

ENDING FEMALE GENITAL MUTILATION

A STRATEGY FOR THE EUROPEAN
UNION INSTITUTIONS



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FGM-HILFE AUSTRIA



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The logo of the END FGM campaign uses the rose to represent infibulation, the most harmful type of female genital mutilation (FGM) in which the genitals are stitched together. The yellow stars of the European Union flag represent the END FGM campaign's endeavour to ensure that the EU protects against FGM in Europe and beyond.



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1 THE END FGM-EUROPEAN CAMPAIGN

END FGM is a European campaign, led by Amnesty International Ireland, working in partnership with a number of organisations¹ in European Union (EU) Member States. The campaign aims to put female genital mutilation (FGM) high on the EU agenda and to echo the voices of women and girls living with FGM and of those at risk of being subjected to it. The campaign advocates for the recognition of human rights and lobbies EU institutions to ensure that the EU adopts a comprehensive and coherent approach towards ending FGM.

The campaign is based on and advocates for the recognition of the principles of the human rights based approach (HRBA). This approach frames FGM as a human rights violation, aims at empowering rights holders (women and girls living with or at risk of FGM) and seeks active and meaningful participation of those directly affected by the practice of FGM. The active participation of rights holders in the development of policies affecting them and their communities is crucial to the success of any measures proposed at EU level.

Although the campaign focuses on tackling the issue of FGM and upholding the rights violated by this practice, it is situated within a broader debate on human rights and fundamental rights within the EU and in third countries. FGM is one manifestation of gender-based human rights violations which aim to control women's sexuality and autonomy, and which are common to all cultures. Though striking because of its severity and scale, FGM cannot be viewed in isolation. To overcome the perception that international interventions on FGM are attacks on particular cultures, it is important to recognise that FGM is one of many forms of social injustice which women suffer worldwide. Recognising that civil, political, social, economic and cultural rights are indivisible and interdependent is a crucial starting point for addressing the whole range of underlying factors behind the perpetuation of FGM.

Campaigning to end FGM contributes to the advancement of a wider spectrum of girls' and women's rights. There is a close link between the practice of FGM and the denial of the right to health. Ending FGM entails protection against violence, protection from persecution, protection from discrimination and torture. Therefore it implies reduction of maternal mortality rates, violence against women and girls and gender and age discrimination. Increased recognition of FGM as ground for asylum claim will contribute to protecting girls and women against gender based violence by non-state actors.

This campaign contributes to an international mobilisation that recognises the need to join forces to end the practice of FGM. This international mobilisation is illustrated by the adoption of the United Nations interagency statement (in 2008); the UNHCR guidance on FGM (in 2009), several calls by UN Special Procedures and by treaty monitoring bodies. The creation of the Donors Working Group on Female Genital Mutilation/ Cutting (FGM/C), to which the European Commission is a partner, contributes to it. This mobilisation is also taking place at a national level within the EU with the development of National Action Plans on FGM in several Member States.²

The EU institutions have an important role to play in the progress towards ending the practice of FGM in the EU and in third countries. Already, the European Parliament has called on the Commission, the Council and Member States to take positive steps towards ending FGM. The Commission has financed projects on FGM in the EU and has supported progress towards ending the practice in third countries. FGM is mentioned in EU partnership agreements, human rights guidelines and policies. Still, more opportunities exist for the EU institutions to contribute towards international progress in ending the practice. Some of these opportunities are outlined in this strategy document.

1 FGM – HILFE in Austria, GAMS in Belgium, MIGS In Cyprus, Vantaan Nicehearts RY in Finland, GAMS in France, AkiDwA in Ireland, AIDOS in Italy, Moteru informacijos centras in Lithuania, FSAN in the Netherlands, APF in Portugal, Female Integrity in Sweden and FORWARD in the United Kingdom.

2 The action plans were developed as part of a Daphne project, financed by the European Commission, coordinated by Euronet-FGM and have been presented by NGOs to EU Member States and Norway in 2008-2009. New action plans were developed in eight countries: Austria, Denmark, Greece, Ireland, Portugal, UK, Germany and Italy. Four countries already had plans (Belgium, France, Netherlands, Norway) but succeeded in raising the issue of FGM, or to give new inputs to an existing plan (Netherlands). At the final stage of the project (end of May 2009), Finland announced that they were going to develop a national action plan to prevent FGM. While Sweden previously had an action plan, that has now expired and a follow-up has not yet been developed.



2 BASIC FACTS ON FEMALE GENITAL MUTILATION

2.1 DEFINITION AND TYPOLOGY

“Female genital mutilation (FGM) comprises 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.”³ FGM can take diverse forms and have different effects on girls and women. In any case it entails the cutting, stitching or removal of part or all of the female external genital organs for non-therapeutic reasons. The mutilation of healthy body parts has a detrimental impact on the health and well-being of women and girls.

There are several forms of female genital mutilation and these differ from community to community. The most recent (2008) WHO classification divides female genital mutilation into four types:

- **Type I** — Partial or total removal of the clitoris and/ or the prepuce (clitoridectomy).
- **Type II** — Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **Type III** — Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
- **Type IV** — All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.⁴

Recent estimates indicate that around 90 per cent of cases include clitoridectomy, excision or cases where girls’ genitals are “nicked” but no flesh removed (Type IV), and about 10 per cent are infibulations.⁵

Usually, FGM is performed in poor hygienic conditions by traditional excisors at the request of the family. In certain cases, medicalisation of FGM has been presented as a way of reducing the negative health effects



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of FGM and involves performing FGM under hygienic and controlled conditions, by medically skilled personnel, and often performing a pricking or incision instead of infibulation. The performance of FGM by medical professionals occurs in a number of African countries⁶ and has repeatedly been suggested as a harm-reduction strategy in EU Member States⁷. However, the World Health Organisation (WHO), the International Council of Nurses (ICN), the International Confederation of Midwives (ICM) and the Federation of Gynaecologists and Obstetricians (FIGO) have all declared their opposition to the medicalisation of FGM and have advised that it should not be performed by health professionals or in health establishments under any circumstances. A main argument against medicalisation is that it goes against the principle of medical ethics which is “do not harm”. Furthermore, FGM of any form is a violation of human rights. “Light” versions of FGM, like incision or pricking, or performance of FGM by medical professionals risks promoting the message that FGM is acceptable and thus legitimises the practice.⁸

6 This is particularly true for Egypt as shown by the comparison in the DHS surveys of 1995 and 2000 in which performance by traditional practitioners reduced from 79.6 per cent (1995) to 38.3 per cent (2000) and performance by medical personnel raised from 17.3 per cent (1995) to 61.4 per cent (2000). It has been also the case in Guinea and Mali. Yoder, PS Abderahim N Zhuzhuni A Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis. Calverton, Macro International Inc. 2004.

7 Health Care in Europe for Women with Genital mutilation, Leye, E. and all, Health Care for Women International (2006) 27, 362-378, pp. 367-369.

8 Leye E, Powell RA, Nienhuis G, Claeys P, Temmerman M. Health care in Europe for Women with Genital Mutilation. Health Care for Women International. (2006)27, 362-378.

3 1997 joint WHO/UNICEF/UNFPA statement. WHO factsheet no 214, 2008

4 FGM Factual Overview, WHO website.

5 Eliminating Female Genital Mutilation an Interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. 2008



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2.2 CONSEQUENCES OF FGM

“Like torture, female genital mutilation (FGM) involves the deliberate infliction of severe pain and suffering. The pain is usually exacerbated by the fact that the procedure is carried out with rudimentary tools and without anaesthetic. Many girls enter a state of shock induced by the extreme pain, psychological trauma and exhaustion from screaming.”⁹

Immediate consequences of FGM include excessive bleeding and septic shock,¹⁰ difficulty in passing urine,¹¹ infections and sometimes death¹². In addition to the severe pain during and in the weeks following the cutting, women who have undergone FGM experience various long-term effects - physical, sexual and psychological. Long-term consequences include chronic pain, chronic pelvic infections, and development of cysts, abscesses and genital ulcers. There can be excessive scar tissue formation, infection of the reproductive system, decreased sexual enjoyment and painful intercourse. Although the scientific research addressing the psychological consequences of FGM is limited, documented psychological consequences in-

clude fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss.¹³

The health consequences continue throughout the woman's life, often producing repetitive trauma when she is about to give birth. Obstetric complications include an increase in caesarean sections and post-partum haemorrhage. The woman often suffers tearing with recourse to episiotomies, and in some cases obstetric fistula as a result of prolonged and obstructed labour due to FGM.¹⁴ FGM is also linked to maternal and infant mortality. A multi-country study by WHO in six African countries showed that women who had undergone FGM had significantly increased risks for adverse events during childbirth, and that genital mutilation in mothers has negative effects on their newborn babies. According to the study, an additional one to two babies per 100 deliveries die as a result of FGM.¹⁵

After childbirth, women of some communities who have had their vaginas stitched up (infibulations) have them re-closed (reinfibulation), which needs a repeated un-stitching (deinfibulation) later. Such cutting and restitching of a woman's genitalia results in tough and painful scar tissue¹⁶, as well as ongoing pain and trauma throughout her life.

9 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak (A/HRC/7/3 of 15 January 2008)

10 Ibid

11 Obermeyer CM. Female genital surgeries: the known, the unknown, and the unknowable. *Med Anthropol Q* 1999; 13:79-106.

12 Interagency statement. 2008, op. cit.

13 Ibid

14 Ibid

15 WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006, op cit.

16 WHO. Female genital mutilation. An overview. Geneva: World Health Organisation 1998.

2.3 PREVALENCE

The WHO estimates that around 100-140 million women and girls have been subjected to FGM, with an estimated 3 million at risk each year. The practice of FGM is widespread in large parts of Africa, some countries in the Middle East and in some communities in Asia and Latin America. The practice is also prevalent in the EU among certain communities originating from countries where FGM is practiced. The exact number of women and girls living with FGM in Europe is still unknown, although the European Parliament estimates that it is around 500,000 with another 180,000 women and girls at risk of being subjected to the practice every year.¹⁷

The table on the right shows the estimated prevalence of FGM as assessed by national survey data (with the exception of Liberia where the estimate is based on a variety of local and sub-national studies). In addition to the listed countries, FGM has been documented in India, Indonesia, Iraq, Israel, Malaysia and United Arab Emirates. Anecdotal reports have been made on the existence of FGM in Colombia, Democratic Republic of Congo, Oman, Peru and Sri Lanka.¹⁸



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Country	Year	Estimated prevalence of FGM in girls and women 15-49 years (per cent)
Benin	2001	16.8
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Ivory Coast	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.7
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea-Bissau	2005	44.5
Kenya	2003	32.2
Liberia		45.0
Mali	2001	91.6
Mauretania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19.0
Senegal	2005	28.2
Sierra Leone	2005	94.0
Somalia	2005	97.9
Sudan, northern (approx 80 per cent of total population in survey)	2000	90.0
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6
Yemen	1997	22.6

Table taken from: Eliminating female genital mutilation – An interagency statement – OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO (2008)

¹⁷ European Parliament resolution of 24 March 2009 on combating female genital mutilation in the EU (2008/2071(INI))

¹⁸ Eliminating female genital mutilation – An interagency statement – OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO (2008)



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2.4 JUSTIFICATIONS FOR THE PRACTICE

The decision to have the girl cut is usually taken by her parents or other close family members. A choice to leave the girl uncut often meets with strong opposition from the community as FGM is a deeply entrenched tradition within social, economic and political structures. The practice has a variety of underpinning beliefs promoting it for perceived health and hygiene benefits, religious, traditional or gender-related reasons. This categorisation is somewhat artificial: in reality FGM might be performed for a number of reasons at the same time. The reasons also vary between regions, ethnic groups or communities.¹⁹ A brief elaboration of these reasons follows, as it sheds light on the complexity of the reasons for continuation of the practice.

