



NORWEGIAN MINISTRIES

Action Plan 2008–2011

Action Plan for Combating Female Genital Mutilation

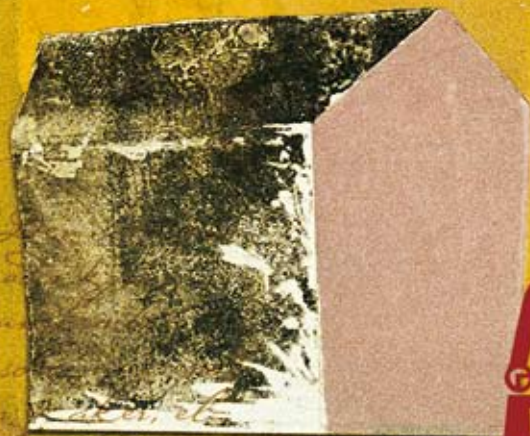
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Foreword

Female genital mutilation is prohibited and punishable by law in Norway. The practice conflicts with fundamental human rights and with the United Nations conventions on the rights of women and of children. Article 24 of the UN Convention of the Rights of the Child establishes that children have a right to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

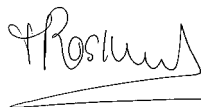
Female genital mutilation (FGM) is a grave violation of these rights and it has serious health-related and social consequences for the girls affected. These violations must be combated through long-term, goal-oriented efforts that focus on prevention and opinion-changing. Everyone must make an all-out effort and cooperation between affected groups and expert communities must be strengthened. Prevention of female genital mutilation is the long-term target. In the meantime, girls and women who have been subjected to genital mutilation must be given relevant and efficacious treatment. This is underlined in this Action Plan.

Female genital mutilation is practised by certain ethnic groups, primarily in Africa but also in some Asian

countries. Many of the people who have come to Norway from areas where FGM is widespread disapprove of the practice. Nonetheless, persons with backgrounds from countries which practise FGM are bound to attract attention, although this may be experienced as stigmatisation. Adult women who have been subjected to genital mutilation themselves, and who are now working to prevent new violations, may find this attention unpleasant. However, the Government deems it important to stress that genital mutilation is regarded an extremely serious violation of girls and that a strong focus is absolutely essential.

This Action Plan places the responsibility for efforts to combat female genital mutilation even more clearly with the national, regional and local authorities. The Government calls for close cooperation between the authorities and the affected groups. A national advisory group will therefore be set up as part of this cooperation.


This Action Plan is the result of the joint efforts of seven ministries. The responsibility for coordinating the work to combat female genital mutilation lies with the Ministry of Children and Equality.



Minister of Children and Equality



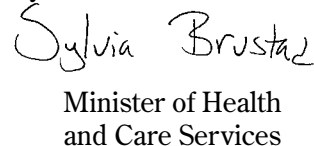
Minister of Labour
and Social Inclusion



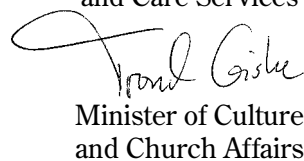
Minister of Justice
and the Police



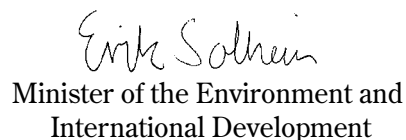
Minister of Education



Minister of Health
and Care Services



Minister of Culture
and Church Affairs



Minister of the Environment and
International Development

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1. Facts about female genital mutilation

FEMALE GENITAL MUTILATION

In research literature and in reports issued by the World Health Organization (WHO), different terms are used to describe female genital mutilation. One of those is female circumcision. Documents issued by Norwegian ministries use the term female genital mutilation, FGM, to emphasise that this is a serious violation of girls and women.

According to WHO, female genital mutilation constitutes all procedures which involve partial or total removal of the external female genitalia or other injury to the female genital organs. Various forms of FGM are practised. The term genital mutilation can also be applied to the so-called Sunna circumcision. Whether the procedure is carried out for cultural, religious or other non-therapeutic reasons, it is still genital mutilation. More information is available on WHO's website.¹

PREVALENCE OF FEMALE GENITAL MUTILATION

Global

WHO estimates that 130-140 million girls and women worldwide have been subjected to genital mutilation and that approximately three million girls undergo the procedure each year. FGM is associated with ethnicity and not with national states. The practice is widespread in 28 countries in Africa and the Middle East, but it is also found among groups in India, Indonesia and Malaysia.²

Genital mutilation is a practice that is constantly changing. This can be seen, for example, in the forms

of genital mutilation that are practised by different groups and in the age at which the child is mutilated. While we see the practice spreading as a result of conflict, it is positive to see that the prevalence of the practice in many countries, such as Ethiopia, Eritrea, Kenya and Tanzania, is falling as a result of focus on education and financial support for local processes of change. This shows that such focus is worthwhile.

Norway

We lack reliable data showing how many girls and women living in Norway have been genitally mutilated. A survey has been initiated to learn more about the scope of FGM in Norway and about the number of girls who may be in danger of being subjected to the procedure. The Ministry of Children and Equality and the Ministry of Health and Care Services have given this task to the Institute for Social Research, which will submit its report in spring 2008. The Institute will also establish whether the duty of prevention is being observed and whether healthcare personnel make use of their duty to report cases to the child welfare service.³

RELIGION AND CULTURE

In countries where female genital mutilation is widespread, the practice has been spun into a web of positive meaning, which gives the tradition a moral and religious rationale. Any practising of the tradition in Norway and other Western countries is closely linked with the practice in the country of origin. People who practise FGM believe that it is necessary in order to be a clean woman with high morals. They claim that

¹ <http://www.who.int/mediacentre/factsheets/fs/241/en/index.html>

² *Progress No 72-2006*: <http://www.who.int/reproductive-health/hrp/progress/72.pdf> (p. 2 and 3)

³ See Chapter 4 for more information about duty of prevention

no man will marry a woman who has not been genitally mutilated. Some of the practitioners believe that the custom has been ordained by their religion, but no religion demands that girls and women have to be genitally mutilated. Female genital mutilation dates back to pre-Christian and pre-Islamic times and it is practised by Christians, Jews and Muslims.

THE ASPECT OF GENDER EQUALITY

Female genital mutilation conflicts with a number of fundamental gender equality principles, in particular the principle that women have the right to control their own bodies, sexuality and health. The procedure is carried out by women and is frequently ordered by mothers, in order to ensure marriage and thus a social and financial future for their daughters. In working to combat FGM, it is therefore necessary to take into consideration the interest, fear, knowledge and beliefs of both men and women. Mothers and fathers as tradition bearers must learn about the legal, cultural and health-related consequences of the procedure, so that they can protect their daughters from genital mutilation. Men also need to learn and understand that it is in everyone's interest that women are not mutilated and thereby have better health and increased sexual enjoyment.

