Common protocol for a healthcare response to Female Genital Mutilation (FGM)

HEALTHCARE 2015
MINISTRY OF HEALTH, SOCIAL SERVICES AND EQUALITY

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Common protocol for a healthcare response to Female Genital Mutilation (FGM)

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

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Foreword

"Mutilation not only takes sex away from women, but also takes away a part of the brain that makes her a submissive woman, because when a girl is mutilated, her rights are violated and that stays with her throughout her life."
(President of the European Network against Sexual Mutilations)

Female genital mutilation is a particularly damaging practice to the physical, psychological, sexual and reproductive health of women and girls. It is a human rights violation of women and girls, a form of violence against women, it is said to be a particularly cruel manifestation of gender discrimination. It is an act of violence perpetrated against women and girls just for being female. It is, ultimately, a global challenge to the individual and the collective human rights.

Spain, in line with international guidelines in this area, has initiated various legislative reforms over the recent years aimed at promoting the prosecution and penalties for FMG, while taking into consideration respect for cultural traditions, it must also have a insurmountable limit in the respect for human rights, so practices like these can in no way, be legitimatized or given protection for such reasons.

On 20 December 2012, The UN General Assembly, for the first time, approved a resolution condemning female genital mutilation; Resolution 67/146, "Strengthening global efforts to eliminate female genital mutilation," it calls on Member States to prohibit and punish under the consideration that it is "an irreparable, irreversible abuse which negatively impacts the human rights of women and girls". Additionally, **it insists that it is a harmful practice which constitutes**; "a serious threat to the health of women and girls, including their mental, sexual and reproductive health. It can also increase their vulnerability to HIV and have adverse results from a obstetric and prenatal point of view and have fatal consequences for mother and newborn baby."

The UN General Assembly called on States, *"to strengthen programs of awareness and the involvement of community and religious leaders, educational institutions, the media and families"*. It also agreed to request that "6 ***February*** *was to be declared the* ***International Day of Zero Tolerance against Female Genital Mutilation***".

In *2013,* the initiative of UNICEF called on all countries to end violence against children. The 2013 UNICEF Report "Female genital

mutilation / cutting: statistical summary and exploration of the dynamics of change", it said that 125 million women and girls have undergone female genital mutilation in 29 countries in Africa and the Middle East. In half of these countries, genital mutilation occurs before the age of five. In the rest, it ranges from 5 to 14 years old, it is a rite of passage to adulthood.

Moreover, the work of civil society, professionals and specialized public and private organizations, raising awareness about the existence and gravity of female genital mutilation and encouraging the detection and teamwork within the communities that have the highest prevalence rates for this practice. These are valuable contributions to raise the vital consciousness of society about it.

In this context, one of the characteristic features of current Spanish society is its multiculturalism, the result of immigration and international adoption, which leads to the integration and coexistence of different cultures and realities in Spain. This diversity brings new challenges, such as the practice of female genital mutilation. At the same time it gives us the opportunity to continue efforts to prevent, detect, and treat mutilated women and girls. This will ultimately contribute to eradicate this practice.

In this respect, in February 2014, during the International Conference on female genital mutilation that took place in this Ministry, it warned that nearly 17,000 girls are at risk within Spain to become victims of genital mutilation[1], meanwhile in Europe the figure is half a million, according to estimates from the European Parliament.

This is an issue that affects everybody, especially as migratory flows are increasing.

Therefore, the National Strategy for the Eradication of Violence against Women 2013-2016, approved by the Council of Ministers on 26 July 2013, contains a specific conduit, referring to "the visibility of other forms of violence against women" since together along with gender violence, the mistreatment suffered by women at the hands of partners or former partners. It is also important to advance confronting other forms of violence against women to gradually make them more visible, so people will know of them, and in doing so effectively act against them.

This will be achieved by working in collaboration with specialized organizations to promote actions to make public the gravity of female genital mutilation and enable professionals in their respective fields to influence, from an interdisciplinary perspective, in preventing, detecting and treating it. It is working on specialised training in order to improve professional response, by providing tools to facilitate their jobs.

For this sense, the Common Health Protocol specifically addresses

[1] KAPLAN, A. & Lopez, A. (2013) Map of the Female Genital Mutilation in Spain 2012, 2. Applied Anthropology Foundation Wassu-UAB, Bellaterra.

Measure 185 of the National Strategy, and is directed at health service professionals. Its main objective is to become a basic tool for raising awareness and training professionals in the fight against FGM and to guide homogeneous actions throughout the National Health System. It will allow to improve the health of women and girls whom have been subjected to female genital mutilation in their home countries and work on the detection and risk prevention of its practice on girls who are in a particularly vulnerable situation based on their family background.

Criteria such as personalized monitoring and support for the family in preventive actions, as well as, multi- and interdisciplinary care by the health team in coordination and collaboration with other sectors (education, prosecutors, forensics, security and police forces, local resources, etc.). Health care practices transversely oriented.

Alfonso Alonso Aranegui
Minister of Health, Social Services and Equality

1. Conceptual Framework

1.1 Definition

Female genital mutilation (FGM) comprises all the procedures of the partial or complete cutting of the external genitalia of women, as well as, any other injuries to the female genital organs caused by cultural or other non therapeutic reasons.

FGM is recognized internationally as a violation of "Human Rights" and "Rights of Children" - CDN explicitly attacking the **rights of women and girls** being practiced more frequently in girls under 18 and sometime between infancy and the age of 15. It reflects a deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women.

Furthermore, FGM violates the rights of health, security and physical integrity, the right of the individual to not to be subjected to torture and cruel, inhuman or degrading treatment, and the right to life in cases where the procedure can cause death[2].

The Declaration on the Elimination of Violence Against Women (Resolution 48/104, 20 December 1993), adopted by the United Nations General Assembly, defines violence against women as (...) "*any act of violence based on the female gender that has or may have resulted in harm or in the physical, psychological or sexual suffering of women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private. "It notes that this violence includes (...) "physical, psychological and sexual violence occurring in the family including abuse, marital rape, sexual abuse of female children in the household, dowry-related violence, female genital mutilation and other traditional practices harmful to women, violence perpetrated by other family members and violence relating to exploitation; physical, sexual and psychological violence occurring within the general community: rape, sexual abuse, sexual harassment and intimidation at the workplace or in educational institutions, the trafficking in women and forced prostitution; and physical, psychological or sexual violence perpetrated or condoned by the State, wherever it occurs. ". The Declaration of violence against women (...) also acknowledges,* "i*t is a manifestation of the*

[2] WHO. Factsheet N°241. February 2012. Consulted on 22 January 2014:
http://www.who.int/mediacentre/factsheets/fs241/es/
CONVENTION ON CHILDREN´S RIGHTS (CDN, 1990)
http://www.un.org/es/events/childrenday/pdf/derechos.pdf
END FGM EUROPEAN CAMPAIGN –Amnesty International NGOs
http://www.endfgm.eu/en/female-genital-mutilation/a-human-rights-violation/fgm-violates-childrens-rights/

historically unequal relationship of power between men and women, which has led to domination of women by men, discrimination against women and interposition of obstacles to their full development and (...) is one of the crucial social mechanisms by which women are forced into a subordinate role compared to men."

In this sense, FGM is a manifestation of **violence and gender inequality**, based on a series of deeply held perceptions and convictions in social, economic and political structures and sometimes even in religious beliefs within some communities.

In most cases FGM is performed by an elderly woman, well respected in the community, and that usually tends to be the midwife or which exercises traditional medicine (healer) in the group; in some countries or ethnic groups, men may practice it, but this is less common. This practice takes place in poor sanitary conditions and the instruments used are very diverse. It can range from a knife, to a can, to a broken piece of glass or any other sharp implement; subsequently, ointments, herbs, milk, ash, etc. are applied. In cases of female circumcision/cutting, in sewing the wound, acacia thorns are often used and sticks are placed between the legs so that the girl will not be stuck by the thorns when she moves and the wound can heal.

It is currently known that in urban areas and in high income families, FGM is performed by qualified medical personnel under local or general anesthesia and in hygienic conditions.

More than 18%[3] of FGMs are practiced by health care providers in their native countries, and this trend is increasing.

1.2 Causes

The etiology of FGM responds to a set of cultural, religious, social and community factors. The link with tradition **is more dependent on the ethnic identity** than their home country. Depending on the ethnic group to which one belongs, it has distinctly different justifications:

- *Customs and traditions*, which determine the role of women within the community.
- *The control of sexuality and the promotion of chastity*. It is believed that it mitigates sexual desire, guarantees fidelity and increases male sexual pleasure.
- *Reproductive functions.* There is a belief that women who have not been mutilated cannot conceive, or that FGM enhances and makes the childbirth easier. It is also thought that there can be a risk to the life of a newborn if he or she, at the time of childbirth, touches the clitoris.

[3] WHO. Factsheet N°241. February 2012

- *Hygiene reasons.* An unmutilated woman is considered unclean and therefore the community prohibits her from handling water and food.
- *Aesthetic reasons, as parts of the female genitalia are considered as devoid of beauty and excessively bulky.*
- *Religious reasons.* Often, FGM is justified by invoking religion with the false belief that it is an Islamic precept of the Quran.

Female genital mutilation is practiced in 29[4] countries mostly in Africa and some Asian. Its origins are unknown, but it is considered a practice that could be from ancient Egypt, prior to the birth and expansion of Islam, which was spread through the influence of Egyptian civilization.

In Sub-Saharan Africa, female circumcision/cutting is performed throughout the Sahel belt and is losing strength closer to the equatorial zone. As of this point it is no longer routinely performed, except in the countries of the Great Lakes Region.

Although some Muslim communities and other religions practice this, it's possible to say that **it is not an Islamic precept, nor that of any other major religion**. Though no religious writings prescribe the practice, those who carry it out often believe that it has religious support. Religious leaders take different positions with regard to FGM: some promote it, some consider it to be irrelevant to religion, and others help lead to its elimination. The practice of FGM predates Islam and is unusual among most Muslim countries, but it has acquired a religious dimension in some of those countries where it is practiced, such as in Egypt, where there is conflict between different religious leaders on whether It is mandated by the Quran or not. The Quran does not contain any call for FGM, but some sayings attributed to the Prophet (Hadith) refer to it by saying: "Reduce but do not destroy." FGM is not an Islamic practice[5], although some religious leaders claim that is an obligation of Islam. Moreover, it is practiced in Egypt[6] by both Muslims and Coptic Christians.

In most societies, **FGM is considered a cultural tradition**, an argument that is often used to keep up its practice. By having a character of social convention, the practice tends to perpetuate because of the social pressure to conform to what others are doing and what has traditionally been done. In areas where it is traditionally practiced, FGM is a matter obedience to the group consistency.

The local structure of power and authority, such as community and religious leaders, people traditionally responsible for the practice of

[4] WHO. Factsheet N°241. February 2012

[5] Abd Amal El Hadi. A step forward for opponents of female genital mutilation in Egypt. Lancet 1997; 349: 11

[6] Kandela, Peter. Court ruling means that Egypt embraces female circumcision again. Lancet 1997; 350: 5.

mutilation, and even part of the native medical staff, in some cases contribute to the continuation of this practice.

In some societies, recent adoption of this practice is linked to the copying of traditions from neighboring groups and is being introduced into new groups displaced to areas where it is practiced by the local population. It has sometimes started as part of a wider traditional or religious revival movement.

Mutilation usually occurs in an environment in which the individual is subject to the will, needs, and decisions of the community.

FGM is often considered a necessary part of good child parenting and a way to prepare her for adulthood and marriage. It may be unavoidable for her in order to get married, to achieve a certain position or simply to be accepted within the community, since the intervention is believed as a cleanliness and purity requirement for the woman. It is conceivable that ablation of the clitoris and labia increases femininity which is sometimes synonymous with docility and obedience. Moreover, it would be the moment when the woman begins to take part in the adult world (e.g. in Burkina, a girl who is mutilated is named differently than she was before). Elsewhere, it seems that FGM could be a learning tool for the time of childbirth, a way to learn the suffering that awaits her in adulthood. However, the trend is that more of these procedures are done at a younger age and is not associated with any type of initiation.

FGM is usually motivated by beliefs about what is considered to be proper sexual behavior, linking procedures to premarital virginity and marital fidelity.

Many communities consider that FGM reduces the female libido, helping women to resist "illicit" sexual acts. For example, when you close or cover the vaginal opening (type 3 procedure), it becomes physically difficult for women to have premarital sex. It is believed that they are afraid of the pain if it is reopened, also the fear of being discovered having sex. This further discourages any "illicit" sex in women to which this type of FGM has been performed. Afterwards, a painful procedure is needed to reopen the vagina to allow for coitus.

There are many other beliefs about FGM; for example, it is believed that to be mutilated is more aesthetic because the clitoris is considered the male part of the woman. It could grow and hang between the legs and this would not be aesthetic. In some languages, mutilation is synonymous with cleaning, purification, etc.; another belief says that the clitoris could kill the child at birth if it touches its head, or that in touching the man's penis he will die or be impotent; it is also said that a woman will be more fertile, the childbirth will be easier, although we know this not to be true.

Ideas about the beneficial effects of female genital mutilation in health

do not occur only in Africa. In England, in the nineteenth century, there were debates that clitoridectomy could cure women's diseases such as hysteria and excessive masturbation. In the USA, the practice of clitoridectomy for these reasons was practiced until well into the 20thcentury.[7]

In the majority of cases, both the people who perform the practice as well as the families and victims are unaware of the relationship between FGM and its harmful health consequences to women.
Therefore, it is important to point out the serious consequences for the short-term and long-term health of the women and young girls it is practiced on, as one of the main arguments to eradicate this practice.

On the other hand, in some countries where it is practiced is the origin of emigration to other more economically developed countries. In this context, **the person who emigrates** is chosen by the extended family as the one responsible for achieving the objectives of migration and, therefore keeping the links in the material sphere as well as on an emotional level.

Regarding the practice of FGM, **the family** that stays in the country of origin often has strong social pressure on the emigrants, reaching a peak at the time when they return home, either permanently or for a holiday. This trip involves the stay in the country during the holidays, or the definitive return of one or several family members including girls who have not been mutilated. This can be a time of real danger for them.

Therefore it is of paramount importance that **the family staying in the new country** of residence is permitted to take steps in this issue and that the child's parents abandon the practice of their own conviction, beyond the legal imposition, and thereby definitively ensuring the safety of their daughters, here and there, now and at any time, to the point of facing, if necessary, the demands of the community.

It is a fact that there are families who for various reasons still defend the practice, so it is necessary to perform tasks of **awareness and take the most appropriate measures according to each situation** as it arises, not to leave potential victims without any protection of their rights.

Approximately half of the countries in which FGM is performed the practice is prohibited but the social convention that surrounds it is so strong that even when an individual woman or family is against doing it to their daughters, it is quite possible that they will continue to do so in order to

[7] Council on Scientific Affairs, American Medical Association. Female Genital Mutilation. JAMA 1995; Dec 6;274(21):1714-6

protect and safeguard their status in the community.

Consequently, we must seek the involvement of women and young girls and affected young people, their families and their communities to pursue a **change in the perception** of these practices. In **preventing** FGM, we need to bear in mind the social and cultural patterns of behavior that are the root causes of FGM which need to be eliminated[8].

Female genital mutilation is **a cultural practice** that takes place in the context of a **community** and a **group** that justifies its **beliefs** from different areas: customs and traditions, control of sexuality, reproductive functions, hygiene, aesthetics and religious. Mutilation usually occurs in an environment in which the individual is subject to the will, needs and decisions of the community.

"About 140 million women and young girls currently suffer from the consequences of FGM."

"It is estimated that there are 92 million women and girls over the age of 10 who have undergone FGM in Africa."

"These practices are more common in the western, eastern and northeastern regions of Africa, and in some Asian and Middle Eastern countries."[8]

[8] The United Kingdom has developed a campaign strategy aimed at changing the behavior of communities practicing FGM. It is a new example of the pursuit of participation.

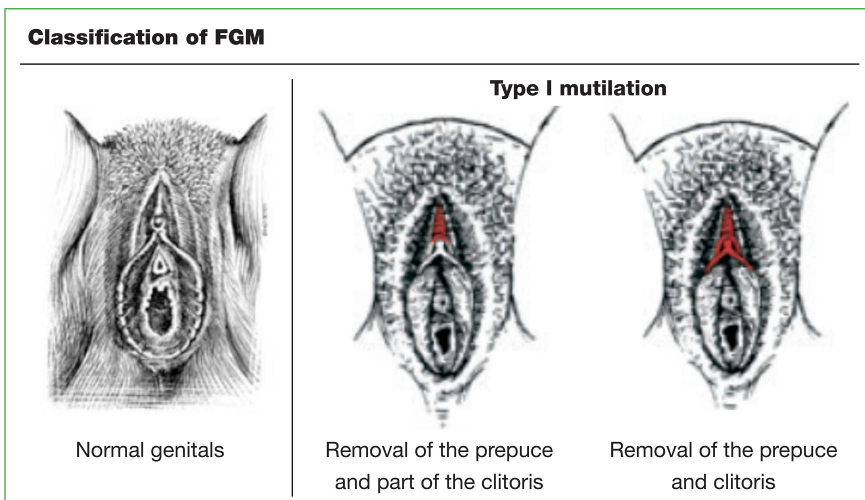
[9] WHO. Factsheet N°241. February 2012

1.3 Types

Female genital mutilation, according to the latest classification by the World Health Organization (WHO)[10], comprises all procedures that involve partial or total removal of the external female genitalia or injury to female genital organs, for non-medical reasons.

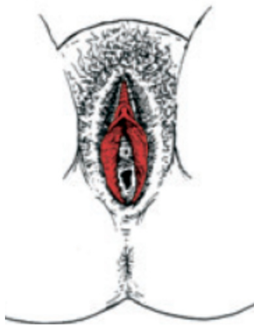
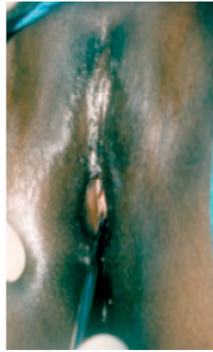
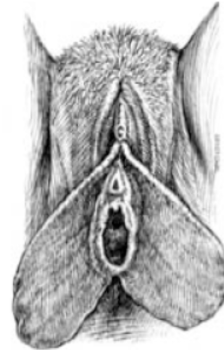
Female genital mutilation is classified into **four major types:**

- **Type I or Clitoridectomy**: partial or total removal of the clitoris (small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Type II or Excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
- **Type III or Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris.
- **Type IV**: wide range of varied and unclassifiable practices. All other harmful procedures to the female genitalia for non-medical purposes, such as; piercing, incising, scraping and cauterizing the genital area.



[10] WHO. (2013). Understanding and addressing violence against women. Female genital mutilation. Washington,DC.

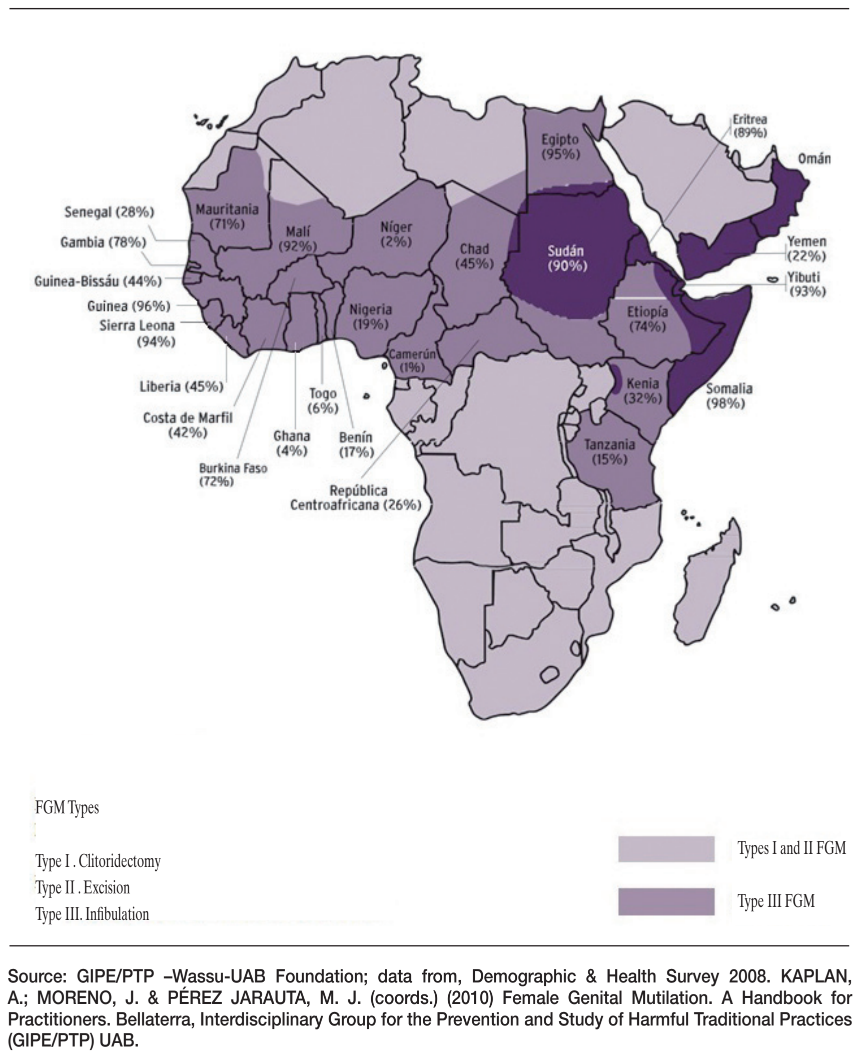
Classification of FGM

Type II mutilation	Type III mutilation	Type IV mutilation
		
Infibulation/ female circumcision	Stretching of the labia minora	Stretching of the labia minora

Types I and II are the most common, representing about 90% of cases, while type III represents about 10% of cases, according to WHO.

