutilation on the person of a minor. (Article 227-24-1 of the French Criminal Code).

In addition, Law 2010-769 of 9 July 2010 on violence against women, violence between spouses, and the effects of these types of violence on children provides for the possibility for the juvenile court judge to have a minor entered in the wanted persons file for a period of two years in order to prevent the minor from leaving the country if there is a risk of genital mutilation abroad.

Legal obligations for health professionals

When dealing with a minor victim of abuse, the doctor "*must, except in special circumstances which he or she considers to be in good conscience, alert the judicial, medical or administrative authorities*". Doctors are required to systematically report Female Genital Mutilation of minors. Finally, it should be noted that health professionals have an obligation to intervene in cases of immediate risk to prevent the practice of Female Genital Mutilation, pursuant to Article 223-6 of the French Criminal Code.

The French Criminal Code authorizes the waiver of professional secrecy in certain specific circumstances. Article 226-14 paragraph 1 of the French Criminal Code (incorporates the amendments of the Law of

5 November 2015: professional secrecy is not applicable in cases where the law requires or permits the disclosure of the secret. Moreover, it is not applicable:
"*To anyone who informs the judicial, medical or administrative authorities of deprivation or abuse, including sexual abuse or mutilation, of which he or she is aware and which has been inflicted on a minor or on a person who is unable to protect himself or herself because of age or physical or mental incapacity*".
For doctors: Article R. 4127-44 of the Public Health Code states: "*When a doctor discerns that a person to whom he is called is a victim of abuse or deprivation, he must implement the most appropriate means to protect that person by exercising prudence and circumspection.*
In the case of a minor or a person who is unable to protect him or herself because of his or her age or physical or mental condition, the doctor shall alert the judicial or administrative authorities, unless there are special circumstances that he or she considers to be of sufficient importance".
With regard to midwives, Article R. 4127-316 determines the circumstances in which professional secrecy may be waived: "*When a midwife discerns that a woman to whom he or she is called or the woman's child is being abused, the midwife must implement the most appropriate means to protect the mother and child.*"
Finally, in the case of nurses, Article R.4312-18 of the French Public Health Code allows such a derogation: "*When a nurse discerns that a person with whom he or she is required to intervene is a victim of abuse, deprivation, ill-treatment or sexual harm, he or she must use the most appropriate means to protect that person, exercising prudence and circumspection.*
In the case of a minor or a person who is unable to protect him or herself because of age, illness or physical or mental condition, the nurse must, except in special circumstances that he or she considers to be of significant importance, alert the judicial, medical or administrative authorities".

The Law of 5 March 2007 reforming child protection provides for the obligation to transmit information of concern concerning a minor in danger or at risk of being in danger, for persons implementing the child protection policy as well as for those providing assistance (Article L. 226-2-1 of the Social Action and Family Code).
Health professionals who are directly involved in child protection are required to transmit information of concern to the President of the Departmental Council.
In all cases, health professionals not directly involved in the child protection policy are authorized to disclose information of concern to the President of the Departmental Council and have an additional obligation to do everything possible to stop the danger.

The legal framework on immigration

In three rulings handed down on 21 December 2012, the French Council of State (Conseil d'Etat) put an end to the case law deployed since 2009 by the National Court of Asylum (CNDA) on the protection - under the heading of asylum (refugee status or subsidiary protection) - of young girls born in France and threatened with excision in the event of their return to their country of origin. The Council of State considered that a young girl born in France could, under certain restrictive conditions, be granted refugee status "on the grounds of the risk of being exposed to the practice of excision in the country of her nationality". The Council considered that, in countries and societies where excision is the social norm, children who have not been mutilated constitute a "social group" within the meaning of the Geneva Convention of 28 July 1951 and are therefore able to obtain refugee status.
At the same time, with regard to the parents of children at risk of Female Genital Mutilation, the Council of State has ruled that they themselves are entitled to refugee status or subsidiary protection, but only if

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they can establish that they personally run the risk of persecution or ill-treatment in their country of origin because of their opposition to genital mutilation. Otherwise, they cannot claim any protection for themselves.
What about parents of children who have been granted refugee status but who themselves are not eligible?
A circular from the Ministry of the Interior stipulates that they must be systematically invited by OFPRA to go to the prefecture of their home city or town with the decision granting their child asylum protection, in order to apply for a residence permit for themselves. As the Code on the Entry and Residence of Foreigners and the Right of Asylum (CESEDA) does not provide for the automatic issue of a special permit to parents in this situation, prefects are encouraged to issue them with a temporary residence permit bearing the words "private and family life" in the context of exceptional admission for residence.
In practice, in view of the time required to process applications at the prefecture, these provisions place families in difficult living situations: without the right of residence, parents cannot claim either legal employment or certain rights relating to the legality of their residence. In this regard, the CNCDH recalls that Directive 2011/95/EU of 13 December 2011 extends the concept of "family member" to "the father and mother of the beneficiary of international protection or any other adult who is responsible for him/her by virtue of the law or practice in force in the Member State concerned, when the beneficiary is a minor and unmarried". It calls on lawmakers to amend the CESEDA accordingly in order to give the parents of refugee minors the full effectiveness of the right of asylum.
The draft law for controlled immigration and an effective right of asylum stabilises the right of residence for parents of minor children recognised as refugees: it amends Article L 314-11 of the CESEDA to make the ascendants of a refugee minor eligible for residence permits.
It also allows parents, in the context of family reunification requested by a refugee minor in France, to enter French territory with their children, provided that they are effectively responsible for them and that they respect, as required by Article L752-1 of the CESEDA, "*the essential principles that, in accordance with the laws of the Republic, govern family life in France*".

Moreover, Law n°2015-925 of 29 July 2015 on the reform of the right of asylum introduced Article L 744-6 into CESEDA, expressly considering genital mutilation as an element of vulnerability that could make the women and girls concerned eligible for refugee status.

Annex 1 List of national and international instruments against FGM

At the national level:

- Article 113-5 of the French Criminal Code
- Article 222-1 of the French Criminal Code
- Article 222-3 of the French Criminal Code
- Article 222-7 of the French Criminal Code
- Article 222-8 of the French Criminal Code
- Article 222-9 of the French Criminal Code
- Article 222-10 of the French Criminal Code
- Article 222-16-2 of the French Criminal Code
- Article 226-14 of the French Criminal Code
- Article 227-24-1 of the French Criminal Code
- Article R.4127-44 of the Public Health Code
- Article R.4127-316 of the Public Health Code
- Article R.4312-18 of the Public Health Code
- Article L. 314-11 of the CESEDA
- Article L. 744-6 of the CESEDA
- Article L. 752-3 of the CESEDA
- Article L. 226-2-1 of the Social Action and Family Code
- Law of 5 March 2007 on the reform of child protection
- Law 2010-769 of 9 July 2010 violence against women, violence between spouses, and the effects of these types of violence on children
- Law 2015-1402 of 5 November 2015 clarifying the procedure for reporting situations of abuse by health professionals
- Law 2015-925 of 29 July 2015 on asylum application
- Directive 2011/95/EU of 13 December 2011
- The Council of State dealing with Female Genital Mutilation (EC, Ass., 21 December 2012, Ms E. F., Ms F., and OFPRA c/ Ms B C)

At the international level:

- International Bill of Human Rights
- International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- International Convention on the Rights of the Child
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- African Charter on Human and Peoples' Rights (Banjul Charter) and its Protocol on the Rights of Women in Africa
- Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention)
- Beijing Declaration and Platform for Action of the Fourth World Conference on Women
- Programme of Action of the International Conference on Population and Development (ICPD).
- Recommendation on female circumcision by the Committee on the Elimination of Discrimination against Women, 1990
- United Nations General Assembly Resolution, February 1994

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- United Nations International Conference on Population and Development, Cairo, 1994
- Joint Statement on the Prevention and Abandonment of Female Genital Mutilation by UNICEF, WHO and the United Nations Population Fund (UNFPA), 1997
- Article 5 of the Maputo Protocol, within the framework of the African Charter on Human and Peoples' Rights, 2003
- International Day of Zero Tolerance for Female Genital Mutilation, held annually on 6 February (established in 2003 by the United Nations)
- Since 2007, a global programme has been conducted jointly by the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) to "accelerate the abandonment of Female Genital Mutilation".
- International Convention on the Rights of the Child
- Istanbul Convention, adopted by the Committee of Ministers of the Council of Europe on 7 April 2011

<u>At the European level:</u>

- European Parliament resolution on combating Female Genital Mutilation in the EU, 24 March 2009
- European Parliament resolution of 14 June 2012 on the elimination of Female Genital Mutilation
- European Parliament resolution of 6 February 2014 on the Commission communication entitled 'Towards the eradication of Female Genital Mutilation'
- Publication of a European Commission document entitled "10 principles for integrated child protection systems", 2015
- Resolution 1247 of the Parliamentary Assembly of the Council of Europe of 22 May 2001 on combating Female Genital Mutilation
- Meeting on 13 October 2016 of the Parliamentary Assembly of the European Council, following a discussion on Female Genital Mutilation in Europe
- The Victim's Rights Directive adopted in October 2012 requires the provision of support services for victims of violence, including FGM.
- The Directive on Reception Conditions for Asylum Seekers, endorsed by the European Council in October 2012, specifically mentions victims of FGM among the vulnerable persons who should receive appropriate health care during their asylum procedure.
- The Asylum Qualification Directive adopted at the end of 2011 included FGM as a ground for consideration for international protection.
- The Asylum Procedures Directive adopted in 2013, which describes adequate procedures adapted to women and children and targeting vulnerable groups, including survivors of Female Genital Mutilation, is presented here. As part of the reform of the Common European Asylum System (CEAS) launched by the European Commission in 2016, the three asylum directives are currently being revised.
- The Spotlight Initiative of the European Union (EU) and the United Nations (UN) to eliminate all forms of violence against women and girls

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Module III
Health Consequences of FGM

Chapter I: Definition and typology

Definition

Female genital/sexual mutilation (FGM) refers to all procedures involving the partial or total removal of the external female genitalia, or any other mutilation of these organs, performed for cultural or other reasons and not for therapeutic purposes (WHO, UNICEF, UNFPA, 1997). Those who suffer from FGM risk serious and irreversible damage to health, as well as severe psychological consequences. It is estimated that in the world the number of women living with genital mutilation is about 125 million (UNICEF). Most of the girls and women who undergo these practices are found in 29 African countries, a smaller proportion live in Asia, India and the Amazon. In some states of the Horn of Africa (Djibouti, Somalia, Eritrea) but also in Egypt and Guinea the incidence of the phenomenon remains very high, reaching 90% of the female population. In others, however, the mutilations concern a minority, such as in Ghana, Togo, Zambia, Uganda, Cameroon and Niger. There are also cases of FGM in Europe, Australia, Canada and the United States, especially among immigrants from Africa and Southwest Asia. In France, an estimated 53,000 adult women have been mutilated.

Typology

The World Health Organization has established a classification of the different types of Female Genital Mutilation into four types (WHO 2007):

- Type I: Partial or total removal of the clitoris and/or prepuce (**clitoridectomy**)
- Type II: partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (**excision**, 80% of FGM)
- Type III: narrowing of the vaginal opening with overlap by the removal and attachment of the labia minora and/or the labia majora, with or without excision of the clitoris (**infibulation**)
- Type IV: other methods of mutilation (scarification, stretching of the labia minora, use of caustic substances on the vulva or as a vaginal application, etc.)

However, this classification does not really correspond to the clinical reality and is of no practical interest. Though the initial mutilation as such is a significant factor, the healing period and the potential absence of care after the procedure must be taken into account as well as the sexual and obstetric complications, which are the cause of more issues.
Furthermore, there is no clinically observable anatomical or correlation between the severity of the mutilation and the consequences, particularly in terms of clitoral sensitivity.

Overview

Female genital mutilation is mainly of traditional origin and is a part of extremely diverse rites, with a variety

of motivations, but all of them are based on a desire to control or destroy female sexuality. In addition to traditional Female Genital Mutilation, there are assaults and intentional mutilation in the context of rape, torture or war crimes. Such violence and mutilation can still be found in many armed conflicts or civil wars, sometimes with appalling and often unrecognised prevalence. We will only address Female Genital Mutilation.

Restorative surgery originated with the care of these frequently very serious traumas in conflict situations, surgery for traumatic fistulas and urological or digestive complications. Later came the treatment of complete infibulations, where the vaginal opening is completely closed; this treatment is often routinely performed to allow for sexual intercourse or vaginal delivery. About fifteen years ago, restorative surgery for excision was discovered, which allows for the reconstruction of the clitoris with good hope of functional recovery.

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Chapter II: Definitions and clinical forms

Definitions

The most common type is **ritual excision**, which is defined as a partial amputation of the external part of the clitoris.
As mentioned, the World Health Organization's classification does not correspond to clinical reality. In reality, there are a multitude of different forms, depending on the location, customs, times and the excisers themselves. As this is a forced practice in the vast majority of cases, it is mostly carried out on non-consenting girls or young women; the way they are immobilized and the disordered movements give excision a highly variable random character. Beyond the mutilation itself, we observe from a distance the challenges of a complex healing process with secondary trauma. Sexual intercourse, forced or not, and obstetric history will further aggravate the situation and add additional scarring or tears. In terms of functionality, surgery requires a prior evaluation of whether there is sensitivity or not. Past experience shows a total absence of anatomical and clinical parallelism, with severe forms of Type III with intact clitoral sensitivity or, on the contrary, forms described as "minimal" where all clitoral function is gone.
Infibulation is the mutilation of the labia minora and/or the labia majora, with a partial or near total closure of the vaginal opening. This type (majority of WHO Type III) is most often practised in East Africa, Maghreb and the Horn of Africa.
Again, caution should be exercised here, as the exterior scarring does not in any way indicate any additional clitoral damage (excision). In Eritrea or Ethiopia, for example, excision is performed before vaginal closure (infibulation), and the surgeon will only discover the severity of the mutilation after deinfibulation. Whereas, in many parts of Somalia, total vaginal closure covers a potentially sensitive and intact clitoris. In contrast, in West Africa, where ritual infibulation is theoretically not practised, the initial mutilation removes the upper part of the labia minora in more than three-quarters of cases.
This is "pseudo-infibulation", mutilation added to the excision itself, which is extremely frequent. This will lead to other after-effects.

Alongside **scarring** or **secondary trauma**, there are other related pathologies, such as chronic vaginal sores or posterior perineal trauma. All these pathologies form a complex set of issues that must be carefully analysed. Restorative surgery is not be limited to a simple reconstitution of the clitoris, but must deal with all these issues in order to restore correct anatomical and genital function.

Other cases of traditional genital mutilation are beginning to show up in requests for reconstructive surgery. So far less well known, they are known because of new waves of immigration, particularly from Central Africa, where mutilation practices are different.
Total vulvar sclerosis caused by mechanical, plant, or chemical agents appears in the form of orifice closures, lycenoids, or pseudo-burns. Complications and chronic infections are frequent, often accompanied by chronic pain.Vaginal scarification is practiced in the same regions and is alarmingly prevalent in Nigeria. Vaginal scarification results in dyspareunia, which is sometimes severe, and dystocia, which can cause life-threatening complications.

Crimes of genital mutilation, traumatic vulvectomies, injuries from weapons of war, acts of torture or impalements seem to have existed throughout history. They have either been overshadowed by the issue of overall mortality or ignored for political or economic reasons. The development of conflict medicine, the presence of humanitarian or military surgical teams as close as possible to the operating fields and the need for testimony have enabled us to access this life-saving surgery. The relative recognition of reconstructive surgery has led to the

reappearance of these treatments in specialised centres. The experience gained by specialists in obstetric fistula surgery is leading to a better response to the care of these inhumane traumas.

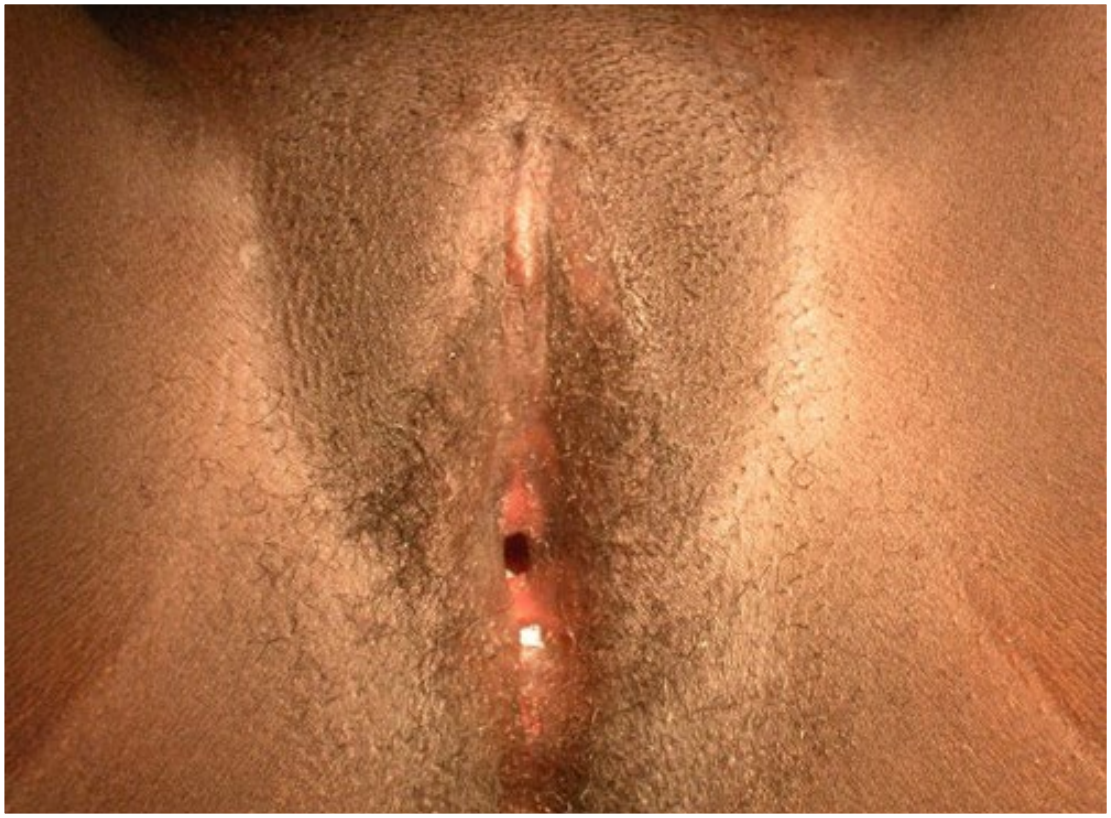

Fig. 1 Excision, pseudo-infibulation, classic form in West Africa

Pathophysiology

Ritual excision is performed without any anaesthesia, either at birth (30% of cases before the age of three), or on conscious girls, sometimes until the age of twenty. The legs of the infant young girl are kept in hyper-extension by several adults. The excisor grasps the tip of the clitoral glans and the upper part of the labia minora and usually cuts vertically.Blood flows, and the pain is atrocious. It is not uncommon for the excisor to be forced to repeat the procedure, as the presence of matrons is sometimes required for the amputation to be completed.

A clitoral amputation stump will then form. This stump will undergo an upward and retropulsive movement which will make it retract to the pubic symphysis. This stump will generally be surrounded by a fibrotic scar tissue. It is this chronic physiopathological condition that will make the vulva and the bony structure adhere to each other. In more than three quarters of cases, the upper part of the labia minora will fuse causing a type of scarring, which can result in what is called pseudo infibulation.

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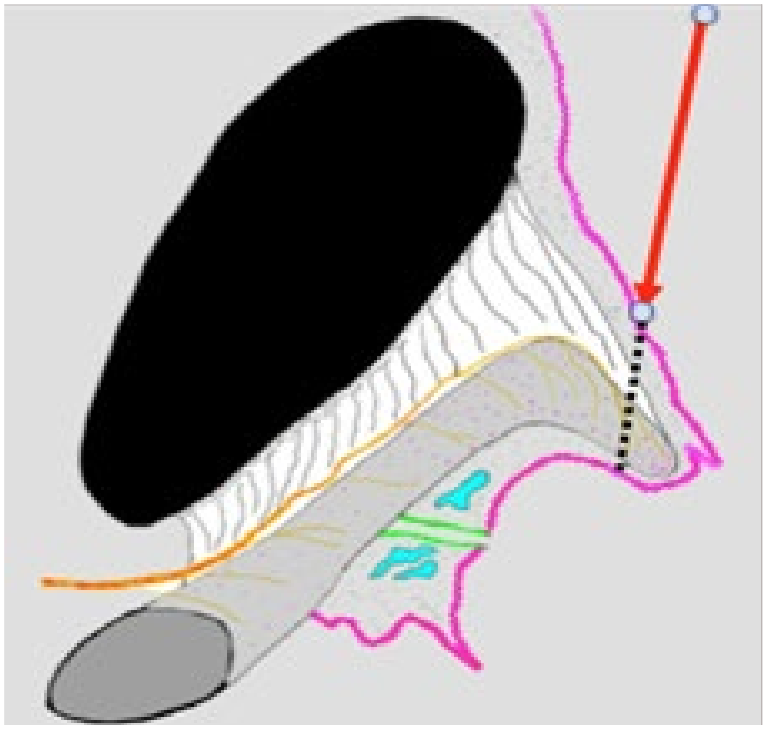

Fig. 2 Pathophysiology of excision /1: The cut is tangential and takes away a distal part of the glans clitoris. The neurovascular bundle, running along the dorsal surface of the glans clitoris, is, in general, preserved. However, the hood and the upper section of the labia minora are most often removed by excision. Skin avulsion may be much greater.

