Universitat de Girona
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HOW INFLUENCES THE MIGRATION AND ACCULTURATION PROCESSES IN ATTITUDES AND CHANGES IN BEHAVIOUR REGARDING FEMININE GENITAL MUTILATION ?

End-of-Degree Research Project

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Fatou ye siyelelao
Fatou fai fai Fatou, Fatou clema siye,
Fatou ye siyelelao.

Sokoyoko nuyongo
Sous nous societée yenga tuna
Nanyu am faida
Nanyu respecter sous nous Senegal.

Et adounat portundala,
Kunan jojsa moronunan.

Abou Maissa Maissa
Nanyu respecter sous nous Senegal.

Trancscripció fonètica de la cançó "Fatou", que parla sobre els drets de la dona i el respecte.

Les meus més sincers agraïments per a les tres dones que em van acompanyar a Senegal i que van fer possible la transformació d'unes pràctiques en una experiència personal amb un abans i un després.
Gràcies Lurdes, Inma i Fina.

INDEX

I. ABBREVIATIONS

FGM/C: Female Genital mutilation/cutting

WHO: World Health Organization

UNICEF: United Nations International Children's Emergency Fund

UNFPA: United Nations Population Fund

LO: "Ley Orgánica"

EU: European Union

CEIC: "Comité Ético de Investigación Clínica"

CRC: Convention on the Rights of the Child

CEDAW: Convention on the Elimination of all forms of Discrimination Against Women

CAP: "Centre d'Atenció Primària"

II. ABSTRACT

Background

Female genital mutilation/cutting (FGM/C) comprises all procedures that involve partial or total removal of female external genitalia and/or injury to the female genital organs for cultural or any other nontherapeutic reasons. FGM/C is practiced in 28 African countries and in some nations in Asia and the Middle East. As a result of international migration, FGM/C is a global problem and is not limited to any cultural or religious groups. FGM reflects a deep rooted inequality between the sexes and can be seen as extreme discrimination against women and girls and, not only this, it also causes serious physical, mental, sexual and social consequences. For this reason, in June 1993 the Vienna World Conference on Human Rights agreed that FGM was a violation of Human Rights. The different European communities have developed a set of weapons to address the issue and try to eradicate the problem.

Objectives

The main aim of the present study is to evaluate if there is a difference in attitudes and changes in behaviour regarding Feminine Genital Mutilation in immigrant mutilated women who have lived in the region of Girona for more than two years compared to those who have lived here for less than two years.

Design

This study design will be an observational, cross sectional and muticentric study. It will be performed in “Can Gibert del Pla” and “CAP de Salt” which will takes part of the study during a period of 6 months.

Participants

The population of the study will be every immigrant mutilated women from any of the 28 African countries at risk of FGM who come to the primary care centre, independent of the reason for visiting.

Interventions/Methods

A non-probabilistic consecutive sampling will be used in this study. We will use a questionnaire to collect the information.

Keywords: Female genital cutting, Female genital mutilation, Traditional practices, Migration, Public health, Ethics, Cultural sensitivity, effectiveness of interventions.

III. INTRODUCTION

1. Theoretical context of FGM

Terminology and definitions

Female circumcision, female genital mutilation, female genital cutting, sunna, female genital surgery, operation, traditional practice... all this terms refers to “all procedures involving partial or total removal of the female external genitalia or the injury to the female genital organs for non-medical reasons.”

For a long time, we used to use the term “circumcision” which does not have any violent connotations, but is incorporated into both, male and female initiation, rites. From relativists positions they keep defending the use of this and other terms like operation or traditional practices.

The Muslims who carry out the practice refers to it as **sunna** or the particular term of their language: for example, in Mandinga is **Ñyakaa** and in Somali is **Gudniin Gadbahaada**, that has more symbolic and less emotional sense.

From an academic point of view, the term utilized is Female Genital Cutting (FGC). It contemplates the three types described later and avoids stigmatization or moral judgments[(1)].

The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children adopted the term ‘female genital mutilation’ in 1990, and in 1991 the World Health Organization (WHO) recommended that the United Nations adopt it as well. However, objections have been raised because the term also confers judgement and condemnation of what is an age-old practice in many communities. UNICEF and the United Nations Population Fund (UNFPA) currently use a hybrid term, ‘female genital mutilation/cutting’ or FGM/C. This is meant to capture the significance of the term ‘mutilation’ at the policy level and highlight the fact that the practice is a violation of the rights of girls and women. At the same time, it recognizes the importance of employing respectful terminology when working with practising communities[(2)].

Types

The precise anatomical descriptions are provided by a typology developed by WHO in 1995 [(2)]:

Type I – Clitoridectomy:

Partial or total removal of the clitoris and/or the prepuce. A number of practising communities also refer to it as *sunna*, which is Arabic 'tradition' or 'duty'.

Type II – Excision:

Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora. There is considerable variability in the form or degree of cutting.

Type III – Infibulation:

Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. The adhesion of the labia results in almost complete covering of the urethra and the vaginal orifice, which must be reopened for sexual intercourse and childbirth, a procedure known as 'defibulation'.

Type IV – Others:

All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

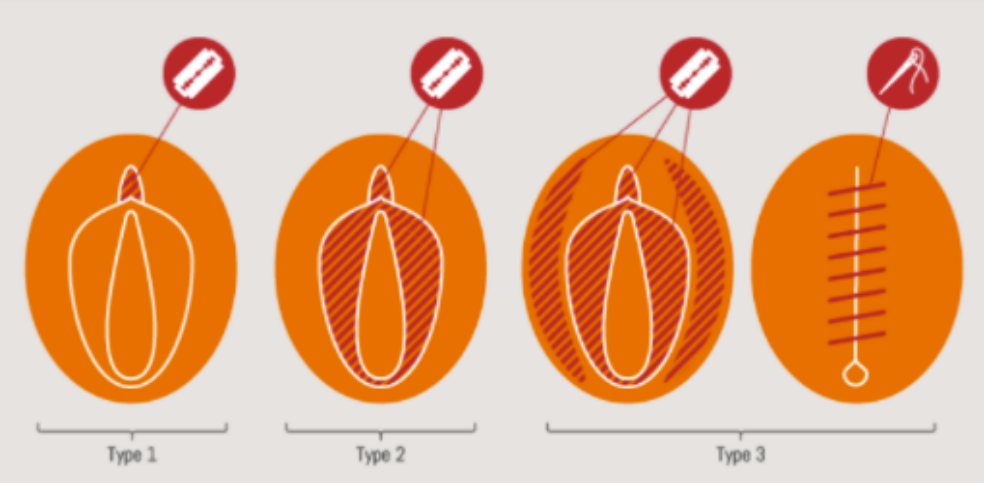


Fig. 1 Different types of female genital mutilation[(3)]

The **type of procedure** performed also varies, mainly with ethnicity. Current estimates (from surveys of women older than 15 years old) indicate that around 90% of female genital mutilation cases include either Types I (mainly clitoridectomy), II (excision) or IV ("nicking" without flesh removed), and about 10% (over 8 million women) are Type III (infibulation). Infibulation, which is the most severe form of FGM, is practiced mostly in

the north-eastern region of Africa: Djibouti, Eritrea, Ethiopia, Somalia, and Sudan. In West-Africa (Guinea, Mali, Burkina Faso, etc.), the tendency is to remove flesh (clitoridectomy and/or excision) without sewing the labia minora and/or majora together[4].

Consequences

The consequences of FGM are various. Most of the time the kind of mutilation conditions the degree of complication, and logically, they are always worst in infibulated women.

Immediately consequences

We have to take in consideration that is a high vascularized and innerved area. This accounts for the intense pain and, in most cases, this pain can cause difficulties in urination, and this can lead to urinary retention.

Haemorrhage is another important and frequent consequence along with shock, not only from bleeding, but from pain and fear, as well.

Because of a lack of hygiene and proper sterilization of the chirurgic material, wound infections are also relevant. There are also urine infections derived from urine retention or from urethra damage, as well as septicaemia and tetanus.

We must not forget that these women are at a very high risk of suffering from HIV due to the utilization of the same tools for all the girls.

Injury to adjacent tissue and fractures, because of the resistance employed, could be other immediately consequences.

Fear and anguish are feelings present at the time of mutilation and from then on[1][5].

Mid and long time consequences

As we have already mentioned, MGF is practiced in a low hygienic conditions. That is because vulvar infections, urinary and gynaecologic, are frequents. If gynaecologic sequels persist, they can induce sterility or infertility.

Sever haemorrhaging together with poverty and nutritional deficiency, can produce sever and chronic anaemia[1][5].

a. Psychological and social problems occur, especially, in women who can remember their MGF, mainly in those who were over 12 at the time of the practice.
Some of these consequences are:

-Depression, terror, fear, anxiety, neuroses and other mental disorders.
-Confusion and contradictory feelings because of the cultural differences.
-Fear of rejection from their social group or ethnic group if they do not submit the practice.
-Fear of the first sexual contact or birth.
-Feeling of guilt.

Not much investigation exists about the psychological effects of MGF, but many women affected related the experience associated with some mental and psychosomatic problems, such as loose of appetite, nightmares, panic attack and difficulties in concentration and learning. They can experiment low self-esteem, chronic anxiety, phobia, panic and depression[(1)(5)(6)(7)].

b. Obstetric complications

It depends on the type of mutilation. Type I does not have frequent complications, but tears in the scar are possible.
Type II and III, due to the extirpation of tissue, scars or keloids scars, the perineum area is less elastic. Problems in dilatation during the expulsion period and this increase the chances of caesarean operation, postpartum haemorrhage, more episiotomies, and an increase in maternal mortality. Postpartum mortality is also higher in the group of babies with mothers mutilated by type II and III.
Urinary catheterization is also difficult because of the anatomical destruction[(1)(5)].

c. Sexual and gynaecologic consequences

The clitoris is the most sensible part of the female genital organs. After its excision, is unavoidable the modification of sexual sensibility, which in most cases may lead to anorgasmia and even frigidity. Pain during intercourse, vaginismus, fear and rejection to sexual intercourse or decreased libido, are other sexual problems. Husbands resort to anal intercourse or even used the urethral meatus as an opening in cases of tight infibulations, when they are unable to penetrate into the vagina.
Direct gynaecologic effects are urinary retention with difficulties in urination (these women have to urinate drop by drop). Furthermore they are reticent to drink liquids due to the dysuria.

Menstruation can last for more than 10 days due to the blood retained inside the vagina (hematocolpos). The retention can cause dysmenorrhea and bad smell.
Other sequels can be keloids, dermoid or inclusion cysts, vulval abscesses, fistulae and incontinence[1][5][6][7].