Despite the fact that FGM is not prescribed by any religion, religious beliefs play an important role in its continued support. It is predominant among Muslims, but also occurs among Christians, animists and Jews.²⁰ Research showed that the incidence of FGM in the

Central African Republic, Ivory Coast, Egypt, Eritrea, Mali, Sudan and Yemen is higher among Muslim women than among Christian women.²¹ However, the majority (80 per cent) of Muslims worldwide do not practise FGM.²² Among different ethnic groups in Africa there is a persistent belief that FGM is an Islamic rule. There has been an ongoing discussion between advocates and opponents of FGM as to whether the practice is recommended in the Koran or not. At present, there is a general understanding, supported by various statements made by religious leaders that FGM is not recommended in any religious text.²³

In some ethnic groups FGM is believed to increase fertility, male potency and the health of babies. In many regions women need to undergo FGM to get married.

19 De Bruyn M. Discussion paper: socio-cultural aspects of female genital cutting. In Leye E, De Bruyn M, Meuwese S, eds. Proceedings of the expert meeting on female genital mutilation. Ghent-Belgium, November 5-7, 1998. ICRH Publications N°2. Lokeren: De Consulterij 2003 : 68-82.

20 Ibid

21 Carr D. Female genital cutting. Findings from the Demographic Health Surveys Program. Calverton: ORC Macro 1997

22 Mohammad R. Cultural and social dimensions of FGM. Moving Forward. Conference on female genital mutilation. London, February 23 1999. London: Forward 1999.

23 At the Cairo Conference of scholars in November 2006, Muslims leaders from all over the world came together. They adopted a Resolution with all the weight of a fatwa, that FGM is to be considered a punishable offence as an act of aggression and a crime against humanity, BBC News website. Also "Female Genital Mutilation and Islam", website of GTZ, Federal Ministry of Economic Cooperation and Development, Germany. "Kenya: Religious leaders join anti-FGM fight", IRIN news, published 30 March 2007. "Sudan: religious leaders speak out against FGM", UNICEF website, published 15 November 2005

“Female genital mutilation/ Cutting (FGM/C) is an important part of girls’ and women’s cultural gender identity and the procedure may also impart a sense of pride, of coming of age and a feeling of community membership. Girls who undergo the procedure are provided with rewards, including celebrations, public recognition and gifts. Moreover, in communities where FGM/C is almost universally practiced, not conforming to the practice can result in stigmatization, social isolation and difficulty in finding a husband. Girls and women living in immigrant communities may also value the procedure because it can play a role in reinforcing their cultural identity in a foreign context.”²⁴

The economic disadvantages of FGM, such as medical costs or loss of productivity because of illness, are often not recognised as being caused by FGM. Excisors themselves also gain a living through the performance of the “operations” and enjoy a certain status as guardians of tradition – another factor that has an influence on the resistance to ending FGM.²⁵

FGM may be seen as a ritual that strengthens community cohesion, since it is thought to promote identification with a culture or lineage group. Girls and women who have not undergone FGM may be prohibited from activities within their communities, such as participating in funeral rites or preparing food for men and genitally cut women. Their condition could also affect other family members. Among the Samburu in Kenya, boys with uncut older sisters may not be initiated as warriors. It can be seen as a demarcation ritual in some cases where it serves as a characteristic that helps to distinguish ethnic groups from one another. When an uncut woman from one ethnic group marries into another that practises FGM, she may be pressured by her female in-laws to undergo the procedure so that it becomes obvious she has joined the new ethnic group.²⁶

Gender-based ideas relying on discriminatory attitudes towards women and girls, undermine women’s sexual autonomy and play a major role in the perpetuation of FGM. This justification is related to concepts and norms regarding “proper” womanhood, femininity and female sexuality. Women of some groups refer to FGM when speaking of a girl’s honour. It is often in this context of honour that FGM is defended. The practice is assumed to reduce women’s sexual desire and lessen temptations to have extramarital sex (thus also reducing chances of children being born outside the patriarchal lineage) and to help preserve a girl’s virginity.²⁷ A study from New York City revealed that African parents are in favour of FGM because they fear “promiscuity in their daughters in a society that has no sexual limits”.²⁸



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24 United Nations Children’s Fund, “Changing a Harmful Social Convention: Female genital mutilation/cutting”, *Innocenti Digest*, 2005

25 De Bruyn et al, *op cit*

26 *Ibid*

27 *Ibid*

28 Yega Z, Conneely E. Facts and fiction regarding female circumcision/female genital mutilation. A pilot study in New York City, *JAMWA* 1997; 52:174-87.



3 FGM IS A VIOLATION OF HUMAN RIGHTS

Female genital mutilation (FGM), in any form, is recognised internationally as a gross violation of human rights of girls and women. The practice amounts to human rights abuses, in particular of the:

- Right to physical and mental integrity
- Right to the highest attainable standard of health
- Freedom from discrimination on the basis of sex including violence against women
- Rights of the child
- Freedom from torture, cruel, inhuman and degrading treatments
- Right to life (when the procedure results in death)

The rights denied by the practice of FGM can be found in a range of treaties and consensus documents, including:

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Covenant on Civil and Political Rights
- Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of all Forms of Discrimination against Women
- Convention on the Rights of the Child
- Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees
- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa (the Maputo Protocol)
- African Charter on the Rights and Welfare of the Child
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- Charter of Fundamental Rights of the European Union

- Beijing Declaration and Platform for Action of the Fourth World Conference on Women
- UN General Assembly Declaration on the Elimination of Violence against Women
- Programme of Action of the International Conference on Population and Development
- UNESCO Universal Declaration on Cultural Diversity

Repeated statements calling for an eradication of FGM have been made in international forums including the United Nations. Mr Paulo Sérgio Pinheiro, the independent expert for the UN on violence against children, said in his report that harmful traditional practices such as FGM affect children disproportionately and are most often imposed on them by parents or leaders of their community.²⁹ Ms Halima Embarek Warzazi, the Special Rapporteur on traditional practices affecting the health of women, states in her report from 2005 her strong concerns regarding the spread of the practice of FGM among immigrant communities in Europe, Australia, Canada and the US. She is also worried about the increased tendency to subject infant girls to the practice, as a way to avoid daughters voicing their protests, stating that it has “disastrous consequences for the health and survival of the infants concerned, who struggle to survive the pain of this practice, which is carried out without an anaesthetic”.³⁰

²⁹ Report of the independent expert for the United Nations study on violence against children A/61/299

³⁰ Ninth and final report on the situation regarding the elimination of traditional practices affecting the health of women and the girl child, E/CN.4/Sub.2/2005/36 – UN website



3.1 FGM IS TORTURE, CRUEL, INHUMAN AND DEGRADING TREATMENT

The UN Special Rapporteur on Violence against Women has clearly stated that FGM amounts to torture. The report “views cultural practices that involve pain and suffering and violation of physical integrity as amounting to torture under customary international law, attaching to such practices strict penal sanctions and maximum international scrutiny regardless of ratification of CEDAW or reservations made thereto.”³¹

According to the 2008 Report of the UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, FGM “can amount to torture if states fail to act with due diligence”. It further adds, “even if a law authorises the practice, any act of FGM would amount to torture and the existence of the law by itself would constitute consent or acquiescence by the state”.³²

A 2001 Resolution of the Council of Europe expresses concerns that FGM is practiced in Member States of the Council of Europe and clearly denounces a position of cultural relativism. It states “genital mutilation should be regarded as inhuman and degrading treatment within the meaning of Article 3 of the European Convention on Human Rights, even if carried out under hygienic conditions by competent personnel.”³³

3.2 FGM VIOLATES THE RIGHT TO HEALTH

Women and girls who are subjected to FGM are exposed to short and long-term effects on their physical, psychological, sexual and reproductive health. As a result, FGM is a violation of the right to enjoyment of the highest attainable standard of physical and mental health, enshrined in Article 12 of the International Covenant of Economic, Social and Cultural Rights. As provided by the Committee on Economic, Social and Cultural Rights (CESCR) the right to health requires that health and health care facilities, goods and services and the underlying determinants of health be available, accessible, acceptable and of good quality. It also requires

31 15 years of the united Nations Special Rapporteur on Violence Against Women, its Causes and Consequences (1994-2009)

32 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak (A/HRC/7/3 of 15 January 2008)

33 Council of Europe Resolution 1247 (2001) Female genital mutilation

that states adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children.³⁴

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has explained that within the context of sexual and reproductive health, the right to control one's health and body is an important freedom. FGM constitutes a “serious breach of sexual and reproductive freedoms” and is “fundamentally and inherently inconsistent with the right to health.”³⁵

Concerning the realisation of the right to health, the Rapporteur also emphasised the fact that the realisation of the right to sexual and reproductive health as relating to FGM is “subject to neither progressive realisation nor resource availability” and therefore should be implemented without delay.³⁶

In May 2008 the World Health Assembly adopted a resolution on FGM in which it states deep concern for the medical consequences of this practice, including the increasing evidence of this practice being carried out by medical personnel. The resolution urges states to take actions to prevent this harmful practice and also “to formulate and promote guidelines for the care, particularly during childbirth, of girls and women who have undergone female genital mutilation” and to “develop or reinforce social and psychological support services and care and to take measures to improve health, including sexual and reproductive health, in order to assist women and girls who are subjected to this violence”.³⁷

3.3 FGM VIOLATES WOMEN'S RIGHTS

The practice of FGM is a violation of the rights of women as it contributes to the unequal position of women in society and to discrimination against women. FGM attempts to control women's sexuality and to enforce stereotypes that denigrate women's position in society. Furthermore it prevents women from advancement and full participation in society because of the painful short and long-term health consequences.

34 General Comment 14 of the UN Committee on Economic, Social and Cultural Rights, The right to the highest attainable standard of health: 11/08/2000. E/C.12/2000/4. (General Comments). Paragraph 22.

