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Advancement of women

Intensifying global efforts for the elimination of female genital mutilation

Report of the Secretary-General

Summary

Pursuant to General Assembly resolution 71/168, on intensifying global efforts for the elimination of female genital mutilation, the present report provides information on the root causes of and factors contributing to the practice of female genital mutilation, its prevalence worldwide and its impact on women and girls, including relevant evidence and data. It also provides an analysis of progress made to date by Member States and the United Nations system. The report includes conclusions and recommendations for future action.

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I. Introduction

1. In its resolution 71/168, the General Assembly reaffirmed that female genital mutilation was a harmful practice, a form of violence against women and girls, and that it was inherently linked to deep-rooted negative norms, stereotypes, perceptions and customs that negatively impact women and girls' human rights, along with their physical, mental, sexual and reproductive health. The Assembly reaffirmed that the elimination of female genital mutilation could be achieved through the efforts of a comprehensive movement, involving a wide range of stakeholders from different sections of society.

2. The Assembly called upon States, inter alia, to place a stronger focus on comprehensive prevention strategies and the provision of multisectoral services and to put in place accountability mechanisms to monitor the implementation of legislation. The Assembly stressed that the empowerment of women and girls was crucial to breaking the cycle of discrimination and violence that they faced and urged States to allocate sufficient resources to the implementation of policies and programmes aimed at eliminating the practice.

3. In paragraph 26 of the resolution, the Secretary-General was requested to submit to the Assembly at its seventy-third session an in-depth, multidisciplinary report on the root causes of and factors contributing to the practice of female genital mutilation, its prevalence worldwide and its impact on women and girls, including evidence and data, analysis of progress made to date and recommendations for its elimination.

4. The present report examines the latest developments, ongoing challenges and innovative practices in eliminating female genital mutilation, in the context of the implementation of the 2030 Agenda for Sustainable Development and its central tenet of "leaving no one behind". The report is based on information and submissions received from Member States[1] and relevant entities of the United Nations system[2] and is informed by the latest research findings, evidence and data. It covers the period from 1 August 2016 to 30 June 2018.

II. Global and regional normative developments

5. The 2030 Agenda for Sustainable Development includes, under Sustainable Development Goal 5, targets for both the elimination of harmful practices, such as female genital mutilation (target 5.3), and the elimination of all forms of violence against women and girls (target 5.2). Female genital mutilation is part of a continuum of violence that women and girls can experience at any time throughout their life cycle. Female genital mutilation has a serious impact on the lives and health of women and girls, including their sexual and reproductive health, and severely restricts their equal access to education and income-generating opportunities, along with the ability to have an equal say in decisions that affect their lives. As an impediment to realizing gender equality and the empowerment of all women and girls, the eradication of female genital mutilation and other forms of violence against women and girls should

[1] Submissions were received from Andorra, Argentina, Austria, Cameroon, Cabo Verde, Croatia, Colombia, Cyprus, Denmark, El Salvador, Georgia, Germany, Greece, Indonesia, Ireland, Kenya, Liberia, Mali, Mauritania, Mexico, Nigeria, Sierra Leone, Senegal, Switzerland, Togo, Tunisia, Turkey, Uganda and the United Kingdom of Great Britain and Northern Ireland.

[2] Submissions were received from the United Nations Children's Fund (UNICEF), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the United Nations Population Fund (UNFPA) and the United Nations trust fund in support of actions to eliminate violence against women.

be pursued within broader efforts to implement the Beijing Declaration and Platform for Action and the gender-responsive implementation of the 2030 Agenda.

6. Efforts to eliminate harmful practices, such as female genital mutilation, should also target the groups of women and girls who are most at risk, in particular those who face multiple and intersecting forms of discrimination, including refugee and migrant women, women living in rural and remote communities and young girls, so as to leave no one behind. Similarly, the principles of universality and respect for human rights that underpin the 2030 Agenda mandate that stakeholders address female genital mutilation, regardless of individual circumstances, prevailing cultural and social norms, or country of origin or destination.

7. During the reporting period, the international community made clear commitments at global and regional venues, including at a high-level ministerial meeting on female genital mutilation, held on 15 and 16 November 2017 in Accra, and the Commonwealth Women's Forum, held from 16 to 18 April 2018 in London, to eliminate the practice of female genital mutilation. Commitments were made to engage in closer regional cooperation, in particular in regard to rural, refugee and migrant women and girls, to greater engagement with local communities, and to increase resources for policies and programmes. There was greater recognition that harmful practices, such as female genital mutilation, child, early and forced marriage, and violence against women and girls, have common root causes, including gender inequality and discrimination perpetuated by patriarchal structures and the unequal distribution of power between men and women.

8. Regional forums[3] also acknowledged the need to frame the issue within the broader child protection framework and to support the elimination of the practice within the context of Agenda 2063 of the African Union and the 2030 Agenda. States have also been called upon to be more vigilant in relation to detecting, investigating and prosecuting cases of female genital mutilation.[4]

9. At its sixty-second session, in its agreed conclusions (E/CN.6/2018/L.8), the Commission on the Status of Women urged Governments and invited other stakeholders to eliminate female genital mutilation and other harmful practices, which disproportionately affected women and girls living in rural areas, including by empowering parents and communities to abandon such practices.

10. The Human Rights Council has addressed female genital mutilation as a human rights violation, recognizing that the practice constitutes torture and degrading treatment, and has noted that the trend towards its medicalization does not make it more acceptable (see A/HRC/RES/38/6). It has called upon States to strengthen their national legislation to address the cross-border practice of female genital mutilation through enhanced transnational cooperation between law enforcement and judicial officials (ibid). In addition, the Council has acknowledged the links between the practice and maternal mortality, the lack of health-care services, information and education, as well as malnutrition and poverty (see A/HRC/RES/33/18).

11. In its general recommendation No. 35 (2017) on gender-based violence against women, updating general recommendation No. 19 (CEDAW/C/GC/35), the Committee on the Elimination of Discrimination against Women affirmed that harmful practices were forms of gender-based violence against women affected, inter alia, by cultural, ideological and political factors. In addition, the Committee recommended that State

[3] For example, the fifty-second ordinary session of the Economic Community of West African States (ECOWAS) Authority of Heads of State and Government, held on 16 December 2017 in Abuja, and the tenth annual women's conference of the Pan-African Parliament, held on 12 and 13 October 2017, in Johannesburg, South Africa.

