An End to Inaction: 
Addressing Female Genital Mutilation in Canada

by
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Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Policy

in the
School of Public Policy
Faculty of Arts and Social Sciences

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SIMON FRASER UNIVERSITY
Spring 2019

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Abstract

Female genital mutilation (FGM) is a human rights and health issue affecting women and girls across the world. As Canada is lagging behind other countries in tackling FGM, this study addresses this gap. The research includes interviews with nine experts in Canada and Europe, and a case study analysis examining the legislative and policy frameworks in the United Kingdom, the Netherlands, Germany, and France. Drawing on the research findings, the study recommends creating a multi-sector policy framework on FGM with a lead ministry and a national action plan. Key action plan items include an FGM prevalence study, a multi-agency guide, and training formats for relevant professionals. These policies are assessed based on effectiveness and feasibility criteria, and recommended for short-, medium-, or long-term implementation. For Canada, it is time to end inaction and Canada’s Strategy to Prevent and Address Gender-Based Violence provides now an important policy window for addressing FGM.

Keywords: FGM; female genital mutilation/cutting (FGM/C); human rights; health; policy framework; Canada
Dedication

I dedicate this capstone to survivors of female genital mutilation, to girls who were protected from or escaped female genital mutilation, to girls who are still at risk of being subjected to female genital mutilation, to courageous people everywhere who are defying the practice and protecting girls, and to all those relentlessly working to ensure that FGM will soon become a practice of the past.
Acknowledgements

As a newcomer to this land, I would first like to acknowledge that I conducted my research while residing on the traditional, ancestral, and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkʷəy̓əm (Musqueam), and Séilílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

For my research project, I would like to thank my capstone supervisor, Olena Hankivsky for her consistent encouragement, her guidance and advice. I also thank my internal examiner, Marina Adshade, for her questions and feedback.

I would like to thank all interview participants for sharing their knowledge, perspectives, and experience with me. Thank you to Emily Allwood, Sokhna Fall Ba, Naana Otoo-Oyortey, Corinne Packer, Reyhana Patel, Rohma Ullah, Jacobet Edith Wambayi, Charlotte Weil, and Entisar Yusuf.

I first started working on the issue of female genital mutilation during my internship at Terre des Femmes where I supported the European CHANGE Plus Project. I like to extend special thanks to Charlotte Weil and Idah Nabaterega and the wonderful change agents – your work and efforts to raise awareness and to end FGM inspired me.

And thank you to Farzana Doctor, Giselle Portenier, and Malaika Somji for taking me a step further as co-founders of the End FGM Canada Network.

Finally, to my loved ones for supporting me and lightening my heart.
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Executive Summary

Female Genital Mutilation (FGM) refers to deeply rooted cultural practices that involve cutting female genital parts or inducing any other injury to the female genitalia for non-medical reasons. The practice can be life-endangering and causes severe physical, psychological, and sexual health problems. FGM is a human rights violation and a transnational health issue affecting more than 200 million girls and women worldwide (WHO.int(a)). Although mostly practiced within communities in Africa, the Middle East, and Asia, FGM is also prevalent in diaspora communities in Western countries.

It is evident that FGM survivors and girls at risk of being subjected to FGM are living in Canada. However, Canada has not done enough to [i] understand the scope of the problem, [ii] provide adequate supports for survivors, and [iii] protect girls from FGM, and Canada is said to be lagging behind other countries in efforts to prevent and address FGM (Marchildon 2018; Packer, Runnels and Labonté 2015; Patel 2017; Poisson 2017a).

To investigate this gap and develop policy recommendations for Canada, this study adopts a qualitative approach, including a literature review and jurisdictional scan, a comparative case study of selected Western countries, and nine interviews with experts from Canada and Europe. The case study analysis examines the legislative and policy frameworks on FGM in the United Kingdom, the Netherlands, Germany and France to explore and discuss features of such frameworks.

Drawing on the research findings, the study recommends creating a multi-sector policy framework to address FGM in the areas of healthcare, education, childcare, social work, law enforcement, immigration and asylum. The study then focuses on policies that are foundational to building a policy framework and that provide relevant actors with knowledge and guidance so that they can work towards the policy objectives of preventing FGM, protecting girls, supporting survivors, and enforcing laws against FGM.

The policies under consideration are: [1] A statistical FGM prevalence study, complemented by qualitative research with the target population to learn about support needs and gain a better understanding of attitudes towards FGM within the communities; [2] A multi-agency guide to clarify roles and responsibilities and provide guidance on how to respond to FGM; [3] Three training options for professionals in relevant fields:
[3.1] an e-learning platform, [3.2] in-person training workshops, and [3.3] the integration of FGM into the curricula of relevant professional groups.

The policy analysis is based on a number of criteria. First, the policies are assessed based on their effectiveness in terms of how they contribute to FGM prevention, protection and support, and law enforcement (i.e. the Istanbul Convention framework). Furthermore, the criteria for policy implementation include prospective stakeholder acceptance, the possibility of pan-Canadian implementation, and political feasibility including administrative ease and cost-effectiveness. Based on the study’s analysis, policies are recommended for the short-, medium-, and long-term.

For developing a multi-sector policy framework on FGM, the study recommends determining a lead ministry (e.g. the Department for Women and Gender Equality) responsible for policy coordination and establishing a national action plan on FGM. The action plan should be informed by knowledge gained from the statistical prevalence study and qualitative research, hence both are recommended as crucial first steps. In the medium-term, it is recommended to create the multi-agency guide and provide training opportunities through the e-learning platform and the training workshops. Integrating FGM into professional curricula has more implementation barriers and is thus recommended as a policy step in the long-term.

The ultimate challenge to achieving the objectives of FGM prevention and providing support for women and girls lies in political willingness to address FGM with a robust policy framework. Less than two years ago, the government announced It’s Time: Canada’s Strategy to Prevent and Address Gender-Based Violence. While FGM has thus far not been a focus, this strategy provides an important policy window as it creates new momentum and an anchor to Prevent and Address FGM.
Chapter 1.

Introduction

Female Genital Mutilation (FGM) or Female Genital Cutting (FGC), also referred to as FGM/C,\(^1\) is the intentional alteration or injury to female genitalia for non-medical reasons (WHO.int(a)). It causes severe health problems and is internationally recognized as a human rights violation. Worldwide more than 200 million girls and women live with FGM and every year about 3 million girls are at risk of undergoing FGM (WHO.int(a)). Although FGM is most prevalent within communities in Africa, the Middle East, and Asia,\(^2\) it is a transnational human rights and health issue that also affects women and girls in diaspora communities in Western countries, including Canada.

While there are no official statistics on FGM prevalence in Canada, it is evident that FGM survivors and girls at-risk live in the country. In 1996, the Ontario Human Rights Commission (OHRC 2000) asserted that FGM is practised in Canada and that some girls are sent abroad to undergo the procedure – a practice referred to as ‘vacation cutting.’ In 2017, stories of FGM survivors were featured in the Toronto Star’s investigation series and two recent research studies – one by anti-FGM activist organization Sahiyo (Taher 2017) and one by Uzima Women Relief Group International (Uzima 2017) – included participants who are FGM survivors and live in Canada. The Canadian government is aware of the issue. Through an access of information request, the Toronto Star obtained e-mail correspondence between government employees, Canadian consulates, and officials abroad. In one email, Elaine Cukeric from the federal government’s Vulnerable Children’s Unit wrote: “based on the limited information available, it is possible that a few thousand Canadian girls are at risk, some of whom will be taken overseas for the procedure” (Poisson 2017a). FGM practitioners also enter Canada to perform the practice on girls here, according to reports from the Intelligence Operations and Analysis Division of Canada Border Services Agency that Global News obtained through an access to information request (Bell 2017).

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\(^1\) See Appendix A for a note on terminology.
\(^2\) See Appendix B for global prevalence rates.
Canada is a signatory to human rights instruments on gender-specific violence and is thus expected to meet its obligations in taking effective policy steps (OHRC 2000). In June 2017, Status of Women Canada\(^3\) announced *It’s Time: Canada’s Strategy to Prevent and Address Gender-Based Violence*. Significantly, the Strategy lacks a clear focus on FGM, and in the Strategy’s first-year review Minister Maryam Monsef acknowledges important knowledge and data gaps on the issue (Monsef 2018). Except for scattered initiatives, Canada’s stance condemning FGM has not yet been translated into effective policy action. The Toronto Star references e-mails between government officials who admit that Canada’s response “has not been adequate” (Poisson 2017a). Arguably, Canada has not done enough to [i] understand the scope of the problem, [ii] ensure there are adequate services for survivors, and [iii] prevent FGM from happening to girls living in Canada (Poisson 2017a; Harris 2018; Poisson and Henry 2017; Marchildon 2018). Thus, Canada lacks a robust policy framework and is said to be lagging behind other Western countries in efforts to prevent and address female genital mutilation (Packer, Runnells and Labonté 2015; Patel 2017).

This study uses a qualitative approach to investigate that gap and make policy recommendations for Canada. For this purpose, the focus of this study is on Western countries where FGM is prevalent in diaspora communities. Based on a jurisdictional scan, four countries were chosen for a case study that analyzes policy approaches in the United Kingdom, the Netherlands, Germany, and France to identify promising practices and discuss components of a robust policy framework. The case study analysis is complemented with insights from nine interviews with experts from Canada and Europe.

The study is organized as follows: Chapter 2 outlines the context of FGM and summarizes information on the approach to FGM in Canada. Chapter 3 outlines the methodological approach. Chapter 4 contains the results of the case study analysis and chapter 5 presents the interview findings. Chapter 6 outlines policy action for Canada and describes the selected policy options for analysis. Chapter 7 introduces the policy objectives and evaluation criteria, followed by the policy analysis. Chapter 8 presents the study’s recommendations, followed by concluding remarks in chapter 9.

\(^3\) Status of Women Canada became the Department for Women and Gender Equality on December 13, 2018.
Chapter 2.

Background

2.1. Female Genital Mutilation (FGM)

Dating back over 5,000 years, FGM is a deeply rooted cultural practice that has been practiced throughout generations and across social classes and religious affiliations for a variety and blend of motives and beliefs (see Nyangweso 2014; Serour 2013; Berg and Denison 2013, Costello et al. 2013). It is often associated as a rite of passage into womanhood and cited as a means of curbing women’s sexuality to safeguard their premarital virginity and ensure marital fidelity. FGM is a social norm and the lack of knowledge about health consequences and taboos around sexuality contributes to its preservation (Nyangweso 2014).

The practice of FGM is defined by the World Health Organization as comprising “all procedures that involve the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” (WHO.int(a)). The WHO broadly categorizes four types:

- **Type I – Clitoridectomy**: Cutting and removing the external part of the clitoris. In rare cases, only the prepuce is removed.
- **Type II – Excision**: Cutting and removing the external part of the clitoris and the labia minora (inner vaginal lips); possibly also the labia majora (outer vaginal lips).
- **Type III – Infibulation**: Narrowing of the vaginal opening by means of creating a covering seal: The labia minora and/or labia majora are cut and repositioned to cover the vaginal opening, sometimes through stitching of the vulva. Only a very small opening is left for urine and menstrual blood. The practice may also include cutting and removing the external part of the clitoris.
  - **Deinfibulation** refers to the re-opening of the vagina by cutting open the covering seal (scar tissue) to allow penetration during intercourse or to facilitate childbirth.
  - **Reinfibulation** may follow intercourse or childbirth.
- **Type IV – All other harmful procedures**: This category encompasses all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, and cauterizing the genital area (WHO.int(a)).
In praxis, there is considerable overlap between these types, and procedures differ between regions, communities, and among circumcisers (Kübler 2017). Current estimates indicate that most cases (90%) fall under Type I, II, or IV, while Type III, infibulation, is prevalent in 10% of FGM-cases (WHO.int(b)). FGM is practiced on girls from infancy to adulthood. The majority are cut before they turn 15 (WHO.int(a)), and in many communities before the age of 5 (UNICEF 2013). It is usually carried out by traditional excisers/circumcisers with available instruments such as knives, scissors, pieces of glass or razor blades, which are often unsterilized. For infibulation, also referred to as ‘pharaonic circumcision,’ the legs are bound tightly together for up to six weeks so that scar tissue can develop to close the wound (Nyangweso 2014). Typically, FGM is performed without anaesthesia, and if anaesthesia is used it is not always effective (WHO.int(c)). The practice can be life-endangering and causes severe health problems – physically (e.g. pain, excessive bleeding, possible HIV transmission, inflammations, chronic infections, tissue damage, painful urination and menstruation, obstetric complications), psychologically (e.g. post-traumatic stress disorder, anxiety disorders, depression), and sexually (e.g. pain during intercourse, reduced sexual sensitivity) (WHO.int(c)). In some places, FGM is increasingly performed by medically trained staff (‘medicalization’), but this does not prevent the long-term psychological and physical damage of the procedure (Serour 2013).

