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Intensifying global efforts for the elimination of female genital mutilation

Report of the Secretary-General

Summary

Pursuant to General Assembly resolution 73/149 on intensifying global efforts for the elimination of female genital mutilation, the present report provides information on the root causes of the practice of female genital mutilation, its prevalence worldwide and its impact on women and girls, with reference to the most recent data and evidence. It also provides an analysis of progress made to date by Member States, United Nations entities and other relevant stakeholders to end the practice, and information on the challenges, needs of women and girls, and efforts made to anticipate and address the impacts of the coronavirus disease (COVID-19) pandemic on the elimination of female genital mutilation. The report includes conclusions and proposes recommendations for future action.

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I. Introduction

1. In its resolution 73/149, the General Assembly recognized that female genital mutilation was an act of violence against women and girls and that increasing numbers of women and girls globally were at risk of undergoing the practice. The Assembly reaffirmed that the practice had no documented health benefits, but rather could have adverse physical, mental, sexual and reproductive health outcomes, including fatal consequences.

2. The Assembly acknowledged that awareness-raising was critical to addressing the harmful stereotyping and negative social norms, perceptions and customs that are inherently linked to female genital mutilation, and noted that such negative stereotyping hindered the implementation of legislative and normative frameworks that prohibit discrimination against women and girls, and guarantee gender equality.

3. The Assembly called upon States to increase their focus on developing comprehensive prevention strategies aimed at eliminating female genital mutilation, and emphasized the importance of adopting a non-stigmatizing approach in all interventions. It urged States to hold those who perform female genital mutilation within or outside a medical institution to account, to establish mechanisms to monitor accountability and to ensure access to health care and other essential services for survivors and those at risk of undergoing the practice.

4. The present report is submitted in a seminal year, 2020, and coincides with anniversaries marking key milestones in the protection and promotion of women's rights, gender equality and women's empowerment. It examines the latest developments, and innovative and effective approaches to eliminating female genital mutilation, in the context of the implementation of the 2030 Agenda for Sustainable Development and the decade of action and delivery for sustainable development, and the twenty-fifth anniversary of the adoption of the Beijing Declaration and Platform for Action. The report is based on information and submissions received from Member States[1] and relevant entities of the United Nations system.[2] Those submissions included information on efforts to anticipate and address the impacts of the coronavirus disease (COVID-19) pandemic on the elimination of female genital mutilation. The report covers the period from 1 August 2018 to 30 June 2020 and is informed by the latest research findings, evidence and data.

[1] Submissions were received from Argentina, Australia, Austria, Belgium, Bosnia and Herzegovina, Brunei Darussalam, Colombia, Cuba, Czechia, France, Germany, Greece, Guatemala, Ireland, Israel, Japan, Paraguay, Philippines, Portugal, Saudi Arabia, Serbia, Sweden, and the United Kingdom of Great Britain and Northern Ireland. They are available at www.unwomen.org/en/how-we-work/intergovernmental-support/major-resolutions/general-assembly/ga75-2020. National reports for the national-level review of the implementation of the Beijing Declaration and Platform for Action on the twenty-fifth anniversary of its adoption, and the outcomes of the twenty-third special session of the General Assembly were considered for the report. They are available at www.unwomen.org/en/csw/csw64-2020/preparations#reports. Replies for the present report were received from the Council of Europe and the Organization of Islamic Cooperation.

[2] Submissions were received from the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the Office of the United Nations High Commissioner for Human Rights (OHCHR), the Economic Commission for Africa (ECA) and the United Nations trust fund in support of action to eliminate violence against women.

II. Global and regional developments

A. Normative framework

5. The 2030 Agenda includes specific Sustainable Development Goals and targets for the elimination of all forms of violence against women and girls (target 5.2) and female genital mutilation (target 5.3), that have been identified as barriers to the achievement of many other Goals and targets, and to the advancement of women's empowerment and gender equality. At the sixty-fourth session of the Commission on the Status of Women, States adopted the political declaration on the occasion of the twenty-fifth anniversary of the Fourth World Conference on Women (see E/2020/27), in which they committed to the full, effective and accelerated implementation of the Beijing Declaration and Platform for Action by strengthening their efforts towards achieving gender equality and the empowerment of women and girls. They also recognized the need to address the challenges hindering the implementation of the 12 critical areas of concern, including by increasing efforts to eliminate, prevent and respond to all forms of violence and harmful practices against all women and girls.

6. At the regional level, the African Union launched its ambitious Saleema initiative at its thirty-second ordinary session of Heads of States and Government, held in Addis Ababa on 10 and 11 February 2019. The initiative, which is aimed at ending female genital mutilation and preventing 50 million girls at risk on the continent from undergoing the practice, is supported by the United Nations Population Fund (UNFPA)-United Nations Children's Fund (UNICEF) Joint Programme on the Elimination of Female Genital Mutilation. It marks a critical step towards ensuring high-level political commitment and strengthening accountability towards abandoning the practice. Spearheaded by the President of Burkina Faso, Roch Marc Christian Kaboré, designated the African Union champion on eliminating female genital mutilation, the initiative calls for, inter alia, the implementation of robust legislative frameworks, increased allocation of financial resources and better engagement with community groups most affected by the practice.[3]

7. During its thirty-fourth session, held in Cairo from 25 November to 5 December 2019, the African Committee of Experts on the Rights and Welfare of the Child, announced that it would develop, together with the African Commission on Human and Peoples' Rights, a general comment on female genital mutilation. Once adopted, the general comment will provide guidance, in particular to the 22 countries in Africa with the highest prevalence of female genital mutilation, on how to effectively enforce their respective legislation criminalizing the practice.

8. At the International Conference on Ending Female Genital Mutilation, held in Ouagadougou from 22 to 25 October 2018, Kenya, Uganda and the United Republic of Tanzania, with the support of the UNFPA-UNICEF Joint Programme, established a tripartite initiative to end cross-border female genital mutilation. Following the first regional interministerial meeting to end female genital mutilation, held in Mombasa, Kenya, on 17 April 2019, Ethiopia and Somalia joined the three nations in adopting a declaration and action plan calling for improved coordination and collaboration between States, stronger legislative and policy frameworks, enhanced communication and advocacy on cross-border prevention and response, and better data collection specifically targeting vulnerable communities living along their borders.[4]

[3] See https://au.int/en/pressreleases/20190211/african-union-launches-continental-initiative-end-female-genital-mutilation.

