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Ending female genital mutilation

Report of the Secretary-General

Summary

The present report was prepared in response to resolution 51/2 of the Commission on the Status of Women on ending female genital mutilation. It outlines key issues on female genital mutilation addressed by intergovernmental bodies and human rights treaty bodies and focuses on activities undertaken by Member States and United Nations entities to end the practice. It concludes with recommendations based on lessons learned and good practices.

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I. Introduction

1. In its resolution 51/2 on ending female genital mutilation, the Commission on the Status of Women requested the Secretary-General to report on the implementation of the resolution to the Commission at its fifty-second session.

2. The present report outlines the key issues on female genital mutilation addressed by intergovernmental bodies and human rights treaty bodies and focuses on activities undertaken by Member States and United Nations entities to end the practice. It is based, inter alia, on contributions by Member States[1] and United Nations entities.[2] The report provides recommendations for consideration by the Commission on the Status of Women.

II. Background

3. According to a World Health Organization (WHO) estimate,[3] between 100 and 140 million girls and women in the world have undergone some form of female genital mutilation in more than 28 countries in Africa and some countries in Asia and the Middle East. Every year, approximately 3 million girls and women are subjected to genital mutilation. The practice is also prevalent among immigrant communities in Europe, North America and Australia. Fifteen African States, where female genital mutilation is prevalent, and a number of States in other parts of the world, have enacted laws criminalizing the practice (see A/61/122/Add.1 and Corr.1).

4. In 2006, WHO published a landmark study that showed a strong association between female genital mutilation and obstetric complications.[4] The study included over 28,000 women in 28 obstetric centres in six African countries. The results showed that, compared to women who had not undergone female genital mutilation, deliveries to women with female genital mutilation were significantly more likely to be complicated by caesarean section, post-partum haemorrhage, episiotomies and prolonged maternal hospitalization. In addition, babies born to mothers with female genital mutilation had a greater risk of needing resuscitation immediately after birth and of dying during birth.

5. Since the prevalence of female genital mutilation remains high after nearly three decades of efforts by countries to eradicate the practice, new approaches

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[1] Angola, Australia, Austria, Belgium, Canada, Czech Republic, Egypt, El Salvador, Finland, Germany, Ghana, Italy, Lebanon, Luxembourg, Malta, Mexico, Montenegro, Morocco, Nigeria, Peru, Poland, Spain, Trinidad and Tobago, Uganda, United Kingdom of Great Britain and Northern Ireland, Bolivarian Republic of Venezuela and Yemen.

[2] Economic Commission for Africa, Economic Commission for Europe, Economic and Social Commission for Asia and the Pacific, Economic and Social Commission for Western Asia, Food and Agriculture Organization of the United Nations, International Labour Organization, International Research and Training Institute for the Advancement of Women, Office of the United Nations High Commissioner for Human Rights, United Nations Educational, Scientific and Cultural Organization, United Nations Population Fund, United Nations Children's Fund, United Nations Development Fund for Women and World Health Organization.

[3] WHO, *Progress in Sexual and Reproductive Health Research*, No. 72 (2006); UNICEF, *Female Genital Mutilation/Cutting: A Statistical Exploration* (2005).

[4] "Female genital mutilation and obstetric outcome: WHO collaborative perspectives in six African countries", in *The Lancet*, vol. 367, issue 9525 (2006).

continue to be developed that are both culturally sensitive and address the practice as a human rights violation.[5] Programmes are increasingly informed by an understanding of the social dynamics of female genital mutilation as a self-enforcing social convention. Social dynamics determine why the practice persists and why women as well as men still support the continuation of the practice despite harmful health consequences. Working towards the abandonment of the practice requires the involvement of entire communities in accelerating social transformation, including the empowerment of women and girls.

6. In order to guide the approaches of the United Nations in supporting Member States to eradicate female genital mutilation, in 1997, WHO, the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) issued a Joint United Nations Statement on the Elimination of Female Genital Mutilation. WHO is leading the revision of the statement, which is expected to be published before the end of 2007. Based on new evidence and lessons learned, the revised statement will call for action to develop, strengthen, support and accelerate efforts directed towards ending female genital mutilation within a generation. UNICEF and UNFPA have launched a joint initiative to reduce the practice by 40 per cent by 2015, with the goal of ending female genital mutilation in one generation.

7. A number of non-governmental organization (NGO) networks working at different levels have provided impetus for individual attention to the issue of female genital mutilation. For example, the advocacy of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children and its national committees led to legislation in some African countries and to the public abandonment of the practice by communities. The Inter-African Committee also initiated the International Day of Zero Tolerance of Female Genital Mutilation, on 6 February. In December 2005, the Inter-African Committee brought together African religious leaders from 28 countries in Burkina Faso. Participants pledged to participate in efforts to eradicate female genital mutilation and created the African Network of Religious Leaders for the Fight against Female Genital Mutilation and for Development.