Table. 1 Immediate, mid and long time consequences [Adapted from:[1]]

Immediate consequences	Mid and long term consequences
Intense pain, urinary retention	-Infection (Vulvar, urinary and gynaecologic), HIV, tetanus -Sterility and infertility -Severe anaemia
Local infection, Injury to adjacent tissue Fractures	Psychological problems
Haemorrhage, shock	Obstetric problems -Type I: laceration -Type II and III: caesareans, haemorrhages, episiotomies, mortality
Fear and anguish	Sexual and gynaecological problems -Pain, rejection, decrease of libido -Urine retention, hematocolpos, dysmenorrhea - Keloids, dermoid or inclusion cysts, vulval abscesses, fistulae and incontinence

2. The social Dynamics of FGM/C and anthropological context

The practice of FGM/C can be considered a social norm in a particular context if it meets the following conditions:

First, individuals are aware of the rule of behaviour regarding the cutting of girls and know that it applies to them.

Second, individuals prefer to conform to this rule because: a) they expect that a sufficiently large number of their social group will cut their daughters, and b) they believe that a sufficiently large number of their social group thinks that they ought to cut their daughters and may sanction them if they do not[2].

The social group, technically referred to as the reference group, basically includes the people who matter to an individual with respect to FGM/C. Thus, it may include other members of the ethnic group or people of the same faith if the practice is associated

with ethnicity or religion. Power relations also play a role. It is not just what is said or done, but also who says or does it[1][2].

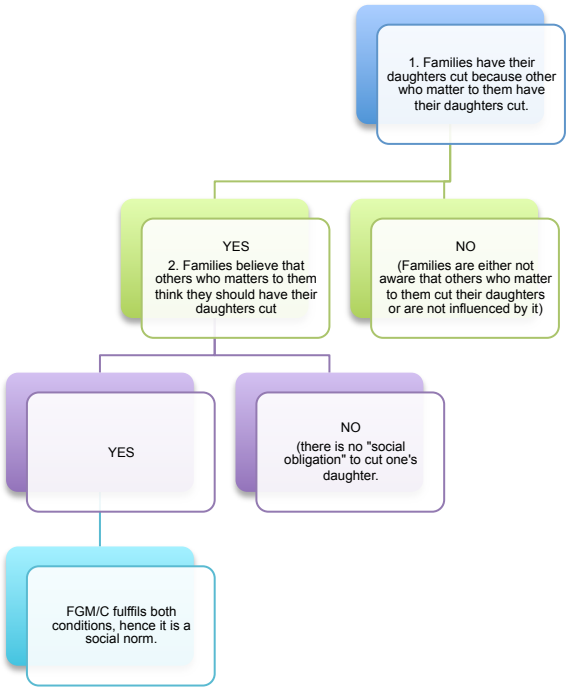
There is a social obligation to conform to the practice and a widespread belief that if they do not, they are likely to pay a price that could include social exclusion, criticism, ridicule, stigma or the inability to find their daughters suitable marriage partners.

Conversely, families will be encouraged not to cut their daughters if they are convinced that a sufficiently large number of other families do not practise FGM/C or are ready to abandon the practice [8].

In addition to **social norms**, mechanisms that regulate behaviour also include **legal norms**, which may prohibit the practice, and **moral norms**, such as doing what is best for one's daughter. These norms may act in harmony, reinforcing one another, or they may be at odds. If individuals continue to see others cutting their daughters and continue to believe that others expect them to cut their own daughters, the law may not serve as a strong enough deterrent to stop the practice[2].

Discrepancies between support for the continuation of FGM/C and its prevalence also suggest the possibility that the attitudes of individual families are kept in the private sphere and are not known by most other families. This phenomenon is referred to as '**pluralistic ignorance'**. The opposite of pluralistic ignorance is **'common knowledge'**, which can be stimulated by facilitating access to information and discussion within communities. Social and economic variables, including educational level and wealth, are among the factors that are associated with changes in FGM/C over time[1][9].

Fig. 2 A behaviour is considered a social norm if it meets certain conditions [2]



As we told, MGF has deep social and cultural origins. One of the main reasons stressed on women who do the practice is the hygiene: a circumcised woman is a "clean woman". Men are circumcised because of hygiene too but a relevant difference between the two practices is the religion. The male circumcision is a rule induced by the "Coran". Feminine circumcision is a **sunna**, which means that it plays a role in the tradition, so it is recommended but not compulsory. On the other hand, it is necessary to specify that neither in all African countries it is practiced, nor do all the ethnic groups practice it. Other contextual factors have been documented to perpetuate FGM, for example: aesthetic aspects, ensure virginity prior to marriage, girls' marriageability and social acceptance, prevention of promiscuity, to prevent the birth of dead children and to protect their own health [(10)(8)].

Social and moral terms make reference to a ritual to introduce them to the adult sphere. **"Kaseo"** (Male initiation) and **"Ñyakaa"** (female initiation) are essential rituals to the future access for child to the adult world and that is why it takes part of a context of social cohesion: the difference between being in or out [(1)(9)].

Three steps compose the rite: separation, marginalization and aggregation[(1)].

First step – Separation:

Boys and girls are separated from the community and circumcised. The cut of the prepuce or the excision of the clitoris, the blood and the pain, marks the breaks with the childhood stage.

Second step – Marginalization:

The time of marginalization depends on the cicatrisation of the wound. For boys it takes two or three weeks, but is longer for girls, that can be between two to eight weeks. It is a period with a high risk, full of strict rules, cures, specific hygiene, nutrition, dresses and general behaviour.

Third step – Aggregation:

It consists in a big "graduating" party where they are introduced publicly and by this time, they are avowed, legitimized and accepted by the community.

The belonging feeling of being in a social group grants an identity signal.

During the initiating process they have to overcome specific tasks, moral and social norms in addition to non-verbal language such as **lenjengo** (dances) and **Kijo** (percussion)[(1)].

FGM/C practitioners

The practice is mostly carried out by people who also play other central roles in the community, such as birth attendants and traditional circumcisers. So, they tend to be leaded by the oldest in town, called **Ngnangsimbah,** that means "mother or father of the initiated". These characters have been instructed by their ancestors to become spiritual guide and leaders of the ritual[(9)(11)].

A worrying trend is that, FGM/C is increasingly performed by health professionals. They claim that they are fulfilling the cultural demands of the community, enhancement of women's value in the society, and respecting patients' cultural rights since some of those making the decisions are of mature age and capable of autonomy. However, the real reason is that it is a source of income for those who perform it; the fees are high, especially in countries where it is illegal[(10)].

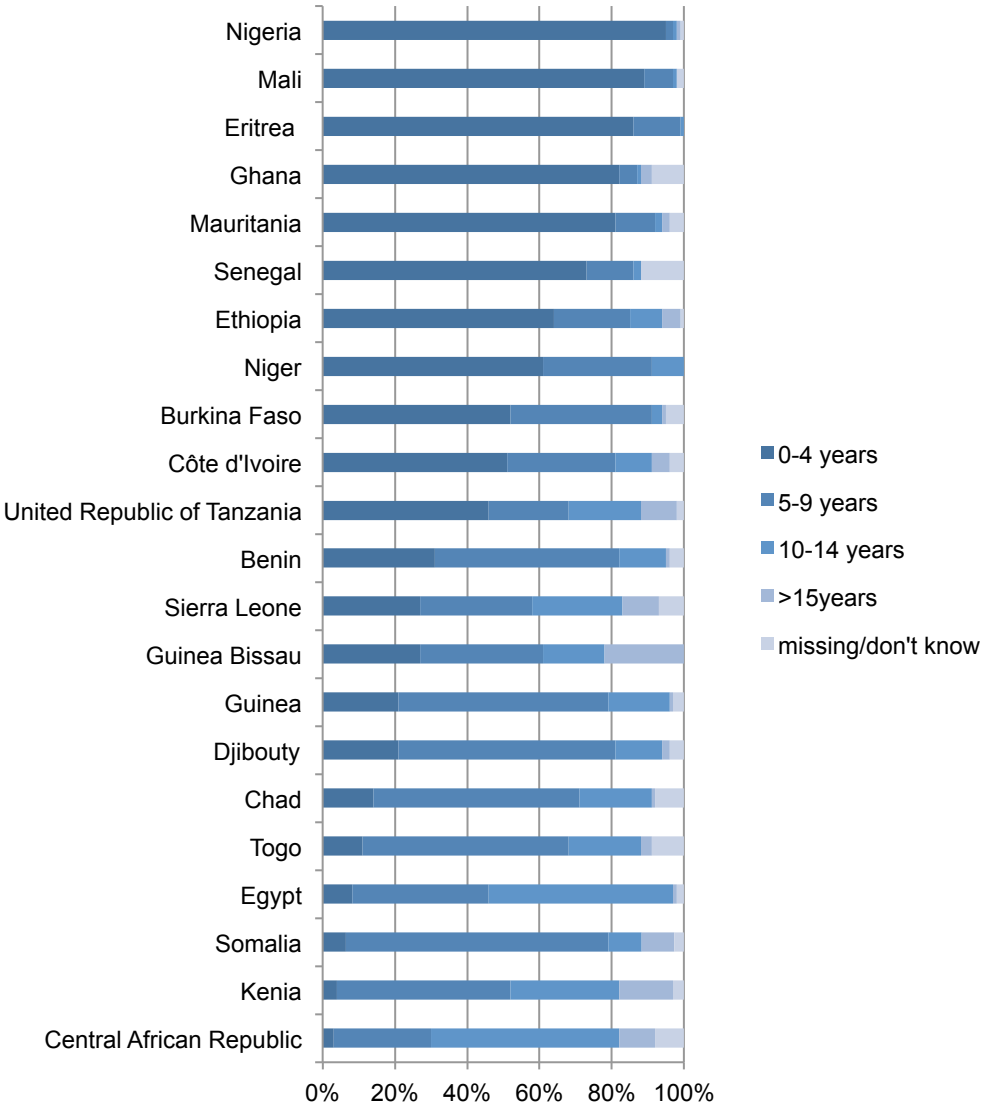
Age at cutting[a]

The initiation rite does not correspond to the physiologic puberty. The ages of initiation depend on the sex, ethnical group, geographical area and demographic density of the group[(1)].

Data on age at which FGM/C is performed are helpful in understanding when girls are more at risk of being cut. The ages at which large proportions of girls experience FGM/C vary substantially across countries but important differences in age at cutting are also found among ethnic groups living in the same country. In general terms it is done on young girls from infancy up to 15 years of age and occasionally on adult women[(2)(11).]

[a] These web pages are the most recognized and reliable source regarding FGM
https://dhsprogram.com/publications/publications-by-country.cfm
https://www.childinfo.org/mics_available.html

Graphic. 1 Percentage distribution of girls who have undergone FGM/C (reported by their mothers), by age at which cutting occurred[2].



3. Worldwide epidemiology and geography

It is estimated that more than 200 million girls and women alive today have undergone female genital mutilation in the countries where the practice is concentrated. Furthermore, there are an estimated 3 million girls at risk of undergoing female genital mutilation every year. The majority of girls are cut before they turn 15 years old.

