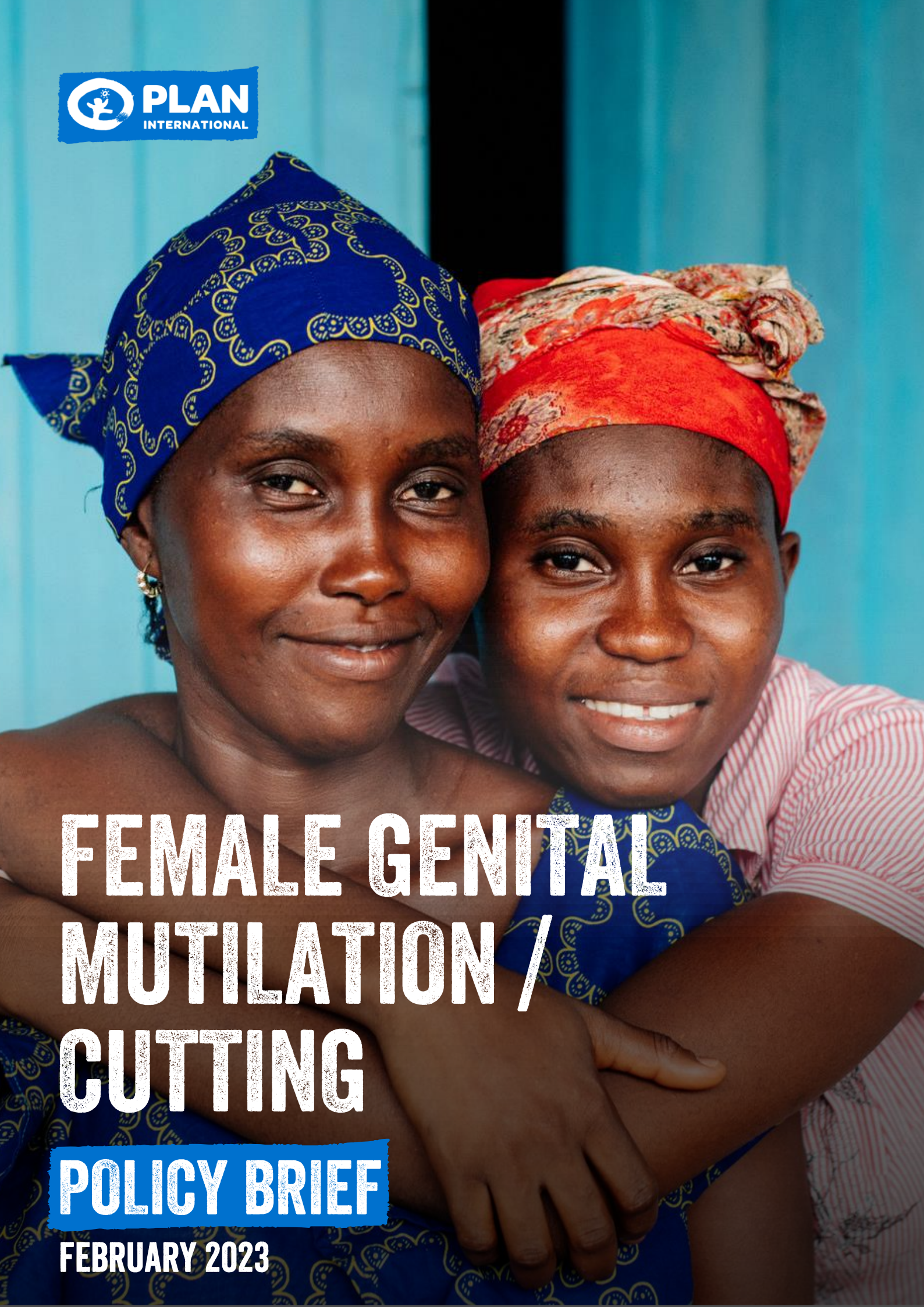

FEMALE GENITAL MUTILATION / CUTTING

POLICY BRIEF

FEBRUARY 2023

FEMALE GENITAL MUTILATION / CUTTING

PLAN INTERNATIONAL'S POSITION STATEMENT

Overarching policy positions

- Plan International recognises that the practice of female genital mutilation/cutting (FGM/C) is global in nature, affecting at least 200 million women and girls in over 96 countries worldwide, the majority of which do not have nationally representative data on the scale of the practice. The practice is not confined to any particular region or religion, and effectively ending all forms of FGM/C in line with international law and Sustainable Development Goal (SDG) 5.3.2 requires acknowledging the global nature of FGM/C and taking global action to ensure that all girls everywhere are able to live free from this practice.
- Plan International condemns all forms of FGM/C, defined by the WHO as 'the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons.' The practice has no health benefits. All forms of FGM/C are a violation of the human rights of girls and women, including their sexual and reproductive health, and are an extreme form of gender-based violence.
- Plan International supports a total abandonment approach towards all forms of FGM/C, recognising that all types of FGM/C are human rights violations with serious consequences throughout the lives of women and girls, including their health, education and economic empowerment. We take a rights-based approach towards ending all forms of FGM/C, centred on the rights of girls to bodily autonomy and consent, including girls' rights to sexuality.
- Plan International believes that ending all forms of FGM/C requires a multisectoral and social norms-based approach to support communities to abandon the practice. Effective action to end FGM/C must involve the entire community and engage all relevant stakeholders in the process, including girls themselves, grandmothers and older women[1], community and religious leaders, men and boys, health professionals, teachers, and the justice system.
- Plan International recognises that the practice of FGM/C is deeply rooted in discriminatory and harmful gender norms. Plan International takes a gender-transformative approach towards ending FGM/C that addresses gender inequality and harmful gender norms and empowers girls and women to realise their rights to sexuality and bodily autonomy.

Cover page: Zainab, 17, and her mother Kadiatu, 35. Zainab is an outspoken advocate against FGM/C in her community in Sierra Leone.

Photo credit: Plan International / Quinn Neely

- Plan International believes that FGM/C is a cultural practice that is not associated with, and pre-dates the modern religions of Judaism, Christianity, and Islam. Plan International works with religious leaders and scholars to dispel religious myths surrounding the practice as a way to support community abandonment of the practice.
- Plan International recognises that humanitarian contexts and crisis situations can lead to increasing rates of FGM/C, either as a negative coping mechanism or where the practice is linked to child, early and forced marriage and unions (CEFMU). Plan International considers FGM/C prevention and response to be lifesaving and essential in times of crisis and believes that FGM/C should be comprehensively integrated into humanitarian prevention and response planning and delivery. This should address the particular FGM/C related risks as well as the opportunities for abandonment resulting from disturbances brought about by the crisis.
- Plan International believes that girls' access to education is vital as a human right in and of itself, but firmly recognises that access to education also acts as a protective factor for girls at risk. FGM/C should be included in comprehensive sexuality education (CSE) curricula as an effective way of shifting the harmful and discriminatory gender norms and negative attitudes towards female sexuality that drive the practice.
- Plan International recognises that the practices of both CEFMU and FGM/C are linked in some contexts and share similar social drivers and underlying discriminatory social and gender norms. In these contexts, effective interventions should seek to address both practices.
- Plan International recognises that girls and young people are agents of change in ending all forms of FGM/C. However, Plan International also recognises that abandonment of FGM/C requires the support and participation of the entire community, as well as an understanding of the grave consequences of isolating and ostracising girls who openly oppose the practice.

Criminalisation position

- Plan International recognises that national legislation prohibiting FGM/C supports an enabling environment and legitimises campaigning, advocacy and programming to end all forms of FGM/C. However, a focus on criminalisation of FGM/C alone is ineffective as it drives the practice underground, making social norms change harder in ending the practice sustainably. Where legislation is adopted, in line with evidence, Plan International supports comprehensive

legislation that defines and prohibits all forms of FGM/C, including medicalised versions and where the practice is carried out abroad.

Cross-border cutting position

- Plan International believes that the abandonment of all forms of FGM/C requires coordinated and comprehensive international and regional approaches that can effectively engage practising communities that straddle traditional international borders.
- Plan International believes that engaging diaspora communities in social norms-based and gender transformative approaches to abandon FGM/C can be a useful entry point in challenging the social norm in origin countries where diaspora groups act as influential reference groups. Engaging with diaspora groups can also support the abandonment of 'vacation cutting' in high-resource settings.

Medicalisation position

- Plan International believes that all forms of FGM/C, regardless of whether they are carried out by medical professionals or in health settings, are harmful and a violation of the human rights of girls and women. Plan International takes a rights-based approach towards ending all forms of FGM/C and believes that a harm-reduction approach is incompatible with human rights, including girls' rights to health, to bodily autonomy and to sexuality, as well as to be free of all forms of violence. Plan International affirms that the practice of FGM/C by health professionals is contrary to medical ethics and the Hippocratic oath to 'do no harm'. This includes the practice of re-infibulation.
- Plan International affirms that there is no 'lesser' or 'less severe' cut when considering the long-term physical and psychosocial health impacts, in addition to socio-economic impacts of the practice, including ongoing gender discrimination. All types and forms of FGM/C, regardless of where they are carried out, are a violation of human rights.
- Plan International recognises that health professionals are uniquely placed as trusted members of communities to provide evidence-based information on FGM/C and its impacts, and to influence and change community attitudes and harmful practices. Plan International supports the education and engagement of medical professionals as key stakeholders in the movement to abandon all forms of FGM/C.

The right to asylum position

- Plan International strongly affirms that girls and women who fear persecution on the grounds of FGM/C have the right to refugee status, in line with international human rights and refugee law, including the 1951 Refugee Convention.

RECOMMENDATIONS ON FGM/C

Overarching recommendations

- Governments should enact, fully implement and resource comprehensive national legislation and evidence-based national action plans to support an enabling environment for gender-transformative social norms change that prohibits all forms of FGM/C, including medicalised versions of the practice and where it is carried out abroad. National legislation and strategies for social norms change should be costed with dedicated budget-lines for effective multisectoral implementation at local and community level, which must include the justice and policing sectors, education, health professionals and child protection actors. The focus of national legislation should not be punitive or stigmatising in approach to practising communities but should seek to support community engagement and outreach on abandoning the practice.
- All governments should undertake representative data collection on the scale and scope of FGM/C, including its prevalence, in line with global commitments under SDG 5.3.2 to eliminate all harmful practices, and international human rights law, including in diaspora contexts. All data collection on FGM/C must be undertaken in accordance with ethical, safeguarding and data privacy standards.
- Donors must scale up funding commitments towards interventions aimed at the abandonment of all forms of FGM/C ten-fold in order to end the practice by 2030 in line with SDG commitment 5.3.2.
- Donors should increase funding towards research and evidence into the scale, scope and impacts of FGM/C, and on expanding the evidence base on successful and effective interventions to support abandonment of the practice. In particular, further support should be provided to improve survivor-centred access to services in addition to prevention measures, including provision for clitoral reconstructive surgery.
- Interventions and activities to support the rights-based abandonment of FGM/C should be evidence-based, gender transformative in nature, and seek to address harmful social norms underlying the practice. Interventions must engage all members of a community, including girls themselves, and key stakeholders such as traditional, religious and community leaders, grandmothers and older women, men and boys, health professionals, teachers, police, and the justice system.
- Religious leaders should openly dispel myths that associate FGM/C with any religion, as well as the harmful gender norms underlying the practice. They should support communities to abandon FGM/C through local and national advocacy and the issuance of religious edicts or fatwahs, where relevant, that prohibit the practice under religious law.

