

Ireland's
National Plan of Action
to Address
Female Genital
Mutilation





Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Ireland's National Plan of Action to Address FGM National Steering Committee Members

- ▶ AkiDwA
- ▶ Amnesty International (Irish Section)
- ▶ Barnardos
- ▶ Cairde
- ▶ Children's Rights Alliance
- ▶ Christian Aid
- ▶ Comhlamh
- ▶ HSE
- ▶ Integrating Ireland
- ▶ Integration of African Children in Ireland
- ▶ Irish Aid
- ▶ Irish Family Planning Association
- ▶ National Women's Council of Ireland
- ▶ Refugee Information Service
- ▶ Somali Community in Ireland
- ▶ Somali Community Youth Group
- ▶ UNICEF
- ▶ Women's Health Council

The formation of the National Steering Committee and the development of the Plan of Action is partly funded by the European Commission through EuroNet-FGM, a European network dedicated to the prevention and eradication of harmful traditional practices which affect the health of women and children. 15 EU countries are participating in this project and all will launch their respective National Actions Plans on November 25th 2008, International Day for the Elimination of Violence against Women. The Irish Steering Committee came together in early 2008 to develop the Plan of Action. Members contributed their time, experience and expertise to ensure Ireland's Plan of Action meaningfully addresses the varied consequences of female genital mutilation.

CHAPTER 1: INTRODUCTION

Female genital mutilation (FGM) is a harmful practice that violates the human rights of women and girls, perpetuates negative gender based stereotypes, infringes upon children's rights to special protections and has serious social, health and psychological consequences. International human rights instruments including the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa specifically target FGM as a practice that jeopardises the sexual and reproductive health and rights of women and girls and call upon all States to enact measures leading to its abandonment.

Irish Aid and Irish development non-governmental organisations (NGO) recognise the detrimental effects of FGM and have contributed financially and programmatically to strategies targeted at community abandonment of FGM in developing countries¹. However, as people from communities that practice FGM continue to migrate to Ireland and integrate into Irish society, a proactive and coordinated response is required to prevent the establishment of the practice in Ireland and to provide care for women and girls living in Ireland who have already undergone FGM in their country of origin. This response will involve efforts from a range of actors across Irish society and will require long term strategies. These strategies are necessary because they are premised on the protection of girls and respect for the dignity of women and girls.

Ireland has no coordinated strategy or interagency working group set up to address FGM. Presently, different government agencies, health care professionals, communities, organisations and individuals are working in isolation from one another and often in a reactive and ad hoc basis. Best practice from other countries such as Sweden² and Norway³ demonstrates that strategic interagency cooperation on FGM is not only possible but imperative. Such interagency cooperation ensures women and girls who have undergone FGM receive appropriate care and safeguards the rights and health of resident children. Upon review of best practice literature and analysis of the current situation in Ireland, the Women's Health Council recommended in 2008 the establishment of an Irish interdepartmental working group to address FGM⁴.

With the exception of strong legislation, the Irish policy environment necessary to put in motion a Plan of Action to address FGM is already in place in the form of the HSE Intercultural Health Strategy, National Women's Strategy, Statement on Integration and Diversity Management, Child Protection Policy and Code of Behaviour, National Children's Strategy, National Guidelines for the Protection and Welfare of Children, National Health Strategy and the White Paper on Irish Aid policies. What is now required is a plan to join up these policies across the different agencies so that the women and girls affected or at risk of FGM can benefit from their implementation.

In June 2008, the Women's Health Council published recommendations to improve the health and wellbeing of women and girls affected by FGM in Ireland. Many of the objectives set out in this Plan of Action reflect those recommendations and aim to create a workable framework to support the diverse, yet interrelated, efforts of all involved. Such a framework will allow the relevant sectors to communicate best practice with each other, avoid duplication of efforts and monitor the impact of interventions in order to achieve the following goals:

Goal #1 To prevent the practice of FGM in Ireland

Goal #2 To provide high quality, appropriate health care and support for women and girls who have undergone FGM

Goal #3 To contribute to the worldwide campaign to end FGM

In setting the objectives necessary to achieve the above goals, the Plan of Action has been developed in line with the following principles:

- ▶ Utilises international human rights frameworks at all stages;
- ▶ Acknowledges that FGM is an expression of structural gender inequality related to the broader social, political and economic context in which women have access to less power, resources, education and autonomy than men;
- ▶ Respects the dignity, identity and culture of all people and communities affected by FGM;
- ▶ Considers that communities affected by FGM are well placed to advocate for the prevention of FGM;
- ▶ Rejects any move towards medicalisation of FGM;
- ▶ Recognises that abandonment of FGM requires a holistic approach.

Five Strategies for Action

Five strategies have been identified as being essential to addressing FGM in Ireland and in other countries through Irish development policies. These strategies build upon best practice experiences which combine top-down policy and legislative measures with bottom-up community development approaches to maximise impact⁵.