Female genital mutilation has been documented in 28 countries, mainly in Africa, as well as in the Middle East and Asia. Some forms of female genital mutilation have also been reported in other countries, including among certain ethnic groups in South America. Moreover, growing migration has increased the number of girls and women living outside their country of origin who have undergone female genital mutilation or

who may be at risk of being subjected to the practice in Europe, Australia and North America. The prevalence varies among regions within countries, with ethnicity being the most influential factor[4].

Fig. 3 Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country[2].

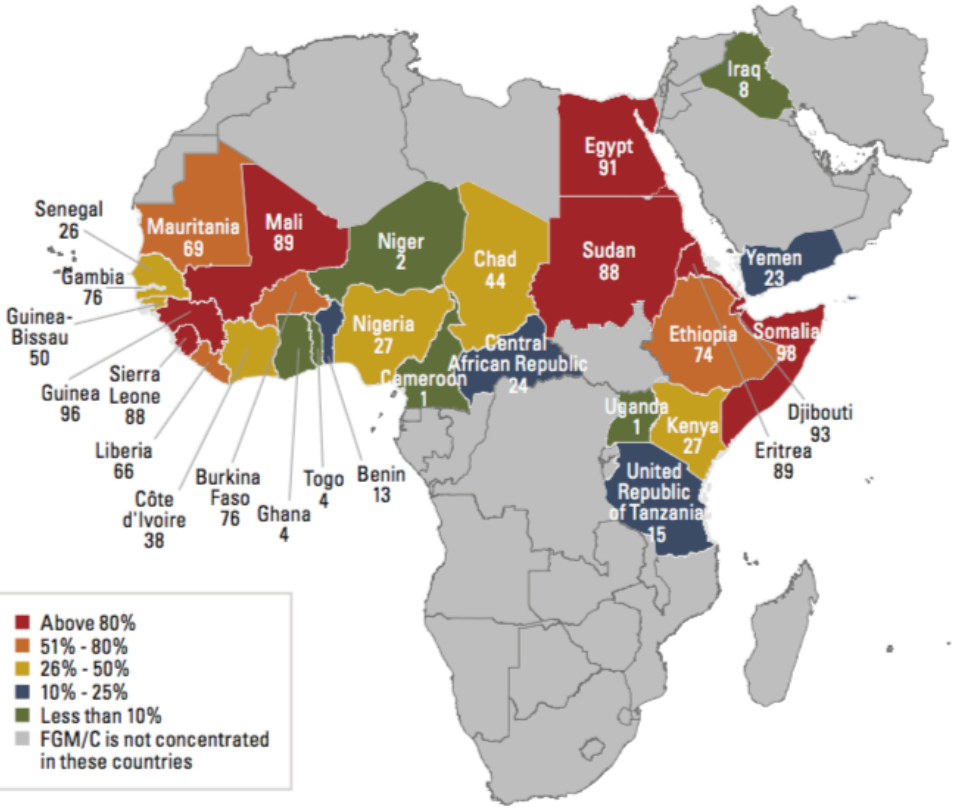


Table. 2 Groupings by prevalence levels among girls and women aged 15 to 40[2]

Group 1: Very high prevalence countries.	Eight countries in which more than 80 per cent of girls and women of reproductive age have been cut: Somalia (98%), Guinea (96%), Djibouti (93%), Egypt (91%), Eritrea (89%), Mali (89%), Sierra Leone (88%) and Sudan (88%).
Group 2: Moderately high prevalence countries.	Five countries in which FGM/C prevalence is between 51 per cent and 80 per cent: Gambia (76%), Burkina Faso (76%), Ethiopia (74%), Mauritania (69%) and Liberia (66%).
Group 3: Moderately low prevalence countries.	Six countries in which FGM/C prevalence is between 26 per cent and 50 per cent: Guinea-Bissau (50%), Chad (44%), Côte d'Ivoire (38%), Kenya (27%), Nigeria (27%) and Senegal (26%).

Group 4: Low prevalence countries.	Four countries in which FGM/C prevalence is between 10 per cent and 25 per cent: Central African Republic (24%), Yemen (23%), United Republic of Tanzania (15%) and Benin (13%).
Group 5: Very low prevalence countries.	Six countries in which less than 10 per cent of girls and women are cut: Iraq (8%), Ghana (4%), Togo (4%), Niger (2%), Cameroon (1%) and Uganda (1%).

Subnational prevalence

While FGM/C prevalence at the national level is important, it often masks differences among regions within a country. These differences are generally greater in countries where national prevalence is lower. This suggests that the presence or absence of the practice is influenced by factors that are shared among specific population groups within various areas of a country. When looking at countries where FGM/C is almost universal (**Group 1**), the data show a lack of substantial variation in prevalence among regions[(2)].

Differences between ethnicities

Variations in FGM/C prevalence across regions are best understood by the ethnic composition of the population in each area.
Ethnic classifications are not, however, static, and are often more complex than can be summarized through simple measures. Ongoing processes of migration, mixing, inter-ethnic marriage and social, economic and political changes can contribute to the shifting of ethnic definitions over time, and may even contribute to the spread of FGM/C in certain situations[(2)]. Some of the ethnicities where MGF is practiced are: Sarahule, Djola, Mandinga, Fulbé, Soninke, Bámbara, Dogon, Edos, Awsa or Fante. Some of them that do not practice it are: Wolof, Serer o Ndiago[(5)].

Differences between urban or rural residence, economic-status and education

As we can imagine, rural areas tends to be communities with limited cultural diversity and by contrast, urban settings may be more culturally diverse, and people may be more likely to associate with multiple reference groups in settings such as work, school, church or the home environment. When this results in a mixing of practising and non-practising groups, urban residents may have greater opportunity to observe that girls and women who are not cut do not experience negative sanctions, such as

repudiation. But this cannot have to be interpreted as a direct influence because, place of residence does not necessarily reflect residence at the time of cutting.

Besides, modernization theory posits that improvements in economic status, particularly for women, will have broad social effects, including a decline in FGM/C. This affirmation has a simple explanation. Like in everywhere, economic development is likely to be accompanied by more commerce, migration, mixing groups and wealthier households and this tends to have greater exposure to information and opportunities.

Caution needs to be taken in interpreting the findings since other factors may be at play[2].

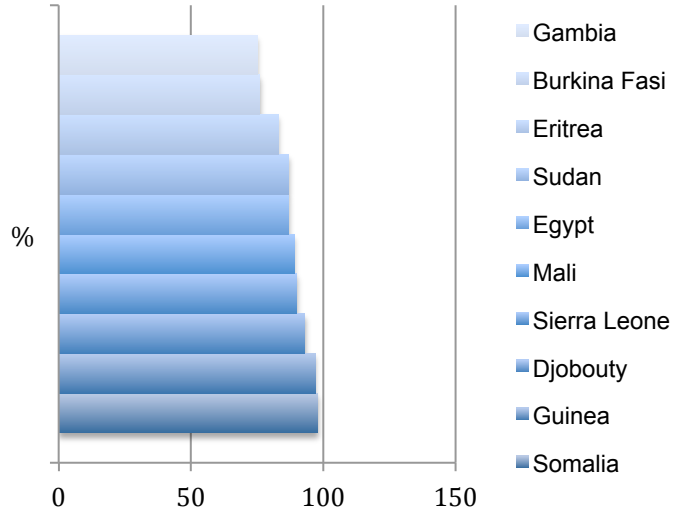
4. What might the future hold?

There has been an overall decline in the prevalence of FGM/C over the last three decades, but not all countries have made progress and the pace of decline has been uneven[12].

The latest worldwide figures, compiled by UNICEF, include nearly 70 million more girls and women than estimated in 2014 because of a raft of new data collected in Indonesia, one of the countries where FGM is most prevalent despite the practice being banned since 2006.

Somalia has the highest prevalence of women and girls who have been cut.

Graphic. 2 Percentage of girls and women aged 15 to 49 who have undergone FGM/C, 2004 to 2015. Top 10 countries[13].



UNICEF said the picture was optimistic in some countries, with FGM prevalence rates declining by 41% in Liberia, 31% in Burkina Faso, 30% in Kenya and 27% in Egypt over the last 30 years.

But in real terms numbers are still rising, largely due to population growth, and if trends continue, the number of girls and women suffering genital mutilation will increase significantly over the next 15 years, even though more young women are starting to speak out against the practice[13].

By 2050, nearly 1 in 3 births worldwide will occur in the 29 countries in Africa and the Middle East where FGM/C is concentrated, and nearly 500 million more girls and women will be living in these countries than there are today. In Somalia alone, where FGM/C prevalence stands at 98%, the number of girls and women will more than double. In Mali, where prevalence is 89%, the female population will nearly triple.

A growing population in the 29 countries means the number of girls and women cut will increase, even if prevalence levels decline. While the proportion of girls aged 15 to 19 who undergo FGM/C may continue to decline, their absolute numbers will increase.

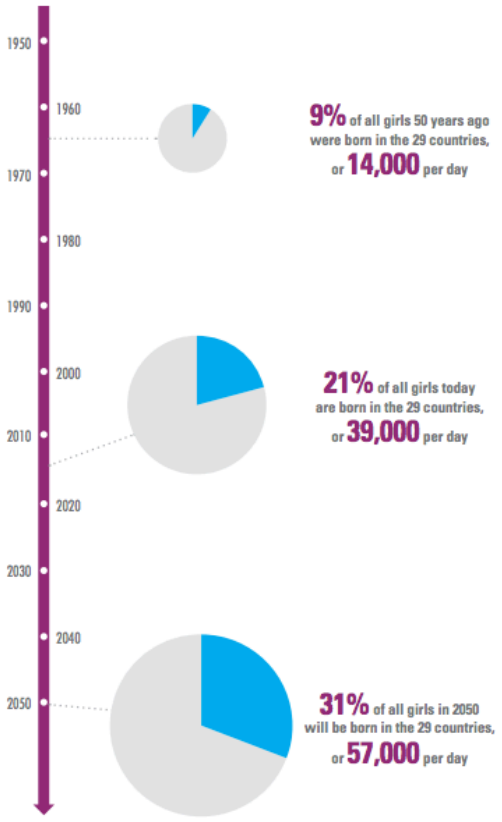


Fig. 4 From "What might the future hold?" [14]

But a pinch of hope flourishes when attitudes towards FGM/C were explored in household surveys. It was found that two thirds of women and almost two thirds of men living in the 29 countries think that the cutting of girls should stop. This can be translated to “even in countries where a majority of girls and women have undergone FGM/C, the level of support is lower than the prevalence level” and these data provide clues about how the practice can be eliminated. If public dialogues can be initiated, people may begin to see that social expectations about the practice are no longer valid[14].

5. Catalan epidemiology

Catalonia is the region with the largest population with nationalities and/or from those countries where FGM is practiced (1/3 women of Spain lives in Catalonia; 0,55% of Catalan population, are from those countries). As in Spain, these countries correspond mainly to Occidental Africa (Gambia, Senegal, Nigeria, Mali and Guinea Conakry). There are a total of 20.814 girls and women, of which 5.811 are between 0-14 years old and 15.003 are older than 14 years old.