- All humanitarian actors have a duty to recognise and mitigate the exacerbating impact of crises on FGM/C during prevention and response planning as life-saving and essential services. FGM/C prevention efforts must be fully resourced through multi-year emergency programming and comprehensively integrated into humanitarian plans, assessments, and responses, including efforts both to prevent all forms of FGM/C and in responding to the distinct needs of survivors of the practice in crisis settings.
- Survivors of all forms of FGM/C have a right to access needed information, education and healthcare services relating to the practice and its impacts, including deinfibulation. All of these services should be provided in child and gender-friendly formats. Healthcare services, including mental health and psychosocial support (MHPSS), must be available, accessible, acceptable and of sufficient quality (AAAQ) to survivors of FGM/C, and sufficient resources should be put in place to deliver these services.
- Girls' access to education should be recognised as a right, as well as a protective factor for FGM/C. Governments must prioritise girls' education, which should include provisions for comprehensive sexuality education (CSE). CSE curricula should include discussion and learning about the practice of FGM/C to support shifts in harmful social norms.
- In contexts where FGM/C and CEFMU are linked, efforts and interventions to abandon both practices should take a gender-transformative approach to identify and shift underlying discriminatory gender norms and social norms in order to address both practices together. Further research should be undertaken to better understand the broader link between both practices, including where FGM/C is considered a social requirement for marriage but is carried out separately from CEFMU.

Criminalisation recommendations

- Where governments adopt national legislation prohibiting FGM/C, legislation should prohibit all forms of FGM/C, including when carried out by medical professionals or in medical settings, and provide extra-territorial jurisdiction to the offence, in line with international human rights law recommendations and best practice. The focus of any legislative approach must be towards community outreach and engagement with the law and should not be punitive or stigmatising to certain communities.
- Legislation should be fully implemented with costed budget lines and corresponding national action plans that engage, fully resource, and provide capacity building to all relevant sectors, including the police and justice sectors, health professionals, teachers and education systems, and child protection services.
- Where criminalisation legislation is adopted, survivors of FGM/C must be exempted from prosecution as participants in FGM/C, regardless of whether they actively sought the practice out themselves. Law enforcement officials and the justice sector should be equipped with technical training and capacity building to handle these types of situations and to avoid the re-victimisation of survivors of the practice.

Cross-border cutting recommendations

- In regions where cross-border cutting is prevalent, governments and regional bodies should seek to establish and implement coordination mechanisms to align legislation, policy, and implementation strategies across border regions to support communities to abandon FGM/C. This should include aligning criminal penalties in legislation and the establishment of effectively resourced monitoring bodies and mechanisms to coordinate a multi-sectoral response across different national jurisdictions, and to improve policing of porous borders.
- Where legislation prohibits FGM/C, provisions should give extra-territorial jurisdiction over the offence of FGM/C, to allow the justice sector to respond to cases of FGM/C that have taken place abroad or in neighbouring jurisdictions.
- Community-based interventions to shift social norms and end FGM/C in border regions should seek to include intermarrying groups and communities from cross-border regions within interventions.
- Further research and evidence is required on the scale, scope and driving factors of cross-border cutting. Donors should increase available funding to support the improvement of the evidence base on FGM/C, including cross-border cutting, and should support increased interventions to interrupt cross-border cutting with robust evaluation frameworks to identify effective approaches, including engagement with diaspora groups.

Medicalisation recommendations

- Legislation should prohibit medicalised forms/settings of FGM/C and national campaigns and awareness raising should take care to avoid focus on physical harms or harm-reduction approach. National action plans to support the abandonment of all forms of FGM/C must include and engage with medical professionals as key stakeholders.
- Medical curricula should include professional training on the causes and consequences of FGM/C and train and equip medical professionals to meaningfully engage with practising communities to influence the abandonment of the practice. Medical professionals should also be equipped with training and support to resist community pressure to perform FGM/C.
- National medical associations should adopt clear codes of conduct that prohibit health professionals from carrying out any form of FGM/C, and should seek to revoke the medical licences of any health professional found to be practising any form of FGM/C in contravention of medical ethics.

The right to asylum recommendations

- Governments must respect and abide by their regional and international commitments under international human rights and refugee law to provide asylum and refugee status to girls and women at risk of FGM/C, regardless of the legal status of FGM/C in the country of origin.
- Border force agencies and immigration officers should receive training and capacity building on FGM/C, including its drivers in countries of origin, to support effective credibility assessment. This should include a focus on age, gender and diversity sensitivities, as well as on the impact of trauma and violence.
- State members of the Council of Europe should ratify and fully implement the Istanbul Convention and further support prevention and response mechanisms

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INTRODUCTION

The purpose of this policy brief is to bring together and supplement Plan International's position on female genital mutilation/cutting (FGM/C) as outlined in our position papers, next to the papers on SRHR and the Rights of Children and Young People to Live Free from Violence. Further, it draws on research conducted by Plan International and others and programmatic practice, and includes case studies from our work globally to:

- Provide positions and recommendations to guide our programme and influencing work on FGM/C, including our global advocacy priorities, and;
- Focus on key topical issues, including FGM/C in humanitarian settings, medicalisation and criminalisation of FGMC.

Plan International's Global Strategy for 2022-2027, 'Girls Standing Strong', positions FGM/C under the Decide Area of Global Distinctiveness (AoGD) which aims for girls to have 'control over their lives and bodies, and make informed choices about identity, relationships, and if and when to have children.' However, it is recognised that FGM/C is a complex and multifaceted issue, with links across thematic areas such as protection from violence, SRHR, education, economic empowerment, early childhood development, and the rights of girls to be involved in decisions about their lives. Consequently, ending FGM/C requires a holistic, comprehensive and multi-sectoral approach that can engage entire communities and create enabling environments to support a collective decision to abandon the practice.

Decades of work to end FGM/C have resulted in significant progress: a girl today is a third less likely to have undergone FGM/C than three decades ago.[2] However, population growth and the impact of humanitarian crises including the COVID-19 pandemic mean that the current pace of progress needs to be scaled-up tenfold in order to meet SDG 5.3.2: elimination of all harmful practices by 2030.[3] When the effects of COVID-19 are included, 70 million girls are currently at risk of FGM/C before 2030. This policy brief has been developed on the basis of currently available evidence to clearly articulate Plan International's global positions on FGM/C across development and humanitarian settings, with the aim of ensuring a cohesive and harmonised approach across the organisation to support ending FGM/C at greater scale.

TERMINOLOGY: FGM OR FGC?

The term 'female genital mutilation' was first coined by American anthropologist, Rose Oldfield Hayes, in 1975,[4] and was later popularised by Fran Hosken, an American feminist activist in 1981.[5] There has been considerable debate over the use of terminology to refer to female genital mutilation/cutting. Some survivors, activists and organisations prefer to utilise the term 'female genital cutting' on the basis that 'mutilation' can be judgemental and victimising. Conversely, some activists feel that 'cutting' does not adequately acknowledge the seriousness of the practice as a human rights violation, which helps to promote national and international advocacy for its abandonment. Plan International uses the term **'female genital mutilation/cutting'** (FGM/C), in line with official UN terminology, but also to encapsulate an inclusive approach that accommodates differing viewpoints.

Nonetheless, FGM/C itself is known or referred to in practising communities by a variety of local terms, including female circumcision, khatna, sunnah and sunat perempuan to name a few. Local terms should be used respectfully when working together with practising communities to avoid stigmatisation and to support open dialogue on abandoning the practice.

THE INTERNATIONAL HUMAN RIGHTS FRAMEWORK

The practice of FGM/C is a violation of the human rights of girls and women, including the right to be free from all forms of discrimination, the right to life and physical integrity, the right to the enjoyment of the highest attainable standard of health, the right to education, the rights of the child, and the prohibition of torture, cruel, inhuman and degrading treatment. The practice also amounts to an extreme form of gender-based violence. Under international human rights law, states have obligations to respect, protect and fulfil human rights, including in relation to FGM/C. This includes a due diligence obligation to prevent the practice of FGM/C where it is carried out by third parties and non-state actors.

The right to be free from all forms of discrimination

FGM/C is a practice carried out on girls and women for the purpose of controlling their sexuality, freedoms, and to maintain rigid and harmful gender norms based on a discriminatory belief about the role of women in society, including chastity, femininity and beauty. As the practice is predominantly carried out prior to the age of 15, FGM/C also discriminates based on age. The Committee on the Elimination of Discrimination against Women has also recognised that rural girls and women are at particular risk of FGM/C.[6]

Article 2 of the Convention on the Elimination of Discrimination Against Women (CEDAW) condemns discrimination against women in all its forms. Under Article 5, states agree to take all appropriate measures 'to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on

stereotyped roles for men and women'. The right to be free from discrimination is also protected by Articles 2, 3 and 26 of the International Convention on Civil and Political Rights (ICCPR), Articles 2 and 3 of the International Convention on Economic, Social and Cultural Rights (ICESCR), and Article 2 of the Convention on the Rights of the Child (CRC).

Both the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child have specifically condemned the practice of FGM/C as a human rights violation giving rise to states' obligations to 'explicitly prohibit by law and adequately sanction or criminalize harmful practices, in accordance with the gravity of the offence and harm caused, provide for means of prevention, protection, recovery, reintegration and redress for victims and combat impunity for harmful practices.' The committees jointly recommend that states develop and adopt comprehensive awareness-raising programmes to challenge and change cultural and social attitudes, traditions and customs that underlie behaviour that perpetuate harmful practices.

The right to the highest attainable standard of health

The right to health is enshrined in Article 12 of the ICESCR, in addition to Article 24 of the CRC and Article 12 of CEDAW. It is also enshrined in Article 25 of the Universal Declaration of Human Rights (UDHR). FGM/C results in a range of short-term and long-term consequences for the physical, psychosocial and sexual and reproductive health of girls and women. Complications arising from the practice include bleeding, infections, post-traumatic stress disorder and even death. Women who have undergone FGM/C are more likely to experience prolonged labour and obstetric fistula. The practice has been recognised by the UN Special Rapporteur on the Right to Health as representing a 'serious breach of sexual and reproductive freedom', which is 'fundamentally and inherently inconsistent with the right to health'.[7]

Rights of the child

Article 24(3) of the CRC requires States to take all effective and appropriate measures towards abolishing traditional practices prejudicial to the health of children. It also provides for the right of the child to be protected from all forms of violence, including physical, sexual or psychological violence (Article 19) and requires States to ensure that no child is subjected to torture or other cruel, inhuman or degrading treatment or punishment (Article 37 (a)). FGM/C also violates the best interests of the child contained in Article 3 of the CRC.

The rights to life and to physical integrity

The right to life is considered a core human right that is protected by a number of international conventions, including Article 6 of the ICCPR, which provides that every human being has the inherent right to life. FGM/C is a violation of the right to life in extreme cases where the practice results in death. The right to life is also protected by Article 3 of the UDHR.

The right to physical integrity is protected by Article 1 of the UDHR and Article 9 of the ICCPR. It encompasses a number of human rights principles, including bodily autonomy and integrity, which comprises an individual's ability to exercise agency and power over their own body, free from violence or coercion. FGM/C is usually carried out on girls between birth and the age of 15, below the age of informed consent, and often involves violent coercion to subject girls to the practice against their own will. The practice also has serious and substantial consequences for girls and women's physical, psychosocial and sexual health across their lifetime, and therefore precludes a girl from being able to fully realise her sexual and emotional life and personal development.[8]

Torture, cruel, inhuman, or degrading treatment

The prohibition on torture is a norm accepted and recognised by the international community under customary international law; it cannot be derogated from by any state under any circumstances, and perpetrators of torture can be prosecuted for the crime in any country regardless of where the torture took place under the principle of universal jurisdiction.

Article 1 of the UN Convention on Torture (CAT) defines torture as 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person' for purposes including 'based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity'. FGM/C, which causes severe pain and suffering and is intentionally inflicted on girls and women as a result of gender-based discrimination, will meet the definition of torture where it is carried out with the consent or acquiescence of a public official, including where the State fails to prevent, investigate, prosecute and punish non-state actors practicing FGM/C.

The absolute prohibition of torture, cruel, inhuman or degrading treatment is also enshrined in Article 7 of the ICCPR, and Article 37 of the CRC. It is also contained in Article 5 of the UDHR.

