Protocol for the Prevention

of Female Genital Mutilation

in Castile La Mancha

Castile La Mancha Women's Institute

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Castile La Mancha Women's Institute (2017)

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INTRODUCTION

From the perspective of the people who practice it, female genital mutilation symbolises the rite of passage from girlhood to womanhood and has a very strong social, cultural and identity component. From the Western point of view, it is considered a practice done against women, usually in the early stages of life and which has, since the signing of the Istanbul Convention, signified a serious affront on their human rights, as well as gender discrimination. It also signifies a lack of protection of children as rightholders against all forms of abuse and therefore requires the urgent legal actions in place around the judicial protection of minors.

The practice injures the female genital organs and causes irreversible damage, triggering very negative repercussions for those who undergo it in terms of their physical, mental and sexual health. All sectors that work with girls, as potential victims, must therefore address it to stop it from occurring.

There is some debate around the most appropriate term for the phenomenon. Academics tend to call it Female Genital Cutting (FGC). This proposal is because it respects the people from the cultures that practice it. However, areas more closely related to gender studies and human rights advocate calling it Female Genital Mutilation (FGM).

At the most general level, terms such as ablation, female circumcision, genital cutting, female genital surgery or traditional practice are used to call what the Inter-African Committee itself calls FGM, and it refers to all the traditional practices performed on the external genitalia of young women without medical reason and with negative repercussions for their health.

With institutions increasingly sensitive to issues like it, several initiatives have begun in recent years that have resulted in work to prepare guidelines and protocols to raise awareness around the issue for institutions and professionals in a position to detect situations of risk. Hernández and Almansa (2014) conducted a study on FGM protocols and publications that confirmed the importance of drafting protocols to help professionals address the problem in a comprehensive fashion and optimise actions

in its regard. Although these authors refer to the health area, we understand it can be applied to other settings related to the phenomenon as well. The most significant studies and protocols published in recent years include the following: the study on Female Genital Mutilation in Spain prepared by the Government Delegation for Gender Violence in 2016[1]; the Protocol for Prevention and Action on Female Genital Mutilation in Aragon (2016)[2]; the Common Protocol[3] for Health Action on Female Genital Mutilation (FGM) approved by the Spanish Ministry of Health, Social Services and Equality (2015); the Protocol for Prevention and Action on Female Genital Mutilation in Navarre (2013)[4] and the Action Protocol to Prevent Female Genital Mutilation (Government of Catalonia, 2007)[5].

To draw up this Protocol for the Prevention of Female Genital Mutilation in Castile La Mancha, research[6] was undertaken using the focus group technique, with the engagement of professionals from the different areas of the Autonomous Community related to the FGM phenomenon. Their experience suggests that the protocol presented here is in line with the situation on the ground in Castile La Mancha, which will undoubtedly facilitate its implementation.

The protocol comprises an initial part analysing the meaning of this practice from the many perspectives that help to understand its extent, and addresses the concept of FGM, its different forms, health consequences and legal framework. This first part ends with an analysis of the current situation in the Autonomous Community of Castile La Mancha. The second part is a comprehensive approach to preventing FGM detected in the region and provides concrete intervention measures (awareness-raising, prevention and treatment) in the different areas, as well as coordination between them. The Protocol ends with an evaluation by means of monitoring committees.

[1] http://www.violenciagenero.msssi.gob.es/violenciaEnCifras/estudios/investigaciones/2015/pdf/MGF_definitivo.pdf
[2] http://www.violenciagenero.msssi.gob.es/otrasFormas/mutilacion/protocolos/protocolo/pdf/ARAGon2016.pdf
[3] The Common Protocol for Health Action in Relation to FGM is shored up in the 2013-2016 National Strategy for the Eradication of Violence Against Women, measure 185 of which establishes: "*Propose the Adoption of a Common Protocol for Health Action in Relation to Female Genital Mutilation*". *http://www.violenciagenero.msssi.gob.es/otrasFormas/mutilacion/protocolos/protocolo/pdf/Protocolo_MGF_vers5feb2015.pdf*
[4] http://www.violenciagenero.msssi.gob.es/otrasFormas/mutilacion/protocolos/protocolo/pdf/navarra_2013.pdf
[5] http://www.violenciagenero.msssi.gob.es/otrasFormas/mutilacion/protocolos/protocolo/pdf/cataluna_2007.pdf
[6] The complete study is available for consultation at the Castile La Mancha Women's Institute: Carrasco, C.; Francisco, C.; e Ibáñez, M. {2016}. "*Study for the Prevention of Female Genital Mutilation in Castile La Mancha".*

INTER-INSTITUTIONAL AGREEMENT

At a meeting:

José Luis Martínez Guijarro Vice-President of the Regional Government of Castile La Mancha	Araceli Martínez Esteban Director of the Castile La Mancha Women's Institute
Aurelia Sánchez Navarro Minister of Social Welfare	Ángel Felpeto Enríquez Minister of Education, Culture and Sports
Jesús Fernández Sanz Minister of Health	Mª Estrella Giménez Buiza President, Kirira Foundation Against Female Genital Mutilation
Idoia Ugarte Gurrutxaga Vice-President, Doctors of the World, Castile-La Mancha	

The parties hereto express their will and need to coordinate skills and efforts and to pool personal and material resources to prevent Female Genital Mutilation.

OBJECTIVES

The **general objective** is to prevent the practice of female genital mutilation by providing guidance in identifying the population at risk for professionals involved in dealing with this form of gender-based violence in order to prevent FGM from occurring in girls living in Castile La Mancha, while also attending to women who have undergone the practice.

The **specific objectives** are as follows:

- Provide professionals related to the practice with the awareness, information and training needed to act in risk situations.
- Organise a comprehensive intervention system – awareness, prevention and treatment – on the population at risk in communities that perform the practice with inter-professional and inter-institutional coordination.
- Reduce the effects of FGM on women who have already undergone it.
- Establish mechanisms for monitoring and evaluating the actions included in the protocol.

PART I. FEMALE GENITAL MUTILATION

Rationale and Meaning

Concept and Extent

Types of FGM

Health Consequences

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Analysis of the Situation in the Autonomous Community of Castile La Mancha.

Rationale and Meaning

FGM is an ancestral practice in the communities, ethnicities and groups that perform it due to decisions taken in the family, in which the women who belong to it play a fundamental role. Although men also participate, women generally approve of the practice, supported on what has been highlighted as “positive arguments”, and in most groups the paternal grandmother plays a key role in the decision (Ballesteros *et al*. 2014). Kaplan *et al*. (2016) explain that when a mother decides against having her daughter cut, the paternal grandmother is entitled to force the granddaughter to comply with the rite. It is an obligation stemming from tradition and must be respected, because the physical mark symbolises group membership.

FGM responds to cultural traditions specific to the different territories and ethnicities where it is performed (mainly in countries in sub-Saharan Africa, but also in some communities in Asia and the Middle East), so it is necessary to address the problem with great respect for the sensitivities of those in favour of it, without this indicating the slightest modicum of tolerance. It is a purpose of this protocol to convey this value with education and information actions and without blaming the family, trying to get them to abandon the practice and leveraging the resources of the community itself and of immigrant groups.

This protocol is aimed primarily at professionals in the health, education and social welfare fields in Castile La Mancha due to the relationship they have with this harmful practice against women. Coordinating approach strategies is also essential in partnership with associations in all fields (education, culture, sports, health, development cooperation, etc.) in contact with the population at risk and especially those with experience in FGM. Of particular relevance will be associations of people from the different countries where FGM is practised and intercultural mediators. They have a good grasp on which ethnicities practice cutting and would undoubtedly be good agitators for change. The intercultural mediator does not necessarily have to be from the same country as the girl at risk but must be recognised in the African community. Nor is it essential to have a mediator for each community.

A fundamental aspect to bear in mind is that any proposed measure must consider the need to improve women’s living conditions, powering gender equality as an essential premise for ending discriminatory practices against women. In Spain, the eradication

of FGM is included in the 2013-2016 National Strategy for the Eradication of Violence against Women.

According to Kaplan and Bedoya (2004), to be able to intervene it is necessary to know the reasons why it is performed. Reasons for its practice include:

- It improves the role of women. It involves being accepted in the community, marrying well and achieving a better social position.

- Sexual and reproductive health: it is considered to reduce sexual desire and therefore promote chastity. All the women who engaged in the study by Ballesteros *et al.* (2014) said they did not enjoy sexual relations, although it did not appear to guarantee celibacy before marriage. It is also argued that it facilitates the process of pregnancy and childbirth, making birth safer for the newborn.

- Hygiene: in some languages cutting is synonymous with cleansing and purification. An uncut woman is considered "dirty". She is known as *solima* and it is, as described by Kaplan and Bedoya (2004), the worst insult a woman receive. *"Neither the water nor the food she has handled can be drunk or eaten, because through her state of impurity she exerts a polluting action on everything she touches."*

- Aesthetics: Female genitals are considered overly bulky and ugly.