[4] See, for example European Parliament resolution 2017/2936 (RSP).

parties repeal provisions that tolerated or condoned forms of gender-based violence against women, including harmful practices.

12. In considering the reports of States parties, although the Committee has welcomed legislative and other measures taken to eliminate the practice (see, for example, CEDAW/C/NLD/CO/6 and CEDAW/C/CAN/CO/8-9), it has also expressed concern about the condition of young girls, often from migrant families, who have undergone or are at risk of being subjected to female genital mutilation, as well as the lack of crucial information on where to seek help (see, for example, CEDAW/CHE/CO/4-5 and CEDAW/C/DEU/CO/7-8). The Committee has recommended awareness-raising campaigns and the training of health and social services professionals to identify survivors and to hold the perpetrators accountable (ibid).

III. Current context and progress to date

A. Prevalence of female genital mutilation

13. In 2016, the United Nations Children's Fund (UNICEF) released data indicating that at least 200 million girls and women in 30 countries with representative data on prevalence had undergone female genital mutilation.[5] Of those 200 million, more than half lived in three countries: Egypt, Ethiopia and Indonesia.[6] Increasingly, girls are undergoing female genital mutilation at a younger age, and those who are 15 years of age and younger represent just over one fifth (i.e., 44 million) of those who have been cut.[7]

14. Data from large-scale representative surveys show high or almost universal prevalence in several countries in Africa. In Egypt, Guinea and Somalia, levels of prevalence of female genital mutilation among girls 15 to 49 years of age were 87, 97 and 98 per cent, respectively. By contrast, the prevalence is much lower in other countries of the continent, affecting, for example, 4 per cent of the same age group in Ghana and 2 per cent in the Niger.[8]

15. Female genital mutilation continues to be practiced in areas of the Middle East and Asia. In Yemen, 85 percent of girls undergo the practice within the first week of their life, while in Indonesia, approximately half of girls under the age of 12 undergo some form of the practice.[9] Female genital mutilation is also present in countries that do not have official data, where evidence is derived from small-scale, outdated studies or anecdotal reports. For example, the existence of the practice among the Avar community in the Kakheti region of Georgia was reported.[10] In India, a small-scale study found that 80 per cent of Dawoodi Bohra women surveyed indicated that they had been cut.[11]

[5] UNICEF, "Female genital mutilation/cutting: a global concern" (2016). Available at www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf.

[6] Ibid.

[7] Ibid.

[8] UNICEF, "Percentage of girls and women aged 15-49 years who have undergone FGM (by place of residence and household wealth quintile)". Available at https://data.unicef.org/topic/child-protection/female-genital-mutilation.

[9] UNICEF, "Indonesia: statistical profile on female genital mutilation/cutting". Available at https://data.unicef.org/wp-content/uploads/country_profiles/Indonesia/FGMC_IDN.pdf.

[10] Public Defender of Georgia, "Public Defender's statement on female genital mutilation". Available at http://ombudsman.ge/en/news/public-defenders-statement-on-female-genital-mutilation.page.

[11] Mariya Taher, "Understanding female genital cutting in the Dawoodi Bohra community: an exploratory survey", Sahiyo, 2017.

16. Some recent studies, conducted mainly in Europe, have attempted to quantify the number of immigrant women and girls who have undergone or are at risk of undergoing the practice. Those efforts have not been systematic, however, and the overall prevalence for the continent is unknown. A 2017 report from Germany found that 47,359 women and girls living in Germany had undergone female genital mutilation, an increase of 30 per cent since 2014.[12] In Cyprus, according to data published in 2018, it is estimated that between 12 and 17 per cent of a total population of 758 girls 0 to 18 years of age who originally came from countries where female genital mutilation was practiced were at risk of undergoing female genital mutilation.[13] With population movement, female genital mutilation is becoming a practice with global dimensions, in particular among migrant and refugee women and girls.

17. There is evidence of an overall decline in the prevalence in female genital mutilation in Africa during the past three decades, with 1 in 3 girls who are currently 15 to 19 years of age having undergone the practice, compared with 1 in 2 in 1985. That decline is particularly visible in countries such as Burkina Faso, Kenya, Liberia and Togo.[14]

18. However, the latest research indicates that the prevalence is increasing in other regions. According to data released in 2018, more than 200,000 women and girls in Australia have either undergone or are at high risk of undergoing female genital mutilation, which represents an increase of 252 percent since 2014. The data partially attribute the upsurge to increased migration to Australia from countries in which it is practiced.[15]

19. In addition, according to data released by the United Nations Population Fund (UNFPA) in 2018, previous estimates of the number of girls undergoing female genital mutilation each year did not include data from some high-risk countries such as Indonesia, thus underestimating the true extent of female genital mutilation in those countries. It is estimated that 15 million girls will have undergone female genital mutilation in Indonesia by 2030.[16]

20. Furthermore, youth demographics are a critical factor in estimating the number of girls at risk of undergoing female genital mutilation globally. In some countries with representative data indicating high prevalence rates, 30 per cent or more of the female population is under the age of 15.[17] The latest projections show that the number of girls who will undergo female genital mutilation each year will rise to 4.6 million in 2030 from an estimated 3.9 million in 2015, and that increase will be most evident in countries such as Egypt, Ethiopia, Nigeria and the Sudan.[18]

21. If progress to eliminate female genital mutilation is not accelerated at a faster rate than that witnessed in the past three decades, the number of girls and women undergoing female genital mutilation will continue to increase and the reduction in

[12] Available at https://www.netzwerk-integra.de/startseite/studie-fgm.

[13] European Institute for Gender Equality “Female genital mutilation: how many girls are at risk in Cyprus?”. Available at http://eurogender.eige.europa.eu/system/files/events-files/eige_fgm_cyprus_country_profile.pdf.

[14] UNICEF, “Percentage of girls and women aged 15–49 years who have undergone FGM (by place of residence and household wealth quintile)”.