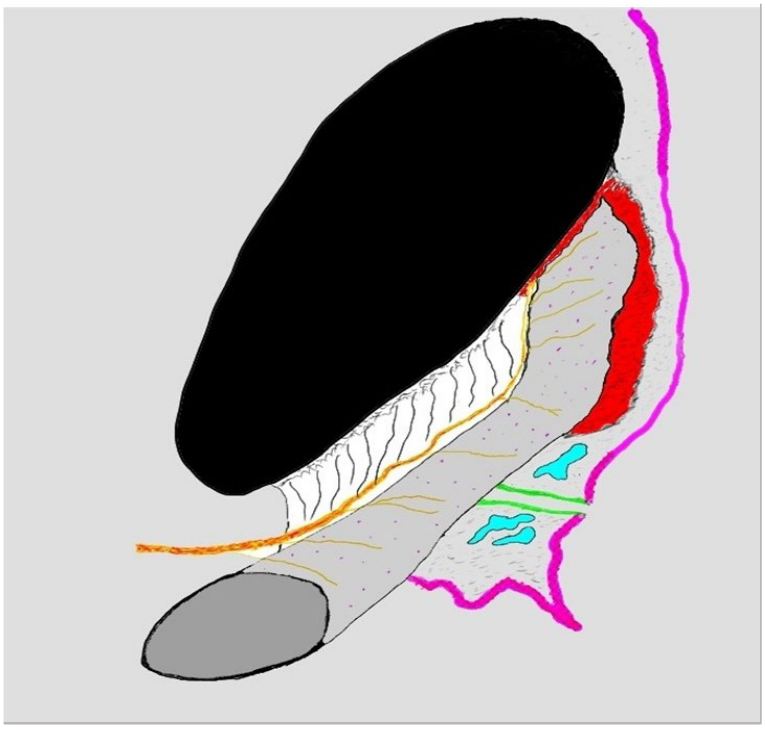

Fig.3 Pathophysiology of excision /2 After resection from the cutaneous plane, the stump of the clitoris is pushed backwards and upwards, bringing it into contact with the periosteum of the pubic symphysis, where it is anchored. The remaining intact clitoral tissue is embedded in a more or less extensive mass of fibrous scar tissue.

The request for restorative surgery and pre-operative evaluation

The first consultation is a major event in the life of these women who have been silence; it is a chance to tell their story. This initial meeting with caregivers provides a space for the victim of Female Genital Mutilation to retrace their story, say what has gone unspoken and find support. The needs that are expressed are diverse and do not necessarily lead to surgery. First of all, it is necessary to listen and to create space for an open discussion. Then we must examine and assess the injuries and describe what we see. From this first interview, the hierarchy of needs must be established: basic information, request for psychological help, sexological care or request for surgical repair. It is necessary to evaluate damage, describe the associated pathologies and explain the impacts in terms of sexuality and obstetrics. The section on pain is particularly complex and multifaceted and must be approached with caution and skill. Sexuality and clitoral sensitivity may be absent or more or less preserved. It is important to take time to understand and explain the issues in terms of sexuality and to assess the benefit/risk of the intervention in functional terms. Above all, in the event of a surgical decision, it is necessary to describe in detail the necessary medium- and long-term follow-up and the complex process of sexual reconstruction.

Finally, the impact and reality of the trauma and the possible need for additional psychotherapeutic or sexological advice must be assessed.

At the end of this pre-operative assessment, with time for reflection if necessary, the decision for surgery may be taken.

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Chapter III: Health complications as a result of FGM

In general, the more extensive the procedure, the greater the risks. Where available data permit, variations by type are specified. Since there is limited data on the different practices covered by Type IV, no information about it has been included.

Immediate risks of health complications for Types I, II and III

Pain: Cutting nerve endings and removing genital tissue causes severe pain. Anaesthesia is rarely used and, if it is used, it is not always effective. The healing period is also painful. Type III mutilation is a relatively more extensive procedure that takes longer (15 to 20 minutes), so the pain is more intense and lasts longer. The healing period is correspondingly longer and more difficult (1).

There may be **shock** due to pain and/or bleeding (2).
Excessive bleeding (haemorrhage) and septic shock have been reported (3).
Difficulty urinating and having a bowel movement may be observed due to swelling, oedema and pain (4).
Urological complications: Cutting or injuries to the urinary tract, urethra, retention, bladder obstruction, urinary tract infections.
Infections may occur after the use of contaminated instruments (e.g. use of the same instruments for several operations) and also during the healing period (5).
HIV (Human immunodeficiency virus): using the same surgical instruments without sterilization could increase the risk of HIV transmission among girls who undergo Female Genital Mutilation at the same time (6). In one study, an indirect correlation was found (7), but no direct correlation was established (8), possibly due to the rarity of group excisions using the same instrument and the low prevalence of HIV among girls of the age at which the procedure is performed.
Death can result from bleeding or infections, including tetanus and shock (9).
Psychological consequences: pain, shock and the use of physical force by those performing the procedure are cited as reasons why many women describe Female Genital Mutilation as traumatic (10).
Unintentional fusion of the labia: several studies show that in some cases, what was once intended to be a Type II mutilation may, because of the fusion of the labia, become a Type III mutilation (11).
Repeated Female Genital Mutilation appears to be quite common for Type III, usually due to failure to heal (12).

Long-term health risks resulting from Types I, II and III mutilation (which may occur at any time)

Pain: chronic pain due to tissue damage and scarring that may result in trapped or unprotected nerve endings (13).
Infections: dermoid cysts, abscesses and genital ulcers may occur, with superficial tissue loss (14). Chronic reproductive tract infections may cause chronic back and pelvic pain (15). Urinary tract infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk of repeated urinary tract infections is well documented in both girls and adult women who have undergone FGM (16).
Excessive scar tissue (keloids): excessive scar tissue can form at the site of the cutting (17).
Reproductive tract infections and sexually transmitted infections: an increased frequency of certain vaginal infections, including bacterial vaginosis, has been demonstrated (18). Some studies report an increased risk of genital herpes, but no association has been found with other sexually transmitted infections (19).

HIV (Human immunodeficiency virus): the increased risk of bleeding during intercourse, which is frequent when deinfibulation is necessary (Type III) may increase the risk of HIV transmission. The increased prevalence of herpes among women who have undergone Female Genital Mutilation may also increase the risk of HIV infection, since genital herpes is a risk factor in HIV transmission.
Sexual health problems: removal of, or damage to, highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure or pain during sex. Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems (20).
Childbirth complications: increased risk of caesarean section and post-partum haemorrhage as well as obstetric tears/lacerations and recourse to episiotomy. The risks increase with the severity of the FGM (21). Obstetric fistulae are a complication of prolonged labour and dystocia and may therefore be a secondary consequence of obstetric complications due to Female Genital Mutilation (22). Studies analysing a possible link between these types of mutilation and obstetric fistulas are ongoing.
Perinatal risks: higher death rates and lower Apgar scores have been found, with the risk increasing with the severity of the FGM (23).
Mental health problems: studies have shown an increased likelihood of fear of sex, post-traumatic stress disorder, anxiety, depression and memory loss. It is possible that the cultural significance of the practice offers no protection against mental health problems.
Social consequences:
Disruptions in sexuality, sometimes severe, can have a serious impact on couples' relationships, with intrafamilial consequences.
Various conflicts can also impact relationships within communities.

Additional risks of complications resulting from Type III FGM

Subsequent surgery: infibulations must be opened (deinfibulation) later in the girl's life to allow penetration during intercourse and for delivery. In some countries, it is common for disinfibulation to be followed by reinfibulation, which will therefore require further deinfibulation at a later time. There is evidence that reinfibulation is also performed on other occasions (26).
Urinary and menstrual problems: the almost complete closure of the vagina and urethra can lead to slower and painful menstruation and urination (27). A haematocolpos may require surgery (28). Urinary incontinence is common in women who have undergone infibulation and is probably due to both the difficulty in emptying the bladder and the stagnation of urine under the hood formed by scar tissue (29).
Painful sexual intercourse: because infibulation must be opened either surgically or during penetration during intercourse, intercourse is frequently painful during the first few weeks after first intercourse (30). The male partner may also experience pain and complications (31).
Infertility: the correlation between Female Genital Mutilation and infertility is mainly due to the removal of the labia majora, with available data showing that the greater the amount of tissue removed, the greater the risk of infection (32).

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Module IV
Social care: from detection to protection

Social care for female victims of FGM

The issue of FGM, which goes hand in hand with immigration, has become a major social and health concern in France and is very much part of the public debate. Prevention and punishment policies aimed at protecting girls at risk, which were introduced in the early 1980s, were strengthened in the 2000s.
Today, some 55,000 women in France are living with the negative consequences of FGM. For several years now in France, it has been possible to undergo surgery to restore injured genitals. This relatively minor operation is generally part of a consultation process involving several health professionals (gynaecologist, psychologist, sexologist, midwife), who work together to manage the cases of women who have been mutilated. The purpose of this programme is to accompany women who wish to have surgery and to oversee and support their postoperative functional rehabilitation. An increasing number of women who are victims of genital mutilation are turning to this type of intervention, particularly among younger women. There are many reasons for a woman to consider this operation, and the result of their decision will have an impact on her life outcome.
The decision to undergo restorative surgery can be perceived not only as an operation to repair the physical and physiological damage caused by the mutilation but also as a way for these women to regain a coherent sense of self. It is a way of re-appropriating their female identity in line with the dominant models in European society without denying their family history and therefore their cultural belonging. Working towards this goal, opening up discussion, within the family, of the existence and significance of FGM appears to be an essential tool at the various stages of the process, from prevention to protection.

(Source: Cairn.info)

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Chapter I: Detection and Information

First contact: an essential contextual assessment

The detection of warning signs during the first interview:

- Behavioural and mood changes: depression, anxiety, signs of emotional and psychological overload, lack of concentration, drop in school performance, eating disorders, sadness, fear, rigidity, mutism and turning inwards;
- Running away from home;
- Aggression towards others and towards oneself;
- Confidence, seeking help from a health professional but not explaining what the problem is;
- Difficulty walking, sitting, pain, discomfort between the legs, pain around the scar;
- Pain during menstruation causing repeated absences of the minor often not justified by a medical certificate;
- Difficulty urinating. This can lead to repeated requests to go to the toilet, prolonged periods in the toilet;
- Fear or inability to perform certain movements: some minors will refuse to participate in sports activities or ask to be excused from physical education classes without a note from the attending physician;
- Refusal of medical examination;
- Missing parts in the child's health record, or even the absence of a health record;
- Unexpected and prolonged absenteeism from school or college or day-care centre; failure to return to school after extended school holidays (consider returning home for genital mutilated and/or to be forcibly married at an early age or not).

Discuss FGM with the patient:

Let the patient tell her story and explain what she knows about the subject. Use her words and terms or clarify them to build confidence and approach the topic gently.

Use appropriate and accessible vocabulary according to the patient's level of understanding of the topic. Try to discuss words for FGM with the minor girl's family, such as: "tradition", "custom", or "ritual"; "cutting", "excision", "infibulation", or "cut below" (using your hand to indicate the lower abdomen).

Identify the patient's mental health and assess her grasp of the subject, her openness to talk (see what the patient is willing to talk about). Discuss the subject with the patient in an empathetic way, do not assume that you know her position.

Building trust takes time, knowing how to adapt and having patience are key for an effective first consultation.

Acknowledge the other subjects surrounding excision→ and the violence experienced (early/forced marriage, rape, etc.), give the patient space to discuss these subjects and do not insist if the patient is not comfortable continuing.

Do not use stigmatizing or uncomfortable terms such as "normal" or "abnormal" (because norms are relative), and most importantly, the goal is to put the patient at ease in a non-judgemental environment. Also with this goal in mind, do not trivialise, minimise, justify or directly compare FGM (even if the act is the same, the feeling and understanding of the subject may be different for each woman).

Be non-judgemental and consider the dilemma in which some women find themselves, with their loyalty split between their family/community and their self-interest.

Acknowledge the patient's emotions and try to understand her overall view of the act.

Analysis of the situation

Different types of analyses must be carried out during the first and on subsequent consultations in order to understand the woman's needs and respond effectively to her expectations:

- Analysis of the context of the excision: age, place, memory, physical pain, psychological trauma, impact on sexuality, impact on private life (sport, work, leisure), impact on relationships with others (especially men).
- Analysis of the person's understanding of her body: analyse whether the patient manages to understand the impact of this mutilation on her body and see how far her knowledge of the subject goes (always with patience and without haste), in order to adapt the quality and effectiveness of the consultations.

A discussion is necessary to check whether the person understands what excision means for her body, her physical and mental health.

The analysis and the consultation will be different depending on the patient's knowledge of her mutilation.

<u>The patient knows that she was mutilated:</u>

If the patient would like to talk about her mutilation, the following steps are recommended:

- Evaluate the impact of the mutilation on her life and health;
- Organize medical, psychological, social and sexual care if requested;
- Ask if she has children and if so, any daughters living in France or abroad;
- Evaluate the risks of FGM for her daughters and those to be born to prevent them from becoming victims one day;
- Taking into account her answers and possibly those of the father, implement the necessary measures for prevention and child protection.

If the patient does not wish to talk about her mutilation: It is recommended that the subject of FGM be systematically addressed as a preventive measure for her daughters and the minors in her community.

- The patient can speak at her discretion. It is important to inform the patient and make it understood that you will be particularly vigilant with regard to her daughters. (It is recommended that you assess the risks of FGM for her daughters and organize prevention.)
- It is recommended that the patient be informed that you are always available to talk and/or that she is referred to a specialist.

<u>The patient is unaware of her mutilation:</u>

Since FGM is a crime, before any examination the practitioner must make it clear to the patient:

- That if mutilation is discovered, the health professional is under a notification obligation with respect to the findings of the examination;
- That the practitioner is available to discuss FGM in accordance with the patient's wishes.
- The disclosure is a major event in the life of the patient. The disclosure must be followed up with sufficient time to talk about it, even if this means postponing the announcement to a later date. It is necessary to disclose the information tactfully.
- Failure to talk about it can have serious consequences:
- For the patient (the woman may feel shame or a subsequent lack of confidence in health professionals);
- For her daughters, facing the risk of FGM, if any.

It is advisable to be attentive to the indirect demands of the patient.

The purpose of the first consultation: an influence on the continuation of care

The first consultation makes it possible to:

- Understand the person, her expectations
- Make comparisons with other women in the same situation, in order to understand the reasons for these mutilations, their origins and to compile essential statistics to understand a subject as delicate as FGM.
- Understand the conditions and repercussions of FGM in order to establish effective prevention and care.

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Chapter II: Mindful and efficient care of the individual

Establishing appropriate follow-up

The first interview builds rapport with the patient in order to:

- Analyse and possibly determine the type of mutilation
- Learn about the patient's knowledge of her mutilation: is she aware of it and if so what does she think about it?
- Assess the physical extent and severity of the mutilation on the patient's body
- Determine the extent of the psychological impact on the patient in order to quickly determine the mental health support she will need.
- Understand the patient's expectations and try to answer her questions and reassure her.
- Develop a provisional roadmap with a breakdown of the various professionals who will accompany the patient on her physical restoration, mental health and legal rights journey.

Establish a roadmap from the first interview:
This roadmap and its guidelines will provide step-by-step information and cover the patient's progress with the practical recommendations of each specialist.
This roadmap with the patient's information will be shared respecting professional secrecy and in complete confidentiality.
This roadmap should include one page for each area of expertise:

- Presentation of the person with their social situation (with the social institutions that take or will take charge of the case) and family situation (is the person alone in France, if she has family, can she receive support from one of her family members, if not, from a friend).
- Medical specialists section: gynaecologist, nurse, surgeon, attending physician
- Mental health section: psychologist, psychoanalyst, paediatric psychologist, therapeutic medicine (massage, mind-body).
- Legal section: legal counsel

Restoration/reparation: objectives and implications

Provide information on the methods of repair and about different possible results:
The technique developed by Dr Foldes "aims to restore a normal anatomy and a normally innervated and if possible functional organ". The double skin flap technique was first tested in the field 25 years ago for the treatment of painful adhesion of the clitoral stump after excision.

The psychological and physical phases of reconstruction

Maintaining a care management plan: appropriate follow-up by all specialists working with the patient: the main objective is to assess the patient's progress and make suitable recommendations for each new stage.
Specialists will thus be able to carry out their examination or their interview with the patient in the most efficient and appropriate manner possible.
Today more than 3,000 women have been treated in France, 14 hospitals perform clitoral reconstruction and the procedure has been reimbursed by French social security since 2004. The care management is organized as follows:

- A preparatory consultation with an anaesthesiologist, a sexologist to validate the request,
- One day in the hospital for the actual operation,
- Post-operative follow-up at 2 weeks, 6 weeks and 2 months,
- Four consultations with a sexologist,
- Follow-up support for two years.

Evaluation and explanation of the steps for reconstruction:

- Localized pain: Pain will be evaluated at 6 months and at 12 months before the procedure. Pain will be defined and assessed using simple scales and questionnaires, by its intensity, duration, frequency, characteristics, associated symptoms, triggering circumstances and previous treatments (e.g. analgesics).
- Neurophysiological examination of the clitoris: The neurophysiological examination will take place 6 months and at 12 months before procedure.

Mental state and sexual function: Overall mental health and sexual function will be evaluated 6 months and 12 months before the procedure.

The iCGI (improved Clinical Global Impression scale) questionnaire will be administered to assess the patient's general mental state.

Sexual function will be assessed using the approved questionnaires: the FSFI (Female Sexual Function Index) and the Arizona sexual experience scale (ASEX), which measure the severity of sexual dysfunction.

The initial interview and examination will collect demographic data including marital status, how long the mutilation has been in place, how long the pain has been present, the type of mutilation, previous pregnancies, and menstrual cycle patterns.

Statistical methodology: In addition to the evaluation criteria, demographic data (age and ethnic origin), information about the mutilation (type and age), gynaecological-obstetrical data (characteristics of the menstrual cycle and previous pregnancies) and surgical data (technique and possible complications) will be gathered. Spontaneous adverse events reported during the study will be recorded and the tolerance to the procedure will be documented (e.g. good, fair, poor).

All data collected will be analysed and described. A univariate and then a multivariate analysis of predictive factors of improvement in pain and sexual function will be carried out.

Support measures for the procedure:

The care provided to a woman having undergone FGM cannot be limited to the reconstruction of the clitoris. It is important that the woman seeking a consultation is able to express her expectations and that the doctor can tell her objectively the results she can expect from the operation. A conversation with the different members of the multidisciplinary team will thus help to better understand the request.

It is important that this multidisciplinary follow-up is also reimbursed.

Example of multidisciplinary follow-up → The multidisciplinary team could include :

- Midwife / Nurse (information, explanation).
- Psychologist, ethnocultural psychotherapist (evaluation of trauma), psychoanalyst / sexologist (evaluation of sexual expectations).
- Surgeon / Gynaecologist / Anaesthesiologist (surgical care).

A nurse will first provide information and general explanations about the operation. Then the woman will have further consultations with the other members of the team.

A regular meeting will need to be organized to share information on the patients, to adjust the care plan if

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necessary and to set the date of the procedure. This is the place to reflect and evaluate their practices.

Adapted care for victims of FGM

Women who are victims of genital mutilation or at risk of genital mutilation are often in an irregular and unstable legal situation in their host country, so it is important to understand what the first steps are to help them establish a regular status before considering any care or surgery.

For adult or minor women who are undocumented or seeking asylum in France

After an individual examination of the asylum application and the OFPRA establishes that a woman or girl is at risk of FGM in her country, she is granted refugee status or alternative protection.