The practice is not linked to any religion. Although it is sometimes associated with Islam, there is no instruction to perform it in the Quran. In 2005, politicians and religious leaders from 50 Muslim states meeting in Rabat at the First Islamic Ministerial Conference on the Child declared FGM an anti-Islam practice and urged countries to work towards its eradication. It is also performed in Christian and Jewish communities.

Not undergoing cutting makes a girl more vulnerable. She may be subject to harassment, exclusion from major communal events and support networks and be marginalised by peers (WHO, 2013).

It is important, following Kaplan, Salas and Mangas (2016) to *"initiate the approach without the pressure of time or the need for immediate intervention in the face of an upcoming trip back home. "We must be aware that for African women, renouncing practices such as FGM is experienced as a clash between their traditional identity and*

values imposed on them from outside. "That is why it must be a process of slow change, to build a new identity".

Concept and Extent

The largest international treaty dedicated to preventing and combating structural violence against women, the Istanbul Convention (Council of Europe), ratified by Spain in 2014, specifically includes FGM as a serious form of violence. For the WHO, it means any practice involving the total or partial removal of women's external genitalia without medical reason. The most common life stage to perform it is between the ages of four and fourteen, although it is practised at a wide range of ages, from shortly after birth to the first pregnancy. The WHO notes there seems to be a tendency to practice it in younger and younger girls, to minimise their resistance. Some authors say this preference for bringing the age forward makes it a purely physical process, thus losing the cultural components of the *"rite of passage"* (Kaplan *et al*. 2016).

It is practised in around 40 countries, 29 of them in sub-Saharan Africa (Sahel strip), some communities in India, Indonesia, Malaysia, Pakistan and Sri Lanka and in Middle Eastern countries such as the United Arab Emirates, Oman, Yemen, Iraq and Israel (UNFPA, 2015)[7]. It is a practice justified on the grounds of cultural traditions. Among the main ethnicities practising it are the Serahule, Mandinka, Soninke, Dogon, Hausa, Jola, Fula, Bambara, Pokot, Edo and Fante communities. It is forbidden in around half of the countries but social pressure is very strong so it continues to be performed, even by people who oppose it, for the sole purpose of maintaining a sense of belonging and promoting social cohesion (Kaplan *et al*. 2006) and recognition by the community.

The phenomenon of migrating to industrialised countries has extended these practices through the immigrant population living abroad but born in countries where FGM is practised. It is generally still performed in the country of origin, taking advantage of a trip home, and is very rare outside these countries, although the literature suggests it may have been performed in industrialised countries.

[7] Answers to the most frequently asked questions on FGM can be found at the web link of the United Nations Population Fund (UNFPA): https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions

Both the decision to carry on with or abandon the practice is influenced by the fact that it is taken in a family, in the group, making it a community decision. Abandonment of the practice individually by the mother or father (or both) is very difficult. The family back home can pressure the emigrant family and in some way force it to practice it on girls, taking advantage of trips home to the country of origin. These periods are therefore considered to be of imminent risk.

FGM affects around 140 million women worldwide, including more than 500,000 in Europe. Around 180,000 are at risk of undergoing it and, specifically in Spain, Kaplan and López (2013) estimate that 17,000 girls are at risk[8].

In Spain, the first cases were detected in Catalonia in 1993 and then in Palma de Mallorca in 1996. The cases in Catalonia were reported by health professionals and relatives were acquitted on the grounds of *"non-intentionality of injury and error of prohibition"*[9]. As a result of this situation, anthropological mediation work was carried out that resulted in a *"pledge with the immigrant community in places where cases were detected to ensure the practices were not performed"* (Kaplan *et al.* 2006). Since then, mutilated girls and women have been identified in their countries of origin[10] but there has been no further discovery of any practice in Spain.

Types of FGM

According to the WHO (2007), four types are recognised, classified according to the anatomical extent removed:

- **Type 1. Clitoridectomy:** partial or total removal of the clitoris.
- **Type 2. Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

[8] According to the Common Protocol for Health Action Against Female Genital Mutilation approved by the Spanish Ministry of Health, Social Services and Equality (2015).

[9] Judgments on FGM cases in Spain can be consulted in the document prepared by Kaplan, A.; Salas, N. and Mangas, A. (2015) on genital mutilation in Spain.

[10] In almost all the discussion groups that were organised to compile this report, some participants said they had had contact with a cut woman. In one of the groups, this was the case of four professionals from different health system specialities. In dealing with the topic, the principles of professional secrecy were applied at all times.

Types 1 and 2 are the most common, accounting for 80-85% of cases.

- **Type 3. Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris. This type represents about 15% of cases. Incisions are stitched up with whatever is available, including acacia thorns. The girl's legs are tied together to prevent her from walking and thus promote healing (WHO, 2012).

- **Type 4.** A variety of practices on the clitoris and labia such as: pricking, piercing or incising the clitoris and/or labia; sewing up the clitoris, labia or both; cauterization by abrasion of the clitoris and adjacent tissues; shaving or cutting the orifice of the vagina; introduction of corrosive substances into the vagina to cause its narrowing.

FGM is usually practised in collective rituals, in groups of girls from the same family or neighbourhood, although it is also performed individually.

It is usually done by a woman with some standing in the community, such as a healer, midwife or simply an elder. Although it is also increasingly performed in health centres by trained staff with guaranteed procedures, this does not make it any less cruel (WHO, 2013).

Health Consequences

As well as representing an issue that undermines human rights, FGM is a public health problem because of the repercussions it has on the health of the women and girls who undergo it and because *"all women and girls are entitled to the highest possible level of health"* (WHO, 2015).

According to the Protocol approved by the Ministry of Health, Social Services and Equality, most people who practise it, families and victims, are unaware of the health problems FGM can cause, so information can help in the decision to desist from it.

Although according to Gallego and López (2010) there has been an increase in health professionals performing FGM in different African countries in recent years, it is generally still a practice carried out by people without training. Indeed, **physical**

complications are related to the lack of knowledge, skills and resources of those who most frequently perform it, who are untrained women (elderly women, healers and midwives). The most common problems are:

- **Severe pain:** it is a very painful procedure, usually done without any type of anaesthesia. It has immediate consequences, such as open wounds which in turn cause pain indefinitely. Then there are the after-effects of the traumatic experience, such as anxiety and fear.

- **Bleeding:** surgical manipulation of a highly vascularized area can lead to bleeding, shock and death. In the long term, bleeding linked to malnutrition can cause severe anaemia.

- **Infections:** the use of non-sterile instruments such as blades, crystals, knives and even sharp stones or pieces of metal can cause wound infection and urinary tract infection, with unforeseeable consequences for the girl. It can also cause infection with HIV/AIDS, hepatitis or tetanus if instruments are shared between infected and uninfected girls without guarantees. In the long term, complications can occur due to pelvic infection, painful periods and keloid scarring.

- **Lesions** in the urethra and vagina.
- **Retention of menstrual blood** in the case of infibulation and, in addition to dysmenorrhea (painful periods), it can produce rectovaginal and vesiculovaginal fistulas, difficulty urinating, infertility and complications in childbirth with risk to mother and baby.

- **Fractures**, caused by resistance by the girls.

The **sexual** complications are very negative for the women, while for men the purpose is to increase sexual pleasure. However, the opposite is also described, as problems with penetration can lead to frustration. The most common sexual and reproductive problems are:

- The need to practice **deinfibulation** as part of the rite of marriage to allow penetration.

- **Painful and unsatisfactory** sexual relations**.**
- Long-term **sterility** due to infections.
- In some cultures, women are stitched up again after childbirth (WHO, 2000).

On a **psychological** level, complications tend to be medium and long term, and in women who had it done to them in adolescence or at later ages the most common are:

- Feelings of humiliation, shame and night terrors, usually manifesting as depression and low self-esteem.
- Mothers who promote the mutilation of daughters often have feelings of guilt.

Legal Framework

In our environment, we must consider that sometimes immigrant women/mothers and immigrant men/fathers no longer see the positive aspects of FGM but are pressured into it by the family back home. According to Kaplan and Bedoya (2004), conflicts in the process of social integration include: loyalty to elders in the home country and *"the myth of the environment that directly impacts the process of child socialisation and the construction of ethnic and gender identity".* Research conducted by Kaplan et *al.* (2016) on knowledge, attitudes and practices of African migrant families shows that women approve of the practice more than men do (90.5% of mothers from Gambia, compared to 78.4% of fathers from the same country).

The United Nations and other international organisations promote the elimination of FGM through declarations, resolutions, conferences, studies and protocols. They include the following:

- The **Spanish Constitution**, article 15 of which states that *"everyone has the right to life and to physical and moral integrity and under no circumstances may be subjected to torture or to inhuman or degrading punishment or treatment".*
- The **UN Convention on the Rights of the Child** adopted by the United Nations Assembly (1989), article 24.3 of which states that *"States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children".*
- The UN Fourth **World Conference on Women** (Beijing 1995). The Beijing Declaration and Platform for Action recommends giving *"priority to both formal and informal educational programmes that support and enable women to develop self-esteem, acquire knowledge, make decisions on and take responsibility for their own health".* It emphasises *"the elimination of harmful attitudes and practices, including **female genital mutilation**"*. It also urges the adoption and enforcement of laws

against those responsible for practices and acts of violence against women, such as female genital mutilation.