35 Report of the UN Special Rapporteur, Paul Hunt E/CN.4/2004/49 16 February 2004

36 Ibid

37 World Health Assembly for FGM resolution, FIGO website, published 20 January 2009



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The rights of women are protected in several international instruments; in particular, the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the Beijing Platform for Action and the Declaration on the Elimination of Violence against Women. The Committee on the elimination of discrimination against women has clearly denounced the practice of FGM in its General Recommendation No. 14 on Female Circumcision (1990). The UN General Assembly too, in its January 2002 Resolution on Traditional or Customary Practices affecting the health of women and girls, called upon all states to ratify or accede to CEDAW, and to adopt national measures to prohibit traditional practices such as FGM.³⁸

FGM has been defined by the UN 'Declaration on the Elimination of Violence against Women' as a form of violence against women and a human rights violation that should incur individual criminal responsibility (Article 2a of UN General Assembly Resolution 1993). The Declaration further states that "women who are subjected to violence should be provided with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm that they have suffered; states should also inform women of their rights in seeking redress through such mechanisms."³⁹

The UN Special Rapporteur on Violence Against Women stressed the importance of empowerment of women in the fight against FGM in a report on violence against women that covered a period of 15 years. The report elaborates that in meeting its responsibility, "the state must include not only legislative, investigative and judicial reform to end impunity, but also empowerment approaches to build women's capacities and to facilitate the questioning of hegemony within cultures by women."⁴⁰

3.4 FGM VIOLATES CHILDREN'S RIGHTS

FGM is usually practiced on girls in the range of 0-15 years. Hence, the practice of FGM violates children's rights as defined in the Convention on the Rights of the Child (CRC), in particular the right to be free from discrimination (Article 2), the right to be protected from all forms of mental and physical violence and maltreatment (Article 19(1)), the right to the highest attainable standard of health (Article 24) and freedom from torture or other cruel, inhuman or degrading treatment or punishment (Article 37). According to the UN Committee on Rights of the Child "discrimination against girl children is a serious violation of rights, affecting their survival and all areas of their young lives as well as restricting their capacity to contribute positively to society".⁴¹

Moreover, the negative effects of FGM on children's development contravene the best interest of the child - a central notion of the Convention (Article 3).

The Committee on the Rights of the Child has said that state parties to the Convention have an obligation "to protect adolescents from all harmful traditional practices, such as early marriages, honour killings and female genital mutilation".⁴² The girl child has no voice in the decision made on her behalf by members of her family. Hence FGM is often performed without her consent. Adolescent girls and women who do agree to undergo FGM, often do so in fear of non-acceptance by their communities, families and peers, according to the 2008 Report of the UN Special Rapporteur on Torture.⁴³

38 A/RES/56/128, UN General Assembly Resolution 56/128, 30 January 2002, UNHCHR website.

39 UN General Assembly resolution 48/104, 20 December 1993, UNHCHR website

40 15 years of the United Nations Special Rapporteur on Violence Against Women, its Causes and Consequences 1994-2009, UNHCHR website.

41 UN Convention on the rights of the child, General Comment No. 7 (2005) Implementing child rights in early childhood (point11)

42 General Comment No. 4 (2003) Adolescent health and development in the context of the Convention on the Rights of the Child

43 Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak (A/HRC/7/3 of 15 January 2008)



4 A COLLECTIVE RESPONSE

4.1 A NEED FOR COLLECTIVE ACTION

Female genital mutilation is a deeply entrenched tradition within communities and their social, economic and political structures. Information on the harm and physical danger connected with the practice does not necessarily lead to a change in behaviour. The social consequences of daughters remaining uncut are considered worse. This 'self-enforcing social convention' is complex and its abandonment often requires a collective choice from within a community so that girls who remain uncut, and their families, are not shamed and alienated.⁴⁴ This social change must have a supportive environment at national level, including collaboration with strategic allies in media, government, parliament and civil society. "At the national level it is also necessary to develop holistic child protection frameworks that bring together legislative, welfare and social services, police and justice systems and basic service providers with local leaders and civil society."⁴⁵

It is imperative to link efforts in countries of origin with communities living in the EU. The social dynamics of a practice like FGM underline the need for collective agreement to end the practice. In many regions women

and girls are economically dependent on men and need to undergo FGM to get accepted in their community and married. Without collective agreement the status of uncut girls in the community is endangered and girls risk facing considerable pressure from their families and peers to undergo the procedure.⁴⁶ The practice of foot-binding in China and its abandonment can be compared to the practice of FGM, as can the desired outcome of its eradication. This example shows that social customs, however deeply entrenched in community tradition and structures, can and do change.⁴⁷ It also points to the importance of building bridges between stakeholders in countries of origin and in Europe, linking organisations, community leaders, health professionals and government representatives. The pressure to subject girls to FGM comes from families and communities both in the countries of origin and in Europe. The practice itself is cross-border in nature, being performed in a variety of countries and therefore needing a cross-border approach in terms of cooperation. Coordinated approaches between countries of origin and migrant communities are necessary, so that advances in combating FGM in countries of origin become known in the diaspora. It should be noted that the last people to abandon foot-binding were the Chinese living in San Francisco, rather than those living in China.⁴⁸

44 Platform for Action, Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C), The Donors Working Group on Female Genital Mutilation/Cutting

45 Ibid

46 UNICEF, 2007, Technical Note, Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in One Generation

47 Ibid

48 Ibid



4.2 POLITICAL COMMITMENTS

The European Parliament has denounced the practice of FGM as a violation of human rights both within the EU and in relation to third countries. In 2001, the European Parliament adopted a Resolution on FGM.⁴⁹ It called on EU institutions and Member States to condemn FGM as a human rights violation and to take action in the EU, in third countries and at the UN level to ensure the end of FGM. Members of the European Parliament reiterated their call in February 2006 in a resolution on the current situation in combating violence against women and any future action.⁵⁰ This document urged the Commission “to devise a comprehensive strategic approach at EU level, with the aim of putting an end to the practice of female genital mutilation in the EU”.⁵¹

The European Parliament has clearly denounced the medicalisation of FGM⁵² (medicalisation is when medical professionals carry out the procedure under hygienic conditions). It has also highlighted existing duties and mechanisms i.e. human rights dialogue, Cotonou Agreement, Millennium Development Goals and European Instrument for Democracy and Human Rights (EIDHR) in its bid to respect human rights and combat FGM.⁵³

In January 2009, the issue of FGM was mentioned in the Resolution on the Situation of Fundamental Rights in the Union 2004-2008.⁵⁴ This resolution stresses the need for public awareness to combat the practice of FGM and the need for a European legal framework “to ensure the physical integrity of young girls from Female Genital Mutilation”.⁵⁵

On 24 March 2009, the European Parliament adopted a Resolution on combating female genital mutilation in the EU.⁵⁶ This resolution reiterates previous resolutions and calls on EU institutions and Member States to take some steps towards ending FGM in the EU and in third countries. It calls for “an overall strategy and action plans aimed at banishing FGM from the EU and,

to that end, to provide the means required – in the form of laws and administrative provisions, prevention systems, and education and social measures, and in particular, wide dissemination of information regarding the existing protection mechanisms available to vulnerable groups – to enable real and potential victims to be properly protected.”⁵⁷

On 26 November 2009, the European Parliament adopted a Resolution on the Elimination of Violence against Women. This resolution calls on Member States “to take appropriate measures to stop female genital mutilation; points out that immigrants residing in the Community should be aware that female genital mutilation is a serious assault on women's health and a violation of human rights; calls on Member States either to implement specific legal provisions on female genital mutilation or to adopt such laws and prosecute all persons who conduct genital mutilation”.⁵⁸

4.3 POTENTIAL FOR ACTION AT EU LEVEL

Human rights are founding principles of the EU, in particular equality between women and men. With the Lisbon treaty entering into force, the EU Charter of Fundamental Rights has the same legal value as the treaty itself. Although it does not extend the competences of the EU, the Charter becomes legally binding on the institutions and bodies of the EU and on the Member States when they are implementing EU law.⁵⁹

In addition, every new piece of legislation is submitted to a fundamental rights impact assessment ex ante, i.e. before its adoption. Finally, EU Member States have all signed the European Convention of Human Rights (as it is a condition for joining the Union) and have signed up to most international conventions.

While many of the actions needed to end FGM lie within the competences of nation states, EU leadership is crucial for a comprehensive and collaborative approach to FGM in view of its cross-border nature. It

49 European Parliament resolution on female genital mutilation (2001/2035(INI)), 20 September 2001

50 European Parliament resolution on the current situation in combating violence against women and any future action (2004/2220(INI)), 2 February 2006

51 Ibid

52 European Parliament resolution adopting the report on human rights in the world 2007(point 91-96), (2007/2274(INI)), 8 May 2008

53 European Parliament resolution on Human rights in the world 2006 and the EU's policy on the matter (point 63). (2007/2020(INI)), 26 April 2007

54 European Parliament resolution on the situation of fundamental rights in the European Union 2004-2008 (2007/2145(INI)), 14 January 2009

55 Ibid. point 61.

56 European Parliament resolution on combating female genital mutilation in the EU (2008/2071(INI)), 24 March 2009

57 Ibid. point 2.

58 European Parliament resolution on the elimination of violence against women, 26 November 2009

59 Article 1(8) of the Treaty of Lisbon provides that Article 6(1) of the Treaty on European Union is to be replaced by the following: “The Union recognises the rights, freedoms and principles set out in the Charter of Fundamental Rights of the European Union of 7 December 2000, as adapted at Strasbourg, on 12 December 2007, which shall have the same legal value as the Treaties. The provisions of the Charter shall not extend in any way the competences of the Union as defined in the Treaties. The rights, freedoms and principles in the Charter shall be interpreted in accordance with the general provisions of Title VII of the Charter governing its interpretation and application and with due regard to the explanations referred to in the Charter, that set out the sources of those provisions.”



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is essential to build bridges between stakeholders in various EU Member States, and also between diaspora groups in the EU and stakeholders in countries of origin. Existing good practices from Member States whose competent authorities and civil society actors have greater experience of dealing with FGM should be exchanged and disseminated. Progress on ending the practice must be communicated cross-border (including from countries of origin to the diaspora) to encourage emulation.

FGM poses several challenges that EU institutions must endeavour to meet where they have the competences to do so. These challenges are briefly outlined below and elaborated in the form of five dimensions in the following section.

1. There is a crucial need for data collection and research to properly determine the prevalence of FGM and to assess related demands on Member State services in the EU. This qualitative and quantitative data must allow for a comparative analysis between Member States in terms of indicators and benchmarks. Furthermore it would be very useful to draw upon EU wide expertise for the design and development of research methodologies. EU institutions are well placed to initiate, fund and coordinate these research activities.
2. The EU and its Member States must seek to enhance the capacity of the health care sector to meet the specific needs of the women and girls living with FGM. While the health sector comes primarily within national jurisdiction, the EU can coordinate and complement the work of the Member States by facilitating exchange of information and best practices, initiating development of health protocols and curriculums, and funding feasibility studies and research projects that contribute to the pool of knowledge in the EU.
3. Appropriate measures must be taken to protect women and girls at risk as the practice of FGM is in clear violation of their rights and in some cases amounts to torture. These measures should be respectful of human rights standards and women's and girls' freedom of movement. EU level strategies to promote the rights and well-being of women and children should include specific provisions for the prevention of and protection against FGM. Resources in the form of research studies, projects and financial support to civil society organisations should also be directed to further the understanding of FGM as a specific form of violence against women and girls.
4. A coherent and common EU policy that is in line with international standards and guidelines should be adopted for those seeking asylum on the grounds of FGM. As asylum now falls under the supranational jurisdiction at EU level, it is crucial that the EU common approach to asylum fully takes into account their rights as established by internationally agreed standards.
5. The EU should use its considerable power as a global actor to actively promote the eradication of FGM worldwide and build bridges with African stakeholders in this joint struggle. In development cooperation the EU is well placed to take a lead in combating FGM through the combined EC/EU official development assistance, its membership in the Donors Working Group on FGM, its voice in international forums (OECD-Development Assistance Committee, UN), and its partnership with regional organisations and third countries.



