

Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda

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Abstract

Asylum seekers and refugees (ASRs) are a heterogeneous population with distinct physical and psychological needs. ASRs with additional health needs are girls and women who have undergone, or are at risk of undergoing, female genital mutilation (FGM). Across the European Union (EU), variation exists in Member States' anti-FGM and asylum legislation, the rigour of existing research programmes, and the operational coherence of the multiple agencies combating the practice. ASRs' needs are, consequently, not being addressed satisfactorily. This paper proposes an integrated future agenda, applicable in all EU countries, capable of meeting these girls' and women's needs.

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Asylum seekers and refugees (ASRs) are a heterogeneous population with distinct physical and psychological needs [1,2]. Whether arising from war, political persecution, torture, or massacres experienced at home [3,4], or from social dislocation, financial hardship and discrimination encountered in their country of asylum [5] or residence, ASRs can have multiple health problems [6,7].

In the European Union (EU), such problems can be exacerbated by the inadequate or culturally insensitive care ASRs receive from statutory health services (e.g. the National Health Service (NHS) in the United Kingdom (UK)) [8–10]. ASRs' problems can

also be compounded by their unwillingness and inability when detained to engage with health authorities until their health status is severely impaired [11]. Moreover, some EU states have legislation that can exacerbate these problems further. In the UK, for example, the Immigration and Asylum Act (1999) enables authorities to disperse ASRs to largely monocultural and ethnically homogenous areas outside London [12], where sensitivity to minority group issues is limited [13,14].

One group of ASRs with additional health needs are girls and women who have undergone, or are at risk of undergoing, female genital mutilation (FGM). Despite commendable work, unacceptable variation exists in EU Member States' anti-FGM and asylum legislation, the rigour of existing research programmes and the

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operational coherence of the multiple agencies combating the practice. ASRs' needs are, consequently, not being addressed satisfactorily. This paper outlines the nature, prevalence and practice of FGM across the EU, and the current legislative environment, identifying areas of deficiency before proposing an integrated European agenda capable of meeting these girls' and women's needs.

1. FGM and its health consequences

The World Health Organisation (WHO) defines FGM as the partial or complete removal of female genital organs performed for cultural rather than therapeutic reasons [15]. FGM is classified into four types ranging from reduction operations (the excision of part or all of the clitoris [Type I] and/or the labia [Type II]), to closure operations that consist of Type II FGM along with the stitching/narrowing of the vaginal opening (Type III, or infibulation). Other procedures, such as pricking or piercing the clitoris, are classified as Type IV [16].

Infibulation (i.e. Type III FGM) accounts for approximately 15% of all cutting procedures, being performed on as many as 90% of women in Somalia, Djibouti and northern Sudan [17]. Types I–III are thought to affect between 100 and 140 million women and girls world-wide [15]. Estimates suggest that approximately 2 million girls annually are at risk of FGM—nearly 6000 per day [17]. Even though practised primarily in 28 African countries from the Horn of Africa, to parts of central, eastern and western Africa, international migration has extended the practice outside the African continent. Existing evidence suggests FGM is increasingly an issue of European concern [18].

The health consequences of FGM have been documented by WHO [19]. Immediate effects can include pain, injury to adjacent tissue, shock, infection, urinary retention, and haemorrhaging resulting in death. Long-term morbidity consequences, particularly of infibulation, can be severe and include: urinary incontinence, recurrent urinary tract infection, pelvic infections resulting in infertility, menstruation difficulties, obstetric complications, fistulae of the bladder or rectum, and sexual dysfunction. While there is no doubt that these health problems can be caused by

FGM, the frequency of such problems and how this relates to the different types of FGM operation is not well established and has led to some controversy among researchers [20–25].

FGM is also considered by many to embody gender inequalities, representing discrimination against women and girls, the torture, cruel, inhumane or degrading treatment of children and women and the abuse of the physical, psychological and sexual health of women and children [16].

2. FGM in Europe

2.1. Prevalence and practice

With increasing migration over the past few decades, the EU has been confronted with an increasing number of women and girls from sub-Saharan African countries where FGM is practised [26–29].