[4] United Nations Population Fund (UNFPA), "Ending cross-border female genital mutilation", 4 October 2019. Available at https://kenya.unfpa.org/en/publications/ending-cross-border-fgm.

9. In another significant development, the first African Summit on Female Genital Mutilation and Child Marriage, convened by the Gambia, Senegal and the survivor-led organization Safe Hands for Girls, with the support of the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and the UN-Women Regional Goodwill Ambassador for Africa, Jaha Dukureh, UNFPA and the World Bank, was held in Dakar from 16 to 18 June 2019. African youth activists, traditional and religious leaders, including the Deputy Grand Iman of Al-Azhar University in Cairo, and representatives of 17 African States, adopted the Dakar Declaration[5] in which they acknowledged that a "one-size-fits-all" approach to ending harmful practices, including female genital mutilation, does not work. They noted that effective responses to the problem must be multisectoral, integrated, sustainable, evidence-based and scaled up, and recommended that interventions should combine approaches that aim to empower girls, mobilize families and communities, provide quality education, protection and health services and establish enabling policy and legal frameworks.

10. At the seventh Ministerial Conference on the Role of Women in the Development of Member States of the Organization of Islamic Cooperation, on the theme "Women empowerment in Member States: challenges and prospects", held in Ouagadougou on 30 November and 1 December 2018, States were urged to address female genital mutilation by enforcing legislation criminalizing the practice, and developing community awareness programmes highlighting its harmful effects.[6]

11. At the international level, the Committee on the Elimination of Discrimination against Women welcomed the efforts made by several States parties to the Convention on the Elimination of All Forms of Discrimination Against Women during the reporting period to eliminate female genital mutilation.[7] However, it expressed concern at the persistence of the practice,[8] underreporting of cases and lack of enforcement of legislation criminalizing the practice (CEDAW/C/ETH/CO/8, para. 21). The Committee called for States to take further measures to effectively prosecute perpetrators (CEDAW/GBR/CO/8, para. 32), and monitor and assess the measures taken to eliminate discriminatory gender stereotypes and harmful practices (CEDAW/C/ETH/CO/8, para. 22(c)).

12. States continued to demonstrate a high level of political support for eliminating female genital mutilation. An analysis of the reports of the third cycle of the universal periodic review indicated that 9 out of 10 recommendations relating to the practice had been accepted by Member States.[9] Given that approximately half of all the recommendations on female genital mutilation related to the enactment and enforcement of laws to prevent and respond to the practice, and considering the broad range of duty bearers and actions taken, it was clear that States considered the practice a national development priority that required a comprehensive multisectoral response.

13. Pursuant to Human Rights Council resolution 38/6, the Office of the United Nations High Commissioner for Human Rights (OHCHR) organized an expert meeting on the issue of female genital mutilation, on 17 and 18 July 2019. The outcome report (A/HRC/44/33) submitted to the Council provided details on innovative approaches to addressing social norms at the community level, including

[5] Dakar Declaration to eradicate female genital mutilation and child marriage in Africa by 2030.

[6] See www.oic-oci.org/docdown/?docID=4426&refID=1249.

[7] See, for example, CEDAW/C/COL/CO/9, para. 23; CEDAW/C/GBR/CO/8, para. 31; and CEDAW/C/ERI/CO/6, para. 21.

[8] See, for example, CEDAW/C/ETH/CO/8, para. 21; CEDAW/GBR/CO/8, para. 31; CEDAW/C/ERI/CO/6, para. 21(b); and CEDAW/C/IRQ/CO/7, para. 19(a).

[9] UNFPA, "Accountability for eliminating female genital mutilation – a focus on the third cycle of the universal periodic review", Fact Sheet, June 2020, available at www.unfpa.org/sites/default/files/resource-pdf/FGM_factsheet_13-online.pdf.

convening consultations with practising communities, especially women and girls, to ensure full ownership and legitimacy of interventions aimed at abandoning the practice. Leadership, political commitment, long-term vision, a participatory and inclusive approach, as well as accountability, were emphasized as key to ending the practice.

14. In its resolution 44/16 on the elimination of female genital mutilation, the Human Rights Council noted the role that national human rights institutions could play in investigating violations relating to the practice, that accountability goes beyond legal protection, the need to incorporate prevention and response into national development plans, and the importance of allocating budgets for programming. With reference to the COVID-19 pandemic, the Council expressed deep concern that the practice of female genital mutilation was exacerbated in humanitarian situations, pandemics and other crises, which resulted in a potential increase in prevalence and delayed programme implementation. It called upon States to take a comprehensive, rights-based, gender-responsive and multisectoral approach to the prevention of and response to female genital mutilation in the context of the COVID-19 crisis, and to pay attention to the specific needs of women and girls, including those in vulnerable situations.

B. The pandemic and its impacts on the elimination and prevention of female genital mutilation

15. The COVID-19 pandemic presents major global health and socioeconomic challenges. Previous responses to humanitarian crises, including disease outbreaks, indicate that the pandemic will exacerbate existing gender inequalities and increase the risk of violence against women and girls.[10] The economic impacts of the Ebola virus outbreak in West Africa, for example, put women at increased risk of exploitation and sexual violence.[11]

16. The COVID-19 pandemic may have a negative impact on efforts to eliminate female genital mutilation.[12] It had previously been projected that scaling up programmes aimed at eliminating female genital mutilation would reduce new cases by approximately 5.3 million over the period 2020 to 2030.[13] However, UNFPA has noted that the pandemic could severely undermine progress towards achieving Sustainable Development Goal 5, target 5.3, with an additional 2 million girls and women undergoing the practice by 2030. That increase would represent an estimated 33 per cent reduction in progress towards eliminating female genital mutilation by 2030.

17. With lockdown measures, including school closures, imposed as a result of the pandemic, many girls are staying at home. Reports from Somalia suggest that families have been approaching medical personnel to perform the practice on their daughters,

[10] United Nations Entity on Gender Equality and the Empowerment of Women (UN-Women), "COVID-19 and ending violence against women and girls", 2020. Available at www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006, pp. 3–5.