Actions flow from the following strategy headings which act to progress the goals of the plan:

- ▶ Legal
- ▶ Asylum
- ▶ Health
- ▶ Community
- ▶ Development Aid

This first Plan of Action is set out over a period of three years 2008-2011. It is important to note that addressing FGM in Ireland will be new to many of the sectors and agencies involved. As such, the Plan of Action is intended to build the capacity of all actors in this area and to lay the foundation for future plans of action. We must begin at the beginning and be realistic about what is achievable in the next three years. For this reason, the objectives and actions may be considered elementary compared to other countries and there are agencies and actions that have not yet been included. This is not because they do not have a role to play in addressing FGM but because the capacity is not yet there to deliver on more complex actions.

It is envisaged that an interdepartmental working group will act as monitor and evaluator of the progress made. An agency such as Cosc, the National Office for the Prevention of Domestic, Sexual and Gender-based Violence, supported by the Department of Health would be well placed to coordinate the Plan of Action. Cosc's mandate is described as "a dedicated Government office with the key responsibility to ensure the delivery of a well co-ordinated "whole of Government" response to domestic, sexual and gender-based violence." At the end of the three years an assessment of the progress made will enable the second plan of action to build upon the successes of the first.

Language & Terminology

Language and terminology have a role to play in addressing FGM, starting with the naming of the practice as female genital mutilation. It is important to note that language is a powerful tool that has the capacity to promote positive social change but when employed without consideration can also contribute to feelings of alienation and disempowerment.

The word 'mutilation' has been subject to criticism because it may stigmatise women who have already undergone the procedure who do not see themselves as being mutilated or their families as mutilators. Furthermore, the term FGM is understood by some communities as an unwelcome imposition of Western judgements and values⁶.

This Plan of Action recognises that different words for FGM are more or less appropriate for different contexts. There is no single term that is suitable for all situations. For example, in community settings, the use of "female circumcision" or "cutting" may be more acceptable and familiar to target groups. Alternatively, doctors and midwives may simply ask women if they have been "closed" or "cut" when assessing their health care needs.

The Plan of Action acknowledges that FGM is not as a neutral term but for the purposes of the Plan, is used as a tool of condemnatory advocacy⁷ in the following ways:

- ▶ To establish a clear distinction between "male circumcision"
- ▶ To emphasise the severity and harm of the act
- ▶ To reinforce the fact that the practice is a violation of girls' and women's human rights

Definition of Female Genital Mutilation (FGM)

The World Health Organisation (WHO) defines FGM as any procedure involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons⁸ (see Table 1 for a breakdown of the types of FGM). Type III is the most extreme form of FGM as it involves the removal of the clitoris, partial or total removal of the labia minora and stitching together of the labia majora. Type III, also known as infibulation, accounts for approximately 20% of all cases of FGM and is usually prevalent in communities from Somalia, Northern Sudan and Djibouti⁹.

FGM is mostly carried out on girls between the ages of 0 and 15 years mainly in parts of Africa and in some Asian and Middle Eastern countries (see Table 2 for specific countries). FGM is also practised amongst some immigrant communities living in Europe, North America and Australia¹⁰.

The WHO estimates that between 100 and 140 million girls and women worldwide have been subjected to some form of FGM and a further 3 million girls are at risk each year. The prevalence, type and age at which FGM is performed varies between and within countries and regions, with ethnicity as the most decisive factor¹¹.

Reasons Given for the Practice

The rationale for the continuance of FGM varies across regions, countries and cultures; however, in every society in which it is practiced, FGM is an expression of gender inequality. Women consistently have less access to power, resources and education, and are also more vulnerable to sexual and physical violence because of the socially constructed roles assigned to them. Control over women, their bodies and their sexuality is a key mechanism of sustaining gender inequality¹².

Framed in this way, FGM can be understood to be motivated by the perpetuation of social systems organised around the subordinate position of women and consequently women's pragmatic strategies for survival within these systems. Women are often the key agents in the continuation of FGM because it is one of the limited avenues in which women and girls can obtain social status within their respective communities¹³. Understanding the reasons why many women may support FGM is essential to develop sensitive and effective intervention strategies.

Sexuality

In many societies, women's innate sexuality is perceived as a potential danger to social order and must be suppressed¹⁴. Furthermore, women's sexual behaviour is often interpreted as a reflection of the values and morals of the families to which they belong. Variations of FGM are therefore performed to inhibit women and girls' sexual desires as a way of preventing sexual behaviour considered deviant, securing virginity upon marriage and finally ensuring marital fidelity¹⁵.

Marriageability

Some cultures dictate that it is inappropriate for men to marry a woman who has not undergone FGM. FGM can denote sexual purity as noted above but also that the woman has been properly initiated into her future role as wife and mother. Due to women's unequal position in society, their economic and social survival is highly dependent upon their ability to secure a marriage. Women recognise that ensuring their daughters undergo FGM can improve their chances of getting married and thereby minimising the risks of absolute poverty and social ostracism¹⁶.