Senegal is the leading country of origin, with more than 5.410 women (25.9%), followed by Gambia, 4.237 women (20.4%) and Nigeria, with more than 3.107 women (14.9%).

Catalonia draw a high prevalence of FGM women in all the metropolitan zone of Barcelona, along de coast (Barcelona and Girona), interior area of Girona and the agricultural axis Cervere-Lerida.

In Barcelona live more than half of these women, far ahead of the regions of Spain with more residents from this collective. Women from Senegal duplicate the number of women from Gambia. Instead in Girona, the second Catalan region and the third Spanish region with more population from FGM countries, those from Gambia triplicate those from Senegal. Lerida and Tarragona, have more Senegalese population. Salt is the third region with more mutilated women in Catalonia, and half are from Gambia. It is the municipality with more women of this collective in Spain (10% of the population). Mataro is the municipality with more women from Senegal of Catalonia.

Children population from 0 to 14 years old represent more than 28%. As is what happens in the women collective, Senegal and Gambia, followed by Nigeria and Mali, and then, Ghana and Guinea[15][16][17].

Girona context

According to our two main sources of information, the real situation of Girona in 2016 is summarized in:

-Observing to the data collected from the sanitary sector of “ICS Girona”, that has 34 primary care centres in 208 municipalities of 7 districts (“Gironès, Pla de l’Estany, La Selva, la Garrotxa, Alt Empordà, Baix Empordà and Ripollès”) we can see that among the municipalities with more population from those countries where FGM is practiced

we can highlight: Salt, Girona, Banyoles, Olot, Blanes, Pineda de Mar, and Lloret de Mar.

The total number of feminine population is 4950, stratified in 1494 younger than 14 and 3456 older than 14 [15].

Table. 3 Total of feminine population of ICS Girona sector. [Adaptet from[15]]

	Girona		
	0-14	>14	Total
Gambia	797	1794	2591
Senegal	255	733	988
Mali	182	223	405
Nigeria	65	227	292
Guinea	96	164	260
Mauritania	36	54	90
Guinea-Bissau	4	8	12
Others	59	253	312
Total	**1494**	**3456**	**4950**

-From the "Taules de Treball", formed by one provincial working table, one advisory table and 20 local working tables that are[18]:

- Garrotxa
- Pla de l'Estany
- Ripollès
- Figueres, Vilafant, Bàscara, la Jonquera…
- L'Escala i Sant Pere Pescador
- Roses, Peralada, Llançà…
- La Bisbal d'Empordà
- Sant Feliu de Guíxols
- Santa Cristina d'Aro
- Torroella de Montgrí
- Bordils, Celrà, Flaçà i Sant Martí Vell
- Cassà de la Selva
- Girona
- Llagostera
- Salt
- Sarrià de Ter
- Arbúcies
- Blanes
- Lloret de Mar
- Santa Coloma de Farners i Vilobí d'Onyar

The conclusions of the situation in Girona are 1057 girls at risk of FGM (the factors that describes a risk situation are explained in *"**Risk Factors**"* section) with 30 girls registered as having gone to their country of origin and not returning and 12 who have come back but have not had any medical review.

They also have detected 114 medical reviews with signed avoidance commitment document (see ANNEX 1), and 16 medical reviews linked to a trip, with no signature.

Finally, regarding our actions, 5 cases have been derived to the courts of justice and 16 community actions aimed at 330 persons have been active in 2016.

6. Human rights violation

The problems associated with the procedure of FGM have brutal consequences for a woman's physical and mental health. For this and other reasons, in June 1993 the Vienna World Conference on Human Rights agreed that FGM was a violation of Human Rights [19][20][21].

FGM sustains gender norms and stereotypes that contravene human rights, and is harmful to the health and wellbeing of girls and women. A number of international human rights conventions explicitly and implicitly address states' obligations to eliminate FGM. The Convention on the Elimination of All Forms of Discrimination against Women **(CEDAW)** requires states to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against women".

The Convention on the Rights of the Child **(CRC)** underscores the importance of ensuing protection and care for children and recognizes the responsibility of state parties in this regard. The CRC also established the "best interests of the child" standard in addressing the rights of children as well as autonomy related to their evolving capacity. FGM is recognized as a violation of that best interest standard and a violation of children's rights. The CRC mandates states to abolish "traditional practices prejudicial to the health of children" [21].

Human rights violated [20]:

- Right to health: the International Human Rights law including the Universal Declaration of Human Rights (1948) proclaims the right for all human beings to live in conditions that enable them to enjoy good health and health care.
- The right of the child: the victims of this harmful traditional practice are infants, little girls and women ranges between the ages of 7 and 8 after birth and 10-14 years-old.
- The right to sexual and physical integrity: FGM is practiced without women's and girl's full consents. An unauthorized invasion of a person's body represents a disregard for that fundamental right.

- Right to be free from discrimination: the practice of FGM is also a gender-based discrimination against women because it has been taken as a pre-requisite for marriage, to gain economic and social security.
- Free from torture, cruel, inhuman and degrading treatment.

Legal Documents [19]**:**

• Convention of Elimination All form of Discrimination Against Women (CEDAW)
• Convention on the Rights of the Child
• Criminal Code of the Federal Democratic Republic of Ethiopia, May 2005
• Declaration and Programme of Action of the International Conference on Population and Development (ICPD)
• International Covenant on Civil and Political Rights (ICCPR)
• International Covenant on Economic, Social and Cultural Rights (ICESCR).
• The Declaration and Platform for Action of the Fourth World Conference on Women, held in Beijing in 1995
• Universal Declaration of Human Rights (UDHR)

Efforts to address FGM are part of a long-term process aimed at ensuring greater government involvement in the protection of women's rights. By invoking human rights standards, advocates can hold governments accountable for their inaction in response to FGM.
The experience of nations around the world in addressing FGM reveals that no single approach can eliminate FGM [22].

7. National Legislation

Any type of FGM practiced is considered an injury crime, typified and sanctioned in our judicial order in articles 147, 148, 149 and 150 of the "Código Criminal".
Article 149 in accordance with the reform introduced by "Ley Orgánica 11/2003", of 29 September, is worded as:

"1. El que causare a otro, por cualquier medio o procedimiento, la pérdida o la inutilidad de un órgano o miembro principal, o de un sentido, la impotencia, la esterilidad, una grave deformidad, o una grave enfermedad somática o psíquica, será castigado con la pena de prisión de seis a 12 años. "

"2. El que causare a otro una mutilación genital en cualquiera de sus manifestaciones será castigado con la pena de prisión de seis a 12 años. Si la víctima fuera menor o incapaz, será aplicable la pena de inhabilitación especial para el ejercicio de la patria potestad, tutela, curatela, guarda o acogimiento por tiempo de cuatro a 10 años, si el juez lo estima adecuado al interés del menor o incapaz."

FGM can only be persecuted if it is committed in Spanish territory. The approbation of "LO 3/2005", modification of the old law, it allows the extraterritorial persecution of the practice of FGM, when crime is committed abroad, as happens in most cases during trips to the country of origin. Possible cases:

- The accused has Spanish nationality
- The accused has foreign nationality
- The accused had Spanish nationality at the moment of the procedure

There are others applicable procedures aimed at preventing the commission of crime, for example:

- Article 13 of criminal persecution Law
- Civil Code, articles 9.6 and 158
- Family of Catalonia code, articles 134 and 138
- The law 14/2010, of 27 may, about the rights and the opportunities during the childhood and the adolescence, establishes that the FGM is one of the risk situations that limits or harms the integral development and the wellness of child or adolescent, and it has to lead to a socio-educative intervention in the context, with the goal that the family decides not to practice it.

The utilization of the criminal law cannot substitute in any case the social treatment of the situation and, the utilization of this, remains reserved for those situations where the protection cannot be guaranteed in any other way (see ANNEX 2).
Precautionary measures should start by information, sensitization and education, but if it is necessary, the article 28.2 of the "LO 4/2000", modified by the law 8/2000, allows the administrative forbiddance of the departure from Spain[(1)(9)].

8. Regional legislation

At the same time, autonomous communities have incorporated references about FGM in their laws in terms of equality of opportunities and violence against women. The law 5/2008, of 24 may, of the autonomous community of Catalonia about the right of the women to eradicate male chauvinist violence, includes FGM or the risk to suffer from it, as a manifestation of the violence from the social and community level. Furthermore, some of the autonomous communities such as the Catalan, Aragon and Foral Navarra have elaborated guidance protocols[5].

Prevention protocol for FGM of "Generalitat de Catalunya"

It was done to cover the needs of the professionals when faced by the situation because of a lack of information and formation to take appropriate care of these patients (see ANNEX 3).
The protocol contains information about which is the role of each entity, public or private, that has contact with immigrant population in terms of justice, health, education, social service. Furthermore, we can find the risk factors, suspicion indicators, juridical context of the moment and intervention strategies of everyone implicated[23].

Risk Factors

The factors described as situations of risk of suffering Female Genital Mutilation are[23]:

-Being part of an ethnicity that practices FGM: most of girls and women that have experimented mutilation are from, or their families are from, one of the countries where is it practiced.
-Belong to a family in which the mother and/or sisters are mutilated.
-Belong to a practicing family that intend to return to the country of origin.
-Proximity of a trip with a young daughter to the country of origin.

IV. JUSTIFICATION

Feminine Genital Mutilation constitutes a **large scale problem** around the world. It is estimated that more than **200 million** girls and women alive today have undergone female genital mutilation in the countries where the practice is concentrated [(4)].

In **African countries**, more than **90 million women and girls** over the age of 10 are estimated to have undergone FGM, with some **three million girls at risk every year**. The practice has been reported from all over the world, but is today most prevalent in 28 countries in Africa and some countries in Asia and the Middle East. As a result of **migration**, a **growing number of girls in Europe**, North America, Australia and New Zealand are also affected [(6)].

The presence of FGM in Spain, comes from the immigration. There are around 70.000 women who come from these high-risk countries, representing 5,2% more than in 2012. About 18.400 girls in Spain are at risk of suffering FGM. The 2016 data points out that the **number of girls at risk has increased 63,85% between 2008 and 2016**, although it has decreased 0,35% compared with the map of 2012 [(20)].

But this is not all! Despite these terrifying figures, the **worst is yet to come**. By 2050, nearly 1 in 3 births worldwide will occur in the 29 countries in Africa and the Middle East where FGM/C is concentrated, and nearly 500 million more girls and women will be living in these countries than there are today [(13)].

FGM/C constitutes a **ritual of initiation** into adulthood, conditioned by a **tradition** with deep roots and a strong **social pressure** that, most part of the time, does not allow any other alternative than to submit their daughters to the practice.

Some of the **perpetuating factors** and beliefs are: hygiene, aesthetic aspects, ensure virginity prior to marriage, social acceptance, prevention of promiscuity and prevention of dead children in addition to the protection of their own health [(10)].