FGM/C has been recognised as amounting to a form of torture, cruel, inhuman or degrading treatment by the UN Committee on Torture, the UN Special Rapporteur on Violence Against Women, and the UN Special Rapporteur on Torture under the CAT. Manfred Nowak, the former Special Rapporteur on Torture, acknowledged that the pain inflicted by FGM/C does not stop with the initial procedure, but often continues as ongoing torture throughout a woman's life.[9]

Whilst the practice is usually carried out in private by non-state actors, the practice can amount to a form of torture **if States fail in their duty to take all necessary measures to end the practice**, including investigating and, in accordance with national legislation, punishing FGM/C to address impunity for the practice. States that therefore fail to prohibit FGM/C in national legislation, or authorise any form of FGM/C, including medicalised versions of the practice, may therefore be acquiescing, or consenting to torture.[10] In an asylum context, the principle of non-refoulement means that girls or women at risk of

undergoing or being subjected to FGM/C in their home country must not be deported or extradited on the basis that the practice amounts to a form of torture.[11]

International consensus documents

Although they are not binding forms of international law, international consensus documents form 'soft' international law and can be highly persuasive. Several international consensus documents recognise FGM/C as a violation of the rights of girls and women and affirm the obligations of every state to take steps to end the practice in all its forms.

FGM/C was recognised as a form of violence against women in the Beijing Declaration and Platform for Action in 1993,[12] with states committing to prioritise formal and informal education programmes that emphasise the elimination of harmful practices including FGM/C, to enact and enforce legislation against the perpetrators of FGM/C, and to support the efforts of non-governmental organisations (NGOs) and community-based organisations working to end the practice.

The Programme of Action of the International Conference on Population and Development[13] (ICPD) 1994 also called on states to prohibit FGM/C wherever it exists and to support NGOs, community-based organisations and religious institutions to end the practice. This should include 'strong community outreach programmes involving village and religious leaders, education and counselling about its impact on girls' and women's health, and appropriate treatment and rehabilitation for girls and women who have suffered mutilation. Services should include counselling for women and men to discourage the practice.' The Programme of Action also called on governments to ensure that FGM/C is an integral component of primary health care, including reproductive health care programmes.

In 2012, the UN General Assembly approved a Resolution 'Intensifying global efforts for the elimination of female genital mutilation' by consensus, which emphasized the need for states to develop a long-term strategic vision for ending the practice, coupling legislative measures with awareness-raising, educational measures and the protection of girls and women through the development of comprehensive national action plans and strategies. The resolution also calls on the international community to support ending the practice through the allocation of financial resources.

All states have further affirmed a commitment under Sustainable Development Goal (SDG) target 5.3 to eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations by 2030.

REGIONAL HUMAN RIGHTS FRAMEWORKS

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[14] (The Maputo Protocol) prohibits all forms of harmful practices, including FGM/C (Article 5) and obliges States Parties to take steps to ensure that the practice of FGM/C is eliminated. Additionally, Article 21 of the African Charter on the Rights and Welfare of the Child[15] also prohibits 'customs and practices prejudicial to the health or life of the child'. Article 25 of the African Youth Charter also calls for the elimination of harmful social and cultural practices, calling on State Parties to take all appropriate steps to eliminate these practices that affect the welfare and dignity of youth, with particular focus on customs and practices that harm the health, life or dignity of the youth, and those that discriminate on the basis of gender, age or other status.[16]

The Council of Europe Convention on preventing and combating violence against women and domestic violence[17] (The Istanbul Convention) requires States under Article 38 to take the necessary legislative or other measures to ensure that conduct leading to FGM/C is criminalised.

OVERVIEW OF FGM/C

FGM/C is defined by the WHO as 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.'[18]

The WHO further classifies four major types of FGM/C:[19]

- **Type 1:** the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans).
- **Type 2:** The partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).
- **Type 3:** Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans.
- **Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area.

Deinfibulation refers to the practice of cutting open the sealed vaginal opening (of a woman who has been infibulated – Type 3 FGM/C), which is often necessary to allow intercourse or to facilitate childbirth. The term **reinfibulation** refers to the practice of re-stitching or suturing of the scar tissue resulting from infibulation after a woman has been deinfibulated. Reinfibulation may often take place after a woman has been deinfibulated in order to allow for sexual intercourse or childbirth.

Many girls and women do not know what 'type' of FGM/C they have undergone, and a girl or woman who believes she has had a particular type of cut may on examination be found to have undergone a different form. Some girls and women who were cut at a very young age may not know they have undergone FGM/C at all. **All 'types' of FGM/C are human rights violations and a form of gender-based violence (GBV) with serious impacts on girls and women's physical, mental and psychosocial health, as well as their socio-economic outcomes in life.**

The practice has **no health benefits** and can cause serious physical and psychosocial health problems including bleeding, infections, post-traumatic stress disorder and even death. It is a violation of the human rights of girls and women, including their sexual and reproductive health and rights, and amounts to a form of gender-based violence. The practice is also a serious violation of the rights of the child, as it is usually carried out on girls before the age of 15, with a majority cut before the age of 5. All states have committed to ending the practice, both through SDG 5.3.2, and through the adoption of UN General Assembly Resolution on, 'Intensifying global efforts for the elimination of female genital mutilation'.[20]

FGM/C is a global issue that requires a global response.[21] An estimated 200 million girls and women are estimated to have experienced FGM/C in the 31 countries alone where data is available. Over half of those affected live in Egypt, Ethiopia and Indonesia. Currently, 4.1 million girls undergo FGM/C each year in those 31 countries alone, which will rise to 4.6 million girls a year by 2030 if current rates of abandonment do not increase ten-fold in line with population growth.[22] Only 31 out of at least 96 countries where the practice is known to happen currently report national level data on FGM/C. The true number of girls and women affected by the practice is much higher. In addition, the impacts of the COVID-19 pandemic mean that an additional two million cases of FGM/C will need to be averted in order to meet the SDG target 5.3 of eliminating all harmful practices by 2030.[23]

While the global burden of FGM/C has traditionally been viewed as lying in West and East Africa, the practice is prevalent across Asia and the Middle East/North Africa region, as well as in diaspora populations around the world. It should also be noted that practices amounting to FGM/C were performed on girls and women in Europe and America as recently as the 19th and 20th centuries as a 'cure' for 'hysteria', mental illness and masturbation.[24] Anecdotal reports also exist suggesting that FGM/C may be currently practised by conservative Christian communities in the U.S.[25]

FGM/C is usually carried out on young girls between birth and 15 years. In nearly half of countries with nationally representative data, the majority of girls are cut before the age of 5 years old. However, notable exceptions are found in countries such as Kenya, Egypt, and the Central African Republic, where cutting is carried out well into adolescent and teenage years.[26] In countries where girls undergo the practice at a later age, the age of cutting appears to be falling.[27] FGM/C has traditionally been carried out by elder women within the community or by traditional birth attendants (TBAs). Alarmingly, around one in four girls and women today have reported being cut by a health professional, and the proportion is twice as high among adolescents, indicating a growth in medicalisation of FGM/C.[28]

In 2020, prior to COVID-19, UNFPA estimated that the cost of ending FGM/C in the 31 countries with nationally representative data amounted to $2.4 billion USD. However, the anticipated spend in development assistance was only $275 million, leaving a shortfall of $2.1 billion USD. UNFPA further estimated that the average cost of preventing one case of FGM/C was $95.[29] Separately, the WHO estimates that the treatment of health complications of FGM/C alone in 27 high prevalence countries cost $1.4 billion USD per year.[30]

The Committee on the Rights of the Child has expressed concerns that the circumcision of male

infants and children, as well as other initiation rites, may have detrimental impacts in certain contexts.[31] This is not however, comparable to FGM/C and the gender-based violence, trauma and long-term health complications, including death, experienced by those who have undergone FGM/C.

DRIVERS AND ROOT CAUSES OF FGM/C

SOCIAL NORMS

The practice of FGM/C is widely recognised as a social / gender norm.[32] This means that the practice is held in place by a complex set of beliefs, expectations, sanctions and benefits that are ascribed to within a certain community. Families within a community will choose to cut their daughters because they believe that others within their community have *also* cut their daughters, but also because they believe that the community *expects* them to cut their daughters. By cutting their daughter, the family knows that she will be accepted into her community and by her peers. She may attain a higher bride price or be more marriageable if she is cut. If she is not cut, she may be ostracised by the community for rejecting culture and tradition. She may be viewed as 'unclean' or 'unchaste' and she may struggle to find a husband. In these circumstances, changes in personal attitudes towards FGM/C don't necessarily lead to changes in the practice of FGM/C. This is because, while attitudes might change at an individual level, a more communal process is needed to achieve a change in practice. This is especially true for societies characterized by collectivist values which ascribe less value to individual agency, to which many of the communities affected by FGM/C belong.

Legal and moral norms, which are distinct from social norms, may support or prohibit the practice of FGM/C by contributing to or restricting an enabling environment for positive social norms change. For example, where communities have not abandoned FGM/C and continue to value the practice, criminalising FGM/C may lead communities to carry it out in secret, making the practice much harder to identify and to effectively work with them towards abandonment. **Successfully and sustainably ending FGM/C requires a holistic and multi-sectoral approach that engages whole communities in non-judgemental open dialogue and supports communities to collectively choose to abandon the practice for themselves.**

GENDER NORMS

Gender norms are a significant subset of social norms that define expected behaviours from people of different genders in a given group or society, to the point that they become a profound part of people's sense of self. They are often age-specific and are influenced by other markers of identity (ethnicity or class for example). They reflect and sustain a hierarchy of power and privilege that typically favours that which is considered male or masculine over that which is female or feminine. Gender norms are embedded in institutions, nested in people's minds, and reinforced through people's actions. They are sustained by social rewards and sanctions, and often violence. They play a role in shaping girls and women's often unequal access to resources and freedoms, affecting voice, agency and power.[33]

The practice of FGM/C is both held in place by, and reinforces, discriminatory and deeply harmful gender norms and stereotypes that define the limits of a girl's aspirations. While families and communities will usually cite cultural, religious and social reasons for practising FGM/C, reasoning often centres on harmful gender norms, including that girls and women should be chaste and modest, that girls and women are less economically valuable than boys and men, the belief that uncut girls are 'dirty' and ugly, or that cutting a girl signifies a rite of passage into womanhood.[34] The

CASE STUDY: PLAN INTERNATIONAL ETHIOPIA – HOLISTIC COMMUNITY APPROACHES

Plan International Ethiopia worked in partnership with the Beza Posterity Development Organization and government bodies to deliver a series of FGM/C awareness capacity building and community learning events. These brought community members together - teachers, parents, young people, religious leaders, cutters – in open dialogues and events to address the harmful social norms underlying the practice. Girls' Clubs in schools promoted resilience against harmful practices. For survivors of FGM/C, practitioners worked to improve coordination of case management, and provided psychosocial, medical and economic support.

7,480 community members were engaged, with a reported 231 cases of prevented FGM/C, and 69% of cutters choosing to end the practice and become community volunteers to raise awareness of the negative impacts of FGM/C.

"I was a child when I was circumcised and didn't know that was happening to me. I decided to serve as a community volunteer to fight against FGM/C. I received basic training on FGM and learned and understood the negative impacts. I serve communities through conversation forums and peer discussions and create awareness for women due to give birth at the health center."

Zehara Ali Mirah, (21), community volunteer, Ethiopia.

practice is often heavily linked to the concepts of virginity and fidelity, and is often carried out as a way of controlling female sexuality to ensure chastity before and fidelity during marriage.[35] Equally, the impacts of FGM/C on a girl in turn may result in lifelong health complications, limit her access to education and economic opportunities, and access to power and agency within her own family and community.[36] As the practice is carried out on a majority of girls before the age of 5 but sometimes up to the age of 15, the practice deprives girls of their right to make autonomous decisions about their own bodies and bodily autonomy.

Supporting communities to sustainably and meaningfully abandon the practice of FGM/C requires transformation of these harmful gender norms. Gender transformative approaches actively examine, question and aim to shift rigid and discriminatory gender norms and imbalances of power that advantage boys and men over girls and women.[37] Successful gender transformative approaches actively engage children and young people from an early age to challenge harmful gender stereotypes and equip them with the knowledge, power and agency to fully exercise their own rights. They also work to engage entire communities in dismantling power relations, including through the creation of an enabling environment that engages men and boys, religious and traditional leaders, and community elders, both male and particularly female, as active champions for ending FGM/C, and securing gender equality.