5 KEY DIMENSIONS OF FGM AT EU LEVEL

5.1 DATA COLLECTION

“I see over 400 women and girls at the African Well Woman’s Clinic at Guy’s and St Thomas hospitals in London with FGM related problems such as flash backs, memories, recurrent urinary infection and difficulties during pregnancy and childbirth. Moreover, the fact that FGM is intricately located within a sexual and reproductive sphere, making it ‘taboo’ in many cultures, women are often disinclined to talk about their experiences. These compounding factors have made FGM increasingly convenient to ignore. However, I believe that health professionals are in the best position to recognise and monitor cases of FGM, and inform the communities about the law. As a specialist in this field, I believe it is essential that the EU gets involved in data collection and co-ordinates activities on FGM at a European level. We need to know the extent of the problem in each European country, we need data collection to give an idea of incidence and we also need to look at child protection issues.”



Dr Comfort Momoh, FGM/Public Health Specialist, African Well Woman’s Clinic, United Kingdom

Data is essential as a foundation for policies and legislation

The collection of reliable data on the prevalence of FGM in the European Union is essential to design effective policies that can have a decisive impact on the lives of women and girls living with FGM, and to protect those at risk. While the research on women with FGM in individual EU Member States may be quite limited, research at a European level would relate to a significant number of affected women whose lives could be considerably improved. Data collection and research on health at the EU level, in addition to national research, is already recognised as having significant benefits.



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“While not wishing to underestimate the richness of Europe’s enormous cultural and social diversity, the fact that health research is mainly carried out on a national basis is a great obstacle to progress. It reduces the scale of efforts and limits the possibilities for sharing data methods and insights. For this reason, the emergence of health research at a European level is greatly to be welcomed, especially in relation to migrants and ethnic minorities.”⁵⁹

Dr David Ingleby

Prevalence (women and girls living with FGM in the EU as well as women and girls deemed at risk) needs to be assessed through the collection of quantitative and qualitative data, preferably aggregated by age, nationality and ethnicity. It would also be useful to know the age and geographic location of the woman/girl when she was subjected to FGM, as well as the type of FGM. In 2003 UNICEF organised a ‘Global Consultation on Indicators’ and it was agreed that “physical examination of girls is unethical for survey purposes and should be done only in hospital settings, during antenatal care or in other situations associated with medical services”.⁶¹ Agreed indicators that should be included in surveys to measure progress and impact on ending FGM were the prevalence of FGM in women aged 15-49 (as agreement could not be reached on the methodological challenges for establishing prevalence in girls under the age of 15); the FGM status of all daughters (including information of age of daughters); the percentage of ‘closed’ and ‘open’ FGM (a simplified category in view of the difficulty in identifying the specific type of FGM undergone); the performer of FGM; and support/opposition to FGM by women and men aged 15-49.⁶²

Administrative data collected from national services and agencies should include asylum cases on grounds of FGM (number of people claiming asylum in FGM-

60 Ingleby, David “European Research on Migration and Health”, *International Organisation for Migration (IOM) Background Paper*, (In the framework of the “Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities” project)

61 UNICEF Technical Note, Coordinated Strategy to Abandon Female Genital Mutilation/Cutting in One Generation, 2009

62 Ibid

related cases as well as granted asylum cases on this ground), and criminal justice cases. Administrative data from health agencies should include cases of FGM discovered through medical visits, maternal mortality cases related to FGM, reconstructive surgery in terms of deinfibulation and also reconstruction of the clitoris.

Qualitative data on the socio-cultural dimension of FGM is needed to analyse whether the beliefs underlying the practice in the EU differ from the beliefs in the country of origin. An understanding of this dimension is essential when designing strategies for behaviour change.

The collection and assessment of qualitative data in terms of good practices, guidelines and protocols would provide policy makers at both EU and national level with an evidence based knowledge foundation that can be used to design and develop new policies and programmes. In view of the sensitive nature of this data, the research methodologies should be developed in close consultation with civil society organisations, community representatives, women and girls directly affected by FGM, and experienced sociologists, ethnologists and anthropologists.

The current lack of data on FGM in the EU

Data on FGM prevalence has been compiled through large scale surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Cluster Indicator Surveys (MICS).⁶³ This data is also used by the OECD in the Social Institutions and Gender Index (SIGI) to measure gender equality in developing countries. The estimated prevalence of FGM, together with the estimated existence of women’s legal protection against violent attacks, form the two indicators for women’s physical integrity, a part of the total number of indicators of gender equality.⁶⁴

A resolution adopted by the European Parliament states that an estimated 500,000 women and girls living in Europe have been subjected to FGM.⁶⁵ In some EU countries estimates of women living with FGM or girls at risk of FGM have been published.⁶⁶ In most

63 “Female genital mutilation and other harmful practices”, WHO website

64 “The Social Institutions Variables”, Social Institutions and Gender Index, OECD website

65 European Parliament resolution on combating female genital mutilation in the EU (2008/2071(INI)), 24 March 2009

66 Including: Leye E, Deblonde J. *La législation Belge en matière de mutilations génitales féminines et l’application de la loi en Belgique*. ICRH Publications n° 9, 2004; Andro A, Lescling and M. *Les mutilations sexuelles féminines : le point sur la situation en Afrique et en France*. *Population & Sociétés*, N° 438, October 200; Johnsdotter S. *FGM in Sweden. Swedish legislation regarding “female genital mutilation” and the implementation of law*. Lund: Lund University 2003

cases, these estimates have been extrapolated from the prevalence data in countries of origin onto the census data in countries of residence. This method indicates the scale of the problem in Europe, but it is important to note that it also raises several critical problems.⁶⁷ In particular, it refers to the nationality and not the ethnic group to which women and girls belong and it usually does not take on board asylum seekers and undocumented migrants. Finally, it is also difficult to trace second generation migrants at risk of FGM.

To date, there is no data collection which would allow for comparison and for an assessment of the size of the problem in Europe. Such an assessment is crucially important if we are to monitor any increase or decrease in the number of women with FGM, girls at risk and also to measure changes in behaviour and attitudes towards FGM. Data is also needed to substantiate the claim for funds and to implement efficient programmes and measures.⁶⁸ Finally there is a need to measure the impact of policies put in place to eradicate FGM.

Legal and policy commitments

State parties to the Convention on Elimination of All Forms of Violence against Women (CEDAW) are asked in General Recommendation no. 14 to take appropriate and effective measures to eradicate FGM, including the collection and dissemination of data on the practice. In Article 24 of the Convention on the Rights of the Child (CRC) it is stated that all state parties shall “take effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children”. In this respect it is important to note that all EU Member States have ratified CEDAW⁶⁹ and CRC⁷⁰.

The founding principles of the EU include respect for human rights and fundamental freedoms. Article 3 of the Treaty on European Union stipulates that the Union shall promote equality between men and women and the protection of the rights of the child. The Charter



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of Fundamental Rights of the EU recognises freedom from discrimination on any grounds in its article 21 and equality between women and men in its article 23. The rights of the child are protected under article 24 of the Charter. Within the EU institutions, the acknowledged need for comprehensive and substantial data collection on fundamental rights and gender equality in the EU has resulted in the creation of two new agencies, the European Union Agency for Fundamental Rights and the European Institute for Gender Equality.

The European Parliament in its Resolution combating female genital mutilation in Europe has called on Member States to quantify the number of women who have undergone FGM or are at risk.⁷¹ It further calls on the Fundamental Rights Agency and the European Institute for Gender Equality “to take a leading role in combating FGM; believes that these agencies could carry out priority research and/or awareness-raising actions, thus helping to improve understanding of the FGM phenomenon at European level.”⁷²

EU instruments

The **European Union Agency for Fundamental Rights (FRA)** was established in 2007.⁷³ Its mission is to raise awareness on fundamental rights and to provide comparative data, advice and evidence-based expertise to EU Institutions and EU Member States. The Agency has the right to formulate opinions to the EU Institutions and Member States, on its own initiative or at the

67 Powell RA, Leye E, Jayakody A, Mwangi-Powell FN, Morison L. Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda. *Health Policy* 2004;70:151-62. Understanding circumcision. A multidisciplinary approach to a multidimensional problem. New York: Kluwer Academic/Plenum Publisher 2001:113-28. Leye E. The struggle against female genital mutilation/female circumcision: the European experience. In: Denniston G, Hodges FM, Milos MF, eds. Leye E, De Bruyn M, Meuwese S. *Proceedings of the expert meeting on female genital mutilation. Ghent-Belgium, November 5-7, 1998*. ICRH Publications N°2. Lokeren: De Consulterij 2003.

68 Leye E, Deblonde J, García-Añón J, Johnsdotter S, Kwateng-Kluvitse A, Weil-Curiel L, Temmerman M. An analysis of the implementation of laws with regard to female genital mutilation in Europe. *Crime Law Soc Change* (2007) 47:1-31.

69 UN Convention on the Elimination of All forms of Discrimination Against Women, UN website

70 UN Convention on the rights of the child, UN website

71 European Parliament resolution on combating female genital mutilation in the EU (2008/2071(INI)), point 8, 24 March 2009

72 Ibid, Point 17.

73 Council Regulation (EC) No 168/2007 of 15 February 2007, establishing a European Union Agency for Fundamental Rights

request of the European Parliament, the Council or the Commission. In the Agency's mission and strategic objectives for 2007-2012⁷⁴ short-term objectives relative to the objectives of the FGM campaign include:

- the identification and analysis of indicators for service providers regarding children, especially the rights of children at risk, including asylum seeking children and children with ethnic minority backgrounds
- the identification and analysis of practices and measures that relate to the provision of and access to health care and other social services for asylum seekers
- the identification and analysis of good practices that ensure equal access to justice for all

The key activities are listed as the collection and analysis of data, conducting surveys, delivering information to targeted audiences, conducting awareness raising activities and organising training sessions for targeted audiences.⁷⁵

The **European Institute for Gender Equality (EIGE)** was established in 2007.⁷⁶ Its overall objective is to promote gender equality and to contribute to the fight against gender-based discrimination. It will also provide technical assistance to EU Institutions and to Member States. The tasks of the Institute include:

- Collection, analysis and dissemination of relevant information regarding gender equality
- Develop methodological tools to support gender mainstreaming and the integration of gender equality into all community policies
- Carry out surveys in Europe on gender equality
- Organise meetings, facilitate information exchange and set up documentation resources⁷⁷

Eurostat is the Statistical Office of the EU with the mission to provide the EU with European level statistics that can allow comparisons between Member States and between regions. It carries out research in various fields, including health, living conditions and social protection, and criminal justice. It further focuses on gender in a variety of fields.⁷⁸ Eurostat can coordinate and give financial support to national surveys that contribute to Commission objectives and policy goals.⁷⁹

74 FRA Mission and Strategic Objectives 2007-2012, FRA website

75 Ibid

76 Regulation (EC) No 1922/2006 of the European Parliament and of the Council of 20 December 2006 on establishing a European Institute for Gender Equality

77 Ibid

78 European Commission website for Eurostat.

79 Eurostat's grant programme modified on 27 October 2005, European Commission website for Eurostat.

→ RECOMMENDATIONS

The END FGM-European Campaign:

Urges **the EU institutions** (the Commission, the Council and the Parliament) in accordance with the 2009 European Parliament resolution on FGM, to request the following from **FRA**

- Include FGM in the identification of indicators for service providers for children at risk and children's rights. Explore practices and measures that aim to improve the access to health care for female asylum seekers living with FGM. Finally, when analysing good practices that are related to equal access to justice, the Agency could undertake an assessment of legal remedies available to protect women and girls who are at risk of being subjected to FGM.