[11] UNFPA, "COVID-19: a gender lens – protecting sexual and reproductive health and rights, and promoting gender equality", Technical Brief, March 2020. Available at www.unfpa.org/resources/covid-19-gender-lens, p. 6.

[12] UNFPA and UNICEF, "COVID-19 disrupting SDG 5.3: Eliminating female genital mutilation", Technical Note, April 2020. Available at www.unfpa.org/sites/default/files/resource-pdf/COVID19_Disrupting_SDG.3_Eliminating_Female_Genital_Mutilation.pdf.

[13] See www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf, p. 4.

taking advantage of the extended time at home to recover.[14] In the economic downturn caused by the pandemic, traditional cutters have been directly approaching families in search of work. Guidance on social distancing may not be adhered to when female genital mutilation is performed at home, thus increasing the risk of transmission of the virus. Reports suggest that, in the event of complications arising from the practice, families are not taking their daughters to seek urgent medical help out of fear of contracting the virus at health facilities.[15]

18. The impact of social isolation on known drivers of female genital mutilation, for example, weak enforcement of legislation criminalizing the practice, and communities that perform the practice in secret, may lead to an increase in female genital mutilation for the purposes of child, early and forced marriage.[16] On a positive note, reports from civil society organizations in Nigeria and Malaysia suggest that social distancing practices are curtailing medicalized performance of forms of the practice in health centres and hospitals.[17]

19. UNFPA has noted that lockdowns could significantly delay the implementation of programmes to eliminate female genital mutilation by diverting the attention and efforts of health care and social programming to COVID-19 control.[18] Law enforcement may also be overburdened during the crisis and unable to provide adequate protection to women and girls at risk.[19] In addition, social distancing will likely halt many forms of effective prevention programming, such as community empowerment programmes and declarations to abandon the practice, which are usually implemented in group settings.[20] The Ebola virus outbreak had resulted in the disruption and, in some cases, cessation of work by civil society organizations and campaigners to end female genital mutilation.[21] Consequently, there may be gaps in appropriate prevention and protection of female genital mutilation and other forms of violence against women and girls as well as in the provision of good-quality essential services.

III. Latest data and trends on female genital mutilation

A. Prevalence

20. At least 200 million girls and women alive today have been subjected to female genital mutilation.[22] More than 4 million girls annually are at risk of undergoing female genital mutilation, and most are cut before they reach the age of 15.[23]

21. Considering the most recent data available from the Demographic and Health Survey of Maldives, the number of countries globally with nationally representative

[14] See www.theguardian.com/world/2020/may/18/fgm-risk-in-somalia-heightened-by-coronavirus-crisis?CMP=Share_iOSApp_Other.

[15] See www.theguardian.com/global-development/2020/jun/16/coronavirus-millions-more-girls-risk-fgm.

[16] Submission from The Orchid Project, p. 9.

[17] Ibid.

[18] See www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf.

[19] UNFPA and UNICEF, “COVID-19 disrupting SDG 5.3: Eliminating female genital mutilation”, Technical Note, April 2020, p. 2.

[20] See www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf.

[21] See www.28toomany.org/blog/2014/dec/10/will-ebola-help-or-hinder-the-fight-against-fgm-in-liberia.

[22] See https://data.unicef.org/topic/child-protection/female-genital-mutilation.

[23] See www.unicef.org/protection/female-genital-mutilation.

data on the practice has increased from 30 to 31.[24] While there is evidence that female genital mutilation is practiced in at least 90 countries[25] across the globe, robust data to support this remain scarce.

22. Local and small-scale studies indicate that the practice exists in communities in over 20 countries in Eastern Europe, Latin America, the Middle East and South-East Asia,[26] as well as in diaspora communities in North America, Western Europe and Australia. The latest figures from a study conducted by the Australian Institute of Health and Welfare in 2019 estimated that 53,000 women and girls born elsewhere and now living in Australia had undergone female genital mutilation;[27] however, the exact number was unknown. In many countries, anecdotal evidence suggests that the practice is too localized for questions relating to female genital mutilation to be included in national surveys.[28]

23. The prevalence of female genital mutilation varies almost as much within as among countries.[29] Conducting subnational analyses help programmes identify so-called hotspots, or high-prevalence areas, that would benefit from specific intervention. On that basis, a more detailed investigation of specific community characteristics associated with the practice, such as expectations regarding marriage and household decision-making can be undertaken.[30] That, in turn, would help focus investments and develop effective programming, which are essential for elimination.

24. Female genital mutilation is becoming less common in some countries where it was once universal. The percentage of adolescent girls aged 15 to 19 years who have undergone female genital mutilation, for example, in Egypt, has decreased from 97 per cent 30 years ago to 70 per cent today and, in Sierra Leone, the corresponding decrease over the same time frame was from 96 to 64 per cent.[31] Considerable progress has been made in countries supported by the UNFPA-UNICEF Joint Programme, such as Burkina Faso and Ethiopia, where adolescent girls aged 15 to 19 years are now over 33 per cent less likely to undergo the harmful practice than three decades ago.

25. Although there is evidence of progress, the decline in prevalence in many countries is not widespread and is not happening fast enough. In some countries, such as Guinea and Somalia, female genital mutilation remains universal, with over 90 per cent of adolescent girls aged 15 to 19 years having undergone the practice. In other countries, such as Guinea-Bissau, there has been no significant decline in prevalence, where 42 per cent of adolescent girls aged 15 to 19 years have been subjected to the practice, compared with 45 per cent thirty years ago.[32]

[24] UNICEF, Female genital mutilation: A new generation calls for ending an old practice (New York, 2020), p. 8. Available from https://data.unicef.org/resources/female-genital-mutilation-a-new-generation-calls-for-ending-an-old-practice.

[25] See www.equalitynow.org/fgmc_a_call_for_a_global_response_report, p. 11.

[26] Claudia Cappa, Luk Van Baelen and Els Leye, “The practice of female genital mutilation across the world: Data availability and approaches to measurement”, *Global Public Health*, Vol. 14, No. 8 (February 2019).

[27] See www.aihw.gov.au/getmedia/f210a1d8-5a3a-4336-80c5-ca6bdc2906d5/aihw-phe-230.pdf.aspx?inline=true, p.1.

[28] Claudia Cappa, Luk Van Baelen and Els Leye, “The practice of female genital mutilation across the world”.