As we have already highlighted, due to the migratory flows, the practice has become a worldwide problem. In response to a **Human Rights violation**, Europe has proposed different **measures of eradication** and every European Community has taken responsibility for its own immigrants.

It is unacceptable the permission of a practice that violates the right to health, the right of the child, the right to sexual and physical integrity and the right to be free from discrimination and from torture. And it is not part of moral principles to turn a blind eye towards a practice that has awful physical, mental, sexual, obstetric and surely, many other **consequences**.

The last step of the Catalan protocol is the **judicial way**. **But, do we want to reach this point? Does it really help the global change of the situation?**
Without forgetting our roles as health professionals, we have to make them realize that it is about a human right violation but, based on education, not on punishment.
We have the chance of living in a context with an existing tendency of freedom for women, in general terms (our objective is not to make a feminist discussion, but to compare our situation as a woman with theirs), and this is what we want to imbue.

We are convinced that **the migration and acculturation processes influence in changing attitudes and behaviours in terms of Feminine Genital Mutilation**, but it is equally or more important to know if what we are working on really helps our objective of eradicating FGM and if there is any way to improve.
They and only they can change their world. If these women understand that the practice has not religious reasons or positives consequences, if they understand that the right to their body is theirs, they will promote the eradication of the practice among them.

Our objective as professionals is to **understand the problem**, their concerns and beliefs and their opinion about the practice in function of the **years they have lived here**. This will allow us to see **if there is a change** due to the acculturation, and which are the **associated factors** that we have not yet solved.

To conclude this justification I just want to remark that many of us have been born to improve our society. **These women are part of our society**.
Chiefly, to help the society we have to understand their problems. And once we have understood what is happening, we have to make sure that our actions are achieving the main objective and look for improvement points.
If I have to state anything about health professionals it is their desire for improvement. So, let's improve the situation!

V. HYPOTHESIS

Main Hypothesis:

The migration and acculturation processes influence in changing attitudes and behaviours regarding Feminine Genital Mutilation[a].

Secondary hypothesis:

The second-generation daughters of immigrant mutilated women (those born in a member state of the European Union) are at a lesser risk of being victims of FGM.

[a] The term "sociocultural adaptation" or "acculturation" has been proposed to describe the cultural process trough which the immigrants are capable to establish relations in a new culture *(Maydell-Stevens, Masgoret y Ward, 2007),* and one of the steps of this process is the adaptation to lifestyle. (24)

VI. OBJECTIVES

Main objective:

The main aim of the present study is to evaluate if there is a difference in attitudes and changes in behaviour regarding Feminine Genital Mutilation in immigrant mutilated women from any of the 28 African countries at risk of FGM that have lived in the region of Girona for more than two years compared to those who have lived there for less than two years.

Secondary objective:

To analyse which are the factors associated to the different attitudes and behaviours as regards Female Genital Mutilation in those women who have lived in the region of Girona for more than two years.

VII. SUBJECTS AND METHODS

1. Study Design

This project is designed as an observational, cross sectional and multicentric study. It will be performed in "Can Gibert del Pla" and "CAP de Salt" due to its high influx of Sub-Saharian immigrants, which will be part of the study during a period of six months.

2. Subjects Selection

The population of the study will be every immigrant mutilated woman from any of the 28 African countries at risk of FGM who come to the primary care centre, independent of the reason for visiting, and lives in Girona.

Inclusion and Exclusion Criteria

a) Inclusion criteria

- Immigrant women from one African country at risk of FGM. (Senegal, Mauritania, Mali, Gambia, Guinea-Bissau, Guinea, Sierra Leone, Liberia, Côte d'Ivoire, Burkina Faso, Ghana, Togo, Benin, Niger, Nigeria, Chad, Cameroon, Central African Republic, Egypt, Sudan, Ethiopia, Somalia, Uganda, Kenya, Iraq, Yemen, United Republic of Tanzania, Djibouti and Eritrea)
- The woman has to be mutilated
- The woman has to live in the region of Girona
- Women who agree to participate in the study by understanding and signing the "information document for the patient" and the "informed consent" (see ANNEX 4 and 5)

b) Exclusion criteria

- Woman younger than 18

3. Sample and Sampling

At the moment of defining the sample, we have to take into consideration the fact that we are developing an observational study, and these kinds of studies are usually approached from a qualitative perspective. This means that it does not matter neither the size, nor the power, nor de sampling (if it's random or not)[a].

Despite this, with a risk of 5% (alpha), and a potency of 80%, with the assumption of maximum indeterminacy and with an infinite population, the number of women that we need with a bilateral test that will allow us to detect differences up to 5% (precision) will be about 384 without foreseeing drop-outs and 456 with a 15% of drop-outs[b].

This data will be used to have a general idea of the sample size.
A non-probabilistic consecutive sampling will be used in this study. The selection of the sampling will be done in three steps, explained in the following section.

4. Methodology and data collection

The sampling will be done at the same time as the data collection. The sampling will be done in three steps and the data collection will be the fourth one.

First step: the professional who receives the visit will make two easy questions to all immigrant woman who come to the primary centre, independent of the reason for visiting, to make the first selection:

What is your country of origin?

Where are you living?

At this time we will not know if they are mutilated or not. We are only selecting those women from an African country of risk and from these, which live in the region of Girona.

[a] To facilitate the study we have calculated which would be the size of the sample if we follow the "traditional" and easier structure of the Medicine Final Projects.

[b] 'Sample size computed with the Prof. Marc Saez's software, based on the pwr package of the free statistical environment R (version 3.4.2)'.

Second step: These women will be derived to a mediator woman trained for that purpose. And we specify that she will be a woman because we know that this will facilitate the interaction with the patients because of religion and traditional customs. We will have two mediators in each medical centre twice per week during 24 weeks (6 months). The patient will be informed about the study with a document that will summarize all the necessary information to participate (see ANNEX 4). They will have to sign the informed consent for participation showing they have understood the project (see ANNEX 5). These documents will be translated in Catalan, Spanish, English and French to ensure that the information is correctly understood.

Third step: once all documents are signed, we will give to these women the first page of the questionnaire where they will have to fill the fields of "Personal information" and "health information".

With these three steps we will get a sample of immigrants mutilated women that will then be stratified depending on the time they have lived in the region of Girona (<2 years, >= 2years).
We are conscious that the second step takes a lot of time but we consider that we cannot ask about their mutilation without having their consent.

Fourth step: All the information will be collected using a questionnaire (see ANNEX 6). As the second and the third step, those responsible for passing the questionnaires will be the mediators, who will be formed in how to carry out this exchange of information with these women, how to treat them and how to help them answer the questionnaire correctly. Furthermore, after this, the mediators will have a section to remark anything they consider necessary.

5. Variables

Dependent variable

What they think about Feminine Genital Mutilation: in order to be objective and eliminate possible interpretations, we have resorted to a dichotomous question that allows us to collect an opinion (in favour or against FGM), and not an intention, regarding the practice.

"Do you agree with the practice of Feminine Genital Mutilation?"

Independent variable

Number of years lived in the region of Girona: Since integration is a process, the analysis of the level of integration achieved in a society must take into consideration the dimension of time. Changes over the years and decades can indicate the efficiency or the lack of adequacy of integration policies [(22)].

We will take into consideration a minimum of two years to learn a new language and to understand the lifestyle of the host society. This does not mean that, after this time, all immigrants have adapted, but it's the minimum.

So, we will stratify our sample in two groups (more than two years living in Girona Vs less than two years), but also, we will see what is the trend of opinion regarding FGM according to the number of years spent in Girona. Therefore, we will have a dichotomous variable (<2 years, >= 2years).

Co-variables

Under the assumption that our hypothesis are true, "The migration and acculturation processes influence in changing attitudes and behaviours regarding Feminine Genital Mutilation" and "The second-generation daughters of immigrant mutilated women (those born in a member state of the European Union) are at a lesser risk of being victims of FGM", the covariates studied are those that will influence the acculturation process [(22)]:

Country of origin: As we know, there are countries at risk of FGM, and among them, some have more prevalence than others, besides being part of the risk factors. Differences may exist before immigrating regarding their acceptance of FGM.

Ethnicity: in the same way as the country of origin, there are differences in prevalence between ethnicities besides being part of the risk factors.

Age upon arrival: we consider that the ability to adapt is not the same depending on the age upon arrival. As in all societies, the global vision of a teenager is not the same like the one you have when you are older and your abilities are neither the same.

The language (Catalan or Spanish): If they speak or if they are in process of learning it: The language is essential to any kind of interaction within a society. Understanding the language of the host country is the first step towards understanding their culture. If they can communicate, they can form relations easily with native people, exchanging opinions and this gives an important perspective to the concept of integration.

Number of children/number of children at school/number of children at the country of origin: An important condition for the economic status of these people is the integration with the educative system. By studying these factors, we can have an idea as to what their future plans could be, depending on their efforts to continue their education.

Have they attended any group activity? Do they participate in any association? Their wellness is influenced by the social and political integration. We are going to evaluate this point through any kind of participation in social groups. Furthermore, the interaction between natives and immigrants is a demonstration of the acceptance of these people in the host society.

Work: the participation of the immigrants in the working market, is an example of economic integration. Money but also stability, are important factors to determine the quality of life. And, in the same way as the language, if they work, we assume that they are in contact, day after day, with native people. This contact will facilitate acculturation.

Residence city and who they live with: the environment in which they live offers information about their residential integration. The settlement area, the level of regional concentration and the "ghettoization" shows the degree of separation of these with society. There are epidemiological studies that allow us to know the number of immigrants in each city of Girona. Knowing where they live, will help us to understand the social context where they live, and the degree of acclimatization that they have but also, knowing how many people reside under the same roof, can give us a vision of the degree of "ghettoization".

They have lived in other countries of the European Union? We have already said that integration is a process and the analysis of the level of integration achieved in a society must take into consideration the dimension of time, so, having lived in another country of the EU, lengthens the time of interaction with a different culture/language/society…

If the husband works: The role of man in these families holds a lot of weight. Sometimes, the decisions are taken unilaterally. This means that, if he is well integrated in the society, he will decide to stay, and he will decide, in our case, what will happen to his daughters. So, the degree of integration of the male head of the family is very important.

If they plan to return to their country: It is clear that if they plan to return there, they will not make any effort to adapt or understand our culture or abide by our laws.

If they have daughters not mutilated which have already travelled to the country of origin: This is a real demonstration of the change in behaviours and attitudes. If they are mutilated and they have daughters not mutilated, despite being at risk of being mutilated and have not been, it means that something has changed their point of view regarding FGM.

VIII. STATISTICAL ANALYSIS

-Descriptive analysis

The dependent variable will be summarized using proportions in general and stratified by the years of residence (<2 years, >= 2years). And we will estimate the confidence interval of the proportions.