In the UK, FORWARD, a non-governmental organisation (NGO) working against FGM, estimates there are 86,000 first generation immigrant refugee/asylum-seeking women and girls—mostly residing in London, Manchester, Liverpool, Sheffield, Birmingham and Cardiff—who have undergone FGM in their countries of abode [30]. These numbers are increasing with the influx of asylum seekers from Somalia, Sudan and Sierra Leone. For example, asylum applications from Somalia accounted for 9% of all applications to the Home Office in 2001, rising by 29% on the previous year from 5020 to 6465 [31]. Hedley and Dorkenoo [32] estimated 10,000 UK-based children were at risk of FGM, while Boot [33] suggested there are 3000–4000 new FGM cases in this country per annum.

In Italy, based on 1994 Ministry of Interior data, it is estimated there were 'not less than 28,000 immigrant African women who have undergone FGM' [26], and at least 4000–5000 young excised girls based in Italy [34]. Around 25,000 Somalis have settled in The Netherlands, with an additional small number requesting political asylum and an increasing number of unaccompanied minors arriving in the country [35]. It is estimated there are approximately 21,000 genitally mutilated women living in Germany; this number could potentially be doubled if non-registered migrants are included [36]; the same

source estimates the number of girls at risk of FGM at 5500. Across the Nordic countries (including Sweden, Denmark, Norway, Finland and Iceland), FGM is increasingly seen as a health issue requiring attention, though enumeration of the suspected extent of the problem is absent [37], while in Switzerland Jäger et al. [38] estimated there were approximately 6700 girls at risk of FGM and women who have undergone the procedure.

As for the practise of FGM, in several EU countries concern exists that FGM is being performed within the host country. Since the 1980s, it has been believed that FGM is being practised in the UK by various trained practitioners (e.g. doctors) and that children are being sent on ‘holidays’ to be mutilated abroad [39]. Hedley and Dorkenoo’s national survey [32] across social services departments (SSDs) found FGM is more widespread than believed. Ten of 65 SSDs canvassed reported casework intervention because of suspected FGM; a further 18 were concerned about communities possibly practising it.

In Italy, as in Spain, similar reports have been recorded of FGM being performed. A 1993 inquiry among obstetricians in Italy revealed FGM was being carried out in the country, either by medical staff or by traditional birth attendants [34]. Indeed, one Somali doctor has proposed a ‘harmless and symbolic’ ritual alternative (i.e. a puncturing of the clitoris under local anaesthesia) to FGM for African women at a Florence public hospital [40]. In Spain, six cases of illegal circumcision of immigrant African girls were subject to an inquiry; in one case, paediatricians from a Zaragoza hospital suspected that at least one operation was undertaken recently [41]. In France in 1984, several excisions were performed in the 18th district of Paris; in the following year, 500 excisions were performed in a Paris suburb [42].

The problem inherent in these prevalence figures is that they are all too often risk estimates and not derived from rigorous primary social research, extrapolations from (often imprecise) country-of-origin prevalence data that are unsubstantiated by empirical findings (e.g. from court cases or social services documentation). Consequently, quantifying their degree of precision is problematic. Of course, verifying the occurrence of what in some countries is an illegal and secretive activity practised by relatively small sub-groups of the population is problematic in itself,

a fact exacerbated when that activity is seen as both beneficial to the individual and intrinsic to the cultural identity of an exiled group. More generally, reliable cross-national comparative prevalence data on the epidemiology and practice of FGM in Europe and its health-related consequences are largely unavailable [43,44], a limitation that in part constitutes the *raison d’être* for this paper.

However, some authors contend that not only are these estimates erroneous, but that there is a mistaken public discourse on the prevalence of FGM that obscures the fact that the practice is slowly disappearing among exiled communities. For example, Johnsdotter [45,46] has claimed that the exiled Somali community in Sweden have engaged in an internal discourse in which the religious imperative to undertake FGM has been reassessed, re-evaluated and reinterpreted as a violation of fundamental Islamic teachings, resulting in an abandonment of infibulation (Type III FGM) and a belief that the sunnah type of FGM is unnecessary.