HEALTH-RELATED CONSEQUENCES OF FEMALE GENITAL MUTILATION

Female genital mutilation is a procedure that is harmful to health. The acute complications arising from the procedure itself are pain, bleeding, difficulty in passing urine due to swelling, and damage to the urethra, bladder, vagina and rectum. Moreover, sores caused by the procedure can develop and lead to more extensive infections or blood poisoning. Haemorrhaging and infection may be life-threatening and fatal. In many cases where complications arise, the girls and woman have no access to medical care. There are no mortality statistics for this procedure.

A large number of women who have suffered extensive forms of genital mutilation develop chronic abdominal disorders. Known long-term consequences are slow, painful urination, frequent urinary infections, chronic pelvic infection, scar tissue tumours, vaginal cysts, accumulation of menstrual blood in the vagina, menstrual pain, painful sexual intercourse, inability to achieve orgasm and infertility. Some of these disorders can also be caused by less extensive forms of genital mutilation. In the case of women whose vulva has been sewn together (infibulation), surgical opening will alleviate some of these problems.

Women who have undergone genital mutilation have a higher risk of complications in childbirth. Recent research indicates that women with less extensive FGM also have a higher risk, and the risk increases the more extensive the procedure.⁴ There is a higher frequency of acute Caesarean sections, post-natal haemorrhaging, need to resuscitate the baby and stillbirth or death during the first week after birth among women who have undergone FGM.

It is often reported that the pain and experience of the procedure leave a mental trauma that may be reactivated later in life in situations that bring back memories of the mutilation, such as sexual debut, childbirth and vaginal examination.

During the past year, a number of different actors have proposed that compulsory clinical examination of girls' genitalia should be introduced, in order to prevent genital mutilation. Many groups are opposed to such a measure. The question of compulsory clinical examinations will be considered when the results of the Institute for Social Research's survey are available in spring 2008, and it will therefore not be discussed in this Action Plan.

⁴ www.who.int/Health_topics/female_genital_mutilation/publications. *Lancet* 2006, 367: 1835-41.

2. Greater effort to combat female genital mutilation

BACKGROUND FOR A NEW ACTION PLAN

In 1995, Norway passed a law prohibiting female genital mutilation and the government's first action plan against female genital mutilation was launched in 2000. In Autumn 2001 a three-year national project, the OK Project (Care and Knowledge against Female Circumcision), was established for the purpose of implementing a large number of the measures in the action plan. In 2002, further funds and measures were provided to boost efforts. The object of the action plan was to prevent genital mutilation of girls in Norway, help girls and women who had already undergone genital mutilation, establish cooperation with organisations and individuals, and contribute to the elimination of female genital mutilation internationally.

The Government has evaluated parts of the work that has been carried out in compliance with the above action plan. An evaluation of the OK Project⁵ showed that the strategy of using knowledge and care as methodical tools in efforts to prevent FGM was successful. The Government has also undertaken an impact assessment of the opinion-shaping work of the PMV Centre for Health, Dialogue and Development in 2006.⁶ Both evaluations and other feedback, for example from a think tank in spring 2007, have clarified the need for greater effort and continuity in future efforts.⁷

OBJECTIVES AND TARGET GROUP FOR THIS ACTION PLAN

Changes in attitude and changes in practice must take place within the affected groups. It is therefore very important to involve the different groups with backgrounds from countries that practise female genital mutilation. This will be done by establishing a national advisory group, in keeping with the intention of this Action Plan to give representatives of the affected groups/communities the opportunity to provide their own input during the Action Plan period.⁸ Moreover, funds have been earmarked to allow the affected groups themselves, through NGOs, to apply for support for opinion-shaping work. Relevant religious communities will also be involved in the work.

Important elements of the measures in the Plan will be carried out by the public services. The focus of the Plan is on anchoring public measures in, for example, the health service, child welfare service and schools. The aim is to prevent FGM from taking place and to offer relevant treatment to girls and women who have undergone the procedure. Particular importance will also be placed on practising the duty of confidentiality, the duty of disclosure and the duty of prevention, and on coordination and teamwork. It is essential that the measures within the public services meet the needs of the people affected by the practice of female genital

⁵ NIBR Report 2005:8 Inger Lise Lien, *Tiltak mot kjønnslemlestelse (Measures to Combat Female Genital Mutilation)*

⁶ Memorandum No 2:2007 *Dialog og bottom-up som tiltak mot omskjæring (Dialogue and bottom-up as measures to combat female genital mutilation)*, Katrine Fangen and Cecilie Thun, University of Oslo

⁷ Ref also *Endring innenfra (Change from the inside out)*, Final report for the OK Project 2001-2004

⁸ See Measure 19

mutilation in a positive and respectful way. Public services must be adapted to meet the diversity of ethnic, cultural, linguistic and religious backgrounds in the population. Adequate knowledge and efficient methods are needed to make it possible to see the users' needs and viewpoints. This includes the correct use of interpreters and information adapted for the different user groups.⁹

The objectives of this Action Plan for combating female genital mutilation can be divided into six main categories:

- Effective enforcement of legislation
- Competence building and the transfer of knowledge
- Prevention and opinion-building
- Available health services
- Extra effort at holiday times
- Stronger international efforts

The target group for the measures in this Plan is girls and women who have undergone or may undergo genital mutilation, public and private service providers and institutions, men with backgrounds from the risk countries, NGOs and relevant religious communities.

RELATION TO OTHER ACTION PLANS

Female genital mutilation is a form of domestic violence and the measures in this Action Plan tie in with relevant measures in the Government's Action Plan for Combating Violence in Close Relationships,¹⁰ and the Action Plan to Prevent Forced Marriages.¹¹ Many major players, such as the police and the child welfare service, have central roles in all three plans, which

contain a number of overlapping or similar measures. Since genital mutilation is a form of physical violation, the Government's «Strategy to Combat Sexual and Physical Child Abuse» (2005–2009) also touches on the problems.

Norway is involved in international efforts to combat female genital mutilation. A separate international action plan for combating female genital mutilation was launched in 2003 and will be considered for extension in 2010.¹² Measures to prevent FGM are also included in the Government's Action Plan for Women's Rights and Gender Equality in Development Cooperation, which was approved on International Women's Day on 8 March 2007.¹³

RESPONSIBLE MINISTRIES

The Ministry of Children and Equality (BLD) is responsible for coordinating the Government's efforts to combat female genital mutilation. The Ministries of Labour and Social Inclusion, Health and Care Services, Justice and the Police, Education, Culture and Church Affairs, and Foreign Affairs are also responsible for the measures in this Action Plan. Each ministry has the main responsibility for implementing measures within its own area of responsibility and is a partner in the implementation of other measures. The ministry listed first among the ministries responsible for each of the measures in this Plan has the main responsibility for implementation of the measure.

⁹ Go to www.imdi.no for more information about equality in public services

¹⁰ Action Plan against Violence in Close Relationships 2008-2011, Vendepunkt, publication code: G-0398.