What supporting documents must be provided with the asylum application?

Item 1: A medical certificate stating that the child has not been subjected to FGM
In accordance with Article L. 723-5 of the Ceseda, this medical certificate must be issued by a forensic doctor practising in one of the medical facilities referred to in the Decree INTV1721843A of 23 August 2017.
The OFPRA website ofpra.gouv.fr has the contact details of the medical facilities + you will also find an example of the medical certificate in accordance with the decree.
The asylum seeker must take the following documents to the medical examination:

- The child's asylum application certificate;
- Her invitation to the interview at the OFPRA;
- Her health record (carnet de santé).

This medical certificate will be sent directly to the OFPRA by the medical facility.
If on the day of the interview at the OFPRA, the doctor's appointment has not yet taken place, a document certifying that an appointment has been made will need to be provided to the protection officer.

Refusal of this medical examination or failure to carry out the medical examination in the manner described above does not impede the examination of the child's asylum application. Also, in the absence of a certificate drawn up in accordance with Article L. 723-5 of the Ceseda and Decree INTV1721843A of 23 August 2017, a decision may be taken on the child's application on the basis of the only elements in the OFPRA's possession.

Item 2: A medical certificate attesting to the FGM, if any, suffered by the child's mother
This medical certificate is not regulated by the terms and conditions provided for in Decree INTV1721843A of 23 August 2017 issued pursuant to Article L. 723-5 of the Ceseda. It can be requested from the doctor of their choice. Where appropriate, the OFPRA should be notified as soon as possible after the asylum application has been submitted.

Item 3: If the minor girl was born in France, her birth certificate dated than less than three months ago

Who are the people likely to be called for a personal interview at the OFPRA?
Two scenarios are possible:
If the minor child or young girl applying for asylum due to a risk of FGM is accompanied by her father and/or mother present on French territory:

- If she is under the age of 13, only her legal representatives, who have parental authority, i.e. her father and mother, are called to a personal interview at the OFPRA. When her parents are both on French territory, their presence at the interview is essential, whether or not they have applied for asylum in a personal capacity.
- If she is between 13 and 17 years of age, she may be heard personally by a protection officer instructor on the grounds of her application, in the presence of her parent(s), legal representatives.

If the minor child or young girl applying for asylum is an unaccompanied minor, i.e. under 18 years of age and is without the protection of her parents on French territory:
Whatever her age, she is called to appear before the OFPRA and is heard in the presence of her legal representative: the latter, who has been appointed by a judge, is an ad hoc administrator, a guardian or a delegate of parental authority (see the Guide to asylum for unaccompanied minors in France for this point).

Monitoring of international protection granted to children and young girls because of the risk of FGM:
Article L. 752-3 of the Ceseda provides for periodic monitoring of the physical integrity of minors at risk of FGM and protected on these grounds.
In order to ensure that the OFPRA's protection is effective, the legal representatives of a minor child benefiting from refugee status or alternative protection, in accordance with Article L. 752-3 of the Ceseda, are required to have the child undergo medical examinations verifying that the child has not undergone genital mutilation.

There is a five-year interval between two examinations, unless the OFPRA has serious reasons to believe that FGM has been or may be carried out.
For the issuance of these medical certificates, it is imperative that you follow the procedure detailed above, by contacting a forensic doctor practising in one of the medical facilities whose contact details can be found here.

Failure to produce this medical certificate or the finding of genital mutilation of the protected child will result in a report to the public prosecutor and the President of the Departmental Council pursuant to Article 40 of the Code of Criminal Procedure and Article 375 of the Civil Code. In France, violating the physical integrity of a young girl or woman is an offence punishable by criminal prosecution.

Nevertheless, no finding of sexual mutilation can, on its own, lead to the termination of the protection granted to the minor under asylum.
Furthermore, when the parent(s) or legal representatives of a minor child placed under the protection of OFPRA due to the risk of FGM apply on the child's behalf to relinquish her status, this protection is only terminated if the OFPRA is absolutely convinced, after hearing the legal representatives and investigating the case, that the risk of genital mutilation has ceased to exist. Conversely, the protection granted to the child is maintained and a report is sent to the public prosecutor pursuant to Article 40 of the Code of Criminal Procedure.

If the applicant is an adult woman (aged 18) and applies for asylum because of a risk of FGM:

This asylum request may concern adult women who have not undergone FGM, women who have undergone partial mutilation or women who have undergone reconstructive surgery in France who fear that they may be victims of a new mutilation.
The person must provide OFPRA with a medical certificate attesting to the total or partial absence of FGM,

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or that reconstructive surgery has been performed.
This medical certificate is not regulated by the terms and conditions provided for in Decree INTV1721843A of 23 August 2017 issued pursuant to Article L. 723-5 of the Ceseda. It can be requested from the doctor of their choice.
The OFPRA should be notified as soon as possible after the asylum application has been submitted. If the certificate has not been provided prior to OFPRA's notification for the interview, it must be given to the protection officer on the day of the interview.
The absence of this medical certificate is not an obstacle to the examination of your asylum application, and a decision may be taken on your application on the basis of the elements in the OFPRA's possession.

For minors legally residing on the territory

The support provided will be different for a minor girl because of her vulnerability. If she is in a regular situation on the territory, she will be able to immediately take the necessary steps for prevention, support and protection.
Young girls may confide in an indirect way "I don't, but I have a friend I know" because they may feel that the subject taboo or have feelings of fear or shame. In this case it is suggested to give an indirect answer: "You can tell your friend that she can come and talk about it with me".

In case of doubt about a FGM

The professional may ask questions about the issues and difficulties identified.
The professional can use the issues and difficulties observed or reported by the minor to initiate a discussion with her. The purpose is to provide a space where she can reveal any violence she has suffered, in particular, a threat or FGM.

- I'm worried about you, you seem tired / worried / upset".
- I'm worried about you, about your repeated absences from school / the drop in your grades".
- I noticed that you were having difficulties concentrating, is there something you'd like to share?"
- Could you tell me how things are going at home with your parents?"

Interviews with minor girls should be adapted to approach the issue of mutilation in a different way, with much more sensitivity, with a vocabulary adapted to the girl's age and understanding of the subject, so that she feels she can confide in her interlocutor.
After the first interview, the usual care management plan will be put in place, but with redirection to health professionals trained in each of their fields to deal with child-related issues.

Note: In the event of any finding of FGM on a minor, the professional is required to report it to the Public Prosecutor.
There is no legal requirement that an examination of the external genitalia be carried out prior to reporting a suspicion of FGM.
Any medical certificate must be written after a clinical examination that substantiates the injury or lack thereof.
The following advice applies to all patients, taking into account the specifics of their age and circumstance.
After FGM, the patient may develop acute stress disorders and post-traumatic stress disorder. In this case, the victim may be confused and unable to remember all or part of what happened.
→Examination of a young girl
The examination of a patient requires a sensitive approach, remember that any examination requires the

consent of the patient.
As with any medical examination, you must be respectful of the person, for example:

- Respect consent.
- It is not necessary that the patient is fully undressed.
- Each part of the examination should be explained.
- Do not worry the patient by an inappropriate reaction (verbal or non-verbal). The patients do not necessarily have experience with genital examinations.

The clinical examination of the external genitalia is not a gynaecological examination and does not require the practice of vaginal examination or the use of a speculum.
Clinical examination confirms the diagnosis of FGM. It is recommended that the scarring be evaluated.
It is recommended that the woman or girl be offered a mirror to understand explanations provided.
It is recommended that the World Health Organization classification be used or that a description be provided in the patient's health record stating:

- The presence of the clitoral hood;
- The appearance of the clitoris, the labia minora, the labia majora and the urinary meatus.

A diagram may be useful in the medical record.
It is recommended to explain the results of the clinical examination to the patient) using educational tools: drawings, diagrams, mannequins, etc.
If there is any doubt about the diagnosis, it is imperative to refer the patient without writing a medical certificate to a specialist doctor or a team specialising in FGM.
It is also recommended to find out whether the patient has any minor daughters and/or sisters and discuss with her the prevention of FGM for the them.
In the case of minors, it is recommended that the doctor remind the patient of the following:

- That the law prohibits such violence;
- That the patient is in no way responsible, whatever the cause or circumstance.

❍ Examination of a minor child or infant

It is recommended that all minors receive regular external genital examinations, the findings of which should be recorded in the minor's health record.
It is advisable to be vigilant when it comes to FGM.
As with any clinical exam, it is necessary to:

- Speak to the minor in an age-appropriate way and at her level of understanding;
- Explain to her what the clinical examination consists of (ears, heart, lungs, mouth, eyes and vulva);
- Look for genital and urinary symptoms the patient's medical history.
- Take the time to reassure the minor and her parents about the vulva examination because it is not an intrusive examination;

❍ For an infant:

- Advise on vulvar hygiene, while ensuring the integrity of the external genitalia,
- An old and already healed type I mutilation may go unnoticed in a baby, but an infibulation (Type III), on the other hand, is clearly visible.

If the infant shows opposition (e.g. squeezing the legs, screaming) it is advisable not to insist.
Depending on the context and the assessment of the level of risk, it is advisable to propose:

- A follow-up appointment;
- Or call the Departmental Council's Information Gathering Unit, (preferably the doctor).

Note that Article 226-14 of the Criminal Code expressly provides for the waiver of professional secrecy "for

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anyone who informs the judicial, medical or administrative authorities" of the fact of FGM.
It is recommended that the conclusions of the clinical examination, including external genitalia, be noted in the minor's *carnet de santé* and health record.
Certain vulvar pathologies in the girl child may, to the uninformed clinician, have an appearance somewhat similar to the markers of FGM (e.g. coalescence of the labia minora, a posterior part of the labia minora not formed).
If there is any doubt about the diagnosis, it is recommended that the child be referred to an experienced colleague.
Care of FGM provided by primary health care professionals

Note: Specific example of grounds for clinical examination: application for a "non-excision" certificate in the context of a refugee claim for protection of the minor from a risk of mutilation in the country.
In the context of an asylum application (international protection) to the Office for the Protection of Refugees and Stateless Persons (OFPRA) or the National Court of Asylum (CNDA). A certificate of non-mutilation of the minor is requested by these bodies. This certificate, and in this specific context, must be drawn up by a forensic doctor within an approved facility (Medical and Legal Unit).
When applying for asylum in order to protect her daughter, the mother usually also requests a certificate stating that she has been mutilated. These certificates can be issued by any health professional experienced in FGM.

Chapter III: Prevention

Information, a weapon for prevention

First conversation with a woman or girl who has undergone FGM

Recognition of the situation: the person who needs to understand and be aware of the consequences and risks of FGM is the woman victim herself. The need for the first interview establishes the initial approach and assesses the patient's knowledge of what she has experienced and her understanding of the extent of the subject.
Depending on the patient's receptiveness to and knowledge of this sensitive subject, it is up to the nurse and other professionals to discuss the direct and indirect risks as well as the short and medium-term risks surrounding the practice of FGM.

The immediate and long-term health consequences of FGM vary according to the type and severity of the procedure performed.

- Immediate complications:

Immediate complications include severe pain, shock, bleeding, tetanus or sepsis, urinary retention, ulceration of the genitals and injury to adjacent tissue. Bleeding and infections can be fatal.
Recently, there has been concern about the risk of HIV (human immunodeficiency virus) transmission because a single instrument can be used for many operations in group mutilation, but this issue has not been well researched.

- Long-term consequences:

Long-term consequences include cysts and abscesses, keloid scars, damage to the urethra resulting in urinary incontinence, dyspareunia (painful intercourse) and sexual dysfunction.
Infibulation can cause extensive scarring, difficulty urinating and dysmenorrhea, recurrent urinary tract and genital infections and infertility.
Because infibulation often makes intercourse difficult or impossible, it is sometimes necessary to cut the scar formed by the labia majora to allow first intercourse.
An incision may also be necessary at the time of childbirth. If it is not done in time, there is an increased risk of obstructed labour, tears and even vesicovaginal or rectovaginal fistulas. A study conducted by WHO in 6 African countries found increased risk of childbirth complications and stillbirths among women who had undergone FGM.
Although more research is needed, the high rate of anal intercourse among women who have been infibulated (because vaginal intercourse is not possible) and tissue damage when the vulvar opening is too narrow are a possible routes of HIV infection.

- Mental health consequences:

FGM can leave a lifelong mark on the memory of those who have undergone it. Mental health issues can be deeply buried in the child's subconscious and can lead to behavioural problems. Another serious consequence that has been reported is the loss of trust in caregivers. In the long term, women may feel physically diminished, anxious, depressed and irritable. Many girls and women traumatized by their experiences who do not have an opportunity to voice their fears suffer in silence. A study conducted in Senegal comprising 23 excised women and 24 non-excised women showed that 30.4% of the excised women (7/23) suffered from post-traumatic stress disorder with memory loss and 80% suffered flashbacks of their excision.

It is therefore imperative that women be informed about the consequences of FGM on women's bodies and, above all, to give women the opportunity to talk about their experiences with those around them, whether in their family, with their friends, with colleagues or within their community. Information is the foundation of effective and widespread prevention.

Objective: to disseminate information leading to the prevention of FGM and to open up dialogue on a subject generally considered taboo.

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Dialogue with family and immediate circle

In the fight against FGM, it is essential to establish a dialogue within the family in order to prevent future FGM through education and raising awareness, with aim of preventing future FGM.
First of all, the family must understand that FGM is a crime. In France, FGM is prohibited by law, even if the act is committed abroad.

❍ Identify the risk at birth:
To ensure that preventive and protective measures are implemented and maintained. It is important to discuss the subject with the parent(s), those with parental authority to exercise of parental authority.
During the discussion, it may happen that a difference of opinion between the two adults responsible for the child is detected.
Discussing FGM means first of all having a benevolent listening posture without judging family tradition, customs or culture (not only could the minor's mother be excised but also the mother of the minor's father, his aunts, etc.).

❍ In discussion with parents or prospective parents:
Gradually raise the issue of FGM as it concerns the unborn baby and then their older daughters, if any.
It is recommended:

- To explain the immediate and medium-term health consequences for the minor and then the future woman;
- To point to the law, specifying that regardless of the country in which FGM may be committed: a minor who is a resident of France (without condition of nationality) is protected by French law, the perpetrators or accomplices are subject to French law (FGM is a crime), and that FGM is formally prohibited by law in France and in many countries.
- By providing them with informational materials.

It is recommended to note in the health record (carnet de santé) as well as in the professional file "FGM prevention with both parents".

FGM, addressing the subject at key moments

- For the new-born at her first medical examination.
- On first contact with the child.
- During a medical examination; (vaccine, sports certificate, etc.)
- Before departure and on return from a trip abroad, to the country of origin of the parents, during school holidays or outside school holidays.

Objective: To disseminate information widely to prevent FGM. To break the silence, which is an essential step towards healing and reinforcing the prevention and reducing the risk of FGM.

Dialogue and prevention for everyone

Prevention must also take place in public sphere as well as in the private sphere. Group discussions and prevention sessions within schools are a way of alerting the educational community and giving children a voice. This enables children to learn about these acts from an early age and to become actors of protection for their female classmates. In fact, a child who confides in teacher or school nurse about the experience or secret of one of his or her classmates about what the child considers to be a risk of excision can become an additional alert.
In addition, a child with knowledge of the existence of FGM would empower that child to protect herself as a potential victim by confiding in a trusted adult.
Objective: to establish prevention days in schools (primary school, middle school and high school).

It is also necessary to train teachers and educators in contact with children so that they are able to detect the risks of FGM and intervene effectively: Indeed, a student who is the victim of FGM during school holidays "changes her behaviour completely and will see her school results drop, without anyone worrying about her or asking what is wrong"; that "little girls are excised at the age of six and receive no support" is not acceptable.
A delegation from the Senate asked that school medicine be strengthened, Dr Piet lamented that the means and working conditions did not allow him to carry out the complete examination required

to identify girls threatened or victims of FGM: "the medical offices in schools do not have the technical equipment to perform a comprehensive examination," she said.
The possibility of detecting and preventing FGM on children in schools must be made possible, both through informational and procedural means as well as through material means.

Break the silence and establish an effective prevention process, over the long term, both directly and indirectly: all professionals involved in the prevention of FGM (police and gendarmerie services, judges, social workers, consular personnel, medical professionals - including emergency doctors -, personnel in contact with primary and secondary school pupils - teachers, school heads, doctors, psychologists and school nurses, etc.) must be made aware of FGM and trained to refer victims to the associations or medical-psychological structures that can provide them with the help they need.

Furthermore, with a view to training all professionals dealing with FGM, the following information should be disseminated as widely as possible:

- The Practitioner's Guide to FGM, published in 2016 by the French Minister of Social Affairs, Health and Women's Rights in collaboration with MIPROF [Interministerial Mission for The Protection of Women Against Violence and the Fight Against Human Trafficking];
- The Bilakoro kit developed by MIPROF for the identification and care of minors who are confronted with FGM;
- The online information platform United to end FGM.

Training of professionals and associations to better prevent FGM

Procedure to be followed and training tool to be implemented for health professionals

In the case of health professionals in particular, they play a decisive role in detecting cases of FGM and in dealing with its consequences: the necessary medical and psychological care must be discussed with the victims. An untrained doctor sees nothing, has no interest in the subject. An untrained midwife is not necessarily able to see that a woman has been mutilated. This will have consequences for the woman's life, but beyond that, for the little girl who is going to be born.
The CNCDH report of November 2013 confirms the importance of the role of health care personnel in identifying and accompanying victims of FGM, deploring the fact that "very few doctors, midwives or nurses are currently trained in the issue of FGM". The report also insists on the training of PMI doctors (mother and child protection services), forensic doctors and school doctors, who should be "subject to a special obligation of vigilance".
The detection of FGM occurs in many cases during prenatal care or even during childbirth, and too many women discover that they have been excised during childbirth.
During the delegation's examination of the report on 16 May 2018, Françoise Laborde suggested that the prenatal care of women who have been excised is an opportunity for medical personnel to make the women in their care aware of the risks associated with FGM, in order to prevent the replication of the practice on their daughters and in their families.

With regard to medical studies, training modules exist in certain medical cycles thanks to the work of the Interministerial Mission for The Protection of Women Against Violence and the Fight Against Human Trafficking (MIPROF).
PMI doctors play a decisive role in detecting and preventing FGM. In this context, it is important

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to consider a comprehensive examination of all children, regardless of their gender and origin, which has the advantage of also allowing for the detection of possible victims of abuse and sexual violence.

With regard to the tools made available to health professionals, mention should be made of the quality of the guide entitled The Practitioner's Guide to FGM, published in February 2016 by the General Directorate of Health and MIPROF (Interministerial Mission for the Protection of Women against Violence and the Fight against Human Trafficking) with the support of three experts: Dr Emmanuelle Piet, heard on 15 March, Dr Pierre Foldès, heard on 5 February 2018 and on 22 March 2018 as well as Mathilde Delespine, midwife.
This guide outlines the important aspects of French law: sanctions, lifting of professional secrecy for doctors, midwives and nurses, child protection. It guides professionals in how to broach this subject in consultation and how to behave when dealing with a minor victim or threatened with FGM.

Key recommendations:

- All health professionals likely to be in contact with women or girls at risk of FGM (doctors - including emergency physicians, midwives, nurses, psychologists, physiotherapists) should be trained to identify and accompany victims with the appropriate medical treatment or mental health care;
- These professionals should be able to, in the context of prenatal care for women who have been excised, make them aware of the risks associated with FGM in order to prevent FGM to be performed on their daughters and in their families.

The challenge of training professionals: reporting FGM and inter-professional cooperation

The challenge of initial and ongoing training for professionals is not only to ensure that victims are offered the care and guidance they need, but also to ensure that the cases are reported, with a view to prevention.
In this respect, it should be noted that the guide entitled The Practitioner's Guide to FGM provides those working in the medical field with all the information they need to report cases and provides model medical certificates.
As the above-mentioned PACE report points out, health professionals, social services and educational staff may be reluctant to report FGM for fear of legal measures such as parental arrest or the placement of young victims".
The report favours a rigorous legal response to FGM. In addition, it is important that all professionals likely to come into contact with young girls at risk of FGM (police and gendarmerie services, judges, social workers, consular staff, medical professionals - including emergency doctors -, staff in contact with primary and secondary school pupils - teachers, school heads, doctors, psychologists and school nurses, etc.) should be made aware of the importance of reporting FGM. Health professionals must also be reminded that professional secrecy does not allow them to absolve themselves of their responsibilities in this matter.