Whilst offering useful insights into the potential process of cultural abandonment, Johnsdotter’s work is wholly anthropological in nature, gathering data from a non-probabilistic sample of only thirty respondents (15 from each gender) from one Swedish city. Caution has to be exercised, as Johnsdotter acknowledges, when making any generalised conclusions to the wider Swedish Somali community (not to mention the experiences of other Somali and non-Somali African communities in exile elsewhere in Europe) given the ‘representativeness’ of the interviewees. Caution has also to be demonstrated when interpreting similar tendencies in cultural change that have been reported elsewhere in Europe. For example, though Morison et al. [47] found a tendency for abandonment of FGM and the beliefs in sexuality, marriage and religion that underpin it among young (i.e. aged 16–22 years) Somalis living in London, the process of cultural reassessment is neither necessarily inevitable nor linear:

The process involved in any change of values or behaviours of members of minority ethnic groups are complex. Assimilation can occur whereby members of ethnic minority groups gradually take on the values and behaviour of the majority culture. However, there is heterogeneity within the culture of the

receiving country so assimilation may occur into some subgroup(s) of it. It is difficult to make generalisations about assimilation of a particular ethnic group because assimilation might occur to different extents in different parts of the minority group (for example, it might occur more in younger and less in older members) and it might occur in some aspects of life (for example, socialising at work) but not others (for example, marriage). [47]

Moreover, as the authors note, since the study was conducted there has been a substantial increase in the number of Somalis in exile in the UK, which has increased the size of the Somali community. This increase could potentially have altered the dynamics within which cultural change is expected to occur, possibly increasing the pressures for cultural adherence and reducing the opportunities for cultural abandonment by reawakening the fear of social criticism and ostracism.

Lastly, where research has been conducted with the aim of estimating the prevalence of FGM, there is relatively convincing evidence that the practice remains a problem. For example, based upon postal questionnaires among Swiss gynaecologists, canton health representatives and five medical schools, Jäger et al. [38] found 20% of the former had been confronted with patients presenting with FGM, while 40% had been asked about infibulation. Similarly, Kangoum et al. [48] found that among African women resident in the Swedish county of Östergötland, 68% reported being genitally mutilated, a fact corroborated in part by clinical examination.

2.2. Legislation in Europe

On 20 September 2001, the European Parliament (EP) adopted a Resolution on FGM which, although not legally binding, has the potential to prepare the ground for a EU-wide FGM policy. The resolution calls upon Member States to collaborate to harmonise existing FGM legislation. If existing legislation is inappropriate, however, it requests that specific legislation should be enacted [49]. The same Resolution requests the European Commission to undertake an awareness campaign directed at legislators/parliamentarians in all EU Member States affected by FGM with a view to maximising the im-

pact of existing legislation and, where legislation does not exist, to assist in the formulation and adoption of such legislation [49].

National legislation across the EU States leaves many questions unanswered. In some countries, an ongoing discussion exists over whether or not specific FGM legislation should be adopted. Unsurprisingly, in the absence of EU legislation, there is variation in Member States' national laws. Specific anti-FGM legislation exists in some European countries, such as Austria (enacted in 2002), Belgium (2001), Sweden (1982), Switzerland (1982), the UK (1985, amended in 2003), and Norway (1996) [50]. Other national laws applicable to FGM are criminal laws (under the penal code), administrative laws (concerning health centres and health professions), family law/child protection laws (relating to the role of the parents, possible suspension of parental authority and the removal of the child considered at risk of FGM), civil law (on financial compensation), and migration law (relating to the status of refugees and asylum seekers) [51]. In Finland, France, Germany, Greece, Italy, Luxembourg, Portugal and The Netherlands, FGM is punishable under general criminal law (penal code), whereas in Ireland, it is punishable under the Criminal Justice Act 2000 [50,52].

In those European countries that have a specific FGM law, however, no cases have reached the courtroom [53,50]. In contrast, one country with no specific legislation (i.e. France) has taken several FGM cases to court. However, although FGM has been punished in France since the early 1980s, excisions are still being practised there [54].