Urges **the EU institutions**, in accordance with the 2009 European Parliament resolution on FGM to request the following from **EIGE**

- In line with the objective and tasks outlined in the Regulation establishing the Institute, it should develop and establish human rights sensitive methodological tools that can be used for an EU wide approach to quantitative and qualitative data collection on FGM. This should be done in close collaboration with civil society organisations, community representatives, women and girls directly affected by FGM, and experienced sociologists, ethnologists and anthropologists.

Urges **the EU institutions** to request **Eurostat**

- To coordinate and support the development of national surveys to assess FGM prevalence in the European Union. These surveys should be developed in close collaboration with all stakeholders to take into account the national context.



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5.2 HEALTH

“Going to the doctor is an ordeal for me and other girls who have gone through FGM. The first reaction of doctors is of shock and disbelief. They ask what has happened, thinking it is an injury or an accident. Each time I see a new doctor, I have to give them information on FGM. Other girls, I know they avoid going to the doctor because they feel embarrassed having to explain it every time.”

Ifrah Ahmed, Strong Voice
of the END FGM European
Campaign



FGM-related challenges to health care services in Europe

With an estimated 500,000 women and girls living with FGM in the EU, the health systems in EU Member States need to fully meet the needs of these women and girls through health services that are available, accessible, acceptable and of good quality.⁸⁰

Studies have shown that health care professionals in Europe need an increased understanding of FGM and its potential complications during pregnancy, childbirth and the postpartum period. Research has shown that a lack of awareness of FGM among health professionals leads to emergency caesarean sections that pose unnecessary risks and are costly in financial terms.⁸¹ Important issues include the promotion of deinfibulation of FGM before or during pregnancy if possible to avoid complications during delivery. A general sensitisation to FGM among medical staff is also important for all gynaecological examinations as they could be very painful and also stigmatising for women and girls living with FGM. Health protocols on reinfibulation are necessary as there is evidence of medical professionals practising reinfibulation in European countries following deliveries, likely due to a lack of standardised procedures and medical guidelines. Reinfibulation in most states' legislation

80 UN Committee on Economic Social and Cultural Rights (CESCR), General Comment No. 14: the right to the highest attainable standard of health (E/C.12/2000/4)

81 The Confidential Enquiry into Maternal and Child Health (CEMACH) report 2007: women from Black and minority ethnic groups, the colour of health website.

"One morning, I received an urgent phone call from a doctor who was doing his internship in a maternity hospital in Belgium. He didn't know how to manage the case of a Somali woman, 9 months pregnant, in labour. The maternity team didn't know if she could deliver with her infibulation or if they had to perform an emergency C-section. They made several phone calls to different gynaecologists but nobody knew what to do. Finally they called me because I had just returned from a mission in Somalia. I had to explain to the doctor over the phone how to do a deinfibulation following the WHO recommendations. They called me back after the delivery to say that everything went well. This was the event that pushed me to do something and to start writing Belgium's first guideline on deinfibulation. The Ministry of Health is now distributing this guide in all the maternity wards of Belgium."



Fabienne Richard, Midwife, Institute of Tropical Medicine, Antwerp

constitutes a form of FGM and is therefore illegal.⁸² Guidelines should also address the medicalisation of FGM, an increasing trend condemned by WHO.⁸³

There is concern that the current framework to give refugees and other migrants' entitlement to health care within the EU does not adequately address social barriers that may hinder marginalised groups from accessing vital health services. These social barriers include language barriers, a lack of competent interpreters, different ways of understanding and viewing illness, and also a lack of awareness of the health care services available.⁸⁴

Legal and policy commitments

In accordance with article 168 (previously article 152) of the Treaty on the Functioning of the Union, the Union should complement national policies to improve

public health as well as encourage and support cooperation between Member States. In addition, Article 35 of the Charter of Fundamental Rights of the EU states that "Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."

The current EU health strategy is outlined in the Commission White Paper *Together for Health: A Strategic Approach for the EU 2008-2013*.⁸⁵ It is stated in the strategy that while Member States still have the main responsibility for health policy and health care provision, "there are areas where Member States cannot act alone effectively and where cooperative action at community level is indispensable"⁸⁶. This strategy is based on four overarching values that were agreed in the Council Conclusions on Common values and principles in EU Health Systems⁸⁷, namely universality, access to good quality care, equity and solidarity. A commitment to reduce inequities in health is put forward in the strategy together with the value of including a gender dimension, as stated in the Council Conclusions on women's health.⁸⁸

82 Lundberg, Pranee C. And Alganesh Gerezgiher (2008), "Experiences from pregnancy and childbirth related to female genital mutilation among Eritrean immigrant women in Sweden", *Midwifery*, vol 24, other studies with similar findings include Thierfelder, Clara, Marcel Tanner and Claudia M. Kessler Bodiang (2005) "Female genital mutilation in the context of migration: experience of African women with the Swiss health care system", *European Journal of Public Health*, vol 15 and Poldermans Sophie (2006), "Combating Female Genital Mutilation in Europe", Dissertation for European Master's Degree in Human Rights and Democratisation

83 "Female Genital Mutilation", WHO website

84 Pace, Paola "Migration and the Right to Health in Europe", *International Organisation for Migration (IOM) Background Paper*, (In the framework of the "Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities" project)

85 COM(2007) 630

86 EU Commission White Paper, *Together for Health: A Strategic Approach for the EU 2008-2013*

87 Council Conclusions on Common values and principles in European Union Health Systems 2006/C146/01

88 Council Conclusions on women's health 2006/C146/02

The Health Programme, divided into annual work plans, is the main instrument for implementing the EU health strategy. The objectives of the current programme include a commitment to reduce health inequalities.⁸⁹

In line with the objectives of the current health programme, the European Commission issued a communication on health inequities called *Solidarity in Health: Reducing Health Inequalities in the EU*.⁹⁰ This communication was preceded by a consultation paper with a wide variety of respondents, including Member State governments, regional health services, networks of health professionals, umbrella organisations, NGOs and research institutes. The communication states:

“Particular attention needs to be given to the needs of people in poverty, disadvantaged migrant and ethnic minority groups, people with disabilities, elderly people or children living in poverty. For some groups, the issue of health inequality including reduced access to adequate health care, can be qualified as one which involves their fundamental rights.”⁹¹

Tackling health determinants, according to the European Commission website on public health, is of great importance for promoting health. Health determinants include: personal lifestyle; community influences; access to health services; and socio-economic and cultural conditions. Commission action aims to support information gathering and exchange through the creation and development of actions and networks. It should also develop innovative projects that can be used as examples of good practice.⁹²

EU instruments

Once the European Commission has set the objectives for the health programme, it is managed by the **Executive Agency for Health and Consumers**.⁹³ In addition to managing the Health Programme it now also manages the Consumer Programme and the Better Training for Safer Food Initiative. The EAHC has a number of financial mechanisms to support organisations that work in line with the EU health policy objectives, including project grants, operating grants and financial support for conferences.⁹⁴

The **Open Method of Coordination (OMC)** is a framework created for cooperation between EU Member States where their national policies can be directed towards common objectives. A variety of areas are subject to OMC, including employment, social protection, social inclusion, education, youth and training. The methods include defining joint objectives and establishing joint measuring instruments (statistics, indicators and guidelines).⁹⁵ While the OMC does not issue directives, regulations or decisions; it does require the EU Member States to create national reform plans to be forwarded to the Commission – so called ‘soft law’ measures.⁹⁶ The OMC is also used in health care, with reference to subsidiarity and respect for the competence of the EU Member States. According to a recent Commission Communication the OMC has successfully supported mutual learning, promoted wider involvement of stakeholders and also shaped a shared approach to common challenges. As the OMC has proven to be a catalyst for reform in the EU Member States, the Commission is urging for a strengthening of the process to meet challenges of social inclusion and protection in the EU, including “targets related to access and quality of healthcare and social care”. In accordance with Article 211 of the Treaty, the Commission can make recommendations and set out common principles for increased cooperation, including peer review, creation of indicators and reinforcement of analytical tools which should, according to the communication, include gender disaggregated data and statistics on the situation of migrants.⁹⁷

The objectives of the **OMC for social protection and social inclusion** include: social cohesion and equality between men and women; equal opportunities through social protection systems and inclusion policies, access to quality health care that is adapted to needs of society and individuals with standards reflecting best international practice.⁹⁸ While some of the overarching indicators for monitoring this OMC have a health dimension (healthy life expectancy, self reported unmet need for medical care, total health expenditure per capita) there are no indicators relating to women’s health or to the health of marginalised groups.

The **Social Protection Committee (SPC)** was set up in 2000⁹⁹ to promote cooperation between Member States and the Commission on social protection and

89 Health Programme, Executive Agency for Health and Consumers, EAHC website

90 COM(2009) 567 final, Brussels, 20.10.2009 Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, “Solidarity in Health: Reducing Health Inequalities in the EU, EC website on Public Health

91 Ibid

92 “Health determinants”, EC website on Public Health

93 Commission Decision of 20 June 2008 (2008/544/EC)

94 Executive Agency for Health and Consumers website

95 Open Method of Coordination, Europa website

96 Ibid

97 Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions “A renewed commitment to social Europe: Reinforcing the Open Method of Coordination for Social Protection and Social Inclusion”, 2 July 2008, COM(2008)418

98 Ibid.

99 By Council Decision of 29 June 2000 (2000/436/EC) amended later by Council Decision of 4 October 2004 (2004/689/EC).

social inclusion policies, including to ensure high-quality and sustainable health care. The SPC has an advisory role with two representatives from the Commission and two representatives from each Member State. It has a monitoring as well as a facilitating role when it comes to exchange of best practice, information and experience. It can prepare reports and formulate opinions at the request of the Council, the Commission or on its own initiative.¹⁰⁰ The SPC issued in 2008 an opinion in support of the reinforcement of the OMC stating that it will help delivery of common social objectives.¹⁰¹

→ GOOD PRACTICE

One example of a targeted approach to reach vulnerable groups is the attempt to improve the Roma people's health status in the EU Member States through programmes featuring '**health mediators**'. The aims of these programmes were: to mediate between Roma patients and physicians during medical consultations; to communicate on behalf of the public health system with the Roma communities; to provide basic health education; and to assist the Roma communities in obtaining health insurance papers and other necessary identity documents to access health care services.¹⁰² A similar approach to promote understanding of FGM has been developed in Switzerland by the International Organisation of Migration (IOM) in cooperation with the Department for the Promotion of Equality between men and women. This initiative worked through recruitment and training of '**cultural mediators**' from targeted communities (Ethiopia, Eritrea, Somalia and Sudan) to act as agents of sensitisation in order to raise awareness of the health consequences of FGM, as well as to promote knowledge of the legal ban on FGM in Switzerland.¹⁰³

¹⁰⁰ Social Protection Committee, Europa website.