SOCIO-ECONOMIC DRIVERS

Ethnicity is the most significant factor underlying the prevalence of FGM/C. This is largely due to the fact that members of certain ethnic groups adhere to the same social norms, including the practice of FGM/C which is often seen as a marker of community identity, particularly where the practice serves as a cultural rite of passage or initiation. For example, while the national prevalence rate of FGM/C in Kenya is currently 21%, the practice is highly concentrated in Kisii and Somali ethnic groups in bordering regions, and almost zero amongst younger women of other ethnic groups.[38] Members of the same ethnic group are also likely to adhere to the same set of social norms regardless of where they live, which has led to the practice transcending national borders where ethnic groups are concentrated, including in migratory contexts in diaspora communities across Europe, Australia and the United States.[39] However, evidence also shows that the prevalence of FGM/C amongst the Poular ethnic group in West Africa, for example, varies considerably depending on the country context in which the group is situated.[40] This points to the importance of reference groups in shifting social norms, as Poular groups in low-prevalence areas may feel less pressure to conform to the practice or even feel pressure to abandon the practice.

In some contexts where FGM/C takes place, urbanisation, increased household wealth and improved educational outcomes have been associated with the abandonment of FGM/C. This is because rural areas often experience less cultural diversity, preventing the questioning of long-held and deeply rooted beliefs necessary for social norms change.[41] In 22 of the 31 countries with national level data on FGM/C, less than half of their populations reside in urban centres.[42] However, there are notable exceptions to this including in Indonesia, where 56% of girls who have undergone FGM/C live in urban areas[43].

Low household wealth and poverty are also associated with higher rates of FGM/C, where girls from wealthier households are less likely to be cut. Similarly, there is correlation between higher rates of FGM/C on daughters of women with no education, which decreases substantially when the mother's education level rises. Women with higher levels of education are also more likely to oppose the practice of FGM/C. As with most drivers of the practice of FGM/C there are exceptions to these patterns, e.g. in Nigeria[44]. Ethnicity, household wealth, urban or rural residence and educational attainment of the mother are likely to

CASE STUDY: PLAN INTERNATIONAL SUDAN & PLAN INTERNATIONAL GUINEA – PROMOTING MALE ENGAGEMENT

In recognition of the importance of male engagement in tackling the negative social and gender norms that underlie FGM/C, Plan International offices collaborate and work with males in communities as agents of change.

In the White Nile State, Plan International Sudan trained 31 religious leaders and 171 male facilitators to work within their communities in raising awareness and advocating against FGM/C. In Guinea, over 10,368 men in the district of Coyah were supported to understand and engage in the issue. Activities led by male activists included public community events, the agreement of alternative initiation rites, intergenerational dialogues and outreach to religious leaders and health professionals.

"The law, article 141 which criminalizes FGM, gives me hope that change can be real."

Sheikh Alnayer Youif (60), farmer and religious leader, Sudan

"Yesterday, excision was a tradition that we encouraged, it was even a must for our daughters. Today we have understood that it is no longer a good practice, the consequences are enormous."

Mr Abdoulaye, Head of Bangouya District, Guineau

interact, with the effect that a woman who lives in an urban area is more likely to be better educated with a higher household wealth and may therefore be less likely to facilitate or consent to the cutting of her daughter.[45]

RELIGION

Communities and individuals often cite the belief that FGM/C is a requirement of their religion. For example, in Somalia and Somaliland, an estimated 99.2% of women aged 15-49 have undergone FGM/C, with 72% believing that it is a religious requirement.[46] However, the practice is not condoned, and is not a requirement of any religion. FGM/C is first believed to have originated between 2,000 and 5,000 years ago in Egypt,[47] and therefore predates the modern religions of Judaism, Christianity, and Islam. Communities of all religions and faiths have been known to practice FGM/C, including Christianity, Islam, Judaism and indigenous religions. Furthermore, only certain communities of a given faith may practice FGM/C, further indicating that FGM/C is a cultural or traditional practice that has been passed down through generations.

Confusion in particular around the links between FGM/C and Islam perpetuated at community level, stem from the use of religious terms to refer to the practice, e.g. referring to the 'Sunnah' cut, which is an Islamic religious term with connotations of a practice that is recommended by the Prophet Muhammad.[48] According to the Shari'ah, for a practice to be considered 'religious' under Islam, the practice must have a basis in the Qur'an or the Sunnah (the established practices exemplified or approved of by the Prophet Muhammad).

The Qur'an makes no mention of FGM/C or female circumcision, but clearly warns against bringing deliberate harm to oneself or to others, and against temptations to change the form created by God.[49] Similarly, the few hadith (reports of statements or actions of the Prophet), that proponents of FGM/C rely upon to justify the practice of FGM/C as Islamic are considered to be both weak and inauthentic by Islamic scholars. There is also no evidence that any of the female members of the Prophet Muhammad's household underwent circumcision.[50]

While opinion differs widely among Islamic scholars and religious leaders, many leading Islamic scholars, including the prestigious Al-Azhar University, actively advocate against the practice of FGM/C, recognising that it is not an Islamic practice. This has included the issue of a number of fatwahs prohibiting the practice, such as a fatwah by Al-Azhar Supreme Council of Islamic Research in 2007, which stated that FGM/C has no basis in Sharia, but also that it is sinful and should be avoided. While further evidence is required, in contexts where the practice of FGM/C is associated with religion, working with and engaging religious leaders may be effective in supporting those communities to abandon the practice.[51]

FGM/C IN HUMANITARIAN SETTINGS AND DURING CRISES (INCLUDING COVID-19)

Humanitarian situations and crisis contexts have a disproportionate impact on girls and women by exacerbating existing structural gender inequalities, many of which are also root causes of FGM/C.[52] Humanitarian contexts routinely lead to increased rates of gender-based violence, including child, early and forced marriages and unions (CEFMU) and FGM/C, and minimum standards require that all humanitarian actors *assume* that violence increases during these periods.[53] FGM/C in emergencies is under-researched, but available literature and consensus widely indicate that the needs and rights of girls at risk of, or survivors from FGM/C are neglected in humanitarian programmes and responses, and have often been de-prioritised by donors and policy-makers.[54] Analysis of global humanitarian funding data reported to the Financial Tracking Service (FTS) in 2016, 2017 and 2018 found that GBV funding accounted for only 0.12% of all humanitarian funding; with the amount committed directly towards ending FGM/C likely to be minimal.[55]

Impacts of humanitarian or crisis situations on the practice of FGM/C are multifaceted. Where a humanitarian crisis results in the displacement of populations, the cultural practice moves with the community. Research carried out by Plan International in Mali found that internally displaced families from the North who did not practice FGM/C and had fled to live in the South, where FGM/C is much more prevalent, were being ostracised for not cutting their daughters. They felt pressure to perform FGM/C on their daughters. Similarly, media reports from Egypt suggest that Syrian refugees have started performing the practice on their daughters in order to assimilate to the culture, likely influenced by economic pressure and concerns about girls' marriageability.[56] Humanitarian situations can therefore influence the practice as social norm reference groups change with population shifts. While non-practising populations may be pressured to take up the practice, further research is needed to establish whether reversed population dynamics may present opportunities for community abandonment where practising communities migrate to low-prevalence areas.

The impact of humanitarian crises, including those driven by climate change,[57] has also been shown to lead to communities adopting or increasing the practice of FGM/C as a negative coping strategy and as a means of dealing with instability, deterioration of livelihoods and a strain on economic resources. This is particularly true where the practice is viewed as a prerequisite for marriage, as cut girls may receive a higher bride price,[58] demonstrating the significant links between FGM/C and CEFMU. Anecdotal evidence from the COVID-19 pandemic also demonstrates the impact that crises can have on social norms including FGM/C. For example, reports from Kuria district in Kenya demonstrated that community elders and chiefs

CASE STUDY: PLAN INTERNATIONAL SOMALIA – ADVOCACY TO CREATE A LEGAL FRAMEWORK

Within the context of COVID-19, drought and internal displacement, Plan International Somalia, in partnership with Network Against FGM in Somaliland (NAFIS) collaborated with young people, government ministers, and key traditional and religious leaders to address FGM/C and improve child support systems in Somaliland.

Adolescent girls designed and led advocacy activities against FGM/C, resulting in a social media platform for peer-to-peer sharing of support and positive messages. Traditional and religious leaders took part in national radio broadcasts, accompanied by a television, billboard, and leaflet campaign to reach a wider audience. The project provided technical support and guidance to the Ministry of Employment, Social Affairs and Family, who enabled effective coordination among national actors. The bottom-up model that synergised action from community level to the national level consolidated voices of NGOs, religious leaders and the government.

As a result, the Children's Act was passed as a landmark law to protect children, and after achieving consensus, the FGM/C policy was submitted to Parliament for debate.

were blaming the pandemic on the community's perceived abandonment of its traditional and cultural practices, including FGM/C, thereby angering the gods.[59]

Humanitarian crises seriously disrupt access to essential services needed by survivors of FGM/C, not least quality sexual and reproductive health and rights (SRHR) services, and the ability of community-based programming initiatives to access at-risk communities for prevention.[60] Effectively adopting and implementing a humanitarian-development-peace nexus (HDP nexus) approach to FGM/C interventions provides a potential solution to the dual challenges faced by girls at risk of FGM/C, who lack access to effective development-based programming during times of crisis, and for whom services have been systematically de-prioritised by humanitarian actors on the basis that they are not considered essential or life-saving[61]. Humanitarian situations routinely result in increased rates of sexual and gender-based violence (SGBV), which place survivors of FGM/C at significant risk of compounded physical and psychosocial impacts as a result of existing trauma and the physical health impacts of FGM/C. For example, girls as young as 10 living in refugee camps in Sudan were found to be pregnant as a result of rape and subsequently experienced a number of serious complications in childbirth as a result of their FGM/C status and age[62]. Continuity of care and sustained access to services, including sexual and reproductive health and GBV services, are therefore vital to survivors of FGM/C during humanitarian crises, where the interaction of FGM/C with increased incidences of other forms of SGBV, including rape, are more likely to be made manifest.

Taking an HDP nexus approach towards ending FGM/C in crisis contexts would support a stronger focus to identify potential vulnerabilities and risks for girls and communities practising FGM/C, looking beyond the immediate and acute needs.[63] Evidence from the COVID-19 pandemic response demonstrates that local and community-based service providers are best placed during times of crisis to effectively mobilise change, identify solutions and respond to crises in their communities.[64] Strengthening and partnering with local organisations and community-based service providers can offset disruptions to service provision during times of emergency and ensure continuity of care and access to services.[65]

As a result of COVID-19, UNFPA estimates two million cases of FGM/C could occur over the next decade that would otherwise have been prevented.[66] Impacts of COVID-19 restrictions have led to delays and disruptions in the delivery of programming, particularly at community-level, to support the abandonment of FGM/C. These delays have been further compounded by lockdowns and stay-at-home orders or curfews, which have resulted in the closure of schools and other safe spaces, keeping girls at home where they are at much higher risk of undergoing FGM/C and entering into CEFMU. Research carried out by Plan International in Somalia in May 2020 found evidence that cutters were going door to door to perform FGM/C services in Mogadishu. Similarly, a rapid assessment conducted by UNFPA in Somalia and Somaliland found that 31% of respondents stated that there had been an increase in FGM/C compared to before the pandemic,[67] while a survey by Save the Children in September 2020 in the Dadaab refugee camp in Kenya found that 75 per cent of child-protection workers reported a 20 per cent increase in FGM/C.[68]

Lockdown measures were also responsible for weakening justice, protection and health systems, particularly in countries where these were already inadequate, resulting in survivors of FGM/C experiencing significant delays in accessing justice and legal protection, including arrest and prosecution of perpetrators.[69] Similarly, as seen between Kenya and Uganda, weakened border policing structures as a result of lockdown led to an increase in reported crossings in March 2020 from Uganda into Kenya to seek FGM/C practitioners.[70] On the other hand, lockdowns resulting in lack of access to services have also resulted in a positive decrease in the practice of medicalised FGM/C, as practising communities struggled to access health service providers to perform cutting, and health services themselves shifted to prioritise COVID-19 response. For example, in Nigeria where 12.7% of FGM/C is performed by health care providers, reports indicated that restrictions on

movement had prevented families across Enugu State from traveling to health clinics for the performance of FGM/C.[71] Response plans to public health emergencies can therefore offer opportunities to meaningfully disrupt the practice of FGM/C. For example, Sierra Leone's response to the 2014 Ebola epidemic imposed a ban and a substantial fine on the practice of FGM/C for fear that it would spread the disease, which led to a temporary, although dramatic and substantial decline in the prevalence of FGM/C in Sierra Leone during the epidemic.[72]

CONSEQUENCES AND IMPACTS OF FGM/C

HEALTH

There are no known health benefits to the practice of FGM/C. All forms of FGM/C are harmful to the physical and psychosocial health and wellbeing of girls and women across their lifetime, including their sexual and reproductive health.