Types I and II are predominant in western Sub-Saharan Africa countries. Type III FGM is most common in Eastern Africa, particularly in Sudan, Somalia, Eritrea and parts of Ethiopia. In Djibouti, Eritrea, Niger, Senegal and Somalia, more than one in five girls has undergone the most radical form of the practice, known as infibulation, which involves the cutting and sewing of the genitals.

Graph: Geographical distribution of type and prevalence of FGM in African countries.



Source: GIPE/PTP –Wassu-UAB Foundation; data from, Demographic & Health Survey 2008. KAPLAN, A.; MORENO, J. & PÉREZ JARAUTA, M. J. (coords.) (2010) Female Genital Mutilation. A Handbook for Practitioners. Bellaterra, Interdisciplinary Group for the Prevention and Study of Harmful Traditional Practices (GIPE/PTP) UAB.

In any case, the type of mutilation, the age at which is performed and the way it is practiced vary from one country to another, from one ethnic group to another, and even within an ethnic group, from one family to another, and also changes depending on whether it takes place in urban or rural areas.

Overall, **there have been few changes in the type of mutilation / cutting performed over generations**. A trend towards less severe mutilation is

discernible in some countries, as Djibouti, where 83% of women from 45 to 49 years old reported that they had been closed by sewing compared to 42% among girls aged 15-19 years old[11].

1.4 Health consequences[12]

FGM, besides being a serious violation of individual human rights of, that often involves physical and psychological suffering, sometimes the consequences are so severe that it can cause life-long marginalization or death.

FGM has no benefit to the health of women and girls, but causes damage in a variety of ways because it involves ablation and damage to healthy and normal female genital tissue.

The complications that appear after a FGM may occur immediately or in the mid or long-term, without forgetting about the obstetric complications..

Short term

Keep in mind that in general, people who the ritual ablation in the countries of origin have no knowledge of surgery. The instruments used are not sterilized and are performed without anesthesia, so complications can exist and have immediate consequences such as:

- **Intense pain.** It is a painful practice that has several immediate consequences, such as open sores in the genital area and pain from the wounds that remain after the mutilation, anxiety and shock.
- **Hemorrhaging.** Being a highly vascular area, the incision can cause significant bleeding which, if not well controlled, can cause hemorrhagic shock that could lead to the girl´s death.
- **Infections.** Wound infections by poor hygiene and the lack of the sterilization of materials, urinary infection by retention or urethral damage (failure or difficulty in urination, oliguria) and including septicemia and tetanus (if the child is vaccinated, this risk disappears). Exposure and the risk of HIV infection also increase if the same cutting instruments are used repeatedly on the same girls.
- **Injury to organs and the anatomical structures in the area:** urethra, vagina, perineum and / or rectum.

[11] UNICEF. (2013). female genital mutilation/circumcision: Statistical summary and exploration of the dynamics of change. p111

[12] Velasco Juez, Casilda. “Traditional practices that violate the rights of women: female genital mutilation”. Spanish Association of Midwives. Prof. Midwives magazine 2000;1 (2): 10-18. Consulted on 13 January 2014 in: *http://www.federacion-matronas.org/revista/matronas-profesion/sumarios/i/7660/173/practicas-tradicionales-que-vulneran-los-derechos-de-las-mujeres-mutilaciones-sexuales-femeninas*

- **Fractures,** in some cases, depending the resisting by the girl**.**

Mid-term

Severe anemia caused by bleeding, together with **malnutrition** problems may occur. Other complications may also appear such as: *pelvic infection, painful menstruation and keloid scars.*

Long-term

Long-term complications may include:

Psychological

Psychological complications may occur, especially in women who remember their FGM. If the practice is done at an early age (before age 12) it is difficult to detect and measure, although it is very likely to stay with the child and affect her physical and emotional development. Some of the consequences that can be observed are:

- **Depression, terror** (nightmares)**, fear.**
- **Feelings of confusion and conflict** caused by the difference between the social values from their homeland and the society in which they live now. This is in the case of immigrant women.
- **Fear of rejection from their social or ethnic group** if they don´t practice the genital mutilation. Feelings of humiliation and shame**.**
- Uncertainty and fear in the girls and adolescents who now live in a different country than their origin. Becoming aware of their situation of having been mutilated.
- **Fear of first sexual intercourse or of childbirth** in girls and women who have been mutilated.
- **Guilt of mutilated mothers** who have accepted or even encouraged the practice of the mutilation of their daughters.

There is little research on the psychological effects of FGM, but stories of women reporting anxiety and terror before and during the process are the same. The experience of FGM has been linked to a series of **mental and psychosomatic disorders** such as **disturbances of appetite and sleep**, nightmares, panic attacks and difficulty in concentrating and learning.

Growing up, they may experience feelings of low **self-esteem, depression, chronic anxiety, phobias, panic and even psychotic disorders**. The deformation of the genitals caused by dermoid cysts or keloid scars, causing them anxiety, shame and fear because they think their genitals are growing again so huge or fear that it is cancer. Many women suffer their problems in silence, unable to express their pain and fear, and the memory of the

event stays with them for life. In addition, immigrant women who have been mutilated, may present additional problems related to their sexual identity, in front of women not mutilated and because of strong opposition to FGM in the host country.

Physical

- **Infections** genital and urinary tract (bladder) infections.
- **Exposure and risk of infections** such as HIV, hepatitis or tetanus, if unsterilized instruments were used in practicing it.
- **Genitourinary problems:** menstrual cramps, hematocolpos (retention of menstrual contents in the vagina), genitourinary fistula, retention, incontinence, cysts, depending on the type of mutilation practiced.
- Increased risk of **childbirth complications and newborn deaths**, especially in the countries of origin.

In addition to the abovementioned consequences, women with type III mutilations suffer additional problems some of which have already been named above, e.g.:

- **Frequent infections and inflammations,** injuries to open the orifice (or unstitch) for having coital relations or for childbirth.
- **Urinary incontinence, recurrent infections, and menstrual abnormalities**, injuries to reclose the orifice; sterility, the inability to have intercourse, and major difficulties during childbirth.
- **Need for partial deinfibulation** as part of the marriage ritual to allow for penetration. This sometimes involves the need **for additional surgery**, when the sealing process or the narrowing of the vaginal opening must be corrected surgically to allow for childbirth. Sometimes it is closed again, even after giving birth, so the woman is subjected to successive openings and closures, increasing the immediate and long-term risks.

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Sexual

There are more likely to be problems related to sexuality, such as:

- **Decreased sexual sensitivity (pleasure, arousal, lubrication, orgasm)**, lack of satisfaction and pleasure in sexual relations.
- Decrease or absence of erotic desire, intercourse phobia, frigidity, etc.
- Pain during intercourse (dyspareunia).
- Vaginismus.
- Anorgasmia due to the amputation of the clitoral glans clitoris.
- Fear and rejection.

Consequences for third parties

However, not only the women suffer harm from the practice of mutilation.

In connection with the consequences of FGM for **men**, which are less documented, there are reported problems of alcoholism and drug abuse due to the inability to have intercourse, impotence for fear of causing pain to their partner with penetration, looking for sexual pleasure outside the relationship which brings the risk of contracting sexually transmitted diseases, depression, etc.

Moreover, as a result of complications during childbirth **in their home countries, the mortality rate of babies during birth is higher.** There are a series of complications that can harm the baby, such as retention in the birth canal causing increased labour times, which can on occasion cause a lack of oxygen during birth, and fetal distress. These problems are mainly in cases of type II and III mutilations. Although in our environment such problems can be controlled, they should be known about and presented as risks for women who have suffered such mutilation and come to our health services for care in childbirth.

Obstetrics and newborn complications

In countries of origin, the occurrence of complications in both the mother and the newborn during, and in the period immediately after birth, and especially in cases of infibulation many have been described by many in the studies of FGM.

In the large prospective study by the WHO and published in The Lancet in 2006 concerning more than 28,000 women from different African countries and ethnic groups, it became evident that there was a higher frequency of problems during childbirth in women who had undergone FGM compared with the women who had not, especially in types II and III.

These complications include:

- Increased need for cesarean delivery and a higher incidence of postpartum hemorrhage.
- Higher probability of prolonged hospitalization.
- Increased number of episiotomies, especially in type III mutilation.
- Increased maternal mortality.
- The number of children who require resuscitation at birth is significantly higher when the mother has undergone genital mutilation.

Perinatal mortality is higher in children of mothers with type II and III mutilations, it could be attributed to 22% of the perinatal deaths of infants born to women who have undergone FGM.

"The Three Femine Sorrows" associated with female genital mutilation. Include: the pain the day the mutilation is performed, the wedding night when the woman must be cut to have sex and finally, the day of childbirth, as the opening of the vagina is too narrow for a safe delivery.

Fourcroy, J.L. "The Three Feminine Sorrows", Hospital Practice 1998; 33; 15-21.

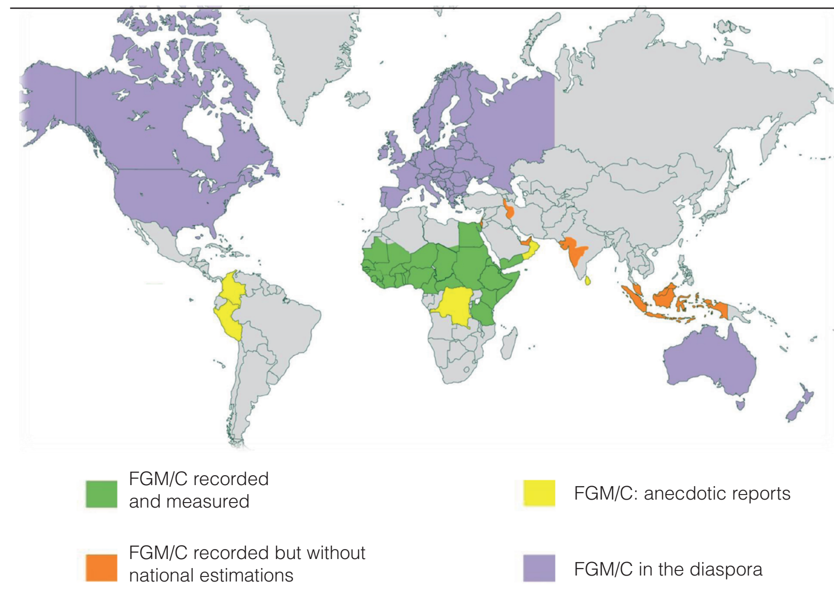
However, in Spain and in other neighboring countries, such complications are observed and addressed, in case of a need for intrapartum deinfibulation or episiotomy of the damaged tissue with these cases.

2. Epidemiology

According to the UNICEF report[13] from 2013, more than 125 million living women and girls have been subjected to this practice and 30 million more girls may be at risk of being victims of mutilation/ ablation in the next decade.

According to the Report by the Secretary General of the United Nations on increasing global efforts to eliminate female genital mutilation in 2014, *"the data shows that the practice is more common in Western, Eastern and Northeastern Africa, but also in some countries in the Middle East and Asia and all around the world in migrant communities from these areas"*.

Graph: Map of FGM in the world.



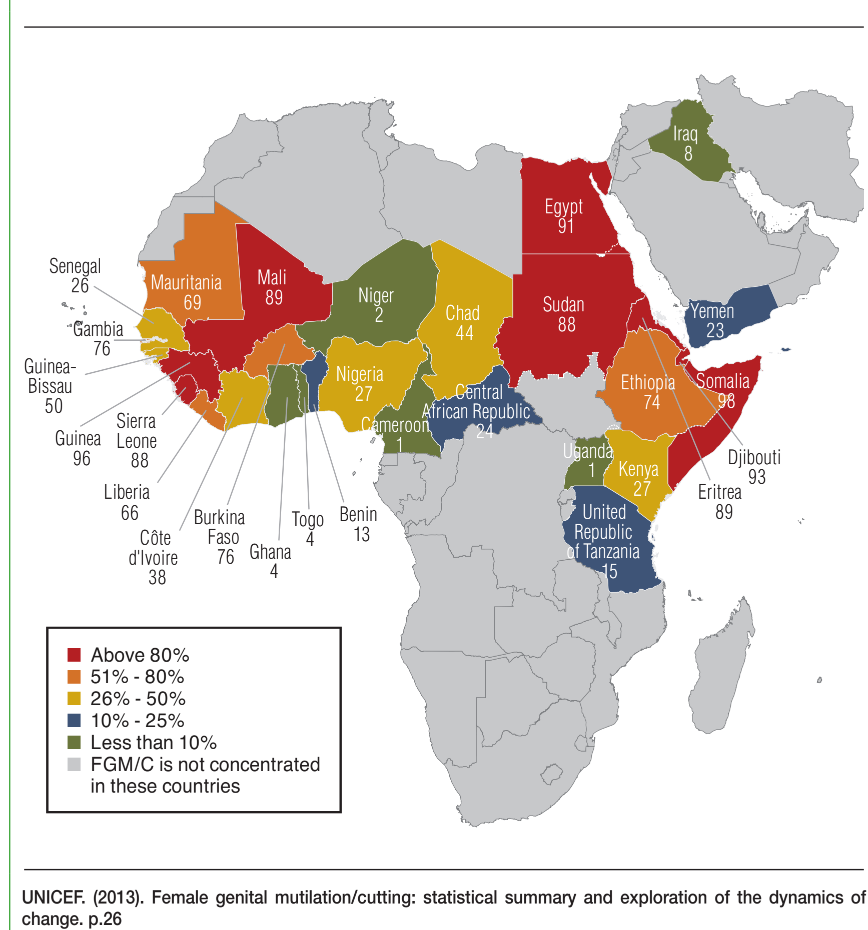
Source: GIPE/PTP –Wassu-UAB Foundation; data from, Demographic & Health Survey 2008. KAPLAN, A.; MORENO, J. & PÉREZ JARAUTA, M. J. (coords.) (2010) Female Genital Mutilation. A Handbook for Practitioners. Bellaterra, Interdisciplinary Group for the Prevention and Study of Harmful Traditional Practices (GIPE/PTP) UAB.

[13] UNICEF. (2013). Female genital mutilation/cutting:statistical summary and exploration of the dynamics of change. p.2

In turn, according to information gathered in the "Guide for Professionals. FGM in Spain Prevention and Intervention UNAF", FGM is practiced in, "about 28 African countries, primarily in the Sub-Saharan area, and in some Middle Eastern countries such as Egypt, Oman, Yemen and the United Arab Emirates and in some communities in Asia: India, Indonesia, Malaysia, Pakistan and Sri Lanka. There are also known cases in Latin America (Brazil, Colombia, Mexico and Peru)".

The 29 countries where the practice is concentrated are: Benin, Burkina Faso, Cameroon, Chad, Ivory Coast, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Central African Republic, Tanzania, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda and Yemen.

Graph: Percentage of girls and women between 15 and 49 years who have experienced FGM, by country.



UNICEF. (2013). Female genital mutilation/cutting: statistical summary and exploration of the dynamics of change. p.26

According to the UNICEF report of 2013, while mutilation is almost universal in Djibouti, Egypt, Somalia and Guinea (the latter with a prevalence of 96%), In Niger 2% are affected, and in Cameroon and Uganda it only affects 1% of the girls and women.

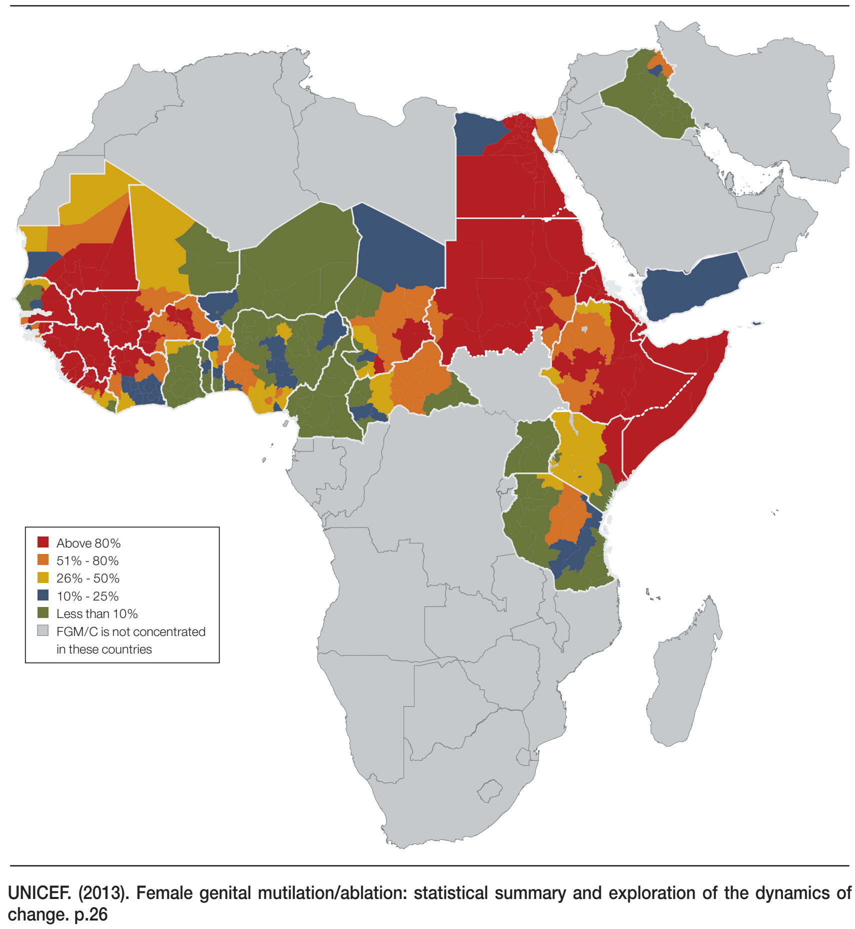
Incidence of mutilation among girls and women from 15 to 49 years old

Country	%	Country	%
Somalia	98	Cóte d' Ivoire	36
Guinea	96	Kenya	27
Djibouti	93	Nigeria	27
Egypt	91	Senegal	26
Eritrea	89	Central African Republic	24
Mali	89	Yemen	23
Sierra Leone	88	United Republic of Tanzania	15
Sudan*	88	Benin	13
Burkina Faso	76	Iraq	8
Gambia	76	Ghana	4
Ethiopia	74	Togo	4
Mauritania	69	Niger	2
Liberia	66	Cameroon	1
Guinea-Bissau	50	Uganda	1
Chad	44		

*Data about mutilation/ cutting was only gathered in the Northern part of what was known as the Sudan before the secession in July 2011 of the Republic of South Sudan by the Republic of the Sudan. The current South Sudan data was not gathered because it is generally thought that the practice is not performed there. This report refers exclusively to the Republic of Sudan.

In countries where mutilation is not widespread, it tends to focus on specific regions of a country and is not limited by national boundaries.

Graph: Prevalence. Percentage of girls and women aged 15-49 years who have experienced FGM, by regions within countries.



UNICEF. (2013). Female genital mutilation/ablation: statistical summary and exploration of the dynamics of change. p.26

Also, the prevalence of female genital mutilation varies among different ethnic groups. Thus, some ethnic groups in which FGM is performed are: Sarahule, Djola, Mandinka, Fulbe (Pular, Toucouleur), Soninke, Bambara, Dogon, Edos, Awusa or Fante, mainly from Gambia, Senegal, Mali, Mauritania, Nigeria, Cameroon and Guinea Conakry. Some ethnic groups that do not practice are: Wolof, Serer or Ndiago.

Nor should we assume that **all African countries** practice FGM, or **within the same the country it is practiced by all ethnic groups.**

Socioeconomic factors also influence the prevalence of female genital mutilation and the attitudes towards it within countries. On the other hand, the prevalence of the practice among women and girls living outside their home countries is due to increasing migration. Although it is not possible to establish a causal relationship, it seems that the practice is more common in rural areas and is less widespread among girls in the richest households. Also, support for female genital mutilation is greater among women and girls from the poorest households. [14]

FGM is carried out at very different ages. According to the WHO, more are performed at younger ages, and this so that the girl, as an adult, does not remember the pain and suffering. It makes it easier to carry out this practice on their daughters. However, there are areas where it takes place just before they marry or with girls only months old.[15] Some girls undergo FGM in groups, that is, with all the girls in the village who are old enough or from the same family, etc. Sometimes it is done individually, especially in urban areas. The place where it is performed in rural areas is usually in the home of one of the girls or out in the fields, away from the town center.