¹¹ Action Plan against Forced Marriages 2008-2011, publication code: Q-1131 B

¹² The Government's International Action Plan for Combating Female Genital Mutilation can be downloaded from <http://odin.dep.no/ud>

¹³ The complete action plan is accessible at www.publikasjoner.dep.no

3. Measures

EFFECTIVE ENFORCEMENT OF THE LAW

1. Prepare a guide on relevant regulations, roles and responsibilities relating to female genital mutilation (BLD)¹⁴
2. Investigate the need to amend the rules governing the limitation period (JD)
3. Draw up guidelines for confiscating passports when FGM is the suspected purpose of the journey (JD)
4. Measures in immigration administration to prevent FGM (AID)

COMPETENCE BUILDING AND KNOWLEDGE TRANSFER

5. Establish a national human resource function focusing on FGM (BLD)
6. Carry out a survey of persons working with FGM and their need for knowledge (BLD).
7. Arrange cross-disciplinary regional network meetings and meetings to exchange experience (BLD)
8. Clarify the scope of FGM cases and the need for special competence in the municipal child welfare service in this field (BLD)
9. Prepare a training programme to raise competence levels among employees in the child welfare service (BLD)
10. Include FGM as a theme in Norway's parental guidance programme (BLD)
11. Evaluate routines for systematic registration of FGM cases (BLD and HOD)
12. Include information about FGM in the training programme for new religious leaders (KKD)
13. Develop resource materials on FGM for the use of pupils and teachers (KD)
14. Strengthen the school counselling service (KD)
15. Make use of parent networks in schools (KD)
16. Raise the level of competence among healthcare personnel (HOD)
17. Strengthen competence and organisation in police districts (JD)
18. Draw the attention of recently arrived immigrants to FGM and the consequences (AID)

PREVENTION AND OPINION-BUILDING IN RELEVANT COMMUNITIES

19. Establish and manage a national advisory group (BLD)
20. Give financial support to NGOs' preventive and opinion-shaping efforts relating to FGM (KKD)
21. Involve religious communities in efforts to combat FGM (KKD)
22. Ensure that family health clinics and school health services address information to young people, women, men and parents in the affected groups (HOD)

¹⁴ In the remainder of this translation, the Norwegian abbreviations for the various ministries (see above) will be used instead of their full names in English, for example BLD for the Ministry of Children and Equality

23. Continue and intensify efforts to combat FGM in the resource groups in the five healthcare regions (HOD)
24. Set up a female genital mutilation helpline (BLD)
25. Continue developing information material about FGM (BLD)
26. Continue developing a web-based question-and-answer service for young people (BLD)

AVAILABLE HEALTHCARE SERVICES

27. Specialist health service measures to prevent FGM (HOD)
28. Review regulations and the guide for family health clinics and school health service and other relevant guides and circulars on FGM (HOD)
29. Review the routines for interaction between first and second-line services in the health sector (HOD)
30. Strengthen information about FGM in connection with prenatal check-ups (HOD)
31. Strengthen information about FGM to affected parents in connection with medical examinations at family health clinics (HOD)
32. Revise the Guide to Healthcare for Asylum Seekers and Refugees (HOD)
33. Evaluate the possibility of offering girls and women documentation that they have not undergone FGM (HOD)
34. Evaluate information work in the health service (HOD)

EXTRA EFFORT AT HOLIDAY TIMES

35. Send out annual information letters concerning the duty of prevention and the duty of disclosure (BLD)
36. The ministries will consider annual summer measures (BLD)

STRONGER INTERNATIONAL EFFORTS

37. Raise the subject of FGM during political talks with other countries (UD)
38. Communicate information about Norwegian legislation on female genital mutilation to relevant countries (UD)
39. Agree with relevant embassies in Norway and the Nordic countries to make information about Norwegian legislation on FGM available to applicants for visas at these embassies (UD)
40. Transfer experience and results of international efforts to combat FGM (UD)

EVALUATION OF THIS ACTION PLAN

41. Evaluation of this Action Plan (BLD)

AID	Ministry of Labour and Social Inclusion	KD	Ministry of Education and Research
BLD	Ministry of Children and Equality	KKD	Ministry of Culture and Church Affairs
HOD	Ministry of Health and Care Services	UD	Ministry of Foreign Affairs
JD	Ministry of Justice and the Police		

4. Effective enforcement of the law

IMPORTANT LEGISLATION IN THIS FIELD

Norway has passed a law prohibiting female genital mutilation, and it is a punishable offence to practise or aid and abet the practice of female genital mutilation. This prohibition also applies when the procedure is carried out outside Norway. For certain groups of professional practitioners and employees, it is a punishable offence not to attempt to prevent FGM.

Furthermore, everyone who works for public bodies or services, and a number of practitioners who have taken a vow of professional secrecy, have a statutory

duty to report to the municipal child welfare service any suspicion that a child is being maltreated in his/her home or exposed to other forms of gross neglect. Genital mutilation is regarded as gross neglect. A justified concern or suspicion that a child may be subjected to genital mutilation must therefore always be reported to the child welfare service. There may sometimes also be a duty to report in cases where genital mutilation has already been carried out.

ACT RELATING TO THE PROHIBITION OF FEMALE GENITAL MUTILATION, SECTIONS 1 AND 2

Section 1. Any person who wilfully performs a procedure on a woman's genital organs that injures or permanently changes the genital organs will be penalized for female genital mutilation. The penalty is a term of imprisonment of up to 3 years, or up to 6 years if the procedure results in illness or occupational disability lasting for more than 2 weeks, or if an incurable deformity, defect or injury is caused, and up to 8 years if the procedure results in death or substantial injury to the woman's body or health. A person who aids and abets another in the practice of female genital mutilation may be penalized in the same way.

Penalties as mentioned in the first paragraph will be imposed for reconstruction of female genital mutilation.

Consent does not provide exemption from criminal liability.

Section 2. A fine or a prison sentence of up to one year may be imposed on practitioners of professions and employees in day care centres, child welfare services, health and social services, schools and out-of-school care schemes and religious communities who deliberately refrain from trying to prevent an act of genital mutilation by making a report or in other manner, cf. Section 1. The same applies to persons of authority in religious communities. The duty to prevent an act of genital mutilation applies without regard to duty of confidentiality. Omission to act is not punishable by law if the genital mutilation does not reach completion or a punishable attempt.

Section 2 added by Act No. 33 of 28 May 2004 (entered into force on 1 September 2004)

ACT RELATING TO CHILDREN, SECTION 6–4, SECOND AND THIRD PARAGRAPHS

«Notwithstanding the duty of secrecy, public authorities shall on their own initiative disclose information to the municipal child welfare service when there is reason to believe that a child is being mistreated at home or is subjected to other serious deficit of parental care, cf. sections 4–10, 4–11 and 4–12, or when a child has shown persistent, serious behavioural problems, cf. section 4–24. Organisations and private entities that perform tasks for the State, county municipality or municipality are considered on a par with public authorities. Public authorities are also obligated to disclose such information when ordered to do so by agencies which are responsible for implementation of the Act. When so instructed by these agencies, public authorities are also obligated in connection with cases to be settled by the County Board pursuant to sections 4–19, 4–20 and 4–21 to disclose information that is necessary to determine whether moving back to parents or spending time with them may lead to a situation or risk to the child as mentioned in sections 4–10, 4–11 or 4–12.