III. Measures taken at the intergovernmental level

8. For nearly 30 years, the United Nations has addressed the issue of female genital mutilation within the legal and policy frameworks developed in the General Assembly, the Commission on the Status of Women, the former Commission on Human Rights, and its Sub-commission on the Promotion and Protection of Human Rights, and the Human Rights Council.

9. Early efforts by the Economic and Social Council to urge States to progressively abolish measures that violated the physical integrity of women (see resolution 445 (XIV)) were often perceived as interference in social and cultural practices (E/CN.4/Sub.2/2005/36, para. 12). When in the early 1980s, the Sub-Commission of the Commission on Human Rights took up the issue it was first

[5] UNICEF Innocenti Digest, *Changing a Harmful Social Convention, Female Genital Mutilation/Cutting* (Florence, Italy, 2005), UNICEF, *Coordinated Strategy to Abandon FGM/C in One Generation* (2007).

addressed as a harmful traditional or customary practice in the context of risks to the physical and mental health of affected women and girls.

10. The focus of attention evolved from a concern for the physical and mental health of women and girls to an understanding that female genital mutilation constituted violence against women and that States needed to take measures to prohibit and eliminate the practice. The Declaration on the Elimination of Violence against Women (General Assembly resolution 48/104) defined violence as physical, sexual and psychological violence and explicitly identified female genital mutilation as a form of violence. It also called upon States not to invoke customs, tradition or religious considerations to avoid taking their obligations with respect to eliminating violence against women. The Beijing Platform for Action and the twenty-third special session of the General Assembly identified female genital mutilation as a form of violence against women and a human rights violation that prevented women's full enjoyment of their human rights and fundamental freedoms.

11. The Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the outcome document of the twenty-third special session of the General Assembly called upon Member States to prohibit female genital mutilation; to adopt and fully implement laws and other measures to eradicate harmful customary or traditional practices, including female genital mutilation; and to provide vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices.

12. The General Assembly has addressed the issue of female genital mutilation in resolutions on harmful traditional practices/traditional or customary practices affecting the health of women and girls, violence against women and the girl child. In the outcome of the twenty-seventh special session of the Assembly on children in 2002 (resolution S-27/2, annex), the Assembly set out its resolve to end harmful traditional or customary practices, including female genital mutilation. At the 2006 High-level Meeting on HIV/AIDS, Member States committed themselves to strengthen legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights, including with regard to harmful traditional and customary practices (General Assembly resolution 60/262, para. 31).

13. In 2006, the Secretary-General's in-depth study on violence against women (A/61/122/Add.1 and Corr.1) and on the report of the independent expert for the United Nations study on violence against children (A/61/299), submitted to the General Assembly, highlighted the persistence of violence and called for strengthened commitment by Governments and other stakeholders to prevent and eliminate violence against women and girls. The study on violence against women placed female genital mutilation in the context of harmful traditional practices that occur within the family and community. It called for concerted efforts to end all forms of discrimination, to advance gender equality and the empowerment of women so that all women enjoy all their human rights, including freedom from violence. The study on violence against children described how harmful traditional practices, which are generally imposed by parents or community leaders, affect children disproportionately. In the study States were urged to prohibit all forms of violence against children, including female genital mutilation. It was recommended that States and civil society work to transform attitudes that condone violence

against children, including stereotypical gender roles and discrimination, as well as the acceptance of harmful traditional practices.

14. Throughout its history, the Commission on the Status of Women has expressed concern for women's and girls' enjoyment of their human rights. In the context of violence against women, human rights and women and health, it has called for the eradication of customary or traditional practices, including female genital mutilation, that are violations of women's human rights and constitute violence against women.[6] Most recently, in its agreed conclusions of 2007,[7] the Commission called upon Member States to implement national legislation and policies prohibiting harmful customary or traditional practices, particularly female genital mutilation, as a violation of and obstacle to the full enjoyment by women of their human rights and fundamental freedoms. It also called for the prosecution of perpetrators of such practices.

15. In 1984, the Sub-Commission of the Commission on Human Rights first appointed a working group on harmful traditional practices and in 1988 a Special Rapporteur on traditional practices affecting the health of women and the girl child. In its resolution 1994/30, the Sub-Commission adopted a plan of action for the elimination of harmful traditional practices affecting the health of women and children. The Special Rapporteur systematically linked the elimination of female genital mutilation with the overall status of women and their full and equal participation in the social, economic, cultural and political life of their communities (E/CN.4/Sub.2/2005/36, para. 82). She also noted the difficulty in challenging a people's culture in order to change a traditional practice that constitutes a human rights violation.

16. Special rapporteurs of the Human Rights Council (and the former Commission on Human Rights) drew attention to female genital mutilation in recent years. The Special Rapporteur on violence against women, its causes and consequences addressed the issue in her 2006 report entitled "Intersections between culture and violence against women" (A/HRC/4/34) and in some country reports.[8] She highlighted the need to uphold universally agreed values, in particular the principle that no custom, tradition or religious consideration can be invoked to justify violence against women. She also noted the challenge to develop common strategies to overcome human rights violations committed in the name of culture without condemning specific cultures. In some cases, suppressing one harmful practice may give rise to other problems, as in the case of Cameroon where the practice of "breast-ironing" is reportedly on the rise as female genital mutilation is declining. The Special Rapporteur also stressed the importance of recognizing female genital mutilation as gender-related persecution when asylum claims are examined.