2.2. Female Genital Mutilation in Canada

In Canada, FGM mostly affects women and girls who are immigrants or children of immigrants coming from countries and communities where FGM is customarily practiced. However, Canada lacks knowledge on the scope and scale of the issue as no official prevalence estimates have ever been calculated.4 The following sections outline Canada’s approach on FGM. In brief, FGM is criminalized and a ground for asylum. Scattered initiatives by professional bodies provide some guidance, however, there is no overarching multi-sectoral response to FGM. At government-level, after efforts in the 1990s faded, there are no signs for the development of an integrated policy framework.

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4 A media-reported estimate stems from an informal analysis based on 2011 census data and UNICEF prevalence statistics from countries of origin. This analysis suggests more than 80,000 FGM survivors live in Canada (Portenier 2019). I also attempted to estimate FGM prevalence, but the problem is that such informal analyses can only produce imperfect estimates because the publicly accessible data is inadequate. In order to produce reasonable estimates based on Canadian census data, we need collated data points that account for places of birth, age, ethnic background, immigration histories, and age at immigration.
2.2.1. Criminal Law

In 1997, the performance of FGM was specifically incorporated in the Canadian Criminal Code as a form of “aggravated assault” under section 268(3), punishable with imprisonment for up to fourteen years; and FGM resulting in death can lead to life imprisonment (Huston 2000). Facilitating the performance of FGM is also punishable with up to five years imprisonment and parents failing to protect their children may also be punishable with up to two years imprisonment (Huston 2000). It is also prohibited to bring a girl abroad for the procedure (Department of Justice 2017a). Thus, anyone involved in submitting a girl to the practice can be charged, usually the practitioner, the parents or other relatives who abet the procedure. However, there has never been a criminal prosecution on FGM in Canada.

2.2.2. Asylum Law

In 1993, Canada became the first country in the world to officially recognize gender-based prosecution as a ground for asylum protection (Ferguson and Ellis 1995), and in 1994, Canada was the first Western country to grant refugee status on the grounds of FGM (Farnsworth 1994). However, two currently ongoing cases cast controversy over Canadian immigration regulations. Two girls at risk of FGM were given asylum, but their families were not granted to stay (Tremonti 2018; Hill 2018). The parents now face the decision to leave their daughters alone in Canada where they would become ward of the state or return with them to where the girls are at danger of FGM as the parents might not be able to protect them. This situation is due to Canadian immigration laws: While parents may include dependent children for residence, this is not possible for when only the child receives protective status. The Immigration Department explains, this is to prevent parents from sending their children on their own to Canada as “anchors” (Tremonti 2018; Hill 2018). However, lawyer Geraldine Sadoway finds no evidence to support that claim (Tremonti 2018).

5 Under Canada’s current system, the only option for the parents is to apply for permanent residence on humanitarian and compassionate grounds; however, humanitarian claims are decided discretionally and can be denied for any reasons, including financial or medical concerns (Hill 2018). Lawyers like Geraldine Sadoway want to change the law by altering the definition of “family members” to include parents of a child upon whom they are dependent (Tremonti 2018).
2.2.3. **Mandatory Reporting under Child Protection Law**

Although not explicitly mentioned in any provincial child welfare legislation, the Canadian Department of Justice (2017a) clarifies that FGM is a form of child abuse. Under child welfare legislation, anyone must report known or suspected cases of child abuse and mistreatment to local child welfare protection services or the police. This applies to the general public, though an added responsibility lies with professionals working with children and youth (CWRP 2011).

2.2.4. **Guidelines for Professionals**

In 1994, an Ontario FGM Prevention Task Force comprised of representatives from practicing communities, provincial/municipal agencies and the Ontario government was established. Its trackable records are two memoranda, one to all Ontario Chiefs of Police and one to Crown Attorneys with guidelines on investigating and prosecuting FGM cases (Ferguson and Ellis 1995). In 2018, the Royal Canadian Mounted Police was said to be developing an internal policy on “honour-based violence, underage and forced marriages and female genital mutilation/cutting” to provide RCMP employees with guidance for such cases (Harris 2018). For healthcare professionals, the Canadian Paediatric Society provides basic FGM information and guidance online (Hunter 2018), and the Society of Obstetricians and Gynaecologists of Canada issued an FGM policy statement in 1992, advising their members that FGM is a criminal offence, that there is a duty to report, and that requests for reinfibulation must be refused (SOGC 2012). The provincial colleges of physicians and surgeons also adopted policy statements, echoing or referring to the SOGC. Additionally, the SOGC published Clinical Practice Guidelines on FGM with relevant information and recommendations on providing culturally competent care (SOGC 2013). Another guideline on pre- and post-natal care for patients with FGM and an information resource for teachers were published by Women’s Health in Women’s Hands in 1995 (Tharao and Cornwell 2007).

There are a few individual healthcare specialists on FGM in Canada (see e.g. Henry 2017). However, most healthcare providers have very limited or no knowledge on FGM (Entisar Yusuf, personal communication; Uzima 2017). Local organizations, such as the Sexuality Education Resource Centre in Winnipeg and the Women’s Health in Women’s Hands Community Health Centre in Toronto are setting up training sessions
on FGM for healthcare professionals. However, there are no national training standards nor urgency to provide training for professionals.

2.2.5. The 1990s: Federal Interdepartmental Working Group

The Federal Interdepartmental Working Group on FGM was established in 1994 (Weir 2000). The group was chaired by Health Canada and included representatives from the Department of Justice, Canadian Heritage, Citizenship and Immigration Canada, Status of Women Canada, and Human Resources Development Canada (Ferguson and Ellis 1995). In the late 1990s, the group commissioned key informant research across Canada to identify healthcare issues and prevention strategies. The report listed important findings; crucial among them is [i] that women with FGM have difficulties accessing appropriate healthcare services due to lack of knowledge about services but also because of cultural, financial and psychological barriers, and [ii] that healthcare providers lack critical training to provide culturally competent services which may make a visit to the doctor a traumatic experience for women (Huston 2000). In 1999, the Working Group met with stakeholders for a National Consultation and developed a long list of recommendations. Among others, these recommendations include community providers to facilitate education workshops and provide information about the Canadian healthcare system; local referral lists for healthcare services; training for healthcare professional with an added emphasis on cultural competency; school boards to provide basic information for teachers. For the government it was explicitly recommended to set up a National FGM Network for collaboration and coordination, and a National Database and Resource Centre on FGM (Huston 2000).

With the Working Group, Canada demonstrated its commitment to address FGM (Ferguson and Ellis 1995). However, the Working Group was disbanded in 2001 (Tharao and Cornwell 2007), and the proposed recommendations appear to have never reached government agenda. Moreover, the same issues in healthcare persist today as evident, for instance, in a 2017 research study with Toronto women from more than ten African countries, community organizations, social service providers, and health care agencies (Uzima 2017). The momentum from the 1990s clearly faded and nothing has been developed in the past 20 years (Entisar Yusuf, personal communication).
2.2.6. **Government Action on FGM Today**

A recent dispute in Parliament over whether the citizenship guide should contain a warning on FGM highlighted a major flaw in Canada’s approach towards FGM: uncertainty over how to deal with FGM – whether and how even to talk about it (Marchildon 2018). Conservative immigration critic Michelle Rempel insisted such a warning should remain and gathered 25,000 signatures in a petition (Harris 2018). While the new citizenship guide has not been released yet, Immigration Minister Ahmed Hussen confirmed that the warning against FGM will remain (Harris 2018).

The government states that Canada remains committed to support international efforts to prevent FGM (Government of Canada 2018; Bibeau 2016). As part of the $650 million funding of Canada’s feminist international assistance policy, $3 million are planned to support FGM intervention strategies in Benin (Harris 2018). However, the Conservatives criticize the Liberal government for not doing enough to prevent the practice at home (Harris 2018). *Canada’s Strategy to Prevent and Address Gender-Based Violence* announced in 2017 has thus far not developed a solid policy response to the issue of FGM in Canada – apart from providing funding to a coalition organization in Quebec for their project to support FGM survivors (Status of Women Canada 2017). The Department of Justice also provided funds to a Quebec-based organization for their project on FGM (Department of Justice 2017b). However, analysts say there needs to be more support for FGM-specific initiatives (Marchildon 2018; Poisson 2017b).

In summary, at the political level there is no trackable efforts in the direction of developing a comprehensive framework on FGM.

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6 As part of the Strategy’s $2.5 million funding for initiatives addressing gender-based violence in Quebec, $352,993 was provided to *Table de concertation pour les organismes au service des personnes réfugiées et immigrantes*. The Department of Justice granted nearly $350,000 funding to *Reséau D’Action pour L’égalité des Femmes Immigrées et Racisées du Québec* (RAFIQ).
Chapter 3.

Methodology

3.1. Theoretical Framework

The practice of FGM was first brought to international attention by African professionals as a health issue and later framed a human rights violation (Latham 2016). From a feminist lens, FGM is sanctioned by patriarchal social systems, though often performed by women to ensure their daughters’ status (Monagan 2010). It is an extreme form of gender-based violence and discrimination against women for the purpose behind the practice reflects deeply rooted gender inequality (UN.org). FGM is internationally recognized as a human rights violation, specifically the rights to health, security, physical and mental integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life since FGM can result in death (UN.org). However, cultural relativism opposes the notion of ‘universal’ human rights (Cassman 2008). As some defend the practice of FGM on grounds of cultural rights, Nyangweso (2014) argues that “current attitudes toward cultural diversity and multiculturalism are responsible, in part, for the persistence of female genital cutting in industrialized countries.” Indeed, there are arguments that FGM should be allowed under sanitary conditions performed by medical professionals as a harm-reduction approach (Johansen 2008). Another argument is that societies should tolerate ‘milder forms’ of FGM (as supposedly comparable to male circumcision or genital cosmetic surgery) in order to uphold cultural rights while protecting girls from more extensive forms of FGM (Arora and Jacobs 2016). Some see medicalization or allowing ‘milder forms’ as interim steps towards the eventual cessation of the practice (Latham 2016). However, medicalization implies health promotion which legitimizes FGM and counters efforts to end the practice (Johansen 2008). Allowing ‘milder forms’ is likewise criticized. The point is that any type of FGM is a form of gender violence and the comparison of ‘milder’ forms to male circumcision as well as the analogy to cosmetic surgery disregards the rationale behind the practice – a means to control and curb women’s sexual desire (Serour 2013).

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7 Several international conventions and declarations address FGM. See Appendix B.
This study is grounded in a human rights approach, adopts the UN’s policy of zero tolerance for FGM and considers FGM on the continuum of gender-based violence. The premise is that FGM is a harmful practice and an issue of child protection which takes precedence over cultural rights.

3.2. Qualitative Study

This study takes a qualitative approach, incorporating a literature review and jurisdictional scan, a case study and expert interviews.

Literature Review and Jurisdictional Scan

A literature review was conducted to identify key components and considerations for addressing FGM. The scope of this study concerns Western countries like Canada where FGM is prevalent among diaspora communities. Within a jurisdictional scan, Canada’s and other countries’ policy approaches towards FGM were reviewed. This process supported the selection of countries for the case study analysis.

Comparative Case Study

For the case study, four European jurisdictions have been chosen. The frameworks on FGM in the United Kingdom, the Netherlands, Germany, and France were analyzed to identify common and distinct features of their legal and policy approaches, and their coordination structures. The objective was to find cross-case conclusions and implications for Canada. Based on the jurisdictional scan, Table 1 presents the selection criteria with regards to the chosen jurisdictions.

Beyond these criteria, the case study jurisdictions have been chosen for a variety of reasons and motivations. These include the countries’ common legal guidance within the European realm, the availability of language-accessible material, personal networks, and, most importantly, salient characteristics in their approaches to FGM that provide insights for comparison. The UK is often described as a pioneer in policy development. France’s approach to FGM is strongly committed to law enforcement and prosecutions. In contrast, the Netherlands places a strong focus on prevention and is well known for the Dutch Chain Approach. Lastly, considering Canadian federalism, Germany’s coordination structures exemplify cross-jurisdictional networking in a federal state.
Table 1. Case Study Selection Criteria

<table>
<thead>
<tr>
<th></th>
<th>Prevalence study</th>
<th>FGM-specific criminal provision</th>
<th>FGM-related child protection measures</th>
<th>Asylum on grounds of FGM</th>
<th>National Action Plan integrating FGM</th>
<th>Institutional Coordination Structure/Body</th>
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<tr>
<td>United Kingdom</td>
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Expert Interviews

Nine expert interviews were conducted with policy and project specialist, community workers, and academics in Canada and Europe. Most have extensive experience in working with communities and engaging with service providers and professionals to increase their awareness. The European interview participants are also experts on national FGM policy, so they informed and complemented the findings of the case study investigation. In addition, all interview participants shared perspectives on various policies and approaches. The participants include the following:

- **Jacobet Edith Wambayi**, Executive Director, Uzima Women Relief Group International, Ontario
- **Entisar Yusuf**, Project Coordinator FLOURISH: Communities Collaborating to Address FGM/C, Women’s Health in Women’s Hands Community Health Centre, Ontario
- **Reyhana Patel**, Head of Public Relations, Islamic Relief Canada, Ontario
- **Corinne Packer**, Assistant Director of Globalization and Health Equity, and Senior Researcher at the University of Ottawa’s School of Epidemiology and Public Health, Ontario
- **Naana Otoo-Oyortey**, Executive Director, FORWARD, England
- **Emily Allwood**, Project Manager and Advisor on FGM, PHAROS, the Netherlands
- **Charlotte Weil**, Policy Specialist, Dept. FGM, TERRE DES FEMMES, Germany
- **Sokhna Fall Ba**, Project Officer, EQUIPOP, France
Limitations

The limitation to this study is that it has no direct means to present the voices of people from diaspora communities and FGM survivors. This study though is an important step in shedding light on FGM and discussing essential components for a policy framework. Next, a participatory approach is needed to include the target population for their invaluable insights on their needs and perspectives for effective policies, which also empowers those directly and indirectly affected to support the abandonment of FGM.
Chapter 4.