Practitioners of professions pursuant to the Act relating to Healthcare Personnel, Act relating to Mental Health Care, Act relating to Municipal Health Services, Act relating to Family Counselling Services and Mediators in Matrimonial Cases (cf. Marriage Act), and the Act relating to independent schools are also obligated to disclose information pursuant to the rules of the second paragraph.»

The duty of the child welfare service to disclose information is also laid down in a number of other Acts, including section 22 of the Act relating to Day Care Centres, section 15–3 of the Education Act, section 8–8a of the Social Services Act, section 13f of the Public Administration Act and section 33 of the Act relating to Healthcare Personnel.

INTERNATIONAL FRAMEWORKS AND HUMAN RIGHTS COMMITMENTS

The right to good health is laid down in the Universal Declaration of Human Rights of 1948. The United Nations Convention on Civil and Political Rights prohibits discrimination on grounds of gender. As does the Convention on Economic, Social and Cultural Rights, which also directs member States to safeguard citizens' rights to health. The United Nations Convention on the Rights of the Child contains a wide range of rules for the protection of children and directs member States to safeguard the child's health and abolish traditions that can harm the child's health. The Convention on the Rights of Women also contains provisions of significance for reproductive health and female genital mutilation. The Maputo Protocol of 2003 is the first legal instrument to protect women in Africa from all forms of violation, including genital mutilation.

Female genital mutilation is also prohibited by law in many of the countries where it is practised, such as Ethiopia, Eritrea, Kenya, Tanzania, Sudan and soon also in Somalia. Although the adoption of legislation prohibiting genital mutilation may have a significant deterrent effect, implementation has proved difficult in practice.

NEW GUIDE

In summer 2007, the Ministries of Children and Equality, Health and Care Services, and Justice and the Police distributed a brief presentation of the regulations regarding female genital mutilation.¹⁵ This letter contained, among other things, information about the duty to disclose information to the child welfare service and about the duty of prevention as laid down in the Act relating to the prohibition of female genital mutilation. It also explained what the child welfare service can do to prevent FGM and what the child welfare service and the health service can do to help girls who have been subjected to FGM.

¹⁵ Go to www.regjeringen.no

The above letter also stated that a circular would be distributed. This circular will instead be issued in the form of a more detailed guide and be included as one of the measures in this Plan. The main purpose will be to provide guidance on what the individual services can or must do if there is any suspicion or concern that a girl is in danger of being, or has already been, subjected to FGM.

RULES REGARDING THE LIMITATION PERIOD

The adults who would normally be the natural persons to safeguard the child's interests will probably be involved in the violation themselves and will give the impression that the procedure is necessary and right. It can take many years before the person who has been mutilated is ready to accept what she has been subjected to and decide whether she wants to report the matter or not. Potential violators must not be allowed to speculate in the crime being statute-barred when the victim is old enough to report the crime. In order to act as a general deterrent, the limitation period should be long. Under current legislation, the limitation period for criminal liability for female genital mutilation is ten years after the procedure took place.

The special considerations that come into play in these types of cases may indicate that the limitation period should first come into effect when the genitally mutilated girl reaches the age of 18. On the other hand, such a long limitation period might significantly weaken the possibility of punishing the offence on the basis of evidence. The question should nonetheless be looked into more closely.

MEASURES IN IMMIGRATION ADMINISTRATION

In recent years, there has been an ever-increasing focus to gender-related notes on applications for asylum. In the draft of a new immigration act (Ot.prp. nr. 75 (2006–2007)) importance has been attached to a special gender perspective in the evaluation of refugees' legal rights. It has not been suggested that the act should contain a special provision, but that special guidelines should be drawn up for this. The Minister

of Labour and Social Inclusion has initiated work on such guidelines and they will be sent to the Directorate of Immigration in the form of a circular. It is planned that the guidelines will be available in spring 2008.

MEASURES 1–4

1. Prepare a guide on relevant regulations, roles and responsibilities relating to female genital mutilation

A guide will be prepared on the regulations relating to female genital mutilation. The guide will contain, among other things, a description of the roles, tasks and responsibilities of the health service, child welfare service and the police in this respect. The guide will moreover present relevant regulations regarding the duty and right to disclose information and the possibility of cooperation between the services. It will present the duty of the health service, day-care centres, schools and other services to report cases of FGM to the child welfare service. The duty of prevention pursuant to the Act relating to Female Genital Mutilation will also be discussed in the guide.

Responsible ministry/ministries: BLD, HOD, JD and KD
Implementation: 2008

2. Investigate the need to amend the rules relating to the limitation period

The Ministry of Justice and the Police will consider whether an amendment should be proposed so that the limitation period for female genital mutilation will run from the date of the injured party's 18th birthday.

Responsible ministry/ministries: JD
Implementation: 2008

3. Draw up guidelines for confiscation of passports when female genital mutilation is the suspected purpose of the journey

Under the provisions of the current Passport Act, it is possible to refuse to issue a passport when there is just reason to believe that the purpose of the journey is unlawful activity. Under the same conditions, it is possible to confiscate a passport. The immigration regulations contain corresponding provisions regarding travel documents and immigrants' passports.

Guidelines will be drawn up for when the police may refuse to issue a passport or demand to have a passport handed in on the suspicion of planned FGM in another country. The guidelines must quote specific reasons for confiscation, describe what can constitute a suspicion and describe the weighing of the information in the light of who provides the information. Specific information must be available from, for example, professionals in the health sector, schools or child welfare service. The guidelines must stipulate which measures should be initiated when persons/families arrive at the place of departure and are recognised on the basis of the report received.

Responsible ministry/ministries: JD
Implementation: 2008

4. Measures in immigration administration to prevent female genital mutilation

The Norwegian Directorate of Immigration has started a project aiming to review various aspects of the handling of cases where female genital mutilation may be relevant.¹⁶ Guidelines will be drawn up explaining how the immigration authorities are to handle such cases. The aim is to ensure that girls who risk genital mutilation by returning to their home country are given protection in Norway.

Responsible ministry/ministries: AID
Implementation: Spring 2008

¹⁶ The project is called UTMOK, go to www.udi.no for more information

5. Competence building and the transfer of knowledge

BACKGROUND

One of the objectives of this Action Plan is to identify girls and women who have been or may be subjected to FGM and give them the help they need, regardless of which public or private institution they contact. This requires a broad focus on cooperation, competence building and the transfer of knowledge.

The Norwegian Directorate for Health and Social Affairs has been working on competence building and opinion-forming in relation to FGM for several years. The aim of this work has been to ensure special competence in the health regions and to take care of genitally mutilated women at out-patient clinics. The Directorate has also arranged annual interdisciplinary national and regional health seminars. To continue the work of the OK Project, the Directorate has established a resource group in each health region.¹⁷ The task of the groups, which consist of representatives of the health services and affected groups with ethnic minority backgrounds, is to spread knowledge about female genital mutilation, particularly among health-care personnel.