The training of all professionals who come into contact with minors or women must lead to inter-professional cooperation and a cohesion of services in order to provide the female victim with optimal care and sustainable and effective support. From this perspective, it is important that the professionals, whether working in a common framework or not, agree to work together on the same case, respecting shared professional secrecy, in order to establish a diagnosis, in their respective fields, for reparation or effective prevention.

Prevention at national and international level

Local actions: prevention on the ground

The fight against FGM takes place primarily at the local level. Associations for the defence of women's rights and the fight against FGM can effectively create a network for the protection and reconstruction of women because of their proximity to patients and their complete understanding of the various facets of this subject. The associations that are equipped to deal with FGM can make prevention more effective and generate measures and guidelines for professionals and other associations that do not yet have the necessary experience to care for these women but wish to do so.
With a view to generalising prevention and training as many associations and professionals as possible, it is important that the associations:

- Disseminate information on the issues surrounding FGM: the practices, the reality in France, the origins of the practice.
- Implement recommendations concerning the care that must be provided for these women and the guidelines of conduct.
- Point to relevant resources on the subject, such as the WHO recommendations or the HAS recommendations.
- Establish an agreement in each territory between the various associations that deal with the subject or that are closely or remotely related to the protection of women in order to address all the difficulties faced by women who are victims of FGM (i.e. housing, health, mental health, legal, social assistance, child welfare, etc.).

The French government supports and encourages the actions of all associations combating FGM with a view to making France an exemplary country in the eradication of FGM.
With support from the French government, the various actors working to combat FGM have been able to develop, over the past few years, projects and tools to strengthen their action, in particular :

- The tools proposed by the Interministerial Mission for the Protection of Women against Violence and the Fight Against Human Trafficking (MIPROF) and available on the website stop-violences-femmes.gouv.fr: the "Bilakoro" training kit and The Practitioner's Guide to FGM);
- The tools deployed in 2018-2019 by the association Excision, parlons-en !: A working project with the diasporas, dissemination of the third phase the Alerte Excision with a new tool (an exhibition of drawings), professional training via the UEFGM platform in France, distribution of the photo report "Fuir l'excision, parcours de femmes réfugiées" ("Fleeing excision, the journey of refugee women");
- The GAMS Guide from A to Z against excision, aimed at professionals and made available electronically;
- Tools for coordinating and standardizing training developed in 2019 by GAMS.

The fight against FGM, an international fight

FGM is now considered by the international community to be a violation not only of the rights of girls and women but also of the rights of children. Mobilization only really began to take off in the 1990s: "*Within the United Nations, the recognition of universal women's rights and respect for their integrity has long come up against the principles of respect for the sovereignty of Member States, on the one hand, and respect for family traditions and transmissions, on the other.*".

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1. The growing importance of international mobilization

The subject of excision was first presented in 1958 by a resolution of the United Nations Economic and Social Council as a problem for the international community; the text also addressed the harm caused by the practice, but without calling for strong condemnation by the Member States. The WHO began to reflect on the consequences of excision on the health of women and girls at the end of the 1970s: in 1977, a working group on "traditional practices affecting the health of women and children" was set up; two years later, work was begun on an inventory of the medical consequences of this practice.
There was also a gradual change of perspective within the World Conference on Women. In 1980, at the Copenhagen conference, a clear opposition was expressed between two points of view: to see the practice as a rite of passage to adulthood or to consider it as a harmful practice. In Nairobi, in 1985, a "*broader consensus*" began to emerge on the problem of FGM. Then in Beijing in 1995 a "*real international consensus in favour of the abolition of FGM*" emerged.

2. The commitment of the United Nations since the 1990s

As early as 1990, the Committee on the Elimination of Discrimination Against Women adopted a recommendation on female excision, expressing its concern "*to note that certain traditional practices prejudicial to the health of women, such as female circumcision, remain in use*", and which highlights the serious consequences of excision, "*particularly in terms of health, for women and children*". The text calls on governments to "*take appropriate and effective measures to abolish the practice of excision*". Among the means of combating these practices, the recommendation mentions the need for statistical data, support for women's organizations working against FGM, mobilization of the education sector and action in the framework of public health policies, emphasizing "*the special responsibility of health personnel, including traditional birth attendants, to explain the harmful effects of excision*". The UN committee also urges Member States to involve political personnel, "*religious leaders and community leaders at all levels*" in raising awareness of the need to abolish excision.
In February 1994, a United Nations General Assembly resolution included "*genital mutilation and other traditional practices harmful to women*" (Article 2) and called on Member States to "*not invoke considerations of custom, tradition or religion to avoid their obligation to eliminate it*" (Article 4).
The Programme of Action adopted at the end of the United Nations International Conference on Population and Development, held in Cairo in 1994, refers to the goal of abolishing FGM and calls on governments to support NGOs and religious institutions working to eliminate this practice.
In 1997, Unicef, WHO and the United Nations Population Fund (UNFPA) adopted a joint declaration on the prevention and abandonment of FGM.

3. The strengthening of international mobilization with the establishment of the International Day of Zero Tolerance for FGM

In 2003, the United Nations strengthened international mobilization against the practice by establishing the International Day of Zero Tolerance for FGM, held annually on 6 February.
Since 2007, a global programme has been conducted jointly by the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) to "*accelerate the abandonment of FGM*".
In 2012, a General Assembly resolution expressed concern about the persistence of FGM "*in all regions of the world*", reaffirmed the health threats to girls and women caused by genital mutilation, "*including psychological, sexual and reproductive health*", and recalled its "*adverse obstetric and neonatal consequences*", expressed

"*concern at the documented increase in the number of cases of FGM performed by medical personnel in all regions where the practice occurs*" and urged Member States to intensify their efforts to end the practice, including through information campaigns "systematically targeting the general public, relevant professionals and communities".

On 6 February 2015, the International Day of Zero Tolerance for FGM, the UN Secretary-General said "*if everyone takes action - women, men and young people - it will be possible, within a generation, to put an end to a practice that affects some 130 million girls and women in the 29 countries for which we have statistics*".

Among the 17 sustainable development goals (SDGs) adopted in September 2015, target 5-3 specifically aims to "*eliminate all harmful practices, such as child marriage, early or forced marriage and FGM*".

Two years later, on February 6, 2017, the UN Secretary General set out a clear vision: "*to put an end to these practices by 2030*".

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Chapter IV: Protection

Protection of the fundamental rights and freedoms of women

What French law says

FGM refers to all procedures involving partial or total removal of the external female genitalia and/or any other non-therapeutic FGM (WHO).

As mentioned, FGM constitutes a violation of fundamental human rights, including physical and psychological integrity and health. It is a form of discrimination against women. Such violence is rooted in the historical inequalities between women and men. Not only does it have immediate health consequences but also over the long term, in particular during childbirth and with regards to sexual pleasure;

It is an example of gender inequality and male domination.

FGM is prohibited and punishable by law: In France, the law protects all children living on its territory, regardless of their nationality.
French law applies when FGM is committed abroad if the victim is French or if the victim is a foreigner and is a resident of France.

The perpetrator of FGM and the person responsible for the child who was excised can be prosecuted for violence resulting in mutilation or permanent disability, an offence punishable by 10 years in prison and a fine of €150,000 (Article 222-9 of the French Criminal Code). The sentence is increased in particular if the mutilation is committed on a minor under 15 years of age, if the perpetrator is an ascendant or legitimate, natural or adoptive parent or by any person having authority over the minor.

In 2013, the legislature introduced two new criminal offences (Article 227-24-1 of the Criminal Code) (see below).
The victim may file a complaint up to 20 years after reaching the age of majority, i.e. up to the age of 38, to prosecute such violence before the French courts.

Recommendations:

- As a victim or a person close to a victim, it is possible to take action to prevent and combat such violence:

Actions to take in case of a threat or witnessing a person in danger:
Any person, health professional or private citizen, who is aware of such a risk has an obligation to report it. Failure to act constitutes an offence for failure to assist a person in danger, punishable under Article 223-6 of the Criminal Code.
Who to call:

- The public prosecutor at the high court (*Tribunal de grande instance*) of your place of residence.
- Social welfare services, in particular the Maternal and Child Protection Centres (PMI) and Child Welfare Services (ASE).
- 3919 - a free and anonymous telephone hotline.
- In case of emergency, call 17 or 112 (police-gendarmerie).

In France, the law protects all minor girls and women living on the territory, regardless of their nationality.

- You can talk to a doctor, a Maternal and Infant Protection Centre (PMI), a Family Planning or Education Centre, a social worker, or the departmental service of Child Welfare Services (ASE).
- You can call the public prosecutor at the high court (*Tribunal de grande instance*) of your place of residence.
- You can notify the police or gendarmerie by going to a police station or by calling 17.
- You can contact associations that actively fight against these practices such as GAMS and CAMS (see the other side for useful contact information).

❍ If you fear excision for yourself or for a relative during a holiday abroad:

Whether you are of French nationality or resident in France, French law applies to mutilations committed in France as well as abroad.

- Contact the Child Welfare Services (ASE). It provides you with protection until the age of 21.
- If you are worried about your younger sisters, cousins or friends under the age of 18, call - 119 - Allô Enfance en Danger, a toll free number available 24 hours a day and 7 days a week for the prevention and protection of children in danger or at risk of danger.
- Contact the public prosecutor at the high court (*Tribunal de grande instance*) of your place of residence. A ban on leaving the country may be ordered by the juvenile court judge without the parents' permission.
- You can ask a social worker to inform the public prosecutor.
- If you are abroad and you are of French nationality, ask for the protection of the Consulate General of France.

After FGM, obtain legal redress

Thus, the convictions of excisers and parents have made it possible to limit the excisions carried out in France.

In civil matters: 3 provisions offering protection against harmful acts on the body:

- Under Article 16 of the Civil Code, "the law ensures the primacy of the person, prohibits any attack on their dignity and guarantees respect for the human being from the very beginning of their life".
- Article 16-1 of the Civil Code stipulates that "everyone has the right to respect for their body", which is "inviolable".
- Article 16-3 of the Civil Code stipulates that "there may be no invasion of the integrity of the human body except in case of medical necessity for the person or exceptionally in the therapeutic interest of others".

The parental authority exercised by the parents over the child until the child reaches the age of majority is a set of rights and duties whose purpose is the interests of the child: to protect the child in his or her safety, health and morals, to ensure the child's education and to enable the child to develop, with due respect for his or her person (cf. article 371-1 of the Civil Code).

Parental authority does not include the right to decide to perform an excision. Accordingly, the judge may be petitioned and may prescribe any measures to prevent or halt unlawful interference with the human body (cf. Article 16-2 of the Civil Code) by issuing a protection order.

There are two types of judge that can be petitioned:

- The juvenile court judge: Article 375 of the Civil Code, as amended by the Law of 14 March 2016, authorizes the juvenile judge to intervene "if the health, safety or morals of an unemancipated minor are in danger (...)".

Responsibility for initiating such a request may rest with the father and mother jointly, or with one of them, the person or department to whom the child has been entrusted or the guardian, the minor herself or the Public Prosecutor's Office.

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This text applies to all children living on French territory, whatever their nationality.

- The family court judge: Excision or the threat of excision for a minor may also justify the intervention of the family court judge. The judge may deprive a parent of his or her rights of access in order to remove the child from his or her authority and preserve the child's well-being. According to Article 378-1 of the Civil Code, the judge may also completely revoke parental authority if the parents endanger the health, safety or morals of their child through abuse, lack of care or lack of guidance.

If the excision was carried out by or at the request of one parent and without the knowledge of the other parent, the latter may bring an action for civil liability.
Adults of legal age may also refer the matter to the family court in the event of a threat under article 515-10 of the Civil Code. The measures are taken for a maximum period of 6 months from the notification of the protection order. This period can be extended.
Under Article 1240 of the Civil Code, excision may result in an order for damages to compensate for the harm suffered by the minor who has been excised. This article also applies to girls who have reached the age of majority.

In criminal matters:

1/ FGM as a crime under the jurisdiction of the Court of Assizes
The French Criminal Division of the Court of Cassation, in its ruling of 20 August 1983, recognized the criminal nature of sexual mutilation, considering that the removal of the clitoris was indeed mutilation within the meaning of the French Criminal Code. This ruling was made thanks to the work of associations active in France since the end of the 1970s. As such, FGM is a crime under the jurisdiction of the Court of Assizes.
While there are no specific provisions condemning or punishing excision, the practice falls under the articles on intentional violence.
It is considered to be voluntary mutilation or even intentional mutilation. The penalties for the perpetrator of mutilation and for the person(s) responsible for the mutilated child are laid down in the Criminal Code:

- Article 222-9 of the Criminal Code: violence resulting in mutilation or permanent disability are punishable by 10 years in prison and a fine of €150,000. Article 222-10 of the Criminal Code increases the penalty to 15 years of criminal imprisonment if the mutilation is committed on a minor under 15 years of age. The same article provides that the penalty is increased to 20 years of criminal imprisonment when the offence is committed against a minor under 15 years of age by a legitimate, natural or adoptive ascendant or by any other person having authority over the minor.
- Article 222-7 of the Criminal Code: violence resulting in unintentional death is punishable by 15 years of criminal imprisonment. Article 222-8 of the Criminal Code increases the penalty to 20 years of criminal imprisonment when the offence concerns a minor under 15 years of age. The same article imposes a penalty of 30 years of criminal imprisonment if the offence is committed by an ascendant or any person having authority over the minor.
- Article 222-1 of the Criminal Code: torture or acts of cruelty are punishable by 15 years of criminal imprisonment. Article 222-3 provides for a penalty of 20 years of criminal imprisonment if the offence is committed against a minor under 15 years of age. The penalty is increased to 20 years of criminal imprisonment under the same article when the offence is committed against a minor under 15 years of age by a legitimate, natural or adoptive ascendant or by any other person having authority over the minor.
Attempts to commit such crimes are always punished with the same penalty as the perpetrator.

2/ FGM as an offence falls under the jurisdiction of the Criminal Court.
The Law of 5 August 2013 introduced two new offences under Article 227-24-1 of the Criminal Code which are punishable by 5 years of imprisonment and a fine of 75,000 euros:
"The making of offers or promises to a minor or the offering of presents, gifts or benefits of any kind, or the use of pressure or coercion of any kind against a minor to submit to genital mutilation is punishable where genital mutilation has not been carried out."
"*the act of directly inciting another person, by one of the means set out in the first paragraph, to commit genital mutilation on the person of a minor, where the mutilation has not been carried out.*"

International protection

FGM committed abroad: French law also applies when the mutilation is committed abroad, this is the principle of "extraterritoriality".
French law is applicable to any person (major) living on the national territory, but also abroad. In this case, the perpetrator of the crime, whether French or foreign, may be prosecuted in France, provided that the victim is of French nationality (Art. 113-7 of the Criminal Code[14]) or, if he or she is a foreigner, that he or she is habitually resident in France (Art. 222-16-2 of the Criminal Code[15]). In France, the law protects all children living on its territory, regardless of their nationality or origin.
Article 222-16-2 has been included in the Criminal Code since the Law of 4 April 2006, which applies to minors of foreign nationality who are ordinarily resident in France and who are victims of genital mutilation abroad. In this case, there is an exception to Article 113-8 of the Criminal Code: a complaint by the victim, an official denunciation by the authority of the country where the acts were committed, or a complaint by the parents are not required for prosecution by the Public Prosecutor's Office.
Parents (but it should be specified that any person) may also be prosecuted as accomplices under Article 121-7 (1) of the Criminal Code if the mutilation was performed on French territory or abroad, provided that the victim is of French nationality (Article 113-7 of the Criminal Code) or, if the victim is a foreigner, that the victim is habitually resident in France (Article 222-16-2 of the Criminal Code). According to the provision of 121-6, accomplices incur the same penalty as the offender. Furthermore, the parents may also be prosecuted as accomplices when the mutilation was committed abroad under the restrictive conditions of Article 113-5 of the Criminal Code[16]. To put it more explicitly, the act of sending one's daughter to the parents' country of origin to have her excised is an act of complicity. This act exposes those responsible to legal proceedings in France.
It is important to note that, according to French public policy, the motivation, i.e. personal motives, do not legally influence either the existence and intentional nature of the offence or its classification. Consequently, arguments for performing an excision based on African custom are not accepted.

The protection of children at risk

Preventing and intervening in cases of imminent risk of excision

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Assess the minor's overall situation

If there is a risk of FGM, the professional must assess the degree of risk, starting with:

- risk factors (e.g. "Assessing the level of risk of FGM", and analyse "Specific indicators in a minor");
- discussion with the parents or the minor child;
- a possible upcoming departure.

The professional can:

- Seek assistance and support from 119 (*service Enfance en danger*),
- Call the doctor of the Departmental Council's Information Gathering Unit (CRIP),
- Or call a professional of the CRIP (if known).
- Or a PMI doctor,
- Or relevant organizations.

Risk factors for a female patient to be the victim of FGM

It is recommended that these elements be examined to assess a patient's risk for FGM. Any one of these criteria may be sufficient to alert the health professional and to implement preventive measures. (See Chapter 6 of the recommendation). "Guidelines for the protection of minors from the risk of FGM"

- A minor whose father and/or mother comes from a community practising FGM.
- The family comes from a community that is known to practice FGM. A woman may be subjected to pressure from her spouse or other family members or from her spouse's family. She may be forced authorise or even organise the genital mutilation of her own daughter.
- The girl's mother, sister and cousin have undergone FGM. Alternatively, a family member (grandmother, aunt, etc.) may arrange for the FGM, with or without the parents' (father and/or mother) consent, on the assumption that the community takes precedence over the individual.
- The family says that people in their community have a high degree of influence or that these people are involved in the education of young girls. When discussing the subject of FGM with the family:
- The family believes that FGM is essential to their culture, customs or religion.
- Parents downplay the health and mortality risks associated with FGM. They are unaware of French legislation and that of the country of origin. Parents believe that the legal risk of performing FGM on their child is less for them if they are outside France.

Specific risk indicators for a minor:

Being born to a mother who has undergone FGM is an major risk factor. FGM is practised at any age and in the family context.

Leaving the country of origin is not always enough to ensure the protection of the girl. On the contrary, this situation can constitute a risk reinforced by a feeling of isolation.

- Parents are planning a trip abroad for their daughter, including to Europe. Various reasons may be given (family celebration, illness of a close relative, etc.) or indicate that they intend to take their daughter abroad for an extended period.
- The minor tells the health professional that she is going to participate in a festival, a special ritual, "like a baptism," where she will receive "gifts," "a beautiful dress," an opportunity to "become a woman" or that she is going away for a long holiday.
- The family does not provide medical records for the minor (e.g. an empty carnet de santé).
- The parents are planning a trip or a return to their country of origin. (The parents request a vaccination, a prophylaxis for a trip abroad, the minor has just been vaccinated against yellow fever). The trip may concern only the daughters of the family.
- A parent or a family member or someone in the community expresses concern about the risk of FGM for

a minor.

- The minor talks about FGM in conversation, for example by talking about another child. Never downplay this risk when the child confides in you or expresses her concern.
- A minor seeks help from an adult because she is aware or suspects that she is at risk of undergoing FGM.

From reporting to the procedure for protecting the child

❍ Guidance for the minor

The health professional can offer simple guidance to the minor at risk of FGM, depending on her age and ability, on how to respond in an emergency situation:

- Contact the emergency numbers: 17 (police), 114 (SMS contact for people who are deaf, hard of hearing or have difficulty expressing themselves);
- Contact: 119 (Enfance en danger) - this is not an emergency number, but a number for local support and possible referral to appropriate child protection services,
- To seek support from the school nurse 10;
- To contact the PMI near her;
- To identify people close to her who can provide support (at school, in the neighbourhood, the family doctor, etc.);
- To find out if there are any sisters who might be involved;
- As a last resort at the airport, to report to security guards or the authorities (for example, slip a small piece of paper "SOS excision", roll on the ground, make a scene, etc.); in order to be taken aside individually by the authorities and to be able to speak.

❍ Guidance for parents

It is recommended that parents be provided with official documents and certificates that they can rely on to protect their children:

- A medical certificate of non-excision for their daughters, (refer to Appendix 5 "Medical Certificate of Non-Excision") with another examination scheduled following the return date;
- An official statement specifying the legal and financial risks and complications for the minor's health. The more documents (with one or more stamps) the health professional gives to the parents, the more deterrent the effect is.
- It is recommended to put them in contact with relevant organizations.

❍ Guidance for the professional in the event of an immediate risk of FGM for a minor: Contact the public prosecutor

The immediate risk of FGM is an extremely serious situation.