[29] Population Council, “Evidence to end FGM/C: Research to help girls thrive – Reflections from five years of research” (2020), p. 5. Available at www.popcouncil.org/research/reflections-from-five-years-of-research-on-fgm-c.

[30] Ibid.

[31] UNICEF, Female genital mutilation: A new generation calls for ending an old practice, p. 3.

[32] Ibid., p. 5.

26. Current progress in reducing the prevalence of female genital mutilation is insufficient to keep up with increasing population growth. If trends continue, the number of women and girls undergoing the practice will rise significantly in the coming years (A/73/266, para. 20).

27. Progress on female genital mutilation must take place at a faster rate than that witnessed in recent years. According to UNICEF,[33] even in countries where the practice has become less common, progress would need to be at least 10 times faster to meet the global target of elimination by 2030. If immediate action is not taken, the number of girls and women undergoing female genital mutilation globally will continue to increase, and any reduction in prevalence will be overtaken by population growth in countries in which the practice is performed.

B. Girls are being cut younger

28. In most countries, female genital mutilation is performed within the first five years of life (A/71/209, para. 15). In Yemen, cutting is most often performed during the first week of life;[34] while in the Gambia, Mali and the Niger, the risk of undergoing the practice in the first five years of life is high.[35] Other research conducted in "Somaliland" indicated a gradual decrease in the age at which girls undergo female genital mutilation, from 15 to 16 years of age to 5 to 8 years of age.[36] Reasons for undergoing the procedure at a younger age include parental authority exerted "in the interest of the girl" and in the name of tradition.

29. Identifying the age at which girls are being cut is critical to informing the design of efforts to eliminate female genital mutilation and tailoring them effectively to the local context. Interventions targeting parents and community leaders and members, for example, and concerning girls who undergo female genital mutilation at a young age, have proven effective. For adolescent girls, additional awareness-raising and empowerment initiatives can be very effective in abandoning the practice.[37]

C. Increasing trend towards medicalizing female genital mutilation among adolescents

30. According to the most recent data, one in four girls and women who have undergone female genital mutilation, or 52 million survivors globally, have been cut by health-care providers.[38] Available figures indicate that adolescents are twice as likely (34 per cent of those aged 15–19 years) as older women (16 per cent of those aged 45–49 years) to have the practice performed by medical personnel.

31. Medicalization is common in Egypt and the Sudan, where almost 8 in 10 girls have undergone female genital mutilation performed by medical personnel.[39] Medicalization of the practice has also increased in Guinea, Kenya, Nigeria and

[33] Ibid.
[34] See https://data.unicef.org/resources/female-genital-mutilation-in-the-middle-east-and-north-africa.
[35] See www.unfpa.org/sites/default/files/resource-pdf/Age_at_FGM_.pdf, p. 4.
[36] See www.popcouncil.org/uploads/pdfs/2018RH_FGMC-Somaliland.pdf, p. 10.
[37] See www.unfpa.org/sites/default/files/resource-pdf/Age_at_FGM_.pdf, p. 8.
[38] UNICEF, Female genital mutilation: A new generation calls for ending an old practice, p. 8.
[39] See https://data.unicef.org/resources/female-genital-mutilation-in-the-middle-east-and-north-africa.

Somalia, owing partly to families' belief that the procedure will pose less of a health risk if performed in that way.[40]

32. There is no evidence, however, to indicate that medicalization will make the practice of female genital mutilation any safer[41] as it removes and damages healthy tissue and interferes with the natural functions of a girl's body. Health-care providers who perform female genital mutilation are violating girls' and women's rights to life, physical integrity and health. They are also violating the fundamental medical obligation to "do no harm".

33. Findings from a recent qualitative study conducted in Egypt suggest that parents who seek medicalized female genital mutilation for their daughters are conforming to social expectations that undergoing the practice is a necessity and will spare them from the stigma of being uncut.[42] The link between girls' well-being and physical beauty may be fuelling the trend for some health-care providers to market the practice as a cosmetic procedure, possibly to avoid criminal sanctions in countries where the practice is banned. The results of that research indicate that, where medicalization is concerned, social norms continue to override both legal provisions criminalizing the practice and the medical ethic of doing no harm. Medicalization therefore represents a threat to efforts to eliminate the practice of female genital mutilation.

D. Cross-border practice of female genital mutilation

34. A significant challenge to the elimination of female genital mutilation is the cross-border nature of the practice. Cross-border practice stems from a deeply rooted social norm, based on shared traditions between communities on different sides of the same border, which contribute to perpetuating female genital mutilation.[43] It is a strategy employed by communities to ensure that the practice is conducted in secret, without fear of prosecution in neighbouring countries or without being monitored.

35. Of 22 African countries with legislation prohibiting female genital mutilation, the majority (19 countries) do not address the cross-border nature of the practice and only three countries have legislation that criminalizes it (Guinea-Bissau, Kenya and Uganda).[44] Challenges to successfully addressing the practice of cross-border female genital mutilation include continued socioeconomic benefits to the families and traditional practitioners, low prosecution rates, lack of regional monitoring and data collection on the nature of the practice, and lack of joint regional cooperation mechanisms.[45]

IV. Factors contributing to the practice of female genital mutilation

36. There are well-documented reasons supporting the continuation of the practice of female genital mutilation, which have their roots in gender-based discrimination

[40] Population Council, "Evidence to end FGM/C: Research to help girls thrive – Reflections from five years of research", p. 10.

[41] UNICEF, Female genital mutilation: A new generation calls for ending an old practice, p. 8.

[42] Omaima El-Gibaly, Mirette Aziz and Salma Abou Hussein, "Health care providers' and mothers' perceptions about the medicalization of female genital mutilation or cutting in Egypt: A cross-sectional qualitative study", *BMC International Health and Human Rights*, Vol. 19, No. 26 (2019).

[43] See www.unfpa.org/sites/default/files/pub-pdf/Beyond_the_Crossing_Female_Genital_Mutilation_Across_Borders_Final.pdf, p. 25.

[44] See www.28toomany.org/Law.

[45] See www.unfpa.org/sites/default/files/pub-pdf/Beyond_the_Crossing_Female_Genital_Mutilation_Across_Borders_Final.pdf, p. 31.

against women and girls, gender roles, lack of economic and educational opportunities, location (rural versus urban settings), community influence, cultural codes concerning female virtue and family honour, as well as the desire to belong (A/73/266, paras. 22–24).