¹⁰¹ Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: A renewed commitment to Social Europe: reinforcing the Open Method of Coordination for Social Protection and Social Inclusion – Social Protection Committee Opinion. SPC/200816

¹⁰² European Public Health Alliance <http://www.eph.org/a/2214>

¹⁰³ "Supporting the abandonment of female genital mutilation in the context of migration", IOM website

→ RECOMMENDATIONS

The END FGM-European Campaign:

Urges the **EU institutions** to take concrete steps to support the goal to reduce health inequalities affecting women and girls living with FGM, and therefore requests the following from the **Executive Agency for Health and Consumers (EAHC)**

- to launch tenders and commission the design and delivery of targeted training modules for health care professionals that can also be included in the curricula for the education of midwives, nurses, family doctors, gynaecologists and other relevant health care professionals. It should further support holistic projects that aim to give psychological and medical support together with information on rights and legal remedies to women and girls living with FGM
- to encourage the exploration of health or cultural mediator projects. This would promote the access to health care and health literacy among communities affected by the practice of FGM. These projects should be developed in collaboration with health care services, community representatives, representatives of women and girls living with FGM, and national asylum and immigration authorities

Urges the **EU institutions** to request the following from the **Social Protection Committee (SPC)**

- to promote the exchange of information and best practices addressing FGM among EU Member States representatives from the health and social services sectors

Urges the **EU institutions** to use the **Open Method of Coordination (OMC)**

- to develop indicators relevant for women and girls living with FGM to assess, monitor and evaluate their access to health care services and the availability of acceptable and good quality health care.
- to promote cooperation between EU Member States to shape targeted policies, guidelines and initiatives that can improve the quality of life and the health of women and girls living with FGM.

5.3 VIOLENCE AGAINST WOMEN AND GIRLS

Women and girls need protection in the EU

FGM is prevalent in the EU among certain communities originating from countries where the practice is a tradition. There are numerous cases of girls being mutilated while abroad on holiday¹⁰⁴ and anecdotal evidence and criminal cases point to the practice being carried out also within the EU¹⁰⁵. While legislation is very important to protect women and girls from this harmful practice, the onus should be put on strong preventive measures as the main instigators are often the parents or other close family members. It is imperative to recognise the social pressure to conform to tradition that often lies at the core of this practice.

Most EU Member States have criminal legislation which defines the practice of FGM as an offence, either as a specific criminal act or as an act of bodily harm or injury. Specific criminal provisions have been adopted in nine EU Member States: Austria, Belgium, Cyprus, Denmark, Italy, Portugal, Spain, Sweden and the UK. In other EU Member States, FGM can be addressed under general criminal law provisions in the Penal Code.¹⁰⁶

It is noteworthy that specific criminal law provisions have not resulted in more prosecutions than general criminal laws, and that some specific criminal laws have failed to cover emerging issues such as pricking or reinfibulation. The number of cases brought to court has been limited because of issues around conditions attached to the extraterritorial application of criminal law, the secrecy surrounding the practice within communities, the reluctance of girls to formally implicate parents and the reluctance of professionals to follow through on all complaints and concerns.¹⁰⁷ Factors obstructing an effective implementation of both criminal law and child protection laws to FGM include the lack of knowledge and attitudes of both professionals and practicing communities confronted with FGM. They

“We need now to see leadership from the EU institutions – we cannot do this on our own and as long as we are working independently at grassroots level in separate EU Member States, we do not have the resources or the networks to truly make an impact. I know we can succeed in eradicating FGM if we make a collaborative effort to reach the girls, raise awareness and support communities in abandoning this practice.”



Khadia Diallo, President, GAMS Belgium

both have an influence on the process of law enforcement in the reporting of cases and finding evidence.¹⁰⁸

The large majority of EU Member States has included the principle of extraterritoriality in the criminal provisions, thus enabling the prosecution of FGM when the practice has been committed outside the EU. “Conditions for the application of this principle differ: often, either the offender or victim – or both – must be a citizen or at least a resident of the European country, and sometimes FGM must also be considered an offence in the country where the crime was committed (double incrimination).”¹⁰⁹

Child protection laws and measures exist in all EU Member States. Measures applicable to girls at risk of being subjected to FGM include voluntary child protection measures (providing information, hearings with the family, counselling and warnings to the family) and compulsory child protection measures (suspending parental authority, removing the child, withdrawal of travel permission).¹¹⁰ In some EU Member States, FGM specific child protection protocols and/or guidelines have been developed (including in the UK, France, Spain, Sweden and the Netherlands).¹¹¹

104 Powell R. et al. Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda. *Health Policy* 70 (2004) 151–162

105 Weil-Curiel, Linda, *Combating sexual mutilation in France through the application of the law*, C.A.M.S., 2002.

106 Leye E, Sabbe A, *Overview of legislation in the European Union to address Female Genital Mutilation: challenges and recommendations for the implementation of laws*, Expert paper, Expert Group Meeting on good practices in legislation to address harmful practices against women, 25 to 28 May 2009

107 Leye E, Deblonde J, García-Añón J, Johnsdotter S, Kwateng-Kluyitse A, Weil-Curiel L, Temmerman M. An analysis of the implementation of laws with regard to female genital mutilation in Europe. *Crime Law Soc Change* (2007) 47:1-31.

108 Leye E, et al (2007), op cit.

109 Leye E, Sabbe A, *Overview of legislation in the European Union to address Female Genital Mutilation: challenges and recommendations for the implementation of laws*, Expert paper, Expert Group Meeting on good practices in legislation to address harmful practices against women, 25 to 28 May 2009

110 Ibid

111 Ibid

To facilitate exchange of information and best practices, and to shape a common EU approach to child protection policies, EU level cooperation is necessary. This cooperation should include Member State judiciaries as well as other competent authorities such as the police, social services, health services and school administrations. Additionally, the EU should facilitate cooperation and coordination between organisations and professional staff working in the EU and in countries of origin, to protect girls who may be at risk of mutilation when abroad on holiday.

Legal and policy commitments

As listed earlier in this strategy (section 3: FGM is a violation of human rights), there is an array of international and regional treaties that specifically point to state responsibility in protecting women and girls at risk of FGM. These obligations are included in the Charter of Fundamental Rights of the EU. In addition to these legal commitments, there is a range of political commitments at EU level that aim to promote women's rights and children's rights.

The roadmap for equality between women and men aims to drive the agenda on gender equality forward. Six priority areas are identified and objectives and actions are set for each area, followed by an implementation report and a final evaluation. The six priority areas are: equal economic independence for women and men, reconciliation of private and professional life, equal representation in decision making, eradication of all forms of gender-based violence, elimination of gender stereotypes and promotion of gender equality in external and development policies. The current roadmap is covering the years 2006-2010 and will be followed by a new roadmap in 2010.¹¹²

The EU commitment to the rights of the child is outlined in the 2006 communication *Towards an EU Strategy on the Rights of the Child*. Violence against children is a special priority area and the rights of the child should be central to EU internal policies as well as to EU external action. FGM is listed as one of the global challenges facing children today.¹¹³ Following this communication, the European Commission created the **European Forum on the Rights of the Child**. The role of this forum is to provide advice and assistance to the European Institutions for the promotion of children's rights in internal and external action. It should meet

in plenary twice a year.¹¹⁴ An updated strategy on children's rights will be developed in 2010 by the European Commission in liaison with various stakeholders.

The **Stockholm Programme** is the five year work programme for EU cooperation on justice and home affairs. This programme was adopted on 10 December 2009 under the Swedish Presidency of the EU. A Stockholm Action Plan will then be put in place to operationalise the programme. The need to address FGM is stated in the programme: "Vulnerable groups in particularly exposed situations, such as women victims of violence or of genital mutilation or persons who are harmed in a Member State of which they are not nationals or residents, are in need of greater protection, including legal protection. Appropriate financial support will be provided, through the available financing programmes."¹¹⁵

EU instruments

The European Law Enforcement Organisation (Europol) was set up in 1995 to promote cooperation of competent authorities in the Member States in preventing and combating international organised crime.¹¹⁶ Combating crimes against persons is also a main priority for Europol and it supports EU Member States by facilitating the exchange of information between Europol liaison officers who are seconded by Member States to Europol as representatives of the national law enforcement agencies. Europol can also provide operational analysis, generate strategic reports and crime analysis, and provide technical support and expertise for investigations. As of 1 January 2010 the Europol mandate was extended to include giving support to investigations into crimes that are not carried out by organised groups.¹¹⁷

Eurojust was established in 2002 as a network of judicial authorities in EU Member States.¹¹⁸ It aims to enhance the development of EU cooperation on criminal justice through hosting meetings between investigators and prosecutors on individual cases, as well as on specific types of criminality. It also facilitates the execution of international mutual legal assistance and the implementation of extradition requests. Eurojust also supports Member States in their investigations to

112 "Roadmap for equality between women and men (2006-2010)", Europa website

113 "Towards an EU strategy for the rights of the child", European Commission website on Freedom, Security and Justice

114 European Forum on the rights of the child, European Commission website on Freedom, Security and Justice

115 Council Note 17024/09, 2 December 2009, The Stockholm Programme – An open and secure Europe serving and protecting the citizens

116 Council Act SN 3549/95, 26 July 1995, drawing up the Convention based on Article K.3 of the Treaty on European Union, on the establishment of a European Police Office (Europol Convention)

117 Europol Profile, Europol website

118 Council Decision 2002/187/JHA, 28 February 2002, setting up Eurojust with a view to reinforcing the fight against serious crime.



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cross-border crime. The competence of Eurojust covers the same types of crime as Europol (organised crime, trafficking, terrorism), but Eurojust can also assist in investigations and prosecutions of other types of offences at the request of a Member State.¹¹⁹ The **European Judicial Network (EJN)** forms part of Eurojust staff but functions as a separate unit. It aims to support Eurojust through the promotion of judicial cooperation as a network of national contact points.¹²⁰

The **Daphne Programme** is part of the General Programme 'Fundamental Rights and Justice' with the aim to combat violence against children and women. Its objective is to protect women, young people and children against all forms of violence as well as to promote a high level of health protection, well-being and social cohesion. The current Daphne III programme runs for the period 2007-2013.¹²¹ The mechanisms used in the programme include grant funding for

transnational action, actions initiated by the Commission and operating grants to NGOs.¹²² The issue of FGM has been considered in this context. From 1997 to 2007, the Daphne programme financed 14 projects on FGM in the EU for a budget of €2.4million, contributing to the creation of the European Network for the Prevention of FGM, evaluating existing legislation on FGM in the EU, developing tools for prevention and the formulation of recommendations for policy makers.¹²³ The current Daphne programme has commissioned a study on traditional harmful practices which will map existing legislation in the EU, the implementation of the relevant laws and proven relevant practices. This study should develop indicators to evaluate the actions taken to end harmful traditional practices.¹²⁴

119 "Eurojust's mission and tasks", website of Eurojust

120 Website of European Judicial Network

121 DECISION No 779/2007/EC of the European Parliament and the Council of 20 June 2007, establishing for the period 2007-2013 a specific programme to prevent and combat violence against children, young people and women and to protect victims and groups at risk (Daphne III programme) as part of the General Programme 'Fundamental Rights and Justice'

122 "Prevent and combat violence against children, young people and women and to protect victims and groups at risk", EC website on Freedom, Security and Justice

123 Report of the International Conference on FGM and forced marriages. 2007, Euronet-FGM. A list of existing projects is available on the Daphne webpage.