If there is an imminent risk of FGM, the professional must first make an emergency REPORT - i.e. the professional MUST:

- Inform the public prosecutor at the high court (Tribunal de grande instance) of the place of residence of the patient or minor by telephone, fax or email with acknowledgement of receipt (the police or gendarmerie services have the contact details of the judges on duty). If in an emergency the prosecutor was notified only by telephone or fax, the report will be acknowledged in writing, with a dated and signed document. The professional will verify that it has been received.
- Send a copy of the report to the doctor or the person in charge of the CRIP.
- It is recommended that the health professional keep a copy of the report and also note it in the medical file.

It is recommended at this stage not to inform the parents in order not to put the minor at additional risk.

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Where any other method of prevention appears to be unsuccessful, the public prosecutor or a juvenile court judge may issue an order prohibiting the minor from leaving the country. Police or other law enforcement (Brigade for the Protection of Minors and/or Families) can also be called in to ensure that the law is properly enforced.
Some prosecutors may also recommend an examination of the child's examination of the external genitalia before departure and upon return; with penalties in the event of failure to comply with French law.
The Public Prosecutor has a wide range of powers to protect the child, ranging from referral to the juvenile court judge by request, for educational assistance, to take a decision for a temporary placement order to protect the child if it is deemed necessary.
Referral to the Public Prosecutor's Office is then the starting point for a judicial review of the situation and investigation.
It is recommended that the same risk indicators be taken into consideration for the sisters.
An examination of the vulvar anatomy is recommended.
This information on FGM as well as the examination of external genitalia will be explicitly recorded in the medical record.
Reporting does not prevent further follow-up by the health professional, on the contrary.
It is useful to inform parents about the requirement to respect the physical integrity of their child and possibly to give them a medical certificate stating that FGM was not observed on the day of the examination, on letterhead that is signed and stamped.
The provision of such a medical certificate can be a deterrent.
The family is then informed that:

- The same medical examination will be carried out upon return (note the expected date of return);
- The law compels all health professionals to report to the competent authorities any knowledge of FGM, which is a crime in France, as in many countries.

Guidance for the health professional in the case of a non-imminent risk of FGM: Information of concern to the Information Gathering Unit
If there is a non-imminent risk of FGM, the professional must first provide an INFORMATION OF CONCERN REPORT to the Departmental Council's Information Gathering Unit (CRIP):
In other words, the professional must alert the CRIP in writing and sending a report to the doctor or the person in charge of the CRIP with the elements that lead the professional to assess the presence of this risk.
On the basis of this information of concern, the CRIP (in accordance with the Law of 14 March 2016 on the protection of children) carries out "an assessment of the situation [of the] minor [...] carried out by a multidisciplinary team of professionals [...]. On the basis of this, the risk of the other minors present in the home is also assessed".
It is recommended that the health care professional inform the parents that the Information of Concern was sent.

Reporting and prevention of forced marriage

In the case of FGM of a minor: Contact the public prosecutor

In the case of FGM, the professional must first make an emergency REPORT: The professional MUST without delay:

- Inform the public prosecutor at the high court (Tribunal de grande instance) of the place of residence of the patient or minor by telephone, fax or email with acknowledgement of receipt (the police or gendarmerie

services have the contact details of the judges on duty).

- If in an emergency the prosecutor was notified only by telephone or fax, the report will be acknowledged in writing, with a dated and signed document. The professional will verify that it has been received.

It is recommended that you contact the public prosecutor by telephone, if possible (a member of the public prosecutor's office is always on duty), to find out what position to take in the event of a finding.
A copy will be sent to the President of the Departmental Council so that the official can also be informed of the existence of a minor in danger in their department.
The question of removing the child from the family unit will be addressed as a matter of urgency by the investigation and prosecution services in order to ensure the victim's protection.

FGM also carries the risk of other forms of violence, including the forced marriage of the minor.
Forced marriages are against French law, just as they are in other countries in the world.
Since the Law of 4 April 2006 went into force in France, all marriage is now prohibited under the age of 18, whether it concerns a woman or a man. However, this new law does not respond to the problem of traditional and/or religious marriages, which still exist.

- Minors under the age of 15

With regard to religious or traditional marriages involving forced or even unwanted sex, the law is uncompromising. **Minors under the age of 15 are not considered capable of consenting to sexual intercourse.** This prohibition is the basis for the protection of minors under 15 years of age at risk of being or having been forced into marriage.
There are three provisions that punish sexual relations between a minor under the age of 15 and an adult:
Article 227-25 of the French Criminal Code: A person over the age of majority can be prosecuted and sentenced to 10 years in prison and a fine of €75,000 if he or she that person has had sexual intercourse (with penetration or not) without violence, coercion, threat or surprise with a minor under the age of 15. **This is a case of sexual assault.**
Article 222-29-1 of the French Criminal Code: A person over the age of majority can be prosecuted and sentenced to 10 years in prison and a fine of €150,000 if he or she has made a gesture of a sexual nature, with or without physical contact, e.g. touching, directed at a minor under the age of 15. **This is a case of sexual aggression.**
Articles 222-23 and 222-24 of the French Criminal Code: A person of full age may be prosecuted and punished by a term of 20 years in prison if he or she has committed an act of sexual penetration, of any kind, on the person of a minor under the age of 15 by violence, coercion, threat or surprise. **This is a case of rape.**

Young minors under the age of 15 who are at risk of being married or who have already been married must therefore be given maximum protection. **It is therefore everyone's duty to report and act on the risk of the crime of rape or other offences.** This protection is ensured by notifying the Public Prosecutor's Office, Child Welfare and/or the Brigade for the Protection of Minors. Article 375 of the Civil Code provides for the possibility for the legal guardian to refer the matter to the juvenile court judge if there is a risk of forced marriage concerning the child. According to Article 375-7 of the same code, the judge may order a ban on leaving French territory for a maximum period of 2 years. The minor, herself, may request a protective order from the high court of her residence without the consent of her parents. She can also contact an association (number: 119), which supports the girl with the help of a lawyer, who works free of charge for children.

- Minors aged 15 and over

With respect to sexual relations, the law considers a minor over 15 years of age to be able to consent to a

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sexual relationship with a person having reached the age of majority. Article 227-27 of the Criminal Code provides for a penalty of 3 years in prison and a fine of €45,000.
However, as with minors under the age of 15, rape and sexual assault (i.e. non consensual sex) are punishable by law:
Article 222-27 of the Criminal Code is applicable to sexual assault of a minor over the age of 15, the penalty is 5 years in prison and a fine of €75,000.
Article 222-23 of the Criminal Code relates to rape committed against a minor over 15 years of age; the penalty is 15 years in prison.
Coercion to marry provides an opportunity to introduce the concept of rape and thus to take appropriate protective measures. This protection requires a report to the Public Prosecutor's Office, Child Welfare and/or the Brigade for the Protection of Minors.
In addition, regardless of the age of the minors, there is an offence of non-violent removal by ascendants, which is aggravated in the case of foreign travel. This offence is provided for in Article 227-7 of the Criminal Code, which carries a penalty of one year in prison and a fine of €15,000.
Similarly, there is an offence of non-violent abduction by a third party under article 227-8 of the Criminal Code, which carries a penalty of 5 years in prison and a fine of €75,000. This is the case when the future in-laws abduct the child to take her to another country. The Judge may act urgently if he or she is informed when the girl is likely to leave French territory.

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Module V
General Therapeutic Approach

Introduction: The battle against Female Genital Mutilation and the need for a general and multidisciplinary approach

Sexual genital mutilation is a scourge that is very difficult to tackle and treat: apart from the obvious health and bodily dangers it represents for women and girls, it also encompasses a multiplicity of other related topics (forced marriage, rape, psychological violence, immigration, etc). Hence, when associations try to help these women and girls, they find it very difficult to meet all of their needs. In addition to having suffered a most traumatic ordeal, these women will also have to face many other obstacles along their journey as female victims of mutilation. That is the reason why it is absolutely necessary that associations, but also governments, public services and private individuals, manage to understand the scope of the problem, if they really want to help these women and girls and prevent the continuance of these crimes.
The approach to Female Genital Mutilation (FGM) must therefore be multidisciplinary and generalized: this is the only way to fight it effectively, and provide a lasting treatment for that issue.

Chapter I: The implementation of a multidisciplinary protocol

FGM, the need for a transverse and multi-tiered approach

A surgical and medical approach, the primary context of FGM

Reminder: W.H.O definition of the different types of excision

Type I: "Clitoridectomy" is the partial or total removal of the foreskin and / or the clitoris. This method of FGM is designated by certain groups under the term "Sunna".

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

Type III: "Infibulation" is the narrowing of the vaginal opening with the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, with or without excision of the clitoris.

Type IV: Unclassified, represents all other harmful interventions performed on the female genital organs for non-therapeutic purposes, such as puncture, piercing, incising and cauterization.
Two types of FGM were selected: excision and infibulation. The first consists of partial or total, and occasionally asymmetrical, amputation of certain external genitalia. The second combines such removal with the occlusion of the vulva introitus. In addition to all the usual complications encountered among young girls and women who are circumcised, Infibulation causes a range of other specific problems, including obstetrical issues. In practice, almost all excisions are of type II, because they take away a more or less important portion of the glans.

Nowadays, very specific techniques for reconstructing the clitoris have been defined. They are implemented in France, in particular by Doctor Pierre Foldès. This reconstruction of the clitoris is implemented through several stages. These stages are necessary for the smooth running of the operation, and in order to allow a complete and efficient healing of the patient.
Firstly, it should be noted that surgical treatments now exist, when confronted with the complications due to excision and infibulation. In Belgium, for example, a few doctors practice surgical treatments to relieve excised or infibulated women : disinfibulation of the labia majora in the case of type 3, or the labia minora in the case of pseudo-infibulation, removal of dermoid cysts, surgical treatment of neuromas. A technical guide was produced in 2000 and was distributed to all Belgian maternity hospitals. It explains how to take care, during childbirth, of women who have been infibulated, and it describes the technique of disinfibulation.
Disinfibulation can be performed outside of pregnancy, before a first sexual intercourse, before marriage, for urination problems, etc. In cases of pregnancy, it can be performed during the second trimester of pregnancy, or during the expulsion phase itself in the hospital delivery room.

Regarding the reconstruction of the clitoris and the surgery it requires, "conservative" clitoral reduction techniques had been proposed so far, but only for the treatment of sexual ambiguity, clitoral hypertrophy or transsexualism. The technique developed by Dr Foldès "aims to restore a normal anatomy and to obtain a normally innervated and - whenever possible - functional organ". The double skin flap technique was first tested in the field, 25 years ago, for the treatment of nociceptive adhesions of the clitoral stump, resulting from a previous excision. During missions in Africa that were initially aimed

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at solving the problem of vesico-vaginal fistulas, women have come forward to ask for a solution to permanent and disabling pain they were experiencing in the pubic region. This was the first time that Dr. Foldes saw these adherent stumps, which were "freezing" the vulva at the pubic periosteum, and sometimes creating permanent pain when walking, prohibiting the use of any even slightly tight underwear. The first attempts at surgery led to the discovery of a "clitoral stump" : this stump was at first released, then the surgeon tried to reposition it in a more normal location. The idea then arrived to find and release the pudendal pedicle. After some anatomical research the technique was codified. The technique has since been simplified, in order to ensure it can be correctly reproduced, and so as to make it easier to achieve in an unstable environment, with reduced anesthetic means and low funding (Foldes, 2006).
Today, more than 3,000 women have been operated on in France, 14 hospitals are practicing the reconstruction of the clitoris, and the operation is reimbursed by social security since 2004.

Monitoring is organized as follows:

- A preliminary consultation with an anesthesiologist and a sexologist, in order to validate the request,
- One day at the hospital for the operation itself,
- Post-operative follow-up at 2 weeks, 6 weeks and 2 months,
- 4 consultations with a sexologist,
- Medical follow-up for two years.

For more information on reconstruction and the procedure for surgical reconstruction of the clitoris, see module II.

The psychological perspective : support during the journey and post-operative reconstruction.

The path to reconstruction after an operation is as much a matter of medical follow-up as of psychological follow-up. The latter is crucial in order to help the woman reclaim her body and heal from the trauma that this ordeal may have caused her. This aspect is especially important because the trauma may have been buried for a very long time, since FGM is often performed at a very young age.
Sexual mutilation can scar the memory of those who suffered it for life. Psychological complications can be buried deep in the child's subconscious and cause behavioral problems. Another serious consequence that has been reported is the loss of confidence in caregivers. In the long term, women may feel physically weak, anxious, depressed and irritable. Many young girls and women who are traumatized by their experiences but cannot express their fears, suffer in silence.
The psychological consequences of Female Genital Mutilation are therefore very frequent and contribute to the increased risk of developing psychiatric and psychosomatic disorders. These consequences are part of the spectrum of violence against women and further worsen their experience (early marriage, violence within the couple, domestic and sexual violence, etc.).

As a rule, there are several psychological consequences to Female Genital Mutilation:

- Post-traumatic stress disorder (for example: day and night re-enactments, nightmares, etc).
- Post-traumatic dissociative states (for example: detachment, absence of affect when mentioning mutilation)
- Depression, suicidal behavior
- Behavioral problems
- Anxiety, elective phobias, anxiety about sex and childbirth
- Withdrawal, loss of self-esteem, feeling of being different, abnormal, feelings of shame, feelings of injustice, anger

In order to overcome these psychological problems, it is important to start by acquiring an overview of the consequences of FGM for the patient, before the operation. This way, follow-up will be more efficient and appropriate. It is therefore necessary for the psychological work to begin from the very first interviews with the medical professionals. The follow-up sheet, set up for all the professionals who will take care of the patient, will allow them

to monitor her evolution before and after the operation. This way, psychologists or psychiatrists will be able to have an overall assessment of the patient and adapt their sessions so that psychological healing takes place as quickly and efficiently as possible.
The steps of psychological assessment are therefore divided into two categories: one before the operation and one after the operation. Both are essential.

Before the operation, and in order to start forming a base for the healing process, the psychological process must endeavour to understand the general psychological state of the patient, as well as her level of understanding and her feelings towards what has happened to her:

- The general psychological state of the patient →perception through the support group, in particular
- Her understanding of what happened to her and how she sees her injuries
- Her vision of FGM (does she think it is normal because it is part of a traditional process, is she angry, does she know that what happened to her is illegal, how does she deal with these injuries, etc.)
- Her relation to sexuality and her life as a woman in general, as well as her expectations (if she has any)
- If she is considering a repair operation. You have to know if she is ready to undergo another change in her body, to know if she understands the lengthy process of repair that it implies (generally over several months or years)
- Begin the stages of psychological healing and new approaches to her body and sexuality

After the operation, the process will consist in following the first steps of the patient's psychological healing, but also in accompanying her through the new changes brought about by the operation, and in helping her adapt to the new vision of her body and of her sexuality:

- Monitoring of the patient's pain and feelings after the operation
- Reappropriation of the female body and life
- Reappropriation of sexual intercourse and pleasure
- Support during the long journey she is undertaking for the reconstruction and healing process
- Implementation of a more in-depth procedure for the psychological healing and trauma journey
- Adaptation and evolution of the healing path, both bodily and psychologically
- Proposal for varied activities adapted to the patient, allowing a renewed confidence in others, a renewed confidence in herself as well as in her body (theater, therapeutic massage, support groups, sports, music, writing, etc.).

Legal involvement in the defense of women and the attempt at protecting their rights

In order for a woman who was the victim of FGM to recover from her trauma, she needs to have a sense of justice rendered. This requires the use of legal procedures. They will allow those who wish to take legal action to obtain punishment for the perpetrators of these crimes, when it is possible and/or obtain at least a level of recognition and compensation for the damage they suffered.
As far as the legal system is concerned, there exist several possibilities to punish the perpetrators of FGM. They usually depend on the person making the request (minor, adult, immigrant) and also on where the FGM was committed (France, EU country or third world country).

<u>FGM is a crime for which the french "Cour d'Assises" has jurisdiction.</u>
In France, thanks to the work of several associations that started at the end of the 1970s, the judgment rendered by the criminal chamber of the french "Cour de Cassation" on August 20, 1983 recognizes the criminal nature of Female Genital Mutilation. It states that the removal of the clitoris is indeed a mutilation within the meaning of the French penal code. FGM is therefore a crime that falls under the jurisdiction of the Cour d'Assises.
If there is no specific provision

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condemning or punishing excision per se, this practice falls under the articles relating to willful violence.

These actions are considered as voluntary/intentional mutilation. The penalties for the perpetrator of mutilation and for the person(s) responsible for mutilating the child are defined by the penal code:

- Article 222-9 of the Penal Code: this article deals with cases that involve violence resulting in mutilation or permanent disability, which are punished with a 10 year prison sentence and a fine of 150,000 euros.
- Article 222-10 of the Criminal Code increases the penalty to a 15 year prison sentence if the mutilation is perpetrated on a minor under 15 years of age. The same article stipulates that the penalty incurred is increased to a 20 year prison sentence when the offence is committed against a minor under 15 years of age by a legitimate, natural or adoptive family member or by any other person having authority over the minor.
- Article 222-7 of the Penal Code: this article deals with cases of violence that resulted in death without intention of giving it. These actions are punished with a 15 year prison sentence.
- Article 222-8 of the Criminal Code increases the sentence to 20 years of prison when it concerns a minor under 15 years of age. The same article imposes a sentence of 30 years of imprisonment if the act was committed by a family member or any person having authority over the minor.
- Article 222-1 of the Criminal Code: this articles deals with cases of torture or acts of barbarism which are punishable by 15 years of imprisonment.
- Article 222-3 provides for a sentence of 20 years of imprisonment if the offence was committed against a minor under 15 years of age. The penalty incurred is increased to 30 years of imprisonment by the same article when the offence is committed on a minor under 15 by a legitimate, natural or adoptive family member or by any other person having authority over the minor.

As far as FGM is concerned, the author of any attempted crime is subject to the same punishment as an actual perpetrator.

<u>FGM as an offence falls under the jurisdiction of the Criminal Court.</u>

The law of August 5, 2013 introduced two new offences, through article 227-24-1 of the penal code, which are punishable by 5 years of imprisonment and a 75,000 euros fine. These offences are the following:

- "The act of making offers or promises to a minor, or offering her gifts, presents or any advantages, or using pressure or constraints of any kind against her, so that she submits to a sexual mutilation is punishable, when this mutilation has not been carried out. "
- "the act of directly inciting others, by one of the means set out in the first paragraph, to commit sexual mutilation on a minor, when this mutilation has not been carried out."

<u>FGM perpetrated abroad.</u>

French law also applies when mutilation is committed abroad, according to the principle of "extraterritoriality".

French law is applicable to any (adult) person living in the national territory, but also abroad. In this case, the perpetrator, whether French or foreign, may be prosecuted in France, provided that the victim is of French nationality (art. 113-7 of the penal code) or, if she is foreign, provided that she usually resides in France (art. 222-16-2 of the penal code).

In France, the law protects all children living in its territory, regardless of their nationality or origin.

Article 222-16-2 has been included in the Penal Code since the law of April 4, 2006. It applies to any minor of foreign nationality who is a habitual resident in France and who is victim of sexual mutilation abroad. In this case, there is an exception to article 113-8 of the Criminal Code: a complaint by the victim, an official denunciation by the authority of the country where the acts were committed, or a complaint by the

parents are NOT required for a prosecution to be brought by the Public Prosecutor's Office.

Parents (but it must be specified that it could be, in fact, any person) can also be prosecuted as accomplices under article 121-7 paragraph 1 of the Criminal Code if the mutilation was practiced on French territory or abroad, provided that the victim is of French nationality (art. 113-7 of the penal code) or, if she is a foreigner, provided that she usually resides in France (art. 222-16-2 of the penal code). Under the provisions of article 121-6, accomplices face the same penalty as the perpetrator. In addition, parents can also be prosecuted as accomplices when the mutilation was committed abroad under the restrictive conditions of article 113-5 of the penal code. Furthermore, sending one's daughter to the parents' country of origin, in order to have her excised, is considered an act of complicity. This act exposes those responsible to legal proceedings in France.

It also needs to be noted that according to French law, the motive, that is to say the personal reasons for doing something, has not influence (from a legal viewpoint) either on the existence or on the intentional nature of the offence, nor on its qualification. Thus, the arguments stating that the excision was committed because of the existence of an African custom are not accepted.

Prosecution for failure to assist a person in danger: Social or medico-social professionals, as well as teachers, are expected to provide assistance and protection to any endangered child. More generally, this obligation applies to all citizens. It is therefore their duty to report any risk of FGM they might encounter.
In the event that they choose not to report a case, they can be prosecuted for not assisting a person in danger and / or for not reporting a crime.
Article 223-6 of the Criminal Code provides for two crimes of non-assistance of a person in danger:
"Anyone who can prevent by his/her immediate action, without risk to him/her or to third parties, either a crime or an offence against the bodily integrity of a person and who voluntarily refrains from doing so, will be punished with 5 years of imprisonment and a fine of 75,000 euros.