[15] No FGM Australia, “FGM prevalence in Australia, 2018”. Available at http://nofgmoz.com/2018/03/07/new-report-fgm-prevalence-australia-2018.

[16] UNFPA, “Bending the curve: FGM trends we aim to change”. Available at https://www.unfpa.org/sites/default/files/resource-pdf/18-053_FGM-Infographic-2018-02-05-1804.pdf.

[17] United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision*. Available at https://esa.un.org/unpd/wpp/Publications/.

[18] UNFPA, “Bending the curve: FGM trends we aim to change”.

global prevalence will be eclipsed by overall population growth in countries where the practice takes place. That projection is supported by results from phases I and II of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting.[19] For example, it has been estimated that Kenya, which has achieved the highest annual average rate of change towards the elimination of female genital mutilation of all 17 countries participating in the programme, would have to undergo a four-fold increase in its current rate of change in order to eliminate the practice by 2030.[20]

B. Root causes, contributing factors and consequences

22. There are complex underlying motivations and reasons behind the perpetuation of female genital mutilation that stem from deep-seated gender inequalities and gender-based discrimination against women and girls. Those include a desire to control female sexuality and to limit the right of women and girls to decide on matters relating to their own bodies. Other reasons include to ensure chastity, social status and marriageability, in particular where female genital mutilation is a pre-requisite; religious narratives that sanction the practice; the ritual marking of a girl's transition into adulthood, which is often linked to other harmful practices including child, early and forced marriage; and limited access to education and economic opportunities for women and girls.

23. Female genital mutilation crosses economic, educational, social and geographical lines. There are various influences and protective factors that link the abandonment of female genital mutilation to household income, urbanization and education (see A/71/209). Recent research has demonstrated that attitudes towards elimination are changing among younger, formally schooled women, who are taking up leading roles in reshaping gender norms.[21] Also, changes in traditional family structures, shifts in women's economic and social roles and their influence on household and community decision-making processes, along with changing attitudes regarding female genital mutilation and marriageability, may influence the abandonment of the practice. Studies have also shown that structural interventions, such as the introduction of legislation banning child marriage, can also have an indirect but far-reaching influence on other harmful practices such as female genital mutilation. Further research is needed, however, to better understand the broader social, economic and political factors that can affect the decisions that families and communities make about the practice.[22]

24. Female genital mutilation operates as a social convention and norm and is held in place by reciprocal expectations within communities. As a result, the social rewards and sanctions associated with the practice are a powerful determinant of both the continuation and the abandonment of the practice.[23]

25. Data released in 2016 by UNICEF indicate that, although over two thirds of women and girls 15 to 49 years of age (67 per cent) and almost the same percentage

[19] The Joint Programme operates in Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Somalia, the Sudan, Uganda and Yemen.

[20] UNFPA and UNICEF, "Proposal for phase III of the UNFPA-UNICEF Joint Programme — Elimination of female genital mutilation: accelerating change" (2017).

[21] Hannelore Van Bavel, Gily Coene and Els Leye (2017), "Changing practices and shifting meanings of female genital cutting among the Maasai of Arusha and Manyara regions of Tanzania", Culture Health and Sexuality, vol. 19, No. 12 (2017).

[22] Bettina Shell-Duncan, Reshma Naik and Charlotte Feldman-Jacobs, "A state-of-the-art synthesis on female genital mutilation/cutting: what do we know now?" (New York, Population Council, 2016).

[23] UNFPA and UNICEF, "Proposal for phase III of the UNFPA-UNICEF Joint Programme — Elimination of female genital mutilation: accelerating change".

of men and boys (63 per cent) oppose the continuation of the practice in their communities,[24] those attitudes vary widely across and within countries. For example, in Mali, a comparison of multiple indicator cluster survey data across a five-year period showed that, in regions where female genital mutilation is less practiced, such as Timbuktu and Gao, the approval rate for its continuation had almost doubled and increased by five-fold, respectively.[25] Such a significant increase may be due to various factors, including the displacement of populations and the aftermath of occupation by various Islamist groups.

26. The desire for social acceptance and to avoid social ostracism as a result of not undergoing female genital mutilation is the most significant factor influencing the practice. Families and girls who refuse to undergo female genital mutilation may even experience violence.[26] In Indonesia, in 8 out of 10 cases, it is parents who make the decision as to whether their daughters undergo female genital mutilation, and they are likely influenced by religious and cultural beliefs about the practice. In contrast, traditional leaders are influencers in 18 per cent of cases.[27]

27. Experiencing female genital mutilation is invariably traumatic for women and girls, and the risk of adverse health outcomes rises with the degree of severity of the practice. According to the World Health Organization, women and girls can experience a range of symptoms, including shock, severe pain, excessive bleeding, genital tissue swelling and impaired wound healing.[28] Female genital mutilation is estimated to lead to an additional one to two perinatal deaths per 100 deliveries. There are also reports of post-traumatic stress disorder, anxiety, depression and memory loss associated with the practice.[29] Many women, however, who undergo the practice as infants or young children may not link complications arising later in life directly to the practice that they underwent when they were younger.[30]

28. While women and girls are subjected to female genital mutilation, their families, including their children and other male and female relatives, as well as the wider community, may be psychologically and emotionally affected by their suffering, including long after the community has abandoned the practice.[31]

C. Innovative practices to eliminate female genital mutilation: challenges and lessons learned

29. Eliminating female genital mutilation should involve a multidisciplinary approach to both preventing and responding to the practice. It should involve the engagement and coordination of key stakeholders, including various sectors of Government and a range of civil society organizations, along with United Nations entities. Adopting that approach requires stakeholders to undertake comprehensive interventions such as adopting laws and policies, providing high-quality multisectoral interventions for girls and women who have been subjected to female genital

[24] UNICEF, “Female genital mutilation/cutting: a global concern” (2016).

[25] UNICEF, “Multiple indicator cluster survey: final report”. Available at http://mics.unicef.org/surveys.

[26] Hannelore Van Bavel, Gily Coene and Els Leye (2017), “Changing practices and shifting meanings of female genital cutting among the Maasai of Arusha and Manyara regions of Tanzania”.