The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) was founded in 2004, as a inter-ministerial¹⁸ initiative to strengthen research, development work, knowledge dissemination and competence building in the field of violence and trauma. The Norwegian Centre for Minority Health Research (NAKMI) was established in 2003 to engage in knowledge dissemination, research and develop-

ment, and exchange of information nationally and internationally on somatic and mental health and care of persons with ethnic minority backgrounds. Regional centres for violence and traumatic stress studies and prevention of suicide (RVTS) have been established to contribute to better, more comprehensive services, by working to increase competence and improve interdisciplinary and inter-agency cooperation in the regions.

Pursuant to this Plan, a national human resource function will be established. If a comprehensive, interdisciplinary effort to combat FGM nationally, regionally and locally is to be achieved, the new function will have to work closely with the Directorate of Health and Social Affairs and other relevant national and regional resource centres. Both the Directorate and the newly established human resource function will be given responsibility for several measures in this Plan which involve surveys and competence building and transfer.

RAISING COMPETENCE LEVELS IN THE CHILD WELFARE SERVICE

Female genital mutilation is a new area of work for many child welfare services. The Child Welfare Service needs more knowledge and competence, which includes learning how to identify girls who may be in danger of being subjected to FGM and which steps can and must be taken. The Child Welfare Service must also acquire knowledge about relevant regulations relating to this type of violation.

¹⁷ See Chapter 6, Measure 23

¹⁸ Ministry of Children and Equality, Ministry of Health and Care Services, Ministry of Justice and the Police, Ministry of Labour and Social Inclusion and the Ministry of Defence

TRAINING IN MULTICULTURAL CHILD WELFARE SERVICE

At the request of the Ministry of Children and Equality, the Norwegian Institute for Urban and Regional Research (NIBR) has drawn up a report on a multicultural child welfare service.¹⁹ The Ministry of Children and Equality is following up that report by developing a practical competence building programme for employees in the child welfare service.

PARENTAL GUIDANCE PROGRAMME

The aim of the parental guidance programme (ICDP)²⁰ that is run by the Norwegian Directorate for Children, Youth and Family Affairs is to support and strengthen parents in their role as educators and care persons for their own children, by increasing their awareness and making them attentive to their children's needs. One of the programme modules has been adapted for families with ethnic minority backgrounds, taking into account cultural differences in care values and care practices. The work takes place in groups, mainly in the participants' mother tongue and is led by two promoters: one belonging to the same ethnic minority as the participants and one with a Norwegian background.

PREVENTIVE WORK IN DAY-CARE CENTRES AND SCHOOLS

The social mandate of day-care centres is to offer children under school age a caring and learning environment to the benefit of the children. Day-care centres have a particular responsibility to prevent difficulties and to identify children with special needs. In 2006, more than 80 per cent of all children in Norway between the age of one and five attended a day-care centre. This means that the day-care centre has a prominent place in the everyday lives of very many children and parents. Day-care centre employees have a duty of prevention regardless of their duty of confidentiality. It is therefore important to give information

about female genital mutilation to day-care centre employees in order to emphasise the duty of prevention and also to increase their knowledge in general.

One of the primary objectives of basic education is to ensure that every pupil acquires an understanding of, and accepts, basic human rights, democratic values and equality. Section 9a-1 of the Education Act states that all pupils in primary and secondary schools have the right to a good physical and psychosocial environment which promotes health, well-being and learning. If they are to be able to carry out good preventive work in school and help pupils in difficult situations, school staff must be aware of problems that affect the pupils.

Pupils in primary and secondary schools have the right to the necessary counselling on education, career opportunities, career choices and social questions. Pupils in difficult situations, such as a girl who is worried about being subjected to genital mutilation, may feel the need to speak openly and confidentially with an adult. The school counselling service is a place that pupils can turn to in such a situation. The service must also be bracketed with, for example, the school health service when it comes to competence building and knowledge of public bodies that can provide help.

Parent-school cooperation will help to increase awareness of the parents' role in relation to school, society and their children.

RAISING LEVELS OF COMPETENCE AMONG HEALTHCARE PERSONNEL

If they are to be able to prevent female genital mutilation and provide beneficial treatment, healthcare personnel must have the relevant knowledge about the physical and mental problems and complications FGM can cause. Personnel who wish to achieve a good dialogue with girls/women who are affected by FGM must also have good communicative skills and cultural

¹⁹ NIBR Report 2007:10

²⁰ International Child Development Programmes (ICDP)

understanding. More schooling and information is needed for health visitors/school nurses, midwives, psychologists, general practitioners and municipal medical officers, as well as specialist healthcare personnel.

THE INTRODUCTION ACT

Under the provisions of the Introduction Act²¹, the municipal authorities have a responsibility to arrange Norwegian language training and social studies for immigrants who have been granted a residential or work permit that provides the basis for permanent residence in Norway. This tuition shall be based on the curriculum for Norwegian and social studies for adult immigrants. The social studies curriculum includes such subjects as health, children and family relationships. The subject of FGM is taken up with certain participant groups where this is natural in connection with the other subjects.

MEASURES 5–18

5. Establish a national human resource function focusing on female genital mutilation

The Government will establish a knowledge centre with a national human resource function focusing on female genital mutilation. Its tasks will be to disseminate available knowledge, develop human resources, build networks, carry out research and development and have a general advisory and guidance function vis-à-vis professional practitioners and employees who work in the field.

This measure will be the responsibility of the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS).

Responsible ministry/ministries: BLD, HOD, JD
Implementation: 2008 – 2011

6. Carry out a survey of persons working with female genital mutilation and their need for knowledge

Only by finding out who is working in this field will it be possible to achieve a better and more efficient cooperation across professional groups and relevant communities. The result of this survey will be a document showing who is working with what in the field, using which methods and targeting which groups. The document will be accessible on the Internet. A survey will also be made of competence among professional practitioners and other persons working with FMG in order to facilitate training in the best possible way.

Responsible ministry/ministries: BLD, AID, HOD, JD, UD
Implementation: 2008 – 2001

7. Arrange cross-disciplinary regional network meeting to exchange experience

Interdisciplinary regional network meetings will be arranged for public agencies and organisations that may face problems relating to FMG, such as family health clinics, the school health service, child welfare service, police, day-care centres, schools and NGOs. The object is to build up competence, transfer experience, improve cooperation routines and develop good practice.

Responsible ministry/ministries: BLD, AID, HOD, JD, KD, UD
Implementation: 2008 – 2011

8. Clarify the scope of FGM cases and the need for special competence in the municipal child welfare service

The task of clarifying the scope of cases, experience and need for competence relating to FGM in the municipal child welfare service will be given to the County Governors. Further measures to raise competence levels in the child welfare service will be based

²¹ Act No. 80 of 4 July 2003 relating to an introduction scheme and tuition in the Norwegian language for recently arrived immigrants (the Introduction Act)

on the results of this survey and recommendations from the County Governors.

Responsible ministry/ministries: BLD
Implementation: 2008 – 2011

9. Prepare a training programme to raise competence levels among employees in the child welfare service

Selected university colleges have cooperated on drawing up a training programme for use in a multicultural child welfare service. This programme will be tested out on 120 students at four university colleges. After a trial period, the programme will be evaluated for possible implementation throughout Norway.