In half of the countries with available data, **most girls suffer mutilation / circumcision before the age of 5 years old.**

The age at which many of the girls are subjected to FGM varies greatly from one society to another, **ranging from 5 to 14 years old.** In **Chad, Egypt, Central African Republic and Somalia** at least 80% of girls are victims of the practice between the ages of 5 and 14 years old, sometimes in rituals that mark the **transition to adulthood**.

The average age at which FGM is performed has decreased significantly in Burkina Faso, Ivory Coast, Egypt, Kenya and Mali. This may be because parents want to hide the practice from government authorities or to minimize the resistance from the girls themselves.

As for trends, the 2013 UNICEF report notes that **more than half of the 29 countries** where FGM is concentrated, **girls are less likely to be subjected**

[14] "Intensification of global efforts to eliminate female genital mutilation." Report of the UN Secretary General. 2014

[15] Velasco Juez, Casilda. "Traditional practices that violate the rights of women: female genital mutilation". Federation of Midwives of Spain. Prof.Midwives magazine 2000; 1 (2): 10-18. Retrieved on January 13, 2014 in: *http://www.federacion-matronas.org/revista/matronas-profesion/sumarios/i/7660/173/practicas-tradicionales-que-vulneran-los-derechos-de-las-mujeres-mutilaciones-sexuales-femeninas*

to it today than their mothers. In Kenya and Tanzania, girls between 15 and 19 are three times less likely to have had this experience than women aged 45-49 years. In Benin, Iraq, Liberia, Nigeria and the Central African Republic, the prevalence has dropped by almost half among adolescent girls.

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3. FGM situation in Spain[16]

Although there have been some reported cases of female genital mutilation performed in Catalonia in 1993 and later in Palma de Mallorca in 1996, there is no strong evidence that any more mutilations have taken place in Spain. However, there have been reported cases of mutilated immigrants, especially in Catalonia and Andalusia.

There is no nationwide data of women mutilated who reside in Spain. It is subject to data gathered at the regional level in some of the Protocols on female genital mutilation in the Autonomous Communities. Therefore, the development of this Health Protocol will lead to obtaining National data on FGM, the common indicators of one more type of gender violence around the national territory.

Knowledge of the countries in which the practice of FGM is concentrated is fundamental for the detection and prevention of possible cases in both immigrant children and girls born in Spain. One of the main risk factors of this practice to happen is in coming from a country where this practice occurs.

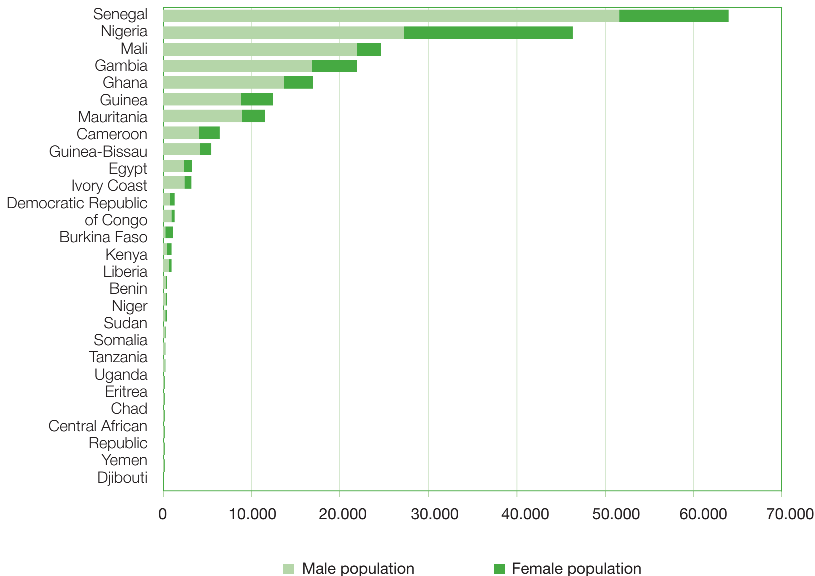
In addition to the country from which the people living in Spain are from, it is necessary to consider other circumstances to collectively determine the existence of risk factors. In this regard, to consider ethnicity, the level of FGM prevalence in the country of origin and age (as we have explained, the age that FGM is performed varies greatly from one society to another but generally ranges between 5 and 14 years old).

Moreover, knowledge about what autonomous communities where these people from high risk countries risk live, provides useful information to identify potential people / families / groups at risk and thereby being able to take actions in support of the detection, care and prevention of FGM.

> The resident population in Spain from countries where FGM is practiced, originate mainly from Senegal, Nigeria, Mali and Gambia.

[16] This whole section of the Protocol bases its detaled information on, KAPLAN, A. and Lopez, A. (2013) Map of FGM in Spain 2012, Applied Anthropology 2. Wassu-UAB Foundation, Bellaterra.
We appreciate all the information and the regular updating it requires every four years. Comprehensive information and educational materials about FGM published by the Foundation can be viewed at the web address: *www.mgf.uab.es*

Graph: Total population residing in Spain from countries where FGM is practiced and by gender.



KAPLAN, A. & Lopez, A. (2013) Map of the Female Genital Mutilation in Spain 2012, 2. Applied Anthropology Foundation Wassu-UAB, Bellaterra. p.20

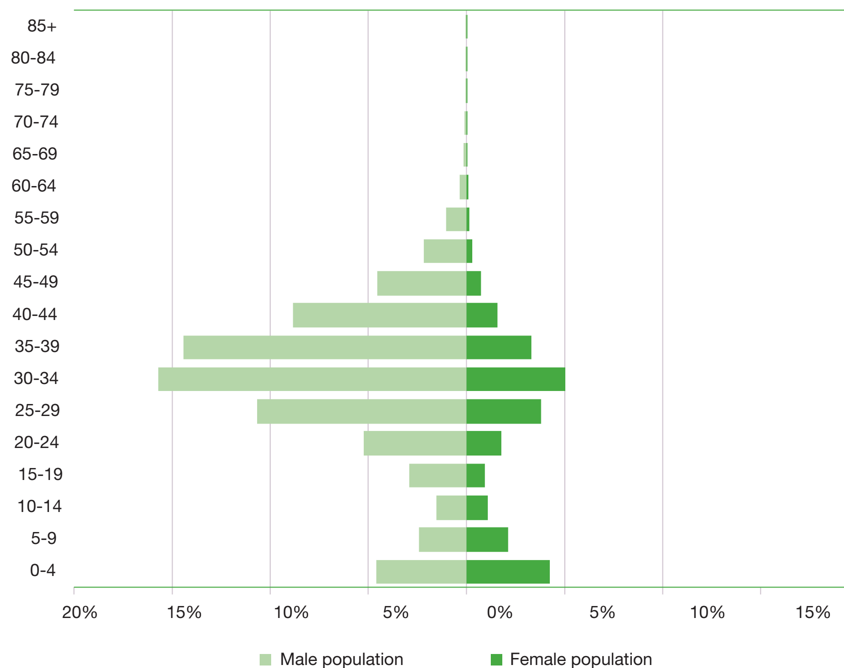
Another significant event that defines the demographic profile of the immigrant population living in Spain coming from countries in which FGM is practiced, is its masculinization. Of all the countries in which FGM is practiced, except for Kenya and Ethiopia, more men than women live in Spain.

"In some nations, such as Mali, Ghana and Senegal, the masculinization ratio is particularly high; in the case of Mali, there are 8 men for every woman residing in Spain" (Kaplan & Lopez, 2013: 20)

This masculinization of the population from countries where FGM is practiced is a relevant factor for the implementation of preventative actions.

Also significant is the great representation in the range of young adult age groups.

Graph: Demographic structure of age from the people residing in Spain from countries where FGM is practiced, 2012



KAPLAN, A. & Lopez, A. (2013) Map of the Female Genital Mutilation in Spain 2012, 2. Applied Anthropology Foundation Wassu-UAB, Bellaterra.p.21

Almost 60% of the population is between 20 and 39 years old. While this ratio is high, it has been declining **in recent years in favour of an increase in the proportion of child population, which through 2012 census data represents 16%** of all these nationalities.[17]

With regard to women and girls at risk, "*among the 6 million foreigners who resided in Spain in 2012, more than 55,000 women came from Sub-Saharan Africa, where the practice of FGM persists*" (Kaplan & Lopez, 2013: 4).

Meanwhile, *"approximately 8% of residents, some 17,000 people are girls from 0 to 14 years old"*. (Kaplan & Lopez, 2013: 21) The target population when assessing the risk of suffering from FGM, whether she was born in Spain or born in another country and moved to Spain. *"60% of those girls were Nigerian, Senegalese and Gambian nationals, with 5,000, 3,500 and 2,100 girls, respectively"* (Kaplan & Lopez, 2013: 21).

[17] KAPLAN, A. & Lopez, A. (2013) Map of the Female Genital Mutilation in Spain 2012, 2. Applied Anthropology Foundation Wassu-UAB, Bellaterra. p.21

Resident population in Spain, according to the census, coming from countries where fgm is practiced					
	PREVALENCE %	TOTAL	WOMEN	GIRLS>14 YEARS OLD	A.C. OF RESIDENCE
Benin	17	348	96	17	
Burkina Faso	72	1.122	290	66	
Cameroon	1	5.826	2.134	514	Cataluña, Madrid Valencia , P. Vasco
Chad	45	73	21	7	
Ivory Coast	42	2.869	714	162	
Djibouti	93	9	4	1	
Egypt	95	2.946	866	298	Cataluña Madrid, C. Valenciana, Andalucía
Eritrea	89	96	36	2	
Ethiopia	74	781	402	114	
Gambia	78	20.640	5.064	2.084	Cataluña Aragón
Ghana	4	14.807	2.978	890	Cataluña, Aragón , Madrid, País Vasco
Guinea	96	10.960	3.285	501	Cataluña Madrid, Aragón, Canarias, C. Valendana, Andalucía
Guinea-Bissau	44	4.998	1.183	222	Andalucía, Cataluña, Canarias, P. Vasco
Kenya	32	1.031	809	13	
Liberia	45	395	95	15	
Mali	92	23.459	2.701	1.098	Cataluña. Madrid, Aragón, C. Valencíana
Mauritania	71	10.767	2.447	772	Cataluña, Madrid; Andalucía, C. Valenciana
Niger	2	263	61	19	
Nigeria	19	43.253	17.806	4.680	Madrid, Cataluña, C. Valencíana, Andalucía
Central African Republic	26	81	26	1	
Senegal	28	57.739	11.583	3.354	Cataluña, C. Valenciana, Andalucía, Aragón

Resident population in Spain, according to the census, coming from countries where fgm is practiced					
	PREVALENCE %	TOTAL	WOMEN	GIRLS>14 YEARS OLD	A.C. OF RESIDENCE
Sierra Leone	94	846	247	64	
Somalia	98	215	77	6	
Sudan	90	249	96	24	
Tanzania	15	164	80	2	
Togo	6	433	134	24	
Yemen	22	64	16	7	
TOTAL		204.434	53.251	15.690	

KAPLAN, A. & Lopez, A. (2013) Map of the Female Genital Mutilation in Spain 2012, 2. Applied Anthropology Foundation Wassu-UAB, Bellaterra.

In view of the data, the population residing in Spain from countries where FGM is practiced live mainly in the regions of Catalonia, Madrid, Andalusia, Valencia, and Aragon.

In 2012, "*a third of the population from the group of nations where female genital mutilation is practiced, reside in Catalonia. With more than 70,000 residents this is by far the most populous region of this origin. This proportion increased to 36.6% in exclusively analyzing this female population group under 15 years old. Andalusia was the second most populated territory with these nationalities, although the Community of Madrid exceeded it in the number of women and girls. Valencia, Aragon, the Canary Islands, the Balearic Islands and Basque Country are the other regions with more than 10,000 people in these groups of nationalities. By provinces, Barcelona that held the most people, with nearly 40,000; followed by Madrid, 25,000; and Girona, Valencia, Almeria, Lleida and the Balearic Islands each with more than 10,000*" (Kaplan & López, 2013:27)

Graph: People from countries where FGM is practiced by autonomous community of residence and gender, 2008-2012

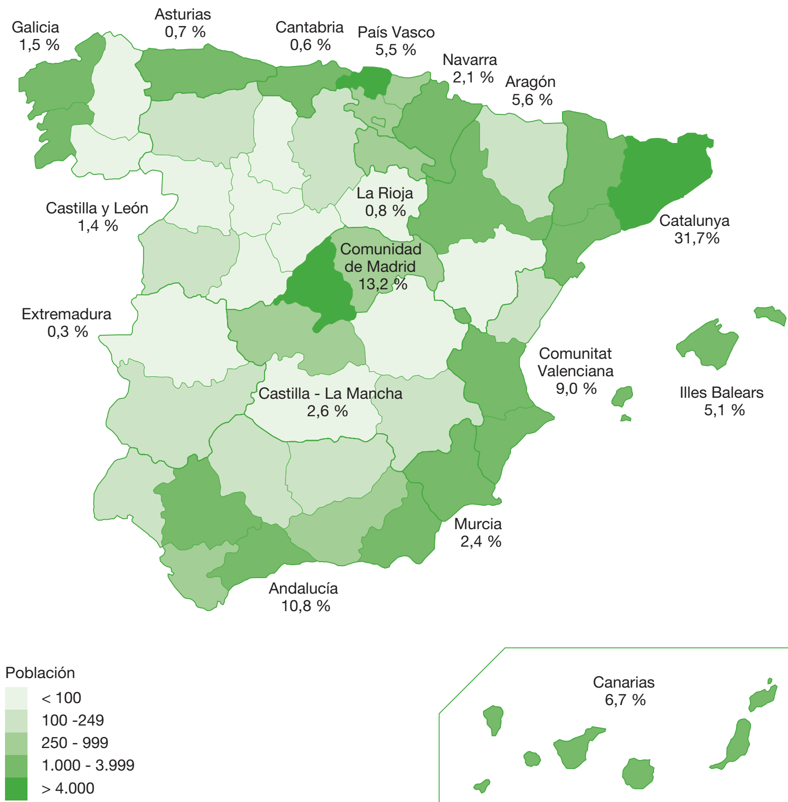
	Total FGM population	Difference 2012 – 2008	Relative Growth (%)	Female FGM population	Difference 2012 – 2008	Relative Growth (%)	Female 0-14 FGM population	Difference 2012 – 2008	Relative Growth (%)
Cataluña	71115	12998	22,40	18122	5133	39,5	6182	1826	41,9
Andalucía	33533	11983	55,60	6197	2285	58,4	1501	612	68,8
Comunidad de Madrid	24786	532	2,10	7558	784	11,6	2059	779	60,9
Comunitat Valenciana	19882	2131	12,00	5135	948	22,6	1477	633	75
Aragón	12245	1869	18,00	3195	726	29,4	1074	258	31,6
Canarias	11220	978	9,50	3860	813	26,7	1000	342	52
Pais Vasco	11066	5564	101,10	3171	1861	142,1	818	544	198,5
Balears (Illes)	10165	2291	29,10	2921	975	50,1	937	477	103,7
Región de Murcia	7831	964	14,00	1399	397	39,6	403	211	109,9
Castilla-La Mancha	5916	2386	67,60	1512	868	134,8	422	264	167,1
Galicia	4159	1407	51,10	832	331	66,1	168	82	95,3
Comunidad Foral de Navarra	3589	832	30,20	1185	427	56,3	321	148	85,5
Castilla y Leon	2991	945	46,20	784	279	55,2	179	73	68,9

Graph: People from countries where FGM is practiced by autonomous community of residence and gender, 2008-2012

	Total FGM population	Difference 2012 – 2008	Relative Growth (%)	Female FGM population	Difference 2012 – 2008	Relative Growth (%)	Female 0-14 FGM population	Difference 2012 – 2008	Relative Growth (%)
Principado de Asturias	2136	708	49,60	380	183	92,9	64	50	357,1
Rioja (La)	1438	148	11,50	459	137	42,5	156	60	62,5
Cantabria	1410	534	61,00	372	158	73,8	86	56	186,7
Extremadura	539	147	37,50	159	51	47,2	19	1	5,6
Ceuta y Melilla	119	105	750,00	10	5	100	3	2	200
Overall total	224140	46522	25,40	57251	16361	40	16869	6418	61,4

KAPLAN, A. & Lopez, A. (2013) Map of the Female Genital Mutilation in Spain 2012, 2. Applied Anthropology Foundation Wassu-UAB, Bellaterra. p.29

Graph: Territorial distribution of the female population from countries where FGM is practiced



KAPLAN, A. & Lopez, A. (2013) Map of the Female Genital Mutilation in Spain 2012, 2. Applied Anthropology Foundation Wassu-UAB, Bellaterra. p 30

4. Legal framework

4.1 Internacional Legal Framework

The UN and other international organizations

The UN promotes the elimination of female genital mutilation through various agencies that must be emphasized: The United Nations International Children´s Educational Fund (UNICEF), the World Health Organization (WHO), the United Nations Population Fund (UNFPA), The Committee on the Elimination of Discrimination Against Women (CEDAW) and the Commission on the Status of Women (CSW). It is remarkable the cross-working functionality of them all.

At the **UN World Conference on Women held in 1980** in Copenhagen, urgent measures were called for to combat traditional practices harmful to women's health. It was driven by the growing demand from African women´s associations for more attention to be paid to these practices.

In 1984, the UN Working Group on Traditional Practices Affecting the Health of Women and Children is created.

The United Nations launched a policy on FGM in 1990 through **General Recommendation No. 14 of the CEDAW Committee**. Since 1992, the term 'mutilation' that appeared in Recommendation 19 from the CEDAW about violence against women[18]. This Recommendation emphasized the health aspects but pointed out that the inequality between women and men and discrimination were determining factors for FGM.

The **Declaration in the Elimination of Violence Against Women**, was adopted by the United Nations in Vienna, in December 1993. The international community accepts the existence of this universal phenomenon of domestic violence which affects only women, violence is recognized in both public and private areas as a concept in the importance to treat the problem. Article 4 declares that member states must not invoke any custom, tradition or religious considerations in avoiding their obligations to eliminate violence against women.

[18] *Committee on the Elimination of Discrimination against Women (CEDAW)*
- General Recommendation 14 (1990)
- General Recommendation 19 (1993)

Legal and Social Commission on the Status of Women (CSW)
- Ending female genital mutilation (Resolution 51/2 of 2007, E/CN.6/2007/9)
- Ending female genital mutilation (Resolution 52/2 of 2008, E/CN.6/2008/11)
- Ending female genital mutilation (Resolution 54/7 of 2010, E/CN.6/2010/11)

The **Declaration and Platform for Action in Beijing**, which emerged from the Fourth World Conference on Women in 1995, contains a clear condemnation of FGM as a form of violence against women, and affirms the duty of member states to take measures to reduce this type of violence.

The **UN Convention on the Rights of the Child** was the first binding document addressing harmful traditional practices as a violation of human rights and commits governments to "*take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while the child is in the custody of the parents, legal guardian or any other responsible person*" (Article 19).

A new declaration with the support from more UN agencies advocated an increase in the activities which promote the abandonment of FGM was published in February 2008.

The declaration of 2008, documents data about the practice gathered over the previous ten years. It highlights the acknowledgement about the expanding legal dimensions and the link with human rights and provides data on its scope and frequency. Also, research into the causes of its persistence, how to stop it and its adverse health effects on women, girls and infants are summarized.

The reports of the Secretary-General on ending female genital mutilation, prepared in accordance with the resolutions 51/2 and 54/7 of the Commission on the Status of Women (CSW), and more recently in 2014, the report on increasing global efforts to eliminate female genital mutilation, expose fundamental issues about FGM considered by intergovernmental bodies and the bodies of Human Rights Treaties, provide information on measures taken by Member States and the activities undertaken by the entities of the United Nations system to end this practice, also making recommendations on the basis of experience and good practices in this area for action in the future.

In December 2012, the United Nations General Assembly unanimously adopted a resolution that prohibits the practice of FGM.

In July 2013, UNICEF published its report "Mutilation/ ablation: statistical summary and exploration of the dynamics of change"[19] It is the most comprehensive collection of data and analysis on this issue to date.

[19] The 29 countries represented in the report are: Benin, Burkina Faso, Cameroon, Chad, Ivory Coast, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Central African Republic, United Republic Tanzania, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda and Yemen.