[27] UNICEF, “Indonesia: statistical profile on female genital mutilation/cutting”.

[28] World Health Organization (WHO), “Health risks of female genital mutilation (FGM)”. Available at http://www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en.

[29] Samuel Kimani, Jacinta Muteshi and Carolyne Njue, “Health impacts of FGM/C: a synthesis of the evidence” (New York, Population Council, 2016).

[30] Ibid.

[31] End FGM European Network, “How to talk about FGM”, position paper, December 2016.

mutilation, and robust prevention strategies, taking into consideration those girls and women who are most vulnerable. Data are also needed to inform policy and programming, as well as to monitor progress.

30. It is essential that adequate financial resources be provided to pursue a comprehensive approach to addressing female genital mutilation as a form of violence against women and girls with increased short- and long-term health risks, including sexual and reproductive health risks. The recently launched Spotlight Initiative,[32] a joint effort by the United Nations and the European Union, supported by an initial investment of 500 million euros, has galvanized such a comprehensive approach, which encompasses measures in the areas of law and policy, prevention, services and data collection to address violence against women and girls, including harmful practices. The Spotlight Initiative will focus on harmful practices and sexual and reproductive health in its programming in Africa. It aims to strengthen collaboration among relevant actors, including national Governments and civil society, and to demonstrate that interventions addressing gender inequality and violence against women, when adequately funded, can positively impact the realization of all Sustainable Development Goals.

31. During the reporting period, States reported on measures to address female genital mutilation, often with a focus on the principle of leaving no one behind, as set out in the 2030 Agenda, as well as on the need to make connections with efforts to address other forms of violence against women and girls and gender inequality more broadly.

a. Enabling environment

32. Political commitment at the highest levels is critical to successfully eradicating female genital mutilation. At the regional level, such expressions of commitment have included the appointment by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children of the First Lady of Burkina Faso as a Goodwill Ambassador to address harmful practices such as female genital mutilation.[33]

33. At the national level, the temporary ban on female genital mutilation, issued by the President of Sierra Leone in 2014 as part of efforts to halt the spread of the Ebola epidemic, has remained in place and has not been lifted by the newly elected Government. Similarly, in 2018, in Liberia, the Ministry of Internal Affairs re-issued a circular that suspended the activities of so-called “bush schools”, among which included conducting female genital mutilation in rural areas.

34. A review of the first two phases of the Joint Programme has concluded that developing laws that criminalize female genital mutilation is important in creating an enabling environment to end the practice.[34] In addition, drafting laws through a consultative and participatory process greatly facilitates and enhances the effectiveness of enforcement.[35] The implementation of legislation is a crucial next step. The effective investigation, prosecution and enforcement of legislation, in addition to the provision of sufficient financial resources in support of interventions, are necessary for the successful abandonment of female genital mutilation.[36]

[32] See http://www.un.org/en/spotlight-initiative/index.shtml.

[33] See http://iac-ciaf.net/iac-goodwill-ambassador.

[34] UNFPA and UNICEF, “Proposal for phase III of the UNFPA-UNICEF Joint Programme — Elimination of female genital mutilation: accelerating change”.

[35] Bettina Shell-Duncan, “From health to human rights: female genital cutting and the politics of intervention”, *American Anthropologist*, vol. 110, No. 2 (2008).

[36] UNFPA and UNICEF, “Proposal for phase III of the UNFPA-UNICEF Joint Programme — Elimination of female genital mutilation: accelerating change”.

35. A major barrier to ending the practice is the lack of enforcement and implementation of legislation criminalizing female genital mutilation, in particular given the sensitive, intimate and often secretive nature of the practice. During the reporting period, Governments strengthened legislation, policies and their implementation. To date, 25 of 55 States members of the African Union have legislation criminalizing the practice.[37] In the European Union, 18 of 28 member States have ratified the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), which addresses the criminalization of female genital mutilation and provides a comprehensive framework for prevention, protection and prosecution.

36. In 2017, to address cases of female genital mutilation, Georgia amended its Criminal Code to include a provision criminalizing all forms of female genital mutilation and the coercion of a girl or woman to undergo that procedure, which is punishable by imprisonment for a term of two to six years. The Joint Programme also supported the amendment of laws in Egypt, Mauritania and Uganda, resulting in increased penalties for those convicted of performing female genital mutilation, while Mali adopted two regulations banning female genital mutilation by health-care workers.

37. In the United States of America, the states of Michigan and Virginia adopted legislation prohibiting female genital mutilation, with the result that the practice is now criminalized in just over half of all states in that country. Other countries, including Andorra, Argentina, Cameroon, Croatia, Denmark, El Salvador, Mexico, Tunisia and Turkey, have addressed the practice within broader national legal frameworks, including child protection frameworks, to protect girls from violence, including female genital mutilation. Mauritania has addressed the issue within national legislation on reproductive health.

38. In its Development Policy Action Plan on Gender Equality (2016–2020), Germany committed itself to eliminating all forms of violence against women and girls, including female genital mutilation. With support from the United Nations, Sierra Leone developed a draft national strategy for the reduction of female genital mutilation, and Ireland is due to publish a second national intercultural health strategy, which will reference all health-related elements of the practice.

39. The cross-border aspect of the practice of female genital mutilation continues to pose a major barrier to prosecution. To address this, several States (Austria, Cabo Verde, Cyprus, Denmark and Kenya) reported that they had strengthened legislation to punish offenders in cases when the crime had been committed in another country. The United Kingdom of Great Britain and Northern Ireland reported that it had strengthened the implementation of such legislation, including through special protection orders.

40. In many countries, however, such actions have not afforded vulnerable girls sufficient protection, especially during the so-called “vacation cutting season”, when they return to their home countries to undergo the practice during holidays. In 2018, similar to the model introduced in the United Kingdom by the Metropolitan Police Service, the Border Force and the National Crime Agency in 2016, “Operation Limelight USA” was initiated at several domestic airports in the United States by US

[37] UNFPA, “Female genital mutilation (FGM) frequently asked questions”. Available at https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#banned_by_law.