Economics

Women's lack of access to resources, education and power is the crux of the perpetuation of FGM. The combination of poverty among families, limited access to education and vulnerability to violence means that there are no viable alternatives to marriage for some women. If women were less dependant upon marriage for their economic and social survival, families may not fear the dire repercussions of non conformity¹⁷.

Tradition

Some societies view FGM as a way of preserving and communicating a set of value systems upon which communities are organised. Rituals and symbols associated with FGM are designed to teach girls about their roles as mothers and wives within their society and to instil a sense of belonging within their particular culture. Criticisms of FGM can be interpreted as criticisms of an entire cultural identity¹⁸.

Religion

The practice of FGM predates Christianity and Islam, has existed in one form or another in almost all known civilisations throughout history and has not been confined to a particular culture or religion¹⁹.

Many communities believe that FGM is required by their particular religion and that rejection of FGM could therefore be interpreted as a rejection of religious teaching and authority. Although practised by Christians, Muslims, Animinists and other faiths, FGM is commonly believed to be a religious obligation of Islam. This is reinforced by descriptions of FGM in some Muslim communities which include words linked closely with Islam such as Sunna or Tahur. Islamic scholars have refuted the links between FGM and Islam through interpretation of texts but also by noting that FGM is not specified as a requirement in any religious text. Furthermore, FGM is not widely practised among Muslims globally²⁰.

Aesthetic

In some communities, a woman's genitals are considered to be ugly and unattractive to men unless they have been subjected to FGM. The clitoris, in particular, can be considered unsightly and its removal a sign of a girl's maturity²¹.

FGM is a Violation of Women's & Girls' Human Rights

Any type of FGM is a harmful practice, a contravention of internationally recognised human rights and constitutes violence against women and girls. Specifically, FGM violates the right to the highest attainable standard of health, the right to be free from all forms of gender discrimination, the right to life, the right to bodily integrity and children's rights to special protections. All of these rights are codified within international treaties, regional instruments and reinforced by political consensus documents (see Appendix I for complete list of documents). The rights enshrined in these documents are considered indivisible, inalienable and universal and no social or cultural claims can justify their infringement.

Addressing FGM in the context of human rights is critical to the eventual abandonment of the practice for three reasons: First, responsibility is placed on governments to ensure the human rights of women and girls are realised and to take all measures necessary to eradicate the practice. Second, similar to many of the violations of women's rights, an act that was once considered a private affair and therefore not subject to state intervention is firmly placed in the public sphere as a manifestation of structural gender inequality. Finally, recognising the universal nature of human rights of girls and women de-legitimises any claims for the continuation of FGM for social or cultural reasons²².

Health Consequences of FGM

FGM has no health benefits. It involves removing and/or damaging healthy and normal tissue and interferes with the natural functions of girls' and women's bodies. Immediate health consequences of FGM can include: severe pain, shock, haemorrhage, difficulty passing urine, infection, psychological trauma, sepsis and can lead to death. Long term complications include: chronic urinary and menstrual problems, chronic pain, pelvic inflammatory disease, cysts, infection, increased risk of HIV transmission and infertility²³.

FGM has serious and adverse consequences for mothers and children during childbirth. A WHO study found significant associations between FGM (all forms, but type III more than types I and II) and various obstetric sequelae. Although obstructed labour was not one of the outcomes measured in this study, the obstetric complications related to FGM (caesarean section, extended maternal hospital stay, stillbirth and early neonatal death) are often the results of obstructed labour²⁴. Obstructed or prolonged labour is the main factor for obstetric fistulae.

CHAPTER 2: ABOUT FEMALE GENITAL MUTILATION (FGM)

The risks to women and girls' health is invariably aggravated by the use of unsterile equipment, unsanitary environments, lack of any anaesthetic and the procedure being carried out by unskilled members of the community. In an effort to reduce the health risks to women and girls, there is a growing trend in some countries of medical professionals performing FGM in clinical settings. The WHO consistently and unequivocally rejects this harm reduction strategy and notes that any attempt to medicalise the procedure is unacceptable and contrary to medical ethics²⁵. Furthermore, involvement of medical professionals in carrying out FGM undermines the message that FGM is a discriminatory act of violence that denies women and girls their rights to the highest attainable standard of health and physical integrity²⁶.

In addition to physical health consequences, women who have undergone FGM also report negative psychological effects. The trauma for some women subjected to FGM can be reactivated in situations that bring back memories of the mutilation, such as sexual debut, childbirth and vaginal examinations²⁷. Appropriate acknowledgement and care for women and girls suffering psychological affects is an essential part of providing care for women and girls who have undergone FGM.

Migration to Ireland from Countries with High FGM Prevalence

Women and families from countries with high prevalence of FGM such as Northern Sudan (90% estimated prevalence of FGM in girls and women aged 15-49) and Somalia (98%)²⁸ are continuing to migrate to Ireland. Migration is challenging for families as they try to integrate and adjust to a completely different environment and at the same time preserve essential elements of their cultural identity. Continuing the practice of FGM in a new country is one way in which families may choose to maintain a cultural link to their country of origin²⁹. While there is no evidence to suggest that girls are undergoing FGM in Ireland, evidence from other countries suggests some families may feel pressured to bring their daughters to their country of origin to undergo FGM. The United Kingdom, Norway and Sweden responded to this situation by enacting legislation that not only prohibits FGM within the country but also protects girls from being taken out of the country to undergo FGM. This legal principle is known as extraterritoriality and is supported by child protection measures already in place³⁰.