INTERNATIONAL GENERAL FRAMEWORK. Main declarations and resolutions

- Joint declaration WHO/UNICEF/UNFPA (1997)
- The elimination of female genital mutilation. An interagency statement of OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO (2008)

UN General Assembly

- Intensification of global efforts to eliminate female genital mutilation. 67/146 of 20 December 2012
- Intensification of global efforts to eliminate female genital mutilation. 69/150 of 18 December 2014

Secretary General Reports

- Ending female genital mutilation. Report of the Secretary General, 52nd session of the Commission on Status of Women, 25 February to 7 March 2008.
- Eradication of Female Genital Mutilation. Report of the Secretary General. Commission on the Status of Women (CSW) - 56th session, 29 February to 9 March 2012. (E/CN.6/2012/8).
- Intensification of global efforts to eliminate female genital mutilation. Report of the Secretary General.2014. General Assembly. 69 session.

High Commissioner Study on Human Rights

- Thematic study on the issue of violence against women, girls and the disabled. Report of the Office of the United Nations High Commissioner for Human Rights, 30 March 2012 (A / HRC / 20/5)

African Union

- African Union Protocol to the African Charter on Human and Peoples' Rights regarding the Rights of Women in Africa, "Maputo Protocol". 11 July, 2003.

While certain groups and countries have almost completely abandoned female genital mutilation is still common in many others despite the dangers to health of girls, the existence of laws against the practice and the efforts of governments and NGOs directed to persuade communities to end it.

Although the level of support has fallen, **millions of girls are still highly exposed to this risk**. The UNICEF report emphasizes the difference between personal opinion on genital mutilation and **a strong sense of social obligation** which favours continuity, and then compounded by a lack of open communication about such a sensitive and private subject like this.

The report is based on surveys conducted in the 29 countries in Africa and the Middle East where mutilation persists. They show that, at present, girls are less likely to suffer this practice than 30 years ago, and that support for the mutilation is declining even in countries where the incidence is nearly universal, such as **Egypt and Sudan.**

According to surveys in which the UNICEF report was based, not only girls and women are against the practice. In fact, a significant number of men and boys oppose it. In three countries - Chad, Guinea and Sierra Leone more men than women want an end to female genital mutilation.

Although the report welcomes laws against female genital mutilation which has been adopted by the vast majority of countries where it is practiced, it urges action to complement legislation and build on the positive social dynamic for change in social norms.

The report recommends subjecting the practice of mutilation be put to greater public scrutiny and question the misperception that "everyone else" approves it. It also highlights the role of **education** in social change, and notes that the daughters of mothers with higher educational levels have a lower risk of becoming victims of the practice. It also points out the fact that school attendance helps girls build relationships with others who oppose genital mutilation.

The report exposed several **crucial aspects to eliminate female genital mutilation**:

- *Working with local cultural traditions*, and not against them, recognizing that attitudes and the acceptance of this practice vary between groups within and beyond national borders.
- *Seeking to change individual attitudes* related to genital mutilation and at the same time tackle ingrained notions about this practice existing in larger social groups.
- Finding ways to make the hidden attitudes favouring the abandonment of the practice more visible, so *that families know they are not alone*-a crucial step in creating a critical mass and generate a chain reaction against genital mutilation.

- Increasing exposure of groups that still practice the mutilation to groups that have already abandoned it.
- *Promoting* both the *elimination of female genital mutilation as improving the conditions of life and opportunities for girls,* instead of defending less drastic forms of this practice, as "symbolic" circumcision.
- *Continuing to collect useful data to guide public policies and programs,* as an essential part of efforts to eradicate female genital mutilation.

In October 2013, the United Nations Fund for Population Activities (UNFPA), together with UNICEF, promoted the holding of an international conference on FGM held in Rome from 22 to 25 October, which was attended by Spain. The overall objective of the Conference was the consolidation of the global high-level political commitment, momentum for national action and planning of specific strategies to strengthen broad-based social movement that seek to eradicate FGM and discriminatory practices carrying into the next generation.

> "Mutilation/ female genital mutilation is a violation of girl´s rights to health, well-being and self-determination ... This report clearly shows that laws alone are not enough .... Now the challenge for girls and women, children and men, is to give their opinion fearlessly and let it be known that they wish this harmful practice will be eradicated".
>
> (Geeta Rao Gupta, UNICEF Executive Deputy Director)

WHO

In 1979, the World Health Organization (WHO) organized a seminar in Khartoum (Sudan), where patterns of international initiatives on FGM were set for the first time. Among its recommendations: was the adoption of clear national policy, the creation of committees to coordinate the activities of various government agencies, the adoption of laws and the organization of public education and work with specific sectors involving health professionals and traditional healers.

Some time ago, the World Health Organization (WHO) tackled female genital mutilation with the perspective of the right of women and girls to enjoy the highest attainable standard of health and establishes that "*Female genital mutilation is a Public Health problem, all women and girls have the*

right to enjoy the highest possible level of health".

In 1997, *The WHO issued a joint statement with the United Nations International Children´s Education Fund (UNICEF) and the United Nations Population Fund (UNFPA)* against the practice of FGM.

Since 1997, efforts have been made to combat FGM through research, working with communities and the change of public policy.

In 2008, the World Health Assembly approved a *resolution (WHA61.16)* on the elimination of FGM, in which the need for concerted actions among all sectors was stressed – health, education, finance, justice and women´s matters.

In 2010, the WHO published a global strategy in collaboration with international organizations and other UN agencies, *Global Strategy to Stop Performing Healthcare Providers from Female Genital Mutilation*, to end female genital mutilation for health care providers.

The WHO is particularly worried about the growing trend in the participation of medically trained personnel practicing FGM in the countries of origin, mostly due to a wrong answer as an alternative to this practice which is so detrimental for the health of girls and women, is done in complete and with an utter lack of hygiene and safety. WHO strongly urges health professionals not to perform these procedures.

Progress at both the international and local level includes:

- broader international participation in the elimination of FGM;
- the creation of international monitoring bodies and resolutions that condemn the practice
- the review of legislative framework and growing political support for its elimination (it highlights the passing of laws against FGM in 22 African countries and in various states of two other countries also in 12 industrialized countries with immigrants from countries where FGM is practiced);
- most countries notice a decrease in the practice of FGM and an increase in the number of men and women from affected communities who are in favour of its elimination.
- Research shows that, if practicing communities themselves decide to abandon FGM, the practice can be eliminated very quickly.

WHO activities to eliminate FGM focus on:

- *promotional measures:* the development of tools and publications that encourage international, regional and local efforts to end FGM within a generation;
- *research*: the acquisition of knowledge about its causes and consequences, how to eliminate it and care for those who have

suffered from it;

- *guidance for health systems:* developing training materials and guidelines for healthcare professionals to help them attend to and counsel women who have undergone these procedures.

It is worth noting that there is only one example of guidelines about treatment information which was developed in Austria in 2008.

Pre-emptive work is, as stated by CEDAW[20], an obligation for all States. It can be fixed in awareness-raising initiatives in the development of teaching materials or training professionals.

Currently, resources are scarce and long-term projects can not be implemented. Some states, such as, in Sweden, in the Netherlands or in Italy, they strongly support the work and collaborate with NGOs in this field. A serious commitment from the State in supporting civil society is required if we want to combat FGM.[21]

In May 2014 the 67th World Health Assembly was held, in which Spain participated. In particular, it pushed for the adoption of resolution A67 / 22, "Facing the global problem of violence, particularly against women and girls" which addresses the role of the healthcare system in facing this issue. In the draft resolution, FGM is seen as one of the forms of violence that must be studied from the point of view of the health system, providing figures, analyzing the causes of this practice and the legal framework and also stressing the importance of developing empirical base and cross and multisectoral action in this area.

WORLD HEALTH ORGANIZATION (WHO)
http://www.who.int/topics/female_genital_mutilation/es/

- **Resolution WHA61.16** on Female Genital Mutilation approved by the 61st World Health Assembly on 24 May 2008.
- **Global strategy to eliminate the various forms of female genital mutilation** practiced by health care providers (2010).

[20] The CEDAW is the Convention on the Elimination of All Forms of Discrimination Against Women adopted on 18 December 1979 United Nations General Assembly

[21] Female Genital Mutilation in the European Union and Croatia: Report. European Institute for Gender Equality, (EIGE, 2013)

European Council

The European Council[22] included FGM to the agenda in 1994.

Resolution 1247 (2001), on Female Genital Mutilation[23] recognizes that this practice has become common among Member States of the European Council, in particular among immigrants.

The European Council considers FGM as an inhuman and degrading treatment it is included in the European Convention on Human Rights, in particular in its third article.

In this context, it highlights the of the European Council Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), opened for signature since 11 May 2011. Spain has placed the Instrument of Ratification of the Convention on April 11, 2014, having been published in the BOE on 6 June 2014.[24]

Ratification by Spain has meant that the Convention shall enter into force generally to all signatory States and in particular for Spain on 1 August 2014, as the minimum number of 10 member states of the European Council to ratify it has been achieved, as stipulated in Article 75 of the Convention.

The following countries have ratified the Convention **as of 14 January 2015**: Albania, Andorra, Austria, Bosnia and Herzegovina, Denmark, France, Italy, Malta, Monaco, Montenegro, Portugal, Serbia, Spain, Sweden and Turkey.

The significance of the Convention is because it is the first binding instrument within the European region/ European Council on violence against women and domestic violence.

Moreover, the Convention provides that all forms of violence against women are a crime, of which FGM is a part.

With respect to initiatives related to FGM which have been promoted by the European Council, highlights the launch on 25 November 2014, by

[22] The European Council is the regional international organization to promote, through the cooperation of the states of Europe, setting up a common political and legal area, based on the values of democracy, human rights and the rule of law. Its legal status is governed in accordance with its Statute, adopted by the founding Treaty of London in 1949 and is based in the French city of Strasbourg.

[23] Between 2007 and 2012, the European Court of Human Rights has ruled on five cases related to asylum motivated by FGM. In all cases, those interested feared being subjected to FGM if they were sent back to their countries of origin. But the Court has rejected this claim despite acknowledging the judgments that FGM violates the protection under Article 3 of the European Convention. But despite everything, these statements are a step forward in the protection of women and girls who face FGM. The Convention on preventing and combating violence against women and domestic violence (CETS No. 210) Article 38 speaks specifically about FGM and also all the other articles herein are applied (prevention, protection and prosecution apply this crime, etc...)

[24] *http://www.boe.es/boe/dias/2014/06/06/pdfs/BOE-A-2014-5947.pdf*

the European Council in collaboration with Amnesty International, the guide “Istanbul Convention: a tool to end female genital mutilation”[25]. This guide is based on the Istanbul Convention and is intended to situate FGM on the political agenda and contribute to the design of policies and measures to address this issue with greater effectiveness.

European Council

- European Council Parliamentary Assembly. Resolution 1247 (2001) Female genital mutilation (22 May 2001)

- European Council Convention on Preventing and Combating Violence against Women and Domestic Violence, “Istanbul Convention” of 11 May 2011 (CETS 210). Ratified by Spain on 11 April, 2014 and published in the BOE as of 6 June 2014.

[25] “The Istabul Convention – A tool to end female genital mutilation” Consulted, November 2014 in:
http:/www.coe.int/t/dght/standardsetting/convention-violence/brochure/IstanbulConventionFGM%20Guide%20EN.pdf

European Union[26]

The **European Union (EU)**, under the Treaty of Lisbon the area of Freedom, Security and Justice becomes competent in intergovernmental cooperation and Article 82 lays the foundation for developing the Directive on Victim's Rights recently passed.

The **European Parliament** passed its first Resolution concerning FGM in 2001 (2001/2035 (INI)). In March 2009, Parliament adopted a new resolution specifically to combat FGM in the EU (2008/2071 (INI)). Again on, 14 June 2012, the Parliament stressed the problem with a new resolution which considers the eradication of FGM an achievable goal.

Within the **Council of the European Union**, it is working in the same direction. In March 2010, the Council adopted Conclusions on the eradication of violence against women in the European Union where it was urged to establish a clear legal basis and set a plan at the EU level to eliminate all forms of violence against women.

Subsequently, on 6 December 2012, the Council adopted conclusions on combating violence against women and provide support services to victims of domestic violence. It was expressly noted, with regard to FGM, the support of the EU in all initiatives to establish measures to face this practice, in particular its cross-border aspects and considering the progress made at an international level and within the sphere of the European Council.

Later, on 5 and 6 June 2014, the Council of the European Union adopted conclusions on "Preventing and combating against all forms of violence against women and girls, including FGM." In this document, the Council urged Member States and the European Commission to develop and take effective multidisciplinary action to eliminate FGM in those places where it is practiced, ensuring the participation of all relevant people affected, especially in the areas of justice, police, health, social services, child protection, education, immigration and asylum and external actions. Also, it has urged the collection and dissemination of reliable, comparable data and periodically updated on the prevalence of FGM at the EU level and at national level where FGM is practiced; promotion of training activities for professionals in the field and to ensure access to specialized help services for women and girls. Finally, to emphasize the need, underlined by the Council to provide clear guidelines at national level to ensure the benefits of international protection to women and girls at risk of FGM with the aim of establishing a uniform status for persons

[26] Study-Based on the Report by EIGE in 2012 with a total of 27 Member States (including Spain) and Croatia called "Female genital mutilation in the European Union and Croatia". Consulted during 2013 and 2014 on:
http://eige.europa.eu/content/document/female-genital-mutilation-in-the-european-union-and-croatia-report

with refugee status or those susceptible to be beneficiaries of subsidiary protection[27].

Regarding the **European Commission** it must be emphasized the Communication from its own Commission to the European Parliament and the Council, "towards the elimination of female genital mutilation" (COM (2013) 833 final), filed 25 November, 2013. This document is the first real political commitment of the European Commission with specific measures in eradicating FGM in the EU. The most prominent objectives mentioned are a better understanding of FGM in the EU, promoting effective prevention and supportive measures for victims, including the rules of social change and the "empowerment" of women, support the implementation of laws prohibiting FGM, ensuring protection for women at risk within the existing EU legislative framework on asylum and, finally, promoting the elimination of FGM worldwide, improving the protection of women at risk in countries outside the EU.

As for the participation of Spain in FGM initiatives promoted by the EU, it emphasizes the role of the Ministry of Health, Social Services and Equality, through the Government Delegation for Gender Violence (DGVG), in the 8th Rights of Children Forum, organized annually by the European Commission (Brussels - December 2013).

In this edition, it discussed the operation of child protection systems with the cases, among other circumstances, of FGM. The DGVG presented the Spanish policy in FGM during the session entitled "The role of childhood protection systems to protect children from violence - FGM", it also stresses the sharing of experiences, information and best practices in this area.[28]

In relation to the legislation of EU countries, it is worth noting that Sweden was the first European country to adopt specific legislation to FGM in 1982, followed by the United Kingdom in 1985. On the other extreme, Ireland and Croatia have developed specific provisions in their criminal codes on FGM.

[27] Other initiatives of the Council are the Strategic Framework Plan of the EU, and the Action Plan on Human Rights and Democracy adopted by the Foreign Affairs Council in June 2012, expressly refers to FGM and demands develop initiatives against it before 2014 and directives 2003/9 / EC (on minimum standards before the application for asylum); 2004/83 / EC (on the refugee status of third-world country nationals or stateless persons); the 2005/85 / EC. (on procedures for granting or denying refugee status); and 2011/95 / EU (on the international protection of third-world country nationals or stateless persons)

[28] You can consult more information about the VIII Forum on the following link: *http://www.msssi.gob.es/ssi/violenciaGenero/laDelegacionInforma/pdfs/ForoInfancia.pdf*

Only nine EU countries, including Spain, have specific legislation for FGM (Austria, Belgium, Cyprus, Denmark, Ireland, Italy, Sweden and the UK).

4.2 National legal framework

In Spain, genital mutilation in any of its forms, is a crime of injury. Article 149.2 of the Organic Law 10/1995 on 23 November, of the Penal Code (as amended by Organic Law 11/2003) provides that *"Whoever causes another genital mutilation in any of its forms will be punished by a prison sentence of six to 12 years. If the victim is a minor or incompetent person, a penalty of specific disqualification from exercising parental authority, guardianship, custody or foster care for a period of 4 to 10 years shall apply, if the judge considers it appropriate in the best interests of the minor or incompetent person."*

Spanish jurisdiction is competent to prosecute genital mutilation performed both in Spanish territory and outside the national territory (extraterritorial persecution). In this latter case, under the provisions of Article 23.4 of the Organic Law 6/1985 of 1 July, of the Judicial System (as amended by Organic Law 1/2014 of 13 March), Spanish jurisdiction is competent to know about genital mutilation performed by Spaniards or foreigners outside the national territory when the specified conditions in this article are met. Specifically, when the criminal case is directed against a foreigner who habitually resides in Spain; when FGM is practiced on a person who, at the time of its completion, had Spanish nationality or habitual residence in Spain, provided that the person who commits the offense (the FGM) is charged in Spain.

The statute of limitations to prosecute this offense is 15 years from the date the mutilation was performed.

As female genital mutilation is a crime, it has to be taken into account the provisions of Article 262 of the Criminal Procedure Act:

"Those who by reason of their position, profession or occupations have information of any public offense, shall be obligated to report it immediately to the public prosecutor, a competent court, a judge and, or failing that, to the nearest municipal police station or police officer, if it were a flagrant crime."

Furthermore, Article 355 of this Act explicitly mentions the obligation of the medical professionals in this regard:

"If the criminal event causes the formation of any injuries which require doctors to attend to the injured, they shall be obligated to give their statement."

In Spain, **the medical staff has a legal obligation to inform the judicial authorities of the possible existence of a criminal act.**

Moreover, since FGM is usually practiced on minors, **it should be known the provisions of the Law on the Legal Protection of Minors** (Organic Law 1/1996 of 15 January, partially amending the Civil Code and the Civil Procedure Act), that would be applicable in risky situations in the practice of FGM or when a minor has already been performed.

Article 12.1 provides that the protection of children by public authorities will take place by preventing and repairing dangerous situations, with the establishment of appropriate services for the purpose; exercising custody, and in cases of abandonment, the assumption of guardianship by the appropriate public legal entity.

Article 13.1 provides that any person or authority, especially those whose profession or function, detect a situation of risk or potential neglect of a minor, shall inform the authorities or their immediate agents, without prejudice to lend the immediate assistance needed.

And Article 14 states that the authorities and public services have an obligation to pay immediate attention to the needs of any minor, to act, if applicable in their area of competence or otherwise transfer the minor to the relevant body and to present the facts to the legal representatives of the child, or when necessary, the Public Prosecutor.

Moreover, the Common Protocol for Healthcare Action against Gender Violence 2012, approved by the Interterritorial Council of the National Health System, at its meeting on 20 December 2012, replaces the one approved by the Joint Interterritorial Board of the National Health System in December 2006, includes several references to female genital mutilation.

Specifically, it includes, among other forms of violence against women that can arrive for a health consultation, is female genital mutilation. These forms of violence are also gender violence but because of its special characteristics require a specific protocol.

Finally, the Plenary Childhood Observatory, a body in the Secretary of State of Social Services and Equality, has adopted at its session on 9 June 2014, the **basic protocol for interventions against child abuse in the family**, which updates that of 22 November 2007, including cases of child victims in gender violence and therefore other forms of violence against girls such as female genital mutilation.

Keeping its identity as the framework protocol for joint and integrated action protocol is susceptible to its development in each Autonomous Community.

In virtue of it the agencies involved are committed to, among other things, "Incorporate and use the reporting and detection worksheets of child abuse as one of the basic tools for its implementation. These notification worksheets do not replace, but complement, the procedures already in place (injury reports, police inquiries, complaints, etc...)"

4.3 Regional legal framework

At the regional level there are various Autonomous Communities that have included FGM in their regulations; for equal opportunities between women and men, and against violence on women, or in their own legislation regarding children.

Up to now, two autonomous communities, Valencia and the Generalitat of Catalonia, have included references to FGM in their own child protection laws:

- The Law in the Community of Valencia 12/2008 in 3 July, provides comprehensive protection of childhood and adolescence, in Article 9.1 that states the Government shall take appropriate measures to protect the physical and mental integrity of children facing situations of mistreatment, abuse, violence, threats, and genital mutilation.
- The Law from the Autonomous Community of Catalonia 14/2010 in May 27, of the rights and opportunities in childhood and adolescence, Article 76 regulates the prevention of ablation or genital mutilation in girls and adolescents; Article 102.2 considers the risk of suffering genital mutilation, according to the effects of the measures corresponding to the Autonomous Community, as a risk situation.

In turn, several Autonomous Communities have incorporated references to FGM in their regional laws for equal opportunities and in violence against women:

- The Law from the Autonomous Community of the Canary Islands 16/2003 of 8 April, of the prevention and the comprehensive protection of women against gender violence, includes in Article 3, relative to forms of gender violence, FGM.
- The Law from the Autonomous Community of Cantabria 1/2004 on 1 April, Comprehensive Law in the Prevention of Violence Against Women and Victim Protection, it also includes in Article 3, relative to forms of gender violence, FGM.
- The Law from the Community of Madrid 5/2005, dated 29 September, of Gender Violence, includes any forms of FGM in its scope of application. Article 7.4 states, the Community of Madrid shall, in

collaboration with the municipalities in its territory, create a specific protocol for detecting and preventing situations in risk of genital mutilation. In addition, Article 29 provides that the Community of Madrid will exercise the popular actions in criminal proceedings as a result of genital mutilation.