- In 1997 the World Health Organization (WHO) issued a joint statement with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) against the practice of FGM.

- The African Union's Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (**Maputo Protocol**, 11 July 2003) (24 African countries have now legislated against FGM).

The Council of Europe Convention (**Istanbul Convention**, May 2011) is the first binding instrument in the European region on violence against women and domestic violence and criminalises all forms of violence against women, including FGM. The Convention was ratified by Spain and entered into force on 1 August 2014.

Finally, FGM is classified as a felony assault in **Spain** under the Criminal Code (Article 149.2, Organic Law 10/1995 of 23 November 1995, amended by Organic Law 11/2003), punishable by imprisonment for between six and 12 years. When the victim is a minor, the most common situation, or has a disability, the penalty may be accompanied by disqualification from exercising parental authority or guardianship for a period of between four and 10 years. In addition, for professionals in the different fields who may have knowledge of a case, Organic Law 1/1996 on the **Legal Protection of Minors** acquires special importance.

- Article 13 states that *"any person or authority, and especially those who, due to their profession or function, detect a situation of risk or possible distress of a minor, shall inform the authority or its closest agents thereof, without prejudice to providing the minor with any immediate assistance required".*

- Along the same lines, Article 14 establishes that *"public authorities and services have the obligation to provide the **immediate attention** required by any child, to act if it corresponds to their area of competence or otherwise to transfer the case to the competent body and inform the child's legal representatives or, where necessary, the Prosecution Service".*

Organic Law 3/2005 of 8 July 2005 amending Organic Law 6/1985 of 1 July 1985 on the Judiciary says something similar about pursuing the practice of FGM extraterritorially:

"by enabling the extraterritorial prosecution of the practice of female genital mutilation when the crime is committed abroad, as occurs in the majority of cases, taking advantage of travel or stays in the countries of origin of people living in our country.

However, experts such as Kaplan and Ballesteros argue that legal remedies are no substitute for treating the phenomenon from a social perspective. They hold that the complexity of the issue requires *"addressing it with time, from a perspective of unpacking its deep roots, from respect and from education".* This idea is highlighted in the 2004 Barcelona Declaration on FGM, point 3 of which states: *We support more humane legislation that prevents the humiliation of immigrant African communities*. All authors agree on the importance of preventive measures to address the problem.

Analysis of the Situation in the Autonomous Community of Castile La Mancha

The number of foreign nationals residing in Spain, according to data from the Continuous Register at 1 January 2017, was 4,549,858, of whom 3.5% were living in the Castile La Mancha region (160,815 people), representing 8% of the total population of this region (2,030,661 people).

The population of foreign nationals in Spain with the nationality of one of the countries where FGM is practised was 327,537, of whom **6,463** were living in Castile La Mancha (National Institute for Statistics, 1 January 2017).

The presence and distribution across Castile La Mancha of people from countries where FGM is practised, according to the map prepared by Kaplan and López (2013) referring to 2012 (relating to the African population), showed there had been a significant increase since 2009, with this region, together with the Basque Country, being the place where the population had increased most - in some places even doubling. In 2012, the female population of foreign origin from FGM countries was 1,512 women, the main countries being Nigeria, Mali, Senegal, Guinea, Cameroon and Mauritania. Under no circumstances should provenance be assimilated to imminent risk; it is simply an indication that would justify looking more closely at the immigrant family. However, awareness-raising and outreach should concentrate on the

geographical areas where there is a greater presence of immigrants from countries where FGM is practised.

According to data from the National Institute for Statistics (INE), the number of female populations of the same nationality as the countries listed on the map prepared by Kaplan and López (2013), cited above, was **1,419** women at 1 January 2017[11]. Based on this data, women nationals of African countries where FGM is practised and who are registered in Castile La Mancha is as follows: Nigeria (593 women), Mali (254), Senegal (153), Cameroon (61) and Guinea (56). The remaining African countries have an incidence of less than fifty (see Table 1).

[11] See Continuous Register Statistics, 2017, provisional data. The data comes from the municipal census register and could therefore be understated if the foreign national was not registered in the municipality, or overstated if she had left and not been removed from the census list (either of her own free will or automatically by the office after two years if she was not a permanent resident). In any event, it is advisable not to take these figures as a faithful reflection of reality.

Table 1. Territorial distribution of female population by nationality (Africa) and province of residence (Castile La Mancha) at 1 January 2017

Nationality	Albacete	Ciudad Real	Cuenca	Guadalajara	Toledo	Total Castile La Mancha
Nigeria	4	9	4	357	219	**593**
Mali	53	10	2	5	184	**254**
Senegal	86	4	4	31	28	**153**
Cameroon	6	2	1	18	34	**61**
Guinea-Conakry	17	3	4	5	27	**56**
Ghana	3	2	4	38	8	**55**
Ivory Coast	6	1	2	7	15	**31**
Egypt	5	5	0	11	9	**30**
Mauritania	7	3	4	3	5	**22**
Kenya	2	0	2	3	12	**19**
Ethiopia	0	0	2	14	2	**18**
Gambia	6	0	0	4	1	**11**
Democratic Republic of the Congo	0	0	0	10	0	**10**
Guinea-Bissau	3	0	0	2	2	**7**
Togo	0	0	1	3	2	**6**
Benin	0	0	0	0	1	**1**
Other African Countries (Niger, Yemen, Somalia…)	7	8	4	36	18	**73**
Totals	**221**	**47**	**34**	**549**	**568**	**1,419**

Source: INE, 2017 (provisional data).

However, as has already been pointed out, it is also practised in some communities in Asian and Middle Eastern countries. This is why data concerning African countries is supplemented by that on two of the main groups from Asia: Pakistan and India. There were 303 Pakistani women registered as living in Castile La Mancha on 1 January 2017 and 162 from India. Again with due caution, people from these countries, together with Indonesia, Iraq and Israel, should be considered as potential practitioners of FGM.

The distribution of this population in Castile La Mancha is very uneven. At the provincial level, Toledo and Guadalajara are the places with the largest female populations, especially of Nigerian nationality, and in the case of Toledo, Malian as well. However, the data must be interpreted with some caution since these provinces border the Autonomous Community of Madrid and the immigrant population is characterised by great geographical mobility.

The municipality with the largest female population from Nigeria is Azuqueca de Henares (304), followed by Guadalajara city (56), Ocaña (30), Yuncos (26) and Camarena (24), the last three municipalities belonging to the province of Toledo. The female population from Mali is concentrated in two municipalities also in Toledo province: Recas (109) and Yuncos (30). The female population of Senegalese nationality resides mainly in the cities of Albacete (88) and Guadalajara (9). Examples of municipalities with Pakistani residents are: Sonseca (82), Talavera de la Reina (16), Mora (12) and Los Yébenes (10), all in Toledo province, together with Cuenca (17) and Albacete (11). Finally, other municipalities with female populations from FGM countries are: Illescas, Torrijos, Cedillo del Condado, Seseña, Campo de Criptana, Valdepeñas, Alovera, Sigüenza, Mondéjar, Marchamalo, Yunqueda de Henares, etc. However, there is a great dispersion among municipalities and countries of origin.

In this context, girls under the age of 15 living in families from countries where FGM is practised should be the focus of preventive care. According to INE data for 2017, **520 girls** under the age of 15 were living in Castile La Mancha, the largest group being from Nigeria (160), followed by Mali (113), Pakistan (73) and Senegal (44) (see Table 2).

In this case too, the provinces with the highest number of girls who were nationals of any of the countries where FGM is practised were Toledo and Guadalajara, with the first being noted for girls from Nigeria and Mali, and the second with girls from Nigeria.

Table 2. Territorial distribution of foreign girls under 15 years of age from FGM countries by province of residence (Castile La Mancha) at 1 January 2017

Birth country	Albacete	Ciudad Real	Cuenca	Guadalajara	Toledo	Total
Nigeria	0	0	0	87	73	**160**
Mali	23	6	1	2	81	**113**
Pakistan	8	12	20	10	23	**73**
Senegal	26	1	2	8	7	**44**
India	1	3	0	0	8	**21**
Other African countries (Niger, Yemen, Somalia…)	2	0	0	8	8	**18**
Ghana	0	1	1	15	0	**17**
Guinea Conakry	6	1	1	0	8	**16**
Egypt	2	3	0	7	4	**16**
Cameroon	1	0	0	3	8	**12**
Ivory Coast	1	0	1	3	3	**8**
Mauritania	1	2	1	1	1	**6**
Ethiopia	0	0	1	4	0	**5**
Gambia	1	0	0	2	1	**4**
Burkina Faso	3	0	0	0	0	**3**
Togo	0	1	0	2	0	**2**
Guinea-Bissau	0	0	1	0	0	**1**
Kenya	0	0	0	0	1	**1**
Totals	**75**	**29**	**30**	**154**	**232**	**520**

Source: INE, 2017 (provisional data).

PART II. COMPREHENSIVE APPROACH TO FGM

The reference framework for the **comprehensive approach**[12] to FGM is the Joint Protocol on Health Action on FGM approved by the Spanish Ministry of Health, Social Services and Equality in 2015[13].