These descriptive will be stratified by the co-variables. When the co-variables are quantitative, they will be properly categorized (in quintiles). And some variables will be summarized as mediums.

-Bivariate inference

The relationship between the dependent and the independent (categorized by <2 years, >= 2 years) could be tested using a cross table by means of a chi-square test. Relative risk will be also estimated.

Example:

	For FGM	Against FGM
<2 years in Girona		
>=2years in Girona		

These analyses will be stratified by de co-variables. When the co-variables are quantitative (Number of child/number of child schooled/number of child at the country of origin), they will be properly categorized.

-Multivariate analysis

The relationship explained above will be adjusted by the co-variables in a logistic regression.

IX. WORK PLAN

1. Personnel

It is expected that trained mediators, specialists on the subject, will carry out the field work. We will also need the collaboration of the doctors of "Can Gibert del Pla" and "CAP de Salt".

2. Schedule

As we have already specified in the section ***"Sample and Sampling"***, we have an idea as to what the size of the sample should be in order to have sufficient precision. So, a non-probabilistic consecutive sampling will be used until we have enough samples. We estimate that this will take about 6 months, twice mornings (5h/morning) per week.
This study is expected to last a total of 20 months, from July 2018 until February 2020. It will be divided in 3 months of pre-filled work, 6 months of field work and data collection, 3 months for data analysis and 8 months for result interpretation and publication. The activities carried out during this time will be organized in 4 phases.

- **First phase: Informative and formative phase (3 months)**

Firstly, the study will be presented to the Ethical Committee for its evaluation and approval.
Once it is approved, we will ask to the medical centres of "Can Gibert del Pla" and "CAP de salt" for permission and coordinating meetings will be arranged in order to inform the doctors about the project and their role into the first step of the sampling.
At the same time, two mediators will be selected to carry out the field work. We assume that they would be mediators who have previously worked in the context of female genital mutilation. It is a sensitive issue that you have to know how to deal with. The treatment of these patients is paramount, and any situation of insecurity that occurs can cause the abandonment of the study, the refusal to answer the questionnaire or the simple fact of lying.
A three-day course will be held to train the mediators on the specific subject of the study.

- **Second phase: field work and data collection (6 months)**

This second phase starts with the patients recruitment "every immigrant mutilated women from any of the 28 African countries at risk of FGM who come to the primary care centre, independent of the reason for visiting and live in the region of Girona" who meet the inclusion criteria for the study after signing the informed consent form.
At the same time the selection is made they will be asked to answer the questionnaire (see ANNEX 6) with the help of mediators.
Data collected from each patient will be registered in our database.
During this period a pilot test will be conducted in order to depurate data procedures and detect possible errors.

- **Third phase: Data analysis (3 months)**

After processing the database, all data will be analysed by our statistician using the statistical tests described in the " Study and Methods" chapter.
The final results will be sent to the main investigators, who will then proceed to their interpretation and discussing, elaborating the conclusions of the study.

- **Fourth phase: Interpretation, publication and dissemination of the results (8 months)**

The person responsible for the study will write and edit a scientific paper with the intention of publishing in order to disseminate the results.

3. Chronogram

		PHASE 1			PHASE 2			PHASE 3	PHASE 4	
		Presentation to the CEIC	Inform the centre and Drs	Mediators formation	Recollection	Questionnaire	Database	Statistical analysis	Interpretation	Publication
2018	July									
	August									
	September									
	October									
	November									
	December									
2019	January									
	February									
	March									
	April									
	May									
	June									
	July									
	August									
	September									
	October									
	November									
	December									
2020	January									
	February									

X. ETHICAL AND LEGAL ASPECTS

This research protocol will be presented to the Clinical Reserch Ethical Committee (CEIC) of Hospital Universitari Dr. Josep Trueta in Girona for its assessment and approval and their recommendations will be taken into account to carry out the study.

This study will be conducted in accordance to the Human Rights and to the Ethical Principles established by World Medical Association in the Helsinki Declaration of Ethical Principles for Medical Research Involving Human Subjects (last actualization, October 2013).

According to the "Ley 41/2002 Básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica" all participants interested in being part of the study, will be asked to sign voluntarily the informed consent (see ANNEX 5).

The confidentiality of personal and clinical information of all participants involved in the study will be guaranteed, according to the "Ley Orgánica 15/1999 de Protección de Datos de Carácter Personal". All the information will be only used for the purpose of the research. Patients will always be allowed to modify or destruct any of their collected data study.

XI. LIMITATIONS AND OPORTUNITIES

Due to the subject of the project and the kind of study we have encountered some limitations:

LIMITATIONS	OPORTUNITIES
The first one and main one, is the few studies done about it. So we don't have any example to follow.	
Besides being a delicate subject, we find a clash of cultures that we have to consider in order to develop the study correctly. It is possible that we have drop-outs during the sampling. This could be done for three main reasons: →They are not ready to talk about this kind of intimacies. →They do not understand why some of them are selected and not the others, so, as a "social group" if some do not participate, they will not want to participate either. →They think that they do not have to give any kind of explanation about their culture.	The importance of this point could be silenced trough a good work by mediators. If they have the ability to transmit the aim of the study and to communicate with these patients, making them feel understood and motivating them to participate in the study, we will have less drop-outs. Furthermore, the doctors who will carry out with the first step of the sampling could help too by creating a trust context and maybe, not proposing the project to them until the second or third visit.
At the moment of defining the sample, we have to take into consideration the fact that we are developing an observational study, and this kind of study is usually approached from a qualitative perspective. This means that it does not matter neither the size, nor the power, nor de sampling (if it's random or not). However, as it is a Final Project of Medicine, we have followed a standard quantitative approximation.	A future objective is to develop this project in a qualitative approximation.
The data collection is carried out with a questionnaire ad hoc, and this means that it has not been validated but is inspired by others[22].	This may not be a limitation but rather an opportunity to create a questionnaire that can be validated in the future.

Asking about an opinion it may not be very accurate, but it has been the only way we have seen possible to avoid being involved in major ethical issues.	Explaining to the patients that we are evaluating an opinion, and not an intention, and that this is not going to have any negative consequence, could motivate them or at least, not conditioning their answers.
As in any questionnaire we are subject to the risk of being lied to.	At this point we highlight again the importance of the doctors and mediators role.

XII. IMPACT ON THE NATIONAL HEALTH SYSTEM

We have already commented the **epidemiological impact** that FGM has around the world and how **migratory flows** are taking this practice to our **daily worries**.

In the ***"Introduction",*** we have summarized briefly how it is regulated into international, national and regional level but, we do not have any objective way to determine how these different ways of acting (laws, protocols, etc) nor how the migration fact influence the attitudes and behaviours in terms of FGM. Especially when these host countries have ethical and moral principles against a conduct that violates Human Rights.

The **fact of migrating** to a country where the reality of the subject is unmasked and where solutions are proposed to all the consequences caused by FGM, **do help these patients to perform the cruelty they have gone through? And, in this way, it helps to prevent the following generations from suffering it too?**

With the results of our study, we can see if the migration and acculturation process influence their ideals.

We will rely on the time lived in a country of the EU, in our case in Girona, because we know that an immigrant needs some time to being adapt to the new country. But, furthermore, we will analyse some factors to determine the degree of influence.

Apart from making us **feel more at ease about the work** done so far, it will be useful to focus in the **future** on **those factors** that, with insistence, can help us in our goal **to eradicate the practice**.

In conclusion, the study will allows us to have **a global vision** about the **opinions** of the immigrants living in our countries and will give us **clues to improve** our action and prevention plans **to keep fighting against** the practice with more precise objectives.

Some of these improvements could be:

-**Increase the insistence on those factors** that facilitate adaptation in the host country, such as, facilitate language courses or facilitate information about different associations or services for the care of these women.

-The study will be useful **to have a point of comparison** with other future studies that can be done in other countries of the European Union.

-The results in favour of our hypothesis **could motivate us to want to improve** our registration system to have more exact databases of the situation to facilitate the dispersion of the consequences of the results of the study.

XIII. BUDGET

Expenses for the professional formation	
Expenses for the course	60/pers (x4)= 240€
Expenses for meals and transport	40/pers (x4)= 160€
Expenses for material	
Impression	200€
Personal expenses	
Statistician	35€/h (x100h)= 3500€
Mediator's salary	10€/h (240hx4pers)= 9.600€
Publication and dissemination expenses	
Publication in open access journal	1500€
National travel meetings	1000€/pers (x2)= 2000€
International diffusion	3000€
TOTAL	**20.200€**

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XV. ANNEXES

ANNEX 1.

MODELO DE COMPROMISO DE PREVENCIÓN DE LA MUTILACION GENITAL FEMENINA

Desde el Centro de Salud:

.....

Se certifica que, hasta este momento, en los exámenes de salud realizados a la niña cuyos datos se consignan a continuación, no se ha detectado alteración en la integridad de sus genitales.

NOMBRE	FECHA DE NACIMIENTO de la niña	PAÍS AL QUE VIAJA

Por ello se informa a los familiares/ responsables de la niña sobre las siguientes circunstancias:

- Los riesgos socio- sanitarios y psicológicos que presenta la mutilación genital, y el reconocimiento a nivel internacional que tiene esta práctica como violación de los Derechos Humanos de las niñas.

- El marco legal de la mutilación genital femenina en España, donde esta intervención es considerada un **delito de lesiones** en el Articulo 149.2 del Código Penal, aunque haya sido realizada fuera del territorio nacional (por ejemplo en Gambia, Malí, Senegal, etc.), en los términos previstos en la Ley Orgánica del Poder Judicial, modificada por la Ley Orgánica 1/2014, de 13 de marzo.

- La práctica de la mutilación genital se castiga con pena de prisión de 6 a 12 años para los padres, tutores o guardadores; y con pena de inhabilitación especial para el ejercicio de la patria potestad, tutela, guarda o acogimiento de 4 a 10 años (es decir, los padres no podrían ejercer la patria potestad ni tener consigo a su hija, por lo que la entidad pública de protección de menores correspondiente podría asumir su tutela, pudiendo la niña ser acogida por una familia o ingresar en un centro de Protección de Menores).

- El compromiso de que, al regreso del viaje, la niña acuda a consulta pediátrica/médica de su Centro de Salud para la realización de un examen de salud en el marco del Programa de Salud Infantil.

- La importancia de adoptar todas las medidas preventivas relativas al viaje que le han sido recomendadas por los profesionales de la salud desde los Servicios Sanitarios.

Por todo ello:

- DECLARO haber sido informado, por el profesional sanitario responsable de la salud de la/s niña/s sobre los diversos aspectos relativos a la mutilación genital femenina especificados anteriormente.

- CONSIDERO haber entendido el propósito, el alcance y las consecuencias legales de estas explicaciones.
- ME COMPROMETO a cuidar la salud de la/s menor/es de quien soy responsable y a evitar su mutilación genital, así como a acudir a revisión a la vuelta del viaje.

Y para que conste, leo y firmo el original de este compromiso informado, por duplicado, del
que me quedo una copia.