While the physical, psychosocial and sexual health impacts of FGM/C are significant, it is important to note that focusing entirely and only on health impacts of the practice has been shown to encourage a harm-reduction approach to FGM/C, resulting in increased rates of medicalised FGM/C[73] (FGM/C carried out by medical professionals or in health settings), cutting girls at younger ages, or adopting 'less severe' types of cutting, which in turn normalises and further entrenches the practice.

The immediate or acute complications of the practice can include severe pain, excessive bleeding, shock, genital tissue swelling, fever, infections, urinary problems and wound healing complications .[74] In some cases, the practice may result in death as a result of severe bleeding, pain and trauma, and/or severe infection.[75] Type 3 FGM/C is associated with the greatest risk of immediate physical harm.[76] While there is often a preoccupation with the perceived varying levels of severity of different types of FGM/C, evidence from reconstructive surgery pioneer, Dr Pierre Foldés, shows that women from India and Indonesia who have undergone Type 4 can experience a deeper cut and more immediate, physical harm than even Type 1 due to damage to the clitoral nerve.[77]

Girls and women who have experienced the cut are likely to suffer gynaecological health conditions later in life, including painful or difficult urination, problems with menstruation if the vaginal opening is partially closed, vaginal itching and discharge due to infection and trauma, and chronic infections of both the urinary tract and the vagina. Women who have been cut also experience a range of obstetric complications during childbirth as a result of the practice, including notably prolonged labour, tears and lacerations, caesarean sections, episiotomies, instrumental deliveries, postpartum haemorrhages, and difficult labour. Notably, FGM/C has also been associated with cases of obstetric fistula, likely as a result of prolonged and difficult labour, with the highest risks for girls and women experiencing Type 3 (infibulation), and it is notable that countries where FGM/C is prevalent also have higher maternal mortality rates. Obstetric complications resulting from FGM/C can result in a higher incidence of infant resuscitation on delivery, intrapartum stillbirth and neonatal death.[78]

Beyond the physical health impacts of FGM/C, the practice has also been associated with sexual and mental health complications that directly interfere with the rights of girls and women to sexual health.[79] Girls and women who have undergone FGM/C are more likely to report painful intercourse, no sexual desire, less sexual satisfaction, and are less likely to experience orgasm compared to girls and women who have not undergone FGM/C. Girls and women who have experienced FGM/C have also reported a number of associated mental health and psychosocial risks, including anxiety and depression, neuroses, psychosis, memory loss, and post-traumatic stress disorder (PTSD). Evidence shows that the age at which the practice is undergone is a contributing factor to the mental health and psychosocial impacts of FGM/C, where women who were older at the time of the cut and could therefore recall the experience were more likely to report anxiety, depression, and PTSD.[80] While available evidence suggests that the ability to recall the practice has a greater impact on the mental health of girls and women, FGM/C is physically and psychologically harmful no matter at what age it is performed.

At a societal and global level, the WHO estimates that the total cost to the global economy of treating the health impacts of FGM/C in only 27 countries with adequate data alone would amount to $1.4 billion USD per year, if all resulting medical needs of survivors were addressed. If FGM/C were abandoned now, the associated savings in global health costs to address complications arising from FGM/C would be more than 60% by 2050.[81]

ACCESS TO SURVIVOR-CENTRED SERVICES

Despite an urgent need for accelerated efforts to prevent and end FGM/C in all of its forms, ending the practice would still leave millions of girls and women living with the lifelong physical and psychosocial consequences. Access to services for survivors is often forgotten alongside necessary funding for prevention activities.

Article 5 of the Maputo Protocol provides that 'States Parties shall take all necessary legislative and other measures to eliminate such practices', including 'provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting'. The UN General Assembly has also urged countries to protect and support girls and women who have undergone FGM/C and those at risk, including 'by developing social and

psychological support services and care' and taking 'measures to improve their health, including sexual and reproductive health, in order to assist girls and women who are subjected to the practice.'

Governments are required to ensure access to prenatal and postnatal care and family planning for survivors of FGM/C. States have also been urged to develop age-responsive, safe and confidential programmes and medical, social and psychological support services to assist girls who are subjected to violence, which should include counselling for women and men to discourage the practice. Both the UN General Assembly and the UN Special Rapporteur on violence against women have called for specialised shelter services for girls and women at risk, noting that 'while shelters are generally associated with intimate partner violence, such sanctuary is also required by girls and young women escaping, for example, female genital mutilation.'[82]

Clitoral reconstructive surgery aimed at restoring normal genital anatomy and function, has been pioneered by Dr Pierre Foldès since 2004[83]. The procedure involves opening up scar tissue to expose the clitoral nerve endings and grafting fresh tissue. The procedure can relieve chronic pain associated with FGM/C, restores clitoral sensitivity in some women, and in some cases allows women to experience orgasm. The procedure is beneficial for many women in restoring self-esteem and quality of life. Although the procedure is available at specialist clinics in Europe, the United States, Senegal and Burkina Faso (among others), it remains widely unaffordable and inaccessible to many survivors.

SOCIO-ECONOMIC IMPACTS

There is scarcity of data, evidence and research on the impacts of education on FGM/C. Existing evidence does suggest that better educated women are less likely to cut their daughters, as access to education allows new concepts to be introduced and facilitates the exchange of ideas and information to foster critical thinking skills and social relations.[84] Education is therefore likely to be a protective factor in reducing FGM/C prevalence.[85] Mainstreaming information on FGM/C in schools, for example, through comprehensive sexuality education, has also been shown to be effective in shifting attitudes from the practice.[86]

Research shows that girls who experience FGM/C are more likely to drop out of school,[87] or that it can result in diminished participation in school activities.[88] In Kenya, small scale studies have shown that girls who are cut usually withdraw from school afterwards and their education ends,[89] often as a direct result of FGM/C in a context where the practice is seen to mark the transition into adulthood. Reasons for school dropout usually cite medical complications associated with the practice,[90] particularly during recovery periods. Equally, uncut girls in Tanzania were shown to have experienced social exclusion, bullying and stigmatisation in school, while girls that have actively rejected the practice lost parental or family support for their education.[91] In practice, schools also function as safe spaces for girls at risk of FGM/C, as lockdowns and stay-at-home orders resulting from the COVID-19 pandemic left girls at home and limited the monitoring and reporting of cases of FGM/C through schools and teachers.[92] Where the practice is a precursor to CEFMU, a girl will also be withdrawn from school.[93] The impacts of FGM/C on girls' access to education are also likely to have considerable impacts on girls' economic empowerment and future opportunities, although further evidence and research on the links here are required.

CHILD, EARLY AND FORCED MARRIAGE AND UNIONS (CEFMU) AND FGM/C

In countries where both FGM/C and CEFMU is practiced, data shows that only a minority of girls are affected by both harmful practices.[94] Although the practices of FGM/C and CEFMU share many of the same social drivers, including harmful and inequitable gender and social norms, rural residence, low household wealth, and low levels of education they appear to be less closely linked than often assumed and seem to coexist rather than one conditioning the other. Yet, there is evidence that suggests that, for example in Kenya, Senegal, Burkina Faso and Sierra Leone, FGM/C acts as a direct prerequisite for CEFMU,[95] where both practices are linked to ideas about controlling girls and women' sexuality and maintaining cultural and religious norms.[96] Where cutting takes place during adolescence as part of rites of passage or initiation ceremonies, FGM/C often acts as a precursor to CEFMU.[97]

In other contexts, where FGM/C takes place at younger ages, FGM/C may not be an immediate precursor to CEFMU, but is often practised in the belief that it will ensure a girl's chastity or virginity in order to secure better marriage prospects or a higher bride price later on. In Somalia, men consider FGM/C essential for marriage, and girls who have undergone a Type 1 cut as opposed to infibulation expressed concerns that they are viewed by the community as being more likely to have premarital sex, and therefore sought out early marriages to prove their value and respectability.[98] Evidence from Ethiopia suggests that girls themselves have arranged their own circumcision as a result of peer pressure.[99] Although both practices are often linked or practised by the same community, evidence shows that in these contexts, the abandonment of one practice does not necessarily impact the practice of the other if they are not addressed together. For example, interventions to end CEFMU within a community that do not explicitly reference and address FGM/C may leave the practice of FGM/C in place and entrenched. Where the two practices co-exist and share the same drivers and social norms, addressing both issues together is the most effective way to address both issues.[100]

Due to the complexity of the two practices, it is important to not make assumptions about their causality, and further studies at global as well as local levels are needed to better understand the connection

between girls who are cut at an early age, and later being at risk of CEFMU.

TOPICAL ISSUES

CRIMINALISATION OF FGM/C

As the global movement to abandon FGM/C has grown, so too has the number of countries introducing legislation to criminalise the practice. As of November 2021, 52 countries, including 29 in Africa, have criminalised the practice in law,[101] with penalties including both criminal sanctions and fines. In June 2020, the UN Committee on the Elimination of Discrimination Against Women held that Mali's failure to criminalise FGM/C was a violation of the fundamental human rights of girls and women in allowing impunity for the practice.[102]

Many activists and survivors feel that having a direct law prohibiting FGM/C sends a clear message that FGM/C is wrong and legitimises their campaigning, advocacy and programming efforts. Conversely, where the practice is not prohibited in law, the practice is effectively legal and is either carried out with impunity at best, or normalised and medicalised at worst. For example, no country in Asia has legislated to prohibit FGM/C on the basis that governments refuse to acknowledge the existence of the practice or that it amounts to 'mutilation' rather than so-called 'female circumcision'. While Indonesia did legislate to ban the practice of FGM/C by medical professionals in 2006, religious opposition led to the issuing of a decree allowing medical professionals to perform FGM/C in 2010. As of 2014, the Indonesian government revoked the decree, but the practice is currently not prohibited in legislation.[103] An estimated 49% of girls aged 0-14 have undergone FGM/C in Indonesia, with 15 million expected to be cut by 2030. The practice is heavily medicalised and often offered as part of 'birth packages' in hospitals alongside ear piercing.[104]

Criminalisation of FGM/C differs in approach, with some states such as Kenya enacting FGM/C-specific legislation, while other states include reference to the practice within wider legislative measures on child protection, ending violence against girls and women, or domestic violence laws. However, the effectiveness of legislation is often hampered by poor enforcement and implementation, a failure of law enforcement authorities to follow the law, and corruption.[105] In many countries with legislation criminalising FGM/C, there are no effective mechanisms for reporting, referring, and protecting girls and women at risk, resulting in very few prosecutions and ineffective enforcement mechanisms.[106]

Despite increasing criminalisation of FGM/C, research demonstrates that legislation criminalising FGM/C 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 girls and women, as opposed to the punishment of practising communities.[107] Where parents and caregivers are prosecuted under criminal legislation, this can often have harmful unforeseen consequences for girls themselves if they are removed from primary caregivers or local communities, as depriving them of wider familial care and support is often not in their best interests. While legislation can contribute to an enabling environment for social norms change, where the legal norm conflicts with deeply-rooted social norms and customs that value FGM/C, fear of criminal sanctions can motivate practising communities to carry out FGM/C in secret rather than obeying the law.[108] For example, research in Kenya has shown that in spite of comprehensive anti-FGM/C legislation, 13% of the population would choose to disobey the law in order to carry out FGM/C in future.[109]