Based on knowledge of **risk factors** and the **prevalence map** of the African continent, the proposed actions are developed at three times (not associated with a chronological order):

- Awareness-raising and training of professionals to identify risk factors.
- Prevention of FGM in girls through risk detection and assessment (relative or imminent risk), as well as reduction of the effects of FGM on women who have already undergone it.
- Monitoring Committees.

It is concluded with the following **Annexes**:

- **ANNEX I: Notification Sheet for Social Services**
- **ANNEX II: Notification Sheet for Health Centres**
- **ANNEX III: Notification Sheet for a Specialised Children's Service**
- **ANNEX IV: Notification Sheet for the Juvenile Court or Juvenile Prosecution Service**
- **ANNEX V: Prevention Pledge on Female Genital Mutilation**
- **ANNEX VI: Institutional Resources.**

[12] It is a comprehensive approach since it describes the actions of the main areas involved (health, education, social and community) and coordination between them.

[13] See: *http://www.violenciagenero.msssi.gob.es/otrasFormas/mutilacion/protocolos/protocolo/pdf/Protocolo_MGF_vers5feb2015.pdf*

Risk Factors

The professionals best placed to identify risk factors and prevent FGM in girls are those working in the health, education, social and community systems. Kaplan and Bedoya (2004) refer to them as *front-line staff*. To prevent FGM it is essential to know its risk factors.

Risk Factors

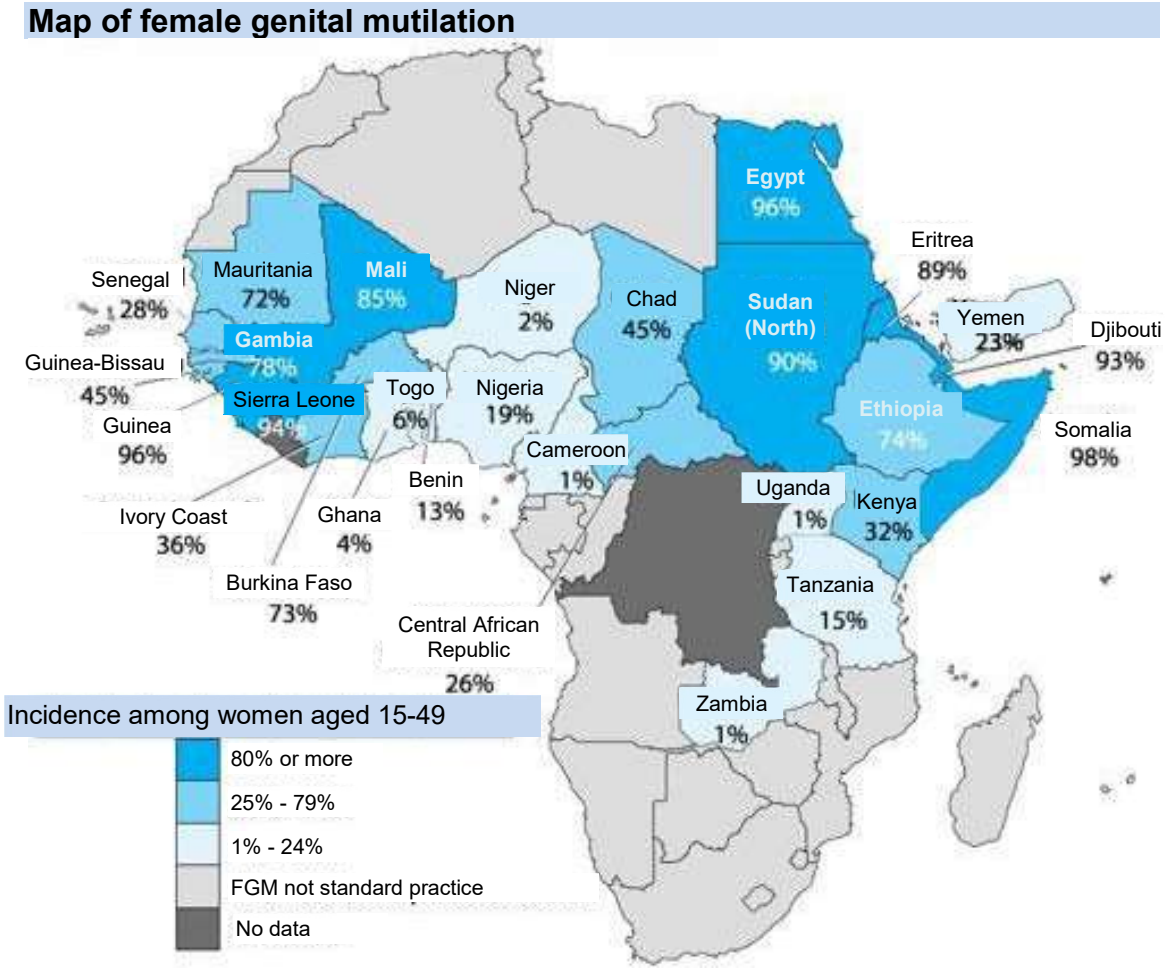
- **Be a woman**
- **Be under 15**
- **Be born into a family from a country where FGM is practised and belong to an ethnic group/community/tribe with a prevalence of this cultural tradition**
- **Belong to a family where a woman has already undergone FGM**
- **Where there is a plan to travel to a country where FGM is practised (imminent risk)**

Prevalence Map

It is equally important to consider the FGM prevalence[14] map of the African continent (see Figure 1) prepared by Kaplan and López (2013) with data from Demographic Health Surveys (several years), Yoder & Khan, 2007 and UNICEF Multiple Indicator Cluster Surveys (MICS). Based on this map, countries with a prevalence above 80% are: Somalia, Egypt, Guinea-Conakry, Sierra Leone, Djibouti, Eritrea, Sudan (North) and Mali. Prevalence data is not available for Asian or Middle Eastern countries.

[14] Percentage of women who have undergone FGM

Figure 1. African countries where FGM is practised (prevalence)



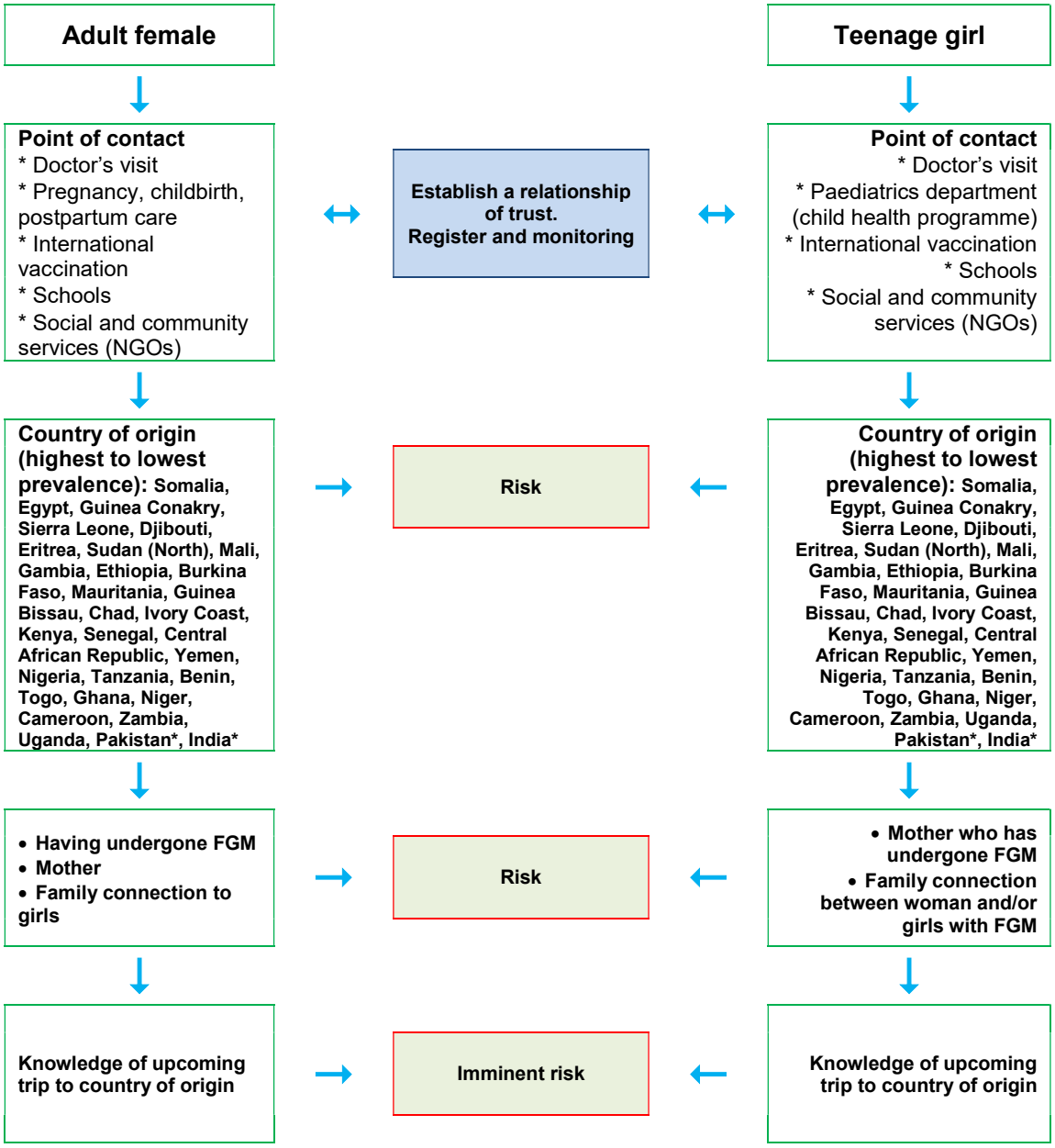
Awareness Raising and Professional Training

Personnel acting in areas with high populations at risk should show a special interest in training, information and awareness-raising.