En ....., a ..... de ..... de 20.....

Firma. Madre/Padre/Responsable de la niña **Firma:**
Pediatra/ Médico

ANNEX 2.

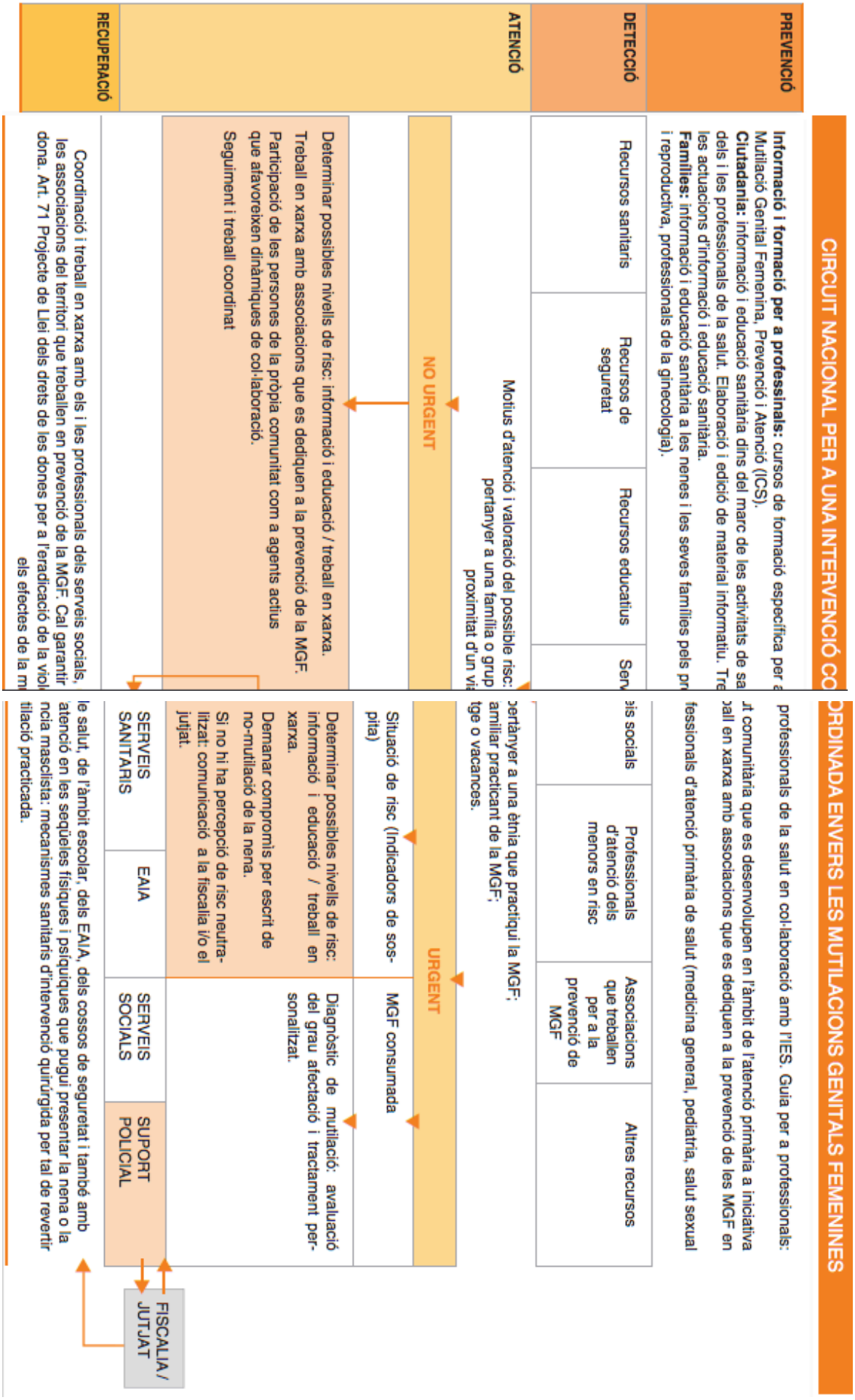
Normativa internacional	El Dret Penal	El Dret Civil
-Convenció per a l'eliminació de tota forma de violència contra les dones, 54 període de Sessions ONU (Resclució 54/133) Violència contra les dones, (l'any 2000, en formaven part 165 estats). El Comitè dels Drets de l'Infant, per exemple, ha recomanat que s'aprovin, promulguin i apliquin les lleis per prohibir les Mutilacions Genitals Femenines. -Convenció ONU sobre els Drets del Nen. Adoptada el 20 de novembre de 1989. L'article 24 obliga als Estats a: "assegurar l'atenció sanitària prenatal i postnatal apropiada a les mares" i exhorta als Estats a: "Adoptar totes les mesures eficaces i apropiades possibles per abolir les pràctiques tradicionals que siguin perjudicials per a la salut dels nens" en referència explicita als efectes de la MGF.	La Mutilació Genital Femenina, qualsevol que sigui la classe de mutilació practicada, constitueix un DELICTE DE LESIONS tipificat en els articles 147, 148, 149 i 150 del Codi Penal: **Article 149 del Codi Penal**, segons la redacció donada per la Llei Orgànica 11/2003: *"El que causi a un altre, una mutilació genital en qualsevol de les seves manifestacions, serà castigat amb la pena de presó de sis a dotze anys".* Si la víctima fos menor o incapaç, serà aplicable la pena de inhabilitació especial pel exercici de la pàtria potestat, tutela, curatela, guarda o acolliment pel temps de quatre a deu anys, si el jutge ho considera adequat al interès del menor o incapaç.Bé jurídic protegit, en aquest tipus penal: **A** La integritat corporal o física ha constituït l'objecte de protecció en el que sempre s'ha coincidit per doctrina i jurisprudència. Es pot entendre com l'estat del cos en la concreta plenitud anatòmica/funcional interna i externa. Resultarà vulnerada a través de tota pèrdua, inutilització, menyscapte o desfiguració de qualsevol òrgan, membre o part del cos. **B** La menció de la integritat corporal i la salut com un bé jurídic protegit en els delictes de lesions ha merescut una àmplia acollida tant doctrinal com jurisprudencial. **C** Integritat i salut personals tant física com mental de l'ésser humà, segons la definició de SALUT de l'OMS. El bé jurídic protegit en aquestes figures delictives té un directe reconeixement constitucional en el dret a la integritat física i moral recollit en l'article 15 de la Constitució.	-Conveni de l'Haia, sobre *"Competència de les autoritats i llei aplicable en matèria de protecció de menors"* de 5 d'octubre de 1961. **Article 9.6 del Codi Civil** sobre la competència dels tribunals espanyols en matèria de tutela i les mesures de protecció de l'incapaç (menor).

Marc jurídic relatiu a la MGF[1].

Jurisdicció penal	Jurisdicció civil
Ministeri de l'Interior: Dicta la resolució de Prohibició amb informació als ciutadans dels Recursos Legals contra aquesta mesura. **A** Prohibició de sortida del territori espanyol, per evitar que els progenitors traslladin la menor fora d'Espanya. La mesura es dictarà davant del risc cert i imminent de la pràctica de la MGF: *Article 28.2 de la Llei 4/2000 modificada per la Llei 8/2000* (Llei orgànica de Drets i Llibertats dels estrangers a Espanya i la seva integració social) i *article 34 del Reglament d'Execució d'aquesta llei*, aprovat pel *Reial Decret 864/2001*. Raons: **B Motiu:** Raons de salut pública. **C Qui pot sol·licitar-ho:** delegat del Govern a la comunitat autònoma, subdelegat del Govern a la província; Direcció General de la Policia, personal sanitari del sistema nacional de salut. Jutjat d'instrucció penal: Quan s'hagi iniciat un procediment d'Instrucció per a l'esbrinament de la comissió d'un fet delictiu o a proposta del Ministeri Fiscal i s'acordi la prohibició de traslladar la menor fora del territori espanyol, es pot acordar la presentació periòdica de la menor.	Procediment de jurisdicció voluntària: **A Competent:** Jutjat de Família. **B Motiu:** Protecció de menors. **C Qui pot demanar-ne la iniciació:** La Fiscalia de Menors, la menor, qualsevol parent, l'Organisme Tutelar d'Atenció a la Infantesa. **D Mesures:** Urgents de protecció de tutela

Mesures cautelars l'adopció de les quals correspon a la jurisdicció Espanyola[1].

ANNEX 3.



Circuit Nacional per a una intervenció coordinada envers a les Mutilacions Genitals Femenines(23).

ANNEX 4. Study information for the patient. [a]

4.1 Catalan version

FULL D'INFORMACIÓ PER AL PACIENT

PROJECT: HOW INFLUENCES THE MIGRATION AND ACCULTURATION PROCESSES IN ATTITUDES AND CHANGES IN BEHAVIOUR REGARDING FEMININE GENITAL MUTILATION

Introducció

Ens dirigim a vostè per informar-lo sobre un estudi en el qual està invitat a participar. L'estudi ha estat aprovat pel Comitè Ètic d'Investigació Clínica de l'Hospital Universitari de Girona Dr.Josep Trueta.

La nostre intenció és que vostè rebi la informació correcte i suficient perquè pugui avaluar i jutjar si vol o no participar en l'estudi. Llegeixi amb atenció aquest full informatiu i nosaltres li aclarirem els dubtes que en puguin sorgir. A més a més, pot consultar amb les persones que consideri convenient.

Participació voluntària

Ha de saber que la seva participació en aquest estudi és voluntària i que pot decidir no participar i retirar el seu consentiment en qualsevol moment, sense que això suposi cap alteració en la relació metge – pacient, ni es produeixi cap prejudici en el seu tracte. Si decideix participar haurà de firmar el consentiment informat que hi ha a continuació.

Descripció general de l'estudi

Aquest estudi ha estat dissenyat per estudiar com la migració i el grau d'aculturació canvien les seves opinions al respecte de la mutilació genital femenina.
Definim aculturació com el grau d'adaptació i de comprensió de la cultura i l'estil de vida del país de destí, juntament amb la capacitat de crear noves relacions socials.
El que volem és entendre com influeix el fet de portar un temps vivint en una comunitat de la Unió Europea a les vostres cultures i tradicions, principalment en el subjecte de la mutilació genital femenina.
→Vostè ha estat seleccionada perquè l'estudi està basat en una mostra de dones que hagin patit la mutilació genital femenina, que provinguin d'un dels 28 països Africans

[a] This document will be accesible in Catalan, Spanish, English and French

amb més incidència de la pràctica i que estiguin vivint en una de les comarques de Girona en aquest moment.

→La metodologia de l'estudi es basa en la contestació d'un qüestionari amb preguntes sobre informació personal, sanitària, familiar, del seu context social i altres preguntes d'interès. Volem aclarir que en tot moment, estem avaluant una opinió, sense que el coneixement d'aquesta suposi cap conseqüència per a vostè.