Comparative Case Study Results

In this study, the legislative and policy frameworks on FGM in the United Kingdom, the Netherlands, Germany and France are explored to analyze features of such frameworks and to identify different mechanisms of policy coordination and oversight. First of, FGM is a recognized concern in these countries as all have statistical estimates that indicate the scale of the issue. These are presented in the Table 2 below.

Table 2. FGM Prevalence and At-Risk Estimates

<table>
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<tr>
<th>United Kingdom</th>
<th>Netherlands</th>
<th>Germany</th>
<th>France</th>
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4.1. Legislative Framework

4.1.1. FGM Criminalization

FGM is outlawed and penalized in all four countries and all countries apply the principle of extraterritoriality, enabling the prosecution of FGM crimes done abroad ('vacation cutting'). The UK created an entire legislative act on FGM and Germany introduced an FGM-specific criminal law provision. France and the Netherlands, whereas, apply general provisions of their penal code referencing violence leading to mutilation and child abuse respectively. All countries prescribe different degrees of punishment depending on whether the offender was performing, abetting, or instigating FGM and whether the offender had parental authority over the girl. Among the four countries, punishment for FGM offences then varies (see Home Affairs Committee 2016;

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8 A summarizing table is provided in Appendix C. It should be noted that NGO-led initiatives and programs that are crucial for supporting survivors, protecting girls, and promoting attitude change among practising communities, are largely excluded from this overview.
UEFGM 2016a; EQUIPOP et al. 2018; Pharos et al. 2018). The overall highest penalties are prescribed in French law with a fine up to 150,000 euros and imprisonment up to 20 years if FGM was practiced on a minor under 15 years old and also if it was performed by a relative or any close person with authority over the girl (EQUIPOP et al. 2018).

The UK with the Female Genital Mutilation Act\textsuperscript{9} is most prescriptive and detailed in its legislative stance, aiming to cover all circumstances of FGM explicitly. The UK also prohibits the publication of any identifying information to ensure victims’ life-long anonymity which is to encourage girls to report offences (Home Affairs Committee 2016). Another means to encourage prosecutions of FGM offences is the extension of the limitation period for bringing cases to court. This was done in France, Germany and the Netherlands to enable victims to initiate court action against those who subjected them to FGM at a younger age (UEFGM 2017; UEFGM 2016a; UEFGM 2016b).

To date there have been no convictions in the Netherlands and Germany. The UK had three acquitted cases and its first conviction in early 2019 (Summers and Ratcliffe 2019). In contrast, France had between 30 and 40 trials with numerous convictions since 1979 (EQUIPOP et al. 2018; EIGE.europa.eu (c)).\textsuperscript{10} In fact, among all European countries, France stands out with the largest number of FGM court cases by far. This shows that FGM can be successfully prosecuted without having FGM-specific criminal legislation. In comparison to other jurisdictions with higher thresholds of proof, the French legal system makes it easier to initiate trials because the survivor must not herself pursue e.g. her parents in the court but can be represented by someone appointed as her guardian by the judge (Home Affairs Committee 2016). Organizations working in the field of sexual violence and protecting children from abuse can play a pivotal role, either by assuming the role of ‘civil party’ in criminal procedures that must be initiated by public prosecutors or by initiating civil action (EIGE.europa.eu (c); UEFGM 2017). The high rate of prosecution is also linked to the routine medical examination, including genitalia, of children under six years old, which is a means to detect cases

\textsuperscript{9} In the UK, the Prohibition of Female Circumcision Act was enacted in 1985. It was replaced in 2003 with the Female Genital Mutilation Act for the jurisdictions in England, Wales, and Northern Ireland, and with the 2005 Female Genital Mutilation Act in Scotland.

\textsuperscript{10} The exact number of FGM court cases in France is unknown. The imprecise data on the judicial activity on the subject matter stems from the fact that FGM is prosecuted under general provisions of the penal code and different provisions can be applied to different cases. Hence there is a lack of knowledge on the number of cases registered, the rate of prosecution, the rate of convictions, and quantum of sentences (Commission nationale consultative des droits des l’homme 2013).
It is argued that the media coverage of FGM cases and convictions contributed to a decrease of FGM in France among settled diaspora communities (UEFGM 2017).

4.1.2. Child Protection Orders

The courts in all four countries are not only a venue for possible prosecutions. To respond to threats of FGM, judges can also issue protection orders for girls. The measures of these orders vary and may contain: ordering individuals not to aid, procure or in any way encourage or assist another person in performing FGM; placing a girl under supervision; mandating an educational assistance measure; withdrawing the girl’s passport to prevent ‘vacation cutting’; blocking certain individuals from the child; placing the girl in custody care; and requiring the girl to undergo medical examination upon return from countries of origin/ancestry (see UK Government 2016; Pharos et al. 2018; UEFGM 2016a; EQUIPOP et al. 2018).

To further strengthen the role of protection orders, the UK created specialist FGM Protection Orders (FGM POs) in 2015. In comparison to ‘regular’ (non-FGM-specific) protection orders, the threshold for issuing FGM POs is lower, the burden of proof is not that high, and third parties may apply for FGM POs (Rohma Ullah, personal communication). FGM POs are issued by a court, following an application for such an order from (i) the person who has had or is at risk of FGM, (ii) a local authority, or (iii) any other person who is permitted standing by the court – for instance the police, a teacher, a family member, or an organization (UK Government 2016).

4.1.3. Mandatory Reporting

In all four countries, professionals are required to report when they suspect a case of FGM. In France, professionals are under specific duty to report, yet there is also a general public duty to report as child protection is a collective responsibility and it is a criminal offence not to report (imminent) abuse on minors (UEFGM 2017). Likewise, all people in Germany are required to report any knowledge of a serious crime (UEFGM 2016a). In the Netherlands, the 2013 law on Mandatory Reporting of Domestic Violence and Child Abuse, which encompasses FGM, requires professional organizations and self-employed professionals, such as doctors, teachers, youth-institution staff, to abide
by a reporting code (Pharos et al. 2018). The reporting code lays out a ‘roadmap’ that guides professionals in responding appropriately to signs of mistreatment in the home (UEFGM 2016b). France also provides guidance on reporting requirements (EIGE 2018). In the UK, professionals are under statutory obligation to refer cases to the local child protection services. In addition, since October 2015, healthcare professionals, social workers, and teachers in England and Wales are required to report all known/visually confirmed cases directly to the police (UEFGM 2016c). With the new reporting duty, professionals are encouraged to do both, report to the police and inform child protection services (Rohma Ullah, personal communication).

4.1.4. Mandatory Recording

The UK is the only country to have introduced mandatory recording of known FGM cases. The duty applies to clinicians of National Health Service (NHS) healthcare settings, acute hospital trusts, mental health trusts, GP practices and community services with mental health trusts (UEFGM 2016c). When, for instance, clinicians identify a case of FGM during their examinations, they must record this. The data is collected through NHS Digital on behalf of the Department of Health, then published in the FGM Enhanced Dataset. The system still suffers though from incomplete datasets. One problem is that visual confirmation of FGM is not always straightforward and not all practitioners can make solid diagnoses of the different types of FGM (Mathers and Rymer 2015). Despite the caveat of having many ‘unknowns’ in the date entry, the policy is praised by some as a starting point for gathering better information on the needs of FGM-affected women and girls (UEFGM 2016c; Rohma Ullah, personal communication), which helps the planning of relevant support services (RCGP 2014). Despite its recognized benefits, the policy is also criticized for deterring women from seeking support and impacting women’s confidence in their doctors’ confidentiality, and the problem of consent over data collection arises (Mathers and Rymer 2015, Naana Otoo-Oyortey, personal communication), yet others stress that the data collection is regulated to ensure the statistics are anonymous (Rohma Ullah, personal communication).
4.1.5. Asylum Protection

All four countries grant asylum on the grounds of FGM (EIGE 2018). Though their processing systems differ, asylum laws are not compared here within the scope of this study.

4.2. Policy Framework

4.2.1. National Action Plans

For an effective policy framework on FGM, it is recommended to create national action plans (UNICEF 2010). All four countries embed FGM within national action plans on preventing violence against women, domestic violence, or child abuse.\(^{11}\) Scotland, meanwhile, adopted a distinct national action plan that is dedicated solely to FGM (Scottish Government 2016).\(^{12}\) There have been calls for such FGM-specific action plans from various advocacy organizations, including Germany’s INTEGRA network (TDF 2012). All countries’ action plans are monitored and renewed periodically, with the exception of Germany’s plan that has no time-frame, was last updated in 2012 (BMFSFJ 2012), and has no monitoring system is in place (Johansen et al. 2018).

4.2.2. Coordination Structures

In every country, there is some form of institutional mechanism for policy coordination and structures for collaboration between national and local level.

The UK: Strategic Policy Lead and Policy Operationalization Structures

In the UK, since December 2014, policy coordination on FGM across government agencies is led by the **FGM Unit**, housed within the Home Office (Home Affairs Committee 2016). The Unit also promotes government resources on FGM, including the multi-agency guidelines, communication products, and e-learning opportunities. It

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\(^{12}\) Other EU countries with FGM-specific national action plans are Portugal and Finland (EIGE 2018).
provides support for local strategies on FGM and as such, it is well situated to identify effective practices across local areas and professional bodies, and to develop policies with the community sector and professionals (Home Office 2016a). Essentially, the FGM Unit is the strategic policy lead, but it relies upon institutions and organizations to implement policies on the grounds. Local Safeguarding Children Boards (LSCB) are crucial in putting policy into practice at local level. The LSCB is a multi-agency body set up by the Local Authority to coordinate the roles of various actors involved in promoting child welfare (Citizensadvice.org.uk). LCSBs are like the middle ground between government and professionals, which makes them an effective policy operationalization structure (Rohma Ullah, personal communication). Many areas in the UK also have local FGM steering groups where community members and professionals try to find ways of tackling FGM effectively in their region (Rohma Ullah, personal communication; Naana Otoo-Oyortey, personal communication).

Since 2015, the National FGM Centre also assumes a significant role. They operationalize national FGM policy through their work with Local Authorities, professional training, and community engagement. Its primary objective is to work towards system change in social work through modelling good practice (Rohma Ullah, personal communication). National FGM Centre staff are embedded within Local Authorities to support with FGM cases by taking on case management, providing guidance to frontline professionals, and heading child protection proceedings and FGM Protection Order applications (McCracken et al. 2017). The Centre offers accredited training for professionals and community organizations to establish FGM expertise and ensure good practice in the provision of services (McCracken et al. 2017). Training includes guidance on the mandatory reporting duty, FGM Protection Orders as well as on how to talk with families about FGM (Rohma Ullah, personal communication). The Centre also provides resources on FGM and an overview of regional FGM services in the country (Nationalfgmcentre.org.uk).

The Netherlands: The Dutch Chain Approach (Ketenanpaak)

The Dutch multi-agency coordination structure on FGM is the so-called Chain Approach that is operationalized at municipal level. The Chain Approach links relevant actors and their intervention roles or service provisions together within a multi-agency chain to facilitate collaboration between governmental and non-governmental agencies,
and key professionals in healthcare, child-protection institutions, child abuse advice and reporting points, schools, the police, as well as members from FGM-practising communities (Pharos et al. 2018).

The Chain Approach began as a pilot in six major cities (2006-2009) that was financed by the national health ministry. Today, each municipality in the Netherlands is responsible for tackling FGM locally by managing and financing its local chain approach. In order to connect the actors within the chain and to clarify their roles and responsibilities, every local chain establishes multi-agency agreements, protocols and guidelines. (Pharos et al. 2018; EIGE.europa.eu(b)). This builds joined responsibility and a coordinated response to tackling FGM (EIGE.europa.eu(b)).