124 "Brussels: Study on Harmful Traditional Practices" 2009/S 75-107903, 18 April 2009, Tenders Electronic Daily website

→ GOOD PRACTICE

The London Safeguarding Children Board launched an FGM Resource Pack in November 2009 with the aim for it to be a key tool in the fight against FGM. The main audience consists of professionals who work with children, including midwives and other health professionals, social workers, teachers and police officers. The pack includes information on FGM, guidelines on how to detect abuse and girls at risk, and questions that midwives can ask women attending health clinics. The pack further contains advice on how community groups can assist in the prevention of FGM.¹²⁵

Project Azure is another UK based initiative in which the London Metropolitan Police Service joins forces with partner agencies to reach out to families from FGM practising communities. Project Azure aims to educate parents and families about the health and legal implications of female genital mutilation while simultaneously empowering children at risk for the practice. It has also produced guidance to investigations in relation to FGM.¹²⁶

→ RECOMMENDATIONS

The END FGM-European Campaign:

Urges the **European Commission, the Council** and **EU Member States**

- to include and adequately address FGM in all new legislative and policy proposals on violence against women and violence against children.

Urges the **European Commission**

- to address FGM in the Roadmap on equality between women and men and in the Strategy on Children's Rights, as a violation of women's and children's rights
- to continue making Daphne funding available for projects aiming to combat FGM in Europe and to disseminate lessons learned to relevant authorities in Member States
- to include concrete measures and monitoring benchmarks addressing FGM in the Stockholm Action Plan as this harmful practice relates to several dimensions of justice and home affairs cooperation in the EU, including asylum, judiciary and police cooperation
- to include in coming meeting agendas of the European Forum on the Rights of the Child the issue of FGM and the role European institutions can play in combating the practice within the EU as well as worldwide.

Urges the **EU institutions** to encourage **Euroapol**

- to, in accordance with the 2009 European Parliament resolution on FGM, "coordinate a meeting of European police forces with a view to intensifying the measures to combat FGM, tackling the issues related to the low reporting rate and the difficulty of finding evidence and testimonies, and taking effective steps to prosecute offenders"

Urges the **EU institutions** to encourage **Eurojust**

- to host meetings to facilitate information exchange between competent authorities in Member States on best practices with a view to promote the knowledge and expertise in relation to FGM cases, to promote cooperation, and to promote harmonisation and/or development of common standards in relation to FGM related judicial cases.

¹²⁵ London Safeguarding Children Board website

¹²⁶ UK Metropolitan Police Service website

5.4 Asylum

“I lived in Freetown in Sierra Leone. I had a happy childhood... The only difficult thing I had to face was that my aunts used to come from the village to see my father and tell him it was time for me to join the secret society. That meant that it was time for me to be cut, to be circumcised. My father... didn’t want me to go, he said, it’s evil. ... He protected me and said I didn’t have to do it. But then the war came, and I lost my father and mother and my brothers. I was taken by a soldier into the bush, to be his sex-partner. He would rape me whenever he wanted. These soldiers were terrible. I saw many things that no one should have to see. Then, after the war my uncle came from America, looking to find what had happened to us all. I was the only one of my family left in Freetown. I couldn’t stay in Freetown because everyone knew I had been taken to the bush by Timboy but I couldn’t go back to the village, because I didn’t want to be circumcised. I knew I didn’t want to do it because I have heard how it is done – they don’t even sterilize the knife and the girls bleed a lot and sometimes they die. The government has tried to stop it, I know, but they had to back down because all the people protested. So if a family member wants to do it there is no one to stop them. So my uncle helped me to get to England. ... I am 18 now and I am going to college. I want to be a social worker to help other people.

Esther, Sierra Leonean who fled to the United Kingdom and was recognised as a refugee
[Taken from UNHCR Handbook for the Protection of Women and Girls]

FGM-related cases and asylum

The 1951 Geneva Convention defines a refugee as a person who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country”. (Article 1) Since its adoption, the scope of the definition has broadened.¹²⁷ At first, the persecution was interpreted as being initiated by the state or its agents. Currently persecution exists when states do not offer proper protection from the persecution by non-state actors. The application of the Convention to the cases of gender related persecution has been clarified by the UN Refugee Agency (UNHCR)

*Guidelines on gender related persecutions.*¹²⁸ “There is no doubt that rape and other forms of gender-related violence, such as dowry-related violence, female genital mutilation ... are acts which inflict severe pain and suffering – both mental and physical – and which have been used as forms of persecution, whether perpetrated by state or private actors.”¹²⁹

The *UNHCR Guidance Note on Refugee Claims relating to Female Genital Mutilation* states that FGM constitutes a form of gender-based violence amounting to gendered persecution and child specific persecution. This means that the age of the child and whether or

127 AI Index: ACT 77/13/97 Female genital mutilation and asylum.

128 Guidelines on International Protection: Gender-Related Persecution within the context of Article 1A (2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees HCR/GIP/02/01 7 May 2002, UN website.

129 Ibid.



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not there is an expression of fear are irrelevant and the claim should be assumed to be well-founded. “In these circumstances, it is up to the decision-makers to make an objective assessment of the risk facing the child, regardless of the absence of an expression of fear.”¹³⁰

The Guidance Note on Refugee Claims relating to Female Genital Mutilation provides an overview of case law and international standards related to FGM and asylum. It notes that an increasing number of jurisdictions have recognised FGM as a form of persecution in their asylum decisions.

This guidance note also clarifies the fact that FGM can constitute a “continuing form of harm” which means that FGM-related claims not only involve applicants facing an imminent threat of being subjected to the practice, but also women and girls who have already suffered from it. It also defines the agents of persecution, the convention grounds which can be invoked, conditions for an internal flight alternative and procedural issues, in particular the request for a medical certificate.

Although gender is not a ground specified in the Geneva Convention, states should take a gender sensitive approach in determining the grounds on which the claim is based. In general, asylum cases related to FGM are dealt with under membership of a particular social group i.e. women and girls from a particular group who practice FGM. The fact that in some countries nearly all women are subjected to FGM cannot disqualify them from membership of a particular social group.¹³¹

¹³⁰ UNHCR Guidance Note on Refugee Claims relating to Female Genital Mutilation, May 2009, available at UNHCR website.

¹³¹ AI Index: ACT 77/13/97 Female genital mutilation and asylum.

“The size of the group has sometimes been used as a basis for refusing to recognise ‘women’ generally as a particular social group. This argument has no basis in fact or reason, as the other grounds are not bound by this question of size. There should equally be no requirement that the particular social group be cohesive or that members of it voluntarily associate, or that every member of the group is at risk of persecution. It is well-accepted that it should be possible to identify the group independently of the persecution, however, discrimination or persecution may be a relevant factor in determining the visibility of the group in a particular context.”¹³²

In addition, asylum claims in FGM-related cases can also be based on political opinion when the asylum seeker is perceived as critical or challenging of the practice. UNHCR advises to take a broad understanding of political opinion which can include opinion on gender roles.¹³³ Finally, asylum seekers might fear persecution on the ground of religion as certain societies justify the practice on moral and religious grounds. In such cases, a woman opposing FGM could have a well founded fear of being persecuted on religious grounds.¹³⁴

Claimants are usually the girls or women who fear being subject to FGM and young girls are often accompanied by their parents. According to the guidance note on refugee claims related to FGM, refugee status for parents derives from their child's refugee status. Parents can be the principal applicant where she or

¹³² Guidelines, *Supra*

¹³³ UN High Commissioner for Refugees, Guidance Note on Refugee Claims relating to Female Genital Mutilation, May 2009, available at UNHCR website.

¹³⁴ *Ibid.*

he is found to have a claim in their own right, such as political opinion. They are also in principle protected by the Convention according to the UNHCR guidelines on gender-related violence¹³⁵ when it is their opposition to a social norm discriminating against women which creates a fear of persecution. The fact that the parent did not demonstrate opposition to FGM in their country of origin does not mean that the fear is unfounded.¹³⁶

Ensuring a coherent approach to granting asylum in the EU

Some EU Member States have recognised FGM as a form of persecution for the women and girls and/or their parents. These include Belgium¹³⁷, France¹³⁸, the UK¹³⁹ and Germany¹⁴⁰. However, in a 2004 comparative analysis of gender related persecution in national asylum legislation and practice in Europe, the UNHCR highlighted some issues with the recognition of FGM in asylum claims. “Although women or particular groups of women have been found to be members of a particular social group (PSG) in asylum decisions, an assessment of how cases involving FGM and failure to conform to religious mores indicate that there can be a tendency by decision makers to take a restrictive view of the PSG category.”¹⁴¹ This is illustrated by the fact that certain Member States grant subsidiary protection in cases of FGM instead of refugee status, with lesser protection and a status to be renewed every year.¹⁴²

The child specific nature of the persecution is not necessarily acknowledged when the refugee status is considered, as the child is considered to be unable to express fear or opposition to the practice.¹⁴³ Even when justified by the duty to protect girls, the practice of mandatory gynaecological examinations prior to granting refugee status is questioned.¹⁴⁴ Finally, data on the number of successful asylum claims based on FGM are not currently widely available.

135 Guidelines on International Protection: Gender-Related Persecution within the context of Article 1A (2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees HCR/GIP/02/01 7 May 2002, UNHCR website.

136 UNHRC Guidance note, op cit.

137 CCE, No. 29110, 25 June 2009.

138 *Mlle Kinda*, CRR, No. 366892, 19 March 2001; *M. et Mme Sissoko*, CRR, SR, No. 361050 and No. 373077, 7 Dec. 2001; CRR, No. 369776, 7 Dec. 2001; CRR, SR, No. 369776, 7 Dec. 2001. Although the recent cases grant subsidiary protection.

139 Secretary of State for the Home Department (Respondent) v. K (FC) (Appellant) Fornah (FC) (Appellant) v. Secretary of State for the Home Department (Respondent) [2006] UKHL 46, UK House of Lord, 18 October 2006

140 VG Wiesbaden, 5 E 31472/98.A (2), 27 Jan. 2000; VG Regensburg, RO 5 K 00.30162, 23 March 2000.

141 “Comparative analysis of gender-related persecution in national asylum legislation and practice in Europe”, UNHCR website

142 *Mlle Kahdija Leila Darbo*, CNDA, No. 637717, 12 March 2009.

143 *Mlle Hélène Awa Kouyate*, CNDA, No 639907, 12 March 2009.

144 Verbrouck, C and Jaspis, P. “Mutilations Génital Féminines/ Quelles protection? », *Revue du droit des étrangers* - 2009 - n° 153, 133-150.