→El projecte s'està desenvolupant en dos centres mèdics, a Can Gibert del Pla i el CAP de Salt, durant sis mesos a través del seu metge de capçalera i amb l'ajuda de mediadores.

Beneficis i riscs de la participació

És possible que els resultats obtinguts de l'estudi tinguin poc impacte per a vostè, però ajudaran als professionals a tenir una comprensió més profunda de la situació i és possible que això permeti desenvolupar activitats en un futur de les quals se'n pugui beneficiar. El fer de participar en l'estudi no li suposa cap tipus de risc. Consisteix en un estudi descriptiu en el que estudiarem les opinions sobre un determinat tema, a un determinat col·lectiu social.

Confidencialitat

El tractament, la comunicació i la cessió de les dades de caràcter personal de tots els participants s'ajustaran segons el que dicta la Llei Orgànica 15/1993, del 13 de desembre de protecció de dades de caràcter personal. D'acord amb el que estableix la legislació mencionada, vostè podrà exercir els seus drets d'accés, modificació, oposició i cancel·lació de les dades, dirigint-se al responsable de l'estudi. Les dades recollides per l'estudi estaran identificades per un codi que només vostè i el responsable de l'estudi o col·laboradors podran relacionar amb vostè.

Les dades recollides en aquest estudi podran ser compartides amb la finalitat de recerca amb altres grups, i garantint la confidencialitat com a mínim nivell de protecció de la legislació vigent al nostre país.

L'accés a la seva informació personal quedarà restringida al responsable de l'estudi, col·laboradors, autoritats sanitàries i Comitè Ètic d'investigació clínica.

Al firmar la fulla de consentiment adjunta, es compromet a complir amb els procediments de l'estudi que s'han exposat.

4.2 Spanish version

HOJA DE INFORMACIÓN AL PACIENTE

PROJECT: HOW INFLUENCES THE MIGRATION AND ACCULTURATION PROCESSES IN ATTITUDES AND CHANGES IN BEHAVIOUR REGARDING FEMININE GENITAL MUTILATION

Introducción.

Nos dirigimos a usted para informarle sobre un estudio al que se le invita a participar. El estudio ha sido aprobado por el comité ético de investigación clínica del Hospital Universitario de Girona Dr.Josep Trueta.

Nuestra intención es que usted reciba la información correcta y suficiente para que pueda evaluar i juzgar si quiere o no participar en este estudio. Para esto lea esta hoja informativa con atención y nosotros le aclararemos las dudas que le puedan surgir. Además, puede consultar con las personas que usted crea convenientes.

Participación voluntaria

Debe saber que su participación en este estudio es voluntaria y que puede decidir no participar y retirar su consentimiento en cualquier momento, sin que esto le suponga una alteración de la relación médico - paciente ni se produzca perjuicio alguno en su tratamiento. Si decide participar en el estudio tendrá que firmar el consentimiento informado después de leer esta hoja de información.

Descripción general del estudio

Este estudio ha sido diseñado para estudiar como la migración i el grado de aculturación de una mujer, cambian sus opiniones en cuanto la mutilación genital femenina.

Definimos “aculturación” como el grado de adaptación y de comprensión del la cultura y del estilo de vida del país de destino, juntamente con la capacidad de crear nuevas relaciones sociales.

Lo que queremos es entender como influye el hecho de llevar un tiempo viviendo en una comunidad de la Unión Europea a vuestras culturas y tradiciones, sobretodo en el tema de la mutilación genital femenina.

→Usted ha sido seleccionada porqué el estudio está basado en una muestra de mujeres que hayan sufrido mutilación genital femenina, que provengan de uno de los

28 países Africanos con más incidencia de la práctica y que ahora estén viviendo en una de las comarcas de Girona.

→La metodología del estudio se basa en la contestación de un cuestionario con preguntas sobre información personal, sanitaria, familiar, de su contexto social y otras preguntas de interés. Queremos dejar claro que estamos estudiando una opinión, sin que el conocimiento de esta pueda tener ninguna consecuencia para usted.

→El proyecto se está desarrollando en dos centros médicos, "Can Gibert del Pla" y "CAP de Salt" durante seis meses, a través de su médico de familia y la ayuda de mediadoras.

Beneficios i riesgos de participación

Es posible que los resultados obtenidos de este estudio tengan poco impacto para usted, pero ayudara a los profesionales a tener una comprensión más profunda de la situación y es posible que esto permita desarrollar actividades de las cuales pueda beneficiarse en un futuro. El hecho de participar en el estudio no le somete a ningún tipo de riesgo. Se trata de un estudio descriptivo en el que estudiamos las opiniones de un determinado grupo social.

Confidencialidad

El tratamiento, la comunicación y la cesión de los datos de carácter personal de todos los sujetos participantes se ajustarán por lo dispuesto en la Ley Orgánica 15/1993, del 13 de diciembre de protección de datos de carácter personal. De acuerdo con lo que se establece en la legislación mencionada, usted puede ejercer los derechos de acceso, modificación, oposición y cancelación de datos, para lo cual se tendrá que dirigir a su responsable del estudio. Los datos recogidos para el estudio estarán identificados mediante un código y sólo su responsable del estudio o colaboradores podrán relacionar estos datos con usted.

Loa datos recogidos podrán ser compartidos con la finalidad de investigación con otros grupos de trabajo, garantizando la confidencialidad como mínimo a nivel de protección de la legislación vigente en nuestro país.

El acceso a su información personal quedará restringido al responsable del estudio, colaboradores, autoridades sanitarias y al Comité Ético de Investigación Clínica.

Al firmar la hoja de consentimiento adjunta, se compromete a cumplir con los procedimientos del estudio que se le han expuesto.

ANNEX 5. Informed consent for participation[a]

5.1 Catalan version

CONSENTIMENT INFORMAT
PROJECT: HOW INFLUENCES THE MIGRATION AND ACCULTURATION PROCESSES IN ATTITUDES AND CHANGES IN BEHAVIOUR REGARDING FEMININE GENITAL MUTILATION
Jo…… Confirmo que: • He llegit el document informatiu que se m'ha entregat. • He pogut fer preguntes sobre l'estudi. • Han pogut respondre a les meves preguntes de forma satisfactòria. • He rebut informació suficient sobre l'estudi. Entenc que la participació és voluntària i que puc retirar-me de l'estudi en qualsevol moment sense que això repercuteixi en la qualitat de la meva assistència. En conseqüència, dono lliurement la meva aprovació per participar en l'estudi i dono consentiment per l'accés i utilització de les meves dades en les condicions detallades a la fulla informativa, sempre en conformitat amb la Llei Orgànica 15/1999 del 13 de desembre, sobre protecció de dades personals.
Firma del participant: En data _ / _ / _

[a] This document will be accesible in Catalan, Spanish, English and French

5.2 Spanish version

CONSENTIMIENTO INFORMADO
PROJECT: HOW INFLUENCES THE MIGRATION AND ACCULTURATION PROCESSES IN ATTITUDES AND CHANGES IN BEHAVIOUR REGARDING FEMININE GENITAL MUTILATION
Yo…… Confirmo que: • He leído la hoja de información que se me ha entregado. • He podido hacer preguntas sobre el estudio. • Han respondido mis preguntas de forma satisfactoria. • He recibido información suficiente sobre el estudio. Comprendo que la participación es voluntaria y que puedo retirarme del estudio en cualquier momento i sin que esto repercuta en la calidad de mi asistencia médica. En consecuencia, presto libremente mi aprobación para participar en el estudio y doy mi consentimiento para el acceso y la utilización de mis datos en las condiciones detalladas en la hoja de información, siempre en conformidad con la Ley Orgánica 15/1999, de 13 de diciembre, sobre la protección de datos de carácter personal.
Firma del participante: En fecha _ / _ / _

ANNEX 6. Questionnaire for data collection[a]

6.1 English version

1.

PERSONAL INFORMATION

Identification code: Date of birth (DD/MM/YYYY):

Country of origin: Region:

Ethnic group:

Number of years in Catalunya: (age of arrival) Resident city:

Resident status:

HEALTH INFORMATION

Are you mutilated?

2.

FAMILIAR INFORMATION

Number of members of the living place:

Relation with these members (mother, wife, …)

Is the husband working?

Number of children: Number of children at school:

Number of children at the country of origin:

Are you considering having more children here in Catalunya?

SOCIAL CONTEXT INFORMATION

Are you working? Where? Since when?

Do you speak Catalan? Do you assist any Catalan lessons?

Have you been living in another European country? For how long?

Have you attended any group activity? Do you participate in any association? Which?

Do you plan to return to your country?

MORE THINGS

Are your daughters mutilated? If some of your daughters are not mutilated, have they ever been to the country of origin?

Have you received information about what mutilation is? Through who or how?

Some woman of your environment have had reconstructive surgery?

Have you ever thought about having reconstructive surgery?

CONCLUSION

Do you agree with the practice of Feminine Genital Mutilation? If you agree what are the reasons?

- Hygiene ☐
- Tradition/Customs ☐
- Aesthetics reasons ☐
- Health ☐
- Because of your husband ☐
- Because of your family ☐

3.

CONSIDERATIONS

6.2 Catalan version

1.

INFORMACIÓ PERSONAL

Codi d'identificació: Data de naixement (DD/MM/YYYY):

País d'origen: Regió:

Grup ètnic:

Numero d'anys a Catalunya (Edat d'arribada): Lloc de Residència:

Estatus com a Resident:

INFORMACIÓ MÈDICA

Ha estat mutilada?

2.

INFORMACIÓ FAMILIAR

Número de persones amb les que viu:

Relació amb els membres amb qui conviu (mare, filla, dona, …)

El seu marit treballa?

Número de fills: Número de fills escolaritzats:

Número de fills al país d'origen:

Ha considerat alguna vegada tenir més fills aquí a Catalunya?

INFORMACIÓ DEL CONTEXT SOCIAL

Vostè treballa? On? Des de quan?

Parla Català? Va a classes de Català?

Ha viscut en un alter país d'Europa abans de venir aquí? Durant quant de temps?

Ha participat mai en alguna activitat en grup? Forma part d'alguna associació? Quina/es?

Ha pensat mai en tornar al seu país d'origen?

ALTRES

Estan les seves filles mutilades? Si alguna ho està, ha viatjat mai al seu país d'origen?

Ha rebut informació sobre la mutilació genital femenina? A través de qui o com?

Alguna dona del seu entorn ha estat sotmesa a una cirurgia reconstructiva?

Ha pensat mai en una cirurgia reconstructiva?

CONCLUSIÓ

Estàs d'acord amb la pràctica de la mutilació genital femenina? Si ho estàs, quins són els teus motius?

- Higiene ☐
- Tradició/costums ☐
- Raons estètiques ☐
- Salut ☐
- Pel meu marit ☐
- Per la meva família ☐

3.

ASPECTES A DESTACAR

[a] This document will be accesible in Catalan, Spanish, English and French