17. The Special Rapporteur on freedom of religion or belief stressed that the right of freedom of religion, like other human rights, cannot be used to justify the violation of other human rights and freedoms. Both the Special Rapporteur on freedom of religion and the Special Rapporteur on violence against women, its causes and consequences welcomed the recommendations of a 2006 conference at

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[6] *Official Records of the Economic and Social Council, 1998, Supplement No. 7* (E/CN.6/1998/12-E/1998/27); ibid., *1999, Supplement No. 7* (E/1999/27-E/CN.6/1999/10).

[7] Ibid., 2007, *Supplement No. 7* (E/2007/27-E/CN.6/2007/9), chap. I.

[8] Mission to Sweden, A/HRC/4/34/Add.3; Mission to the Netherlands, A/HRC/4/34/Add.4, para. 51.

Al-Azahr University in Cairo, where a group of Islamic scholars concluded that "there are no written grounds for this custom in the Qur'an" and acknowledged that "female genital circumcision practiced today harms women psychologically and physically" and should be "seen as a punishable aggression against humankind". They stated that "the practice must be stopped in support of one of the highest values of Islam, namely to do no harm to another", and called for its criminalization (ibid., para. 55).

18. The Special Rapporteur on the situation of the human rights and fundamental freedoms of indigenous peoples recommended, during his visit to Kenya in 2006, that the Government should reinforce its efforts to achieve the effective eradication of female genital mutilation in all communities, by helping to promote culturally appropriate solutions such as alternative rites of passage and supporting the involvement of women's organizations in this work (A/HRC/4/32/Add.3). Following his visits to Nigeria and Togo in 2007, the Special Rapporteur on torture welcomed the adoption of legislation prohibiting female genital mutilation in both countries.

IV. International human rights conventions

19. A number of international human rights conventions include provisions that can be applied to female genital mutilation. The International Covenant on Civil and Political Rights provides that no person can be subjected to cruel, inhuman or degrading treatment (art. 7). The Convention on the Elimination of All Forms of Discrimination against Women calls upon States parties to eliminate discrimination against women and to take appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women (art. 2 (e) and (f)). The Convention on the Rights of the Child calls for the protection of every child against all forms of discrimination, including from traditions or customs which harm their health. The Convention calls upon States parties to take steps to prevent or prohibit traditional practices that are not good for children (art. 2 (2) and 24 (3)).

20. Several human rights treaty bodies have addressed female genital mutilation in their concluding observations and comments[9] as well as in their general recommendations.[10] They have called on States parties to prohibit female genital mutilation, to adopt and implement adequate legislation prohibiting female genital mutilation and to ensure that offenders are prosecuted and punished. State parties are urged to develop comprehensive plans of action, including through education and/or the implementation of public awareness-raising campaigns to change cultural perceptions connected with the practice, in collaboration with civil society organizations, women's NGOs, community, traditional, and religious leaders as well as teachers, midwives and traditional health practitioners. Programmes should be

[9] Committee on the Elimination of Discrimination against Women; Committee on the Rights of the Child, Human Rights Committee, Committee against Torture.

[10] Committee on the Elimination of Discrimination against Women: General recommendations No. 14 on female genital circumcision, No. 19 on violence against women and No. 24 on women and health; Committee on the Rights of the Child: General Comment on adolescent health and development; Human Rights Committee: General Comment No. 28 on the equality of rights between men and women.

developed to assist practitioners of female genital mutilation to obtain alternative sources of income.

21. The Committee on the Elimination of Discrimination against Women identified the practice of female genital mutilation as the result of entrenched patriarchal attitudes and deep-rooted stereotypes and cultural norms (CEDAW/C/BEN/CO/1-3; CEDAW/C/BFA/CO/4-5). It characterized female genital mutilation as a form of discrimination and violence against women and as a harmful traditional practice constituting a violation of human rights. The Committee on the Rights of the Child stressed the need to protect children's rights and recommended comprehensive, culturally appropriate strategies to prevent and combat such harmful traditional practices, and to support victimized children, in particular in rural areas. Children themselves were encouraged to take an active role in reporting these practices to health professionals and competent authorities (CRC/C/KEN/CO/2; CRC/C/COG/CO/1). The Human Rights Committee encouraged States parties to increase efforts to combat the practice of female genital mutilation and the granting of residence permits, where appropriate, on the basis of humanitarian concerns (CCPR/C/NOR/CO/5). In recent years, the Committee against Torture increasingly urged authorities to take measures to eradicate female genital mutilation (CAT/C/CR/33/3; CAT/C/TGO/CO/1).