Responsible ministry/ministries: BLD
Implementation: 2008 – 2009

10. Include female genital mutilation as a theme in Norway's parent guidance programme

FGM and related themes will be included as a supplementary part of the training of promoters in the minority project (ICDP). These themes can be integrated as part of the larger picture, where the main focus is on body, gender and gender equality. Courses will be arranged in 2008 to bring qualified promoters and trainers up to date on these themes.

Responsible ministry/ministries: BLD
Implementation: 2008 – 2011

11. Evaluate routines for systematic registration of cases of female genital mutilation

A work group will be set up by the Ministry of Children and Equality to put forward proposals for how cases of female genital mutilation can and should be registered in sector systems and/or administrative systems in the relevant services. The work group will explain how registration of these cases can form the basis for better communication between administrative levels

and different agencies, for more research and for national statistics.

Responsible ministry/ministries: BLD, HOD, JD
Implementation: 2008 – 2009

12. Include information about FGM in the training programme for new religious leaders

Leaders in religious communities are important players and disseminators of information. Information about female genital mutilation will be incorporated in the training programme for new leaders. This information will include the health-related consequences of FGM, the prohibition of FGM and the duty of prevention in the Act prohibiting FGM.

Responsible ministry/ministries: KKD, HOD
Implementation: 2008

13. Develop resource materials on female genital mutilation for the use of pupils and teachers

Resource materials on family relationships and sexuality will be updated. These materials will have a positive approach, but it will still be natural to raise issues that may be problematic. The object is to help pupils to acquire knowledge about and an understanding of fundamental human rights, the right to codetermination and gender equality. The material will include background information and advice to teachers, the school counselling service, the school management and owners about how they should react to the suspicion of female genital mutilation, and how to bring the subject up in class and in talks with parents. New information will also be developed that is suitable for pupils and parents. The material will be translated into the relevant languages. A competence building programme for teachers, school counsellors and the school health service will be prepared in connection with this material. Information and links will be updated continuously at www.skolenett.no.

Responsible ministry/ministries: KD, HOD
Implementation: 2008 – 2011

14. Strengthen the school counselling service

Work is being done to strengthen the school counselling service. This will be done, for example, by splitting the service into an educational and career guidance part and a special education counselling part. Regulations will be issued, specifying the responsibilities of each service. Competence criteria will also be drawn up for counsellors, particularly in the field of special education.

Knowledge about special factors that may concern pupils with an ethnic minority background, such as female genital mutilation and honour-related violence, is relevant in the new work of developing indicative competence criteria for the counselling service.

Responsible ministry/ministries: KD
Implementation: 2008 – 2001

15. Make use of parent networks in schools

A project entitled «Minority language parents – a resource for the pupil's education in school»²² will be used as the basis for establishing parent networks in a number of municipalities. Information will be distributed by the National Parents' Committee for Primary and Lower Secondary Education (FUG) in collaboration with the Norwegian Centre for Multicultural Education (NAFO). Material dealing with cooperation between parents in multicultural schools, such as guides and brochures from FUG (translated into many languages) will be used in establishing cooperation between home and school. Here, themes such as female genital mutilation and honour-related violence will be brought up where relevant.

Responsible ministry/ministries: KD
Implementation: 2008 – 2009

16. Raise the level of competence among healthcare personnel

With the assistance of the Directorate for Health and Social Affairs, the regional centres for violence, traumatic stress and prevention of suicide (RVTS), the Norwegian Centre for Minority Health Research (NAKMI) and the regional health authorities, the health sections in the County Governors' offices will arrange county-by-county courses and seminars and other educational measures for district nurses, midwives, psychologists, general practitioners and municipal medical officers, and for specialist healthcare personnel.

The Directorate for Health and Social Affairs will help to ensure that the trade unions prepare their own upgrading courses for the above professionals.

Responsible ministry/ministries: HOD
Implementation: 2008 – 2011

17. Strengthen competence and organisation in the police districts

The National Police Directorate will implement competence-building measures for family violence coordinators, chiefs of police and senior officers in all districts by organizing a national training seminar. Routines will also be drawn up to ensure that knowledge is updated as required and that new appointees in relevant posts receive the necessary training. The National Police Directorate will update its handbook for family violence coordinators.

Responsible ministry/ministries: JD
Implementation: 2008 – 2011

²² Go to www.fug.no/cgi-bin/fug/imaker?id=39205

18. Draw the attention of recently arrived immigrants to female genital mutilation and the consequences

Preparations will be made to include a knowledge-based dialogue on female genital mutilation in the special course in Norwegian language and society for adult immigrants, and background material will be developed containing advice and guidance on how teachers can bring this subject up during the course. This measure ties in with Measure 11 in the action plan to prevent forced marriages and Measure 45 in the action plan to combat violence in close relationships.

Responsible ministry/ministries: AID
Implementation: 2008 – 2011

6. Prevention and opinion-building in affected communities

BACKGROUND

It is a considerable challenge and it can take time for both women and men to abandon a practice they have personally regarded as positive. If we are to prevent girls living in Norway from being subjected to genital mutilation, we will have to cooperate with the affected communities, with women and men, with the young and the old. We will have to inform them about the negative factors of the practice, including the legal prohibition and the fact that FGM is a danger to health and is not prescribed by religion.

NON-GOVERNMENTAL ORGANISATIONS

The NGOs that work to prevent female genital mutilation do a socially important job. They are in dialogue with the risk groups and they are key partners and bridge builders between the minority communities and the public services. Information that is shared directly between young people has a powerful impact. We must therefore involve the non-governmental children and youth organisations and the minority communities in opinion-shaping campaigns.

RELIGIOUS COMMUNITIES

Some people believe that FGM is required by their religion, but no religion demands that girls and women be genitally mutilated. Religious leaders and communities should therefore help to spread this information. Different religious beliefs, cultural backgrounds and traditions pose different challenges for religious communities. Dialogue is a valuable tool for improving understanding of different opinions and beliefs and thus for combating FGM. Dialogue between authorities and religious communities, and between religious communities and members of society, is an important and valuable tool for all parties.

FAMILY HEALTH CLINICS AND THE SCHOOL HEALTH SERVICE

One of the tasks of the family health clinics and the school health service is to promote mental and physical health and to prevent illness and injury in children and young people, and expectant mothers. These institutions have a duty to inform relevant groups about the health-related consequences of FGM and to tell them that because of this, FGM is prohibited in Norway. This information must be given to expectant mothers and to couples before and during pregnancy and after childbirth, and also to children, young people and parents.

MEASURES 19-26

19. Establish and manage a national advisory group

A national advisory group consisting of representatives of affected communities and the authorities will be set up and meet regularly to work on FGM.

Responsible ministry/ministries: BLD, AID, HOD, JD, KD, KKD
Implementation: 2008–2001

20. Give financial support to NGOs' preventive and opinion-shaping efforts relating to female genital mutilation

Support will be given to NGOs to finance preventive and opinion-shaping efforts in the field of FGM.

A number of specific priority areas have been defined for which NGOs can apply for grants, in addition to their general opinion-shaping work.