The chain approach is well known in other countries (Pharos.nl(b)). It is highlighted as a good practice to address FGM by the European Institute for Gender Equality (EIGE.europa.eu(b)) because its structure effectively connects relevant actors and involves the communities. Given the cultural anchoring of FGM, the indispensable role of the key persons is especially emphasized (EIGE.europa.eu(b)). Key persons are members of practising communities who receive training to carry out activities, home visits and information sessions within communities (Pharos et al. 2018; EIGE.europa.eu(b)). In the Netherlands, the Federation of Somali Associations (FSAN) and the organizations for refugees in the Netherlands (VON) have an extensive network of key persons. Key persons are trained by FSAN and Pharos (the National Expertise Centre on FGM) on an annual basis, and they can then later train new key persons (Pharos.nl(a)). Key persons also act as liaison between the communities, professionals and authorities (Pharos et al. 2018) as they play a crucial role for the understanding of language, culture and believes (Emily Allwood, personal communication). To further strengthen the crucial role of community members in the promotion of ending FGM, the Dutch Ministry of Health, Welfare and Sports nominated four National FGM Ambassadors from affected communities in 2009 (Pharos, et al. 2018).

Germany: Federal-State-NGO Working Group and Local Roundtables

Germany has a federal-state-NGO working group on FGM since 2009, involving several Federal Ministries and representatives from state-level, the German Medical Association and a delegation of non-governmental organizations. Since mid-2014, the Ministry for Family Affairs, Senior Citizens, Women and Youth assumes the
lead of the group (BMFSFJ 2015). They convene annually, though there have been interruptions in the regularity of meetings and the presence of representative actors varied. The idea is to develop strategies together, however, it is mostly an exchange of information to hear what is being done in the state jurisdictions (Charlotte Weil, personal communication).

Apart from the rather inconsequential working group, state governments are active on FGM intervention at local level to varying degrees. In some German states or cities, there are **local roundtables** on FGM that were set up by civil society organizations. The roundtables include NGOs and sometimes government representatives who exchange information and discuss local intervention strategies (UEFGM 2016a). The extent of their work varies widely across jurisdictions (Charlotte Weil, personal communication). For instance, North-Rhine Westphalia created an education portal, providing specific knowledge for various profession groups, referencing medical experts and counselling services (Kutairi.de). The roundtable in Hamburg meanwhile developed a comprehensive outline on interdisciplinary intervention which in its purpose resembles the cooperation structure of the Dutch Chain Approach as it details intervention possibilities for various professional groups and areas for cooperation among members of the intervention chain (Hamburger Runder Tisch 2015).

Overall, there is little work and policy development done at federal level. In Germany, like in the other countries, NGOs are the indivisible actors when it comes to tackling FGM. An important structure in Germany is the **INTEGRA network** where 28 organizations exchange information, experiences, different approaches and good practices (Netzwerk-integra.de). Commissioned by the Ministry for Family Affairs, Senior Citizens, Women and Youth, INTEGRA conducted a qualitative study on FGM among African diaspora communities in five major cities in Germany (INTEGRA 2017).

**France: MIPROF**

In France, the Secretariat of State for Equality between Women and Men with the Women’s Rights and Gender Equality Service (**SDFE**) takes on responsibility concerning violence against women with regards to proposing, implementing and evaluating measures on violence against women. In 2013 the Secretariat established the Inter-Ministerial Mission for the Protection of Women against Violence and the Fight against Human Trafficking (**MIPROF**). MIPROF has since led actions *inter alia* on FGM by
collecting, analyzing and distributing information as well as sensitization tools, such as a brochure and leaflets (EQUIPOP et al. 2018). MIPROF also organizes information and exchange opportunities with the NGOs working on FGM (Sokhna Fall Ba, personal communication). However, in recent years the Secretariat had increasingly fewer financial resources at its disposal due to budget allocations which weakened the institutional coordination function as well as collaborations with and funding for the organizations working on FGM (Sokhna Fall Ba, personal communication).

**Coordination Structures Comparison**

In comparative terms, the UK and the Netherlands appear to have stronger government commitment to facilitating mechanisms for policy coordination. Germany and France, whereas, are lower on the continuum of integrated policies and government coordination frameworks.

The UK demonstrates a promising approach in the combination of strategic policy lead by the central government and the operationalization of policies at local level through the National FGM Centre, LCSBs, professional bodies, and community work through NGOs such as FORWARD. This approach is effective in that the National FGM Centre relies upon strong backing from government and the government relies upon feedback from the Centre and other organizations working directly with communities for policy development (Rohma Ullah, personal communication).

The Netherlands pioneers a unique structure. The Chain Approach is based on municipal leadership and collaboration among relevant actors with the critical involvement of community members. Evaluations of the Chain Approach's effectiveness are very positive in terms of reaching the target groups and involving all actors with designated roles and connection to the chain (EIGE.europa.eu(b)). It is a promising model that stands out in Europe as successfully integrating prevention, care, law enforcement and education (Emily Allwood, personal communication).

**4.2.3. Multi-Agency Guidelines and Protocols**

Guidelines and protocols are meant to enable relevant actors to contribute to prevention, protection, support, and prosecution within their roles and responsibilities (UNICEF 2010). The UK has an overarching Multi-Agency Statutory Guidance on FGM
In the Dutch Chain Approach, each municipality establishes a multi-sector protocol to establish roles and responsibilities among all links in the chain. There is also a model protocol on medical care that is being converted into a multidisciplinary guide (Pharos.nl(b)). In addition, numerous agencies and professional bodies in both countries produced guidance and policy documents for their members. Germany and France have no national multidisciplinary guidelines or protocols on FGM. In Germany professionals rely upon guidance and recommendations drawn up by NGOs, the German Medical Association and the Society for Gynaecology and Obstetrics (UEFGM 2016a). In France, the health and education sector developed relevant guidance material and two Maternal and Child Protection Centers established FGM protocols (EQUIPOP et al. 2018).

4.2.4. Training Professionals

It is critical to train professionals who may interact with survivors and girls at-risk to enable them to play a key part in addressing FGM. Training on FGM in the four countries is primarily provided through various NGOs, individual healthcare specialists, as well as online learning platforms. As a pan-European initiative, United to End FGM launched an online platform in 2017 with general and sector-specific learning modules.

FGM training is usually voluntary for individual professionals, yet in the UK and the Netherlands institutional training requirements are an integrated part of their policy frameworks on FGM. In the UK, the Multi-Agency Statutory Guidance requires relevant organizations to have staff trained on FGM and to have a lead person on FGM who has taken additional training. The Dutch Chain Approach ensures FGM expertise in relevant institutions through the policy of Focal Point Officers: All relevant institutions and organizations in each municipality are supposed to have a specialist FGM expert, so-called Focal Point Officer. They receive annual training from Pharos so that they can take the lead on FGM case management and function in a supporting role for their colleagues (Pharos.nl(a)). Germany has no overarching structure on training professionals, but the German Medical Association published FGM-relevant recommendations which are distributed in the speciality training for gynaecologists (Bundesärztekammer 2013). MIPROF in France developed a multidisciplinary training kit on FGM for health professionals and social workers (Sokhna Fall Ba, personal communication).
Moreover, France is the only country among the four that incorporates a compulsory module on FGM into the medical curriculum (EQUIPOP et al. 2018). French NGOs are advocating for making FGM training compulsory for initial and continuous training for all relevant professionals (Sokhna Fall Ba, personal communication).

4.2.5. Healthcare Support

In the healthcare sector, the four countries share some common features. FGM is integrated in their medical record systems to cover FGM-related treatment costs, however, a cross-national review revealed that the system is only used systematically in the UK and the Netherlands (Johansen et al. 2018). All countries’ health insurance systems cover deinfibulation. Clitoral reconstruction on the other hand is not everywhere integrated in publicly funded services, not least because the WHO remains apprehensive on recommending the procedure as evidence on its safety and efficacy is thus far inconclusive (Johansen et al. 2018). Among the four countries, only France reimburses clitoris reconstruction through public healthcare (Karim and Dekker 2017).13 Women and girls affected by FGM are entitled to psychological and sexual counselling in the four countries, yet while France and the Netherlands are reported to have good coverage of these services, in the UK there is significant variation between regions, and the availability of counsellors in Germany is very limited (Johansen et al. 2018).

In France, services such as surgical reconstruction are offered in a few medical units. However, these units lack multidisciplinary teams (sexologists, gynaecologists, psychologists), human and financial resources to provide well-rounded care (EQUIPOP et al. 2018). In the UK, 25 specialist Africa Well Women clinics were created since the 1990s. The clinics fall under National Health Service (NHS) and services are thus free of charge. They offer medical support, psychological and psychosexual counselling, and health services for FGM-related complications as well as deinfibulation and even surgical intervention where appropriate. The clinics are also involved with research, advocacy, training, and activities with communities (EIGE.europa.eu(a)). The European Institute for Gender Equality identifies these Africa Well Women clinics as a good practice on providing women and girls affected by FGM with adequate supports. While the clinics are remarkable in the provision of specialized services, there is a concern of

13 Clitoral reconstruction surgery repositions the internal part of the clitoris that remained intact and thereby can help to improve sexual function.
accessibility as they tend to be centralized in London and south England, and many clinics have limited operating times (UEFGM 2016c; EIGE.europa.eu(a)).

In absence of specialist clinics, the Netherlands established **FGM consultation hours** within healthcare centers in 2012. These consultation hours are financed by the Ministry of Health, Welfare and Sport, led by the Dutch Public Health Services, and monitored for effectiveness by Pharos. Women living with FGM are made aware of these consultation hours through the key persons who may also accompany them (Pharos.nl(a)). In addition to FGM consultation hours, having Focal Point Officers also ensures in-house expertise in Youth Health Care institutions. The Youth Health Care is an important component to the Dutch FGM prevention policy as they see all children up to age 18 and their parents on a regular basis. As doctors and nurses are mandated to speak to parents from ‘risk countries’ about FGM, all children who are potentially at risk can be ‘targeted’ for prevention activities and monitored if necessary (Emily Allwood, personal communication).

In France, under the Maternal and Child Welfare system, all children up to the age of six have regular medical check-ups which includes genital examination, and girls who are perceived to be at risk of FGM are checked usually once a year and every time they return from abroad. The appointments are also meant for healthcare providers to talk with the parents about FGM and inform about health consequences (EQUIPOP et al. 2018). Although the check-ups are not universally mandatory, they are routine practice and in fact required for families receiving social security (Home Affairs Committee 2016). However, fear of criminal prosecution likely deters parents from taking their daughters who have been subjected to FGM to the doctor, putting them at risk of other health consequences. Another unintended consequence is that parents may postpone the procedure for their daughters for when they are older. This requires more intervention efforts for girls between 7 and 18 (Sokhna Fall Ba, personal communication). The examination of girls’ genitals is somewhat controversial. The Royal College of General Practitioners in the UK considers this policy tool as possibly traumatic for children and a cause for alienating hard-to-reach communities (RCGP 2014). Another concern is that compulsory gynaecological testing amounts to a violation of individuals’ right to freedom (UNICEF 2010), specifically with regards to ‘my body my rights campaign’.
4.2.6. Measures to Prevent Vacation Cutting

The Netherlands created a brief “Statement Opposing Female Circumcision” signed by government ministries and other institutions. Available in numerous languages, the document emphasizes FGM health impacts and legal consequences for the families if their daughters were to undergo FGM. It is also dubbed the ‘health passport’ as it fits discretely in a passport. The health passport is distributed through Youth Health Care professionals and is meant to support families in averting pressure from relatives and community members to subject their daughters to FGM while abroad (Pharos.nl(a)). The UK also adopted the health passport and it is expected to be coming soon in Germany (already piloted in Hamburg). In the UK, the FGM POs can play a similar role in averting pressures from relatives to subject daughters to the procedure. The FGM POs may in fact be stronger than the health passport because they are court orders that are specific to a certain girl and may explicitly be addressed towards a relative who would subject the girl to FGM (Rohma Ullah, personal communication).

The UK’s Operation Limelight, a policy that was recently adopted in the United States, is an air-site operation targeting inbound and outbound flights to countries with high prevalence of FGM. The Metropolitan police together with Border Force officers and subject-matter experts carry out educational and enforcement activities which include training airport staff to recognize girls at-risk and detect possible FGM offences, and conducting intelligence-led checks on passengers with questioning and baggage searches. All frontline Border Force staff are required to take an e-learning course on modern slavery which includes an FGM module (Home Affairs Committee 2016). Operation Limelight is carried out only for a few weeks of the year during school holidays, the so-called ‘cutting season’ (Safeguarding Hub 2018). In 2017, the policy was extended to rail terminals, targeting predominantly passengers to and from Brussels and Paris (Murphy-Bates 2017). Operation Limelight received positive media coverage. However, there are also concerns about aggressive questioning (Naana Otoo-Oyortey, personal communication). The policy is also accused as discriminatory and racial profiling, potentially causing more harm than good (Safeguarding Hub 2018). On the other hand, it is argued that targeting certain passengers is justified for the purpose of safeguarding children (Safeguarding Hub 2018). Overall, the operation has limited impact on preventing and detecting FGM (Safeguarding Hub 2018) but it forms an integral part to the UK’s policy framework.
4.3. Summary: Promising Practices

All four countries have statistical estimates on FGM prevalence. Germany’s are being updated regularly by the NGO Terre des Femmes, and new prevalence-estimate studies are currently ongoing and to be published soon in France and the Netherlands. Knowledge about FGM prevalence in Wales and England is improving with increased data collection through the mandatory recording policy. This is a promising practice for improving data, yet there are also concerns.