Diagram 1 presents the recommendations for professionals to **identify FGM risk**. Coordinated information and awareness-raising campaigns must be promoted by the Castile La Mancha Women's Institute in collaboration with NGOs, associations, intercultural mediators, leaders of the affected communities and other expert professionals, as well as reference social workers.

Diagram 1

Recommendations for identifying FGM risks



Channels for the distribution of information, awareness-raising and training in the Castile La Mancha region include:

Educational Setting

- Outreach of the protocol among schools based on the channels established by the Directorate-General's Diversity and Programmes Service with these remits through meetings to coordinate professionals in educational guidance and socio-educational intervention, meetings with management teams, publication in the Castile La Mancha Education Portal and any other actions that may be carried out for this purpose.

- Training sessions organised by the government in identified risk areas, run by the Castile La Mancha Regional Teacher Training Centre in collaboration with the Diversity and Programmes Service.

- Workshops organised by schools in areas where they have the remit for attendance by students and/or families, run by associations with experience and knowledge in the field of FGM in collaboration with the teaching teams.

Health Setting

- Outreach of the protocol in different channels such as the Castile La Mancha Ministry of Health website, the paediatrics web platform of the Independent Group of Computerised Paediatricians (GIPI), contacts with professional medical and nursing bodies, the Association of Primary Care Paediatricians of Castile La Mancha, etc. The different services related to FGM intervention will be provided to local hospitals and primary care centres through the Castile La Mancha Health Service (SESCAM) departments.

- Use of the SESCAM online training platform, reporting to the Directorate-General for Human Resources and responsible for the planning, design, certification and dissemination thereof.

- Completion of clinical sessions.

Social Welfare Setting

- Outreach of the protocol among primary care social service teams, organised by the Primary Care, Inclusion and Economic Provision Service of the Provincial Departments, leveraging the Social Services Information System, MEDAS, used by professionals from Primary Care Social Services for widespread outreach. The system will be incorporated into the Instructions and Protocols section already defined by the system.

- Plenary meetings with professionals from the primary care teams where the Protocol will be presented, as well as information on its most important aspects.

- Outreach of the protocol to the Children's Service.

University Setting

- University of Castile La Mancha and University of Alcalá de Henares through training in degrees and postgraduate degrees in education, nursing, medicine, social work and other areas that may be related to the subject.

Entities and Associations

- Contextualisation of the protocol in workshops, talks, seminars and forums for the general population.
- Awareness-raising and training of the different social welfare, education and health professionals involved, from detection to eradication intervention, from the human rights and gender approach and with an anthropological insight.

Castile La Mancha Women's Institute

- Outreach of the protocol by including information on the Women's Institute website for its promotion.

- Outreach to the resource network of the Castile La Mancha Women's Institute.

- Training of staff in the resource network of the Castile La Mancha Women's Institute.

Intervention and Recommendations to Prevent FGM in Girls

Phase 1
Detection of Risk Factors at Schools, Health Services, Social Services and Women's Centres

The first action by the professional is to reach out to the nuclear family, with the specific aim of understanding the risk for girls from countries where the practice is performed.

The recommendations for such an approach are to create **a relationship of trust with the family** in the risk-detection process. In all areas of action (education, health, social services, specialist and community centres), intervention will begin with a first interview/consultation/meeting within the framework of the ordinary actions of each administration, in which questions are asked about the country of origin, ethnicity, family data, information relating to the migration process, etc.

The second and subsequent interviews/consultations/meetings within the framework of the ordinary actions of each administration will aim to ascertain whether there is a woman or girl in the family who has undergone FGM, as well as the position of the parents (or parties responsible) with regards the practice. Once a risk is detected, whether relative or imminent, the professional will move onto phase two.

Given the complexity of addressing the phenomenon, its circumscription to the private sphere of the family and its invisibility, coordination is advisable, where possible, with intercultural mediators, experts, community leaders and associations with experience in and knowledge of FGM. A list of resources will be provided for each area, specifying email addresses, telephone numbers and reference persons to consult and receive advice from on FGM.

Information for families for prevention is particularly important. The family must be informed of and educated in the physical and psychological consequences of cutting and its legal consequences. The professional should avoid making the family feel guilty (when FGM is detected), as this will make it easier to intervene in new cases.

Kaplan and Martínez (2004) consider that the following skills are needed: active listening, respect for the person and what they are going through, keeping an open attitude to traditions, informing and educating families to mobilise their own resources, implementing motivation strategies and providing emotional support. They also describe required attitudes such as: consistency (professional constancy and authenticity), acceptance (which does not mean accepting the behaviours), positive assessment (considering the person as valuable) and empathy.

Phase 2
Interdisciplinary Approach to Situations of Risk (Relative or Imminent) of FGM in Girls

○ Schools

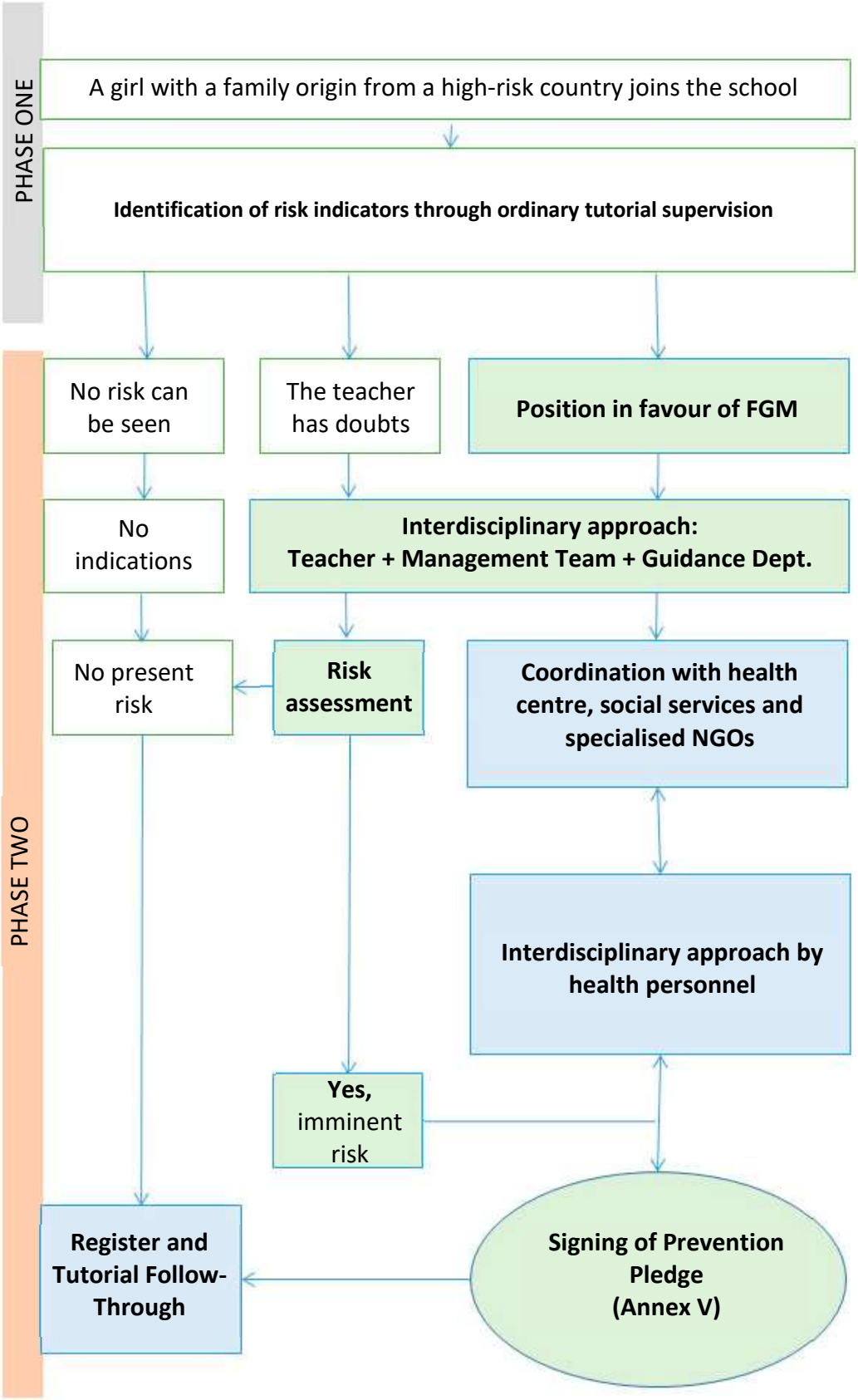
If a teacher detects a situation of relative risk (if they have concerns or the family takes a position in favour of FGM) or imminent risk (the girl is set to travel to a country where it is practised), he/she will inform the management team and guidance and support team or the school's guidance department of the situation so the interdisciplinary approach can be implemented. This consists of a joint assessment of the risk and issuance of the corresponding notification sheets (see Annexes I and II) to both the local health centre and social services. The school will also be informed of the situation.