- The Law from the Autonomous Community of Aragon 4/2007 on 22 March, of Prevention and Comprehensive Protection for Female Victims of Violence in Aragon, Article 2 refers to FGM as a form of gender violence against women.
- The Law from the Autonomous Community of Murcia 7/2007 of 4 April, on Equality between Women and Men and the Protection against Gender Violence in the Region of Murcia, Article 40 establishes that FGM is considered gender violence for the purposes of law.
- The Law from the Autonomous Community of Catalonia 5/2008, of 24 April, Women´s Rights to Eradicate Sexist Violence, includes female genital mutilation or the risk of suffering from it, as a manifestation of violence at the social or community level (Article 5). Article 57.3 provides that emergency attention and foster care are intended for women who suffer from FGM among other forms of violence. Substitute foster services regulated in Article 59.2, are allocated to women who have undergone FGM or are at risk of suffering from it. And Article 75 lists the measures to be taken by the regional government.
- The Law from the Autonomous Community of La Rioja 3/2011 of 1 March, in the prevention, protection and institutional coordination of material about violence in La Rioja, includes FGM as a form of violence in Article 5.
- The Law from the Autonomous Community of Valencia 7/2012, on 23 November, Comprehensive Law against violence on women in the Community of Valencia, refers to Article 3, that FGM is a manifestation of violence against women.

Finally, it is worth noting that the Autonomous Communities of Catalonia, Aragon and Navarra have developed protocols to act against FGM:

- Protocol of actions to prevent female genital mutilation, from the Autonomous Community of Catalonia in 2007.
- Protocol for prevention and action against female genital mutilation in Aragon, of the Autonomous Community of Aragon in 2011.
- Protocol for prevention and action against female genital mutilation in Navarra, in the Community of Navarra in 2013.

These include specific actions in the field of healthcare together with educational activities and social services (inter-sectoral coordination), and are directed to consider actions in both the adult women who have experienced FGM, and girls at risk, guiding the pre-travel and post-travel actions. The Autonomous Community of Aragon has incorporated into the Clinical History of Primary Care (OMI), hospitals and emergency rooms, the protocol must be followed when FGM, differentiating when it is a case of FGM in adult women, from those related to girls at risk or already mutilated. Also in the health section, including specific mediation and specific intervention for women with FGM during hospitalization for childbirth, to address the possible consequences of FGM having been performed.

The bibliography of this NHS Common Protocol contain references to existing protocols in the Autonomous Communities of Catalonia and Aragon, and in Navarra, which were consulted in its drafting.

5. Healthcare actions to female genital mutilation

Times of Intervention

> *"Health care and social services, by virtue of their proximity, accessibility and universality, are the ideal places to allow this approach to the intercultural challenge posed by new citizenship in the country."* [29]

Healthcare professionals hold a key position in the **detection, intervention and prevention of FGM**. Health care and social services, by virtue of their proximity, accessibility and universality, are the ideal place to allow this approach to the intercultural challenge posed by new citizenship in the country. In this sense, **health professionals working directly with the population at risk** (people from countries where FGM is practiced) play a key role in the prevention of FGM and could contribute to its eradication.

The actions of health professionals should be made from a **comprehensive, multi- and interdisciplinary perspective**, covering both primary and specialized care (pediatrics, pediatric nursing, family medicine, family nursing, midwifery, social work, gynecology, obstetrics, urology, psychology, psychiatry, etc...), as well as, emergency services, in order to ensure the **coordination of actions and guarantee the continuity of care** for the mutilated person and her family. It is necessary to take into account involvement from professionals in other healthcare sectors, such as admissions staff and citations.

In this section, we consider the various health actions to be performed, taking into account the **comprehensive approach in prevention and therapeutic intervention** which is required in these situations, and **the age of the person** at risk of suffering FGM or has already had it performed.

To do this, we can distinguish the following moments of intervention:

[29] KAPLAN, A.; TORAN, P.; BEDOYA, M. H. et al (2006) "Genital mutilation in Spain: prevention possibilities from the fields of primary health care, education and social services", in Revista Migraciones 19, Madrid. pp. 189-217.

1. The **confirmation** of FGM practiced in adult women
2. The existence of risk factors in young women over 18 years old who are still socioeconomically dependent on her family
3. The existence of risk factors or the **imminent risk situation to the girl**
4. The **confirmation that FGM** has been performed **on the girl**

However, we must take into account previous aspects of community prevention, the professional training and multi-professional coordination to be considered and always carried out, regardless of the situation or timing of intervention that then has to be worked on specifically.

The following describes these common previous aspects for moving forward to the specific moments of intervention according to the case.

5.1 Previous aspects: prevention, training and coordination[30]

Specific and non-specific prevention must be one of the strategic priority lines in all protection systems in order to eradicate violence against women in general and with FGM as a specific form of violence. Specific actions to develop include a wide range of options that can go from awareness, to the training and education of professionals and society in general.

There are recommendations that can be useful for any professional, whatever their field is, or in others more specific, derived from the type of services offered, for example health services. All interventions join efforts and are important to accompany and guide families toward a thinking process that leads them to a change in their initial position. Thus, the final result will depend on joint and coordinated work with a a comprehensive and multidisciplinary aspect in the fight against FGM.

Prevention is aimed, on the one hand, to **"inform-make aware"** to try ensure that the families change their attitude towards mutilation and therefore to prevent the mutilation of another girl or woman that may occur in the future. On the other hand, **"anticipate",** that is, to act before FGM is practiced in order to avoid it, so it is necessary to detect situations of FGM risk.

[30] The fundamental ideas that are reflected in this section are drawn from the recommendations offered in the Guide UNAF 2013. "Guide for professionals. FGM in Spain. Prevention and Intervention".

Therefore, preventive activity can be performed at various times:

- With the **health education activities** developed basically in the field by primary care and community healthcare.
- In general, during **scheduled consultations or under existing protocols,** for example, the program/protocol to promote children's health.
- In a **one-off** manner, either on demand or at a scheduled consultation before the girl travels to her home country. The goal is that the mothers and fathers know all the implications about this practice so they can make decisions against FGM.

Since health services constitute one of the key places for the early detection and prevention of FGM or the risk of suffering from it, it is essential and necessary to work on the **awareness and training of its professionals** to know about this serious health problem enable them to confront different situations that they may encounter and to know, at all times, what type of actions are recommended to perform.

Scope of Activities

Healthcare programs

Primary Care

- Program for women
  - Pregnancy
  - Detection of cervical cancer
  - Family Planning
- Program for children´s health
- Community Programs collaborating with schools and social service

In the case of **Primary Care**; awareness and training should encompass the whole team, both the professionals who provide health care and admissions or administrative staff.

It is important that the professionals adopt a **facilitating role**, to aid and support the family at risk from the first contact with the health system and to ensure the universality and continuity of all therapeutic and preventive interventions. This process should take into account:

- ***Networking with other professionals and organizations*** *(educational community, social work / community social services, Child Protection Departments / Public Prosecutor / Security Forces, cultural mediators, immigrant associations, NGOs)*
- **The constant recording,** (according to the criteria and procedures

of all the services) of its own activities, and those derived from coordination with other sectors/ professionals. This record, guaranteeing the confidentiality, must facilitate networking and the coordination of actions carried out with people (contacts in consultation, examinations carried out on people at risk, the monitoring and intervention with the girls, women or families at risk, etc.)

Always remember it's possible to resort to **inter-cultural** mediation if there are problems understanding those affected or at risk. The support might even be with the help of interpreters for the language barrier.

In any of the key moments and the type of intervention we have with the family that comes from a country at risk, specific strategies will be outlined, although all of them are articulated through two fundamental pillars:

- **Individual action**, directed towards the person or family at risk.
- **Networking activities,** coordinated with other professionals who have leading roles in the prevention process.

In whatever case, the priority objective in the Planning and training programs will be to educate and make the population aware:

- **Professionals involved in Primary Care:** *pediatricians and pediatric nurses, midwives, family medicine, family nursing and social workers.*
- **Professionals more involved in Specialized Care:** *medical and nursing personnel from Gynecology, Obstetrics, Urology, Pediatrics, mental health and emergency rooms.*
- **Other professionals involved:** *staff from international vaccination centers, admissions and administrative staff.*

The logical framework for action in front the FGM must to provide the backbone along the following programs:

- Childhood Health Program (CHP) / Adolescent-Youth Health Program[31]
- Preventive Activities Program for Sexual and Reproductive Health
- Women´s Program
- Prevention Program for Cervical Cancer
- International Immunization Program

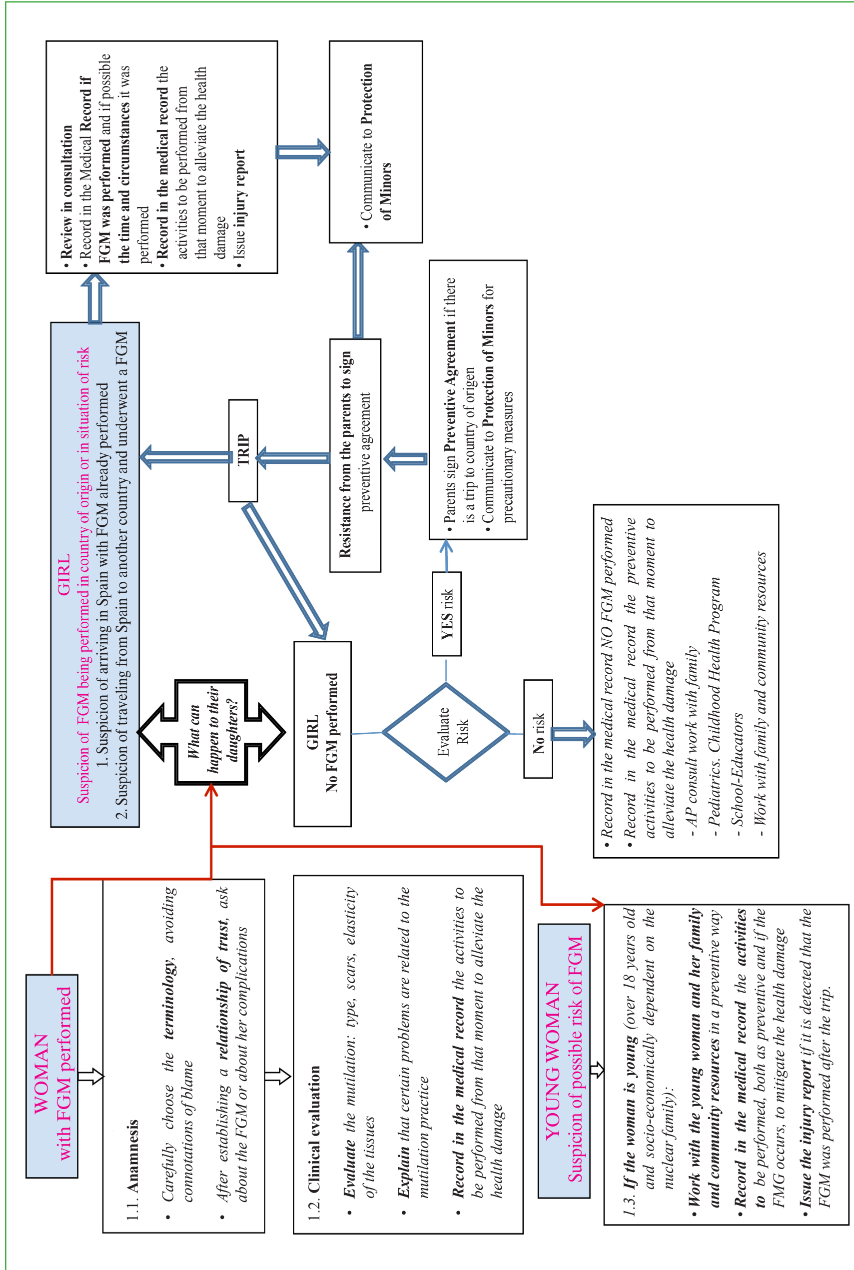
In the different actions necessary to follow in the perspective of prevention and early detection, professional teams in the health field must have information on the network of community resources to facilitate the continuity of patient care, and in cases that the risk of mutilation exists or

[31] Adolescent-Youth Health Program may exist in some Autonomous Communities / Primary Care

has occurred, be familiar with the existing tools for health notification and, if necessary, the established communication channels to inform other sectors and get agents involved (public entities to protection children, prosecutors, courts, etc.) for proper monitoring of the case, implement the necessary protective measures or prosecution if any crime exists.

Re-emphasizing the training of professionals enables them to inform and guide women in cases when they require specific care and treatments for themselves or their daughters.

And finally, coordination is necessary among the different social care systems for the purpose of being able to take effective action in the prevention and awareness of FGM.



WOMAN with FGM performed
1.1. Anamnesis
• Carefully choose the terminology, avoiding connotations of blame
• After establishing a relationship of trust, ask about the FGM or about her complications
1.2. Clinical evaluation
• Evaluate the mutilation: type, scars, elasticity of the tissues
• Explain that certain problems are related to the mutilation practice
• Record in the medical record the activities to be performed from that moment to alleviate the health damage
YOUNG WOMAN
Suspicion of possible risk of FGM
1.3. If the woman is young (over 18 years old and socio-economically dependent on the nuclear family):
• Work with the young woman and her family and community resources in a preventive way
• Record in the medical record the activities to be performed, both as preventive and if the FMG occurs, to mitigate the health damage
• Issue the injury report if it is detected that the FGM was performed after the trip.
What can happen to their daughters?
GIRL
Suspicion of FGM being performed in country of origin or in situation of risk
1. Suspicion of arriving in Spain with FGM already performed
2. Suspicion of traveling from Spain to another country and underwent a FGM
• Review in consultation
• Record in the Medical Record if FGM was performed and if possible the time and circumstances it was performed
• Record in the medical record the activities to be performed from that moment to alleviate the health damage
• Issue injury report
• Communicate to Protection of Minors
TRIP
Resistance from the parents to sign preventive agreement
• Parents sign Preventive Agreement if there is a trip to country of origen
• Communicate to Protection of Minors for precautionary measures
GIRL
No FGM performed
Evaluate Risk
YES risk
No risk
• Record in the medical record NO FGM performed
• Record in the medical record the preventive activities to be performed from that moment to alleviate the health damage
- AP consult work with family
- Pediatrics. Childhood Health Program
- School-Educators
- Work with family and community resources

5.2 Detection and intervention with women who have undergone FGM: a preventive and therapeutic approach

General preventive activity

This is the activity that aims to prevent the practice of FGM in a family with risk factors, in particular, the one in which a woman who has suffered a FGM, who has daughters or girls under her charge, or who is pregnant. This activity takes place in primary care, in sexual and reproductive healthcare services, during routine pregnancy checks and family planning consultations and in the midwife consultations. One of the most ideal times for this activity will be during pregnancy and after childbirth.

The action that is performed during scheduled visits or consultations on demand, because of subjects such as a vaginosis, urinary tract infection (UTI), etc... by both primary care and specialty care professionals. It makes it easier for healthcare professionals to establish a relationship of trust with the family which, in turn, will facilitate the gradual approach about the practice of FGM and it will allow to create an ideal framework for general preventive action.

Medical and nursing staff can provide information about the consequences on physical, mental and sexual health in the short, medium and long-term effects this practice can have and on the legal implications.

This activity can be developed in a unique way when it is addressed by the primary and/or specialty healthcare services for a woman who has had complications as a result of FGM. Although it is always better to deal with the issue calmly and through scheduled consultations.

Working in consultation

In order to identify the existence of FGM, healthcare workers, essentially in **gynecology and obstetrics, but also with family practitioners, midwives and pediatrics**, should be aware of the existence of this practice and its health consequences.

Although the first contact with the healthcare system often occurs for issues not related to FGM, women could go to the consultation for the **after effects of FGM** such as **recurrent urinary tract infections, pelvic inflammatory disease, infertility and others**. Although usually the first contact between women who have undergone FGM and the health system occurs during pregnancy, as discussed below.

It is not appropriate to talk about it during the first consultation, but to wait until you have created a **relationship of trust to guide the clinical history** towards FGM as well as its complications and after affects. The terminology should be carefully chosen, **avoiding connotations that denote blame or rejection.**

The most ideal way to address the issue of FGM is **to take advantage of the different consultations**, both during pregnancy and those made in **family planning or gynecology,** as well as consultations within the **Children´s Health Program**, or more opportunely, when women attend a first consultation about issues that may be related.

The right questions must be introduced in the anamnesis in AP (in primary care consultations), with women from these countries or ethnic groups who go to consultations for symptoms or signs that may have been produced by FGM, the right questions must be introduced in the medical history.

It is very important to work with women who have undergone FGM, because:

- The mutilated women can and should benefit, **as soon as possible** and by any measures possible, from **therapeutic action to repair the damage caused**, by any means possible in each case.
- **They themselves are an indicator of the possible risk** in cases of their own daughters or if they live with girls from the same family or ethnic group.
- They can be conveyors of this practice, so it should start an **educational and preventive appro**.

There is a work to be done in **accompanying** the woman who has undergone FGM and her family, reporting on the **impact it is having on their health** and how to alleviate it, including **her partner** due to the impact on their relationship and the serious impact on the **health of their girl**, (born or unborn) if they are subjected to this practice.

Respecting time needed in changing attitudes and approaches and overcoming the pressures from the rest of the **community of origin.** It is possible to develop **strategies in collaboration with other resources and services in the area**, adapted to their family situation and supporting their efforts to make autonomous decisions that can stop this practice in the current family context. It will be provided by **information on nearby support resources** (educational scope and specialized social entities) and about **the law and the consequences of breaking it** if a FGM is performed on any girl

their family, both within the territory of our country and on a trip to the original home country of their parents.

It would be advisable to insist on establishing a clinical relationship based on **respect for the individual** and ensuring the women's **confidentiality and privacy.**

Facing a woman of a nationality and/or ethnicity at risk, with or without symptoms or signs that make us suspect, a **medical history and examination** should be performed to allow for the detection of any possible existence of FGM. This should also be performed on their daughters.

Questions should be asked naturally like with any other health problem, choosing the appropriate terminology to avoid guilt, feelings of shame, fear, etc.

It is essential to involve individuals from affected communities. Prevention tasks are typically handled by organizations of civil society and therefore it is essential to build strong ties between them and the public administration (health, social, etc.). The centerpiece of these organizations are **support** activities, such as general public **awareness** and the **specific communities** and the **training** of professionals.

In any case, when it is found that an adult woman has undergone FGM:

- It shall be **recorded in the medical record**, as fully and comprehensively as possible, the **type** of FGM and existing **sequelae, planning and prevention** and the **care** that may be required.
- **If the woman has young daughters**, or is in charge of young girls, it **must communicated to AP/AE Pediatrics and initiate preventive activities**, exploring beliefs / feelings and inform them of the health consequences.

Collaboration with resources / services in the area is very important the social worker from a healthcare resource (specialized or primary care) get

involved as a means of liaison with community social services and NGOs.

Women

1.1 Case history
- Carefully choose the terminology, avoiding connotations that make her feel guilty
- After establishing a relationship of trust, ask about FGM or its complications

1.2 Clinical evaluation
- Evaluate mutilation: type, scarring, tissue elasticity
- Explain that certain problems are related to the practice of mutilation
- Record in the medical history

Gynecological care and family planning

Gynecological care for women with genital mutilation must take into account not only the specific physical aspects but also all the circumstances surrounding this situation that have already been exposed.

Take care with the **privacy, intimacy and confidentiality** while performing the examination, always with the **consent of the woman**.

Remember the **value of anatomical models and charts** to explain the tests to be conducted, and the relationship between the mutilation and the gynecological problems that may affect her.

Extreme care in the examination and adapting it to the anatomical circumstances.

Except in cases of severe FGM blocking access to the cervix, these women must have cervical pap smears performed as it is stated in the **screening program for cervical cancer.**

Explaining step by step with sensitivity, the necessary examinations and the different treatments required in each case.

Birth control options should be adjusted in terms of health, as in any other woman to the **eligibility criteria of the WHO**, which is respecting the choice of women and taking into account their values with respect to fertility

and her perception of her own body.

In cases of major FGM or having frequent or severe consequences, the choice of feminine barrier methods such as the female condom, diaphragm and cervical cap is not appropriate, for the obvious difficulty in its placement.

Planning and defining the surgical treatment required in each case (*see later in this Protocol, in the corresponding section*).

Regarding the **IUD, it is not indicated in cases in which visualization of the uterine cervix is difficult or impossible**, or if the woman suffers from **frequent vaginal infections.** It can be offered after deinfibulation.

Natural methods, such as symptothermal and/or the cervical mucus method may be difficult to get into effect, as much for the training and self-knowledge that is needed, as for the possibility of a **modification of vaginal discharge by the increase of vaginitis in these women.**

Care during pregnancy

The consequences of FGM are harmful, not only for women. It causes childbirth deaths in two of every hundred babies born in their countries of origin.