Kenya's anti-FGM/C law is held by some campaigners to represent 'best practice'.[110] The law provides a comprehensive definition that includes all forms and types of FGM/C, applies the prohibition regardless of a girl's or woman's age or status, provides extra-territorial jurisdiction to allow prosecution of FGM/C that occurs outside of Kenya's borders, and explicitly prohibits the medicalisation of FGM/C. Notably, the law penalises both direct and indirect participants in procuring FGM/C. While Kenya's anti-FGM/C law is both comprehensive and robust, it is in practice difficult to enforce without meaningful social norms change, as girls are unlikely to bring prosecutions against parents or caregivers owing to strong familial and community bonds. Where girls are willing to bring prosecutions or to seek refuge by running away to rescue centres, they are simply removed from the community, often without the consent of family members, thus creating hostility and greater barriers to community dialogue and efforts to end the practice.[111]

Where communities choose to continue to practice FGM/C in secret in order to avoid detection and possible sanction, reporting and monitoring cases and engaging communities in non-judgemental dialogue to shift social norms underlying the practice becomes much more difficult. Criminalisation of FGM/C has also been associated with communities choosing to cut girls at a younger age to avoid detection, and a rise in the medicalisation of the practice as communities perform 'less severe' cuts.[112]

CROSS-BORDER CUTTING

Cross-border cutting occurs in regions where practising ethnic groups are highly prevalent and share porous national borders, resulting in the transportation of girls or 'cutters' across national borders for the purposes of carrying out FGM/C. As a cultural practice and social norm carried out by communities of shared ethnicities, FGM/C is highly prevalent in regions where practising ethnic groups are concentrated, often spanning national borders. For example, while the national prevalence of FGM/C in Kenya is 21%, the practice is highly concentrated among Somali and Kisii ethnic groups located in border regions with Somalia and Uganda.[113] In Uganda, where FGM/C prevalence is the lowest in East Africa at 0.32%, the vast majority of FGM/C takes place in the regions of Karamoja and Sebei, where prevalence is much higher at 26.7% due to higher populations of the Pokot, Kadama, Tepeth

CASE STUDY: PLAN INTERNATIONAL TANZANIA – TACKLING CROSS-BORDER CUTTING

Plan International Tanzania is working in the regions of Geita and Mara to reduce the incidence of FGM/C and CEFMU. Many cutters work across the borders of Tanzania and Kenya, complicating both prevention efforts and provision of support to survivors.

In response, a cross border task force was formally established comprising of government ministries, community leaders and local NGOs working on prevention of FGM/C. The task force is collaborating to deliver awareness raising programmes and events in schools on FGM/C in border towns where there is high prevalence. Police cooperation across borders will be coordinated to share successful strategies in managing cases, and the project will work directly with cutters on both sides of the border to engage them directly in prevention strategies.

and Sabiny ethnic groups.[114] Similar population dynamics are also found in West Africa in relation to Mali, Burkina Faso, Guinea, Guinea-Bissau and Senegal.

The practice of cross-border cutting is increasingly related to the criminalisation of FGM/C, as communities seek to evade criminal sanctions and prosecutions by carrying out the practice in a bordering jurisdiction where the practice is not illegal or is less likely to be enforced.[115] A 2018 study of the law and FGM/C identified that of 22 African countries with legislation prohibiting FGM/C, 19 do not address cross-border cutting, and only three countries criminalised it (Guinea-Bissau, Kenya and Uganda),[116] giving national courts extra-territorial jurisdiction over the crime of FGM/C where it has taken place in a neighbouring country. It should be noted that the issue also affects girls outside of the African continent in diaspora communities in Europe and the United States, many of whom are subject to so-called 'vacation cutting'.

Fear of prosecution and criminal sanctions are not the only driving factors behind cross-border cutting. A study carried out by UNICEF Kenya found that 71% of survey respondents said that they crossed into Kenya to access FGM/C services.[117] The study also found that increased trends towards cross-border cutting were motivated not only by a view that it was easier to evade the authorities in Kenya, who are believed to be more likely to 'turn a blind eye' to the practice, but that FGM/C services in Kenya are of better quality and more affordable.[118] Other reasons cited include a lack of proximity to FGM/C services in the origin country, and intermarriage between closely related communities and within ethnic groups occupying both sides of an international border.

The issue of cross-border cutting demonstrates the need for a comprehensive and coordinated regional approach towards ending FGM/C that should include the harmonisation of laws and policies and take a multi-sectoral approach to support community abandonment that engages all sectors and stakeholders. To illustrate, although avoiding prosecution and legal sanction is not the only driver of cross-border cutting, financial penalties and sentencing differs widely across East Africa. In Kenya and Tanzania, minimum sentencing for the offence of FGM/C is three and five years respectively, while in Ethiopia the penalty is only three months. Financial penalties also vary widely, from a $17 USD fine in Ethiopia to $1,935 in Kenya. There is currently no law prohibiting FGM/C in Somalia.

Currently, two regional frameworks are in place that clearly address cross-border cutting. The East African Community (EAC) Prohibition of FGM bill, 2016,[119] which has been assented to by Kenya, Tanzania, South Sudan, and Uganda but has not yet entered into force. The EAC act seeks to establish a sub-regional coordination mechanism for the harmonisation of laws and policies to prevent FGM/C, and provides a minimum sentence of three years for the offence of performing FGM/C. Notably, Article 6 explicitly provides for the offence of cross-border cutting, which is applicable in all States Parties as taking precedent over national law. At the African Union, the Pan-African Parliament also adopted an action plan in 2016 to end FGM/C in Africa, which highlights the need for strengthening action against cross-border cutting.[120]

MEDICALISATION

'Medicalisation' of FGM/C (or 'medicalised' FGM/C) refers to situations in which FGM/C is practiced by any category of health care providers, whether in a public or a private clinic, at home or elsewhere.[121] The definition of medicalised FGM/C also includes the procedure of reinfibulation at any point in a girl or woman's life, which refers to the practice of re-stitching or suturing of the scar tissue resulting from infibulation after a woman has been deinfibulated. There is currently debate about whether the use of medical instruments such as sterilised tools, antibiotics, or anaesthetics, particularly by traditional practitioners, should be included within the definition of medicalised FGM/C.

The medicalisation of FGM/C is an increasing trend in the practice globally; data from 24 countries with information on the practitioner of FGM/C found that 18% of girls under the age of 15 who had undergone FGM/C had the practice performed by a health professional.[122] There are eight countries with available data in which more than 10% of girls who undergo FGM/C, 4.5 million in total, are cut by a health professional (Djibouti, Egypt, Guinea, Indonesia, Iraq, Kenya, Nigeria, Sudan and Yemen). Among the total number of girls and women who undergo medicalised FGM/C, 94% live in Egypt, Nigeria and Sudan, and over 50% live in Egypt alone where rates of

medicalisation have more than doubled between women and daughters.[123] In Indonesia, where 49% of girls undergo FGM/C, the practice is offered in hospital and clinic settings as part of 'birth packages' alongside ear piercing, and is sometimes carried out automatically before parents are even asked to consent to the practice. In Egypt, 67% of FGM/C is carried out by a doctor as the most common health professional, while 77% of FGM/C in Sudan is performed by a nurse, midwife or other health worker.[124] Reinfibulation is estimated to affect over 20 million women globally, and between 10 and 16 million women are likely to experience medicalised reinfibulation, which has been documented in Sudan, Somalia, Djibouti and Eritrea, as well as in Europe and North America.[125]

The medicalisation of FGM/C is driven both by requests from practising communities to medical professionals,[126] and by medical professionals themselves. Most medical professionals who perform FGM/C do so because they themselves are part of the practising communities that they serve professionally. They are therefore also influenced by the pressures of existing social norms[127] and gender norms and perceived religious obligations. For example, one study in Nigeria demonstrated that most health workers perform FGM/C because they share the same beliefs as the community, evidenced by the fact that four out of five health workers with daughters had cut their own daughters.[128] Similarly, a study in Sudan concluded that medicalisation is primarily driven by social norms-based demand for the practice.[129] Health professionals who decline to carry out the practice cite concerns that community members are unlikely to return to the health clinic, and that by condemning the practice, community members may seek it outside of the health clinic with potentially worse health outcomes. Performing FGM/C can also be a major source of income for health professionals, particularly if the practice is criminalised in law,[130] providing additional motivation for the growing medicalisation of the practice.

A substantial focus on the physical health impacts as part of a harm-reduction approach to campaigning against FGM/C has also bolstered the desire for medicalisation of the practice, both by health professionals and by communities responding to the messaging and opting for an alleged 'safer' or 'lesser' form of cut.[131] This kind of messaging sometimes relies on assumptions that minimising the harm caused by FGM/C is a pragmatic approach towards full abandonment of the practice. For example, harm-based messaging in Somalia has led to a shift in the type of cut practised from pharaonic infibulation (Type 3) to the 'sunnah' cut (Type 1). However, focusing solely or exclusively on reducing the immediate physical health risks by adopting a harm-reduction approach fails to recognise or account for the human rights violations entailed in the practice of FGM/C, including the right to physical and mental health, the right to be free from violence, the right to education, and rights to bodily autonomy, informed consent, and equality.[132] It also fails to challenge the underlying objective and perceived need of controlling female sexuality.

As noted before, there are no health benefits to FGM/C, and even where the practice is medicalised, considerable physical and psychological harm to girls and women is caused. In addition, adopting harm-reduction messaging and the subsequent medicalisation of the practice risk legitimising the practice and entrenching it further, by falsely communicating to practising communities that the practice can be carried out 'safely' and is acceptable when performed by health professionals.[133] Conversely, health professionals themselves often cite concerns that they feel the practice will be safer, if they themselves carry it out rather than traditional practitioners. However, this assumption is erroneous, as there is no official training for medical professionals in practising FGM/C on the medical curriculum, and health professionals instead learn the skills from other colleagues, who also lack formal training.[134]

The available evidence on medicalisation of FGM/C does not show that medicalisation correlates with any decline in support for the practice.[135] Although there is limited data to suggest that in some contexts medicalisation may be associated with a trend towards less 'severe' forms of cutting,[136] evidence from Indonesia and Malaysia contradicts the idea that medicalisation leads to 'lesser' forms of cutting, where findings have established that a shift from traditional practitioners to health professionals has led to a shift from Type 4 to Type 1.[137]

Medicalised FGM/C has been denounced by the WHO and other UN agencies,[138] and is a violation of medical

CASE STUDY: PLAN INTERNATIONAL EGYPT – ADDRESSING THE MEDICALISATION OF FGM/C

In response to the ongoing medicalisation of FGM/C in Egypt, Plan International Egypt collaborated with health care professionals from the community up through to the national level. The project trained 107 community-based health care providers and 2,198 students from the Faculty of Medicine on understanding the harms of FGM/C and advocating against the practice. Health units collaborated on social awareness campaigns on FGM/C within their communities, hosting and facilitating discussions, holding outreach sessions at schools, and providing clear messages on the abandonment of FGM/C. A national roundtable was held with representation from government ministries and medical bodies, leading to the production of policy papers that called for the resourcing and training of health care professionals.

During the project 3,474 girls and young women were provided access to FGM/C related healthcare and 3,919 received mental health and psychosocial support.

ethics and the Hippocratic Oath undertaken by medical professionals to 'do no harm'. Opposition to medicalised FGM/C is also supported by professional medical organisations, including the World Medical Association in 1993[139] and the International Federation of Gynaecology and Obstetrics (FIGO), which passed a 1994 resolution opposing all forms of FGM/C, including its medicalisation. As of 2018, nine out of 22 countries with anti-FGM/C legislation in Africa explicitly prohibited the medicalisation of FGM/C within anti-FGM/C legislation.[140] In addition, in Mali, which does not have anti-FGM/C legislation in place, a government circular prohibits the performance of FGM/C in health facilities. However, it does not include sanctions and it does not cover FGM/C performed by health professionals outside of facilities[141].