Migration is also challenging for Irish society as it attempts to meet the needs of an increasingly diverse population. Many Irish service providers may be unfamiliar with the health and care needs, child protection issues, legal technicalities and community development approaches related to FGM. This can be frustrating for service providers, as well as communities affected by FGM, in their desire to provide high quality and culturally appropriate services and care. The HSE acknowledges these challenges and has committed in its Intercultural Health Strategy 2008-2001 to "implementing an intercultural approach towards planning and delivery of care and support services in an equal, accessible and effective way, acknowledging the value and diversity of all service users."³¹

Prevalence of FGM in Ireland

Irish FGM prevalence data collation by AkiDWA was modelled after a similar study by the UK organisation FORWARD, in conjunction with the London School of Hygiene and Tropical Medicine and City University London, which estimated the prevalence of FGM in England and Wales. To determine an estimate for the number of women living in Ireland with FGM, relevant population data from the 2006 national census was obtained from the Central Statistics Office (CSO). The collected data included the number of women residing in Ireland from FGM-practising countries between the ages of 15 and 44, broken down by age group and country of origin. The number of women from each country and in each age group was then integrated with applicable global prevalence data from the World Health Organisation. The result of these calculations presents a preliminary estimate for the number of women living in Ireland who have undergone FGM as at April 2006 of 2,585 women³². (See Table 4 on page 20 for full data).

It is important to note that the estimates determined in this study provide initial statistics of the prevalence of FGM in Ireland and are subject to several limitations. Census data are likely to be an underestimate, as some individuals and groups may be hesitant to participate in the census. Recent trends in inward migration to Ireland have shown an increase in the number of women from FGM-practising countries which would also mean that these figures are an underestimate. The implication of these statistics is that Ireland needs to be pro-active regarding FGM prevention and legislation.

Care for Women and Girls who have Undergone FGM

Women and girls who have undergone FGM are presenting to maternity hospitals, GPs, and sexual health services. Many health care professionals and other organisations supporting migrant women are not yet aware of the existence of FGM, the health implications of FGM particularly as they relate to childbirth and/or an appropriate referral pathways including child protection pathways. As a result, women and girls are not able to access the care and services they need and health care professionals and others charged with supporting migrant women are unsure of how to provide appropriate support.

Child Protection

A proportion of young girls living in Ireland are at risk of undergoing FGM because they are born into families that practise FGM. It must be noted that families, most often mothers, arrange for their daughters to undergo FGM. This is done out of love for their daughter and is not considered by the parents as cruel or harmful. However, several agencies in Ireland including but not limited to teachers, doctors, public health nurses, community services and social workers have a role in ensuring the protection of children and reporting potential or past abuse to relevant authorities. Without policies that reflect the complexities of FGM and support for parents to abandon the practice, some girls living in Ireland will continue to be at risk of FGM.

Linking International Efforts with National Realities

Irish Aid recognises FGM as form of gender based violence and in 2008 contributed to the joint UNICEF/UNFPA fund to end FGM³³. Furthermore, development NGOs have been working on the ground in developing countries in different ways to encourage communities to abandon FGM. As families from high prevalence FGM countries migrate to Ireland there is much to be learned from the successes and challenges experienced by Irish development NGOs and Irish Aid in raising awareness of FGM, promoting women and girls' human rights and engaging with communities to abandon the practice.

Interagency Cooperation

As noted above, Ireland has no coordinated strategy or interagency working group set up to address FGM. Consequently, different government agencies, health care professionals, communities, organisations and individuals are working in isolation from one another and often in a reactive and ad hoc basis. FGM is a complex issue and has implications for health, justice, education, immigration, equality, development aid and social care departments. Furthermore, with the exception of strong legislation, the Irish policy environment necessary to put in motion a Plan of Action to prevent FGM is already in place. The National Women's Strategy 2007-2016 has committed to improving the sexual and reproductive health status of women living in Ireland and to provide an effective and appropriate response to victims of violence against women. These objectives, as they relate to FGM, are supported by the HSE Intercultural Health Strategy, National Women's Strategy, Statement on Integration and Diversity Management, Child Protection Policy and Code of Behaviour, National Children's Strategy, National Guidelines for the Protection and Welfare of Children, National Health Strategy and the White Paper on Irish Aid policies. As recommended by the Women's Health Council in 2008, a high level interdepartmental working group to address FGM in Ireland needs to be established to monitor the implementation of the Plan of Action, ensure joined up thinking in policy measures across the different agencies so that the women and girls affected or at risk of FGM can benefit from their implementation.