Controlling the gestation must be established in **each health area**.

Planned activities will be conducted in these types of consultations in their Autonomous Community and with all cases following the general criteria set out in the **Strategy for Reproductive Health at the National Health System (NHS)** and established guidelines for its development[32].

It is always fundamental to count on the help and support of the partner. Depending on support networks, that the women have the collaboration with some woman from the community or cultural mediators can be valuable. In cases of difficulties with the language, these last two, can be of great help to facilitate some person as an interpreter if the healthcare provider does not have this service. Due to a lack of knowledge that these women may have of the normal protocols in our environment, it is necessary **to explain** every necessary action or intervention.

During the visits of pregnancy monitoring it is fundamental to communicate the necessary health care information about pregnancy. In some societies there are cultural traditions concerning food during pregnancy. They must always be asked about this in order to advise in this regard, making a specific emphasis on the need to follow a proper diet during pregnancy.

Different strategies can be used to address the issue of FGM, not only in terms of health and care, but also in the very important fact about the expectations and attitudes of women and their communities in terms of continuing the practice on girls.

Obstetric examination and evaluation of FGM

Among women in which the existence of FGM is suspected, the first visit may not be the most suitable to carry out the gynecological examination. This examination may be carried out in subsequent visits, in a way that the woman has greater confidence with us.

[32] Strategy for Reproductive Health at NHS and related documents on: *http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/e02_t04.htm*

In light of suspicions FGM, **the first visit of pregnancy monitoring is not the best time to carry out the gynecological examination.** This examination can be done at subsequent visits so the woman has greater confidence with the attending team.

We must be **especially careful in the handling of the genitals**, especially when we find major secondary effects that make certain examinations difficult and sometimes impossible certain examinations.

Explaining every step of examination to the woman. After observing the external genitalia, to verify the integrity of the clitoris and the existence or not, of the labia minora.

Sometimes it can be difficult to recognize the existence of a mutilation, especially in type I (*See Section 1.3 Types, in this Protocol, by the classification of the WHO 2013*).

When there is extensive scarring or serious mutilations, it is possible that the vaginal introitus, the perineum and even the lower third of the vagina are stenosed or rigid, which sometimes blocks both the introduction of the speculum as well as two-handed examinations, representing a problem of major or minor importance at the time of delivery.

It is at this time when **the necessary interventions should be planned with the woman**, not only in facing childbirth, but rather in a **comprehensive manner about their sexual and reproductive health.**

The clinical history must be recorded, in the most complete and comprehensive manner possible. Including the type of FGM and any existing sequelae, as well as the planning and the care that is required.

This will avoid any unnecessary examinations in the future. In addition, the information will be fundamental when it comes to certain procedures that may be difficult in these women, such as urethral catheterizations or transvaginal ultrasounds.

It is also necessary at this time, **to find out the intentions and expectations of the woman about FGM in cases where she has a daughter**, informing her of the serious **health, emotional, psychological and social consequences** it would have in performing this practice **on her daughter/s** and making sure she knows about Spanish legislation and the legal consequences for her and her partner as the parents of the girl.

In case of **detecting the intentions of performing FGM on their daughters it is a priority to know** about it and launch **coordinated actions with other agents and resources in the area** (health, social, educational and the existing community) to work on awareness and in changing attitudes, supporting the woman and her family in the preventive process of FGM.

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Treatment of the sequelae of FGM in pregnant women

Some of the complications from FGM must be treated when they appear, according to the protocols, clinical guidelines and with suitable treatment for each of the processes. Special care must be observed in the **detection and early treatment of recurrent urinary tract infections** due to its importance during gestation.

If the woman has repeated vaginal infections it is necessary to take vaginal cultures in order to identify the germ, establish specific treatment, and if necessary, treat her partner and monitor developments, since in some cases these infections can progress to vaginal and/or vulvar abscesses requiring surgical drainage despite antibiotic treatment.

In those cases where **vulvar or vaginal cysts**, or **extensive keloid scars** are detected, they should refer the woman **to a level of specialized care**.

Care after childbirth

Puerperium checks will be the norm both during hospitalization and in the home.

Communication between the team of professionals involved in care is crucial. They must be informed if any type of reconstructive surgery or deinfibulation (see the relevant section of this Protocol) has been performed, and the anatomical and functional changes involved.

Continuity of care and tracking clinical evolution are essential. Explaining the importance of **hygiene and how to do it properly**.

It is necessary to adapt cures, according to the state of the perineum and tears occurring during delivery. It should provide guidance on the proper care and **recovery exercises for the pelvic region.**

Likewise, it is necessary to advise on the initiation of **sexual relations** depending on the clinical progress of every woman:

- Waiting 4 to 6 weeks, unless adequate healing occurs sooner.
- Using an adequate contraception method.
- The use of a vaginal lubricant may be advised.
- Involve the partner in information and advice, explaining the changes that they are going to perceive.

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Discharge reports of the mother should be complete and clear about the **diagnosis**, the interventions carried out and the exact **care**. The women operated on should have an appointment to be reviewed in the same unit in order to verify the evolution and results.

If a girl is born, the discharge report must reach the pediatrician and primary care team, to continue with the follow up and in the necessary awareness-raising and prevention actions.

Both pediatrics and the rest of the primary care team must know if **preventive efforts** have been made with the mother and what is the positioning attitude of the mother's family about FGM.

The **puerperium period** and the various health actions must be taken advantage of to **reinforce the information** addressed to the parents about the various **consequences** for their daughter in performing a FGM and the **legal repercussions**.

In the case of Type III FGM, insisting on the positive aspects that deinfibulation has for the woman, for the couple, giving psychological

support. The healthcare professionals must not only focus their speech on the negative aspects. **Highlight the positive aspects that may exist in relation to birth in their culture**, such as **breastfeeding or family support.**

Obstetric and postpartum complications

Since the publication of the multi-centric study conducted in several African countries by the **Study Group of the WHO on female genital mutilation and the obstetric results (The Lancet, 2006)**, we know that women who have undergone genital mutilation have a clearly higher probability of obstetric complications than those who have not. It also seems that the risk and severity of these complications increases how much larger the mutilation is.

In the countries of origin they show a high rate of perinatal mortality during and immediately after birth because of complications. This is mainly due to FGM, especially in the case of type III FGM.

This data is of great interest to make the general public, families, women from at risk ethnic groups, and healthcare professionals aware of this matter, although we know that the reality in our health care system is not the same nor the mortality data.

Complications at the moment of childbirth
The rate of intrapartum fetal mortality / neonatal mortality is also much greaterr
- 15 % greater in cases of FGM I - 32% greater in cases of FGM II, and - 55% greater in cases of FGM III. - It is estimated that in the African continent the practice causes between 10 - 20 additional deaths of babies per 1000 births WHO published in Lancet
Complications at the moment of childbirth FGM type III relative to other types
- Greater need for cesarean, 30% more - More postpartum hemorraging, 70%more - More resuscitation of children, 66% - High probability of prolonged hospitalization - Increase in the number of episiotomies, especially in type III mutilations - Higher maternal mortality WHO published in Lancet

The WHO study considers serious complications during childbirth, as the need to:

- perform a caesarean section
- have heavy post-partum bleeding
- prolonged hospitalization after childbirth.

The estimates presented in this study suggest that genital mutilation may cause one or two additional perinatal deaths per 100 births among mutilated African women. Therefore, we can add the adverse obstetric and perinatal results to the list of the harmful immediate and long-term effects of genital mutilation.

This information is important for those communities of origin where FGM is practiced, both for women who have been mutilated and for future generations of women and girls who are at risk of suffering a FGM.

With respect to postpartum complications, women who have suffered serious mutilations are also exposed to significant risks after delivery such as:

- Increased incidence of postpartum uterine bleeding.
- Increased incidence of lacerations or tears in the birth canal that can cause, if not identified and properly repaired, urinary and fecal incontinence.
- Perineal infections and hematomas.
- Dyspareunia and/ or difficulty in sexual relations.
- **Obstetric fistula**.

Although the situation in the countries of destination is very different and with better health services, it is necessary that all this data is known for raising the awareness of professionals and information-awareness among families in which women have been mutilated.

Surgical treatment of the sequelae of FGM

In case of severe mutilation (infibulation) or poor healing (pseudoinfibulation, rigidity, cysts, etc.) restorative surgical interventions may be required, like deinfibulation and others.

These try to treat the impossibility or difficulty maintaining sexual intercourse without pain. The problems arising from the menstrual and/ or urinary retention and in the case of pregnancy, facilitating vaginal delivery and avoiding the risks to life of the newborn.

Treatment of **serious consequences caused by type III, IV mutilation or alterations in the scarring of type I or II mutilations**, must be addressed as soon as possible.

If the problem is not previously detected, the option will be to perform **reconstructive surgery during childbirth**.

The ideal time to do restorative surgery is before the pregnancy but, if this is not possible, the best time is at the end of the second trimester, between 20-28 weeks. This period is considered safer for performing any surgery and anesthetic procedure a and also allow the complete healing of wounds before delivery. The last and worst option for restorative surgery would be during labour, if the problem had not been detected previously.

If surgery is required it is recommended that **they are referred to the hospital of reference for CA**, so there should be proper coordination. These patients should be considered as **preferential**, this way **there is no long delay from making the decision, to perform the intervention, until its completion**. It is important that the clinical report is as complete as possible.

When we propose the need to perform reconstructive surgery to a woman, there are a few issues to keep in mind:

- The **information** about it, as much as possible, will be given **to her and her partner** so they understand the immediate and long-term benefits for their sexual and reproductive health and the reduction of risks for the newborn.
- **The intervention should thoroughly explained**, if possible with graphs or drawings. You have to answer questions that arise, stressing that in cases of a specified deinfibulation, **reinfibulation will not, under any circumstances, be performed after delivery**.
- They must be reminded and informed about the **legal aspects.**
- As with any intervention, **specific informed consent** must be obtained.
- Do not forget the **emotional and psychological aspects** that will undoubtedly arise about the deinfibulation. Offer coordinated resources available to treat them.
- Appease the woman regarding **treatment of the pain**, assuring it will be appropriate and sufficient (try to avoid the idea of re-living the mutilation).
- Offer and ensure **specific post-operative care**, in both hospital and outpatient visits.
- Thoroughly explain **the perceived changes** in terms of urination,

menstruation and sexual intercourse.

- **Reinforcing during the entire process**, to both the woman and her partner, with information about the **benefits derived from this action.**
- Ensure **privacy and confidentiality**.
- Leaving this **whole process** properly documented **in the medical records**.

Deinfibulation technique

Prior to its implementation, we must take into account everything stated above for any type of reconstructive surgery and welcome the woman and remind her of the benefits from the intervention.

The procedure can be performed under local anesthesia, but in many cases - *especially when performed before pregnancy* - women who cannot tolerate it because of unleashing painful memories, can lead to the need for general anesthesia.

If deinfibulation is performed **during childbirth**, the most convenient and safest anesthesia for the mother and baby is an **epidural**.

After a thorough cleansing of the genitals with antiseptic (do not use antiseptics in pregnant women), carefully and gently explore with a finger under the scar to assess its extent and the area to be injected, if using local anesthesia (Figure 1).

Inject local anesthesia with a fine needle at a 45º angle, injecting small doses under the skin on either side of the scar of the infibulation in a fan-shaped form (Figure 2).

Afterwards injecting anesthesia lengthwise in the thick tissue on either side of the scar and using an IM needle at an angle of 45 °.

For the incision, insert your index finger (or index and middle fingers) of the left hand through the vaginal opening toward the pubis. Using scissors to cut along the midline over the scar until the urethra is visible (Figure 3).

Graph: Deinfibulation technique.

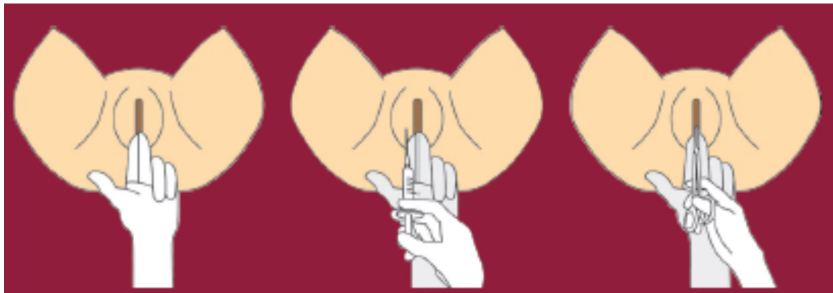

Figure 1: Exploring under the scar with a finger	Figure 2: Injecting local anesthesia in both sides of the scar	Figure 3: Cutting along the middle line

Source: Médicos Mundi (Andalucía). Guide "Female Genital Mutilation. Approach and prevention" 2009

Extreme care must be taken in this area due to the hypersensitivity of the clitoris to stimuli.

Do not cut beyond the exposure of the urethra as this is an highly hemorrhagic area.

Then, suturing both sides of the infibulation separately. Using fine, atraumatic sutures of the absorbable type.

In the event the reconstructive surgery, or deinfibulation, was not carried out prior to delivery

In this situation women, in addition to the usual uncertainty that birth causes, their fears may be increased if they think that the health professionals don´t have the expertise to adequately attend to them (unnecessary caesarean sections, etc.).

Explain in detail the **need for intervention**, the technique, as well as the **positive consequences for the development of labour, the baby's health and the very health of the woman.**

Obtaining after these explanations, **informed consent**.

It is very important to properly address the needs of **analgesia** during childbirth, as well as **limiting the number of examinations** to not cause pain.

The management during the first stage of labour will be normal. The exact steps and actions to perform the deinfibulation must be planned carefully with the professionals involved. .

Explain that infibulation will **NOT** be performed after childbirth.

The deinfibulation technique should be performed as soon as possible, once the problem is detected and after the mother is admitted to the hospital.

In the case of being in the **pushing stage**, it is recommendable **to make the incision during a contraction.**

If the mother does not have epidural analgesia, injection with local anesthetics will be assessed after the evaluation of the scar tissue. Pudendal blocking can later supplement analgesia.

- During the expulsion, perform the **front episiotomy.**
- **Midlateral episiotomy** is performed only when necessary.
- Assistance at childbirth in women who have undergone genital **mutilation** of **types I and II, assess tissue elasticity** and consider the **mediolateral episiotomy only in necessary cases, NOT systematically.**

After delivery, **suturing the front episiotomy leaving the clitoris (or remains) covered with skin**. Suturing both sides of the infibulation separately, as well as any possible tears that may have occurred during the pushing, with fine, atraumatic sutures of the absorbable type.

Also insist on emotional and psychological support for these women and meet their analgesic needs.

It is known that **fetal morbidity** - such as perinatal asphyxia and obstetric trauma- increases in women who have undergone FGM, so the **control of fetal well-being should be rigorous.**

But also in cases where the pushing is extended, due to specific conditions of the perineum and/or because of the exact interventions, we must have the necessary means for this situation to not affect the health of the fetus.

5.3 Detection and intervention with young women over 18 years old, at risk of suffering from a FGM

The general preventive activity must take into account the specific situation of those families in which the daughters are adults (over 18) but young.

It is adult daughters who have not had a FGM performed, with ages near adulthood, who live with and depend on their families. These young women may encounter a worrying situation at the time of a trip or vacation to the country of origin, or to marry because, as explained in the section on the causes of FGM, it can be an unavoidable requirement to get married.

When the medical personnel has evidence that a family with risk

factors is preparing a trip to the country of origin, a pre-emptive activity before the trip is recommended in order to prevent the FGM procedure from happening.

Specifically, medical personnel summon the girl to a scheduled consultation in which information about FGM, health consequences, legal, etc... will be provided with more or less detail, depending on whether general preventive activity has been previously carried out or not.

It also seeks to know the position of the young women about this practice and their mood in relation to it. In this consultation, a examination is performed and all actions carried out until that time are recorded in the medical record (preventive and anamnesis).

In every case, a medical visit will be scheduled for when the young woman returns from her trip.

In case a FGM is suspected of being performed during this medical examination, they will be assessed and therapeutic actions needed to remedy the consequences will be made. The type of FGM will be recorded in the medical record, the circumstances in which it was performed as well as the therapeutic actions. The relevant injury report also has to be submitted.

5.4 Detection and intervention with female minors at risk of suffering from a FGM

In the health sector it is also necessary perform tasks of identification or early detection and prevention of FGM in the population who are at greater risk and are more vulnerable, as with girls / young women under 18 years old from families where there are other women who have undergone FGM (*mother, sisters, aunts, cousins, etc...*).

It is important to start the approach process with correct identification of the girls at risk. All official documents make it clear that the practice is not confined to Africa, nor coincide with the Muslim religion.

In order to make an accurate assessment of what girls are at risk/ potential victims, training is essential for the professionals who carry out the direct care to girls, women and families.

RISK FACTORS that are known:

- **Being female and in a family from a native country** and/or ethnic group where the practice of FGM is admitted.
- Belonging to **a family in which a woman has undergone FGM.**

IMMINENT RISK / Precipitating factors:

- The immediate organization of a **trip to the country of origin** by a family with risk factors.
- The **girl informs of the expectations** of the family about the practice of FGM

A single service can not address such a complex phenomenon. There must be coordinated and systematic actions to act effectively. *(health, judicial and social services)*

5.4.1. General preventive activity

It is the activity that aims to prevent undergoing FGM in a family with risk indicators, in particular, when girls under care come from countries and ethnic groups in which FGM is practiced and from families where there are other women who have undergone a FGM (mother, sisters, aunts, cousins, etc...). This activity takes place mainly in the pediatric consultations and with primary care pediatric nurses as part of children´s health programs, as well as in family medicine consultations. Intercultural mediation can be of great support on general preventive activity to the primary care team in all actions at the community level.

The medical and nursing staff can provide information about the negative health consequences FGM can have in both the short and mid-term, as well as its legal implications. Also, during primary care consultations with the midwife, taking advantage of the visits capturing and monitor the pregnancy and the protocol for the prevention of cervical cancer.

As stated, the action that is performed during scheduled visits makes it easier for primary care professionals to establish a relationship of trust with the family which, in turn, will facilitate the gradual approach to the practice of FGM and will create an ideal framework for general preventive action.

When health professionals attend to a girl of foreign origin, belonging to a country and/ or ethnicity that admits to the practice of FGM, it is particularly important to do a routine physical examination of the genitals

within children´s health programs because it will permit to determine when the girl is attended to for the first time at the health service, whether or not they have undergone FGM, and if so, whether it was performed before the girl had come to Spain.

If FGM has not been performed, it must be recorded in the medical record that FGM does not exist and what activities, from that moment, are going to be done in the general prevention of the practice.

If a FGM has been performed, it must be recorded in the medical record, the type of FGM and, if it is possible to determine the time (whether recent or not) and the circumstances in which it was practiced. It is also recorded in the medical record the therapeutic actions taken to mitigate the consequences of the FGM. The entity of the Public Protection of Minors shall be notified.

The injury report will be issued in view of the estimated time that the FGM was performed, bearing in mind that the crime of female genital mutilation is prosecuted in Spain, in accordance with Article 23 of the Organic Law the Judicial Power, even if it has been practiced outside the national territory, provided that the procedure is directed against a Spanish person, the procedure was directed against a foreigner who usually resides in Spain or the offense was committed against a victim who, at the time of committing the acts, had Spanish nationality or habitual residence in Spain, provided that the person to whom the commission of the offense is charged to is in Spain.

5.4.2. Action before a situation of imminent risk: pre-trip preventive activity

If there is proof that a family with risk factors is preparing a trip to the country of origin, a pre-emptive activity before the trip is recommended in order to prevent the practice of any FGM activity. The trip may be imminent or short-term, and we can find out directly because some person of the family tells us or because the minor tells us about the family planning the trip and about the practice of FGM[33].

At this time networking is the key. The actions here may be more or less imminent, depending on the intended date of travel, so it is essential to have identified the professionals with whom we have to coordinate.

The ideal situation is if a general preventive action had been made previously with the family, so the potential risk had already been identified and a process had been started, and therefore some progress in the prevention had been made. This way the work is easier and the results are usually better.

[33] "Guide for professionals. FGM in Spain. UNAF prevention and intervention."

Medical personnel shall summon the girl/ young minor to a scheduled consultation, in which information about FGM, health, and legal consequences will be provided to the family with varying degrees of detail, depending on whether general preventive activity has been previously carried out or not. It is there that the state of health of the girl will be assessed. Then the medical personnel will offer the family a Preventive Agreement to sign, which consists of keeping the integrity of the girl's genitals.

The preventive agreement is a document developed for the parents of the girl / young minor, it can be utilised on the trip to their country of origin as an element supporting their decision that their daughter is not mutilated. It also reveals the position of the family to the practice of mutilation.

Moreover, their signature, and filing of a copy in the medical record, enables to have evidence for health professionals knowing of a risk situation, have conducted preventive action and informed the parents of the consequences for the health of the minor and the legal consequences that entails the practice of FGM.