Immigration and Customs Enforcement to increase public awareness and help deter the practice.[38]

41. The enforcement of legislation criminalizing female genital mutilation also remains a challenge owing in part to either weak capacity and reluctance of police and justice officials to hold perpetrators accountable, underreporting for fear of prosecution,[39] lack of knowledge of the law and secrecy surrounding the practice,[40] or the difficulty of meeting the burden of proof that the practice has taken place. Moreover, there is limited monitoring of prosecutions of cases of female genital mutilation, given that most States are not uniformly collecting data on the practice.[41]

42. Despite those challenges, it was evident during the reporting period that Governments have made efforts to enforce existing laws. Data reveal that, in 2016, 253 cases of female genital mutilation were brought to court and 77 individuals were convicted in the 17 countries where the Joint Programme operated, which was more than double the respective figures for the previous year.[42] Kenya, for example, established a specialized unit, developed guidelines for the prosecution of the practice and deployed 20 prosecutors to high-prevalence counties. In the United States, the first federal prosecution of a case involving female genital mutilation performed by doctors on two seven-year-old girls was filed in Michigan in 2017.

43. Through a joint initiative of UNFPA and the Africa office of Equality Now, and under the auspices of the Joint Programme, a tracking tool to address the challenge of effectively monitoring reported cases of female genital mutilation has been developed. The tool promotes accountability during the reporting, investigation and prosecutorial stages of cases and allows authorities to document instances where the girls have been spared the practice, owing to proactive judicial mechanisms and alternatives to criminal prosecution, such as injunctions and parental agreements. With support from the Joint Programme, innovative training on a tool for collecting and sharing data on cases of female genital mutilation through mobile phones and computers was conducted for law enforcement officials in Guinea, which resulted in the prosecution of 44 cases, the arrest of 11 people and 2 convictions.[43]

b. Addressing the needs of survivors

44. Girls and women who have been subjected to or are at risk of female genital mutilation should have access to a set of comprehensive, high-quality and coordinated support services that respond to both their short- and long-term needs. These include health-care, psychosocial and legal support, and assistance from the police and with finding suitable shelter. The services should, at a minimum, uphold the rights, safety and dignity of all girls and women.

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[38] United States Department of Justice, “OVW Principal Deputy Director Katie Sullivan participates in outreach efforts for Operation Limelight”. Available at https://www.justice.gov/ovw/blog/ovw-principal-deputy-director-katie-sullivan-participates-outreach-efforts-operation.

[39] Hannelore Van Bavel, Gily Coene and Els Leye (2017), “Changing practices and shifting meanings of female genital cutting among the Maasai of Arusha and Manyara regions of Tanzania”.

[40] European Institute for Gender Equality “Female genital mutilation: estimating the number of girls at risk in the EU–Report”. Available at http://eurogender.eige.europa.eu/system/files/events-files/eige_fgm_report_0.pdf.

[41] Ibid.

[42] UNFPA-UNICEF, “Accelerating change by the numbers: 2016 annual report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting — accelerating change”. Available at https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_UNICEF_FGM_16_Report_web.pdf.

[43] Ibid.

45. Several United Nations entities, programmes and funds have supported Governments and local organizations in providing access to services for survivors. For example, the Joint Programme reported that, during phase II (2014–2017), more than 3 million girls and women, including those at risk, received health, protection, legal and welfare services, and over 36,000 delivery points had been set up in schools, health facilities, community centres and child protection units to offer services to address female genital mutilation.[44]

46. The United Nations trust fund in support of actions to eliminate violence against women has supported grass roots organizations in providing access to medical and psychosocial services for survivors of female genital mutilation. For example, in 2017, 5,182 participants (both female and male) in Mali received information on the negative consequences of female genital mutilation on women and girls' sexual and reproductive health, and some were also referred to appropriate care services for follow-up. Kenya has developed standard operating procedures for service providers on the management of complications involving female genital mutilation.

47. In 2018, the World Health Organization launched a new clinical handbook on the care of girls and women living with female genital mutilation to assist health-care workers in providing high-quality and appropriate health care for girls and women who have undergone any type of procedure at any time in their lives.[45]

48. States have taken measures to address the needs of particular groups, including migrant women and girls. Greece, for example, reported that it was establishing reception centres to provide safe refuge to migrant women and girls at risk. Ireland was supporting a specialist clinic operated by the Irish Family Planning Association, where girls and women who have undergone female genital mutilation could access free specialized medical and psychological care.

49. There was evidence during the reporting period of the greater use of information technology to provide services to women and girls who have undergone or were at risk of female genital mutilation. The European Knowledge Platform for Professionals Dealing with Female Genital Mutilation, developed by the End FGM Network in partnership with Cyprus University of Technology, provides information, tools and support for professionals in the health, social services, child protection, immigration, police and justice sectors. Similarly, as part of the Network Against Female Genital Mutilation, Switzerland has launched an Internet platform that provides information, tools and resources for professionals, along with a separate community site for women at risk.

50. Evident during the reporting period is the increasing trend in medicalization, namely, the performance of female genital mutilation by health personnel. While medicalization is concentrated in Africa, health professionals worldwide have been asked to perform the practice.[46] Medicalization of female genital mutilation both institutionalizes and normalizes it, making the process of complete abandonment more difficult. It can also give the impression that the practice is without health consequences.[47] The World Health Organization (WHO) is opposed to the practice being carried out by health-care providers.[48]

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[44] UNFPA-UNICEF Joint Programme performance analysis for phase II, forthcoming.

[45] WHO, *Care of Girls and Women Living with Female Genital Mutilation: A Clinical Handbook* (Geneva, 2018).

[46] Samuel Kimani and Bettina Shell-Duncan, "Medicalized female genital mutilation/cutting: contentious practices and persistent debates", *Current Sexual Health Reports*, vol. 10, No. 1 (2018).

[47] Ian Askew and others, "A repeat call for complete abandonment of FGM", *Journal of Medical Ethics*, vol. 42, No. 9 (2016).

[48] WHO, "Health risks of female genital mutilation (FGM)".