V. Regional instruments and actions

22. Regional legal instruments have also called for the elimination of harmful traditional practices. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa,[11] which entered into force in 2005, addresses issues of traditional and cultural practices that are harmful and discriminatory towards women. It calls upon States parties to combat all forms of discrimination against women and to prohibit and condemn all forms of harmful practices which negatively affect the human rights of women. States parties are expected to take legislative and other measures to eliminate such practices through public awareness in all sectors of society; to prohibit and sanction all forms of female genital mutilation, including its medicalization and para-medicalization; to provide necessary support to victims; and to protect women who are at risk of being subjected to harmful practices.

23. In 1997, the Southern African Development Community member States issued a Declaration on Gender and Development,[12] which was complemented in 1998 by a statement on the Prevention and Eradication of Violence against Women and Children. The statement strongly condemned violence against women and children and recognized that such violence reflected the unequal relations of power between women and men, and resulted in the domination and discrimination of women by men. It listed female genital mutilation as a form of violence against women. The statement committed member States to the adoption of laws that defined violence against women as crimes, as well as to other measures, including education, training and awareness-building to ensure the prevention and eradication of all forms of violence against women and children. It also promoted the eradication of elements in traditional norms and religious beliefs, practices and stereotypes which legitimize

[11] Available from http://www.achpr.org/english/_info/women_en.html.

[12] Available from http://www.sadc.int/key_documents/declarations/gender.php.

and exacerbate the persistence and tolerance of violence against women and children.

VI. Recent measures taken by Member States and United Nations entities

24. Member States and United Nations entities have worked towards ending female genital mutilation by implementing international human rights conventions through national legal frameworks, national policies, programmes and mechanisms for the prevention and treatment of the practice and support to victims.

A. Prevalence and data collection

25. A number of Member States reported that they had no available data on female genital mutilation (Czech Republic and Poland), or that no cases had been reported (El Salvador, Luxembourg, Malta, Montenegro and Peru). Angola, Lebanon, Mexico, Morocco, Trinidad and Tobago and the Bolivarian Republic of Venezuela reported that the practice did not exist in their countries. Ghana reported that female genital mutilation is not widespread, but is still practised in some communities in the northern part of the country (namely among the Kusasis, Frafra, Wala, Lobi, Kassena, Nankanist, Sissala and Grunshie). Similarly, female genital mutilation is practised in Nigeria by ethnic groups, irrespective of religious affiliation and level of education. The practice can take place any time from a few days after birth to a few days after death. In Uganda, the affected communities are the Sabiny, Pokot, Tepeth, Nubian, Nandi, So and other minority and migrant groups. Mauritania reported that 71 per cent of women had undergone the practice with significant variations of prevalence according to ethnicity. The Central African Republic noted a decline in the practice in recent years.[13]

26. The systematic collection of data on female genital mutilation remains a challenge. Nigeria, for example, reported that the data collection system is not unified across the country and that the lack of sufficient financial resources has prevented the National Statistical Agency from collecting data on the issue of violence against women. UNICEF collects data on female genital mutilation, mainly using household survey data from the demographic and health surveys and the multiple indicator cluster surveys. The indicators utilized measure the proportion of women aged 15-49 who have undergone female genital mutilation and the proportion of women aged 15-49 with at least one daughter who has undergone genital mutilation. In recent years, there has been some progress in documenting the extent of female genital mutilation through the addition of a special module on female genital mutilation in demographic and health surveys.

27. The Economic Commission for Africa (ECA) has been using the African Gender and Development Index as a tool to monitor the extent to which countries have reported on the implementation of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa through national laws, policy commitments and other action. In early 2007, ECA, in collaboration

[13] Based on responses to the review and appraisal of the implementation of the Beijing Platform for Action.

with the United Nations Development Programme (UNDP) Regional Gender Programme, launched the African Women's Rights Observatory and its Advisory Panel to complement the Index in Africa and to contribute to the strengthening of tracking and monitoring women's rights violations in African countries.

B. Legal frameworks

28. Member States used their legal systems to work towards the eradication of female genital mutilation in different ways, including by banning the practice in health institutions; fully prohibiting it and making it a specific crime, or covering it through existing provisions in the Criminal Code. They have also taken steps to strengthen sanctions for these crimes. However, enforcement of these laws remains a major challenge as the practice continues to be seen as an issue at the private or family level that should not be brought into the public domain for discussion and action.

29. A number of African countries have criminalized female genital mutilation in their Penal Codes or through other laws. Penalties include fines and imprisonment of up to 10 years. In Ghana, practitioners and others who aid and abet in the crime can be prosecuted. In order to implement the new law and create lasting change, the Government works with civil society organizations such as the Ghana Association for the Welfare of Women. In Uganda, the Child Act prohibits female genital mutilation and states that it is unlawful to subject a child to social or customary practices harmful to the health of the child. Morocco has criminalized female genital mutilation in the Penal Code as a violation of physical integrity. In 2007, Eritrea adopted a proclamation against female genital mutilation as a result of many years of campaigning supported by the National Union of Eritrean Women and by UNICEF.