The same penalties will be imposed on anyone who voluntarily refrains from providing assistance to a person in danger when, without risk to him/herself or to third parties, he/she could have assisted the victim either by his/her own action or by calling for assistance."

Regarding failure to report, professionals can be prosecuted for non-assistance of people in danger if, despite their knowledge of the imminence of a FGM, they did not contact the authorities in charge of child protection, be it administrative (Social Welfare for Children) or judicial (Public Prosecutor).
When a minor has just been excised, professionals must, in the same way, refer to the same authorities.
In principle, professionals are forbidden from disclosing confidential information (provided for in article 226-13 of the Criminal Code, which carries a penalty of 1 year of imprisonment and a fine of 15,000 euros). However, there are some exceptions to this article:
° article 226-14 of the Penal Code authorizes professionals "to inform the judicial, medical or administrative authorities of any deprivation or ill-treatment they became aware of. This includes all cases of sexual assault or mutilation, which came to their knowledge and which were inflicted on a minor or a person who is unable to protect herself because of her age or physical or mental incapacity."
The same article gives authorization to "the doctor or any other health professional who, with the victim's agreement, decides to reveal information relating to minors in danger or at risk of being in danger, or information relating to the ill-treatment or deprivation which was detected, physically or mentally, in the exercise of

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his/her profession and which allows him/her to suppose that physical, sexual or psychological violence of any kind has been committed. When the victim is a minor or a person who is unable to protect themselves because of their age or a physical or mental incapacity, their agreement is not deemed necessary.

Consequently, professional secrecy cannot be invoked when a minor is threatened with excision.

- Article 434-1 of the Criminal Code is a general article, which provides a penalty of 3 years of imprisonment and a 45,000 euro fine. It applies to anyone who does not report a crime on a minor to the authorities, when the effects of said crime could have been prevented or limited.
- Article 434-3 of the Criminal Code: this article deals with a penalty of 3 years of imprisonment and a fine of 45,000 euros for all those who have become aware of any deprivation, ill-treatment or sexual assault or attack inflicted on a minor or a person who is unable to protect herself because of her age, illness, infirmity, physical or mental impairment or state of pregnancy, and have chosen not to inform the authorities.
- Article 434-5 of the Criminal Code: this article deals with a penalty of 3 years of imprisonment and a fine of 45,000 euros for any person who incites the victim of a crime or an offence not to bring complaint or to withdraw a previous complaint.

The minor herself can request a protective measure from the children's judge at the High Court of her place of residence, without the consent of her parents. She can also call 119 (Phone Number of Allo Enfance Maltraitée) or contact an association that will accompany her and provide the help of a lawyer (free of charge for children).

As regards the doctors : Article R4127-4 of the Public Health Code and article 226-13 of the Criminal Code enforce professional secrecy on doctors. The doctor is also bound by professional secrecy vis-à-vis the parents of a minor. Exceptions to this principle exist:

The Code of Medical Ethics states that "The doctor must be the defender of the child when he/she considers that the interest of her health is wrongly understood or badly preserved by those around her."(Article 43) This rule is provided for in article R4127-43 of the Public Health Code.

"When a doctor perceives that a person on behalf of whom he/she is called is the victim of ill-treatment or deprivation, he/she must use all appropriate means to protect her by exercising prudence and circumspection.

In the case of a minor or a person who is unable to protect herself because of her age or her physical or mental state, the doctor must alert the judicial or administrative authorities, except under very specific circumstances that 'he/she will appreciate in conscience' (Article 44). This rule is included in article R4127-44 of the Public Health Code.

At the national level, a free hotline service exists to report cases of at-risk children. If they are in distress, these children can call on their own volition. This service is also available to minors who are threatened with forced marriage (Number for "Allo Enfance Maltraitée" 119). This number is available to children 24 hours a day, 7 days a week.

It should be noted that when the girl is a minor, and even more so when she is a minor under the age of 15, it is the duty of adults, and more particularly of educational, social and medico-social professionals, to protect her from the dangers and violence she could endure. For this reason, it is imperative to refer the situation of FGM or any risk of FGM to child protection institutions.

For more information on national and international legal protection for women victims of Female Genital Mutilation, see Module IV.

From the first visit to the operation: the complementarity of professionals

About the first contact and the adoption of an adapted and efficient monitoring

The first contact with a female victim of FGM constitutes the occasion to set up a follow-up sheet, which will be used by all health and legal professionals who will be involved in the patient's case. This first contact also makes it possible to get to know the patient, to start cautiously broaching the matter of FGM with her and to try and show the patient that she now has someone she can confide in about that matter.
The first contact constitutes therefore a release of the patient's speech; but one must keep in mind that this first contact must be adapted to her sensibility, her understanding of the matter and her age.
Thus the monitoring sheets should be divided into two categories, one being a roadmap for minor subjects and the other a roadmap for adults. Both will obviously include common frameworks. But they will also necessarily include different frameworks for underage patients, because FGM can not be approached in the same way with a minor. The procedures put in place for minors will have to be different.

The first interview is therefore crucial when it comes to initiating a discussion about FGM with the patient, but also when it comes to getting a first glimpse at her personality and correctly identifying the professionals who should be chosen to be responsible for the continuation of her treatment.
Ideally, this interview should be the opportunity to start building trust with the patient, or at least to help her start to become aware of the steps that will follow. The first interview should help her get a clear idea of the expectations she can have and of the possibilities that will be offered to her in the medium and long term.

The first interview should also, whenever possible, be the occasion to consider whether the patient can, and wants to, choose the path of surgical reconstruction. In that case, the stages of reconstruction and the reality of surgical operations should be addressed, to the extent that it is possible.

The following general steps for the first interview should be followed, but must always be adjusted and adapted to the patient:

- Meeting with the patient
- Establishing communication with the patient and obtaining a description of her history and her journey
- Gently asking questions aimed at giving/getting an overview of FGM and evaluating the sensitivity and understanding of the patient when faced with this subject.

❍ Does the patient know that she has been subjected to FGM? If not, explain to her that a gynecological appointment will verify it.

❍ If the patient knows that she has suffered FGM, ask questions about the memories that she has of the event (always check that she is able to talk about it and that it does not disturb her too much, otherwise leave this step for the psychological appointment).

❍ Identify the people who surround the patient: discover who can be trusted among them, who is going to support her and whether, conversely, there are others who will try to dissuade her from obtaining treatment or will interfere with her healing process. Try to detect whether there is a risk for another person around the patient (daughter, sister, granddaughter, niece, friend, etc.).

❍ Try to pinpoint the authors of this specific FGM, and ascertain their link to the patient (is she still in contact with them).

❍ Try to identify the path that this FGM followed: this should be adapted according to the country where

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the FGM was practiced.

- Try to initiate discussions about the patient's understanding of FGM : does she know what it involves, does she identify the pains and problems it causes or has caused her, does she have a notion of the psychological consequences it may have, etc.
- If possible present her with the various possibilities of treatment which are offered to her, either legally, medically or psychologically → try to ascertain whether she knows about surgical reconstruction and if she wants to start a procedure
- Give explanations about the overall health care plan and mention the list of all the different professionals she will see or can consult.
- Explain what other aid schemes she can benefit from, regarding her living conditions. In particular, in the context of people seeking asylum, or looking for accommodation, redirect the patient to the relevant services and then track the progress of the procedures that have been implemented or are to be implemented.

The medical approach to the matter of FGM and the establishment of appropriate care

Support when dealing with a minor who has suffered sexual mutilation:
Reminder: any finding of Female Genital Mutilation in a minor must be reported to the public prosecutor. Failing to report such a mutilation constitutes an offence of "failure to report a crime" (see module IV). Reporting of the offence also helps protect other potential sisters among the siblings.
In order to obtain a medical assessment of Female Genital Mutilation, it is advised to refer the minor to:

- A pediatric surgery department or a multidisciplinary team experienced in the management of Female Genital Mutilation
- Or to a pediatric service.

Do not hesitate to:

- Contact the doctors of specialized associations
- Inform the minor of the presence, in every french school, of a nurse from the department of education, and invite her to talk to this professional about her case, if necessary.

The multidisciplinary team or service will assess the situation, its causes and consequences.
The main objective is to provide follow-up for the child (diagnosis and early management of complications).
It is advised :

- That the specialized service and the doctor treating the child work together
- To offer psychological monitoring, based on the latest findings in the field of child psychiatry.

How should one react when a minor has been exposed to Female Genital Mutilation?
Highlighting the act of courage and confidence that revealing her case of mutilation constituted, for instance, is highly recommended.
To say: "You did well to come and speak to me", "This is forbidden in France", "It's your body, no one has the right to harm you "," Nobody is entitled to commit such an act of violence against you, neither in France, nor in other countries "," If you want, you can come back to me to talk about it".
It is also recommended to warn the minor that the doctor has a legal obligation to inform the authorities.

It is advised NOT to use the following phrases: "It does not matter", "I will keep your secret", "I will not tell anyone, it will stay between you and me", "Everything will work out", "Your parents are barbarians."

Support when dealing with a grown woman who has suffered Female Genital Mutilation:
It is recommended to take time to talk with the patient in order to fully understand her wishes and needs. The

final objective is to be able to offer her, should she wish it, multidisciplinary care (gynecological, urological, obstetrical, surgical, psychological, sexual, social).
Several possibilities exist:

- A new medical appointment can be set to meet with the patient again and carry on with the dialogue that has been initiated, if she so wishes
- Gynecological monitoring can be obtained through obstetrics, surgery, and medico-psychosocial gynecology units for multidisciplinary treatment
- Psychological care can be set up
- Sexological monitoring can be organized, in order to assess the repercussions of the mutilation on her sexuality and the consequences on sexual desire and pleasure
- Contact can be made with an association or an institution which organizes discussion groups around these questions.

It is also recommended to assess as quickly as possible the potential risk of Female Genital Mutilation for the patient's daughters.
A woman can occasionally report having adult daughters who have undergone Female Genital Mutilation. In that case, the daughters should be encouraged to consult for themselves.
Support when dealing with a pregnant woman:
Any pregnant woman who has suffered Female Genital Mutilation should be reassured about the possibility that her pregnancy and childbirth may take place without complications, provided that adequate obstetric monitoring is implemented.
It is strongly recommended that any sexually mutilated woman be monitored in a maternity service, starting at the beginning of the second trimester of pregnancy. Many pregnant women present a greater risk of urinary tract infections, iron deficiency anemia, etc.
Desinfibulation can be performed during the pregnancy, or during labor just before delivery, or during the surgery of a cesarean section.
The guiding principles that will be followed during the delivery phase of a sexually mutilated patient must be discussed and planned as early as the first prenatal consultations, in order to fully prepare the woman and those around her.
In order to avoid the mutilated woman having to repeat her story over and over, all efforts must be made so that as much information as possible is noted and available in her file.
During obstetrical monitoring, the patient should be informed :

- That she will not systematically have a cesarean section or an episiotomy
- that in the event of a disinfibulation, re-infibulation will not be performed, as it is strictly prohibited in France.

Management of Female Genital Mutilations by primary health care professionals :
the woman and those around her should be informed that re-infibulation is totally illegal.

Surgical management:
The clitoral repair operation is considered an act of restorative surgery and not of simple cosmetic surgery. It is therefore covered by Social welfare.
It should be emphasized that caring for a sexually mutilated woman cannot be reduced to simply reconstructing the clitoris.
It is highly recommended that clitoral repair surgery be accompanied by psychological and sexological care.
Lesions that can be surgically treated are, for example :

- For any type of mutilation : stumps of the labia minora, neuromas of the dorsal nerve of the clitoris, epidermal inclusion cysts, keloid scars

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- For types II and III Female Genital Mutilation: occlusion of the vagina through vulvar sclerosis
- For type III Female Genital Mutilation: infibulations.
- For types III and IV Female Genital Mutilation: urinary complications (for example, stenosis of the urethra).

Psychological support, an essential step

Psychological support is a powerful tool in the reconstruction of the identity of women who were victims of FGM. To understand how essential this psychological stage is, it is very important to pinpoint the risks linked to the impact of FGM on the psyche and on the patient's relation to her own life.
Risks to sexual functioning:

- Dyspareunia (painful intercourse). The risk of dyspareunia is higher for type III FGM than for types I and II
- Decreased sexual satisfaction
- Decreased desire and arousal
- Decrease in lubrication during intercourse
- Decreased frequency of orgasms or anorgasmia

For many young girls and women, undergoing FGM can be a traumatic experience that will leave lasting psychological marks and lead to many mental health problems.
The sexual consequences of FGM include:

- Dyspareunia, which can occur due to the vaginal narrowing or the presence of a painful scar (relative risk: 1.53, 95%; CI: 1.20–1.97)
- Apareunia and vulvovaginal lacerations during intercourse have been reported (level of evidence 2+)
- The removal of sensitive sexual tissues such as the clitoris or the labia minora, can lead to a decrease in sexual sensations
- Scars on the clitoris can be painful
- A decrease in desire and excitement
- A reduction in the frequency of orgasms or anorgasmia
- A decrease in lubrication and sexual satisfaction (level of evidence 2+).

Women who have experienced FGM often express a feeling of "shame at being different".
These feelings of shame result in an increased vulnerability when they meet with the maternity care teams. These women also tend to express having had negative experiences when they accessed care services for the first time.
In addition, sexual disorders are the main reason why mutilated women end up consulting a gynecologist.
If the vulvar opening has been narrowed as a result of infibulation or the presence of a neuroma, sexual intercourse usually causes severe pain.
The trauma can be explained by the fact that violent practices continue after the initial genital mutilation.
In reality, FGM does not stop just after the cut. This first act leads to an avalanche of other painful practices that amplify the sufferings for the woman. In her home country, the infibulated woman must be "opened" by her husband on the wedding night. To do this, he will either use a sharp object or his own sex; the latter practice is considered as a proof of his manhood. Some husbands who were interviewed said that they had been traumatized when they made their wives suffer on this occasion.
In some cases, a matron is put in charge of making the incision. Sometimes, full sexual intercourse can only be successful after many failed attempts. Some women conceive without having been penetrated. Anal intercourse is frequent.
Difficulty in having a satisfying sex experience is a source of tension within the couple. It can have a significant

impact on married life.
After the act of FGM, the sexual consequences are numerous. The injury of the clitoris, or the partial or total removal of the clitoris, inevitably leads to an impairment of sexual sensitivity. The lack or absence of sexual stimulation, which is necessary for achieving orgasm, results in a sexual deficiency for the woman.
The main consequences, when it comes to sexuality, are:

- A Permanent pain linked to neuromas
- A dyspareunia related to scar reorganizations
- The impossibility of sexual intercourse, when these changes are particularly important and have resulted in scar tissue (which often happens as an aftermath of traumatic deliveries).

An evolution towards vaginismus, disturbances of desire (hypoactive desire, and even anaphrodisia), or sexual aversion, is always possible, even in the context of communities where the mutilation is supposed to be well accepted. Orgasmic disorders are common, as was already mentioned. Mutilated women can therefore be severely penalized in terms of their sexuality.
Along with the sexual consequences, there are general psycho-traumatic consequences. The psychological risks are :

- Post-traumatic stress disorder (PTSD)
- Anxiety disorders
- Depression.

After suffering from FGM, women may experience recurring sexual, psychological and physiological problems. FGM can be extremely traumatic and have an impact on the overall life of women.
There is an increasing awareness of the fact that FGM has serious psychological consequences and causes mental health problems, as well as alcohol and drug dependence disorders.
Young women also reported feeling that they had been betrayed by their parents, and mentioned feelings of incompletion, regret and anger.
Research carried out in communities affected by FGM in Africa has shown that:

- Women who have undergone FGM have a level of post-traumatic stress that is identical to that of adults who have been sexually abused in childhood
- The majority of women (80%) suffer from anxiety disorders.

For a girl or a woman, the fact that FGM is accepted in their communities and in their culture of origin does not protect them from developing post-traumatic stress or other psychiatric disorders such as:

- Flashbacks
- General anxiety
- Disorders linked to a state of post-traumatic stress.

There is evidence of a link between FGM and the increase of domestic violence in Africa. A corresponding increase in violence has not been reported so far in Europe or in the United Kingdom.
It should generally be noted that among all the psychological consequences of FGM, the child or adolescent who was subjected to FGM under duress (in most cases without any forewarning) experiences a profound feeling of incomprehension and helplessness, whatever type of Female Genital Mutilation she suffered.

The psychological consequences of genital mutilation are frequent:

- Disorders such as neurosis, anxiety, depression, withdrawal, and loss of self-esteem are often seen.
- Women who have undergone genital mutilations present an increased risk of developing psychosomatic illnesses or even psychiatric problems. This situation has repercussions on their married life.
- Some victims suffer from post-traumatic stress disorder (PTSD).

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Similar psychological reactions are usually encountered in victims subjected to a traumatic event involving a risk of death or serious injury. The victims of PTSD experience the recurrence of the traumatic event, in the form of nightmares or frequent reminiscences when awake, since their bodies are marked by an amputation that will last for their entire lives.
A study in Senegal showed that 30% of the mutilated women who were evaluated had PTSD with memory loss and that 80% had flashbacks (reminiscences) of their excision.
These women also suffer from increased genital and urinary infections, a deterioration of their sex life (with frequent anguish at the start of their sexual activity, dissatisfaction, dyspareunia and frigidity) and a general feeling of uneasiness.
The psychological complications are even more severe when the mutilations were performed late in the lives of the women. The following can be observed:

- Behavioral problems
- Anxiety
- Depression
- Chronic irritability
- Perception of an amputation of their bodily integrity
- Feeling of being different from other women, vis-à-vis men. Women are afraid that men will say "You are not normal"

Female genital mutilation can be considered as a "victimization", that is, as events or acts that have created a trauma, whatever their objective severity is.
In most cases, excision is experienced in a state of terror and mental shock. The subject is projected upon, nullified, reified (considered as an object), which means that she can have a feeling of nullification / annihilation of herself.
The invasion of her mutilated body can cause an intense shock. The woman becomes unable to make sense of the event on a psychological level, and unable to attribute a meaning to the inanity of the event.
Sometimes, the victim will develop a permanent mental state organized around repetitive symptoms (hallucinatory re-enactments, mental rumination, nightmares, etc.). This state is called traumatic neurosis.
In this case, the subject is unwillingly brought back to the traumatic scene that she could not control in real life, and re-lives the scene.
In addition, a set of so-called "non-specific" symptoms can also appear: asthenia (physical, mental and sexual), anxiety, elective phobias, hysterical crises, protection or verification or even conjuration rituals.
"Psychosomatic" symptoms are also possible: headaches, various pains.
Depending on the subject's tolerance, the pathogenic effects of this "injury" will be more or less important and their duration will vary. In effect the singular story of the woman, and the subjective, cultural, ritual and anthropological dimensions surrounding her life play an important role in the way the victim will interpret the event, and in the way it will be processed mentally. When the individual point of view is deemed more important than the collective one, as it usually happens in western societies, one can assume that the possible consequences of the mutilation will not have the same impact.
The mutilated/excised woman is considered to be "different" in western societies, whereas in the countries that habitually perform genital mutilations, the un-excised woman is the one who will be ostracized. The question of belonging to a reference group is at stake here and this aspect is obvious in many representations and individual stories of excision.
In some cases, the victim will experience a new surge of the traumatic experience and symptomatology from time to time, especially following events (even minor ones) that remind her of the initial traumatic event.
Pregnancy and childbirth constitute moments of especially great vulnerability. In effect, pregnancy and

childbirth directly implicate the part of the body that was formerly assaulted.
Similarly, any violent assault on a sexually mutilated woman, especially a sexual assault, can "wake up" the trauma which had been formerly suppressed.
The alteration of the personality can be profound and far-reaching, challenging at the same time the relationship of the subject to the world, to others, as well as to her relatives and to herself. This is especially true for her relationships with her mother, father, with men, but also whenever the situation is related to aspects involving sexuality, motherhood, femininity. All these relationships can become particularly complex, and even pathological.
In some clinical cases, the link has been clearly established between the problematic relationship with others and the traumatic experience of mutilation.
Some subjects will, however, be able to escape the throes of such a tragic fate and will prove capable of not being "wiped out" by the trauma. The term used to describe this capability is resilience.
Faced with the same event, not all subjects will be "affected" in the same way and they will not react identically, whatever the objective reality, the age at which the mutilation took place or the seriousness of the facts. In effect, not all mutilated women will develop post-traumatic symptoms or neuroses.
It is important to note that there is a wide individual variability in the psychic and physical assimilation of what, from a "western civilization" cultural point of view, is necessarily considered as a trauma.