51. The Joint Programme reported that, in 7 of the 17 countries in which the programme operates, more than 1 in 10 girls who had undergone the practice had been cut by health professionals.[49] In those countries, more than 20 million girls and women have undergone female genital mutilation at the hands of a medical professional, which represents one third of all women and girls worldwide who have undergone the practice. In Egypt, health personnel were responsible for 68 per cent of cases involving girls 15 to 19 years of age. Whether medicalization is hindering the overall decline in the prevalence of the practice remains unclear.

52. In 2017, the Joint Programme, in partnership with the League of Arab States, conducted a high-level regional meeting on the role of health professionals in combating female genital mutilation. At the meeting, doctors and midwives issued two statements on the abandonment of female genital mutilation and medicalization and stressed the importance of adopting a multisectoral approach to its elimination, taking into account regional, cultural, medical, religious, legal, human rights, academic and media perspectives.

53. Despite the commitments expressed, there has been limited funding to provide high-quality, coordinated and integrated support services and care for girls and women who have been subjected to harmful practices such as female genital mutilation. As a result, many service providers, often non-governmental organizations, remain under-resourced and are unable to guarantee sustainable care and support for those who most need it.

54. However, several States reported having pledged or provided resources to address the issue during the reporting period. The United Kingdom provided almost 4 million pounds towards improving the response by social services to women and girls who had undergone or who were at risk female of genital mutilation. As part of its national development plan for the period 2014–2018, Colombia pledged both financial and human resources support for girls and women from indigenous communities who had undergone the practice and to initiate intergenerational dialogues aimed at its elimination.

c. Addressing root causes

55. Preventative measures are an important element in efforts to end female genital mutilation. Addressing prevention effectively can prove complex, owing to the difficulty of establishing new attitudes and behaviours in a social system strongly rooted in gender-based discrimination and unequal power relations. It is that respect, however, that a multidisciplinary approach can ultimately be the most successful in the eliminating the practice.

56. In order to address the root causes of female genital mutilation, preventative strategies must address attitudes and belief systems that legitimize and normalize harmful practices, such as female genital mutilation, and encompass a range of measures at the societal, institutional, community and individual levels. Those efforts must also engage a variety of actors, including national and local governments, civil society and women's organizations, families, affected communities, traditional and faith leaders, as well as men and boys, while at the same time supporting their capacity to act as agents of change. Prevention measures that have proved to be effective in addressing female genital mutilation include community mobilization, advocacy and awareness-raising, the education of women and girls, and economic empowerment.

57. In 2017, the Joint Programme, in partnership with Drexel University, developed a framework to measure change in social norms related to female genital mutilation.

[49] Djibouti, Egypt, Guinea, Kenya, Nigeria, the Sudan and Yemen.

The framework includes monitoring and evaluation tools, based on good practices and lessons learned, will support the design of effective interventions to influence social norms, and will measure the impact of those interventions. In addition, the framework will serve as a reference for other areas of work, in particular child, early and forced marriage and violence against children.

58. During the reporting period, several States experienced success in promoting the abandonment of female genital mutilation through community mobilization and public declarations. In 2016, with the support of the Joint Programme, 989 communities in Guinea, involving 273,800 individuals, made public declarations to abandon female genital mutilation. That marked a significant increase from the 422 community declarations made the previous year and represented 18 per cent of the country's population living in villages. Such statements made it possible to identify and protect 20,563 girls 0 to 15 years of age from female genital mutilation and 15,320 girls 12 to 17 years of age from child marriage in the targeted communities.[50] Further follow-up is needed, however, to determine whether the groups of girls identified above have not undergone, or are at no further risk of undergoing, the practice in the future. In 2016, the Joint Programme reported that 79 outreach activities had been conducted in 76 communities in Asyut, Egypt, reaching a total of 3,111 women and men. As a result, 1,080 families had publicly declared that they would abandon the practice of female genital mutilation.[51] Such declarations are important, in particular in the case of families, since they overcome a communication barrier and help the families to understand that others are also changing their attitudes and that they are not alone in the change process.[52]

59. Several measures reported by States leveraged the momentum created by global advocacy platforms to link the practice with other forms of violence against women and girls and to join broader initiatives to address such violations. For example, a worldwide social media campaign against female genital mutilation was launched in Ireland in 2018 to mark the International Day of Zero Tolerance for Female Genital Mutilation, with the support of the #MeToo movement, reportedly reaching double the target of 1 million Twitter users across Africa, the United States, Asia and Australia to support a call to end the practice.[53]

60. United Nations entities also intensified their efforts to bring attention to the issue. In 2018, on the International Day of Zero Tolerance for Female Genital Mutilation, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) announced the appointment of Jaha Dukureh as its Regional Goodwill Ambassador for Africa, who will focus on ending female genital mutilation and child, early and forced marriage, including through the mobilization of youth. From 2017 to 2018, in partnership with *The Guardian* and the non-governmental organization Safe Hands for Girls, she organized a series of training sessions in Sierra Leone and Senegal for journalists and those who had performed female genital mutilation, with a view to building strong relationships among those interested in changing attitudes on female genital mutilation and reaching wider audiences through both traditional and social media platforms.

61. Owing to the respect they receive from and standing within local communities, religious leaders and faith-based organizations have a unique role in mobilizing

[50] UNFPA-UNICEF, "Accelerating change by the numbers: 2016 annual report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting — accelerating change".

[51] Ibid.

[52] Ibid.

[53] "#MeTooFGM campaign garners huge support across social media", *Irish Examiner*, 6 February 2018. Available at https://www.irishexaminer.com/breakingnews/ireland/metoofgm-campaign-garners-huge-support-across-social-media-826655.html.

communities towards changing attitudes and norms that perpetuate female genital mutilation. For example, during the reporting period, both the Islamic Centre of Ireland and the Ministry of Religious Affairs of Somaliland issued fatwas against female genital mutilation.[54]

62. The successful involvement of men and boys as part of a community-wide approach to shifting deep-rooted norms is critical for the abandonment of female genital mutilation. In Belgium, the non-governmental organization initiative Men Speak Out has engaged men in the process of ending female genital mutilation, training male peer educators from practicing communities in Belgium, the Netherlands and the United Kingdom to perform outreach activities and conduct awareness campaigns in their communities. In Kenya, the involvement of elders in campaigning against female genital mutilation has encouraged greater numbers of men from the Masaai and Embu communities to become champions of the rights of girls.