30. While there is no federal law banning female genital mutilation in Nigeria, 11 States have adopted legislation against some harmful traditional practices, including female genital mutilation. However, the enforcement of these laws has been weak because of the lack of adequate accountability mechanisms at the national and local levels to monitor implementation of the existing laws.

31. Some Governments have taken steps to curb the practice within the health-care system and to ban health professionals from performing it. The Ministry of Health in Yemen published a decision in 2001 to ban female genital mutilation from being performed in health institutions. Similarly, the Minister of Health and Population in Egypt issued decision No. 271 of 2007 that prohibits physicians, nurses and others from making any incision, mutilation or alteration to a woman's reproductive organs, regardless of whether the act takes place in government or private hospitals or in any other location.

32. United Nations entities have supported Governments to put in place laws and mechanisms to prohibit female genital mutilation with a view to its full elimination. UNICEF, in collaboration with an NGO, No Peace Without Justice, assists Governments in the review, revision or amendment of laws on female genital mutilation in a number of countries. In Egypt, UNFPA, together with UNICEF, UNDP and the International Labour Organization (ILO), provided support to the National Council for Motherhood and Childhood in developing appropriate legal measures against the practice. The African Centre for Gender and Social

Development of ECA supports intergovernmental processes that result in policy instruments for the elimination of violence against women.

C. Prevention and response strategies and interventions

33. Member States have developed a number of strategies on the prevention of female genital mutilation and adequate responses. Measures include the development of national policies and action plans, sector-specific guidelines and handbooks, and the provision of alternative livelihoods for ex-practitioners. Member States have also taken initiatives to educate and train health professionals, police, judges and prosecutors. They offer health services and support civil society organizations. Governments also make significant community development and public education initiatives, including through partnerships with community-based, civil society organizations. In some countries positive experiences have been made through peer educators and the increased involvement of local and religious leaders.

34. The Federal Ministry of Health of Nigeria developed a National Policy and Plan of Action on Elimination of Female Genital Mutilation (2002-2006), with a view to reducing the prevalence and incidence of female genital mutilation. It was complemented in September 2007 with the second Action Plan of the Federal Government to Combat Violence against Women, with the goal of preventing female genital mutilation and supporting victims.

1. Responses by the health sector

35. In Ghana, programmes for the prevention of female genital mutilation and treatment of victims of female genital mutilation and other harmful traditional practices are integrated in reproductive health policies and programmes with a focus on prevention strategies.

36. A number of Governments have taken measures to train health professionals to eliminate the practice. In Ghana and Nigeria, the issue of female genital mutilation has been incorporated into the curricula of medical, nursing and midwifery schools. Nurses and midwives have been trained on assisting victims in affected communities. With the support of United Nations entities, Nigeria's National Primary Health-Care Agency, the Federal Ministry of Health and the national women's machinery initiated the training of traditional birth attendants who are considered the custodians of culture and tradition and are the first primary health contacts at the local level. Government and civil society organizations continue to train and retrain traditional birth attendants on safe motherhood, child survival and the eradication of harmful traditional practices such as female genital mutilation.

37. Specialized health services are being offered to women who have undergone female genital mutilation. Ghana supports victims to register with the National Health Insurance Scheme to get medical surgery for reconstruction and fistula repairs. Efforts are also made to inform women and girls of their rights, the harmful effects of female genital mutilation to their health and the illegality of the practice.

38. The WHO Regional Office for Africa has supported national Governments through regional guidelines for the elimination of female genital mutilation in the Eastern Mediterranean region. In South-East Asia, the Regional Office works with

the Ministry of Health in Indonesia to address concerns about the increasing medicalization of the practice.

39. Strategies to create alternate employment opportunities have been developed. The Nigerian Federal Ministry of Health, in collaboration with WHO, developed strategies for alternative employment for ex-circumcisers in seven States. The Osun State Ministries of Health and Women's Affairs and several NGOs, in cooperation with UNFPA, trained some ex-circumcisers as community-based delivery agents to provide reproductive health services for women especially in pregnancy, labour and delivery.

2. Advocacy and awareness-raising

40. Partnerships between relevant stakeholders, including Government ministries, national and regional NGOs, community and faith-based organizations, religious and community leaders have been established to raise awareness on the harmful consequences of female genital mutilation and to enhance the involvement of communities. Governments, United Nations entities and NGOs collaborate on efforts to eradicate the practice, using a range of approaches, including national campaigns on positive social transformation, awareness-raising activities, outreach to communities with the involvement of religious leaders, and encouragement of written declarations promoting the abandonment of female genital mutilation by different stakeholders.

41. Successful experiences of reaching and involving local communities, youth, peer educators and traditional authorities in educational and sensitization programmes, particularly in affected communities have been reported. In Ghana and Nigeria, youth peer educators are trained to work in schools and with out-of-school youth and communities through house-to-house campaigns, sensitizing youth on the dangers of female genital mutilation and the benefits of its eradication.