All countries criminalize FGM, and it might not matter as much whether FGM is criminalized through general or FGM-specific provisions (UNICEF 2010), as France demonstrates. Nevertheless, robust FGM-specific legislation is evident of a strong focus on the issue in the UK. The case study also shows promising legislative provisions to support the prosecution of FGM, such as ensuring victims’ life-long anonymity and extending the limitation period. In terms of prevention, all four countries have means of court-ordered child protection measures, and the UK presents a promising practice with its FGM Protection Orders. Also, to enhance child protection, most countries provide guidance and protocols for professionals on how to report suspected cases of FGM.

Most countries have current action plans on FGM with a degree of monitoring in place (Johansen et al. 2018). All countries also set up coordination bodies or structures, which appear strongest in the UK and Netherlands, albeit their mechanisms differ. The UK Home Office and moreover the National FGM Centre support local implementation, whereas in the Netherlands, the responsibility rests upon the municipalities from the outset. Both practices appear promising for a national strategy with local intervention efforts. These two countries also adopted multi-sectoral guidance protocols, which prove important for an integrated policy framework.

Furthermore, the Dutch Chain Approach presents a promising practice on ensuring professional capacity through the policy of training Focal Point Officers to act as FGM experts in relevant institutions. All countries address FGM through their health-care system, and a common feature is the integration of FGM within their medical record system. To support survivors, providing spaces for FGM-specialist services is a good practice realized in the UK through the Africa Well Women clinics or through the Netherlands’ consultation hours. Another promising practice is the health passport, which started in the Netherlands and is now being adopted in other countries.
Chapter 5.

Concurrent Interview and Literature Findings

The interviews indicated that first steps in building a policy framework on FGM entail setting an action plan, estimating FGM prevalence (ideally complemented by qualitative research), and creating spaces to engage with community actors, professionals, and policy-makers in developing a multi-sector approach. It was also emphasized that community-led programs are key to promote the abandonment of FGM, that support services must be accessible, and that certain professionals who are in a key position to protect girls and support survivors need to receive training. It should be noted that these insights resonate closely with what is being discussed as essential policy components and best practices in the literature.

5.1. National Action Plan

Jacobet Edith Wambayi highlighted that FGM is not perceived as a Canadian problem, thus national action is missing. All interview participants expressed strong support for creating national action plans on FGM. Such a plan could be embedded within wider national strategies on child protection or on preventing violence against women. However, this runs the danger of not having FGM-specific targets formulated which might lessen the focus and efforts on FGM according to Naana Otoo-Oyortey: “The targets [in the UK’s Strategy on Ending Violence Against Women and Girls] are not explicit, whereas the targets in the Scottish Government policy [distinct FGM Action Plan] are very clear – unfortunately both approaches fail to include information on funding.”

The need for national action plans is also expressed in the literature. Nyangweso (2014) states that acknowledging FGM as a national concern rather than an exclusive immigrant issue is an important step to effectively addressing it. UNICEF (2010) explicitly recommends drawing up national action plans with allocated budgetary and non-financial resources for various entities to implement action items, and provisions for monitoring and evaluation.
5.2. Prevalence Study

The immediate problem in Canada is the lack of knowledge on FGM prevalence as Reyhana Patel emphasized: “We know it is happening here. But we don’t know the extent of it. No statistics, no in-depth research to tell us what is happening.”

All interviewees expressed the importance of having FGM prevalence statistics. Numbers are important for regional planning purposes and according to Charlotte Weil, having prevalence statistics can help enormously in urging for action on political level: “Whether there are 300 or 500 affected women [in a region], … in any case, something must be done; but numbers are relevant in politics.”

Some interviewees stressed that statistical estimates should be complemented with qualitative research at community-level to learn about attitudes towards FGM and the needs of those affected, and to learn about existing resources to better understand the gap in order to develop concrete solutions and strategies.

Providing an overview of the nature and prevalence of FGM is the first item listed on UNICEF recommendations’ checklist (UNICEF 2010). The Home Affairs Committee (2016) in the UK also states that the first step towards addressing FGM effectively is to measure and understand the issue properly. Qualitative research then helps to tailor messages and activities to the respective audience (Berg and Denison 2013).

5.3. Multi-Sector Action at National and Local Level

Emily Allwood stressed that tackling FGM “requires a comprehensive and targeted approach.” To ensure comprehensive action, interviewees spoke to the need of a multi-agency approach, including the healthcare and education sector, child protection services, the police, immigration services, community and non-governmental organizations. As Rohma Ullah put it: “It’s all about that joint effort.”

To ensure a concerted multi-agency response, international agencies’ guidelines for national FGM policy recommend establishing a multi-sectoral entity responsible for the overarching policy framework and coordination as well as for facilitating collaboration and the development of common guidelines (UNICEF 2010; Council of Europe and Amnesty International 2014).
Within the interview conversations, there was also an understanding that policy implementation needs to focus on operationalizing an effective FGM response at the local level. Thus, in addition to an overarching national approach, Rohma Ullah added: “If I were to say should Canada adopt anything else, it would be those localized strategic groups where, you know, there are representatives from the health sector, education, police, social care, but also community organizations as well. […] It’s about knowing what’s going on nationally and then how to implement that locally, and you can’t do that without everyone being on the same page.”

For integrated national and local efforts, Charlotte Weil highlighted a promising practice is having a national FGM reference centre or knowledge hub where relevant information, materials and existing projects are documented. Charlotte Weil said this would enhance efficiency in collaboration because organizations across the country had a single hub where they can learn about other organizations’ projects and programs, and access existing materials, thus avoiding duplication of efforts among stakeholders: “That would be great because otherwise we don’t always know what other organizations are doing. […] It would be a very small investment that would yield so much benefits.”

5.4. Funding for Community Organizations

The interviews addressed the need for social change at communal level. Naana Otoo-Oyortey said: “Ultimately, change can only happen on the ground and engaging key communities to play a lead role in ending FGM is the best way to prevent the practice and safeguard those at risk and affected, including empowering them to access needed support.” The interviewees stressed that community activities are best led by organizations with close community ties. Jacobet Edith Wayambi said: “This will be good because communities are being approached in a culturally appropriate way by people they can relate with.”

This understanding is mirrored in the literature as research shows that programs on FGM that are most effective are community-led (Connelly et al. 2018) and participatory in nature so that communities “define the problems and solutions themselves,” ideally developing a collective choice to abandon FGM (WHO 2008). It is recommended to create a forum for community dialogue (WHO 2008), where the topic of FGM is embedded in a broad range of issues, including culture, values, sexual and
reproductive health, gender, and human rights (Costello et al. 2013; UNICEF 2010). A promising practice is that such programs are led by members of the community, so-called ‘cultural mediators’ who receive training and support from activist organizations (IOM 2009), because they have an insider perspective (Khaja, Lay and Boys 2010). This was also identified a good practice by Women’s Health in Women’s Hands, community health centre in Toronto (Tharao and Cornwell 2007).

The interview participants agreed that with regards to interventions at community level the vital role of government is to support and provide funding to organizations with close community ties. Naana Otoo-Oyortey envisioned the “government should provide the policy framework on best practice in relation to community engagement and provide the needed resources and funding to support this work.” Funding is an ongoing challenge as many interviewees mentioned. Charlotte Weil highlighted the need for consistent funding to ensure sustainability of community organizations’ engagement projects: “It is really about the provision of funding, in the long-term. These scattered 2-year funded projects will not abolish a century-old practice.”

5.5. Support Services

UNICEF (2010) notes that supporting FGM survivors includes legal assistance as well as health and psychological support services, and highlights that a network and referral system would ensure that service provisions are not siloed but integrated.

The Canadian interview participants found a lack of accessible information about relevant support services for women living with FGM. Corinne Packer suggested that immigration and integration services could play a stronger role in providing information for newcomers about such services. She also considered that health/patient advocates (also referred to as health navigators) in community health centres could play an important role, especially if they share ethnic background and/or immigration patterns with people from FGM-practising communities. She referenced utilizing health advocates from immigrant populations is generally a good practice to target community-specific health concerns: “I think there is definitely an understanding that that works and an interest to work with that strategy.”
5.6. Training Professionals

Interviewees emphasized the important role of professionals who may come in contact with FGM survivors and girls at-risk, including healthcare providers (general practitioners, gynaecologists, midwives, maternity care, paediatricians, psychologists) as well as childcare professionals, social workers, school teachers, refugee and immigration board officers, and police officers. These professionals are in key positions to provide women and girls with support as well as to identify girls at-risk and prevent FGM. The need to train professionals is highlighted in the literature and was a recurring theme in the interview conversations. Sokhna Fall Ba stressed: “And really what we noticed as organizations, that really all professionals should be trained in women’s rights in general and also in FGM.”

Speaking from Canada, Entisar Yusuf confirmed that training healthcare providers on FGM is critical, and Jacobet Edith Wambayi expressed specifically the need for culturally appropriate training for service providers, especially primary care practitioners. European interview participants also highlighted the promising practice of having individuals from FGM-practicing communities become trainers for professionals.

5.7. Summary: Key Elements for a Policy Framework

In conclusion, establishing a policy framework on FGM entails establishing a national action plan; commissioning a prevalence study; and setting up a coordination structure (nationally and locally) to bring actors from relevant sectors together. The government can best promote community interventions by (a) providing consistent funding, and (b) supporting collaborations, networking and distribution of good practices. Other crucial steps are means to improve support services, especially in healthcare, and to ensure capacity building on FGM among professionals.
Chapter 6.

Policy Action for Canada

There is a general understanding that Canada lags behind other Western countries in efforts to address FGM (Poission 2017a; Packer, Runnels and Labonté 2015; Patel 2017). Canada has no statistics on FGM prevalence and no multi-disciplinary approach nor comprehensive policy framework to address and prevent FGM.

6.1. The 4 Ps approach

A policy framework on FGM requires a comprehensive approach with measures to support and protect survivors and girls at-risk, improve education and prevent FGM (UNICEF 2010). An influential tool for building a policy framework is the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) that was adopted by the Council of Europe in 2011. It is the first legally binding instrument in Europe requiring signatory states to take effective action. The Council of Europe published guidance on how to apply the Istanbul Convention to FGM, which provides a useful framework for reference.

The Istanbul Convention envisions action on FGM following the 4Ps approach: Prevention, Protection, Prosecution, and Integrated Policies. The latter refers to creating a comprehensive policy framework. It requires government to set up a coordinating body to facilitate collaboration and to monitor policy implementation. In addition, creating a national action plan provides a framework to integrate all necessary policies. The integrated-policies category also demands for a robust data collection and research system (Council of Europe and Amnesty International 2014). Hence, first steps towards a policy framework on FGM are:

- Determine lead ministry to act as coordinating body or to set up such a body as a sub-unit. A suitable lead would be the Department for Women and Gender Equality (formerly Status of Women Canada) given its administration of Canada’s Strategy to Prevent and Address Gender-Based Violence.
- Determine FGM prevalence estimates in Canada.
- Establish a National Action Plan.
The Action Plan would contain policies that address FGM by promoting prevention, protection, and prosecution. Prevention requires action to avert FGM from occurring. This also entails measures to promote the total abandonment of FGM at individual and communal level, including information campaigns, community programs as well as engagement by professionals. Protecting women and girls from FGM includes asylum protection as well as safeguarding measures for imminent risks, and reporting structures and guidance for action from relevant authorities. It further entails professional support services (e.g. health, legal) for those affected. Law enforcement is meant to prevent imminent cases of FGM and also to prosecute perpetrators of the criminal law (Council of Europe and Amnesty International 2014).

This study focuses on policies that are meant to provide relevant actors with knowledge and guidance to contribute efforts to prevention, protection and prosecution.

6.2. Policy Options

The following policies are selected items from a longer list of Action Plan items proposed for consideration in Chapter 8, Table 4. The list stems from case study and interview insights. The following policies were chosen for analysis because they are considered primary and urgent or foundational for building a Canadian policy framework.

6.2.1. Policy 1: Prevalence Study and Qualitative Research

Establishing FGM prevalence statistics in Canada would be based on census, ethnic background and immigration data in relation to prevalence rates in countries of origin [UNICEF data]. Ideally, Statistics Canada would be engaged in the generation/collation of Canadian data. The methodology should consider implications and impacts of migration,¹⁴ and the demographics of immigrants from FGM prevalent countries. For estimating the number of women living with FGM in Canada, it should be taken into account whether they spent parts of their childhood in countries of origin, hence age at immigration is important. For estimating the number of girls at-risk, an assumption could be made that only half the girls from diaspora communities would be subjected to FGM given influences of migration and attitudes of parents (compare TDF 2018).

¹⁴ See e.g. Berg and Denison 2013; Johnsdotter and Essén 2015; IOM 2009; Costello et al. 2013
Such numerical estimates may be distorted because prevalence rates in countries of origin can vary widely between regions, and prevalence within diaspora communities may deviate from these rates especially for second generation children. To enhance the prevalence study, qualitative research with diaspora communities in Canada should be conducted to gain better understanding of attitudes towards FGM within the communities. Such research should be led by organizations with close community ties, such as Uzima Women Relief Group International, Women’s Health in Women’s Hands, Reséau D’Action pour L’égalité des Femmes Immigrées et Racisées du Québec (RAFIQ) in collaboration with academics, universities or research bodies.