- Dialogue and conversation groups about FGM
- Work to change attitudes among men and boys
- Young-to-young information and opinion-shaping work among young people
- Cultural events for target groups in Norway using resource persons from the relevant countries of origin
- More cooperation between NGOs with a view to reaching isolated groups
- Closer cooperation with religious communities and leaders

Responsible ministry/ministries: BLD, AID, HOD
Implementation: 2008 – 2011

21. Involve religious communities in efforts to combat female genital mutilation

The Ministry of Culture and Church Affairs will have a dialogue meeting with the Council for Religious and Life Stance Communities and the Islamic Council of Norway to inform them about and define the Government's view of FGM and to encourage the Councils to spread this information and discuss it in relevant communities.

Responsible ministry/ministries: KKD
Implementation: 2008

22. Ensure that family health clinics and the school health service address information to young people, women, men and parents in the affected groups

The Directorate for Health and Social Affairs will cooperate with the County Governors in encouraging the relevant municipalities to establish youth, women's and men's groups under the direction of the family health clinics and the school health service. The family health clinics and school health service will distribute information aiming to persuade groups and individuals to disassociate themselves from FGM and to help girls

and women who have been subjected to FGM to receive the care they need. This information can be linked with the work of the family health clinics and the school health service in the field of family relationships, sexuality and contraception.

Responsible ministry/ministries: HOD
Implementation: 2008 – 2011

23. Continue and intensify efforts to combat female genital mutilation in Norway's five health regions

The Directorate for Health and Social Affairs will cooperate with the Norwegian Centre for Violence and Traumatic Stress Studies (NKTVS), regional centres for violence and traumatic stress studies (RVTS) and the Norwegian Centre for Minority Health Research (NAKMI) in educating the regional resource groups. These groups have representatives from the affected communities. This education will cover the health-related consequences of FGM, the prohibition of FGM, the duty of prevention, religious aspects, etc. This will enable the resource groups to initiate local measures to combat FGM, such as network meetings, theme evenings, think tanks, courses for employees in reception centres for asylum seekers and groups for young people, mothers, parents and men.

Responsible ministry/ministries: HOD
Implementation: 2008 – 2011

24. Set up a female genital mutilation helpline

A national telephone helpline will be set up or further developed to deal with enquiries about FGM.

This will give children and young people who need advice and guidance about FGM somewhere to turn for help. Other people who need information about FGM will also be able to use this telephone service.

Responsible ministry/ministries: BLD, HOD
Implementation: 2009 – 2011

25. Continue developing information material about female genital mutilation

Available information material on FGM will be revised and updated. A general, interdisciplinary guide will be issued and consideration will be given to whether new material should be prepared in addition to what has been suggested in other measures in this Plan. Good routines will be drawn up for how and to whom the information material is to be distributed. An information page will be set up on the Internet.

Responsible ministry/ministries: BLD, AID, HOD, KD
Implementation: 2008 – 2011

26. Continue developing a web-based question-and-answer service for young people

The ung.no website, which is run by the Directorate of Children, Youth and Family Affairs, will play a central role in the Government's information work directed at children and young people. The website covers a wide range of subjects and news topics which concern young people and is visited by an increasing number of users. Ung.no already has a question-and-answer service on rights, health and sexuality. Information about FGM is also accessible on the site, and links will be set up to a question-and-answer service and to other websites, such as Klara-klok.no. When required, information about FGM will be posted in relevant languages.

Responsible ministry/ministries: BLD, HOD
Implementation: 2008 – 2011

7. Available health services

BACKGROUND

Girls and women who have been subjected to FGM have the right to the necessary medical care and follow-up by the health service for both physical and mental problems. The specialist health service must provide guidance and treatment for genitally mutilated girls and women. Since 2004, treatment has been provided at gynaecological outpatient clinics at the teaching hospitals and genitally mutilated girls and women can contact these clinics to arrange treatment without a doctor's referral. The hospitals' outpatient, paediatric and maternity departments have a duty to supply information about health problems and other possible health-related consequences of FGM. More information about female genital mutilation is also needed by family health clinics, midwives in private practice and general practitioners in connection with pre-natal examinations.

Affected women who have received medical care for FGM must be invited to take part in further prevention work with their families and in affected communities in order to prevent FGM and to encourage other women who have been genitally mutilated to seek medical care. This is followed up in several of the measures in this chapter.

The family health clinics and school health service are low threshold services for children and young people from 0 to 20 years of age and for expectant mothers. The local authorities have a duty to offer medical examinations (both somatic and mental) and guidance with follow-up or a referral where required, ref. Regulations No. 450 of 3 April 2003 regarding the local authorities' health-promoting and preventive work in the family health clinics and school health service.

Pursuant to Section 2-2 of the Municipal Health Services Act, every child is entitled to medical check-ups and parents have a duty to make sure that their children keep these appointments. If they do not do so, the health service will contact the home and actively repeat the offer. If the parents continue to ignore their duty in this respect, the health service will be obliged to consider whether the child welfare service should be contacted.

The offer of medical care for asylum seekers and refugees in transit centres helps to identify illnesses or conditions that require immediate treatment. Persons who have been reunited with their families in Norway have a duty to report to the police within seven days of their arrival in Norway. The police must inform the municipal health service of their arrival and they must be offered the possibility of a medical examination. It is important that the municipal medical officer follows up these groups after arrival in Norway. All girls and women who come from countries where female genital mutilation is practised, must be asked whether they have any special health problems which require attention or treatment, such as a gynaecological examination and reopening.

MEASURES 27–34

27. Specialist health service measures to combat female genital mutilation

With a view to preventing FGM, healthcare personnel in relevant hospital departments and outpatients clinics must actively supply affected individuals and groups with information about the health-related consequences of FGM and about the prohibition of FGM in Norway. Healthcare personnel must make a note in patients' medical records that they have received this information.

Responsible ministry/ministries: HOD
Implementation: 2008 – 2011

28. Review regulations and guide for family health clinics and the school health service and other relevant guides and circulars on female genital mutilation

Review and if necessary update regulations, guides and relevant circulars concerning prevention of FGM and medical care for genitally mutilated women.

The review must include Regulations No 450 of 3 April 2003 relating to local authorities' health-promoting and preventive work at family health clinics and in the school health service and related guide IS-1154, Circular IK-07/93 on check-ups at family health clinics and the school doctor, Circular IK-20/2001 on legal problems relating to female genital mutilation and IK-2723 (5.2000), a guide to FGM for healthcare personnel in Norway.

Responsible ministry/ministries: HOD
Implementation: 2008–2009

29. Review the routines for interaction between the first and second-line services in the health sector

In order to provide the best possible medical care before and after childbirth, the routines for exchange of information on FGM between the health service levels at prenatal examinations and during and after delivery will be reviewed and if necessary revised. The review will also be carried out in order to ensure that information about FGM accompanies the mother with a view to preventing a girl child from being subjected to FGM.

Responsible ministry/ministries: HOD
Implementation: 2008 – 2009

30. Strengthen information on female genital mutilation in connection with pre-natal examinations

Genitally mutilated women who go to a family health clinic, midwife in private practice or general practitioner for a prenatal check-up must be given information about possible damage to health caused by FGM. These women must be offered the necessary medical care, including opening prior to delivery. They must also be informed that FGM is prohibited by law. Healthcare personnel must make a note in the patient's medical record that she has received this information.