42. Community volunteers have been trained to educate community members on the dangers of female genital mutilation and the need to report perpetrators to the nearest health post or police station or to the community. Efforts are made to reach community leaders and to discuss the practice during community meetings. In a number of countries, sensitization activities are carried out in markets, places of worship, workplaces and via media campaigns. Member States reported their participation in the annual International Day of Zero Tolerance of Female Genital Mutilation, on 6 February, which helped to create more awareness on the practice.

43. Advocacy and awareness-raising activities have targeted different levels of government as well as religious leaders and members of parliament. In Yemen, progress has been made in awareness-raising and training on women's and girls' rights by targeting influential stakeholders, including religious leaders. The National Commission on Women published a guide on gender roles and reproductive health, including harmful practices and female genital mutilation, targeted at religious leaders. Civil society organizations held several workshops with influential religious and local leaders in communities. In Ethiopia and Nigeria, UNFPA built alliances with faith-based organizations which have been critical in working towards the elimination of harmful traditional practices such as early marriage and female genital mutilation.

44. Little information was provided on specific interventions targeted at men and boys. One promising practice in this area was reported from Nigeria, where in 1999 the Federal Ministry of Health in collaboration with WHO, the Inter-African Committee and the Federal Ministry of Women's Affairs, organized "all-male" seminars across the country to encourage men to discuss female genital mutilation and other forms of violence against women and girls and make recommendations from a male perspective. More recently, boys have been trained as peer educators across the country.

45. Conferences and workshops at different levels have been effectively utilized to raise awareness and advocate for the eradication of the practice. In 2005, UNICEF and UNDP, together with national and international NGOs, supported a subregional conference hosted by the Government of Djibouti. The conference adopted by consensus the Djibouti Declaration on the abandonment of all forms of female genital mutilation in Djibouti and the subregion (Ethiopia, Eritrea, Kenya, Somalia and the Sudan). The Dar al-Ifta', the highest Islamic authority in Egypt, declared that female genital mutilation is a custom and not a religious rite and noted that the practice is prohibited under sharia law. The declaration concluded that female genital mutilation must be prohibited because it is a harmful practice, both physically and psychologically.

46. In 2007, UNFPA organized a Global Consultation on Female Genital Mutilation/Cutting, held in Addis Ababa. In its final declaration, the participants made recommendations to various stakeholders and reaffirmed zero-tolerance on female genital mutilation. The Consultation called upon medical professionals to end any form of medicalization. Governments were called upon to accelerate abandonment of female genital mutilation by enacting and enforcing laws banning any form of the practice; by building broad partnership and networks at the national, regional and international levels to implement culturally sensitive approaches for sustainable behaviour change; and by building national capacity for law enforcement institutions and health providers on counselling, treatment and reparation. Religious and traditional leaders were encouraged to dispel the myths and misconceptions within cultures and religious communities that are used to justify the practice and to educate their constituencies on the rights of women and girls. Development partners were called upon to increase their technical and funding support to Governments, civil society organizations, faith-based organizations and community-based organizations and to support continuing research.

47. The Economic Commission for Africa cooperates with the Inter-African Committee on Traditional Practices Affecting the Health of Women, based in Addis Ababa, particularly on advocacy work. The Centre for Women of the Economic and Social Commission for Western Asia (ESCWA) has organized workshops and released publications aimed at raising awareness on violence against women, including female genital mutilation.

3. Community-based programming

48. New approaches have been developed in working with communities as a whole to eliminate female genital mutilation. In cooperation with the National Council for Childhood and Motherhood, UNICEF supported a community-based project in 40 communities in four Upper Egypt governorates which builds the capacity of the local communities to abandon the practice and protect girls from female genital

mutilation. In Senegal, UNICEF worked with the NGO Tostan to establish a community empowerment programme which promotes behavioural social change. It has led tens of thousands of people to declare their abandonment of female genital mutilation. Since 2005, the number of village communities that have publicly declared their decision to abandon the practice has increased 20-fold from 114 villages in 2005 to 2,300 villages in 2007. Building upon the success of this model in Senegal, UNICEF and Tostan are collaborating to expand its replication in the Gambia, Guinea, Mauritania and Somalia.

49. The United Nations Population Fund promotes culturally sensitive programming to address the underlying social values of the practice. In Kenya, for example, UNFPA supported the local Tsaru Ntomonik Initiative that calls for alternative rites-of-passage ceremonies. The community-based organization serves as a "safe house" for an increasing number of young girls who escape from female genital mutilation. Tsaru Ntomonik also works with ex-circumcisers to ensure that they can find alternative sources of income. In Uganda, UNFPA supported work with local politicians, cultural leaders, health workers, youth and women's groups through its Reproductive Education and Community Health Programme.

D. Targeted measures for refugee and immigrant communities

50. A number of countries where female genital mutilation may be practised among immigrants have passed laws criminalizing the practice as a form of violence against women and a human rights violation. Such laws were adopted in Canada in 1997, in Belgium in 2000, in Spain in 2003 and in Italy in 2006. In the Bolivarian Republic of Venezuela and Peru, legal protection is provided by the Penal and Civil Codes and laws on the protection of children and adolescents.