CHAPTER 4: STAKEHOLDERS

STAKEHOLDERS (including but not limited to)	
Communities affected by FGM	<ul style="list-style-type: none"> ● Girls at risk of FGM ● Women who have undergone FGM ● Communities that practice FGM ● Religious / Community Leaders
Health Care Professionals	<ul style="list-style-type: none"> ● General Practitioners ● Midwives ● Nurses, including Public Health Nurses & Practice Nurses ● Obstetricians/Gynaecologists ● Social Workers ● Paediatricians ● Children's' Hospitals ● University and Teaching Hospitals
Government Departments	<ul style="list-style-type: none"> ● Department of Health & Children <ul style="list-style-type: none"> ▸ Office of the Minister for Children and Youth Affairs ▸ Office of Social Inclusion ● Department of Foreign Affairs <ul style="list-style-type: none"> ▸ Irish Aid ● Department of Justice, Equality & Law Reform <ul style="list-style-type: none"> ▸ Reception & Integration Agency ▸ Cosc ▸ Gender Equality Unit ▸ Irish Naturalisation and Immigration Service ▸ Office of the Attorney General ▸ Office of the Minister for Integration ● Department of Social & Family Affairs <ul style="list-style-type: none"> ▸ Office for Social Inclusion ● Department of Education & Science <ul style="list-style-type: none"> ▸ Gender Equality Unit ● Department of Finance ● Local Governments
Statutory Agencies	<ul style="list-style-type: none"> ● An Garda Síochána ● Director of Public Prosecutions ● Courts Services ● Economic and Social Research Institute ● Equality Authority ● Health Information and Quality Authority ● Health Research Board ● Health Service Executive ● Irish Human Rights Commission ● Office of the Refugee Applications Commission ● Ombudsman for Children ● Refugee Appeals Tribunal ● Refugee Legal Services ● Women's Health Council

CHAPTER 4: STAKEHOLDERS

Non Governmental Organisations	<ul style="list-style-type: none">● AkiDwA● Amnesty International● Barnardos● Cairde● Children's Rights Alliance● Christian Aid● Comhlamh● Immigrant Council of Ireland● Integration of African Children in Ireland● Irish Refugee Council● Irish Family Planning Association● Integrating Ireland● National Women's Council of Ireland● Refugee Information Service● Somali Community in Ireland● UNICEF● UNHCR
Regulatory Bodies	<ul style="list-style-type: none">● An Bord Altranais● Irish College of General Practitioners● Irish Medical Council● Law Society of Ireland● Royal College of Physicians in Ireland
Legal Professionals	<ul style="list-style-type: none">● Solicitors● Barristers● Judges
Platform Associations	<ul style="list-style-type: none">● Joint Consortium on Gender Based Violence● Dochas● National Consultative Committee on Racism and Interculturalism

Legal

Legislation by itself is not sufficient to prevent FGM but it can strengthen the ability of agencies to protect children at risk and provide appropriate care. Human rights treaties such as the Convention on the Elimination of all forms of Discrimination Against Women specifically call upon signatory governments to take all measures necessary including legislation to prevent FGM³⁴. In addition, the European Parliament and the Council of Europe both passed resolutions in 2001 calling upon member states to enact domestic legislation to prohibit FGM³⁵.

From a health perspective, Ireland requires an appropriate legislative basis from which to support prevention and health intervention initiatives. Doctors, nurses, midwives and social workers report that the lack of specific legislation hinders the development of policies and regulations within their respective institutions³⁶.

From a legal perspective, enactment of legislation to prohibit FGM needs to be motivated by Irish society's responsibility to protect girls at risk and to reinforce existing child protection policies and mechanisms such as the Children's First Guidelines. Many African and European states have passed legislation criminalising FGM as part of an overall strategy to reinforce child protection policies.

According to the Department of Justice, the Non-Fatal Offences against the Person Act 1997 criminalises the practice of FGM in Ireland. This Act is intended to criminalise intentional harm to others. However, as noted by the Women's Health Council, this legislation is not particularly appropriate for FGM prosecution for three reasons³⁷.

- ▶ First, Article 3 states that a crime has not been committed if the act *"is in the circumstances such as is generally acceptable in the ordinary conduct of daily life and the defendant does not know or believe that it is in fact unacceptable to the other person."* This means that parents who subject their daughters to FGM could reasonably argue that they had not committed a crime because they did not know it was unacceptable in Ireland and is a normal part of their culture.
- ▶ Second, there is no section of the 1997 Act that protects children resident in Ireland from being taken to other countries to undergo FGM.
- ▶ Third, violations of women and girls human rights to bodily integrity because of their gender require specific legislation that acknowledges the severity of the crime and the conditions under which the crime is committed.