THE RIGHT TO ASYLUM AND FGM/C

The Convention Relating to the Status of Refugees 1951 defines a 'refugee' as encompassing any person who has a 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion'. A successful application for asylum must therefore establish a well-founded fear of persecution based on one or more of the Convention grounds, in addition to establishing the lack of ability and/or unwillingness of the origin State to protect that person from persecution. The UN High Commissioner for Refugees (UNHCR) explicitly recognises FGM/C as a form of persecution warranting refugee status and the granting of asylum,[142] on the grounds of political opinion, membership of a particular social group or religious beliefs, as well as the recognition of FGM/C as a child-specific form of persecution which 'disproportionately affects the girl child'.[143]

UNHCR further recognises that the consequences of FGM/C continue beyond the initial procedure, and that both girls and women at risk of the practice and those who have already undergone FGM/C can qualify for international protection as refugees. This position is reinforced by the Istanbul Convention, which clearly acknowledges that women and girls who suffer from GBV, including FGM/C, can seek protection in another state when their own fails to prevent persecution or to offer adequate protection and effective remedies.[144] The EU also has a directive which explicitly states that EU member states must give international protection (asylum) to girls and women at risk of or suffering from FGM/C.[145]

UNHCR has estimated as of 2017 that over 24,000 girls and women could have already been affected by FGM/C at the time of their asylum application in the EU, equivalent to 37% of all female asylum applicants coming from FGM/C-practising countries. While most countries do not collect data specific to the grounds for application, Belgium received 609 asylum applications in 2015 on the grounds of FGM/C, representing 17% of asylum claims from girls and women from FGM/C-practising countries. The scale of asylum applications is significant, and points to the reality that FGM/C is not a negligible ground for asylum. EU member states have received asylum applications from girls and women who seek protection relating to FGM/C.

Reasons for seeking protection vary and include girls and women seeking protection from FGM/C or reinfibulation in their home countries (including after they have undergone reconstructive surgery abroad). In addition, asylum applications have been received from parents who seek to protect their daughters from FGM/C, as well as women who are under pressure from their families and communities to become cutters themselves.[146]

Nevertheless, substantial evidence shows that despite clear guidance on FGM/C as grounds for asylum,[147] many survivors of FGM/C face significant procedural challenges in attaining refugee status. These include language barriers, the lack of child-responsive services for unaccompanied minors, lack of knowledge on the part of immigration officers, and the taboo nature of FGM/C that makes discussing the practice difficult for many survivors and community members.[148] There are examples of asylum claims being rejected simply on the basis that the law in the applicant's home state prohibits FGM/C, without an assessment of the actual enforcement or implementation of the law. Similarly, asylum applications to the UK have been rejected under the notion that a woman should be able to protect her child from undergoing FGM/C, without considering the immense community pressure and social norms that often make rejection of the practice impossible or not without significant risk.[149]

REFERENCES

[1] Newman, A. (2019). 'Grandmothers Can Help Us Stop FGM - So Why Do Grassroots Projects Often Ignore Them?'. *Huffington Post.*

[2] UNICEF (2021). Female genital mutilation.

[3] UNFPA-UNICEF Joint Programme on the Elimination of FGM: Accelerating Change (2019). Annual Report: Empowering girls and women to lead change

[4] Hayes, R. O. (1975). Female Genital Mutilation, Fertility Control, Women's Roles, and the Patrilineage in Modern Sudan: A Functional Analysis. *American Ethnologist*, *2*(4), 617–633.

[5] Caplan, P. (1981). The Hosken report: Genital and sexual mutilation of females (2nd enlarged revised edition) by Fran P. Hosken. Lexington, Mass: Women's Internat. Network News 1979. See also Female circumcision, excision and infibulation; the facts and proposals for change. By McLean, S., Minority Rights Group Report No. 47 1980. *Africa, 51*(4), 877-879.

[6] Committee on the Elimination of Discrimination against Women (2016). General Recommendation No. 34 on rights of rural women, para. 22: CEDAW/C/GC/34.

[7] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2004): E/CN.4/2004/49.

[8] UNFPA (2014). Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation.

[9] Report by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (1986), para. 38: E/CN.4/1986/15. See also Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (2008), paras 50-54: A/HRC/7/3.

[10] Ibid.

[11] Committee on the Rights of the Child (2018). Views adopted by the Committee on the Rights of the Child under the Optional Protocol to the Convention on the Rights of the Child on a communications procedure in respect of communication No. 3/2016: CRC/C/77/D/3/2016.

[12] Beijing Declaration and Platform for Action of the Fourth World Conference on Women (4-15 September 1995).

[13] Programme of Action of the International Conference on Population and Development (5- 13 September 1994).

[14] African Union (2003). Protocol to The African Charter on Human and Peoples' Rights on the Rights of Women In Africa.

[15] African Union (1990). African Charter on the rights and welfare of the child'.

[16] African Union (2006). African Youth Charter.

[17] Council of Europe (2011). Council of Europe Convention on preventing and combating violence against women and domestic violence.

[18] WHO (2022). Fact Sheet: Female Genital Mutilation.

[19] Ibid.

[20] UNGA (2012). Intensifying global efforts for the elimination of female genital mutilation: A/C.3/67/L.21/Rev.1

[21] Equality Now, End FGM EU & End FGM/C U.S. Network (2020). Female Genital Mutilation/Cutting: A call for a global response.

[22] UNFPA (2018). Bending the Curve: FGM trends we aim to change.

[23] UNFPA (April 2020). Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage.

[24] Rodriguez, S. (2014). Female Circumcision and Clitoridectomy in the United States: A history of medical treatment.

[25] Equality Now, End FGM EU & End FGM/C U.S. Network (2020). Female Genital Mutilation/Cutting: A call for a global response.

[26] Shell-Duncan, B., Njue, C., and Moore, Z. (2017). "The Medicalization of Female Genital Mutilation /Cutting: What do the Data Reveal?" Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

[27] Ibid.

[28] UNICEF (2020). Press release: Approximately 1 in 4 survivors of female genital mutilation were cut by a health care provider.

[29] UNFPA & Avenir Health (2020). Costing the Three Transformative Results.

[30] WHO (2020). The economic cost of female genital mutilation.

[31] Committee on the Rights of the Child (2013). Concluding observations on the second to fourth periodic reports of Israel, para. 41: CRC/C/ISR/CO/2-4. See also Committee of the Rights of the Child (2012). Concluding observations on the combined second to fourth periodic reports of Liberia, para. 51c: CRC/C/LBR/CO/2-4.

[32] UNICEF (2013.) Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change. New York.

[33] Cislaghi, B., Manji, K., and Heise, L. (2018). Social Norms and Gender-related Harmful Practices, Learning Report 2: Theory in support of better practice. Learning Group on Social Norms and Gender-related Harmful Practices, London School of Hygiene & Tropical Medicine. See also Plan International (2022). Defy Normal: Social and gender norms action learning module.

[34] UNFPA (2020). Female genital mutilation (FGM) frequently asked questions.

[35] McArthur, L. (1995). Female Genital Mutilation: Practice, Prevalence, and Prevention.

[36] Kandala, N., Nnanatu, C., Atilola G. et al. (2019). A Spatial Analysis of the Prevalence of Female Genital Mutilation/Cutting among 0-14-Year-Old Girls in Kenya. *International Journal of Environmental Research and Public Health*, Oct 28, 16(21), 4155, 2019.

[37] UNICEF, UNFPA and UN Women (2020). Technical Note on Gender-Transformative Approaches in the Global Programme to End Child Marriage – Phase II: A Summary for Practitioners. See also Building Bridges to End FGM (2021). Gender Transformative Approaches to Ending Female Genital Mutilation.

[38] Kandala, N., Nnanatu, C., Atilola G. et al. (2019). 'A Spatial Analysis of the Prevalence of Female Genital Mutilation/Cutting among 0-14-Year-Old Girls in Kenya'. *International Journal of Environmental Research and Public Health*, Oct 28, 16(21), 4155, 2019.

[39] UNFPA (2015). Demographic Perspectives on Female Genital Mutilation.

[40] UNICEF (2013). Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change.

[41] Shell-Duncan, B., Naik, R. & Feldman-Jacobs (2016). ''A State-of-the-Art Synthesis on Female Genital Mutilation/Cutting: What Do We Know Now?'. Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

[42] UNFPA (2015). Demographic Perspectives on Female Genital Mutilation.

[43] UNICEF (2016). Statistical Profile on Female Genital Mutilation/Cutting: Indonesia.

[44] 28 Too Many (2022). https://www.28toomany.org/country/nigeria.

[45] UNICEF (2013). Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change.

[46] Directorate of National Statistics, Federal Government of Somalia (2020). The Somali Health and Demographic Survey 2020.

[47] WHO (2006). 'Female genital mutilation – new knowledge spurs optimism'. *Progress in Sexual and Reproductive Health Research*, 72.

[48] UNFPA (2008). Delinking Female Genital Mutilation/Cutting from Islam.

[49] Islamic Relief (2016). One Cut Too Many: Policy Brief on Female Genital Mutilation/Cutting; "I will mislead them, and I will create in

them false desires; I will order them to slit the ears of cattle, and to deface the (fair) nature created by Allah." (Qur'an, 4:119)

[50] Ibid.

[51] UNFPA, UNICEF, WHO and Population Council, Kenya (2021). Effectiveness of Interventions Designed to Prevent or Respond to Female Genital Mutilation: A review of evidence.

[52] The 15 countries with the highest prevalence rate of FGM/C include 8 fragile countries in need of humanitarian assistance as of January 2023.

[53] Inter-Agency Minimum Standards for GBV in Emergencies Programming (2019). And Minimum Standards for Child Protection in Humanitarian Action (2019).

[54] UNICEF (2020). The Humanitarian-Development Nexus: The Future of Protection In The Elimination Of Female Genital Mutilation.

[55] International Rescue Committee (2019). Where is the money? How the humanitarian system is failing in its commitments to end violence against women and girls.

[56] Nielsen, N. (2017). 'Syrians find troubled homes in Egypt', *EU Observer.*

[57] Esho T, Komba E, Richard F, Shell-Duncan B. (2021). 'Intersections between climate change and female genital mutilation among the Maasai of Kajiado County, Kenya'. *Journal of Global Health.*

[58] Jones, N., et al. (2020). 'Listening to Young People's Voices under Covid-19: Child marriage risks in the context of Covid-19 in Ethiopia', policy brief, Gender and Adolescence: Global Evidence, London. See also Archambeault, L. (2020). 'Beyond the Shadow Pandemic: Protecting a generation of girls from gender-based violence through COVID-19 to recovery'. Save the Children, Fairfield and London.

[59] Orchid Project (2020). The Impacts of COVID-19 on Female Genital Cutting.

[60] UNICEF (2020). Technical note: The Humanitarian-Development Nexus: The future of protection in the elimination of female genital mutilation.

[61] Ibid.

[62] AIDOS, End FGM European Network and GAMS Belgium (2020). Preventing and Responding to Female Genital Mutilation in Emergency and Humanitarian Contexts Results from the Virtual International Stakeholder Dialogue.

[63] UNICEF (2020). Technical note: The Humanitarian-Development Nexus: The future of protection in the elimination of female genital mutilation.

[64] Duetting G., Karadenizli, M., and Kaiser, B., (2020). 'How to Promote Gender-Responsive Localization in Humanitarian Action', UN Women: Geneva.

[65] UNFPA and UNICEF (2020). Resilience in Action: Lessons learned from the Joint Programme during the COVID-19 crisis.

[66] UNFPA (2020). Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage.

[67] UNFPA (2020). GBV/FGM Rapid Assessment Report: In the Context of COVID-19 Pandemic in Somalia.

[68] Save the Children (2020). Impact of COVID-19 on Protection and Education Among Children in Dadaab Refugee Camp, Kenya.

[69] UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating Change (2021). FGM Elimination and COVID-19: Sustaining the Momentum. Eliminating FGM in Fragile Contexts – Case Study of COVID-19.

[70] UNFPA (2020). Case study on ending cross-border female genital mutilation in the Republic of Uganda.

[71] Orchid Project (2020). The impacts of COVID-19 on female genital cutting.