If a risk is assessed (detected/ identified) that FGM is going to be performed on the trip (factors such as a family position in favour of the practice of FGM, family history or the status of the practice of FGM in the country of origin will be taken into consideration),

Ihe health professionals must inform the corresponding Public Entity for the Protection of Minors and the Public Prosecutor. That will start the process for the adoption of precautionary measures to prevent it.

In any case, a medical examination will be scheduled when the girl/ minor returns from the trip.

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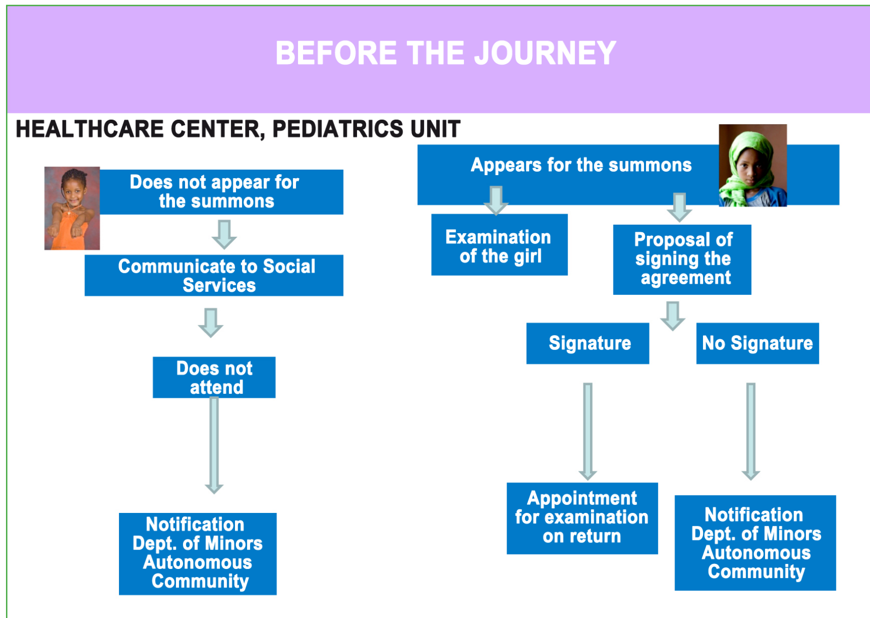


Preventive agreement[34]

The **preventive agreement** is a document developed for the girl´s parents to use during their trips to the countries of origin as a element to help in their decision to not practice FGM their daughters.

This document is intended to strengthen the commitment of the parents to prevent their daughters mutilation and relieve them from the pressures of the family environment in the countries of origin. We should note that there are gerontocratic societies, where power is held by the elderly and therefore it is difficult to question the authority of their elders.

Basic concepts

- **Obtaining** the preventive agreement is not an end in itself. It is a tool available to primary care professionals in the process of addressing FGM and support to the parents that the issue of FGM is questioned.
- The preventive agreement is **owned** by the parents or guardians of the girl and they decide what they have to do.
- The preventive agreement must have the same **protection and**

[34] All content of this specific section on the preventive agreement is directly extracted from the Application Guide of the Preventive Agreement. Wassu-UAB Foundation *http://www.mgf.uab.cat/esp/recursos_para_profesionales.html*

confidentiality as other documentation that forms part of the medical record.

- Like any agreement the acceptance must be **voluntary and mutually agreed** upon between the parties.
- The **current legal framework relating** to FGM, which defines the performance of FGM as a crime of injuries and can be prosecuted **extraterritorially** must be considered. On the other hand, the knowledge and the failure to prevent these practices may also involve legal consequences for the professionals.
- The existence of the preventive agreement is the record that **shows that the health professionals, knowing about a situation of risk, have tried a preventive approach and have informed** the parents of the consequences, both health and legal, that may result because of the realization of the FGM on their daughters. .

Implementing rules

- It should be taken into account that the **main risk situation** of suffering FGM is the **proximity to an impending trip** to the girl´s country of origin.
- Signing a preventive agreement **MUSN´T be the first element of contact between health workers and the families of girls at risk** of FGM. Is ideal that prior preventive actions exist in which they are given information about the legal and health consequences.
- Obtaining this agreement will be the **culmination of a process** that guarantees that parents have received information to allow them to make a decision and take a position in relation to the problem with respect, autonomy and knowledge of the legal environment in the host country and the country of origin.

Basically, this PROCESS should ensure the presence of the following elements:

- ***Identification/detection,*** on the part of the primary care health professionals, a risk situation for girls to undergo FGM (like parents being from a country and ethnicity where FGM is practiced, the mother has had it performed, they are traveling to the country of origin).
- Knowledge of the girl´s **family environment**[35] .
- Approach to the **cultural aspects**.

[35] The knowledge of the girl´s immediate family and social surroundings, such as neighbours/friends, or other nearby social or religious groups and the situation at school which requires action by the social worker of health services and community social services.

- **Identifying attitudes** of the father and/ or mother (at least one) towards FGM.
- Ensuring good communication and **language comprehension**.
- ***Information to fathers and/ or mothers*[36] of:***
    - *Risks and physical problems associated with the practice of FGM.*
    - *Risks and psycho-emotional problems associated with the practice of FGM.*
    - *Risks and legal/ criminal problems associated with conducting a FGM.*
- **Registration of intervention, professional healthcare reference, legal implications, an appointment for consultation after the trip.**

A copy of the preventive agreement will be included in **the clinical history,** by the professional responsible for the care of the girl. The number of interventions performed and the results can be recorded, with **regular monitoring of the case**.

It is recommended that the intervention for offering the preventive agreement is done by the **healthcare professional who regularly attends to the girl,** because it is their professional reference and enjoys the confidence of the family.

Parents/ guardians **will be informed** in writing of the date and time of the **pediatric/ medical appointment** at the Health Center, on the **return from a trip/ stay** in the country of origin.

Obtaining the preventive agreement does **not exclude or replace the other judicial measures** to take in case there is a high-risk situation, when the firm position of the family for FGM to be performed on their daughters.

[36] Its not merely about the information, a motivational interview should be conducted.

PREVENTION AGREEMENT FORM OF FEMALE GENITAL MUTILATION

From the Health Center: ……………………………………………………

This is to certify that, in the health examinations performed up until now, no alterations have been detected in the integrity of the genitals of the girl whose details are reported below.

NAME	DATE OF BIRTH of the girl	COUNTRY TRAVELLING TO

The family members or those responsible for the girl are informed about the following circumstances:

- The health and socio-psychological risks that genital mutilation presents. This practice is internationally recognized as a violation of the girl´s Human Rights.
- The legal framework of female genital mutilation in Spain, where this intervention is considered a **crime of injury** in Article 149.2 of the Criminal Code, even if it was conducted outside the country (e.g. in Gambia, Mali, Senegal, etc...) under the terms provided in the Organic Law of the Judicial Power, as amended by Organic Law 1/2014 of 13 March.
- The practice of FGM is punishable by imprisonment for 6-12 years for the parents or guardians; and a special disqualification from exercising parental custody, authority, guardianship, or foster care for 4-10 years (i.e. parents could lose parental custody and not have their daughter with them. The corresponding public entity for the protection of minors could take custody and the girl may be placed with a foster family or admitted to a center for the Protection of Minors).
- The agreement that upon returning from the trip, the girl go to a pediatric/ medical consultation at her health center to conduct a health assessment under the framework of the Children’s Health Program.
- The importance of taking all the precautionary measures on the trip that have been recommended by the healthcare professionals of Health Services.

Therefore:

- I DECLARE, I have been informed by the healthcare professional responsible for health of the girl/s, about the various aspects of female genital mutilation previously specified.
- I BELIEVE, I have understood the purpose, scope and legal consequences of these explanations.
- I AGREE to care for the health of the minor girl/ s for whom I am responsible and prevent female genital mutilation, and also attend the check-up consultation upon returning from the journey.

And for the record, I have read and signed the original of this recorded agreement in duplicate.

I will keep one copy.

In …………………………….., on ……… of …………………….. of 20……

Signature: **Mother / Parent / Guardian of the child**	**Signature:** **Doctor / Pediatrician**

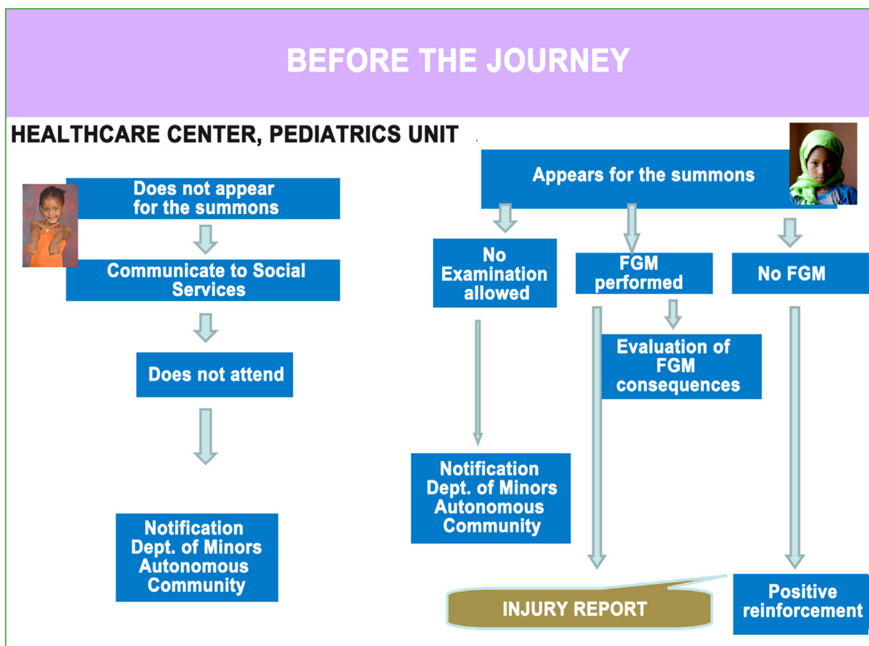
Post-trip activity

The intervention continues when the girl returns from the trip. This is done as follows depending on whether or not the family goes to the scheduled consultation:

- On their return from the trip, the family goes to the health center to attend the scheduled visit: at this time, an evaluation of the pre-trip preventive activity will take place, talking with the family about how the trip was and asking questions directly relating to the health issues of the child. A complete health examination of the minor will be conducted, including exploration of the genitals:
    - If the girl has not been mutilated, positive reinforcement shall be done.
    - If the girl has been mutilated, the nature and consequences are assessed, and the therapeutic actions needed to alleviate them will be made. In addition, an injury report will be prepared.
    - If the examination of the girl is not allowed, it will be communicated to the Public Entity for the Protection of Minors.

On returning from the trip, the family does not go to the health center to attend the scheduled visit: in this case, a coordinated action with other professionals, such as social services, will be necessary to try to locate the family and have them go to the center health.

- If the family is located, it will comprise action as in the previous case.
- If the family is not located, it will be reported to the Public Entity for the Protection of Minors.



5. 5 Detection and intervention with female minors who have undergone FGM: ethical and legal aspects

Female genital mutilation performed on a girl is a public health issue with legal implications, both for the adults who commit the act and those that allow it and also for the healthcare personnel who must report the crime, sometimes posing a ethical dilemma to the professionals in making decisions.

Along with the cases of girls who have already arrived in our country with FGM, those who were born in our country are at risk of suffering from it, and deserve special consideration because there is time to stop it..

> At the time of writing this Protocol, there doesn´t appear to be strong evidence to suggest that FGM is practiced within the European Union (EU). However, **girls and women living in the EU have undergone mutilation** in their home countries before moving to Europe or while traveling outside the borders of the EU. [37]

The ultimate goal of the intervention from the health system with women and girls who have been mutilated or are at **risk of suffering a FGM, is to guarantee the right to health and the restitution of it,** as well as the promotion of conditions for their overall recovery and the development of a life in a non-violent environment.

When there are indicators for suspicion that a girl has undergone a FGM, like the symptoms and signs associated with the consequences of this practice for health, repeated failure of scheduled consultations in Pediatric Nursing or Pediatrics, or not going to a scheduled consultation after travelling to the country of origin, it will be necessary to confirm if the FGM has been performed or not. This confirmation can only be performed by medical personnel.

Once the practice of FGM is confirmed, the health consequences will be assessed and the therapeutic actions needed to remedy them will be performed. An injury report will also be drawn up to bring the matter to the attention of the competent authorities.

[37] Female Genital Mutilation in the European Union and Croatia: Report. European Institute for Gender Equality, (EIGE, 2013)

Ethical and legal aspects

Protecting life and benefit of health (principle of beneficence), avoiding prejudices with the interventions, minimizing damage (principle of non-maleficence), the confidentiality agreement regarding the information known by virtue of professional practice and respecting the autonomy of the patient, constitute basic ethical principles for any healthcare professional when attending to the problem of FGM.

One of the most difficult and conflictive situations for healthcare professionals to face are derived from the collision of legal obligations vs. the ethical principles that govern the actions of health personnel.

This is especially true when it is necessary to issue an **injury report.** It may be considered as being in violation of professional secrecy and a possible loss of confidence for the girl, the mother or family if the girl has undergone FGM before reaching our country.

The law establishes and specifies the cases where the safeguard of confidentiality is not an absolute obligation and medical secrecy must be disclosed, as it is in any **suspicion of a crime** and in the case of being called to **testify in legal proceedings.**

> There is a **general duty to report** under **paragraph 1 of Article 262** of the Law of Criminal Procedure:
> *"Those who by reason of their positions, professions or occupations have any news of a public offense, shall be obliged to report it immediately to the public prosecutor, the competent court, the investigating judge and, failing that, to the municipal police or police officer closest to the location, if it is a case of a flagrant crime."*

Training on the important role played by professional secrecy on this issue can be definitive when protecting women and girls. The professional secrecy about the information in the performance of work is relegated to the duty to report / notify that a minor has undergone a FGM..

Professionals from Family Medicine, Pediatrics, Nursing, Obstetrics and Gynecology, Midwives and Social Workers face the **ethical problem** of correctly understanding that no violation of **professional secrecy** may prevent the application of protection mechanisms and a missed opportunity to prevent FGM. On the other hand, if the competent authorities are informed, the process that it has been doing preventively with the family whose daughters are at risk, could end with the **loss of the family trust** with

the healthcare team, and lose contact and monitoring the girl´s health, her mother and other family members.

It is important to know that the judicial system guarantees the non-prosecution of the professionals for issuing an injury report and can only be called to testify as witnesses or experts.

If necessary, it is possible to activate mechanisms to protect witnesses, including testifying behind a screen without being seen by the person allegedly responsible for the act prosecuted. (Organic Law 19/1994 of Witness and Expert Protection in criminal proceedings) [38]

When medical personnel are in doubt about genital mutilation being performed on a girl and it is not possible to verify it with the corresponding medical examination, they may inform the Public Entity for the Protection of Minors.

In any case, it is important to remember that it is necessary to request their consent to take photographs and to be recognized by the forensic team.

Injury report

If, in spite of all the prevention work with the family and all the measures taken to protect the girl and despite having signed the preventive commitment, FGM is suspected to have been performed on the girl during the medical screening upon returning from the trip and if it is found that FGM has been practiced, is necessary and essential to issue the corresponding injury report to the court, in addition to other measures of notification to the Public Entities for Protection of Minors.

The injury report will be issued in view of the estimated time that the FGM had been performed in light of the crime of female genital mutilation is prosecutable in Spain, in accordance with Article 23 of the Organic Law of the Judicial Power, even though it is practiced outside the national territory, provided that the procedure is directed against a Spanish person, the procedure was directed against a foreigner who resides habitually in Spain or the offense was committed against a victim who, at the time of commission of the offense, had Spanish nationality or resided habitually in Spain, provided that the person to whom the commission of the offense is charged to is in Spain.

[38] To do this it is necessary that once appreciated the existence of a serious danger to the person, liberty or property of the party seeking to invoke the provisions of this Law, The Investigating Judge reasonably agrees, ex officio or ex parte, when deemed necessary in response to the degree of risk or danger, the necessary measures to preserve both identities of witnesses and experts, their addresses, professions and workplace.

The injury report is a health document which is given to the judicial authority to know what professional knowledge has been revealed. **Its purpose is to inform of the possible existence of a crime**, but it is not a complaint. The Judicial authority should define the criminal aspects.

In an injury report for FGM the relevant data varies somewhat from the basic minimum information included on an injury report for other forms of violence against women.

Following are the fields of common basic data to be included in any injury report forms on FGM:

Data of the person who performed the mutilation:
- Family relationship/ connection with the GIRL (grandmother / aunt / other person from community of the country of origin / unknown person):
- Name and surname:
- Address and/ or telephone:

Data of the girl:
- Name and surname:
- DNI/NIE/PASSPORT:
- Date of birth, Age:
- Country of origin (birthplace or nationality, specify):
- Ethnicity:
- Marital Status:
- Address, City (postal code):
- Telephone:

Affiliated data of the mother:
- Name and surname:
- DNI/NIE/PASSPORT:
- Date of birth, Age:
- Country of origin (birthplace or nationality, specify):
- Ethnicity:
- Marital Status:
- Address, City (postal code):
- Telephone:

Affiliated data of the father:
- Name and surname:

- DNI/NIE/PASSPORT:
- Date of birth, Age:
- Country of origin (birthplace or nationality, specify):
- Ethnicity:

Other relevant data of the mother:
- If she has undergone a FGM:
- Type (I, II, III):
- If she has more daughters (number and ages)::

NAME	AGE

Personal / facultative data responsible for the healthcare:
- Health Center:
- Data of the professional issuing it: Name, surname and CNP:

Notification Form of risk and childhood abuse from the health sector
This form can serve as a template for the notification to the Public Entity for the Protection of Minors, confirming that the girl has been subjected to FGM (in addition to issue the corresponding injury report that will be sent to the Court).

This notification form must also be completed if upon returning from the trip, this fact is suspected, but the parents refuse to let the girl go to the relevant medical examination.

Next find the standardized template of this form[39]. Precisely in paragraph 16 it includes the mutilation, surgical removal of the clitoris, as it is stated in the form, shall specify in the paragraph, "Other symptoms or comments".

[39] Contained in the document "Child Abuse. Detection, reporting and registration of cases" from the Observatory of Children. Working Group on Child Abuse. Ministry of Health, Social Services and Equality. Consulted in May 2014:*http://www.observatoriodelainfancia.msssi.gob.es/documentos/HojasDeteccion.pdf*
IN PARAGRAPH 16 it includes the mutilation, surgical removal of the clitoris, as it recorded on said form, shall specify in the paragraph, " Other symptoms or comments"

AUTONOMOUS COMMUNITY LOGO

NOTIFICATION FORM OF RISK AND CHILDHOOD ABUSE FROM THE HEALTH SECTOR

L= Light M= Moderate G= Grave

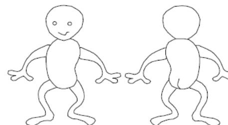
For a detailed explanation of indicators, see back side

Suspicion o

Abuse o

PHYSICAL ABUSE

- L M G Bruises[1]
- L M G Burns [2]
- L M G Bone fractures [3]
- L M G Injuries [4]
- L M G Visceral lesions [5]
- L M G Human bites [6]
- L M G Forced intoxication [7]
- L M G Shaken child syndrome [8]



Mark the location of the symptoms

NEGLECT

- L M G Poor hygiene [9]
- L M G Lack of supervision [10]
- L M G Permanent tiredness or apathy
- L M G Physical problems or medical needs [11]
- L M G Exploited, made to overwork [12]
- L M G Not going to school
- L M G Has been abandoned

Other symptoms or comments

EMOTIONAL ABUSE

- L M G Emotional abuse [13]
- L M G Physical, emotional and/ or intellectual retardation [14]
- L M G Suicide attempt
- L M G Excessive care / Overprotection [15]

SEXUAL ABUSE

- Yes Without physical contact
- Yes With physical contact and without penetration [16]
- Yes With physical contact and with penetration
- Yes Difficulty walking and sitting
- Yes Torn, stained or bloody underwear
- Yes Pain or itching in the genital zone
- Yes Bruises or bleeding in the external genitalia, vaginal or anal region
- Yes Red or swollen cervix or vulva
- Yes Sexual exploitation
- Yes Semen in the mouth, genitals or clothing
- Yes Venereal disease[17]
- Yes Pathological anal tearing [18]

Configuration of the hymen [19]_____________________________

CASE IDENTIFICATION (Check off or fill in as applicable)

Identification of the child Fatal case (death of the child) Yes

Surnames Name

Home address Locality Telephone

Sex F M Date of Birth (day day/month month/year year)

Accompanying person Father ☐ Mother ☐ Guardian ☐ Police ☐ Neighbour ☐ Other (specify)

Identification of the notifier Date of Notification (day day/month month/year year)

Centre: Service / Consultation:

Name: Health Area

Professional Doctor Nurse Social Worker Midwife Psychologist Nº Prof. License

APPENDIX

Suspicion: There is no objective data, only suspicion, which is deducted from the clinical record as not believable or contradictory, or excessive delay in the consultation.