37. There is evidence, however, that attitudes towards female genital mutilation are shifting, creating a momentum to completely abandon the practice, especially among young, educated women (ibid., para. 23). The proportion of women and girls aged 15 to 49 years in high-prevalence countries who want the practice to stop has doubled, from 27 per cent at the start of the millennium to 54 per cent today.[46] In Egypt, Guinea and Sierra Leone, adolescent girls are at least 50 per cent more likely than older women to oppose the practice.

38. Factors such as migration, increased exposure to the media, and changing decision-making dynamics are also contributing to shifts in the social foundations of the practice. In most cases, mothers take the decision to have their daughters cut; however, they do not take that decision alone.[47] They usually consider the views of other family members, including grandmothers, as well as the social group to which they belong. Research indicates that some older women are open to reassessing the practice of female genital mutilation, as their social standing gives them the power to negotiate change. By recognizing the unique role of older women as potential leaders of change, measures aimed at eliminating female genital mutilation could be developed without undermining traditional values.[48]

39. Recent research reveals that a significant percentage of couples hold discordant opinions on the continuation of female genital mutilation, including in countries where the practice is very common.[49] Fathers may often be more opposed to female genital mutilation than mothers; however, any opposition a father may have to his daughter undergoing the practice may not be taken into consideration and he may only be informed by the girl's mother after the practice has been performed.[50] There is also evidence that young men may hold conflicting opinions about female genital mutilation. According to research conducted in Senegal, for example, a group of young men indicated that they would marry a girl who had not been cut; however, they also stated that they would prefer for their own sisters to have undergone the practice.[51]

40. Significantly, there is evidence to suggest that compliance with legislation criminalizing female genital mutilation, coupled with advocacy on the health risks associated with the practice, could lead to its reduction.[52] Findings from a study conducted in Burkina Faso and Mali indicate that most respondents supported the elimination of female genital mutilation (83 per cent and 77 per cent respectively), as long as everyone committed to abandoning it.

41. Despite recent research identifying key stakeholders and entry points for change, challenges to the elimination of female genital mutilation persist. An

[46] UNICEF, Female genital mutilation: A new generation calls for ending an old practice, p. 7.

[47] Population Council, "Evidence to end FGM/C: Research to help girls thrive – Reflections from five years of research", p. 8.

[48] Bettina Shell-Duncan and others, "The role of older women in contesting norms associated with female genital mutilation/cutting in Senegambia: A factorial focus group analysis", *PLoS ONE*, Vol. 13, No. 7 (July 2018).

[49] Claudia Cappa, Claire Thomson and Colleen Murray, "Understanding the association between parental attitudes and the practice of female genital mutilation among daughters", *PLoS ONE*, Vol. 15, No. 5 (May 2020).

[50] See www.popcouncil.org/uploads/pdfs/2020RH_FGMC-Somaliland.pdf, p. 24.

[51] Population Council, "Evidence to end FGM/C: Research to help girls thrive – Reflections from five years of research", p. 8.

[52] See www.popcouncil.org/uploads/pdfs/2020RH_FGMC-LawReducePractice.pdf, p. viii.

investigation[53] identified several factors contributing to its continuation, including resistance from communities, secret performance of the practice and lack of sustainability of interventions, coupled with a short time frame for implementation. Additional challenges included inappropriate selection of change agents to spearhead implementation, reluctance of some religious leaders to denounce the practice, and the exclusion of men and boys. The research found that school clubs addressing harmful traditional practices, including female genital mutilation, excluded boys from discussions relating to such practices, despite the fact that they could also act as change agents in the community.

42. It is clear that further research is needed to understand how and why female genital mutilation is practised at different levels of society, both at the national and community levels and, in particular, the reasons why one community chooses to abandon the practice, while a neighbouring community does not.

V. Innovative practices to eliminate female genital mutilation, including in the context of COVID-19

A. Engagement of key stakeholders in eliminating female genital mutilation

43. Eliminating female genital mutilation requires shifting social norms by addressing the root causes of the practice, such as discrimination, inequality and girls' and women's lack of power and control. The enormity of the consequences of female genital mutilation on every aspect of women's and girls' lives calls for a comprehensive and multidisciplinary approach to prevent and respond to it. That includes providing quality health-care responses and innovative legal solutions for women and girls who have undergone the practice, adapted now to the realities of COVID-19 and focused on those most marginalized and at higher risk of experiencing violence. It also requires engagement with key stakeholders in order for collective efforts aimed at eliminating the practice to be effective.

44. The potential of the education sector is being increasingly recognized as an entry point and States reported that teachers and school psychologists are identifying girls at risk of undergoing female genital mutilation more frequently. Under its National Action Plan on Gender Equality (2016–2020), Greece conducted seminars on the harmful effects of the practice for primary and secondary school students. The United Republic of Tanzania has mainstreamed female genital mutilation into its primary education curriculum. The Council of Europe also reported that notifications to authorities and asking parents to sign a declaration of honour not to have their daughters cut are gaining considerable ground in countries in the region.

45. The evidence points to a respectful, non-stigmatizing and nuanced approach that should be at the core of engagement with communities that practise female genital mutilation. Such an approach builds upon the positive aspects inherent in local traditions, while at the same time moves towards abandonment of the practice.

46. In 2019, the UNFPA-UNICEF Joint Programme supported 109,951 girls in 7,696 communities in 16 countries in acquiring skills and knowledge to advocate for their rights and become agents of change in their communities.[54] That included

[53] Population Council, Getaneh Mehari and others, "Exploring changes in female genital mutilation/cutting: Shifting norms and practices among communities in Fafan and West Arsi zones, Ethiopia" (2020), pp. 28–31.

[54] UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, Annual Report 2019 (forthcoming), p. 5.

supporting girls' clubs, community dialogues, school-based programmes, mentorship, alternative rites of passage programmes, comprehensive sexual and reproductive health education, human rights and life skills training and professional development.