Clearly, the enforcement of laws prohibiting FGM has a number of limitations. For example, more than 30 lawsuits filed by doctors against parents and practitioners of FGM allegedly performed in Spain were dropped because prosecutors could not prove that the procedures were undertaken in the country [41]. Another factor contributing to the non-enforcement of the law/international human rights laws is 'cultural relativism,' with no action undertaken against FGM out of respect for the customs and traditions of different cultures [55]. Moreover, FGM is a historically and socially deeply embedded tradition; severe punishments based on the penal code or on specific legislation do not appear a sufficient deterrent to continuing the tradition [56]. Another factor is ASRs' unfamiliar-

ilarity with EU Member States' legislative systems, as well as their ignorance of existing legislation.

An additional major problem concerning legislation is the protection of children from FGM when they travel abroad. In this context, it is very important to have coherent legislation throughout the EU. The EP resolution on FGM is a step forward in solving this problem, calling on Member States to pursue, protect and punish any resident who has committed the crime of FGM even if the act was committed outside the State's frontier ('extraterritoriality') [57]. In Belgium, for example, this principle of extraterritoriality has been included in the law, thus making FGM punishable even if performed outside the country. By doing this, the principle of universal criminal liability, already applicable for human rights violations and 'sex tourism', has been extended to the punishment of FGM. In March 2003, the UK government similarly extended the 1985 Act to cover children taken out of the country.

Legally, variation also exists across the EU when FGM is used as possible grounds for an asylum claim. In 1997, two families were granted asylum in Sweden on the grounds that the female members of these families would be in danger of genital mutilation if returned to their country of origin (i.e. Togo). Though the authorities did not recognize the families as refugees under the 1951 UN Refugee Convention Relating to the Status of Refugees, they did grant them residence permits on humanitarian grounds [58]. In Austria in March 2002, asylum precedent was set when the Independent Federal Asylum Senate granted asylum to a woman from Cameroon who feared being subjected to FGM. In particular, the decision was based on a well-founded fear of persecution for her membership of a particular social group; that is, Cameroonian women who are to be circumcised. In contrast, in the UK 2 months later, the Immigration Appeal Tribunal overturned the Adjudicator's asylum decision in favour of a Kenyan woman¹ on the grounds that being part of a group of young girls living in tribal communities in Kenya where there is an ingrained practice of FGM does not have an immutable characteristic (and therefore is not subject to the 1951 UN Convention) because 'however ingrained

the practice, not all the girls in such tribal communities will be forced to undergo FGM as many of the girls undergo FGM voluntarily without any means of force or coercion' (quoted in [59]). This incongruity has no internal consistency from a EU perspective; one can be a bona fide EU citizen in one Member State for fearing FGM, and not in another, despite the fact that free movement of EU citizens enables that same person to relocate within the EU. The EP Resolution correctly acknowledged this variation, calling on Member States to recognise the right to asylum of women and girls at risk of being subjected to FGM [49].

2.3. Operational coherence: health and social care, education, judiciary, police and immigration officials

The growing number of ASRs from FGM-affected countries means European health and social care professionals, educational staff, the judiciary, police and immigration officials increasingly face the problem of caring for those affected by the practice. One of the major problems is the degree of operational coherence between health and social care services and other agencies (e.g. police, immigration officials, lawyers) in addressing ASRs' FGM needs. Services often develop their own codes of practice in isolation from the multiple other agencies that could, and should, be involved in a suspected FGM case. This problem is compounded by the relative lack of operational coherence between these agencies, policy makers and grassroots organisations.

In countries such as the UK, Sweden, The Netherlands and Denmark, which have a large number of African immigrants from countries where infibulation is common, professionals have been confronted with the need to pay attention to the practice's potentially severe health complications [60]. However, operational disharmony between services is exacerbated by deficiencies within those services. For example, the care for women with FGM must be provided collaboratively as part of an integrated approach if it is to be effective. Professionals' ability to deal with FGM currently (not least in a collaborative manner) is, however, questionable. Mwangi-Powell [61] found women who have undergone FGM cited lack of FGM knowledge among health professionals as a major problem, identifying the need for increased awareness among

¹ SSHD v. Julia Wanguru Muchomba, Appeal No.: CC-25710-2001 ([2002] UKIATO1348), 2 May 2002.

such professionals. Similarly, Lawrence's [62] study among professionals in health, education, social services and the police in three major UK cities found nearly four-fifths felt ill-equipped to deal with cases. Moreover, Leye et al. [43] showed that in addition to a lack of clinical knowledge of FGM procedures and its complications, knowledge about the underlying socio-cultural beliefs and traditions is deficient. Nienhuis and Haaijer [29] suggest that offering adequate care may become difficult for care providers as a result of their own feelings of powerlessness and anger towards FGM, thus resulting in inadequate care for women with FGM.