L (Light): circumstances which require monitoring,
M (Moderate): needs support / help from health, educational, social services...
G (Grave): requires urgent intervention of social services

[1] Bruises in different stages of healing, on the face, lips or mouth, large areas of the torso, back, buttocks or thighs, not in a normal way, or grouped together or a sign or mark from the object that has inflicted it, on various areas, indicating that the child has been hit from different directions.
[2] Cigar or cigarette burns. Burns that cover the entire surface of the hands (glove) or the feet (like a sock) or fritter shaped burns on the buttocks or genitals, indicative of immersion in hot liquid. Burns on the arms, legs, neck or torso caused by having been tightly bound with ropes. Burns with objects that leave clearly defined marks (grill, iron, etc.).
[3] Fractures to the skull, nose or jaw. Spiral fractures of the long bones (arms or legs), in various stages of healing. Multiple fractures. Any fracture in a child younger than 2 years old.
[4] Wounds or abrasions in the mouth, lips, gums or eyes. In the external genitalia, on the back of the arms, legs or torso.
[5] Visceral injuries (abdominal, thoracic and / or brain). Swelling of the abdomen. Localized pain. Constant vomiting. They are suggestive of duodenal hematomas and pancreatic hemorrhages, or sensory disturbances without apparent cause.
[6] Signs of human bites, especially when they seem to be by an adult (more than 3 cm of separation between the marks from the canine teeth) or are recurrent.
[7] Forced intoxication of the child by the ingestion or administration of drugs, feces or poisons.
[8] Retinal and intracranial bleeding, without fractures.
[9] Constantly dirty. Poor hygiene. Hungry or thirsty. Inappropriately dressed for the weather or the season. Injuries by excessive exposure to the sun or cold (sunburn, freezing of the extremities)
[10] Constant lack of supervision, especially when the child is performing hazardous activities or for long periods of time.
[11] Physical problems or unattended medical needs (eg unhealed wounds or infected.) Or the absence of routine medical care: not following the vaccination schedule, or other therapeutic indications, extensive dental decay, localized alopecia, by being in the same position, flattened skull.
[12] It includes children who accompany adults that "beg", traffic lights vendors and all those who are not going to school but must be enrolled.
[13] Situations in which the responsible adult for mentoring acts, deprives or provokes chronic negative feelings for the child's self esteem. It includes continuous disparagement, undervalue, verbal abuse, intimidation and discrimination. It also includes threats, corruption, interruption or prohibition of social relations in a continuous way. Fear of the adult.
[14] Stunted growth without a justifiable organic cause. Includes psychological, social backwardness, in the language, of overall motility or in subtle motility.
[15] Overprotection that deprives children learning to establish normal relations with their surroundings (adults, children, playing, school activities).
[16] Includes mutilation, surgical cutting of the clitoris, to be specified in the part, “Other symptoms or comments”.
[17] Sexually transmitted diseases because of sexual abuse. Including non-neonatal gonorrhea and syphilis are suspicions of sexual abuse: Chlamydia, genital warts, vaginal trichomoniasis, herpes type I and II.
[18] Includes anal fissures (not always abuse), scars, bruises and warts are highly suggestive of sexual abuse. Tears in the anal mucosa, changes in color or excessive dilatation (> 15 mm, explored the in lateral decubitus of the anus, especially with the absence of feces in the rectal ampulla). The presence of genital warts is highly suggestive of sexual abuse.
[19] Normal, Imperforated

The information contained herein is confidential. The aim of this form is to facilitate the detection of abuse and enable care.
The information provided herein will be computerized with the guarantees established in the Law:

- Organic Law. 15/1999, of 13 December, of the Protection of personal data.
- Directive 95/46 EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and the free movement of such.
- Royal Decree 994/1999 of 11 June by which the regulation of security measures for automated files containing data of a personal nature.
- Relevant laws of the Autonomous Communities regulating the use of information technology in the processing of personal data.

2

Instructions for using the Notifications Form

This instrument is a questionnaire for the reporting and collection of information on cases of child abuse and neglect. This questionnaire is not a diagnostic tool but a standardized notification form of evident or supected cases abuse that may appear in our consultations.

In using the questionnaire cross out with an "X" all the symptoms you have evidence of, or it´s presence is suspected, fill in the identification form and send the questionnaire by mail.

The questionnaire consists of an inventory of symptoms, a figure, an anatomical drawing, a box for comments, an explanatory legend of the symptoms and a section of case identification.

Suspicion
Abuse

The inventory of symptoms is broken down into sections on typologies. These are: symptoms of physical abuse, symptoms of neglect in the treatment of the minor, symptoms of emotional abuse and symptoms of sexual abuse. It is worth noting that ***the symptoms are not mutually exclusive***. It will often be necessary to use one or more indicators of the different sections of symptoms to outline the case.

The first section to be filled in is in the upper right corner. This box must be crossed if this is a ***clear case of abuse*** or if there is only a ***suspicion*** that abuse exists. In the legend a definition can be found of what is suspected.

The inventory of symptoms serves as a guide to remember the most common symptoms of abuse. It is possible to choose several indicators for each and every one of the sections. The indicators are not mutually exclusive.

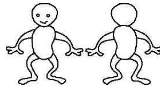
In the first three sections (physical abuse, neglect and emotional abuse), you can choose the degree of severity of the symptoms. The severity is indicated by crossing out the "L" if it is light, the "M" if it is moderate and the 'G' if severe. If there is only suspicion, the pertinent symptoms should be reported as light.

In the section on sexual abuse, those indicators for which there is evidence or having suspicion of their presence must be crossed. Frequently, it will be that indicators of sexual abuse appear associated with symptoms of emotional abuse. When relevant, the configuration of the the hymen be must completed and / or hymenal cleft size in millimeters.

Some symptoms have an explanatory note, which is indicated by a number. The clarification is located on the back of the questionnaire. It is advisable to read these notes when the indicator is not obvious, to become acquainted with the indicators.

If there are other symptoms not included on the list, the comments section must be used and reflected there.

The anatomical drawing should be used to indicate the location of the symptoms. It will suffice to put shading on the figure in the zone in which the symptom is observed. If there are several symptoms to be located and its location on the drawing is not sufficiently evident from the context of the indicator it can be indicated with an arrow indicator that refers to the shading.



There is a box in which you can write other symptoms that are not reflected in the original questionnaire. It is also possible to reflect here comments that may be relevant to the clarification of the case or suspicions (for example... biographical, concerning the credibility of the story told by the subject or due to the recurrence of symptoms and visits) that induce the professional to communicate the case.

Other symptom or comments

In the section on case identification, you collect data that will allow to locate and describe the subject in the cumulative data base that is collected. It is essential to collect the initials of the patient, sex and birth date (if known).

If the notification is derived because of the death of the subject, the box must be crossed.

The date of the notification must be included, as various notifications of the same case can be made in the same or different centers.

Finally, there is an area dedicated to the identification of the person making the notification. The information in this section is not entered in the database of the accumulative registration of cases and is used exclusively to ensure the accuracy of the information contained in the notification. It is therefore essential to fill in this section to get the notification to take effect.

Each notification form consists of three carbonless copies. One copy shall remain in the medical record for tracking the case if necessary, another copy will be mailed to the data processing service and a third copy will be given to the social services professional.

IMPORTANT: Each notification shall be made on a new questionnaire, even when it refers to the same case in dates after the first detection.

The effectiveness of this Notification form depends largely on the quality of itself and the care with which it is used. Careless completion may invalidate the notification of the case.

For any questions regarding this matter you can contact telephone number 012 of Administrative Information.

6. Resource guide

In this Common Protocol of the National Health System, addresses and telephone numbers are collected at a corresponding state level. Those at the regional level must be specified in the existing protocols or are going to be edited in their respective territorial level

MINISTRY OF HEALTH, SOCIAL SERVICES AND EQUALITY

- Government Delegation for Gender Violence: **http://www.msssi.gob.es/ssi/violenciaGenero/home.htm**
- Commission Against Gender Violence of the National Health System **http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/e02_t03_Comision.htm**
- Observatory on Women's Health **http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/e02_t03.htm**
- Childhood Observatory: **http://www.observatoriodelainfancia.msssi.gob.es/**
- Institute for Women: **http://www.inmujer.gob.es/**

MINISTRY OF FOREIGN AFFAIRS AND COOPERATION

- *Spanish Agency for International Cooperation for Development:* ***http://www.aecid.es/***
-

RESOURCE CENTERS CHILDREN´S CARE AND/ OR EDUCATIONAL/ INTERCULTURAL ACTIVITIES:

- UNICEF: **http://www.unicef.es/conoce/organizacion-interna/contacto**
- UNAF: **http://unaf.org/contact-us/** **http://unaf.org/salud-sexual/prevencion-de-la-mutilacion-genital-femenina/**
- SAVE THE CHILDREN: **http://www.savethechildren.es/sedes.php**
- MÉDICOS DEL MUNDO: ***http://www.medicosdelmundo.org/index.php/mod.conts/mem.detalle/idcont.709/menu.1/relcategoria.9858/relmenu.109***
- MÉDICOS MUNDI: **http://www.medicusmundi.net/como-colaborar/**
- FUNDACIÓN WASSU-UAB: **http:www.mgf.uab.es**

7. Annex

Guide for navigating the main pages of the European Union on the issue of Female Genital Mutilation (FGM)

I. European Commission

1. Justice, Gender Equality
   http://ec.europa.eu/justice/gender-equality/gender-violence/eliminating-female-genital-mutilation/index_en.htm;

2. International relations and foreign affairs
   http://ec.europa.eu/news/external_relations/130308_en.htm

3. European campaign 'Zero Tolerance towards female genital mutilation'
   http://ec.europa.eu/justice/newsroom/gender-equality/news/130306_en.htm
   http://ec.europa.eu/avservices/video/player.cfm?sitelang=en&ref=I080547
   https://www.facebook.com/media/set/?set=a.501725093208309.1073741825.107898832590939&type=1

4. Open consultation of the Commission on the fight against FGM in the European Union
   http://ec.europa.eu/justice/newsroom/gender-equality/opinion/130306_en.htm

5. Statements on the International Day Against Female Genital Mutilation
   6 February, 2014
   http://europa.eu/rapid/press-release_MEMO-14-85_en.htm
   6 February, 2013
   http://europa.eu/rapid/press-release_MEMO-13-67_es.htm

II. European Institute for Gender Equality (EIGE)

http://eige.europa.eu/content/female-genital-mutilation

1. Study on female genital mutilation in the European Union and Croatia (2013)
   http://eige.europa.eu/content/document/female-genital-mutilation-in-the-european-union-and-croatia-report

2. Data by country
   http://eige.europa.eu/content/female-genital-mutilation
   Joint report of data by country
   http://eige.europa.eu/content/document/study-to-map-the-current-situation-and-trends-on-fgm-country-reports

3. Good practices:
   Selection
   http://eige.europa.eu/good-practices/female-genital-mutilation
   Publication
   http://eige.europa.eu/content/document/good-practices-in-combating-female-genital-mutilation

4. Resources methods and tools (Queries on "Research and Documentation Centre RDC")
   Resources
   http://eige.europa.eu/resources/female-genital-mutilation
   Methods and tools
   http://eige.europa.eu/methods-and-tools/female-genital-mutilation

5. Selected Bibliography
   http://eurogender.eige.europa.eu/sites/default/files/Additional%20resources%20on%20FGM.pdf

6. Online discussion about female genital mutilation, 29 October 2013
   http://eige.europa.eu/content/document/female-genital-mutilation-report-from-online-discussion

III. Other pages of interest:

International Centre For Reproductive Health
http://icrhb.org/news/fgm-reference-centre-established-ghent-university-hospital

Guide for navigating some of the main pages of the United Nations and dependent agencies on the issue of Female Genital Mutilation (FGM)

UNICEF

1. Statistical data
   http://www.childinfo.org/fgmc_prevalence.php
   http://www.childinfo.org/fgmc_progress.html

2. Publications
   http://www.unicef.org/protection/57929_58022.html#fgmc

3. Other resources
   http://www.unicef.org/protection/57929_57987.html

United Nations Population Fund (UNFPA)
http://www.unfpa.org/topics/genderissues/fgm

8. Bibliography

- African-Women Organization.2009. “What it is consequences, myths FGM in Africa. Consulted in December 2014 at: *http://www.african-women.org/FGM/consequences.php*
- *Casajoana Guerrero, M.; Caravaca Nieto, E.; Martínez Madrigal, M.I.* “Una vision global de la mutilacion genital femenina”.Revisión Bibliográfica. Corporació Sanitaria Parc Paulí. Sabadell. Matronas Prof. 2012; 13(3-4):76-82
- *David Bishai, Yung-Ting Bonnenfant, Manal Darwish, Taghreed Adam, Heli Bathija, Elise Johansen, Dale Huntington for the FGM Cost Study Group of the World Health Organization.* “Estimacion del costo de la atencion obstetrica por mutilation genital femenina en seis paises africanos”. Published in the Bulletin of the World Health Organization. WHO. 2010. Consulted in May 2014 at: *http://www.who.int/bulletin/volumes/88/4/09-064808-ab/es/*
- Joint statement from the WHO, UNICEF and UNFPA. Abril 1997
- Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change. UNICEF. 2013
- Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. WHO study group on female genital mutilation and obstetric outcome. The Lancet 2006;367:1835–1841.
- Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. The Lancet 2006;367:1835-1841. Translation to Castellano done by África Caño Aguilar, Milagros Cruz Martinez y Mª Dolores Ochoa Rodriguez for the Bulletin of the World Health Organization. WHO.
- Female Genital Mutilation in the European Union and Croatia Report. European Institute for Gender Equality (EIGE). 2013
- Female Genital Mutilation Information for Health-Care Professionals Working in Ireland. AkiDwA. 2013. Consulted y obtained pdf in January 2014 from: *http://www.akidwa.ie/publications/gender-based-violence/female-genital-mutilation/file/43-fgm-section-2nd-edition-fgm-information-handbook-for-healthcare-professionals-in-ireland.html*
- Guía para profesionales. La MGF en España. Prevención e intervención. Unión Nacional de Asociaciones Familiares (UNAF). 2013
- Good Practices in combating Female Genital Mutilation. European Institute for Gender Equality (EIGE). 2013
- “Intensificación de los esfuerzos mundiales para la eliminación de la mutilación genital femenina.” Report of the UN Secretary General. 2014
- *Kaplan, A. y López, A.* (2013) Mapa de la Mutilación Genital Femenina en España 2012, Antropología Aplicada 2. Bellaterra, Fundación Wassu-UAB. Consultado en febrero de 2014 en: *http://www.mgf.uab.cat/esp/publicaciones_científicas.html*
- *Kaplan, A.; Toran, P.; Bedoya, M.H. et al* (2006) “Las mutilaciones genitales femeninas: Reflexiones para una intervención desde la atención primaria”, en Atención Primaria 38 (2) 122-6.

- *Kaplan, A.; Toran, P.; Bedoya, M. H. et al* (2006) “Las mutilaciones genitales femeninas en España: Posibilidades de prevención desde los ámbitos de la atención primaria en salud, la educación y los servicios sociales”, en Revista Migraciones 19, Madrid. pp. 189-217.
- *Kaplan, A.; Toran, P. y Moreno, J.* (2009) “Nuevas estrategias para el abordaje de las mutilaciones genitales femeninas: la iniciación sin mutilación. Un abordaje circular Gambia-España”, en MOLINA, E. y SAN MIGUEL, N. (Coords.) Universidad, Género y desarrollo. Buenas prácticas en derechos Humanos de las Mujeres. Universidad Autónoma de Madrid/Ministerio de Asuntos Exteriores, Madrid. pp. 333-351.
- *Kaplan, A.; Toran, P; Moreno, J.; et al* (2009) “Perception of primary health professionals about Female Genital Mutilation: from healthcare to intercultural competence”, in BMC Health Services Research, No9: BioMed Central. pp. 11.
- *Kaplan, A.; Moreno, J. y Pérez Jarauta, M. J.* (coords.) (2010) Mutilación Genital Femenina. Manual para profesionales. Bellaterra, Grupo Interdisciplinar para la Prevención y el Estudio de las Prácticas Tradicionales Perjudiciales (GIPE/PTP) UAB.
- *Kaplan, A.; Fernández, N.; Moreno, J. et al.* (2010) “Female Genital Mutilation: perceptions of healthcare professionals and the perspective of the migrant families”, in BMC Public Health No10: BioMed Central pp. 193
- Ley Orgánica 1/2014, de 13 de marzo, de modificación de la Ley Orgánica 6/1985, de 1 de julio, del Poder Judicial, relativa a la justicia universal.
- *Mangas, A.* (2010) El Ojo de la MGF. Un cruce de miradas. Departamento de Antropología Social y Cultural de la Universidad Autónoma de Barcelona. [Tesina no publicada, en el marco del Master de Investigación Etnográfia, Teoría Antropológica y Relaciones Interculturales, de la UAB].
- Maltrato Infantil. Detección, Notificación y Registro de Casos. Observatorio de Infancia. Grupo de trabajo sobre Maltrato Infantil. Ministerio de Sanidad, Servicios Sociales e Igualdad. Consulted in May 2014 at: *http://www.observatoriodelainfancia.msssi.gob.es/documentos/HojasDeteccion.pdf*
- Mutilación Genital Femenina. Abordaje y Prevención. Guía. Medicosmundi-Andalucía. 2009
- Descriptive note N°241. February 2012. OMS. Consulted on 22 January 2014 at: *http://www.who.int/mediacentre/factsheets/fs241/es/*
- Organización Panamericana de la Salud. “Comprender y abordar la violencia contra las mujeres”. 2013. Accessible at: *http://apps.who.int/iris/bitstream/10665/98838/1/WHO_RHR_12.41_spa.pdf*
- Basic Intervention Protocol against child abuse. MODULE OF REFERENCE FOR THE DEVELOPMENT OF A PROTOCOL FOR ACTION IN CASES OF CHILD ABUSE. Plenum of the Childhood Observatory. Ministry of Labour and Social Affairs. 2007
- Protocol of actions to prevent female genital mutilation. Generalitat de Catalunya. Department of Social Action and Citizenry. Barcelona, 2007.
- Protocol for addressing gender violence in the field of health in Catalonia. Dossier 3. Operational Document of Female Genital Mutilation. Generalitat de Catalunya. Department of Health. Directorate General of Planning and Evaluation. Barcelona, 2011.

- Protocol for the Prevention and Action against Female Genital Mutilation in Aragon. 2011
- Protocol for the Prevention and Action against Female Genital Mutilation in Navarra. 2013
- *Rigmor C. Berg and Vigdis Underland.* "The Obstetric Consequences of Female Genital Mutilation/Cutting: A Systematic Review and Meta-Analysis". Hindawi Publishing Corporation. Obstetrics and Gynecology International. Volume 2013, Article ID 496564, 15 pages. Consulted in March 2014 at: *http://dx.doi.org/10.1155/2013/496564*
- Tackling FGM in the UK. Intercollegiate recommendations for identifying, recording and reporting. Royal College of Midwives. 2013. Consulted y obtained pdf in October 2014 at: *http://www.equalitynow.org/sites/default/files/Intercollegiate_FGM_report.pdf*
- "The Istanbul Convention – A tool to end female genital mutilation". Council of Europe. Consulted in November 2014 at: *http://www.coe.int/t/dghl/standardsetting/convention-violence/brochures/IstanbulConventionFGM%20Guide%20EN.pdf*
- *Velasco Juez, Casilda.* "Prácticas tradicionales que vulneran los derechos de las de las mujeres: mutilaciones sexuales femeninas". Federación de Asociaciones de Matronas de España. Revista Matronas Prof. 2000; 1 (2): 10-18. Consulted on 13 January 2014 at: *http://www.federacion-matronas.org/revista/matronas-profesion/sumarios/i/7660/173/practicas-tradicionales-que-vulneran-los-derechos-de-las-mujeres-mutilaciones-sexuales-femeninas*

Female genital mutilation (FGM) is an especially harmful practice for the physical, psychological, sexual and reproductive health of women and girls. It is a violation of human rights and a particularly cruel manifestation of gender discrimination.

This Joint Health Protocol specifically addresses; Measure 185 of the National Strategy for the Elimination of Violence against Women 2013-2016, approved by the Council of Ministers, 26 July 2013.

Its main objective is to become a basic tool for raising awareness and the training of professionals in the fight against FGM and to guide homogeneous actions throughout the National Health System (NHS) to improve the health of women and girls who have undergone it and work on the prevention and detection of the risk of its practice, when from a family context, they are in a particularly vulnerable situation.

Criteria such as support and personalized monitoring of the family in preventive action and the multi and interdisciplinary care from the health team, in coordination and collaboration with other sectors (education, prosecutors, forensic, security and police forces, local resources , etc.) to orient health policies transversely along the same direction.

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