The local social worker will inform the guidance and support team or the school's guidance department of the actions carried out and the final outcome.

(See diagram 2).

Diagram 2

Recommendations on the way for schools to proceed



○ Social Services

If social services detect a situation of relative risk (if they have concerns or the family takes a position in favour of FGM) or imminent risk (the girl is set to travel to a country where it is practised), they will implement **the interdisciplinary approach** through the reference social worker, who will **assess the risk** in coordination with the health centre, the guidance and support team or guidance department, as applicable, and specialised NGOs (and/or intercultural mediation services).

If during the interdisciplinary approach it is found that there is an **imminent risk** because the girl is set to travel to a country where FGM is practised, the social worker will refer the case to the health centre for follow-through and, where applicable, will ask the family to sign the Prevention Pledge (Annex V).

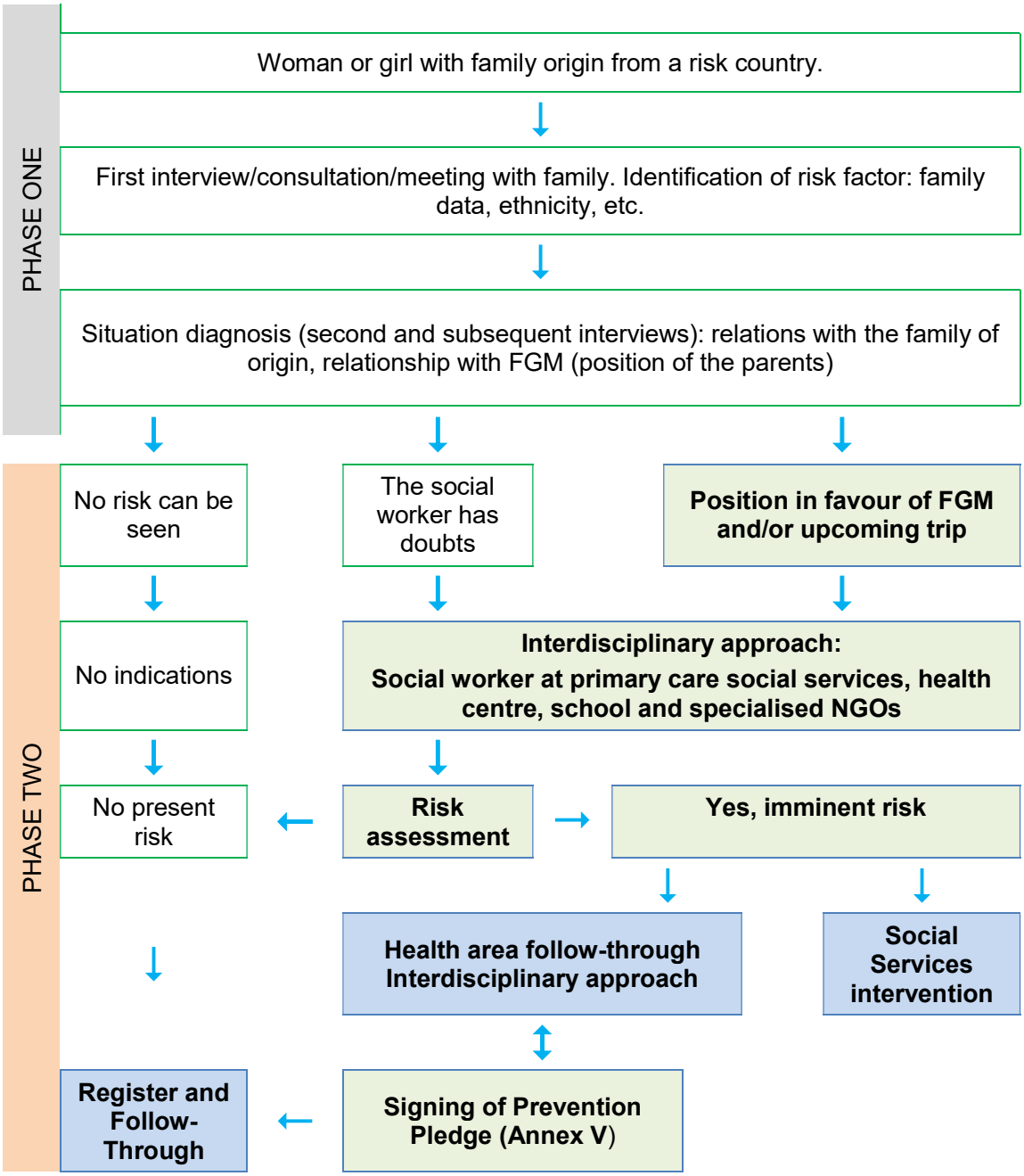
The health centre will inform the reference social worker (social services) of the actions taken and the final outcome.

Coordination between the two bodies will be carried out in accordance with the current Social Healthcare Plan.

(See diagram 3).

Diagram 3

Recommendations on the way for Social Services to proceed



- **Health Field**

Intervention with a girl at risk of FGM.

The first step in this phase is to investigate the family history of FGM (mother or sisters) and record it in the medical record. The healthcare professionals with the greatest chance of identifying and detecting cases of risk, due to their characteristics, are **paediatricians, primary care physicians, nurses and international vaccination centres** (international vaccination consultations are undoubtedly a key resource for detecting cases of imminent risk, since there are mandatory vaccines before travelling to countries at risk and families will undoubtedly avail themselves of this service).

The girl's risk of FGM will then be assessed:

- ✓ In a case of **relative risk**, follow-through will be performed by the Child Health Programme, as well as awareness-raising and informing the family of the legal consequences of practising FGM and its impacts on the girl's health.

- ✓ In a case of **imminent risk** (travel), the girl will be summoned to the doctor's office and the family asked to sign the Prevention Pledge (Annex V), informing them of the legal consequences and social/health risks around FGM[15]. It is essential that prior to signing the pledge, a situation of trust has been created between professionals and family.

Situations to address in a case of **imminent risk**:

a) When the family signs the prevention pledge, the girl is summoned for consultation after the trip and it is confirmed that she has NOT been cut. Reinforcement, awareness-raising and prevention actions will continue.

b) If the family refuses to sign the pledge, Social Services and specialist associations will be notified as a matter of urgency.

c) If the family fails to attend the scheduled appointment after the trip, the paediatrics department will coordinate with social services and/or specialist

[15] According to the study by Kaplan *et al.* (2015), 53.5% of people were prepared to sign a pledge when they were going to leave the country. Men were more likely to, up to 74.1%. They said that signing the pledge helped them make a case against FGM in their communities. Experts see it as a resource to support families when they return to their home countries.

associations to contact the family before notifying the specialised children's service and juvenile prosecution service (Annex IV).

d) If the family does not allow a physical examination of the girl after the trip, social services, specialist associations and the children's service will be notified (Annexes I and III).

In all cases, health personnel must record all actions carried out in the patient file.

(See diagram 4)

Intervention with a mutilated girl or woman.