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Objective #1 *Enact legislation to specifically prohibit FGM in Ireland, including the principle of extraterritoriality as an extension of national legislative protection*

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ACTION	SUGGESTED LEAD RESPONSIBILITY
Political support for introduction of Prohibition of Female Genital Mutilation Bill	Joint Committee on Health and Children
Consultation on Prohibition of Female Genital Mutilation Bill	Cosc
Draft Prohibition of Female Genital Mutilation Bill	Department of Justice, Equality and Law Reform
Targeted advocacy to promote enactment of Prohibition of Female Genital Mutilation Bill	Non governmental organisations

Irish Asylum Process

The 1951 Convention relating to the Status of Refugees is the key legal document in defining who is a refugee, their rights and the legal obligations of states. The definition is reflected in Irish law by the Irish Refugee Act, 2006.

Historically, the refugee definition has been interpreted through a framework of male experiences, which has meant that many claims of women have gone unrecognised. In the past decade, however, the analysis and understanding of sex and gender in the refugee context have advanced substantially in case law, in State practice generally and in academic writing. These developments have run parallel to, and have been assisted by, developments in international human rights law and standards, as well as in related areas of international law, including through jurisprudence of the International Criminal Tribunals for the former Yugoslavia and Rwanda, and the Rome Statute of the International Criminal Court.

Even though gender is not specifically referenced in the refugee definition, it is widely accepted that it can influence, or dictate, the type of persecution or harm suffered and the reasons for this treatment. The refugee definition, properly interpreted, therefore covers gender-related claims³⁸.

The United Nations, including United Nations High Commissioner for Refugees, has long recognised the need for specific guidance on gender related persecution and protection needs. Moreover, countries such as the United Kingdom, Canada, the United States and Australia have recognised that women do not benefit in the same ways as men from the asylum process and instituted gender guidelines to remedy the situation. Gender guidelines allow decision makers to examine women's asylum claims in a way that contextualises their experience and recognises the influence of gender inequality on perceptions of persecution³⁹.

In Ireland, FGM is recognised as a form of persecution and may lead to grant of protection if the other requirements of the convention are met, however there are currently no publicly available gender guidelines in use by the Office of the Refugee Applications Commissioner in relation to how to process claims from women applicants. Implementation of best practice gender guidelines in the Irish asylum process will allow for improved practices in dealing with women claiming gender related persecution.

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Objective #1 ***To enhance the capacity of the asylum process to accommodate gender related claims***

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ACTION	SUGGESTED LEAD RESPONSIBILITY
Adoption of Gender Guidelines for evaluating asylum claims that include provisions of FGM	Office of the Refugee Applications Commissioner
Country of Origin information to include prevalence and conditions of FGM	Office of the Refugee Applications Commissioner
Knowledge and information sharing between asylum support agencies on gender guidelines are utilised	Office of the Refugee Applications Commissioner

Health

The concept of health, as defined by WHO and adopted by the Department of Health, can be understood as “a state of complete physical, mental and social well-being.” This means that there a range of people, agencies and professions involved in the health and well being of all people living in Ireland. This includes, but is not limited to, doctors, nurses, midwives, psychologists, community supports, counsellors and others.

Women who have undergone FGM have specific health and care needs, particularly as they relate to childbirth. Equally, health care professionals and those involved with supporting women in their health, require training, information, guidelines, evidence based research and access to referral pathways in order to respond appropriately to these needs. Furthermore, uniform data collection in maternity hospitals has the capacity to significant contribute to the knowledge and evidence base of FGM in Ireland.

In line with government commitments to improving health and care for migrant women as articulated in the Intercultural Health Strategy 2007-2012, initiatives aimed at improving access to appropriate care for women and girls who have undergone FGM are urgently required. Specifically, the Intercultural Health Strategy has tasked the HSE with developing services that are based on:

- ▶ Intersectoral collaboration
- ▶ Equality and targeting
- ▶ Interculturalism and anti racism
- ▶ Community participation around health needs
- ▶ Partnership working
- ▶ Learning and support for Staff

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Objective #1 *To develop professional supports for those involved with providing care and support for women and girls who have undergone FGM*

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ACTION	SUGGESTED LEAD RESPONSIBILITY
Development and adoption of statements prohibiting the practice of FGM by professional regulatory bodies	Medical Council & relevant professional bodies
Guidance for health care professionals providing care for women who have undergone FGM	Department of Health & Children, Health Service Executive, HIQA & relevant professional bodies
Development of policies on care for women with FGM in maternity hospitals	Health Service Executive, Hospitals Working Group & relevant professional bodies

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Objective #2 *To assist professional capacity building in the provision of health care and support services for women presenting with FGM*

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CHAPTER 5: PLAN OF ACTION

ACTION	SUGGESTED LEAD RESPONSIBILITY
Support the integration of modules on the needs of women and girls with FGM in appropriate third level education and training	Department of Education & Science
Support the integration of training modules on the health needs of women and girls with FGM in Continuing Medical Education	Medical Council, relevant professional bodies & universities/teaching hospitals
Facilitate forum for professionals engaged with the provision of care for women and girls with FGM	Department of Health and Children, Health Service Executive & relevant professional bodies
Develop information sheets for health professionals on FGM	Royal College of Surgeons in Ireland & AkiDwA