Police and immigration officers also need to be aware of the problem of FGM and the relevant international conventions in order adequately to provide information on a country's legislation and to respond to cases of girls at risk of being circumcised reported to them. They will have to receive systematised information on groups that still perform FGM and on NGOs that provide services to deal with FGM [43]. Immigration officials need to inform newly arrived ASRs about the legislation, ensuring that the law is explained positively; that is, as a protector of girls and women, not a weapon for use against their culture. In these encounters, families should be informed about the consequences of breaking the law. Examples of good practice do exist. For example, the Belgian NGO Groupement pour l'Abolition des Mutilations Sexuelles (GAMS) is planning to organise training sessions for the police to sensitise them to the problem of FGM among African migrants. However, more work across EU States that addresses operational inadequacies between, as well as within, professions needs to be initiated.

3. FGM: an integrated European agenda

The above discussion indicates national and international deficiencies in the way FGM is currently addressed. The EU needs to develop an agenda (to be implemented by Member States and relevant NGOs) that must be multi-faceted and integrated if it is to be effective. To this end, national interagency groups should be established comprised of members of at-risk communities, health and social services, police and legislators, researchers and schools' representatives [63,64].

In addition to the need for greater legislative harmony regarding FGM, there are four priority areas that such interagency groups need to address across all EU Member States: research; professionals' training; community education; and the development of culturally sensitive health services. It is contended that while the specific socio-cultural, political and legislative context of each EU Member State differs, these four areas have generic relevance and applicability.

3.1. Research

Any EU Member States' FGM policy initiatives must be premised upon rigorous evidence-based research if they are to be effective. Priority research areas include:

- (a) *Prevalence*: The National Offices of Statistics across Europe provide limited information regarding the number of ethnic minority women from FGM risk countries. For example, non-disaggregated data do not permit analysis by ethnicity or by sub-regions of a country (e.g. in Sudan, the regional prevalence of FGM varies between 0 and 89%), nor do they provide information about the considerable number of illegal immigrants [43]. Moreover, methodologies for determining the number of ASRs vary between EU countries, thereby making inter-country comparisons problematic. Furthermore, statistics are not updated regularly and might not reflect changes in migration and mobility [60].

Methods for estimating the number of ethnic minority women from practising groups using census, immigration and asylum data (where they exist) need to be refined, including their disaggregation by gender. Survey methods for smaller areas (such as local authorities) need to be developed to overcome the lack of available sampling frames and ASRs' suspicion regarding research into this sensitive issue. Additionally, the use of capture-recapture methods (used successfully with other populations that have proven difficult to count, for example the homeless and lesbians) [65,66], should be explored.

- (b) *An inventory of existing interventions and their impact analysis*: Interventions developed at legislative, community and health and social sector

level need to be inventoried across Europe, and an evaluation of their activities undertaken to determine their relative effectiveness.

- *Legislation*: European countries address the practice of FGM as a violation of women's rights and consider such violation under no circumstances justified by cultural heritage. However, in many countries there is still an ongoing discussion about whether or not specific legislation is an effective tool to combat FGM. A coherent strategy throughout Europe concerning legislative measures and their implementation will reinforce the fight against FGM. In this context, an impact analysis of existing laws throughout Europe needs to be undertaken. For example, research is needed to examine reasons why legal prosecution of FGM practitioners is rarely attempted and the extent to which ASRs are aware of existing legislation.
- *Evaluation of interventions*: Community-based programme interventions intended to change people's attitudes to, and practice of, FGM among ASRs in the 'West' have never been prospectively evaluated for their impact. Rigorous evaluation, ideally using a quasi-experimental research design, will enable the replication of effective programmes across Europe (see [67]).
- *Health and social sector*: Research should be initiated on the effectiveness of health and social care for ASRs, in combination with research on the health- and social care-seeking behaviour of ASRs. KAP (i.e. knowledge, attitude and practice) studies among health professionals and social workers in relation to FGM could be a first step in developing efficient interventions for women with FGM [44]. To ensure FGM policies meet affected communities' needs, research investigating the attitudes and experiences of women and girls is necessary. While the physical effects of FGM have been documented in sub-Saharan Africa, there is a paucity of research on the specific problems faced by circumcised women in Europe, where the practice is widely misunderstood. The psychological consequences of FGM also require investigation; it is likely they will be worse