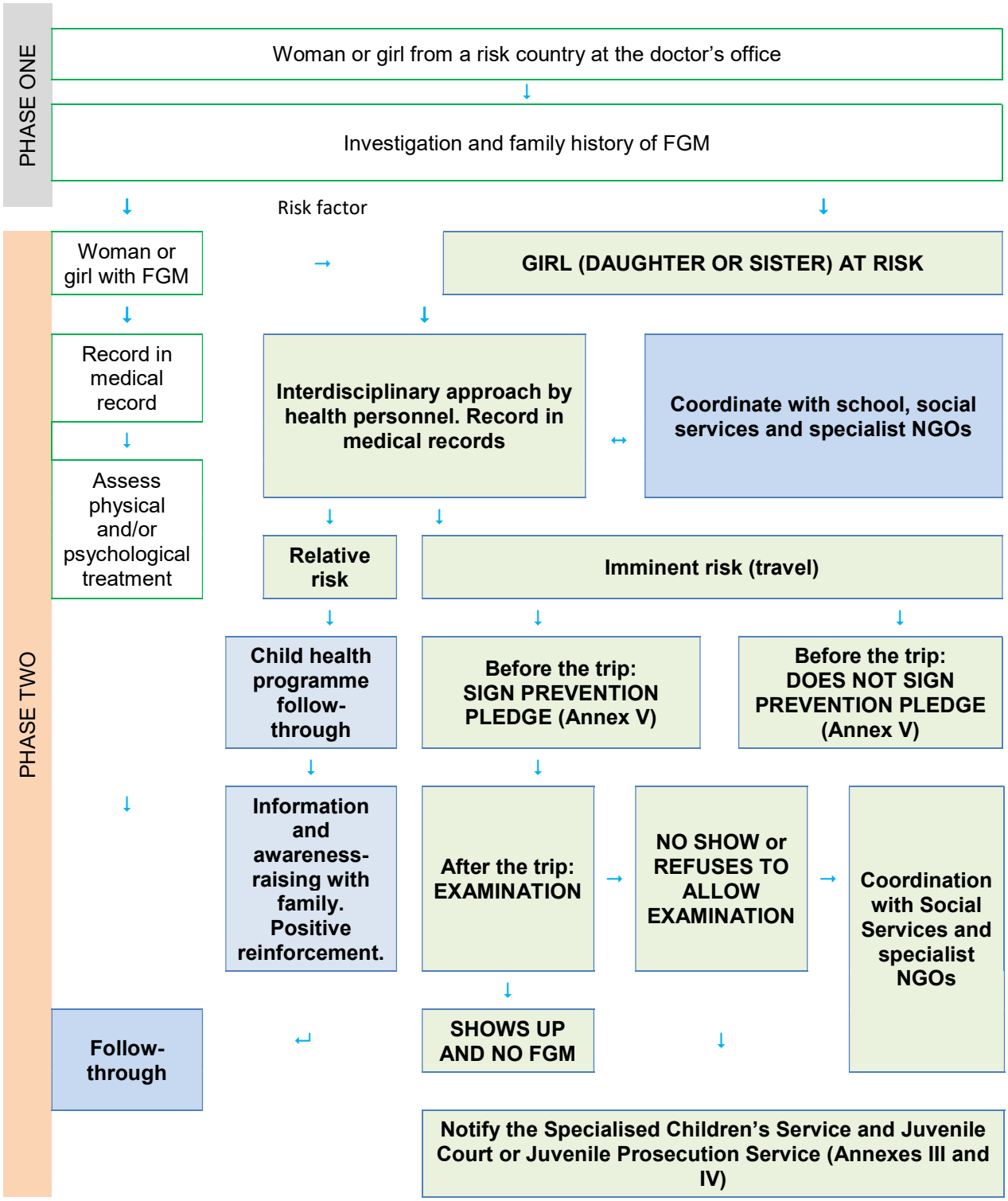
Mutilation can be detected during medical examinations of pregnant women or gynaecological check-ups by midwives and gynaecologists. Confirmation of FGM in a woman prior to her living in Spain has no legal repercussions. In this case the intervention will consist of recording FGM in her medical record and assessing treatment (physical or psychological). It also represents the start of risk assessment in a daughter or sister, where applicable (see "Intervention with a girl at risk of FGM").

When mutilation is confirmed in a girl living in Spain following a trip to a country where it is performed, the Juvenile Court or Juvenile Prosecution Service will be notified by means of Annex IV. At the same time, the health professional will assess the physical or psychological treatment and record the actions in the girl's medical record.

The **register** of girls and women at risk of being cut should be conducted electronically through the medical records of women and girls. Professionals will be guided through a questionnaire (check-list type) to complete in the electronic medical record, as part of the medical history, and there could even be filtering data in the history (obligation to complete the data of the family's home country).

Diagram 4

Recommendations on the way for health professionals to proceed



○ Associations and Entities Specialising in FGM

Specialised entities and associations carry out direct community work around awareness-raising, information and education on social, cultural and identity aspects associated with the practice among migrant communities and with women and men from countries where some form of FGM is traditionally practised.

Actions are developed that focus on locating intercultural mediators or agents influential to the population at risk to facilitate support in interventions, focused on raising awareness around the need to eradicate the practice.

They identify and monitor cases and facilitate communication between women and professionals from different fields.

○ Women's Institute

The Regional Government of Castile La Mancha, and in particular the Ministries of Social Welfare, Health and Education and the Castile La Mancha Women's Institute, will carry out the necessary prevention and awareness-raising actions around FGM to contribute to the eradication of this practice through awareness-raising campaigns, interdisciplinary workshops and training counselling for groups that intervene directly with a population at risk.

The Women's Institute will address FGM as a manifestation of gender violence and the Women's Centres will provide comprehensive assistance.

When a risk situation is detected through the Women's Institute Resource Network, social services, health centres and specialised associations will be notified to start the interdisciplinary approach.

Monitoring Committees

To promote effective implementation of the measures and action guidelines set out in the protocol and to pivot them to any changes that may occur, a regional monitoring committee will be created, with branches in each province, comprising all the bodies deemed necessary. The committees will meet at least once a year.

The functions of the committees will be to:

- Promote the implementation of the measures envisaged in the protocol.
- Propose the necessary improvement measures, adapting them to any new needs that may arise.
- Monitor and assess compliance.

ANNEXES

Annex I. Notification Sheet for Social Services in Cases of Risk or Practice of FGM in Girls

Girl's full name:		
Date of birth:		Place:
Phone:		
Address:		
Postcode:	Municipality:	Province:
Data of mother, father or guardian		
Full name of mother/guardian: Full name of father/guardian:		
Country of origin of mother/guardian: Country of origin of father/guardian:		

Data of the reporting professional		
Full name:		
Institution or Centre:	Profession:	
Phone:		
Address:		
Postcode:	Municipality:	Province:

The professional identified above **reports:** that on …… I detected:

☐ **Girl with risk factors:** The girl belongs to a family from a risk country where the mother/older sister has undergone FGM

☐ **Girl with imminent risk factors:** The girl belongs to a family from a risk country and a trip is planned to a country where FGM is practised

☐ **Imminent risk:** The girl belongs to a family from a risk country where the mother and/or sisters have undergone FGM and a trip is planned to the family's home country. The family has not attended the scheduled appointment or signed the prevention pledge.

Signature of the professional

Annex II. Notification Sheet for Health Centres in Cases of Risk or Practice of FGM in Girls

Girl's full name:		
Date of birth:		Place:
Phone:		
Address:		
Postcode:	Municipality:	Province:
Data of mother, father or guardian		
Full name of mother/guardian: Full name of father/guardian:		
Country of origin of mother/guardian: Country of origin of father/guardian:		

Data of the reporting professional		
Full name:		
Institution or Centre:	Profession:	
Phone:		
Address:		
Postcode:	Municipality:	Province:

The professional identified above **reports:** that on …… I detected:

☐ **Girl with risk factors:** The girl belongs to a family from a risk country where the mother/older sister has undergone FGM

☐ **Girl with imminent risk factors:** The girl belongs to a family from a risk country and a trip is planned to a country where FGM is practised

Signature of the professional

Annex III. Notification Sheet for a Specialised Children's Service in Cases of Risk or Practice of FGM in Girls

Girl's full name:		
Date of birth:		Place:
Phone:		
Address:		
Postcode:	Municipality:	Province:
Data of mother, father or guardian		
Full name of mother/guardian: Full name of father/guardian:		
Country of origin of mother/guardian: Country of origin of father/guardian:		

Data of the reporting professional		
Full name:		
Institution or Centre:	Profession:	
Phone:		
Address:		
Postcode:	Municipality:	Province:

The professional identified above **reports:** that on …… I detected:

☐ **Imminent risk:** the family has not signed the prevention pledge

☐ **Imminent risk:** the family missed the scheduled appointment after the trip

☐ **Imminent risk:** the family did not allow a physical examination after the trip

☐ **FGM performed:** FGM has been proven to have been recently performed and it coincides with the girl's arrival from her family's home country.

Signature of the professional

Annex IV. Notification Sheet for the Juvenile Court or Juvenile Prosecution Service in Cases of Risk or Practice of FGM in Girls

Girl's full name:		
Date of birth:		Place:
Phone:		
Address:		
Postcode:	Municipality:	Province:
Data of mother, father or guardian		
Full name of mother/guardian: Full name of father/guardian:		
Country of origin of mother/guardian: Country of origin of father/guardian:		

Data of the reporting professional		
Full name:		
Institution or Centre:	Profession:	
Phone:		
Address:		
Postcode:	Municipality:	Province:

The professional identified above **reports:** that on …… I detected:

☐ **Imminent risk:** the family has not signed the prevention pledge

☐ **Imminent risk:** the family missed the scheduled appointment after the trip

☐ **Imminent risk:** the family did not allow a physical examination after the trip

☐ **FGM performed:** FGM has been proven to have been recently performed and it coincides with the girl's arrival from her family's home country.

Signature of professional

Annex V. Prevention Pledge on Female Genital Mutilation (FGM)

In the health examination performed on the girl, the details of which are set out below, no alteration in the integrity of her genitals was detected.