63. In 2016, also with the support of the Joint Programme, Kenya engaged schools in mobilization to end female genital mutilation. Teachers trained 3,900 children on how to report cases and access essential support services. Through that initiative, it was made clear that schools could serve as safe temporary shelter for girls escaping female genital mutilation. As a result of the training, teachers identified several girls at risk of or affected by the practice and referred those cases to the appropriate authorities.[55]

64. Initiatives that invest in girls' and women's empowerment, especially through education, skills development and leadership training, and that provide opportunities for employment, are key to eliminating female genital mutilation and discrimination against women and girls and to achieving gender equality. In Kenya, ending female genital mutilation is included in action plans in the education, health, culture, safety and security and legal sectors. In Nigeria, over 6,000 women and girls who have undergone the practice have received vocational training and have received "starter kits" to support them in their new jobs. Through a community empowerment programme created by the non-governmental organization Tostan International, women and girls who have undergone or are at risk of female genital mutilation have enrolled in school and availed themselves of local economic opportunities in the six countries in Africa in which the programme operates.[56] In 2017, 41 women in Goudiry, Senegal, who had participated in the programme were elected to represent their community at the district level.

65. Lessons learned from community empowerment programmes demonstrate that consideration must be given to individuals and communities that practice female genital mutilation, as they may not consider it to be harmful to women and girls. Many girls have undergone the practice at their homes, at the hands of a traditional practitioner or their grandmothers. It is crucial to recognize that, while harmful practices should not be condoned, a respectful, non-stigmatizing approach should be at the core of engagement with families and communities that maintain the practice. Adopting that approach will ensure more sustained progress towards complete eradication of female genital mutilation.

[54] "Islamic Centre of Ireland issues fatwa against FGM", RTE, 13 February 2018. Available at https://www.rte.ie/news/2018/0212/940233-fgm/; and Nita Bhalla, "Somaliland issues fatwa banning female genital mutilation", Thomson Reuters Foundation, 7 February 2018. Available at https://www.reuters.com/article/us-somalia-fgm-fatwa/somaliland-issues-fatwa-banning-female-genital-mutilation-idUSKBN1FR2RA.

[55] UNFPA-UNICEF, "Accelerating change by the numbers: 2016 annual report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting — accelerating change".

[56] Gambia, Guinea, Guinea-Bissau, Mali, Mauritania and Senegal.

d. Data collection and research

66. The need to collect accurate, comparable and disaggregated data, and new evidence, including for reporting on target 5.3 of the Sustainable Development Goals, is critical to informing the development of legislation, policies and programmes aimed at eliminating female genital mutilation and to monitoring progress. It is particularly crucial where the practice reportedly occurs but data is either not available at all or it is missing for certain groups. Collecting and analysing data on female genital mutilation among girls 0 to 14 years of age will also allow for the comparison of trends in prevalence with data collected for girls and women 15 to 49 years of age.

67. Research has demonstrated that the use of a mixed-method approach, which combines quantitative and qualitative research methods in estimating the risk of female genital mutilation and in understanding its nature, causes and consequences results, inter alia, in better insight into risk and protective factors that influence the practice among various groups which, in turn, informs policies that are better tailored to addressing the practice.[57]

68. In Switzerland, the Federal Office of Public Health is currently undertaking a study comparing estimated prevalence rates against recorded cases of female genital mutilation in Swiss hospitals, with a view to conducting a broader needs assessment in 2019 to further inform policy and programming in this area.

69. The Joint Programme is currently partnering with the European End FGM Network on the "Building Bridges between Africa and Europe to Tackle FGM" initiative. The initiative has launched a community of practice on female genital mutilation,[58] which promotes the exchange of knowledge between stakeholders across Europe and Africa.

70. In 2017, the Steering Committee for Human Rights of the Council of Europe released a policy guide to good and promising practices aimed at preventing and combating female genital mutilation and forced marriage, in which it described the features of an integrated response to preventing, combating and addressing the effects of those harmful practices. The guide also provided examples of initiatives that had been taken by States members of the Council of Europe to end female genital mutilation and forced marriage.[59]

e. Coordination

71. Cooperation between all entities working to prevent female genital mutilation and provide support to women and girls who have undergone the practice is key to ensuring a comprehensive and multidisciplinary approach. In Portugal, an intersectorial group consisting of State and non-governmental actors, including immigrant associations, produced a programme of action to prevent female genital mutilation, which has been incorporated into the country's National Plan to Prevent and Combat Domestic and Gender-based Violence (2014–2017).

72. In 2017, as part of phase II of the Joint Programme, UN-Women developed guidance on strengthening policy linkages between different forms of violence against women and girls, including female genital mutilation, as well as a training module on gender equality and female genital mutilation/cutting to accompany a

[57] European Institute for Gender Equality, "Estimation of girls at risk of female genital mutilation in the European Union: report".

[58] See https://copfgm.org.

[59] Council of Europe, "Guide to good and promising practices aimed at preventing and combating female genital mutilation and forced marriage". Available at https://rm.coe.int/female-genital-mutilation-and-forced-marriage/16807baf8f.

manual on social norms and change.[60] Pilot training conducted in Kenya in 2017 for the Government, civil society and United Nations entities demonstrated that the approach was successful in achieving its objective of increasing participants' understanding of female genital mutilation as a form of violence against women and girls. As a next step, UN-Women will participate in phase III of the Joint Programme (2018–2021) which will focus on interventions to support women's and girls' empowerment as part of efforts to eradicate female genital mutilation.

IV. Conclusions and recommendations

A. Conclusions

73. **States are addressing female genital mutilation and other harmful practices within the wider context of discrimination and violence against women and girls. In order to eradicate the practice completely, it is imperative to address its root causes, including gender discrimination and gender inequality, which are similar to those of other harmful practices, such as child, early and forced marriage, and other forms of violence against women and girls**.