for girls and women living in a society that regards circumcision as an abnormality rather than a legitimate means of enhancing social status [64,34]. It is also vital that the opinions and attitudes of FGM-practising communities are heard and understood. Not only do professionals need to appreciate why the practice continues, but also the obstacles encountered accessing appropriate health and social care.

- (c) *Behaviour change research*: Living in a country where such practices are rejected might create circumstances in which it is easier to abandon the practice of FGM. Some researchers have found that acculturation and abandonment of the practice appears to be associated with age on arrival in the country of abode [47]. However, with a few notable exceptions [45], there is minimal research investigating those who have abandoned the practice. Such research could help deconstruct the behavioural change process that leads to that decision. For example, how are gender dynamics among exiled communities affected and what impact does that exert upon the continuation of the practice? What is the impact of generational differences among the exiled community, especially the perspective of the younger generation who may find traditional discourse regarding FGM an alien phenomenon? Future qualitative studies investigating the wide diversity of experiences, attitudes and beliefs of men and women of varying ages from diverse cultures also could play a major role in advancing our understanding of such behavioural processes [68]. Research on the influence of migration context on FGM behavioural changes could also provide an important contribution to the development of more effective interventions [60].

3.2. Training of professionals

Professionals working with ASRs face multiple challenges, including: linguistic differences; pressures of finite time; inadequate cultural awareness; and deficient expertise. Co-ordinated inter-agency training is key for all professionals working with affected communities, enabling them to provide effective and culturally sensitive support to those affected and to

protect children by being sensitised to warning signs. Underlying this training gap is the fact many local agencies are unaware of FGM and do not have FGM-specific procedures to serve affected women. An estimated 65% of local authorities in the UK, for example, have no FGM-specific policies or procedures in place [30].

3.2.1. More specific professional needs include

- (a) *Professionals receiving ASRs (e.g. immigration officials)*: In some countries, the fear of FGM is sufficient grounds for women to seek political asylum (e.g. [69]). To evaluate these claims compassionately and equitably, immigration officials, barristers and solicitors need to receive adequate and appropriate FGM education to make informed judgements and represent their clients effectively.
- (b) *Professionals working with ASRs*
- *Child protection workers*: General practitioners (GPs), social services, police and teachers [32] in the UK suggested specially trained advisers should be available to provide support and advice to professionals in contact with families affected by FGM. Specific child protection guidance should be made available to all professionals potentially involved in identifying the risk of FGM. This guidance should include the early indicators of FGM and the referral process, such as the advice released for UK GPs by the British Medical Association [70]. Although the likelihood of FGM occurring is difficult to detect, it is possible a child may confide their fears that this has happened, or may occur, to a teacher, social worker, medical professional or trusted friend. All referrals should be treated seriously irrespective of how nebulous the substance of the suspicion or allegation appears. Professionals will become aware of the practice through multiple indicators (e.g. a teacher noticing a pupil is suffering with bladder or severe menstrual problems causing frequent school absences). It is also important that referral procedures are made known to all service-providing professionals, as a referral of suspected or actual FGM could arise from a variety of sources, including: nurses, health visitors, doctors, midwives, school nurses, community workers,

social services, friends and families. This highlights the importance of interagency collaboration and dissemination of information.

- *Health Professionals*: All health professionals have a significant role to play in eliminating FGM and providing an effective service for women who have undergone the practice. Training of health professionals will depend on the particularities of the health care sector and training modalities in each European country. However, training could be provided to the following target groups: GPs, gynaecologists and obstetricians, midwives, nurses, medical expatriates, paediatricians, psychologists, and cultural mediators [63].