6.2.2. Policy 2: Multi-Agency Guide on FGM

This policy would require the lead ministry in collaboration with other ministries, institutions, and experts to develop a multi-agency guide. This guide is meant to provide information on FGM; to provide strategic guidance on how to respond to FGM for various institutional agencies; to advice front-line professionals on how to identify cases of FGM and girls at-risk; and recommendations for cultural-sensitive communication.

Collaborators as well as targeted audience of the guide may include but not limited to the following: Department for Women and Gender Equality (formerly Status of Women Canada); Health Canada; Public Health Agency of Canada; Women’s Health Bureau; Immigration, Refugees and Citizenship Canada; Department of Justice; Crown Attorney Office; provincial governments; provincial health authorities; key professionals and professional associations such as the Society of Obstetricians and Gynaecologists of Canada (SOGC), provincial colleges of physicians and surgeons, Canadian Paediatric Society, Canadian Centre for Child Protection, Children’s Aid Societies, the Royal Canadian Mounted Police, and organizations with expertise on FGM (e.g. Women Health in Women’s Hands, Uzima International Relief Group), and any relevant bodies and organizations working with women and girls at risk of FGM or its consequences.

6.2.3. Policy 3: Training Professionals

To enhance the capacity of professionals who may come in contact with women and girls at risk of FGM or its consequences, training for key professionals is an indispensable and urgent component, as emphasized in the interview conversations.
Training must entail information on health consequences, the social and cultural implications of FGM, the human rights framework, the legislation in Canada, and cultural competency training to enable professionals to recognize girls at-risk and to talk about the topic in a culturally sensitive and appropriate manner. Targeted professionals include healthcare providers (general practitioners, gynaecologists, midwives, maternity care, paediatricians, psychologists) as well as children safeguarding professionals, social workers, childcare professionals, school teachers, refugee and immigration board officers, and police officers. The extent and content of training may vary depending on each professional field.

Option 3.1: **E-learning platform**

As an accessible starting point, the lead ministry, in collaboration with experts, is to set up an e-learning platform on FGM. Modules within the platform would include general as well as sector-specific information. This provides for a promising avenue to centralize information and good practices on FGM and develop learning modules accordingly.

Option 3.2: **Training workshops**

This policy offers in-person workshops and accredited training for various professionals. This is for professionals who themselves choose to or are encouraged to take training by their institutions or employers. The training sessions would be provided by expert organizations who can facilitate such training, for instance the Women’s Health in Women’s Hands Centre in Toronto and the Sexuality Education Resource Centre in Winnipeg.

Option 3.3: **FGM in professional curricula**

This policy takes training into the mandatory field, incorporating FGM as part of the curricula for medical students, social workers, teachers, immigration and police officers. It would create a baseline knowledge among all professionals working in the fields critical to intervention on FGM.
Chapter 7.

Policy Analysis

7.1. Evaluation Framework: Criteria and Measures

The policy objectives are prevention of FGM, protection and support for women and girls. The challenge to achieving these objectives lies primarily in the political willingness to create a comprehensive policy framework and, critically, in the effectiveness of the policies. The following table summarizes how the policies are analyzed to assess (a) their effectiveness in addressing FGM within the Istanbul Convention’s framework of prevention, protection and support, and prosecution / law enforcement; and (b) their prospect for implementation in Canada.

Table 3. Summary of Criteria and Measures

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Criteria Description / Measures</th>
<th>Measurement Scale (HML)</th>
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| **Effectiveness:** FGM Prevention, Protection, Support, Law Enforcement | - Extent to which the policy can effectively protect girls from being subjected to FGM / prevent FGM  
- Extent to which the policy provides adequate support to those affected  
- Extent to which the policy can contribute to enforcing the laws | **High:** Policy directly contributes to prevention, protection, support, law enforcement  
**Medium:** Policy creates a base-line that can improve prevention efforts, support services, and law enforcement  
**Low:** Policy is unlikely to contribute to prevention, protection, support, law enforcement |
| **Stakeholder acceptance** | The expected level of support from main stakeholders involved: members from the target population in favour of ending FGM, community organizations and NGO workers, professionals | **High:** The policy’s main stakeholders are expected to support the policy  
**Medium:** The policy’s main stakeholders may be supportive / There may possibly be a split among stakeholders  
**Low:** The policy’s main stakeholders are unlikely to support the policy |
| **Pan-Canadian implementation** | Possibility to have consistent implementation of this policy across Canada | **High:** Policy would apply across Canada  
**Medium:** Policy would apply across Canada, though in variations depending on jurisdictional set-ups or local capabilities  
**Low:** Policy would need to be established in each jurisdiction |
### 7.2. Policy Evaluation

#### 7.2.1. Policy 1: Prevalence Study and Qualitative Research

**Effectiveness: FGM Prevention, Protection, Support, Law Enforcement**

Establishing prevalence statistics as a policy in itself does not prevent FGM nor provide protection and support services to those affected. Rather, the generation of statistics, in combination with qualitative insights, creates a base-line for policy development. Without knowing the scope of the issue and the needs of the population, developing an effective response towards FGM is unlikely to succeed. It is also not politically feasible to initiate policies and allocate resources without demonstrating basic information.

Thus, this policy is a first step and the results and evidence from both quantitative and qualitative studies should inform policies and programs on FGM and can be specifically useful to determine regional concentration of FGM prevalence to establish appropriate local approaches to tackle FGM. Experience from interviewees demonstrates that having numbers and insights into the issue at regional level helps enormously for policy development.

**Stakeholder Acceptance**

Stakeholder acceptance is expected to be high. Organizations and professionals hoping to support affected community members would welcome such a study,
particularly also the qualitative study. Crucially, members from affected communities would be given a voice in the qualitative study – just like the participants in the Uzima study. Women living with FGM and individuals from practising communities who oppose FGM are expected to support the study, especially for the prospect that they would benefit from subsequent policies that are informed by the study and address their needs.

**Pan-Canadian Implementation**

The policy would be a pan-Canadian project. Statistical prevalence estimates would concern Canadian-wide data and the information could be broken down to provincial/municipal level to gain a better understanding of localized prevalence. The qualitative study would be led by community organizations and research partners and funded by the national lead on FGM policy development. As such, it would not depend upon the provinces’ jurisdictional competencies.

For feasibility, conducting the qualitative research would take place in areas with known cases of FGM and where engaged community organizations can facilitate the study. It might thus not represent residents in all Canadian jurisdictions. This does not impose significant limitation to the results of the study but might omit learning about specific local needs and gaps in service provision or learning about attitudes towards FGM within some communities. Nevertheless, the quantitative and qualitative studies are starting points for improving knowledge on FGM prevalence in Canada and support needs which fosters policy development across the country.

**Political Feasibility**

The government’s commitment to addressing gender-based violence appears not only in Canada’s feminist foreign policy approach but also in its domestic *Strategy to Prevent and Address Gender-Based Violence* administered by the Department for Women and Gender Equality (formerly Status of Women Canada). The first-year report of the Strategy makes only one remark on FGM, namely that there “remain data gaps” on certain gender-based violence topics, including FGM. The statement further recognizes that “without this information, we remain unable to fill the necessary gaps in knowledge and support” (Monsef 2018). Hence, the policy’s endeavour to establish more information and statistical data on FGM should be in the government’s interest and mandate.
The statistical estimation of prevalence based on census and immigration data would be a low-cost project as it requires very few resources except for available data which involves support from e.g. Statistics Canada. The benefits are expected to be significant because having even very rough estimates is a significant argumentation tool for further policy development. Complementing the study with qualitative research would require slightly more resources in terms of time, collaboration among experts, cultural-sensitivity training for interviewers, as well as human resources for the analysis. As the study would be commissioned to experts in the field and supporting researchers, funding can be directly allocated to this project which has a foreseeable time-frame. Thus, the policy would remain a one-time project investment and would yield immense benefits as the results of the study would provide valuable insights in the attitudes among diaspora communities – which not only helps to better estimate the number of girls at risk of FGM but also provides important information for the planning of education and prevention initiatives as well as support services. In other words, this policy is a cost-effective policy because it gains knowledge that is crucial to addressing this form of gender-based violence in Canada.

7.2.2. Policy 2: Multi-Agency Guide on FGM

Effectiveness: FGM Prevention, Protection, Support, Law Enforcement

This policy provides guidance for a multi-agency approach on FGM. As the guide provides basic information for relevant actors with regards to their responsibilities in safeguarding and supporting women and girls affected by or at risk of FGM, this policy establishes a base-line of knowledge and a frame of reference to enable and help relevant actors to contribute to prevention, support, and prosecution within their roles and responsibilities. Such a guide would improve professionals’ response to FGM (UNICEF 2010), albeit staying short off providing actual training on the subject. In terms of its effectiveness, this policy relies upon those targeted to act in accordance to the guidance material and upon actual programs and processes.

Stakeholder Acceptance

The stakeholders, that is those targeted with the guidance material, are expected to support this policy and benefit from it as the guide serves to clarify roles and
responsibilities as well as a system of referral. The policy is not expected to receive any backlash because the guide speaks to their existent responsibilities with a focus on FGM, thus the policy does not push a completely new mandate or new roles on these stakeholders. The targeted stakeholders will be required to fulfill their roles in tackling FGM which should establish improved ability to provide services, deliver programs, and create policies that benefit community members and organizations who want to see an end to FGM. Thus, overall stakeholder acceptance is expected to be high.

**Pan-Canadian Implementation**

This policy is a pan-Canadian multi-agency guide on FGM. As general guidance, this policy would be adopted at federal level. Although the targeted institutions and agencies may vary slightly between provinces in terms of their set-up, they can be referred to in overarching terms as they are expected to fulfill the same roles with regards to FGM (e.g. responsibility to protect children; to provide healthcare services) within their distinctive jurisdictional setting.

**Political Feasibility**

The lead ministry would coordinate the development of the multi-agency guide. This would involve a moderate employment of resources as it requires collaboration between various agencies, professional bodies, and experts. However, monetary costs would be low and creating the guide would be a short-term investment as it can be realized within an allocated project timeframe. As soon as it is implemented – that is published, presented and distributed – ongoing maintenance requires moderate efforts. It is recommended to administer the policy with a monitoring component to identify how the multi-agency guide works in practice and whether it needs adjustments over time (e.g. updated knowledge or legislative changes). As such, the policy requires long-term commitment and moderate resources with ongoing monitoring efforts to ensure its effectiveness. Given that the multi-agency guide functions as a foundational component for the national action plan by providing overarching guidance for a multi-agency response to FGM, this policy promises a decisive impact vis-à-vis relatively low costs and moderate resource investment; hence it is deemed a highly cost-effective component within the FGM policy framework. Given the degree of administrative complexity, the policy’s political feasibility is rated medium.
7.2.3. Policy 3: Training Professionals

Effectiveness: FGM Prevention, Protection, Support, Law Enforcement

Professionals in direct interaction with families and girls from FGM-practising communities meet girls who may be at risk of FGM, and hence they inhabit key positions to protect them and prevent FGM. They are also in key positions to provide or refer to support services that meet the needs of those affected by FGM. Caring for women living with FGM can also involve preventative efforts as healthcare providers can talk with the women about FGM with regards to their daughters as well. In this regard, a promising venue of prevention efforts are prenatal and postnatal care (Charlotte Weil, personal communication; EQUIPOP et al. Network 2018). Child protection services, the police and the judiciary are crucial in contributing directly to law enforcement on FGM.

In addition, when professionals in key roles are equipped with the necessary knowledge and skills, they can also promote the ultimate goal – the total abandonment of FGM. Within their work they can contribute to awareness raising and provide information for community members, which complements NGOs’ projects and programs aimed at changing attitudes towards FGM. As such, key professionals play an important role in support of community engagement projects aimed at ending FGM altogether.

However, professionals often lack relevant knowledge and skills (IOM 2009). The Uzima study illustrates specifically that women living with FGM in Canada have serious health concerns, which cannot be met by healthcare practitioners because they are unfamiliar with FGM and not culturally competent nor sensitive to provide adequate support (Uzima 2017). Many professionals in various fields are unaware of FGM or unsure how to recognize cases of FGM and girls at-risk, how to talk about the topic, and how to act when they suspect an imminent threat of FGM. Hence, providing training for professionals in healthcare, childcare, education, immigration, and police is essential to ensure that they can contribute to prevention, protection, support, and law enforcement.

Formats of Training

Options to provide training for professionals include e-learning, in-person training sessions, and addressing FGM in professional curricula. The effectiveness of these options depends on the extent to which they can increase knowledge and skills.
Option 3.1: The e-learning platform entails modules on general aspects of FGM and sector-specific components. Naturally, learning outcomes depend on the individual user. Existing e-learning tools on FGM receive great prominence, however, their efficacy has not yet been evaluated (Balfour et al. 2016). The strength of the e-learning platform is that all users receive the same information, so it ensures consistency in messaging and factual information. However, the online tool falls short of providing opportunities to discuss and develop skills for effective interaction with those affected (Naana Otoo-Oyortey, personal communication).