Name	Girl's date of birth	Country to which she is travelling

The girl's parents, relatives or guardians are therefore informed of the following:

- The social/health and psychological risks of FGM and its recognition as a violation of girls' human rights.
- The legal framework of FGM in Spain, where it is classified as a **felony assault** under Article 149.2 of the Criminal Code, even if it was performed outside the national territory (for example, in Nigeria, Mali, Pakistan, Senegal, etc.), under the terms provided in the Organic Law on the Judiciary, amended by Organic Law 1/2014 of 13 March 2014.
- The practice of female genital mutilation is punishable by imprisonment for between six and 12 years for parents or guardians, and by special disqualification from the exercise of parental authority, guardianship or foster care for four to 10 years (i.e., parents cannot exercise parental authority or have their daughter living with them, so a public child protection organisation could assume guardianship of the child and she could be taken in by a family or enter a Child Protection Centre).
- The pledge that, upon returning from the trip, the girl will return to the paediatric clinic at her local health centre for examination as part of the Child Health Programme.
- The importance of taking all preventive measures regarding the trip as recommended by health professionals.

For these reasons:

- **I declare** that I have been informed by the health professional responsible for the health of the girl (or girls) about the different aspects regarding female genital mutilation specified above.
- **I understand** the purpose, scope and legal consequences of these explanations.
- **I agree** to take care of the health of the girl (or girls) for whom I am responsible and not submit her to genital cutting. I promise she will attend the scheduled medical appointment on our return to Spain.

In witness whereof, I read and sign the original of this informed agreement, in duplicate, a copy of which remains with me.

In ……., on …….……20..

Signature: Girl's mother/father/guardian Signature: Responsible professional

Name:…… Name:……

Signature Signature

Annex VI. Institutional Resources in the Autonomous Community of Castile La Mancha

NON-PROFITS AND ORGANISATIONS

- **Spanish Catholic Migration Commission Association of Castile La Mancha (ACCEM).**

  Territorial network in Castile La Mancha:

  Albacete. Ph. and fax: 967 21 29 52. Email: albacete@accem.es

  Azuqueca de Henares (Guadalajara). Ph.: 949 277310 / 670 56 39 55

  Email: azuqueca@accem.es

  Ciudad Real. Ph. and fax: 926 24 03 94. Email: ciudadreal@accem.es

  Cuenca. Ph. and fax: 969 23 10 97. Email: cuenca@accem.es

  Guadalajara. Ph.: 949 21 95 67 / 949 21 57 74 Email: guadalajara@accem.es

  Sigüenza (Guadalajara). Ph.: 949 39 15 58 / 949 39 30 64 Email: siguenza@accem.es

  Toledo. Ph. and fax: 925 33 38 39. Email: toledo@accem.es

- **Crisol Association (Azuqueca de Henares).** Ph.: 949 277310. Email: crisoligualdadgenero@gmail.com

- **Malienses en Recas Association.** Ph: 620393682.

- **Guada Acoge Association.**

  HQ: Ph.: 949 25 30 76 / 949 21 58 35. Email: guada.acoge@redacoge.org

  Azuqueca de Henares: Ph.:949 27 73 10. Email: guada.acoge.azuqueca@redacoge.org

- **Mancha Acoge Association.** Ph.: 926 31 32 39. Email: mancha.acoge@redacoge.org

- **Doctors of the World Association, Castile La Mancha.**

  TOLEDO. Ph. 925 22 23 12 Email: castillamancha@medicosdelmundo.org

  ALBACETE. Email: albacete@medicosdelmundo.org

- **Talavera Acoge Association**. Ph.: 925 82 70 46 Email: coordinación@talaveraacoge.com
- **Castile La Mancha Professional Association of Midwives.** Email: contacto@matronascastillalamancha.org

- **Albacete Immigrant Support Group**. Contact: Cheikhou Cisse. Ph: 648 24 80 31.

- **Kirira Foundation Against Female Genital Mutilation** (Ciudad Real). Email: fundacionkirira@yahoo.com. Ph.: 926 51 30 76 / 628 196 385.

- **SED (Solidarity, Education and Development) Foundation.** With local branches in Talavera de la Reina and Guadalajara. Ph: 91 877 85 28. Email: sedmadrid@sed-ongd.org

- **Simetrías Foundation**. Ph.: 677 18 30 97. Email: simetrias@simetrias.es

- **UNICEF**
  Castile La Mancha Ph.: 925 25 33 80. Email: castmancha@unicef.es
  UNICEF Albacete. Email: albacete@unicef.es
  UNICEF Ciudad Real. Email: ciudadreal@unicef.es
  UNICEF Guadalajara. Ph.: 949 23 29 86. Email: guadalajara@unicef.es

PUBLIC AUTHORITIES

- **Castile La Mancha Women's Institute** 925 28 60 10 - institutomujer@jccm.es

  Provincial Offices of the Castile La Mancha Women's Institute:

  Albacete 967 19 57 54 - abmujer@jccm.es
  Ciudad Real 926 27 94 62 - institutomujercr@jccm.es
  Cuenca 969 17 68 97 - instituto.mujer.cu@jccm.es
  Guadalajara 949 23 51 95 - institutomujerguadalajara@jccm.es
  Toledo 925 26 50 12 - institutomujertoledo@jccm.es

- **Ministry of Social Welfare:** 925 26 90 02 – gabinete.bienestarsocial@jccm.es

  Directorate-General for Social Action and Cooperation: 925 26 72 13 – dgaccionsocial@jccm.es

  Provincial Offices of the Ministry of Social Welfare:

  Albacete: 967 55 80 00 – direccion.ab.bs@jccm.es
  Ciudad Real: 926 27 62 00 – direccion.cr.bs@jccm.es
  Cuenca: 969 17 68 00 – direccion.cu.bs@jccm.es
  Guadalajara: 949 88 58 00 – direccion.gu.bs@jccm.es
  Toledo: 925 26 90 69 – direccion.to.bs@jccm.es

- **Ministry of Education, Culture and Sports:** 925 24 74 00 – gabinete.edu@jccm.es

  Directorate-General for Programmes, Diversity and Professional Training: 925 24 88 40 – dgpradyfp.edu@jccm.es

  Provincial Offices of the Ministry of Education, Culture and Sports:

  Albacete: 967 59 63 00 – spalbacete.edu@jccm.es
  Ciudad Real: 926 27 91 24 / 926 27 90 71 / 926 27 90 72
  Cuenca: 969 17 63 00
  Guadalajara: 949 88 79 00
  Toledo: 925 25 96 00 – secretaria.edu.to@jccm.es

- **Ministry of Health:** 925 26 70 99 – gabinete.sanidad@jccm.es

  Directorate-General for Public Health and Consumer Affairs: 925 24 87 67 – dgspdc@jccm.es

  SESCAM (Castile La Mancha Health Service) Management Unit: 925 27 41 00 – direcciongerencia@sescam.jccm.es

REFERENCES

1. For further information, below are recommended guides, manuals and good practices available in Spanish for consultation by professionals interested in the topic[16]

- ***Mutilación Genital Femenina: Prevención y atención. Guía para profesionales***. Editada por la Asociación Catalana de Llevadores. Acceso web: http://www.aen.es/docs/guias_vg/guia_mutilacion_genital.pdf
- ***Mutilación Genital Femenina. Más que un problema de salud***. Médicos del Mundo Andalucía, Asociación Andaluza de Matronas, Centro de Iniciativas de Cooperación al Desarrollo de la Universidad de Granada y Junta de Andalucía. Acceso web: http://bbpp.observatorioviolencia.org/upload_images/File/DOC1237830001_Guia1p eq.pdf
- ***Mutilación Genital Femenina. Manual para profesionales*.** Grupo Interdisciplinar para la Prevención y el Estudio de las Prácticas Tradicionales Perjudiciales (GIPE/PTP) de la Universidad Autónoma de Barcelona y Fundación Wassu-UAB. Acceso web: http://www.mgf.uab.cat/esp/resources_for_professionals/manual.professionals.pdf ? iframe=true&width=100%&height=100%
- ***Guía para profesionales. La MGF en España. Prevención e Intervención***. Unión de Asociaciones Familiares. Acceso web: http://unaf.org/wp-content/uploads/2015/10/Guia-MGF-2015.pdf
- ***La ablación o Mutilación Genital Femenina. Guía práctica*.** Organización no gubernamental de desarrollo Paz y Desarrollo, en colaboración con el Centro de Estudios e Investigación sobre las Mujeres de Málaga (CEIM). Acceso web: http://pazydesarrollo.org/pdf/guia_mgf_web.pdf
- ***Diagnóstico sobre la situación de la Mutilación Genital Femenina en la Comunidad Autónoma de Madrid***. Médicos del Mundo. Acceso web: https://issuu.com/mdm_madrid/docs/diagnostico_mgf

[16] All these guides, manuals and good practices are set out in the **RESOURCE GUIDE: Prevention and Awareness Raising Around Female Genital Mutilation** prepared and edited by the Union of Family Associations (UNAF), the Directorate-General for Migration and the European Integration Fund, 2014. This guide also provides a list of audiovisual materials, informative brochures (in various languages), international publications, regulations and protocols in Spain. Web login: http://www.bienestaryproteccioninfantil.es/imagenes/tablaContenidos03SubSec/GUIA-DE-RECURSOS-DE-MGF-2014.pdf.

- ***Comprender y abordar la violencia contra las mujeres****. Mutilación Genital Femenina*. Organización Mundial de la Salud. Acceso web: http://apps.who.int/iris/bitstream/10665/98838/1/WHO_RHR_12.41_spa.pdf

2. For further information, below are recommended protocols and publications on this topic

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