Training should be undertaken at different levels, using varied methodologies and materials. For example, local hospitals and primary care services (for GPs and school health services) could develop guidelines, organise in-service training, or provide information through hospital and university libraries. At an academic level, FGM should be included in all curricula for medical and para-medical courses, as well as in set journals and textbooks. Nationally, guidelines for health care professionals should be developed discussing the socio-cultural, medical and legal aspects of FGM [43].

Training modalities could be organised in the following way: there could be a FGM specialist in every health authority with susceptible ethnic populations who is able to organise FGM training for nurses, midwives, GPs, gynaecologists, paediatricians, health visitors and health link workers. FGM policies and referral systems could be installed in each health authority. Lastly, a networking link and information exchange could be formed with the local practising communities, and statutory and voluntary organisations.

3.3. Community education

The Ghent Expert Meeting [43], the UK Parliamentary Hearings on FGM [71] and the EP Resolution on FGM [49] recommended more support be given to NGOs and local community organisations, both of which are crucial to community education. This education will vary depending on the status of the ASR:

- (a) *For those in transit*: Information available in multiple relevant languages needs to be given to newly arrived ASRs. This information should discuss FGM, the services available for help and relevant orientation information (including legislation on FGM) on living in a specific European country.
- (b) *For those established in a EU country on a longer-term basis*: This could take the form of the training of peer educators in the community to educate on FGM, holding health and capacity-building seminars or using active community groups (including men and religious leaders) to implement FGM education among the community.

3.4. Culturally sensitive health services

In Europe, specialised health services for women who have undergone FGM are more the exception than the rule. Most general health services in Europe are unfamiliar with the consequences of FGM; this can result in inadequate care. Moreover, it discourages women from seeking appropriate care for their FGM-related problems [60]. There is a variety of means to overcome the lack of such culturally sensitive health services.

- (a) *Information workshops*: Information workshops on the health consequences of FGM, UK FGM legislation, and the services available to women affected by the practice can facilitate awareness, improve women's health and help eliminate FGM among ASRs in Europe.
- (b) *Language*: Given European languages are not the first languages of most FGM-practising communities, it is likely women accessing health services will be unable to articulate their problems adequately (e.g. [72]). Interpreters, who are crucial to overcoming these linguistic barriers, should be female, not known socially to the women, and able to translate medical terms in an understandable form. It is important to consider the personal view of each interpreter towards FGM; those in favour of the practice must not, of course, be employed.
- (c) *Specialist clinical services*: In the UK, there are now eight clinics (including African Well Women Clinics) offering FGM services. Since 1993, FORWARD, Northwick Park Hospital, Guy's & St. Thomas' Hospital and others have helped estab-

lish five African Well Women Clinics across London offering women affected by FGM advice and medical help [27]. It is certain, however, that the growing number, and national dispersal in the UK, of women who have undergone FGM will render these capital-focussed clinics insufficient to cater to existing needs. These initiatives should be duplicated across the EU and the lessons learnt. Moreover, not only must Member States be encouraged to provide similar services, but affected communities need to be informed of these specialist clinics through surgeries and grassroots community groups.

4. Conclusions

At the request of the European Parliament, '1999' was designated the 'European Year against Violence Towards Women.' Five years later, the challenge facing the EU remains. The increased numbers of ASRs from FGM-practising countries arriving in the EU means the practice will at best be abandoned by affected populations over time (potentially several generations), and at worst will not disappear through a gradual process of adaptation and acculturation, as some anticipated [73]. Existing evidence suggests FGM will increasingly become an issue of EU-wide rather than localised concern.

Existing variation in anti-FGM and asylum legislation across EU Member States, as well as the inadequacies of existing research and the operational coherence of the multiple agencies involved, means ASRs' FGM needs are not being met. The above discussion has outlined the need to harmonise legislation, improve the rigour of research programmes and strengthen the partnership working of agencies. It is only by initiating such an integrated agenda that the needs of women and girls affected by FGM can be addressed satisfactorily.

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