Objective #3 *To address the physical, psychological and emotional health care needs of women and girls living in Ireland with FGM*

ACTION	SUGGESTED LEAD RESPONSIBILITY
Develop referral pathways for women and girls who present with FGM including psychological care pathways	Health Service Executive
Produce patient information leaflets for women and girls who have undergone FGM in appropriate languages and formats	Health Service Executive

Objective #4 *To improve data collection of women with FGM presenting to maternity hospitals*

ACTION	SUGGESTED LEAD RESPONSIBILITY
Uniform data collection system to record incidence/prevalence of FGM in Ireland	Health Service Executive, Department of Health & Children

Community

In developing strategies to abandon or prevent FGM, UNICEF recommends focussing on non directive communication approaches led by members of the affected community. These approaches create safe spaces for dialogue on sensitive issues eventually working towards a collective will to change⁴⁰. The added value of this approach is that issues related to gender equality, employment, education and violence can also be addressed in this context and indirectly contribute to the abandonment and prevention of FGM.

Objective #1 *To support dialogues relating to FGM within migrant communities*

ACTION	SUGGESTED LEAD RESPONSIBILITY
Incorporation of FGM in community based peer education programmes	Office of the Minister for Integration
Dissemination of information on the effects of FGM on women's and girls' health, rights and well being	Office of the Minister for Integration

Objective #2 *To encourage community abandonment of FGM*

ACTION	SUGGESTED LEAD RESPONSIBILITY
Support migrant women led forums to develop grassroots intervention strategies	Office of the Minister for Integration
Work with religious and community leaders around agreeing ways to discourage the practice of FGM	Office of the Minister for Integration
Engage with male members of community on FGM, gender and violence against women/harmful traditional practices	Office of the Minister for Integration

Objective #3 *To promote the capacity of women to articulate their needs relating to gender equality, human rights and FGM*

CHAPTER 5: PLAN OF ACTION

ACTION	SUGGESTED LEAD RESPONSIBILITY
Advocate for increased access to education, resources and employment for all women living in Ireland	Equality Authority
Increase public support for the realisation of women's human rights	Department of Justice, Equality and Law Reform & Irish Human Rights Commission
Support capacity building initiatives of migrant women and migrant organisations	Office of the Minister for Integration

Development Aid

In order to achieve the goal of preventing FGM in Ireland, strategies must also examine ways in which to contribute to the worldwide abandonment of FGM. The Irish Aid White Paper recognised FGM as a form of gender based violence and its Health Policy has further committed to advocating for action on specific health issues that stem from women's position in society, such as FGM. Furthermore, Irish Development NGOs have been working with communities to encourage abandonment FGM and also to promote women and girls human rights generally. There is a wealth of knowledge from these organisations regarding their successes and challenges. Transference of knowledge and lessons learned has the capacity to significantly impact upon the prevention of FGM in Ireland and also the abandonment of FGM worldwide.

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Objective #1 *To raise the issue of FGM in international fora*

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ACTION	SUGGESTED LEAD RESPONSIBILITY
Raise the subject of FGM during political talks with other countries	Irish Aid & Department of Foreign Affairs

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Objective #2 *To transfer knowledge and experience of international efforts to combat FGM*

.....

ACTION	SUGGESTED LEAD RESPONSIBILITY
Support dialogue between organisations, individuals and agencies working internationally and those working in Ireland	Irish Aid

TABLE 1

WORLD HEALTH ORGANISATION CLASSIFICATION 2007	
<p>Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed: Type Ia, removal of the clitoral hood or prepuce only; Type Ib, removal of the clitoris with the prepuce.</p>	
<p>Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: Type IIa, removal of the labia minora only; Type IIb, partial or total removal of the clitoris and the labia minora; Type IIc, partial or total removal of the clitoris, the labia minora and the labia majora. Note also that, in French, the term "excision" is often used as a general term covering all types of female genital mutilation.</p>	
<p>Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: Type IIIa: removal and apposition of the labia minora; Type IIIb: removal and apposition of the labia majora.</p>	
<p>Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterisation.</p>	

TABLE 2

COUNTRIES IN WHICH FGM IS PRACTISED (NB PREVALENCE VARIES)	
Africa	Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Ethiopia, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda
Asia	India, Indonesia, Malaysia, Pakistan
Middle East	Oman, United Arab Emirates, Yemen, Iraq, Palestinian Territories