47. Over the same period, the UNFPA-UNICEF Joint Programme supported national initiatives enabling 6,312 communities to make public declarations to abandon female genital mutilation. An estimated 230,025 girls were saved from undergoing the practice through the efforts of the surveillance mechanisms established by those communities.[55]

48. Community-based women and youth groups have been at the forefront of protection and prevention activities, especially during the COVID-19 pandemic. The UNFPA-UNICEF Joint Programme has been supporting those groups in tracking and assisting girls at risk of undergoing the practice using WhatsApp and other platforms supporting continued community surveillance. In Nigeria, the Joint Programme has been using the #endcuttinggirls hashtag to support social media advocacy to eliminate female genital mutilation, thereby reaching over a quarter of a million users. The Joint Programme has also strengthened case management for survivors, especially in remote areas, as well as supported the establishment of local rescue brigades in response to gender-based violence and harmful practices within formal and informal referral mechanisms, so as to facilitate survivor referral.

49. The programme of work of the Spotlight Initiative in Africa is the largest programme investment within the Initiative, which supports a multisectoral and coordinated response to violence against women and girls and harmful practices across eight countries in the region,[56] as well as promotes their sexual and reproductive health and reproductive rights.

50. The Spotlight Initiative made significant strides during the reporting period to address female genital mutilation. In Liberia, the Initiative worked with traditional practitioners from the Sande society to provide alternative sources of income, through training in entrepreneur skills, funding to set up businesses,[57] and replacing Sande schools with heritage centres.[58] A key lesson from that work is that awareness-raising aimed at eliminating and preventing female genital mutilation is not sufficient unless lucrative incentives to continue the practice are removed. That commitment to address harmful practices was reinforced by the signing by 112 traditional leaders of the national Seven-Count Policy in 2019, which suspended all such interventions by the Sande society, including female genital mutilation, for one year.[59]

51. In partnership with the National Association of Women's Organizations in Uganda, the Initiative developed an innovative approach to abandoning female genital mutilation by establishing community-based action teams. As a result, local health-care professionals and cultural leaders have joined efforts to denounce the practice and have spurred communities in three districts to bring about change in attitudes and practices, with a view to effecting wider transformation in the communities and replicating the model across Uganda.[60] In Malawi, Mali and the Niger, the Initiative supported religious leaders in making official public statements condemning female genital mutilation and early marriage.[61]

[55] UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation database.
[56] Namely, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Uganda and Zimbabwe.
[57] Spotlight Initiative, Global Annual Narrative Progress Report 2019, p. 178.
[58] Ibid., p. 227.
[59] Ibid., p. 178.
[60] Ibid., p. 222.
[61] Ibid., p. 78.

52. Traditional and faith-based leaders are in a unique position to influence decisions within families and to build consensus in their communities to abandon female genital mutilation. During the reporting period, the UNFPA-UNICEF Joint Programme supported a series of dialogues in 16 countries, reaching 7,359 communities, and encouraging religious leaders to delink the practice from religious requirements.

53. In Mali, local non-governmental organizations, in partnership with and supported by Germany are using the media during the COVID-19 pandemic to disseminate messages on preventing violence against women and girls and harmful practices, through live radio programmes, recorded audio messages and video courses involving faith-based leaders. In Egypt, a fatwa prohibiting female genital mutilation was reissued. The Coptic Church in the country also confirmed its official position against the practice.

54. To address one of the key principles at the core of the 2030 Sustainable Development Agenda – leaving no one behind – civil society in France has been active in raising awareness about the practice of female genital mutilation among diaspora communities. The United Nations trust fund in support of actions to eliminate violence against women has supported the International Solidarity Foundation in awareness-raising among marginalized women on abandoning the practice in rural and internally displaced communities in three regions in “Somaliland”.

B. Health system

55. The health sector can play a central role in eliminating and preventing female genital mutilation, because of the standing it enjoys within communities, its role in managing complications associated with the practice and in educating patients, and the fact that it is bound by the principle of doing no harm.[62] However, there is little evidence as to whether health workers have been involved in either preventing or perpetrating the practice.

56. Investigations conducted in Kenya and Nigeria found that, although there is legislation for preventing and responding to female genital mutilation, it has not been translated into specific guidance for health-care workers.[63] Health workers have a limited understanding of existing policies and guidelines and limited resources for prevention activities. Health services do not keep comprehensive records; and coordination between the justice system and the health sector is weak. In addition, few health-care workers have been trained on how to speak with patients and families about the practice, especially to explain its negative consequences.

57. That research corroborates the results of a recent survey carried out in Australia on the knowledge, experience and training needs of midwives in relation to female genital mutilation, which found that, of the 198 midwives surveyed, 53 per cent knew the correct classification of the practice, while 48 per cent reported that they had not received training on female genital mutilation during their midwifery education. Many midwives were not clear about the law or health data relating to female genital mutilation, nor were they aware of appropriate health-care and social services for affected women and girls.[64]

[62] Population Council, “Evidence to end FGM/C: Research to help girls thrive – Reflections from five years of research”, p. 10.

[63] Ibid., p. 11.

[64] See www.aihw.gov.au/getmedia/f210a1d8-5a3a-4336-80c5-ca6bdc2906d5/aihw-phe-230.pdf.aspx?inline=true, p. 6.

58. Those findings underscore the importance of developing comprehensive guidance based on existing laws and policies for workers in the health sector, as part of an overall coordinated, accessible and quality response strategy for girls and women who have been subjected to the practice.

59. In an effort to address some of those challenges, during the reporting period, the UNFPA-UNICEF Joint Programme supported 20 medical and paramedical associations in declaring that female genital mutilation performed by health professionals is unethical. Those associations are now committed to establishing surveillance systems to track and report health-care professionals who violate the declaration. The UNFPA-UNICEF Joint Programme also partnered with the World Health Organization (WHO) to produce a brief to address the growing trend towards medicalization of the practice.[65]

60. During the same period, the UNFPA-UNICEF Joint Programme trained service providers in 16 countries on comprehensive service delivery for prevention and response to female genital mutilation. A total of 2,413 health service delivery points were supported to provide health services relating to the practice. An additional 1,883 health service delivery points were supported to provide training to at least one health-care worker on female genital mutilation prevention, protection and care services.

61. New Zealand was among many States that reportedly provided specialist training for health providers, and child protection and law enforcement agencies on care for women and girls who have undergone the practice. Japan has provided life-saving assistance and essential health services to highly vulnerable populations in conflict settings, mostly in Africa. Even though there have not been any cases of female genital mutilation in Israel recently, the Ministry of Health regularly conducts training sessions for all medical personnel to identify whether a woman or girl has undergone the practice.