Option 3.2: Training workshops on the other hand allow for questions, discussions, and scenario exercises. In-person training can involve overarching learning goals as well as sector-specific specialist training – for instance for gynaecologists and obstetrics or for immigration officers. Interview participants who are involved in providing training for professionals recognize the benefits of in-person training sessions over online-learning as a more effective way of increasing professionals’ competence to interact with those affected in the areas of prevention and the provision of support. Experience shows that many professionals who absorb information via guideline materials and online courses still feel not completely at ease with talking to families about FGM (Charlotte Weil, personal communication). Rohma Ullah, National Lead for Training and Professional Development at the National FGM Centre in the UK, finds there is a direct link between the delivery of training for professionals and an increase in FGM-case referrals to social care services as more professionals are able to identify FGM and girls at-risk.

Option 3.3: There is strong support among interviewees to integrate the subject of FGM in professional curricula as a compulsory component. The Canadian SOGC also recommends integrating FGM into the medical school curriculum, with a focus on beliefs and values perpetuating the practice, the health consequences and complications for medical care, as well as guidance on counselling women and families (SOGC 2012). Costello et al. (2013) recommend to include FGM in the social work curriculum as social workers would benefit greatly from guidance to effectively and respectfully engage with members from affected communities. Some interviewees also emphasized the need for mandatory training for officers assessing asylum claims.
The integration of the topic in curricula could provide for a level of standardization to ensure that basic information, knowledge and general competencies are consistent (Naana Otoo-Oyortey, personal communication). The policy’s effectiveness depends on how the topic is incorporated into the curricula – whether it is presented through reading material or taught by means similar to in-person training workshops. In any case, the advantage of this policy is that everyone in relevant professions has a baseline knowledge on the subject to ensure they are at least familiar with the circumstances of FGM. Some interview participants advocate for mandating training on FGM for professionals in training (students) and for the continuous training of working professionals (Sokhna Fall Ba, personal communication; Naana Otoo-Oyortey, personal communication). Continuous training could also provide for more specialized knowledge, e.g. for medical students depending on their fields of specialization.

In conclusion, it can be said that all modes of training can genuinely contribute to capacity building for professionals, however, their effectiveness in providing professionals with relevant competencies and confidence varies. The in-person training workshops offer most promising results for professionals’ competency development as it goes beyond factual knowledge that can be acquired online. Yet this option is construed as voluntary training, whereas the integration into curricula mandates that all relevant professionals learn about FGM. An introduction to the topic through course curricula could be the first step, complemented by ensuing in-person training sessions – that could be constructed as accredited training formats for working professionals to enhance skills. In fact, all three options may act in complementary fashion to ensure a variety of training opportunities are available.

**Stakeholder Acceptance**

Stakeholder acceptance for training professionals on FGM is expected to be high. Professionals themselves are expected to welcome adequate training opportunities. Women living with FGM and community members in favour of ending FGM would also support the training of professionals. For instance, the Uzima study with members from practising communities, community organizations, social service providers, and health care agencies emphasized the need to educate professionals on FGM and provide cultural competence training so that service providers can adequately address health concerns and serve women appropriately (Uzima 2017).
An e-learning platform as well as offering in-person training workshops for professionals on a voluntary basis are expected to be supported by all stakeholders. However, there may be a split in support among stakeholders with regards to integrating FGM as a mandatory component into professional curricula. For instance, although the SOGC recommends it, those in charge of the medical curriculum may be reluctant to adjust the curriculum.

Pan-Canadian Implementation

The e-learning platform would be accessible nation-wide in relevant languages. The setting up of in-person training workshops would depend on training needs in the different regions in Canada, which would become clear once regional FGM prevalence is estimated (Policy 1). More critically, the availability of in-person training workshops would depend upon existing local organization who could provide training, which may vary significantly across Canada. As a means to mitigate accessibility issues, participants could attend training workshops remotely through webinar sessions. It is recommended to collectively establish common training standards and guidelines across Canada (Council of Europe and Amnesty International 2014). Integrating FGM into curricula depends on the profession and respective institution of training. As education falls outside federal competency, for most professions this option would have to be established in each jurisdiction and each training institution or university would need to adjust their program curriculum respectively. For medicine students, provincial colleges of physicians and surgeons could collaborate with post-graduate colleges/universities to add FGM to the curricula. In addition, the Association of Faculties of Medicine of Canada could possibly promote and support an introduction of FGM into universities’ curricula across Canada. On the other hand, professionals under federal guidance such as police officers and refugee and immigration board officers would receive mandatory training through the Royal Canadian Mounted Police or Immigration, Refugees and Citizenship Canada. Except for the latter professional groups, integrating FGM into mandatory professional curricula across Canada is difficult to achieve.

Political Feasibility

The development of an e-learning platform requires involving web developers and subject-matter experts to set up learning modules and gather relevant materials.
The implementation of this option thus needs resource investment (time, information material, human resources), which can be realized within the planning and budgeting of a one-time project. Once implemented, the platform provides long-term benefits while the maintenance and administration of the platform would require very few resources. Given that the development of the platform has a foreseeable time-frame and resource investment, this policy’s feasibility is assessed as high, and the project would be cost-effective with regards to the expected high benefits in providing an opportunity for professional training in an accessible format.

In contrast, facilitating **in-person training** requires more resources. The implementation of this policy entails identifying partner organizations and subject experts, creating training manuals and making the training sessions accessible for various professionals. The Canadian government ought to fund organizations capable to provide such training, which could be realized as time-framed project funding. Such an investment appears feasible under Canada’s *Strategy to Prevent and Address Gender-Based Violence* funding opportunities. However, ensuring the sustainability of such training programs through expert organizations requires a consistent stream of funding rather than short-term project funds, and such long-term budget allocations may be more difficult to achieve. This policy’s feasibility might thus depend to some degree on the level and length of funding commitment required. In any case though, the in-person training format is overall assessed as most effective in increasing the knowledge and skills of professionals, and as such, the policy’s resource investment yields greatest benefits and is deemed highly cost-effective.

**Integrating FGM into curricula** requires those in charge to invest time to deliberate the curricula and collaborate with subject-matter experts. The level of required resources depends on the extent of training and would likely vary for professionals in training (students) and for continuous training requirements for working professionals. For professionals in training, the topic would not take much ‘space’ in existing curricula (Entisar Yusuf, personal communication; Charlotte Weil, personal communication). Once implemented, basic training on FGM would be absorbed into curricula routine which makes the policy less cost- and resource-intensive. Requiring ongoing training for working professionals, whereas, may be more resource-intensive but could be feasibly realized through accredited training programs, depending on the profession.
Overall, the policy to integrate FGM into curricula would imply low to moderate resource investment, and it would be highly efficient in ensuring everyone in relevant professional fields has basic knowledge. Nevertheless, the hurdles to implementing this policy option rest with relevant actors’ willingness to address FGM and adjust curricula. Achieving curricula changes is expected to be a slow progress and is also hampered by the fact that Canada has little to no experience with providing voluntary FGM-training opportunities on a large scale, and because many other countries with a stronger focus on FGM have not yet incorporated FGM into mandatory professional curricula either. Hence political feasibility – in terms of political willingness – is expected to be rather low.

7.3. Evaluation Summary

All policies scored medium with regards to the effectiveness criterion because none of them are direct means to achieve FGM prevention, protection of girls, provision of support services, or law enforcement. Rather the effectiveness of the policies lies in achieving interim outcomes. These interim outcomes are essentially means to achieve the ultimate objectives of prevention, protection, support, and law enforcement. These means are: (a) an increase in data and information on the prevalence of FGM, the attitudes within diaspora communities, and the specific support needs of those affected; and (b) an increase in the capacity of relevant actors to respond to FGM and be better equipped to contribute meaningfully to prevention, protection and support, and law enforcement.

The statistical prevalence estimates and qualitative study are clearly means to improve knowledge on the scale and regional concentration of FGM within Canada, and to increase understanding of attitudes towards FGM among diaspora communities and on support needs. This provides a base-line to design and develop targeted programs and policies to reach community members effectively, and it is thus a pre-step for developing effective policy action. The other policies are means to increase the capacity of relevant actors to respond appropriately to FGM, and thus these policies contribute more directly to prevention, protection, support, and law enforcement. The policies’ efficacy in increasing actors’ capacity though varies as indicated in Figure 1.

---

15 Appendix D presents a logic flow table illustrating how the policies contribute to achieving the ultimate outcomes.
The Multi-Agency Guide’s strength is that it addresses all relevant actors, but it does little other than laying out roles and responsibilities. Thus, its effectiveness relies upon those targeted with the guidance material (e.g. those in direct interaction with communities) to act. Policy 3, training professionals, helps these actors more directly to learn how to act and respond appropriately to FGM, hence Policy 3 is a more direct means in terms of achieving FGM prevention, protection, support and law enforcement. Among the training options, the e-learning platform is a very accessible but voluntary tool and the learning outcomes depend upon the individual user. The training workshops are expected to be most effective in helping professionals to develop competencies and confidence. Integrating FGM into curricula as a mandatory component, meanwhile, is most efficacious in terms of reaching all relevant professionals. As such, the policies’ effectiveness increases from policy 1 to policy 3.2 and 3.3, which is indicated in Figure 1.

The prevalence study, the multi-agency guide, and the training policy are fundamental components for an FGM policy framework. Yet moreover, this study’s research and policy analysis suggest that in addition to these policies, more policy options and intervention opportunities should be considered that contribute directly to preventing FGM, protecting and supporting women and girls, and enforcing laws against FGM in Canada.

Figure 1. Policy Analysis Results
Chapter 8.

Recommendations

Several components are important for a comprehensive policy framework on FGM, yet given the preceding analysis and considerations, it is recommended to focus on policy development in the short-, medium-, and long-term.

The research illustrates clearly that establishing prevalence statistics is an important first step towards creating a policy framework on FGM, along with creating a national action plan and determining a lead ministry that acts as coordinating body, initiates policy development, monitors and further coordinates policy action on FGM as well as facilitates cross-sectoral networking. Developing action items for the national action plan should be informed by the knowledge gained from the statistical prevalence study and the qualitative research. Hence both quantitative and qualitative studies are recommended as crucial first steps.

In addition, a foundational item for a multi-agency approach to FGM is clarifying roles and responsibilities through a multi-agency guide which will require some time and resources for development. Moreover, training for professionals is an indispensable component. The preceding analysis suggests that establishing an e-learning platform and facilitating training workshops for professionals are quite feasible to implement. It is thus recommended to develop and promote both training opportunities in the medium-term. Integrating FGM in professional curricula, whereas, is recommended as a policy step in the long-term because it requires different professional training institutions for implementation, and the lack of awareness on FGM and knowledge of FGM prevalence makes it difficult to argue for mandatory curricula changes. It is thus recommended that policy steps in the short- and medium-term precede the integration of FGM into curricula. Figure 2 outlines the recommended action items.
In addition to the policies discussed in the previous chapter, another important action item is **funding for non-governmental and community organizations** that support FGM survivors, implement prevention strategies in community work, and promote the abandonment of FGM. This item, though not part of the preceding chapter’s analysis but strongly highlighted in Chapter 5, is clearly an invaluable and effective component in addressing FGM and working with communities and is thus recommended for immediate implementation. Furthermore, other action items for future consideration and analysis emanate from this study’s case study investigation and interview discussions. These are presented in the non-exhausted list in the table below.
Table 4. Further Policy Considerations for the National Action Plan

<table>
<thead>
<tr>
<th>Further Policy Considerations for the National Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>To further improve collaborative and concerted efforts, consider:</td>
</tr>
<tr>
<td>• National Awareness Raising Campaign</td>
</tr>
<tr>
<td>• FGM Resource Centre / Knowledge Hub to collect, analyze and share information and good practices from community work and policy approaches</td>
</tr>
<tr>
<td>• Coordination Mechanism and Localized Strategies as those existing in the case study jurisdictions. <em>Considering these as templates or inspirations for Canada can better be determined with an understanding of geographic prevalence across Canada, and ultimately depends on existing institutions and infrastructure as well as jurisdictional preferences.</em></td>
</tr>
<tr>
<td>To improve knowledge on the scope of FGM and the needs of those affected, consider</td>
</tr>
<tr>
<td>• Establishing a National Database</td>
</tr>
<tr>
<td>• Improving data on FGM; e.g. through Mandatory Recording policy (example: UK)</td>
</tr>
<tr>
<td>For providing information to diaspora communities, consider:</td>
</tr>
<tr>
<td>• Information Material for newcomers through immigration or integration services, etc.</td>
</tr>
<tr>
<td>• Health Passport (Official Statement Opposing Female Genital Mutilation/Cutting).</td>
</tr>
<tr>
<td>For strengthened legislation on FGM, consider:</td>
</tr>
<tr>
<td>• Legal Analysis study to analyze the applicability of Canadian law on FGM in comparison with other countries’ legislative approaches, and to consider whether Canada could make legislative adjustments to tighten its laws on FGM</td>
</tr>
<tr>
<td>• Court Orders: Study European experience with issuing court-ordered protection measures in cases of FGM, and consider the UK’s FGM Protection Orders.</td>
</tr>
<tr>
<td>To foster safeguarding girls at risk of FGM, consider:</td>
</tr>
<tr>
<td>• Providing guidelines on reporting FGM. Canadian provincial child welfare law requires reporting instances of child mistreatment, but it would be important to provide guidelines for FGM cases.</td>
</tr>
<tr>
<td>• Fostering expertise in relevant institutions through mandating having a lead employee on FGM, e.g. Focal Point Officers (example: Netherlands)</td>
</tr>
<tr>
<td>For improvements in healthcare, consider:</td>
</tr>
<tr>
<td>• Incorporating the four types of FGM in billing codes in medical record system</td>
</tr>
<tr>
<td>• Promoting availability/accessibility of psychological and sexual counselling services</td>
</tr>
<tr>
<td>• Promoting Health Advocates / Navigators to work with women impacted by FGM</td>
</tr>
<tr>
<td>• Healthcare centres to set up special consultation hours (example: Netherlands)</td>
</tr>
<tr>
<td>• Health insurance to cover reconstruction surgeries</td>
</tr>
<tr>
<td>• Consider Airport-site interventions (example: Operation Limelight in the UK). Canada already has a National Action Plan to Combat Human Trafficking which incorporates training for border officers. Similarly, such training should be provided on FGM.</td>
</tr>
</tbody>
</table>
Chapter 9.