51. The Austrian law on violence against women considers female genital mutilation as a form of physical assault to which a person cannot give consent. Similarly, Swedish legislation prohibits the practice regardless of the consent of the victim or her parents. According to the German Criminal Code, the consent of the parents is considered as an abuse of parental custody. In Finland, the authorities have an obligation to intervene when the health and development of a child is being threatened. In the Netherlands, the Government's zero-tolerance policy towards female genital mutilation introduced a protocol requiring health-care professionals to report cases to the Dutch Child Abuse Agency (A/HRC/4/34/Add.4).

52. A number of countries that submitted information to the present report adopted laws that criminalize the practice irrespective of whether it is perpetrated in the country or abroad (Austria, Australia, Belgium, Canada, Ghana, the Netherlands (ibid.), Spain, Sweden (A/HRC/4/34/Add.3) and the United Kingdom). The United Kingdom consular staff can provide assistance and support to potential victims who have been taken overseas, and can arrange for medical treatment and repatriation.

53. Some Member States have taken legal measures to grant women refugee status if they claim well-founded fear of female genital mutilation for themselves or their daughters. Forced female genital mutilation is considered as persecution by Canadian jurisprudence, and refugee status is granted to women and girls who have a well-founded fear of gender-related persecution. Austria and Spain reported that they do not list female genital mutilation explicitly as a ground for asylum, but recognize it in practice.

54. Governments have developed tools to ensure that the health needs of immigrants are met in health centres and maternity and child welfare clinics. The Finnish Ministry of Social Affairs and Health provided guidelines to physicians and school nurses and published a handbook on how to identify violence against immigrant women, including female genital mutilation, forced marriage, honour-based violence, and other earlier experiences of sexual violence in war and conflict situations. The German Medical Association developed "Recommendations on the management of patients with a history of female genital mutilation" and decided to develop a training curriculum in 2007. The Spanish public health system developed training courses for its staff to better support immigrant women. The United Kingdom had seven specialist clinics in the National Health Service catering for the particular health needs of women and girls who have undergone female genital mutilation.

55. In order to strengthen the implementation of existing laws, the German Judicial Academy provided information and training for judges and public prosecutors in specialized or general training courses on domestic violence, female genital mutilation, forced prostitution and human trafficking. In Belgium, the NGO Groupement d'hommes et de femmes pour l'abolition des mutilations sexuelles féminines (GAMS) conducted a course for trainers at the federal police academy in 2005. As a result, information on female genital mutilation is integrated into all basic training courses.

56. Governments supported different measures to reach out to immigrant communities where the practice is assumed to be prevalent. Canada supported a multisectoral approach to address violence against women and children, including female genital mutilation, and worked through schools, the workplace, and the health, social and criminal justice systems. Since 1999, a network on female genital mutilation has brought together representatives from affected communities, government, NGOs and health-care providers to address female genital mutilation from legal, health, religious and sociocultural perspectives. The Australian Government worked through both State and Territory Departments of Health to prevent female genital mutilation, including through community education, information and support, and to assist affected women and girls to minimize adverse health outcomes and psychological harm.

57. In order to empower women immigrants and raise their awareness of their rights, Governments supported community-based projects. For example, in 2006 the City Council of Vienna, in cooperation with the NGO African Women's Organization, set up "Bright Future", the first health centre to counsel women on female genital mutilation. In Belgium, a number of civil society organizations targeted young immigrants with different prevention activities, including a cartoon-based story.[14]

E. Bilateral and multilateral support

58. Financial resources from both multilateral and bilateral sources were provided to support Governments and civil society organizations to work towards ending the practice. A number of Member States reported that they provide core and targeted

[14] "Diariatou face à la tradition", funded by the Daphne Programme of the European Commission.

funding to United Nations entities to protect and promote the rights of women and girls, including ending violence against women (Australia, Canada and Finland).

59. A number of development cooperation agencies have addressed the health aspects of the practice. The Australian Federal Government contributed to a campaign in Burkina Faso to address the high maternal mortality rate which is aggravated by deaths from haemorrhage and obstructed births caused by female genital mutilation. Canada supported the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, which has supported specific research on harmful sexual practices, including a study to assess the effect of female genital mutilation on obstetric outcomes[15] (see also para. 4 above).

60. Development cooperation initiatives have supported advocacy and awareness-raising efforts. The Austrian Development Cooperation supported several projects in this area, such as an awareness-raising campaign in northern Ethiopia involving entire village communities which aimed at promoting sustainable change towards ending female genital mutilation. Since 2002, the German Federal Foreign Office has funded workshops, publications and media in Burkina Faso, Ethiopia, Ghana, Guinea, Kenya, Mali, Niger, the Sudan, Togo, the United Republic of Tanzania and Yemen. Some initiatives in the supra-regional project "Promotion of initiatives to end female genital mutilation", funded by the German Federal Ministry for Economic Cooperation and Development, targeted men in the context of dialogue with religious leaders.