Responsible ministry/ministries: HOD
Implementation: 2008 – 2011

31. Strengthen information about female genital mutilation to affected parents in connection with medical check-ups at the family health clinic

Information provided at ordinary medical check-ups at family health clinics must include information to affected parents about the damage to health caused by FGM and the fact that FGM is prohibited in Norway. Healthcare personnel must make a note in the child's medical record that the parents have received this information.

Responsible ministry/ministries: HOD
Implementation: 2008 – 2011

32. Revise the Guide to Healthcare for Asylum Seekers and Refugees

The Directorate for Health and Social Affairs will revise the guide to include persons who have been reunited with their families in Norway and thus ensure that recently arrived immigrants are aware of the municipal health services that are available to them. This will help to uncover conditions in genitally mutilated women that need treatment.

Responsible ministry/ministries: HOD
Implementation: 2009

33. Evaluate the possibility of offering girls and women documentation that they have not been genitally mutilated

Girls/women and families who wish to receive a doctor's certificate confirming that they have not been subjected to FGM can be offered a medical examination.

This possibility will be evaluated by a work group in collaboration with affected parties.

The document, which will be in the native language, can be used by a girl/women and her family as an argument against being subjected to FGM in risk situations. This will be an optional service.

Responsible ministry/ministries: HOD, BLD
Implementation: 2009 –2010

34. Evaluate information work in the health service

The Directorate for Health and Social Affairs will implement a project to clarify how the health service carries out information work in connection with the prevention of FGM.

Responsible ministry/ministries: HOD
Implementation: 2009 – 2010

8. Extra effort at holiday times

BACKGROUND

Since more people travel during the summer months to areas where female genital mutilation is practised, it is important to consider intensifying the dissemination of information prior to the holidays. Experience gained from emergency measures in the summer of 2007 will be used to consider the best ways of spreading information to relevant target groups before the start of the summer holidays.

radio and television programmes, websites, online newspapers, schools and other relevant media.

Responsible ministry/ministries: BLD, AID, HOD, JD
Implementation: 2008 – 2011

MEASURES 35–36

35. Send out annual information letters concerning the duty of prevention and the duty of disclosure.

It is the responsibility of the individual ministries to send out information letters to professional practitioners and employees in the health and social welfare services, child welfare service, refugee offices, day-care centres, school and other relevant bodies. The letters will provide information about relevant legal provisions and about where to obtain information, advice and help when required.

Responsible ministry/ministries: BLD, HOD, JD, KD
Implementation: 2008 – 2011

36. The ministries will consider annual summer measures

A number of possible measures will be considered prior to the start of the school summer holidays. For example: open family health clinics, information stands and information campaigns in major cities and provision of information in relevant languages for use in

9. Stronger international efforts

BACKGROUND

The Government's International Action Plan for Combating Female Genital Mutilation was adopted in 2003 and remains in force until 2010²³. The plan focuses primarily on measures to prevent female genital mutilation and promote social mobilisation in Norway's partner countries, and on measures to build competence and knowledge. International efforts to prevent FGM should have positive spin-off effects for work in Norway. There are also many interfaces between Norwegian and international measures to combat FGM. The potential benefits of international cooperation lie mainly in the areas of capacity building, research and development of better methods.

Girls' and women's rights are one of the key aspects of the Government's International Action Plan and of the efforts to prevent FGM which Norway supports in countries where the practice is found. These include efforts to protect women's sexual and reproductive rights and to prevent discrimination, oppression and violence against women. Measures to combat FGM are therefore also laid down in the Government's Action Plan for Women's Rights and Gender Equality (2007)²⁴, and are further strengthened in the Government's white paper on women's rights and gender equality in development cooperation policy published in January 2008.

A number of studies show that people in exile often keep up old traditions and do not follow developments

in their home country. In order to influence opinion and generate debate it is important to spread information about the efforts made, and the results of the work that is being undertaken to combat FGM in relevant countries to affected parents, children and young people in Norway. It may be helpful to use material that has been used to combat FGM in the various countries of origin. Good examples are radio programmes and soap operas.

Efforts to change attitudes in relevant countries of origin constitute an important part of Norway's development cooperation with other countries and NGOs in the fight against FGM. This may also help to change attitudes to the practice among the affected groups in Norway. It is therefore important to communicate information about international efforts to combat FGM to affected target groups and to the Norwegian population in general.

²³ <http://www.regjeringen.no/upload/kilde/du/pla/2003/0002/ddd/pdfv/183589-lemlestelse.pdf>

²⁴ See www.publikasjon.dep.no for «Handlingsplan for kvinners rettigheter og likestilling i utviklingssamarbeidet, 2007–2009»

MEASURES 37–40

37. Raise the subject of female genital mutilation during political talks with other countries

The question of FGM should be raised in a suitable way in bilateral political talks with other countries' authorities and in connection with visits from political and sector delegations, when this is a relevant issue. National legislation and other initiatives to combat FGM should also be supported.

Responsible ministry/ministries: UD
Implementation: 2008 – 2011

38. Communicate information about Norwegian legislation on female genital mutilation to relevant countries

Information about Norwegian legislation prohibiting female genital mutilation must be communicated to the authorities in countries which have migration to Norway and where female genital mutilation is a relevant issue. The problems relating to girls living in Norway, who are taken to these countries, must be raised in dialogue with the countries' authorities where relevant.

Responsible ministry/ministries: UD
Implementation: 2008 – 2011

39. Make arrangements with the different embassies in Norway and the Nordic countries to make information about Norwegian legislation on female genital mutilation available to visa applicants at these embassies.

Subject to the consent of relevant embassies in Norway and in the Nordic countries, information about FGM and Norwegian legislation prohibiting this practice

will be made available to visa applicants from Norway at these embassies.

Responsible ministry/ministries: UD
Implementation: 2008 – 2011

40. Transfer experience and results of international efforts to combat female genital mutilation

The Ministry of Foreign Affairs and the Norwegian Agency for Development Cooperation (NORAD) will distribute information about international efforts to combat FGM and their results to relevant ministries, directorates and NGOs.

Responsible ministry/ministries: UD
Implementation: 2008 – 2011

10. Evaluation of this Action Plan

BACKGROUND

Efforts to combat female genital mutilation in Norway have now been underway for more than ten years. We have our own legislation and there have been two action plans in this field, but we still need more knowledge about what we have achieved. An evaluation will therefore be made of this Action Plan to ensure more knowledge, good user participation and target achievement and the best possible basis for future measures.

MEASURE 41

41. Evaluation of this Action Plan

In order to be able to assess whether the measures that are initiated through this Action Plan for combating female genital mutilation are effective and achieve the intended results, and to monitor the quality of the work that is being done, it will be necessary to evaluate the measures in the Plan regularly. Annual evaluation reports will be drawn up during the Action Plan period.

Responsible ministry/ministries: BLD
Implementation: 2008 – 2011

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