74. **States have made critical progress in eliminating the practice, and that success is particularly visible in several countries in Africa. However, with population movement across borders, the practice is taking on global dimensions, where increasing numbers of girls and women, including those from refugee and migrant populations, have undergone or are at high risk of undergoing female genital mutilation**.

75. **Current estimates of the global prevalence of female genital mutilation do not consider data from all countries and communities where the practice is performed, thus underestimating the overall number of girls and women globally that have undergone the practice. If progress to eliminate the practice is not accelerated, any reduction in prevalence will be eclipsed by population growth in countries where it takes place**.

76. **Although current data on the prevalence of female genital mutilation points to areas of high prevalence, identifies populations that may be more amenable to change, and highlights influencing factors related to the practice, there are still gaps in understanding the nature, prevalence and extent of female genital mutilation, especially in countries not traditionally associated with the practice**.

77. **States have demonstrated a visible, high-level political commitment to ending female genital mutilation, and this has been reflected in numerous declarations, the enactment or amendment of national laws criminalizing the practice, and the integration of measures to end female genital mutilation into policy and programming on eliminating violence against women and girls. Despite those advancements, the effective enforcement of national legislation criminalizing the practice remains a challenge**.

78. **Evidence demonstrates the need for targeted support and responses for groups of women and girls facing multiple and intersecting forms of discrimination, including migrant and refugee populations, rural women,**

[60] UN-Women, *Female Genital Mutilation/Cutting and Violence against Women and Girls: Strengthening the Policy Linkages between Different Forms of Violence* (New York, 2017). Available at http://www.unwomen.org/en/digital-library/publications/2017/2/female-genital-mutilation-cutting-and-violence-against-women-and-girls; and UN-Women, UNFPA and UNICEF, Training Manual on Female Genital Mutilation/Cutting (2017). Available at https://trainingcentre.unwomen.org/mod/data/view.php?d=1&rid=5423.

indigenous women and young girls, in the design and implementation of policies and programmes addressing female genital mutilation. Results to date show that successes involving those groups are most evident at the community level, and further work is needed at the national level to amplify and replicate those efforts.

79. **States have demonstrated a holistic, integrated and multisectoral approach to eliminating female genital mutilation, including by using information technology to collect and share data, and by engaging a broad range of actors as part of community mobilization efforts to change social norms. However, limited information has been provided regarding the availability of funding for policies and programmes, including for monitoring and evaluation systems. There was also limited evidence of measures being taken to evaluate the impact of interventions, in particular at the community level**.

80. **The trend toward increased medicalization of the practice may hinder progress in eliminating female genital mutilation. There is a clear need to strengthen the health sector's ability to reverse that trend and to manage complications of the practice, and to strengthen its role as a key change agent in preventing female genital mutilation**.

B. Recommendations

81. **States should adopt a comprehensive and multidisciplinary approach to eliminating female genital mutilation that includes the enactment and/or strengthening of legislation criminalizing the practice, the provision of high-quality, multisectoral support services and comprehensive prevention strategies, as well as coordination between Government, civil society and United Nations entities.**

82. **States should address the socioeconomic and root causes of the practice, paying particular attention to high-risk populations that face multiple and intersecting forms of discrimination, including refugee and migrant women and girls, women and girls living in rural areas, indigenous women and young girls. Those efforts should be embedded within broader efforts to implement the 2030 Agenda for Sustainable Development.**

83. **Taking into consideration population growth in countries where female genital mutilation takes place, especially among girls under the age of 15, States, as a matter of urgency, should intensify efforts to eliminate female genital mutilation, in particular in communities that have not yet been targeted by national efforts.**

84. **States should collect and analyse disaggregated data using standardized methods that allow for the comparison of such data across countries, in particular for women and girls who experience intersecting forms of violence and for the measurement of progress in the implementation of target 5.3 of the Sustainable Development Goals. Such data collection should be initiated in countries where female genital mutilation is reported to exist but where national data are currently unavailable. States should also collect and analyse data on female genital mutilation among girls 0 to 14 years of age to compare trends in prevalence with data collected for girls and women 15 to 49 years of age. Furthermore, States should use a combination of quantitative and qualitative methods to estimate the risk of female genital mutilation to better inform laws, policies and programmes addressing the practice. States should also conduct research on individual, family and community-level factors that may influence whether the practice is performed.**

85. **States should enact and/or strengthen and enforce legislation prohibiting female genital mutilation, whether committed in countries of origin or destination, and hold those who perform the practice accountable. States should use consultative and participatory approaches in strengthening laws and policies and should ensure compliance.**

86. **States should build synergies between initiatives aimed at eliminating female genital mutilation and other forms of violence against women and girls and those aimed at achieving gender equality and the empowerment of women and girls. States should ensure that efforts aimed at the elimination of female genital mutilation and violence against women and girls are integrated into broader national action plans, cross-sector policies and programmes on gender equality.**

87. **To address the trend towards increased medicalization of female genital mutilation, States should ensure that health-care providers, including doctors, community health-care workers and midwives, at national and local levels, are fully aware of its harmful effects and are held accountable under law for facilitating and/or performing the practice.**

88. **States should adopt and continue to implement comprehensive prevention strategies, including advocacy, awareness-raising and community mobilization, with a broad range of key stakeholders, in particular, families, affected communities, schools and teachers, civil society including women's organizations, faith-based and religious institutions, traditional leaders, men and boys, women and girls, and the media, to help change existing norms, attitudes and behaviours that condone and justify gender inequality, violence against women and girls and female genital mutilation. States should adopt a non-stigmatizing approach in all prevention interventions, in particular when engaging with families and communities that maintain the practice. Members of refugee and migrant communities in particular can have a positive impact on abandonment initiatives through awareness-raising and information-sharing within communities, both in their countries of origin and in the countries in which they have settled.**

89. **States should collaborate with research institutions, academia, civil society and United Nations entities to monitor and evaluate the impact of ongoing measures, including public declarations and other interventions at the community level, in particular how those measures have translated into the protection of women and girls who are still at risk of undergoing female genital mutilation. States should also identify, scale up and provide further resources for measures aimed at eliminating the practice, in particular those involving new technologies, and facilitate learning and knowledge-sharing.**