C. Legal practices

62. Increasing numbers of States globally are condemning or banning female genital mutilation and/or amending legislation to criminalize the practice.[66] To date, out of over 90 countries where female genital mutilation is known to be practiced, 51 countries have specifically addressed the practice in their national legal framework.[67] Of the 29 countries in Africa where female genital mutilation is traditionally practiced, 26 have laws criminalizing it.[68] Penalties include both criminal sanctions and monetary fines.

63. Most recently, following a lengthy campaign by women's rights activists, the Sudan criminalized female genital mutilation, whether it is performed inside a medical establishment or elsewhere. During the reporting period, Australia reported that it had criminalized female genital mutilation in every state and territory, including instances where the practice is performed overseas on a child who is normally resident in Australia.

64. The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence, known as the Istanbul Convention, has prompted many States in Europe to introduce provisions criminalizing female genital

[65] See www.unfpa.org/resources/brief-medicalization-female-genital-mutilation.

[66] For example, Argentina, Austria, Belgium, Bosnia and Herzegovina, Brunei Darussalam, Burkina Faso, Colombia, Cuba, Czechia, Guatemala, Greece, Mauritania, Paraguay, Philippines, Saudi Arabia, Serbia, Sweden and United States of America.

[67] See www.equalitynow.org/fgmc_a_call_for_a_global_response_report, p. 12.

[68] See www.equalitynow.org/the_law_and_fgm.

mutilation. Many such provisions follow closely the wording of article 38 of the Convention. The Council of Europe noted that the level of prosecution remained low, as those were new offences and the expertise in investigation and prosecution was slowly developing.

65. During the reporting period, several States successfully prosecuted their first cases of female genital mutilation (e.g., Ireland and the United Kingdom of Great Britain and Northern Ireland). Those decisions are significant, not only in securing justice for victims, but also in sending a strong message to society that the crime will not be tolerated.

66. In Ireland, the national police engaged Akina Dada wa Africa (or AkiDwA), a national network of migrant women, to inform the development of guidance and subsequent training on responding to incidents of female genital mutilation. The guidance is being developed with the support of law enforcement authorities that were involved in the investigation leading to the first successful prosecution of a case involving the practice in 2019.

67. Following the introduction of Female Genital Mutilation Protection Orders in 2015, the United Kingdom held a series of information sessions across England and Wales to raise awareness and build the capacity of service providers, including law enforcement officers, on the use of the orders.

68. The UNFPA-UNICEF Joint Programme supported the training of 3,708 law enforcement officials to enhance their awareness of the practice and the importance of enforcing legislation. In the same period, there was a total of 373 arrests, of which 329 cases were brought to court, and 75 cases resulted in conviction.[69] Those statistics require further analysis in order to understand the readiness of communities to engage with formal justice systems, and the actions being taken by the law enforcement authorities to ensure perpetrator accountability.

69. To promote community surveillance and prevent female genital mutilation across borders through enhanced monitoring, Belgium disseminated the “Stop FGM passport” in its embassies and travel clinics abroad. In addition, its Foreign Affairs website contains information on female genital mutilation in the travel advisory section of countries affected by the practice.

70. Despite progress in addressing perpetrator accountability, new research released during the reporting period found that legislation criminalizing the practice of female genital mutilation is only effective if it focuses on strengthening community awareness of the law and if it is seen to promote the health and well-being of women and girls, rather than as a tool to instil fear and to punish.[70]

D. Resourcing

71. Adequate resourcing is key to the success of any programme to eliminate female genital mutilation. In 2020, WHO launched the Female Genital Mutilation Cost Calculator, which estimates the current and projected financial costs associated with female genital mutilation in 27 countries, and the potential savings by health systems of preventing new cases. It is estimated that treating the health complications of female genital mutilation costs US$ 1.4 billion annually and that amount is expected

[69] UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation database.

[70] Population Council, “Evidence to end FGM/C: Research to help girls thrive – Reflections from five years of research”, pp. 12–13.

to increase by 50 per cent over the next 30 years if no action is taken to reduce the prevalence of the practice.[71]

72. In 2018, the United Kingdom announced an investment of £50 million to help end female genital mutilation by 2030. Under its national action plan addressing harmful practices (2017–2020), Norway allocated 3 million Norwegian kroner annually for research on female genital mutilation, while Australia has committed $A 93.5 million towards its Programme of Assistance for Survivors of Torture and Trauma (2018–2021), which provides counselling and support services for survivors of pre-migration torture and trauma, including survivors of female genital mutilation survivors, who are now settled in Australia. Portugal allocates up to €50,000 per project to grass-roots associations representing communities at risk, and Ethiopia and Kenya have developed costed action plans aimed at eliminating the practice.[72] During the COVID-19 pandemic, Sweden increased funding to civil society organizations to address the evolving needs of survivors.

VI. Conclusions and recommendations

A. Conclusions

73. **Female genital mutilation is a global practice that requires a global response. There is evidence that female genital mutilation is practised in at least 90 countries worldwide; however, robust data to support that claim remain scarce. The absence of data from all countries and communities where the practice is performed is undermining efforts to eliminate it. Although there is evidence of a constant decline in the prevalence of female genital mutilation, it is not widespread, nor is it happening at a fast enough rate to keep up with increasing population growth in countries where the practice is performed. It is estimated that progress would need to accelerate at a pace that is 10 times faster than current rates of decline in order to meet the global target of elimination by 2030.**

74. **The practice of female genital mutilation and its social and cultural underpinnings are changing. To eliminate the practice, a nuanced and comprehensive approach – instead of one size fits all – is needed. Further research is needed to understand how and why female genital mutilation is practised at both the national and subnational levels, and why one community chooses to abandon the practice, while a neighbouring community does not.**

75. **Families and members of the wider social group play a significant role in determining whether girls should undergo the practice. Efforts to eliminate female genital mutilation should focus on engaging those key stakeholders, particularly mothers, traditional cutters, older women, health-care workers, and traditional and faith-based leaders, who contribute to the decision to cut girls. As a priority, awareness-raising should be integrated into education curricula in primary and secondary schools, targeting boys, girls and teachers, as well as engaging survivors' organizations and the media. A non-stigmatizing approach should be adopted in all engagement with communities that maintain the practice.**

[71] www.who.int/news-room/detail/06-02-2020-economic-cost-of-female-genital-mutilation.