In conclusion, FGM can have many serious consequences on physical and mental health, either in the short term or throughout the woman's life. Hence it is essential that the reconstruction journey of these women be accompanied by an adapted and long-term psychological monitoring; mental healing is often a much longer and more complex process than physical healing, in the event of a surgical operation.

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Chapter II: The stages of reconstructive surgery and what can be expected from it

The conditions of preparation for the operation and the comprehension of pain

Preparation before the operation

The repair operation is an option that is to be discussed with female victims of FGM. It can be offered to them but must never be imposed. Medical professionals should never insist on this possibility and pretend that, in order for the patient to regain her previous self, she must necessarily go through this operation. Some women just want to "rebuild themselves" psychologically at the time of the interview, and are not ready to begin a journey of bodily repair.
In effect, surgical repair is just one of the different ways available to them to try and rebuild themselves. That is the reason why, before the operation, it is of paramount importance to make sure that the patient feels ready to begin this long journey, especially on a psychological level.
Psychological monitoring should have already started before the operation is discussed. A plan of care should also have already been carefully developed by several health professionals (attending physician, surgeon, gynecologist, nurse, etc.), so that the patient is made aware of all ins and outs of this operation. A patient more fully prepared pre-operatively will heal more effectively.
Once the patient knows in detail the steps that will be followed for the operation, and once she has been made aware that her journey and all her needs have been correctly identified by the medical professionals that will accompany her, an appointment with the anesthesiologist, and an appointment in the ward operating room for surgery will be set up.

The detailed and explicit explanation of the operation, a prerequisite for a better understanding of the process, and therefore better conditions for the operation

The reconstruction of the clitoris, also known as clitoral transposition or clitoroplasty, is carried out under general or local anesthesia. There is no clear recommendation, or in fact any supportive evidence, regarding the therapeutic use of an antibiotic, prior to the operation, so as to prevent the occurrence of a potential infection.

The surgical technique has been described by Thabet in 2003, Foldès in 2004, and other authors more recently, with slight modifications, such as the neo-glans suture. This reconstruction is performed in cases of chronic clitoral pain, clitoral dyspareunia or for reasons of identity and body image. The main reason cited by patients for requesting surgery is the wish to feel like a "whole, rehabilitated woman"; the second reason is the desire to improve sexual functioning.

The reconstruction or transposition of the clitoris involves the resection of the cutaneous scar near the excised clitoris, the isolation of the clitoral body, the section of the suspensory ligament of the clitoris while respecting the vasculo-nervous pedicle of the organ, the resection of the sub-cutaneous scar tissue that is under the periclitoral skin and the repositioning of a "neo-glans" in physiological and accessible position, followed by the potential creation of a foreskin when it is requested by the patient. There is no need to position an indwelling urinary catheter immediately after surgery. The use of a Level 2 Pain reliever is recommended,

and the patient is usually sent back home on day 1.
The re-epithelialization of the clitoris and postoperative pain can last up to three months. The postoperative monitoring is done once a week until the healing begins and until the postoperative pain decreases (usually about 1 month). Analgesia and postoperative monitoring are particularly important: pain in this area can remind the victim of the initial FGM and awaken psychopathological symptoms, as it can happen with any former PTSD.

The most common complications just after the operation are hematoma, loosening of the sutures, and infection, with rates varying from 5.33 to 40% depending on the case reviews. Readmission is required in 3.7–10% of the cases and repeat surgery is necessary in approximately 4% of the cases. The more severe complications that were observed are keloids, hypersensitivity of the clitoris, and the recurrence of a former PTSD linked to FGM because of immediate postoperative pain.

Experience has increasingly started to show that, in the event of an initial request for reconstruction of the clitoris, if the patients benefit from multidisciplinary care (combining identification and treatment of psychophysical comorbidities with sexocorporeal information and education, and with sexological therapy), some will abandon their initial request for a surgical intervention, because their needs have been ultimately met with non-surgical treatment.

The key stages and the mapping of the operation

As for any restorative surgery, the physiology and anatomy of the patient's organ must first be studied and understood. We are going to remove the injured parts that cause the scar to hurt. It is then necessary to find what remains of the normal anatomy and, with that, to reconstruct a functional organ, as close as possible to normal. Women often ask if we are going to look for something else, to graft tissue : in reality, there is no need for this. There is enough tissue to rebuild a normal clitoris. There are more than 10,000 pleasure sensors (corpuscles of Pacini and Krause) distributed between the glans and the knee of the clitoris, which is well buried and rarely touched by the excision. There are also many of these same pleasure sensors in the beginning of the body and throughout the organ. We can therefore, in the vast majority of cases, restore the capabilities of the clitoris.

Once repaired, the organ lives and evolves. Its interactions with different areas of the brain evolve too. There is no sense in pretending that sexuality is either all in the head or all in the sexual organs. The two are inseparable. Jeopardising the head by misinforming the person or ignoring things can do a lot of harm when it comes to the patient's ability to fully feel her clitoris. Physical mutilation of the sex can also psychologically mutilate a person, by changing her whole relationship to the outside world.

The surgery itself lasts between 45 minutes and one hour, and is fully reimbursed by health insurance, under the Universal Health Coverage and the AME (French Aide Médicale de l'état, state sponsored medical support).

The operative technique is carried out in several stages

Stage 1: Prebubial incision. The excised region sometimes shows an irregular or even keloid scar, the stigmata of an initial gesture that was carried out without asepsis or hemostasis. In that case, a resection is required, in order to uncover the clitoral stump which is located below.

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Step 2: Section of the suspensory ligament and release of the clitoral knee

- The vulvar triangle must be cleared,
- The clitoral knee then needs to be released. This should be practiced very close to the periosteum. It should follow the divergent bifurcation which leads to the clitoral bodies (that descend along the ischiopubic branches).

Step 3: Release of the clitoral body

Full release is achieved by further dissection along the ischiopubic branch, gradually clearing the clitoral body which measures approximately eight centimeters in length.

Step 4: Scar resection:

This stage consists in removing the scar tissue and finding a healthy cross-section of normally innervated and vascularized cavernous body behind, so as to reconstitute a functional neo-glans.

The cross-section in the healthy area reveals the cavernous bodies in the middle raphe, the alveolar tissue bleeds normally; the need for a good hemostasis is important.

Step 5: Reconstitution and reimplantation of the glans

- Preserve the dorsal pedicle by reconstituting a neo-glans. This can be obtained by a hemi overlock in front of the clitoris using vicryl 3/0 and by a point behind the clitoris using vicryl 2/0. This allows the repositioning of the reconstituted glans in its normal position.
- Attach bulbo-cavernous muscles with simple stitches using vicryl 2/0 in order to avoid any elevation of the clitoris.
- Close the skin by simple separate sutures using vicryl 2/0 without drainage.
- Perform a subcutaneous infiltration of local anesthetic (Naropein + clonidine) in order to manage postoperative pain.

<u>Other possible situations: Surgical treatment of type 3 GMF (infibulation)</u>

The operation consists in resecting the vulvar closure over a grooved probe, in order to discover, underneath, the vaginal entry and the urinary meatus and sometimes the labia minora and the clitoris when they have not been severed. If the clitoris has been cut, a clitoral reconstruction can be carried out according to the technique described above.

Sexual rediscovery, a fundamental aspect for the reappropriation of a woman's life

Realities of the post-operative period

Post-operative care: Local care is essential for the proper healing of the wound. The area must be cleansed with Betadine 2 to 3 times a day, the scar must be left to open air as much as possible (friction is slightly painful during the first days). Painkillers and / or anti-inflammatory drugs can also be prescribed for the first weeks. The procedure is rarely affected by medical complications, the consequences being mostly edema or bruises, sometimes a hematoma or an infection. Some oozing from the scar or a slight deviation from its edges is frequently observed, and the patient should not be worried by these phenomena.

An emergency consultation can be considered if the wound becomes too painful or seems abnormally swollen. Once the healing period is over (about 3 weeks, the sutures having fallen out by themselves), the

surgeon will prescribe a lubricating gel to facilitate the stimulation of the clitoris, which is now visible, and thus solicit nerve endings now released from scar tissue.

How to return to normal life after the operation, step by step:
Showers can be taken as early as the day after the procedure, provided that the patient is careful not to rub the wounded area.
Professional activity can generally resume after a week. A week is usually the amount of time needed for the movements of everyday life not to be painful anymore.
For sexual intercourse, the patient must wait until the area is no longer painful at all. This can take on average 5 to 8 weeks, or even more if the patient is still psychologically fragile or too stressed at the idea of having sexual intercourse → psychological monitoring will help coping with her concerns and enable her to find a more confident approach to her sex life.
A sport activity can be resumed after 6 to 8 weeks, depending on the healing.
The stages and aspects of scarring: the clitoris may appear at first very large, but this is only the first stage. It will quickly deflate and return to a normal size. The color will be unusual: in effect, deep tissue has been externalized to restore the clitoris, so it retains the color of the mucous membranes, notably a pretty pink. It should not be covered, lest the clitoris becomes "buried" again, which would make the previous surgery pointless. The clitoris will gradually cover itself with skin. The final appearance will be obtained on average after 6 months, but it can sometimes take more than 2 years. Likewise, the sensations may continue to evolve during the life of the patient.
As for the final aspect of the reconstructed clitoris, this varies from one woman to another.

Post-operative monitoring: regular check-ups must be performed by the surgeon, who will assess the proper healing of the wound, generally after 8 days, 3 weeks, 3 months and 6 months.
The opportunity should be offered to the patient to keep attending the support group meetings. A close monitoring by the psychologist who was already in charge of the patient is necessary in order for the bodily and psychological healing process to continue.

Caregivers and psychologists should make sure that the patient understands that the stages of healing may vary from one patient to another. The stages themselves are quite similar, but their duration is highly variable, as is the reaction of the patient's body. Above all, it should be noted that the patient's psychological acceptance level varies widely from one person to another, and remains very different for every patient.

The liberation of the patient's speech and her sexual questioning, a stage of understanding of the body

After the operation, the healing process of the patient goes through many psychological reconstruction scenarios, and she needs to form a new vision of her body as well as of the sexual intercourse. Thus it is essential that a psychological follow-up is done with the patient, in order for her to speak freely, after the operation, about her feelings and the changes in her body.
Obviously, every woman will react differently during this process. The consequences of an education focused on the submission of the body and on the impossibility for the woman to have control over her own body and sex life should not be under-estimated. These consequences will not disappear quickly, and may even never disappear in some cases.
In addition, her relation to sexuality will be different if the patient is in a relationship, or if she is single. Depending on the case, the stages of reconstruction will be different.
In effect, in the context of a couple's life, it is absolutely necessary for the partner to fully understand the

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patient's change. He/she must support the patient throughout her healing journey. The patient may need to take a long time before even considering having a sex life again. Those around her, as well as the professionals who treat her, must adapt to her vision and never abruptly force her into engaging in sex again.

The patient, if she so wishes, can start rebuilding her body confidence and sex life by first discovering her own body and experiencing her own sexual pleasure. Considering the mutilation that happened to her, sexual pleasure and the new reconstructed clitoris will surely be aspects that are unknown, or very little known, to her. This new aspect of her life should be approached with respect and she should be encouraged to learn about it. It is therefore the duty of the psychologist to approach this new aspect in a manner that is suited to what the patient is capable of accepting (or not). The psychologist should try to ascertain what she hopes for, as far as her sexuality is concerned (some patients may not want to dwell on this kind of subject), and suggest that sexuality should therefore always be a choice and not an obligation in her life as a woman.

After the operation, the patient should be encouraged to continue talking about her surgical experience with women who have gone through the same thing; group discussions or the use of forums are recommended. Emotional rebuilding can also be achieved through writing down her own experiences, or through talking to people around her in order to educate them about FGM, or through supporting other women who are undergoing surgical reconstruction.
Some activities have also been found to be very helpful when it comes to allowing the person to regain her self-confidence, and regain trust in others. Activities such as sport and theater can be advised, in order for the woman to gently rediscover herself.

Several means of psychological reconstruction can be proposed, in order to allow a complete and lasting recovery for the patient. It will be up to the psychologist to sort through these possibilities with the patient and to adapt to her needs and to the changes that her healing process may require over time.

Psychological and medical follow-up, for a complete recovery
The reconstruction of the patient after the operation will be long and must follow several steps, if complete and efficient healing is to be achieved.
Post-operative monitoring therefore includes medical, psychological, but also legal and social stages.
For this reason, the roadmap (monitoring sheets) must remain in use, even after the operation. This will allow all professionals in charge of the patient to assess her progress (or lack thereof), and to treat appropriately, according to her new reactions post-operatively, positive or negative.

The reconstruction of the patient will necessarily go through a wide range of stages and a multitude of procedures covering various domains (medical, psychological, legal), because the trauma of genital mutilation affects several aspects of a woman's life. She becomes deprived not only of a body part, but also a part of her life as a woman, and as a human. The reconstruction goes far beyond the physical aspects, because the trauma experienced by the woman is extremely deep and has, in a way, robbed her of the possibility of living fully and in a healthy way.
Some women do not even realize that they are developing defense mechanisms, or specific behaviors, in response to the trauma they have experienced. Therefore, in addition to the medical support, another important aspect of the patient's reconstruction is psychological support. It is the only way for the patient to be able to fully understand what has happened to her, and also to engage and talk about a subject that is often either a taboo or, on the opposite side, considered as a "normal" situation by those around her.

Some patients are not even aware that they have been victims of excision. Some know it, but do not really comprehend what it means for their body. Others understand the danger of what they have suffered, but have never heard about the existence of surgical reconstruction and of re-appropriation of their body. In order for the treatment course of these women to be effective, one must go back to the origins of these practices and understand how they are rooted in the tradition of some societies.
Many patients will never be able to completely detach themselves from what they have been taught about the practice of Female Genital Mutilation. That is one of the reasons why many women will choose the same practice for their own daughters.
Professionals must therefore be aware of the long time period required for the reconstruction of these women which must involve inter-professional solidarity among the medical, psychological and legal teams in order to be most effective.

The complexity of "becoming a woman like any other"

The importance of obtaining testimony and of making statistical evaluations

Sharing the stories of women who have been victims of excision is of the utmost importance. First, it allows the woman in question to exercise free speech and share her experience, and thus can help her heal psychologically. Some people feel a profound need to write and / or simply tell what happened to them. Through this sharing process, which shows how dangerous and destructive the act of genital mutilation is, they disseminate a message that is essential if we want to fight against these mutilations.
Testifying has therefore a snowball effect: it allows the community and society at large to better understand a topic that is often still taboo, but it also allows professionals to improve their understanding of this matter, and to build a system of solidarity and common struggle against this violent act.
The effects of testimonies go beyond the simple dissemination of an experience. These testimonies constitute a message, by representing a whole tradition and a whole community of women who have lived through it in many countries.
This sharing process also allows women who have lived through these acts to heal, because they discover that they are not alone and can help each other through this obstacle course. Generally, their request for reconstruction stems from a desire to become a "woman like any other". By discovering the multiplicity of women who have experienced the same thing, they realize that they are in fact already "women like any other", and that there is no such thing as a "body standard", only wrongdoings.

In addition to testimonies, statistics can also constitute a powerful tool in the fight against FGM and in the reconstruction of patients.
Statistics make it possible to set up assessments or to contribute to scientific research by offering the possibility of evaluating the actions that have been undertaken and their level of efficiency. Consequently, it allows modeling and modifying the procedures according to the desired end results.
Statistics made it possible, in particular, to set up evaluation grids before and after the operation for female victims of FGM and thus greatly contributed to the establishment of an efficient plan of care and surgical reconstruction, in order to meet the needs of these women.

The various tools surrounding the physical and psychological reconstruction of female victims of FGM involve freedom of speech and learning for these women but also for society in general and professionals. The objective is to fight against these practices and to help women who were victims of FGM to find themselves and to recover.

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The understanding of the self and the re-appropriation of the body

The desire to rebuild oneself, after having suffered Female Genital Mutilation, impacts several aspects of life and can be approached in several ways.
First of all, the request for surgery is linked to the will to restore a pleasure-related sexuality. In effect, excision generally leads to an alteration in female pleasure, or destroys it completely. The possibility for women to rediscover sexual pleasure and to live a sexuality freed from any pain is a major issue in their choice to have restorative surgery.
Beyond a purely sexual aspect, it is also important for these women to entirely re-appropriate their body. Having undergone FGM is often compared by these women to the sensation of having lost a part of their body, the sensation that they are missing something and that they are not "whole". It is therefore normal that, in order to find themselves, to reclaim their "selves", they should want to regain this part of the body that has been stolen from them. As a consequence, the surgical operation is generally followed by a long period of discovery of this new body part, either by simple observation, or through sexual intercourse.

Surgical reconstruction after FGM also allows women to regain control of their bodies. In effect, the education surrounding these practices tells women that they have no control over their bodies, that they are not in charge, and that their bodies necessarily belong to others, first to the people who decided to excise them and afterwards to their husbands.
By entering a reconstruction process, by making the choice of having surgery and of globally "healing", they learn how to become in control of their own bodies again. It is necessary for these women, whether they choose surgery or not, to learn to trust themselves, to love their bodies and to make their own decisions.
Surgical reconstruction must therefore be a personal choice. This choice can, however, be questioned in some cases : in bi-cultural couples, FGM is often considered as a handicap. Once again, the woman will be faced with a negative vision of her body, in which case resorting to clitoral reconstruction is just another way of treating her body as "abnormal". FGM is considered as an abnormality in her body and she is sometimes encouraged to go through surgery, not for herself, but for aesthetical reasons or in order to be considered by her partner as "normal".
It is therefore up to the professionals who treat the woman to detect if this choice is really a personal choice. When it is not the case initially, professionals should make sure that this choice truly becomes hers. They must ensure that the patient fully understands and is ready before entering this healing journey.

The discovery of fundamental rights, and the laws that protect women's sexual choices and human dignity.

One of the most dire violations of women's human rights today is Female Genital Mutilation. FGM is recognized as a serious attack on the integrity of a person, the expression of a physical and psychological domination exerted on young girls and on women. FGM undermines the respect for human dignity that is enshrined in the 1948 Universal Declaration of Human Rights.

Beyond questions of culture and traditions, any Female Genital Mutilation constitutes a serious attack on her physical integrity. No "right to be different", no "respect for cultural identity" should legitimize an attack on the integrity of a person, which constitutes an actual crime. Taking into account a legitimate respect for any culture should in no case induce a "relativism", which would prevent consideration of any Female Genital Mutilation as a violation of the fundamental rights of women.

In order to protect the human rights of women and girls, the National Consultative Commission on Human

Rights (CNCDH, Commission nationale consultative des droits de l'homme) has had to rule on the issue of Female Genital Mutilation (FGM) on numerous occasions.

In a "founding principle" dating back to 1988, the CNCDH challenged the authorities on the need to actively engage in the fight against these practices and to engage in the care of victims. In 2004, the CNCDH conducted more in-depth work on Female Genital Mutilation in France and in the countries of origin of several immigrant populations. It made a number of recommendations to improve the protection and care of young girls and women. 10 years later, in 2013, the CNCDH drew up a new inventory of Female Genital Mutilation in France and analyzed the policies implemented for fighting and preventing the abuse, and for protecting the victims in this area.

Every year, and notably at the occasion of the International "Zero tolerance towards Female Genital Mutilation" Day, the CNCDH calls on public authorities to continue their efforts to prevent this practice in France and abroad.

The right of women to be free from any form of discrimination:
Article 1 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979 gives a broad definition of this type of discrimination, consisting in:
"any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field"

The practice of FGM falls under the definition of discrimination against women, as it was formulated by various human rights organizations, since it applies exclusively to women and girls and has the effect of preventing them from fully enjoying their fundamental rights. FGM also causes short and long-term physical and moral harm to the victims and perpetuates the fundamentally discriminatory notion that women are condemned to play a subordinate role. Article 2 of the Universal Declaration of Human Rights states that : "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, …"

The practice of FGM often constitutes a deeply rooted custom. In areas where it is prescribed or prevails, very strong pressure is placed on women and girls in order to force them into submission. FGM is often a prerequisite for marriage and is a necessary step if the person wants to be considered a full member of society. Governments that enact laws prohibiting FGM should be aware that a woman who has not been subjected to the practice may end up being the victim of other forms of discrimination, being marginalized from society or unable to marry. Public authorities must therefore also take into account broader questions: the situation of women in the family and in the economy, their access to education and health services, as well as social norms and customs on which the practice of FGM is based.