61. Some development cooperation agencies have also supported the efforts of NGOs at different levels. Finland supported the efforts of NGOs to address female genital mutilation in Kenya, Somalia and the Sudan.

62. A Donor Working Group on female genital mutilation, including Member States, United Nations entities and bilateral development agencies, aimed to enhance the coherence and coordination of activities. The Working Group, which has steadily expanded over the years, has been chaired by UNICEF since 2001. It is currently refining a common framework linked to the Joint United Nations Statement on female genital mutilation.

63. Despite international support through bilateral and multilateral assistance to affected countries, Nigeria noted that Government and bilateral funding is insufficient for the implementation of projects aimed at the eradication of female genital mutilation. In recent years much support has been redirected to address HIV/AIDS. Field studies conducted by ECA also show that while countries continue to take actions to eradicate female genital mutilation, budgets remain inadequate.

VII. Conclusion and recommendations

64. **During the last three decades, partnerships between Governments, United Nations entities, civil society, and other stakeholders have enhanced awareness and strengthened efforts towards ending female genital mutilation. There is greater understanding of the practice as a violation of human rights as well as of its harmful health impacts. At the same time, the prevalence of female genital**

[15] See http://www.who.int/reproductive-health/fgm/index.html.

mutilation remains high because of pressures within communities to conform to social norms and expectations. Families who understand the harm of female genital mutilation continue to expose their daughters to the practice because of prevailing harmful traditional norms.

65. **Many actions have been taken to end female genital mutilation, including legal reforms; development of policies, strategies and action plans; training of health-care professionals, law enforcement agents and other relevant professional groups; and advocacy and awareness-raising campaigns at the national and local levels. Promising experiences have included the involvement of highly visible opinion-makers, community and religious leaders, men and young people in prevention strategies and activities, and the development of approaches targeting communities as a whole.**

66. **Challenges identified include lack of enforcement of policies and legislation; insufficient awareness and commitment; persistence of norms that encourage the continuation of the practice; lack of data to facilitate monitoring of progress; and limited resources for sustained programmes.**

67. **A number of lessons learned and good practices have been identified in national and regional efforts to end female genital mutilation. These should be further supported and replicated, where possible.**

68. **All policies and programmes to end female genital mutilation should be guided by a human rights-based approach. Obligations under the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, as well as other human rights conventions and instruments, including those at the regional level, such as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, must be fully implemented.**

69. **Laws need to be put in place to prohibit and criminalize female genital mutilation, including its medicalization. Enforcement of legislation should be enhanced. Governments should act with due diligence and prosecute and punish perpetrators. Police, prosecutors and legal and judicial personnel need to be trained to enforce national laws.**

70. **Comprehensive strategies are needed to develop enhanced awareness among communities, families and the general public on the human rights of girls and to create an enabling environment for girls to exercise those rights. Girls and families that have abandoned the practice should be protected from community harassment.**

71. **The impact of targeted interventions to end female genital mutilation can only achieve their full potential in the context of enhanced overall efforts to achieve gender equality and empowerment of women. Governments should continue and strengthen their efforts to fully implement commitments made in the Beijing Platform for Action, the outcome of the twenty-third and twenty-seventh special sessions of the General Assembly, the Millennium Summit and the 2005 World Summit, and work to achieve the targets established in the Millennium Development Goals.**

72. **Improving women's and girls' access to education and health care is critical to empower them and their communities to end female genital**

mutilation. The level of education for women and girls and the capacity of health-care systems to meet the needs of women and girls need to be further strengthened, in line with internationally agreed development goals, including the Millennium Development Goals.

73. **Different stakeholders, including government agencies, civil society and community leaders, should be targeted in awareness-raising and training programmes to develop capacity for advocacy and awareness-raising on the need to abolish the practice. Health practitioners, social workers, teachers and other relevant professionals should also be targeted for awareness-raising and training.**

74. **Religious leaders should be involved in community-wide campaigns to promote the understanding that female genital mutilation has no basis in religious beliefs. Men and boys need to be targeted in gender equality and women's empowerment programmes, including in efforts to end female genital mutilation. Young people should be encouraged to reach and influence their peers, both inside and outside school settings.**

75. **Governments, civil society actors, and United Nations entities must continue to develop strategic partnerships to work effectively with affected communities to end female genital mutilation.**

76. **Adequate alternatives need to be developed, in cooperation with communities, such as alternative rites of passage and alternative sources of income for ex-circumcisers and practitioners. Safe houses should be established to protect girls from the practice and provide them an opportunity to continue their education.**

77. **Action-oriented research should be undertaken on the sociocultural dimensions of female genital mutilation, including why women as well as men still support the practice, despite its harmful consequences, in order to inform policies and programmes. Data collection must be significantly strengthened.**

78. **To sustain the advances made, adequate and sustainable resources should be made available to all stakeholders working to eradicate female genital mutilation, including relevant Governments ministries, United Nations entities and national and regional civil society organizations and networks.**