[72] End FGM European Network and others, "Global Platform for Action to End Female Genital Mutilation/Cutting: Submission for the United Nations Secretary-General report on female genital mutilation", May 2020, pp. 9 and 14.

76. **States are demonstrating high-level political commitment to ending female genital mutilation. That is evidenced by their efforts to enact, amend and enforce national legislation criminalizing the practice and to integrate measures to end female genital mutilation into broader policy and programming on eliminating discrimination and violence against women and girls. However, despite those advances, widespread effective enforcement of national legislation criminalizing the practice remains weak, and there is continued movement across borders to perform the practice in other countries to evade sanction.**

77. **Legislation criminalizing female genital mutilation can be an effective tool for eliminating the practice if it focuses on strengthening communities' awareness of the law and is seen as promoting the health and well-being of women and girls, rather than as a tool to instil fear and to punish. To be most effective, legislation should be implemented in a manner that does not "attack" communities that practice female genital mutilation.**

78. **The trend towards medicalization of female genital mutilation continues to increase at an alarming rate, and must be addressed if the practice is to be eliminated. Currently, not enough is being done to engage medical professionals and the broader health sector as allies in combating this trend. Considering their unique and trusted role as community leaders, and with appropriate awareness-raising, guidance and skills training, health professionals are well positioned to play a leading role in preventing and eliminating the practice.**

79. **With restrictions on mobility during the COVID-19 pandemic, more girls are staying at home, which may increase their risk of being subjected to harmful practices such as female genital mutilation and child, early and forced marriage. It is estimated that the COVID-19 pandemic could undermine progress towards achieving Sustainable Development target 5.3 of Goal 5 as an additional 2 million girls and women may undergo female genital mutilation by 2030. The pandemic is also having an impact on the provision of a range of essential health, justice, policing and social services for women and girls who have experienced, or are at risk of experiencing, violence and harmful practices, including female genital mutilation. As health-care workers prioritize COVID-19 cases, health services including psychosocial counselling, and sexual and reproductive health services for survivors of the practice are being disrupted. The pandemic is further highlighting the urgent need for prevention efforts to be mainstreamed into broader efforts to address violence against women and girls, and crisis prevention and recovery.**

80. **Although States are making more resources available, there is currently insufficient investment to support the meaningful and long-term implementation of programmes aimed at eliminating female genital mutilation. There is an urgent need for increased investment in programmes to eliminate the practice, especially given the predicted increase in prevalence, as a result of the COVID-19 pandemic.**

B. Recommendations

81. **States should address the socioeconomic and root causes of the practice, especially the needs of those women and girls who face multiple and intersecting forms of discrimination. Those efforts should be prioritized as a matter of urgency, especially considering the rapid population growth in countries where female genital mutilation is performed, and concentrated within broader efforts to implement the 2030 Agenda and the decade of action. With only 10 years left to eradicate the harmful practice by 2030, the time to accelerate action is now.**

To that end, States should identify, scale up and provide additional resources for measures aimed at eliminating the practice, taking into consideration current challenges, including the projected increase in prevalence, as presented by the COVID-19 pandemic.

82. **All States in which female genital mutilation is performed should improve their national and subnational data collection and undertake an in-depth analysis of identified hotspots to inform tailored policy and programmatic interventions aimed at eliminating the practice. Where possible, that data should include information from countries not usually associated with the practice, and on second-generation immigrants. States should also collect data using standardized methods that allow for comparison of such data across countries, and develop robust frameworks for monitoring and evaluation.**

83. **States should initiate further research on individual, family-related and community-level factors that influence the performance of female genital mutilation. Research should also be conducted on the role of the health sector in preventing and managing complications arising as a result of the practice. States should collaborate with research institutions, academia, civil society and United Nations entities to monitor and evaluate the impact of ongoing measures.**

84. **States should adopt and continue to implement scaled-up prevention strategies, including advocacy, awareness-raising and community mobilization, with key stakeholders, in particular those who contribute to the decision for girls to undergo female genital mutilation, such as parents, traditional cutters, older women, traditional and faith-based leaders, and health-care workers. More attention should be paid to educators, survivors' organizations, young girls and men and boys, and their role in changing existing stereotypes, attitudes and behaviours that condone and justify gender inequality and discrimination, violence against women and girls, and harmful practices such as female genital mutilation.**

85. **During the COVID-19 pandemic, States should intensify their collaboration with key line ministries, especially education, in order to identify girls who may be increasingly vulnerable at home and ensure that they receive the appropriate care and support services. States should also engage the media in raising awareness about the harmful effects of female genital mutilation and the possible increase in the performance of the practice during the crisis. The media can also contribute to empowering grass-roots activists and youth to tell their stories so as to reach wider audiences through traditional and social media platforms.**

86. **States should conduct rapid assessments to analyse the impact of the COVID-19 pandemic, and identify challenges and gaps in current policies and programmes aimed at eliminating female genital mutilation as well as opportunities for prevention, ensuring women's and girls' involvement in these processes. To the extent possible, essential health, justice, policing and social services operated by the State and civil society organizations should remain open during the crisis and accessible to survivors of female genital mutilation and those at risk, while adhering to necessary safety precautions. Alternative or remote services should be offered, where possible, for example, consultation with trained counsellors by telephone, text messaging or online chats at specified times. Referral pathways and information for survivors and those at risk on where to seek help should be updated and disseminated regularly. Alternative approaches to traditional community-based interventions for protecting against and preventing female genital mutilation should be promoted. Female genital mutilation should also be included in all COVID-19 response and recovery plans.**

87. **States should take appropriate measures to improve the skill set of health-care providers so that they understand the nature and the risks associated with the practice of female genital mutilation, and their unique role in preventing the practice. Promoting the capacity-building of service providers and other stakeholders should be part of the COVID-19 response and include online training.**

88. **Effective policy and programming responses are required to halt the increase in medicalization of female genital mutilation. States should ensure that health-care providers, including doctors and midwives, at all levels are fully aware of its harmful effects and are held accountable under law for facilitating and/or performing the practice. States should also provide systematic training for the police and the justice sector on legislation, including extraterritorial laws, that prohibit harmful practices, with a view to ensuring that perpetrators are brought to justice.**