[72] Schwartz, D. (2019). '*The Ebola Epidemic Halted Female Genital Cutting in Sierra Leone: Temporarily: Medical, Anthropological, and Public Health Perspectives'*, In: Pregnant in the Time of Ebola.

[73] Leye, E., Van Eekert, N., Shamu, S. et al. (2019). Debating medicalization of Female Genital Mutilation/Cutting (FGM/C): learning from (policy) experiences across countries. *Reproductive Health* 16**,** 158.

[74] Population Council (2016). Health impacts of female genital mutilation/cutting: A synthesis of the evidence.

[75] Trew, B. (2013). 'Unkindest cut: 13-year-old's death shines spotlight on rise of FGM in Egypt'. *Evening Standard*.

[76] El Defrawi, M. H. et al. (2001). 'Female genital mutilation and its psychosexual impact'. *Journal of Sex and Marital Therapy* 27: 465–73.

[77] Middelburg, A. (2020). Visiting the clinic of Dr Foldès in Paris.

[78] WHO (2020). Fact Sheet: Female genital mutilation.

[79] PopCouncil (2016). Synthesis of Evidence on Health Impacts.

[80] Vloeberghs, E., Knipscheer, J., van der Kwaak, A. et al (2012). 'Coping and chronic psychosocial consequences of female genital mutilation in the Netherlands'. *Ethnicity & Health* 17/6: .677-695.

[81] WHO (2020). Female Genital Mutilation Hurts Women and Economies.

[82] Economic and Social Council (2009). Ending Female Genital Mutilation: Report of the Secretary-General, para 41: E/CN.6/2010/6. See also Human Rights Council (2008). Report of the Special Rapporteur on Violence Against Women, Its Causes and Consequences on Indicators on Violence Against Women and State Response, para. 98: A/HRC/7/6.

[83] Foldès P, Cuzin B, Andro A. (2012). 'Reconstructive surgery after female genital mutilation: a prospective cohort study'. *Lancet*. 2012 Jul 14; 380 (9837): 134-41.

[84] ICRW (2016). Leveraging education to end FGM/C worldwide.

[85] UNICEF (2021). Technical Note: Girls' Education, Empowerment, and the Elimination of Female Genital Mutilation.

[86] Ibid.

[87] Magangi, M. (2015). 'Effects of female genital cutting on school attendance and retention of primary school girls in Kuria west district, Kenya'. *African Journal of Education and Human Development*: 1(1). See also: Nyabero, C., Omwenga, E.N. & Okari, F. (2016) 'Alternative rites of passage potency in enhancing girl child self-esteem and participation in education in primary schools in Kisii County, Kenya', *African Journal of Education and Human Development*, 2(1).

[88] Anumaka, I.B. and Sironka, B. (2014). Female Genital Mutilation and Girls' Participation in School activities in Isinya district, Kajiado County, Kenya. College of Higher Degrees & Research, Kampala.

[89] Magangi, M. (2015). Effects of female genital cutting on school attendance and retention of primary school girls in Kuria west district, Kenya. *African Journal of Education and Human Development*: 1(1). See also: Nyabero, C., Omwenga, E.N. & Okari, F. (2016) 'Alternative rites of passage potency in enhancing girl child self-esteem and participation in education in primary schools in Kisii County, Kenya', *African Journal of Education and Human Development*, 2(1).

[90] Nyabero, C., Omwenga, E.N. & Okari, F. (2016) 'Alternative rites of passage potency in enhancing girl child self-esteem and participation in education in primary schools in Kisii County, Kenya', *African Journal of Education and Human Development*, 2(1).

[91] Pesamili, J., Mkumo, K. (2015). Implications of female genital mutilation on girls' education and psychological wellbeing in Tarime, Tanzania. *Journal of Youth Studies* 21/8: 1111-1126.

[92] UNICEF (2021) Technical Note: Girls' Education, Empowerment, and the Elimination of Female Genital Mutilation.

[93] Ibid.

[94] UNICEF (2021). Understanding the Relationship between Child Marriage and Female Genital Mutilation: A statistical overview of their co-occurrence and risk factors.

[95] Population Council (2018). Exploring the Association Between Female Genital Mutilation/Cutting and Early/Child Marriage.

[96] World Vision (2014). Exploring the links: Female genital mutilation/cutting and early marriage.

[97] Ibid. See also: Population Council (2016). Evidence to End FGM/C: Research to Help Women Thrive, A State of the Art Synthesis on FGM/C: What do we know now?

[98] World Vision UK (2013). Untying the Knot: Exploring Early Marriage in Fragile States.

[99] Boyden, J., Pankhurst, A., and Tafere, Y. (2013). Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Child Marriage and Circumcision in Ethiopia. Young Lives, Working Paper 93.

[100] World Vision (2014). Exploring the links: Female genital mutilation/cutting and early marriage.

[101] Equality Now, End FGM EU & US Network to End FGM (2020). 'Female Genital Mutilation/Cutting: A Call for a Global Response', with the addition of Sudan, which criminalised FGM/C through an amendment to the Criminal Code in April 2020.

[102] CEDAW (2020). Inquiry concerning Mali under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women: CEDAW/C/IR/MLI/1.

[103] Orchid Project (2020). Asia Network to End Female Genital Mutilation/Cutting (FGM/C) Consultation report: I didn't know it happened there.

[104] UNFPA (2021). Indonesian religious leaders, health workers advocate female genital mutilation's end.

[105] Meroka-Mutua, A, Mwanga, D, and Olungah, O.C. (2020). 'Assessing the Role of Law in Reducing the Practice of FGM/C in Kenya.' Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.

[106] UNICEF (2021). 'Effectiveness of Interventions Designed to Prevent or Respond to Female Genital Mutilation A Review of Evidence'. See also UNFPA Regional Officer for West and Central Africa (2018). Analysis of Legal Frameworks on Female Genital Mutilation in Selected Countries in West Africa.

[107] Population Council (2022). Evidence to end FGM/C: Research to help girls thrive – Reflections from five years of research.

[108] Meroka-Mutua, A, Mwanga, D, and Olungah, O.C. (2020). "Assessing the Role of Law in Reducing the Practice of FGM/C in Kenya." Evidence to End FGM/C: Research to Help Girls and Women Thrive. New York: Population Council.

[109] Ibid.

[110] G7 France (2019). Biarritz Partnership for Gender Equality. See also 28 Too Many (2020). FGM Model Law.

[111] UNICEF (2021). Effectiveness of Interventions Designed to Prevent or Respond to Female Genital Mutilation A Review of Evidence.

[112] Meroka-Mutua, Agnes K. (2020). 'Commentary: Using law more effectively towards abandonment of FGM/C in Kenya,' Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

[113] Kandala, N. B., Nnanatu, C. C., Atilola, G., et al. (2019). A Spatial Analysis of the Prevalence of Female Genital Mutilation/Cutting among 0-14-Year-Old Girls in Kenya. *International Journal of Environmental Research and Public Health*, *16* (21), 4155.

[114] UNICEF (2021). Case study on ending cross-border female genital mutilation in the Republic of Uganda.

[115] UNFPA (2019). Female genital mutilation across borders.

[116] 28 Too Many (2018). The Law and FGM: An overview of 28 African countries.

[117] UNICEF Kenya and the Anti-FGM Board of Kenya (2017). Baseline Study Report: Female Genital Mutilation/ Cutting and Child Marriage among the Rendille, Maasai, Pokot, Samburu and Somali Communities in Kenya, Nairobi. UNICEF.

[118] UNICEF (2021). Case study on ending cross-border female genital mutilation in the Republic of Uganda.

[119] The East African Community (2016). The East African Community Prohibition of Female Genital Mutilation Bill, 2016.

[120] UNFPA (2019). Female genital mutilation across borders.

[121] WHO (2010). Global strategy to stop health-care providers from performing female genital mutilation: UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA.

[122] UNFPA (2018). Policy Brief on the Medicalization of Female Genital Mutilation.

[123] Ibid.

[124] Ibid.

[125] Leye, E., Van Eekert, N., Shamu, S. et al. (2019). 'Debating medicalization of Female Genital Mutilation/Cutting (FGM/C): learning from (policy) experiences across countries'. *Reproductive Health* 16, 158.

[126] Kimani, S., Shell-Duncan B. (2019). Medicalized Female Genital Mutilation/Cutting: Contentious Practices and Persistent Debates. *Curr Sex Health Rep*. 2018;10(1):25-34. See also Leye, E., Van Eekert, N., Shamu, S. *et al.* (2019) Debating medicalization of Female Genital Mutilation/Cutting (FGM/C): learning from (policy) experiences across countries. *Reproductive Health* 16, 158.

[127] UNFPA (2018). Policy Brief on the Medicalization of Female Genital Mutilation.

[128] Obianwu, O., Adetunji, A., Dirisu, O. (2018). 'Understanding medicalization of FGM/C: a qualitative study of parents and health workers in Nigeria', New York: Population Council.

[129] Bukuluki, P., Wisal, A., Al Gasseer, NH., et al. (2017). 'Drivers for FGM medicalization among community midwives in River Nile and Northern State, Sudan'. *Reproductive Health*; 14 (Suppl 2):6.

[130] Serour, GI. (2013). 'Medicalization of female genital mutilation/cutting', *African Journal of Urology*: 19(3): 145–9; UNFPA/UNICEF (2017) 17 ways to end FGM/C: lessons from the field. New York: UNFPA/UNICEF.

[131] Shell-Duncan, B., Njue, C., and Moore, Z. (2017). "The Medicalization of Female Genital Mutilation /Cutting: What do the Data Reveal?" Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

[132] Ibid.

[133] WHO (2016). WHO guidelines on the management of health complications from female genital mutilation: Geneva.

[134] Rashid, A., Iguchi, Y., Afiqah, SN (2020) 'Medicalization of female genital cutting in Malaysia: A mixed methods study'. *PLoS Med* 17(10).

[135] Shell-Duncan, B., Njue, C., and Moore, Z. (2017). "The Medicalization of Female Genital Mutilation /Cutting: What do the Data Reveal?" Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

[136] Ibid.

[137] Rashid, A., Iguchi, Y., Afiqah, SN (2020) 'Medicalization of female genital cutting in Malaysia: A mixed methods study', *PLoS Med* 17(10). See also Leye, E., Van Eekert, N., Shamu, S. *et al.* (2019) 'Debating medicalization of Female Genital Mutilation/Cutting (FGM/C): learning from (policy) experiences across countries'. *Reproductive Health* 16, 158.

[138] WHO (2010). Global strategy to stop health-care providers from performing female genital mutilation: UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA.

[139] Rashid A, Iguchi Y, Afiqah SN (2020) 'Medicalization of female genital cutting in Malaysia: A mixed methods study', *PLoS Med* 17(10). See also Leye, E., Van Eekert, N., Shamu, S. *et al.* (2019) 'Debating medicalization of Female Genital Mutilation/Cutting (FGM/C): learning from (policy) experiences across countries'. *Reproductive Health* 16, 158.

[140] 28 Too Many (2018) 'The Law and FGM: AN overview of 29 African countries'

[141] 28 Too Many (2018). Mali: The Law and FGM

[142] UNHCR (2009). Guidance note on Refugee Claims Relating to Female Genital Mutilation

[143] UNHCR Executive Committee (2007). Conclusion on Children at risk, No. 107 (LVIII).

[144] Petitpas, E., and Nelles, J. (2015). 'The Istanbul Convention: new treaty, new tool'. *Forced Migration Review,* 49.

[145] European Union (2011). Directive 2011/95/EU of The European Parliament and of The Council on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted.

[146] Novak-Irons, F.(2015). 'Female genital mutilation: a case for asylum in Europe'. *Forced Migration Review,* 49.

[147] Middelburg, A., Balta, A. (2016). 'Female Genital Mutilation/Cutting as a Ground for Asylum in Europe'. *International Journal of Refugee Law*, Volume 28, Issue 3, 1 October 2016, Pages 416–452.

[148] Flamand, C. (2015). 'FGM: Challenges for asylum applicants and officials'. *Forced Migration Review,* 49.

[149] Proudman, C. (2019). 'FGM Asylum Claims'. *Counsel.*