Conclusion

On February 6, the international day of zero tolerance for female genital mutilation, the United Nations re-issued the call upon governments and policy makers to translate their commitments to protecting human rights into concrete actions with the goal of ending FGM by 2030. As Canada has been lagging far behind other countries in efforts to tackle FGM, it is time for Canada to catch up and take effective action now. Recognizing that FGM is an issue in Canada too is the very first step and must be followed by policy actions that address FGM as a human rights violation.

This study provides an investigation of policy approaches in other countries, insights from subject-matter experts, discussions of promising practices, and an assessment of policy options to support the development of a policy framework on FGM in Canada. Building a policy framework entails setting a national action plan and creating an integrated multi-sector approach to address FGM in the areas of health, education, childcare, social work, law enforcement, immigration and asylum. This requires a lead ministry or sub-entity that would oversee and coordinate such multi-sectoral effort.

In developing the national action plan, the crucial first step is to conduct an FGM prevalence study, ideally combined with qualitative research. It is further recommended to advance the multi-sector approach by creating a multi-agency guide and providing training opportunities for key professionals in the various sectors mentioned above. For Canada, these policies are fundamental in increasing knowledge on FGM and increasing the capacity of relevant actors to respond to FGM, providing them with knowledge and guidance to work towards preventing FGM, protecting girls, supporting survivors, and enforcing laws against FGM in Canada. This study also recommends supporting non-governmental and grassroot organizations for their crucial role in supporting survivors, protecting girls at risk, and working with communities to end the practice of FGM.

In addition to the policies recommended in this study, more action is needed to tackle FGM, to protect girls and support survivors. To advance policy development, it is recommended to adopt a participatory approach with community members, relevant
actors in the field, and government representatives. Involving FGM survivors and members from practising communities is essential to gain insights regarding their needs and perspectives for effective policies, which also empowers those directly and indirectly affected to support the abandonment of FGM.

The ultimate objectives of policy intervention are to reach the target population effectively, to reduce the number of new FGM cases, to increase the provision of adequate support for women and girls who live with FGM, and to promote the total abandonment of the practice. The ultimate challenge to achieving these objectives lies primarily in political willingness and commitment to address FGM. Earlier efforts in the 1990s failed to produce committed policy action on FGM. However, today, Canada’s Strategy to Prevent and Address Gender-Based Violence provides an important policy window as it creates new momentum and an anchor for addressing FGM.

Moreover, the recently created End FGM Canada Network that brings together individuals and organizations across Canada is now working towards advancing policy efforts. As a founding member of the Network, I am hoping to utilize the findings of my research as the Network urges the government to Prevent and Address FGM – as per the government’s ambitions to Prevent and Address Gender-Based Violence.
References


Nyangweso, Mary. 2014. Female Genital Cutting in Industrialized Countries: Mutilation or Cultural Tradition? Santa Barbara: Praeger.


Appendix A.

Terminology

There is no consensus on terminology; the following are the most commonly used terms in the literature.

Female Circumcision: When ‘outsiders’ started to talk about the traditional practice, the term female circumcision was being used. Critics point out that the terminological parallel to male circumcision fails to encompass the magnitude of the cutting of female genitalia (Kübler 2017).

“Female circumcision” cannot be equated with male circumcision because the former inflicts more serious damage to the genitalia. In anatomic comparison, only the removal of the clitoris prepuce – which is a very rare form – can be compared with the removal of the male prepuce. Nonetheless, some activists see parallels from a human rights perspective when it comes to the rights of children of bodily integrity (Kübler 2017).

Female Genital Mutilation (FGM): “FGM” emphasizes the severe harm of the practice and indicates the violation of human rights to bodily integrity. The term was first adopted in 1990 by the Intra-African Committee on Traditional Practices Affecting the Health of Women and Children in Addis Ababa, Ethiopia and has since been used by UNICEF, the WHO, and the UN (Nyangweso 2014; SOGC 2012).

Female Genital Cutting (FGC): The term “mutilation” has been criticized for being judgemental, stigmatizing, insensitive to cultural values, and thus contra-productive (Nyangweso 2014; Kübler 2017). A range of more neutral terms emerged, including Female Genital Alteration, Female Genital Excision, Female Genital Surgeries. The most popular term is Female Genital Cutting which has found increased usage since the end of the 1990s with the intention to express sensitivity. The term is deemed “medically correct” (SOGC 2012) but it is also criticized for trivializing the nature of the practice (IAC 2005).
**Female Genital Mutilation/Cutting (FGM/C):** The combined term FGM/C is an attempt to unite both positions. Activists and policymakers may utilize FGM, but FGC may be a better term when working with practicing communities. In conversation with affected women or community members, it is best practice to adopt their terminology (Kübler 2017). Moreover, when working with affected women some prefer the term “survivor” of FGM/C rather than “victim” (Kübler 2017).

**Local terms** for the practice include: “Bolokoli” (Bambara, Mali), “Fanadu” (Kreol, Guinea Bissau), “Qodiin” (Somali, Somalia), “Nyaaka” (Mandinka, Gambia), “Tohara” (Arab), “Khatna” or “Khafz” (Bohra communities, India), and “Sunna” which is used in a Muslim religious context and refers often to inserting a cut in the clitoris for a drop of blood (Kübler 2017).
Appendix B.

Global Prevalence

Table B.1  UNICEF FGM Prevalence Statistics (last updated October 2018)

<table>
<thead>
<tr>
<th>Country</th>
<th>FGM Prevalence rates (women and girls aged 15-49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>9%</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>76%</td>
</tr>
<tr>
<td>Cameroon</td>
<td>1%</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>24%</td>
</tr>
<tr>
<td>Chad</td>
<td>38%</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>37%</td>
</tr>
<tr>
<td>Djibouti</td>
<td>93%</td>
</tr>
<tr>
<td>Egypt</td>
<td>87%</td>
</tr>
<tr>
<td>Eritrea</td>
<td>83%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>65%</td>
</tr>
<tr>
<td>Gambia</td>
<td>75%</td>
</tr>
<tr>
<td>Ghana</td>
<td>4%</td>
</tr>
<tr>
<td>Guinea</td>
<td>97%</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>45%</td>
</tr>
<tr>
<td>Kenya</td>
<td>21%</td>
</tr>
<tr>
<td>Liberia</td>
<td>44%</td>
</tr>
<tr>
<td>Mali</td>
<td>83%</td>
</tr>
<tr>
<td>Mauritania</td>
<td>67%</td>
</tr>
<tr>
<td>Niger</td>
<td>2%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>18%</td>
</tr>
<tr>
<td>Senegal</td>
<td>23%</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>86%</td>
</tr>
<tr>
<td>Somalia</td>
<td>98%</td>
</tr>
<tr>
<td>Sudan</td>
<td>87%</td>
</tr>
<tr>
<td>Togo</td>
<td>5%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>10%</td>
</tr>
<tr>
<td>Country</td>
<td>FGM Prevalence rates (women and girls aged 15-49)</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Iraq</td>
<td>8%</td>
</tr>
<tr>
<td>Yemen</td>
<td>19%</td>
</tr>
<tr>
<td>Indonesia</td>
<td>49%</td>
</tr>
</tbody>
</table>


In addition, other countries have reported cases of FGM in smaller studies, but there is no representative prevalence data yet. These countries include:

- India
- Iran
- Malaysia
- Oman
- Pakistan
- Russia (Republic Dagestan)
- Saudi Arabia
- Sri Lanka
- Thailand
- United Emirates

Appendix C.

International Conventions and Declarations

Several international conventions and declarations call for laws and policies directed towards ending FGM. Under many of the important international conventions listed below, FGM is directly incorporated or referred to in additional notes and recommendations.

- The Universal Declaration of Hum Rights (1948); The International Covenant on Civil and Political Rights (effective 1976); The International Covenant on Economic, Social and Cultural Rights (effective 1996)
  - General Recommendations No. 14 on Female Circumcision (1990)
  - General Recommendations No. 19 on Violence Against Women (1992)
  - General Recommendations No. 24 on Women and Health (1999)
- The Convention on the Rights of the Child
  - General Comment No. 4 on Adolescent Health and Development (2003)
- The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment (effective 1987) – which is now recognized to also address FGM
- The Convention Relating to the Status of Refugees (effective 1954) as those fleeing the threat of FGM qualify for refugee status;
- African Charter on Human and Peoples’ Rights (effective 1986)
  - Added Protocol on the Rights of Women in Africa – Art. 5 (effective 2005)

In addition, the Platform for Action of the Fourth World Conference on Women in Beijing (1995) defined FGM as a human rights issue and called for policies and programmes to eliminate FGM. The African Union adopted declarations on ending FGM, as did the United Nation’s Status of Women and the Human Rights Council. FGM is also included in the UN’s 2015 Sustainable Development Goals. In 2016, the UN General Assembly adopted the Girl Child Resolution that recognizes FGM as a form of violation of the rights of the child girl.
Appendix D.

Jurisdictional Comparison

The table below presents a summary of the jurisdictional comparison. This overview may not capture the differences between the jurisdictional approaches perfectly, but it provides comparative indicators for the various policy components.

<table>
<thead>
<tr>
<th>Table D.1 Jurisdictional Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Prevalence Study</td>
</tr>
<tr>
<td>Mandatory Recording</td>
</tr>
<tr>
<td>Criminalization</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Child Protection Mandatory Reporting</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Asylum on grounds of FGM</td>
</tr>
<tr>
<td>National Action Plan / Strategy</td>
</tr>
<tr>
<td>Coordination Body or Structures</td>
</tr>
<tr>
<td>National Multi-Agency Guidelines</td>
</tr>
<tr>
<td>Training Professionals</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>✓ online learning</td>
</tr>
<tr>
<td>✓ in-person training (National FGM Centre; NGOs)</td>
</tr>
<tr>
<td>x FGM in curricula</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist Healthcare Support</th>
<th>UK</th>
<th>Netherlands</th>
<th>Germany</th>
<th>France</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa Well Women clinics</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>FGM consultation hours</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>Few individual healthcare specialists</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>FGM medical units with healthcare specialists</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Passport</th>
<th>UK</th>
<th>Netherlands</th>
<th>Germany</th>
<th>France</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operation Limelight</th>
<th>UK</th>
<th>Netherlands</th>
<th>Germany</th>
<th>France</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mandatory Genital Examination</th>
<th>UK</th>
<th>Netherlands</th>
<th>Germany</th>
<th>France</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>✓</td>
<td>x</td>
</tr>
<tr>
<td>(children &lt;7)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
</tr>
</tbody>
</table>
# Appendix E.

## Logic Flow

### Table E.1 Logic Flow of Policies

<table>
<thead>
<tr>
<th>Inputs (Policies)</th>
<th>Outcomes</th>
<th>Ultimate Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence Study and Qualitative Research</td>
<td><strong>Better understanding</strong> of the scope and scale of FGM in Canada, regional concentration of FGM prevalence, attitudes within diaspora communities, and support needs of those affected</td>
<td>Ability to design and target programs and policies to reach community members effectively; to prevent new cases of FGM, to provide adequate supports</td>
</tr>
<tr>
<td>Multi-Agency Guide</td>
<td><strong>Increased capacity</strong> of all relevant actors (institutions, ministry agencies, organizations, key professionals) to respond appropriately to FGM in terms of providing support, recognizing girls at-risk and preventing FGM, etc.</td>
<td>Prevention of new cases of FGM and provision of adequate supports</td>
</tr>
<tr>
<td>Training for Professionals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>