TABLE 3

PROGRESS TO DATE IN IRELAND	
November 2008	Lecture to 3rd year student midwives in Dundalk Institute of Technology on FGM and related patient care
October 2008	FGM Seminar as part of the Islamic Cultural Centre of Ireland (ICCI) Health Awareness Week 2008 with over 40 attendees
October 2008	4 Information sessions for Health Care Professionals, student midwives and student social workers on FGM delivered with over 210 attendees from all HSE areas.
September 2008	Input on IFPA Family Planning Training Course to 86 doctors and nurses on “FGM in a family Planning session”
June 2008	Women’s Health Council published <i>Female Genital Mutilation/Cutting: A Literature Review</i> .
April 2008	First meeting of the National Steering Committee to develop a National Plan of Action to Prevent and Abandon FGM in Ireland
February 2008	Irish Aid provided funding of €500 000 to the joint UNICEF/UNFPA trust fund on Female Genital Mutilation/Cutting. This programme is designed to work with cultural and religious leaders to encourage a societal change and abandonment of the practice.
February 2008	Health Service Executive published the National Intercultural Health Strategy 2007-2012
2007	Adjournment debate on FGM in the Dáil
2007	Government funding awarded to AkiDwA to undertake one year action research project focussed on improving access to health care for women who have experienced FGM.
2005	The Crisis Pregnancy Agency published an information pack entitled <i>Reproductive Health Information for Migrant Women</i> as part of its <i>Key Contacts</i> series
2005	AkiDwA facilitated a series of discussions on FGM with migrant women’s groups in midlands region
2004	FGM Coalition hosts roundtable seminar “FGM – Why is it relevant for Ireland?”
2002	Irish Coalition Against FGM was established by Comhlamh
2002	Publication of educational booklet entitled <i>Understanding Female Genital Mutilation</i> by Comhlamh
2001	Prohibition of Female Genital Mutilation Bill 2001 tabled as a Private Members Bill (lapsed)

TABLES

TABLE 4 – ESTIMATED PREVALENCE OF FGM IN IRELAND AS OF APRIL, 2006

Country	Global Prevalence	Estimated number of women aged 15 to 44 resident in Ireland with FGM	Total women aged 15 to 44 enumerated by 2006 Census
Benin	17	5.1	30
Cameroon	1.4	4.06	290
Central African Republic	36	1.08	3
Cote d'Ivoire	45	40.5	90
Democratic Republic of the Congo	5	2.1	42
Egypt	97	173.63	179
Eritrea	89	16.02	18
Ethiopia	80	71.2	89
Gambia	78.3	26.622	34
Ghana	5	18.85	377
Guinea	99	36.63	37
Kenya	32	113.92	356
Liberia	60	43.8	73
Mali	92	7.36	8
Niger	5	4.55	91
Nigeria	19	1311.38	6902
Senegal	28	3.36	12
Sierra Leone	94	99.64	106
Somalia	97.9	335.797	343
Sudan, northern	90	247.5	275
Togo	5.8	3.886	67
Uganda	0.6	0.6	100
United Republic of Tanzania	18	14.22	89
Yemen	23	2.99	13
TOTAL NUMBER		2584.795	9624
TOTAL PERCENTAGE		26.89%	

International and Regional Sources of Human Rights Applicable to FGM

INTERNATIONAL HUMAN RIGHTS INSTRUMENTS

Convention on the Elimination of All forms of Discrimination against Women

Convention on the Rights of the Child

Universal Declaration on Human Rights

International Covenant on Economic Social and Cultural Rights

International Covenant on Civil and Political Rights

United Nations General Assembly

- ▶ Resolution 48/104 of 20 December 1993 - Declaration on the Elimination of Violence against Women
- ▶ Resolution 53/117 of 1 February 1999 - Traditional or customary practices affecting the health of women and girls

International Conference on Population and Development Programme of Action

Beijing Platform for Action

EUROPEAN INSTRUMENTS

European Parliament

- ▶ Resolution on Female Genital Mutilation (2001/2035(INI))
- ▶ Resolution on women's immigration: the role and place of immigrant women in the European Union (2006/2010(INI))

European Directive

- ▶ European Council Directive 2004/83/EC - Minimal rules to qualify immigrants from third countries as refugees

Council of Europe

- ▶ Female Genital Mutilation Resolution 1247 (2001)

Cotonou Agreement

European Convention for the Protection of Human Rights and Fundamental Freedoms

AFRICAN INSTRUMENTS

Declaration on the Rights and Welfare of the African Child

African Charter on the Rights and Welfare of the African Child

African Charter on Human and People's Rights and its Protocol on the Rights of Women in Africa (Maputo)

IRISH POLICY FRAMEWORK

Department of Justice, Equality & Law Reform

- ▶ National Women's Strategy 2007-2016

Health Service Executive

- ▶ National Intercultural Health Strategy 2007-2012

The Office of the Minister for Children and Youth Affairs

- ▶ Child Protection Policy and Code of Behaviour for working with children/young people 2008
- ▶ National Children's Strategy 2000-2010

Department of Health & Children

- ▶ Statement of Strategy 2008-2010
- ▶ The Principles of Good Practice for the Protection of Children & Young People - *Our Duty to Care* 2002
- ▶ National Health Strategy - *Quality and Fairness: A Health Service for You* 2001
- ▶ National Guidelines for the Protection and Welfare of Children - *Children First* 1999

Office of the Minister for Integration

- ▶ Statement on Integration and Diversity Management 2008

Equal Status Acts 2000 & 2004

Irish Aid

- ▶ Health Policy 2007
- ▶ White Paper 2006
- ▶ Gender Equality Policy 2004

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