- The right to life and physical integrity, including the right not to be exposed to violence

The right to physical integrity includes the right not to be subjected to torture, the right to inherent dignity for any human, the right to liberty and security and the right to privacy. This category of rights is guaranteed by several human rights publications including : the Universal Declaration of Human Rights (Articles 1 and 3); the International Covenant on Economic, Social and Cultural Rights (preamble); the International Covenant on Civil and Political Rights (ICCPR) (preamble and article 9 (1)); and the Convention on the Rights of the

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Child (article 19).
FGM inflicts serious physical and psychological damage, which can sometimes be fatal. FGM therefore constitutes an infringement on the right of women to physical integrity, to private life and to a life free from violence.

- The right to health

To the extent that FGM can lead to serious physical and psychological consequences, and to the extent that it constitutes an invasive act inflicted on healthy tissue without the slightest medical necessity, it also represents a violation of the right to health.
The International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone "to enjoy the highest attainable standard of physical and mental health". The World Health Organization considers health to be a state of complete physical, mental and social well-being, and considers that health "does not consist only in the absence of disease or disability". The Action Plan produced by the International Conference on Population and Development in Cairo (Egypt), addressing the issue of reproductive health, speaks in paragraph 7.2 of "sexual health which aims to improve the quality of life and interpersonal relationships ". Furthermore, the Committee on the Elimination of Discrimination against Women, in its General Recommendation No. 24 (20th session, 1999) specifically recommended that States develop health policies that take into account the specific needs of young girls and adolescents exposed to traditional practices such as FGM.

- Rights of the Child

Since FGM mainly affects girls under the age of 18, this issue is fundamental when it comes to protecting the rights of children.
The 1989 Convention on the Rights of the Child, while recognizing the role of parents and of the family in this matter, as well as their right to make decisions where the child is concerned, provides that, as a last resort, the State is responsible for protecting the rights of the child (Article 5). This Convention also establishes, in article 3, the concept of "best interests of the child", when it comes to enforcing the rights of said child. FGM is considered to go against these interests, and constitutes therefore a violation of the child's rights. The Convention instructs States to abolish all "traditional practices that are prejudicial to the health of children" (Article 24 (3)). In its concluding remarks on Togo (Concluding remarks of the Committee on the Rights of the Child : Togo (1997) in English), the Committee on the Rights of the Child encourages governments to adopt laws abolishing the practice of FGM, which is considered as a violation of the rights of the Child.

Many publications do not just state that FGM violates these fundamental rights: they also claim that States have a duty to prohibit this practice and protect the women and girls who are exposed to it. To fulfill this duty, states must adopt specific laws to that effect and implement other methods of social and cultural education. Such laws should cover the aforementioned fundamental rights and also describe the duties of the state in the fight against FGM, namely:

- Duty to change discriminatory practices against women,
- Duty to abolish practices that are harmful to children,
- Duty to provide health care and access to health information,
- Duty to ensure a social order in which people can enjoy their fundamental rights.

Chapter III: Results and Literature

The normative and conventional results of the fight against FGM

The international community is actively involved in the fight against Female Genital Mutilation, through international organizations, NGOs or through the states themselves. The scourge that FGM represents has encouraged several participants to try and help each other, in an attempt to eradicate this practice.
Currently, many conventions make reference to the issues surrounding the practice of Female Genital Mutilation, and several measures have already been taken in order to have this act considered a crime and to have it prohibited in many countries.

The National Consultative Commission on Human Rights has also produced a study on the situation of Female Genital Mutilation, which mentions international commitment and lists the conventions that have occurred dealing with this matter.
In effect, the FGM problem has attracted the attention of the United Nations since the early 1950s. Other contributions should also be noted, such as the W.H.O's work, the resolution 2004/46 of the United Nations Commission on Human Rights dealing with the "elimination of violence against women" of April 20, 2004, and the resolution 2003/38 of the subcommittee on the promotion and protection of Human Rights on "Traditional Practices Harmful to the Health of Women and the Girl Child" dated August 14, 2003.
FGM is an issue that encompasses many subjects. For this reason, a substantial number of conventions, though initially dealing with different matters, also proclaim their will for the abolition of this practice.

The United Nations Convention on the Rights of the Child:
It states in article 24 that: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services"
This convention has been ratified by all states except the United States and Somalia.

The International Convention on the Elimination of All Forms of Discrimination against Women came into effect on January 13, 1984:
It provides in its article 2 that: "States parties to the convention take (...) all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women."
This convention has been ratified by France and by many African countries including Benin, Burkina Faso, Egypt, Ethiopia, Gambia, Ghana, Guinea, Kenya, Liberia, Mali, Nigeria, Central African Republic and Tanzania.

The African Charter on Human and Peoples Rights came into effect on October 21, 1986:
It provides in its article 4 that: " Human beings are inviolable. Every human being shall be entitled to respect for his/her life and the integrity of his/her person. No one may be arbitrarily deprived of this right".
Over fifty African states have signed this charter, including Benin, Burkina Faso, Ivory Coast, Djibouti, Egypt, Gambia, Ghana, Guinea, Kenya, Mali, Nigeria, Senegal, Somalia, Sudan, Chad and Togo.

The African Charter on the Rights and Welfare of the Child entered into force on November 29, 1999:
It states in article 21 that: "State Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices

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affecting the welfare, dignity, normal growth and development of the child and in particular those customs and practices prejudicial to the health or life of the child"

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women, adopted by the African Union on July 11, 2003:
In its article 5 "Elimination of harmful practices", the protocol declares:
"States parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. States parties shall take all necessary legislative and other measures to eliminate such practices, including:

a) Creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;

b) prohibition through legislative measures backed by sanctions, of all forms of Female Genital Mutilation, scarification, medicalisation and and paramedicalisation of Female Genital Mutilation and all other practices in order to eradicate them;

c) provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counseling as well as vocational training to make them self-supporting;

d) protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.
In its article 6 b (marriage), the Charter declares: "the minimum age of marriage for women shall be 18 years".

However even if, in theory, the States and the international community officially rally around the idea of incriminating this practice and trying to abolish it, in practice it is still very present. Female genital mutilations are acts that are performed within the community, and generally in the family environment, with great discretion, which makes the fight against these acts extremely complicated. Therefore, prevention is one of the major means of eradicating FGM. Unfortunately this takes time and the anti-FGM message is not yet sufficiently widespread.

Literature of the evidence and history of FGM

Documentation

- Deconstructing the cultural arguments on Female Genital Mutilation (FGM) / by Adboulaye Doro Sow Nouakchott: ERMGF, 2014

The author, Professor Abdoulaye Sow, is an anthropologist from Mauritania. He has carried out research which highlights the main cultural arguments that justify and legitimize the practice of Female Genital Mutilation (FGM) in order to deconstruct them, using the arguments of the theory of cultural counter-argumentation. This educational document was developed for health and social professionals, in order to allow them to thwart preconceived ideas concerning FGM, while respecting the cultural diversity of the populations concerned by this practice. This document can be used in all countries where FGM is practiced or could be practiced.

- The eyes that watch you night and day: looking at violence against women / Françoise Héritier, Nadia Kaci La Tour d'Aigues: Ed. De l'Aube, 2011;

Collection L'urgence de comprendre
Elimination of girls at birth, excision and other similar customs, burial of living girls in the name of "honor killing", use of vitriol and other mutilations, stoning, forced marriage and marital rape, planned lynching of women, disappearance of women, death of a woman every 3 days under the blows of her husband in France ... Is all of this happening simply because they were born a woman? What is the basis for such a denial of humanity, beyond the pretexts used to justify these unacceptable practices (religion, culture, tradition, customs, honor, demography)?
How can we stop the indifference towards those women, who are victims of violence, never peaceful, never themselves, never free? Women who are stressed. Oppressed.
Provoking a shock of conscience is the objective of this book, which tries to make us react - and act too. A book that mixes texts by
Françoise Héritier and Nadia Kaci with a ten-voice conversation, full of lived testimonies. And finally, three major texts by Voltaire, Condorcet and Olympe de Gouges, which remind us that this fight is not new.

- Our daughters will not be excised / collective work; photogr. Emmanuelle Barbaras

Paris: GAMS [etc.], 2006
Produced in sub-Saharan Africa and in France, these photo reports by Emmanuelle Barbaras bear witness to the complexity of this struggle "in the field". They pay tribute to the individual involvement and to the collective mobilization of women and men, who are more and more numerous when it comes to speaking out against these intolerable attacks on the integrity and health of women, and on human dignity. These images also give every reason to believe, nowadays, in the eventual abolition of excision.

- The Awa Pact: ending sexual mutilation / Agnès Boussuge and Elise Thiébaut; in partnership with GAMS

Paris: Syros, 2006; J'accuse Collection
This work, which deals with sexual mutilation, is very clear and complete. It mainly presents excision by explaining the traditions that exist around the act itself. The strength of this book is that it brings together four testimonies, an "educational" dossier, statistical data and an interview with a sociologist. Thus, it allows us to better understand the customs and traditions of the communities or civilizations which still practice these mutilations. The GAMS (Group for the Abolition of Sexual Mutilation) exposes its point of view on the question of Female Genital Mutilation, by showing their sociological origins but also the dangers they represent for the health of women.

- Excision / Françoise Couchard

Paris: Presses Universitaires de France, 2003;
Collection Que sais-je? 3686
The custom of excision, a total or partial castration that affects millions of young girls around the world, has been the subject of much debate since the beginning of the 19th century. Excision is at the heart of a controversy that opposes the proponents of respect for cultural particularities and those who defend the universality of humanist "values", including the respect for bodily integrity and the rights of the child. Illustrating his point by interviews with excised women but also fathers and sexual partners of these women, the author traces the history of this custom, analyzes its different functions and psychological, sociological and symbolic consequences. He demonstrates that the disappearance of this practice can only come through the education of women.

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Testimonies

- The man who repairs women: sexual violence in Congo, the fight of doctor Mukwege / Colette Braeckman

Brussels: A. Versaille: GRIP, 2012; Collection : L'international en jeu

For fifteen years, Denis Mukwege, chief doctor at Panzi hospital (South Kivu), has been treating female victims of sexual violence, free of charge. Over the past ten years, he has provided care to more than 30,000 women ! The gynecologist sews and repairs destroyed vaginas and dead souls. He also listens, prays when he can, often rebels. He has received numerous awards for his fight, including the United Nations human rights Award in 2008, and the international King Baudouin Award, in 2011. Portrait of a courageous man.

- "Whole", repairing excision / Marie-Noëlle Arras

Montpellier: Goat-starry leaf, 2008

This book, with its testimonies and practical information, is the first to present the problem in its entirety (before, during and after repair surgery). It is supported and prefaced by Dr. Pierre Foldes, the urological surgeon who developed and still practices the surgical repair of excision.

- Mutilated / Khady; with the collaboration of Marie-Thérèse Cuny

Paris: Pocket, 2006; Pocket presses collection 12945

As tradition would have it, excision increases the fertility of women, it guarantees the purity and the virginity of girls as well as the fidelity of wives ... In reality, this mutilation puts the life of young girls at risk and deprives them of pleasure forever, subsequently breaking their lives. "Two women caught me and dragged me into the room. One, behind me, holds my head and her knees crush my shoulders with all her weight so that I cannot move ; the other holds me at the knees, legs apart. My heart starts beating very hard ... " Khady's testimony is that of a child who, at the age of seven, lived through this nightmare, and who, after becoming a woman, realized the barbarity of this practice. It is the journey of a survivor who denounces with incredible courage what she suffered, the story of an activist who tirelessly fights, all over the world, to save children before the horror happens.

- Excision: the path to my reconstruction; My relation to the excision that I suffered, its impact on my life, and how I decided to move past it...

Paris, 2007; blog: http://survivance.blogspot.com/2007/

This blog was created by a female victim of excision, who began the process of surgical reconstruction. In this blog, she tells us about her perceptions of what she suffered, why she chose the path of surgical repair and the course of her operation. She explains, in particular, her post-operative path, her vision of healing, her expectations and the reality.

Novels

- Excision / Olivier May

Geneva: Fresh ink, 2010

In this book, religious fanaticism and tolerance are opposed to each other, in an imagined 2025 Geneva. A female cop, Aayan, who fell victim to absolute evil, is carrying out her investigation at a breathtaking pace. The fight against extremism and prejudice is at the heart of this suspenseful thriller. Aayan, who was excised during her Somali childhood and has become the author of the "Dictionary of Oppression", is investigating an unusual case.

Children's and young adults' Books

- Diariatou is facing tradition (comics) / Patrick Theunen (scenario); El hadji Sidy Ndiaye (drawing)

Gams Belgium, 2005; Audience : Young people (10 to 15 years) and health professionals
This book is an educational tool, suitable for students from the end of primary to the beginning of secondary education, that teachers and health professionals can use. This comic strip makes it possible to tackle the question of FGM with the young, in particular in the case of an occasional visit, during their vacation, to their birth country. It also provides information concerning FGM (What countries are concerned by this practice ? Who practices the mutilations ? Why is it still ongoing ? What are the consequences, what does Belgian law say about it, etc).

- My destiny is in the hands of my father (comic strip): volume 1 and 2 / Diallo K.

Collectif Alpha, 2006-2011; Public : Children from 8 years plus and adult literacy learners
This book provides a gentle approach to sensitive subjects (in Africa and elsewhere), such as Female Genital Mutilations, forced marriage and polygamy. It is above all a love story, but it is also a story about women's fight against Female Genital Mutilations.

- Daughter of the crocodiles / Marie-Florence Ehret

T. Magnier, 2007; Young audience from the age of 12
In Nanou, most families comply with customs. Ma refuses to allow her granddaughters to be circumcised. Fanta, who would like to be like the others, feels a little lost ... She does not know what future awaits her. Will she one day go to France in order to join Delphine, her mother, whom she has not seen for five years, or will she marry in the village ? Delphine works in Paris. She is a black woman who takes care of white children. She sends money to her family. She also phones them regularly and shares in her family's misfortunes and happiness from afar. Because, in the village, things are changing too …

Documentary and fiction DVDs

- The wound and the knife [Video recording] / real. Agnès-Maritza Boulmer

Glam Chic [prod.], 2012; Le doc.ch Collection
Excision, a millennial rite and a painful wound inscribed in the flesh of millions of women. Through the testimonies of women, whether they are young or not, excised or advocating excision, this film takes a subtle and eye-opening look, beyond judgments and accusation, at a practice that follows ethnic groups, not nations. From Mali to Senegal via Switzerland, free speech is gaining traction in order to question and become aware of a different reality, that is also very close to us.

- Mutilations, Crying women [Video recording] / Benedicta Tariere Peretu and Yves Marie Kerlen, director

Paris: L'Harmattan: ADAV [distrib.], 2008
"Mutilations, Crying Women" was released by the United Nations as part of the launching, during the fifty-second session of the Commission on the Status of Women, of the interagency statement on the elimination of Female Genital Mutilation. The movie was also selected and previewed by UNESCO on March 25, 2008 as part of their international program for Women's Day that year. It is a documentary in which the main focus is on the trauma of maimed women. While for lots of people a tradition is not to be discussed, many mutilated women now raise their voices to cry out their distress. In hope of relieving part of their trauma, some of them are moving towards clitoral repair surgery.
Others completely reject this body part, after being eventually disappointed by their long-awaited surgical

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reconstruction. In such cases, "surgical repair" constitutes a second mutilation for the women. Africa is a continent rich with diverse cultures and traditions. Among traditional societies, individuals rebelling against traditions can be excluded and thrown out of communities or even whole societies. "Mutilations, Crying Women" gives a voice to women and men of the countries of the South, which rebelled against excision and infibulation. These practices, known as "Female Genital Mutilation (FGM)", have existed for millennia within the African continent and elsewhere. The World Health Organization (WHO) and hospitals in Paris collaborated in this documentary.

- Desert flower [Video recording] / a film by Sherry Hormann; inspired by the biography of Waris Dirie, co-written by Cathleen Miller

Desert Flower Filmproductions, 2009
Waris Dirie was born in 1965. Coming from a family of Somali nomads, Waris had a rough but happy childhood because she was surrounded by her family. At the age of 3, she was excised in the name of tradition. She was 13 years old when her father decided to marry her to an old man, of whom she would be the fourth wife. The teenage girl fled during the night. Crossing the desert at the risk of dying, she reached the city of Mogadishu and found her grandmother. The latter made her leave the country by finding her a position as "multi-functional maid" at the Somali embassy in the town of London where her uncle lived. When the civil war breaks out in
Somalia, the embassy closes. Waris finds herself left to her own devices in the streets of London, not knowing a word of English. She then meets Marilyn, with whom she becomes friends. This young woman gives her shelter and helps her find a job. Working in a fast food restaurant, Waris is noticed by a famous fashion photographer. Thanks to him, she joins a modeling agency. Despite many adventures, she quickly becomes one of the most famous international top models. She then decides to take advantage of her celebrity to denounce excision.

- Moolaadé [Video recording] / scenario and director. by Ousmane Sembene; music by Boncana Maïga

Bois-Colombes: Les Films du Paradoxe, 2007
With finesse, accuracy and courage, Sembène Ousmane films and stages this fight about values. The filming process moves very fast beyond the essentially feminine scope of the actresses, and ends up becoming a social and societal issue for the whole village. The film shows that behind the tradition, behind the hypocrisy of women and the sexism of men, lurks the weight of religion or at least the weight of a belief ; the belief that Islam forces women to "purify themselves" in this way.
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- Bintou's bet [Video recording] / Kirsten Johnson

CAMS, 1994
A Malian couple comes to settle in Paris. To their friends, they each independently confide their disagreement about the excision of their young daughter. He would like to respect tradition whereas she refuses to perpetuate this custom. Interpreted by African actors, this fiction was produced for education and activism, by CAMS, Commission for the abolition of sexual mutilation.

Literature for understanding and gaining a better knowledge of FGM

- Let's dare talk about excision / with the collaboration of Caritas, HUG, Camarada, AMIC, Arcade midwives, BPE, 2014

Link: http://www.ge.ch/egalite/doc/publications/violence/brochure-MGF-2014-fr.pdf

A prevention brochure against Female Genital Mutilation, a manual for professionals : what type of care has been implemented in the district of Geneva (Canton de Genève) ?

- Prevention Kit for Female Genital Mutilation: concerted strategies FGM, SCMGF, 2014

Link: http://www.strategiescoquertees-mgf.be/scmgf-15/

As the summer vacation approaches, there is an increase in requests for information about the risks of Female Genital Mutilation (FGM) from professionals and front-line associations staff. These requests are linked to the well-identified risks for girls returning to their birth countries during the summer vacation to be exposed to excision.

- Being excised and a refugee : my way of living. A practical guide to know-how and interpersonal skills during interviews, GAMS Belgium, 2012

Link: http://www.strategiescoquertees-mgf.be/wp-content/uploads/Guide-pratique.-Savoir-faire-etsavoir-être-en-maintenance.pdf

This book is intended for professionals who play a role in the journey of the women, either victims or at risk of becoming victims of Female Genital Mutilation and / or forced marriage and who, during their interviews with these women, experienced difficulties. The book is aimed at the psycho-medico-social teams who work at the admissions end of family planning structures (French "Planning Familial"), at hospital workers, but also at lawyers and jurists in charge of asylum requests for these women.

- Eliminate Female Genital Mutilation: interagency statement: OHCHR,

WHO, UNAIDS, UNDP, UNCEA UNESCO, UNFPA, UNHCR, UNICEF, NIFEM, OHCHR, 2008

Link: http://whqlibdoc.who.int/publications/2008/9789242596441_eng.pdf?ua

This declaration is an appeal to all states, national and international organizations, civil society and communities who practice Female Genital Mutilation to stand up for the rights of girls and women. It also calls on these organizations and communities to implement, improve and support specific and concrete actions in order to achieve the elimination of Female Genital Mutilation within one generation.

- Repair of the clitoris and reconstruction of sexuality in excised women : the place of pleasure. By Michela Villani and Armelle Andro; In New Feminist Questions 2010/3 (Vol. 29)

Link: https://www.cairn.info/revue-nouvelles-questions-feministes-2010-3-page-23.htm P 31

This article analyzes the "repair route" of circumcised women living in France. During this journey, women question the notion of "normality" when it comes to their reproductive system and to their sexuality, and question the role of pleasure. Their testimonies express the desire to "become a normal woman". The use of restorative surgery appears as a real strategy of sexual empowerment which aims to increase their sexual "capacities", and obtain the implementation of their sexual rights. The "repair route" allows them to question "cultural excision", and how it manifests itself through speeches, images and more generally representations of female sexuality.

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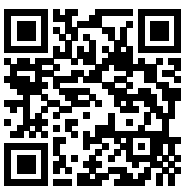

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