Legal and policy commitments

The work towards a Common European Asylum System (CEAS) is progressing and four building blocks – the Dublin Regulation, the Reception Conditions Directive, the Qualification Directive and the Asylum Procedures Directive – have been adopted.¹⁴⁵ These four instruments promote a coordinated approach to asylum issues and ultimately aim to build “a system which guarantees to persons genuinely in need of protection access to a high level of protection under equivalent conditions in all Member States while at the same time dealing fairly and efficiently with those found not to be in need of protection”.¹⁴⁶ The work towards CEAS will continue with the view of having second phase instruments adopted by the end of 2012. The recast of the directives offers a unique opportunity to ensure a strengthened protection for asylum claims relating to FGM in line with the UNHCR Guidelines and Guidance.

The **qualification directive**¹⁴⁷ contains a clear set of criteria for qualifying either for refugee or subsidiary protection status and sets out what rights are attached to each status. The directive recognises that acts of a gender specific or child specific nature can constitute persecution (Article 2). This recognition is, however, limited as the directive states that “gender related aspects might be considered, without by themselves alone creating a presumption for the applicability”.¹⁴⁸ The Commission acknowledges that “sexual violence to refugee women, such as female genital mutilation can also be inflicted for the one and only reason of their gender. In such situations, the persecution ground ‘membership of a particular social group’, as included in the Refugee Convention as one of the five grounds of persecution could apply and therefore such a person can be recognised as a refugee.”¹⁴⁹ The recast of the directive presents the opportunity to avoid ambiguity and diverging interpretation of the notion of membership of a particular group as it relates to gender persecution. The Commission’s proposal to focus “on providing more concrete guidance on the weight to be

145 These are Regulation (EC) 343/2003 (“Dublin Regulation”), Directive 2003/9/EC (“Reception Conditions Directive,”) Directive 2004/83/EC (“Qualification Directive”) and Directive 85/2005/EC (“Asylum Procedures Directive”).

146 Memo/07/229, “Green Paper on the future Common European Asylum System”, Europa website press release, 6 June 2007

147 Council Directive 2004/83/EC on minimum standards for the qualification of third country nationals and stateless persons as refugees or as persons who otherwise need international protection.

148 Ibid. Article 10 (d)

149 “Paying special attention to the situation of minors seeking asylum in the European Union”, EC website on Freedom, Security and Justice



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attached to gender-related aspects” in the recast directive is welcomed.¹⁵⁰ In addition, the proposed changes in the Commission proposal¹⁵¹ could be strengthened further by explicit reference to UNHCR Guidelines and Guidance.

The **procedure directive**¹⁵² ensures that throughout the EU, all procedures at first instance are subject to the same minimum standards. In the Commission’s proposal¹⁵³ for the recast of the directive, reference to applicants with special needs¹⁵⁴ and the focus on gender and children awareness in the procedure directive is welcome. The Commission’s proposal for interviews to be conducted in a gender sensitive manner so as to allow applicants to mention gender persecution is also positive.¹⁵⁵

The **reception directive**¹⁵⁶ sets out minimum standards for the reception of asylum seekers. The Commission’s proposal¹⁵⁷ has strengthened the directive by referring to the need to take into consideration the gender and age of applicants. During the debates on the proposal, the European Parliament has included a specific reference to victims of FGM under the mention of persons with special needs who require special protection.¹⁵⁸

These positive steps in the recognition and inclusion of gender and age specific measures throughout the CEAS are welcome. Harmonious and consistent transposition and implementation of the directives could be ensured by reference to the UNHCR Guidelines and Guidance in the text of the directives.

150 European Commission, Proposal for a Directive of the European Parliament and of the Council on minimum standards for the qualification and status of third country nationals or stateless persons as beneficiaries of international protection and the content of the protection granted, 21 October 2009, 2009/0164 (COD)

151 “Gender related aspects should be given due consideration for the purposes of determining membership of a particular social group or identifying a characteristic of such a group” (29) 2004/83/EC recital 21

152 <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:326:0013:0034:EN:PDF>

153 European Commission, Proposal for a Directive of the European Parliament and of the Council on minimum standards on procedures in Member States for granting and withdrawing international protection (Recast), 21 October 2009, COM(2009) 554 final; 2009/0165 (COD), UNHCR website

154 “applicant with special needs” means an applicant who due to age, gender, disability, mental health problems or consequences of torture, rape or other serious forms of psychological, physical or sexual violence is in need of special guarantees in order to benefit from the rights and comply with the obligations in accordance with this Directive;”

155 European Commission, Proposal for a Directive of the European Parliament and of the Council on minimum standards on procedures in Member States for granting and withdrawing international protection, COM(2009) 554/4.

156 Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers

157 European Commission, Proposal for a Directive of the European Parliament and of the Council laying down minimum standards for the reception of asylum seekers (Recast) Brussels, 3.12.2008 COM(2008) 815 final 2008/0244 (COD)

158 See Amendment 27 Proposal for a directive Article 21 – paragraph 1 “Member States shall take into account the specific situation of persons with special needs in the national legislation implementing this Directive. Vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of trafficking, *victims of female genital mutilation*, persons with mental health problems and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, shall always be considered as persons with special needs.” EP [T6-0376/2009](#) 07/05/2009.

EU instruments

The work towards the **Common European Asylum System** is ongoing and the **European Asylum Support Office** is to be set up as an EU agency in 2010. The objective of the office is to help Member States to implement a more consistent and fair asylum policy and thereby support the CEAS. This should be done by organising trainings; identifying good practices; and facilitating information sharing on countries of origin. The Office will further provide technical and scientific assistance to facilitate the development of asylum policy and legislation.¹⁵⁹

The **European Asylum Curriculum (EAC)** is a project aiming to produce a common vocational training for employees of the EU Member State Immigration Services. Having a common curriculum can contribute to the strengthening of practical cooperation between the various asylum and immigration systems within the EU. This harmonised learning tool is primarily aimed for case workers in all EU Member States encompassing training in knowledge of international and European legal instruments as well as skills necessary for a case office.¹⁶⁰

→ RECOMMENDATIONS

The END FGM-European Campaign:

Urges the **EU institutions**

- to ensure that the recast of the qualification, procedure and reception directives give full consideration to the UNHCR Guidelines on gender-based persecution and the Guidance on FGM. Reference to these documents should be included in the text of the recast directives to ensure that they are given full consideration in transposition and implementation of these directives.

Urges the **European Commission** as guardian for the treaty

- to ensure that the legal framework is properly transposed and implemented at national level. In order to ensure this implementation, the Commission should set up a data collection mechanism disaggregated by gender and age, including number of applications and successful claims based on FGM.

Urges the **EU institutions** to encourage the **European Asylum Support Office**

- to include FGM as an integrated dimension in its work, with trainings and information produced and disseminated among EU Member States

Urges the **EU institutions**

- to encourage the inclusion of UNHCR Guidelines on gender persecution and Guidance related to FGM into the **European Asylum Curricula**.

159 "Setting up of European Asylum Support Office proposed by the Commission" Press release IP/09/275, 18 February 2009.

160 European Asylum Curriculum Phase III, GDISC website.

5.5 EU DEVELOPMENT COOPERATION

“The UN Commission on the Status of Women adopted the Resolution Ending Female Genital Mutilation, recognising that female genital mutilation violates, and impairs or nullifies the enjoyment of the human rights of women and girls. The European Union has made quite clear its position on the unacceptability of traditional practices, both within the Union and in third countries. We need to make sure that all countries understand our position, and advocate for these human rights to be respected, including in the context of human rights dialogues and consultations as well as other policy dialogues with third countries”.

Benita Ferrero-Waldner, Former EU Commissioner for External Relations and Neighbourhood Policy¹⁶¹

The global challenge of FGM

An estimated 100-140 million women are living with FGM worldwide. Their right to sexual and reproductive health has been violated and they may not be able to live up to their full potential as women, as mothers and wives, as farmers and workers in their society. FGM is a practice that continues to cause tremendous suffering to women and girls worldwide.

European Commission development assistance has been given to projects on FGM in third countries; two examples are Sudan¹⁶² and Egypt¹⁶³. Financial support (under EIDHR) has also been given to an international

¹⁶¹ Press Release IP/08/182 for the International Day of Zero Tolerance against Female Genital Mutilation 6 February 2008,

¹⁶² “Promoting land and women rights in Red Sea State, Eastern Sudan”, EuropeAid website

¹⁶³ “Children at risk”, Delegation of the EU to Egypt, Europa website

campaign to stop FGM.¹⁶⁴ While these efforts are worthwhile there is no coherent approach to FGM in EU development cooperation.

Addressing FGM through development cooperation

The aid architecture has changed following the 2005 Paris Declaration on aid effectiveness, which outlined five main principles: ownership, alignment, harmonisation, managing for results and mutual accountability. The underlying reasoning is that untying aid, moving away from donor driven policies to greater local ownership and alignment with partner countries’ national strategies and institutions, would ensure greater aid effectiveness.¹⁶⁵ This move towards budget support, away from targeted interventions, limits the donor’s potential to direct development assistance to specific objectives. Promoting human rights and gender equality in development assistance would therefore to a large extent first have to be raised as issues with the partner government, making the political dialogue and the following policy dialogue of great importance.

Putting an end to the practice of FGM has several dimensions that need to be addressed. There is a need for an enabling environment at the political and legislative level. The health sector must be fully involved in the prevention of FGM as there is a risk of increased medicalisation of the practice. Teachers and the education sector can be strong allies in activities to promote awareness and empowerment of children and youth. The culture sector (media, entertainment) is crucial to disseminate information and to promote an open dialogue on a sensitive issue like FGM. In many developing countries these sectors of government are suffering from a lack of resources – financial resources, human resources and technical expertise. Development cooperation can play an important role in supporting the in-house capacity at government level.

In countries where the government is not able or willing to take measures to end FGM, specific support should be given to national and local civil society organisations (CSOs) working on this issue, and also to other international organisations (partners like UN agencies) which already work to promote the abandonment of FGM in the region.

In all approaches, whether through support to the government or to civil society activities, specific action should be taken to engage women and girls from FGM

¹⁶⁴ “European Commission marks Human Rights Day: EUR 81 million for 116 projects”, Press release on 10 December 2002

¹⁶⁵ “The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action 2005-2008”, OECD website

communities to promote their empowerment, their ability to claim their rights as well as their decision making position in relation to their community and to the various policy structures that affect their lives. Their active participation should be at the core of all abandonment strategies.

Legal and policy commitments

In accordance with Article 3 in the Treaty, all Community activities, including development cooperation, should aim to promote gender equality and to further eliminate inequalities. Article 177 stipulating the priorities for EC development cooperation, also states that EC policy in this area should respect human rights and fundamental freedoms.

The **Cotonou agreement**¹⁶⁶ which outlines the EU-ACP (African, Caribbean and Pacific Group of States) partnership makes specific reference to the goal of preventing FGM in Article 25 (c) on Social Sector Development. It further stipulates that gender should be mainstreamed throughout EC development cooperation and that specific positive measures should be adopted in favour of women, including promoting their access to social services and health care.

The **Development Cooperation Instrument (DCI)**¹⁶⁷ - the framework for EC assistance to developing countries that are not covered by the Cotonou agreement or the European Neighbourhood and Partnership Instrument - does not make specific reference to FGM but it states that the reproductive and sexual health and rights as defined in the Programme of Action of the International Conference on Population and Development (ICPD) should be rigorously observed and respected throughout community assistance. Gender equality is mentioned as an important goal in several articles, in particular the one covering the thematic programme 'Investing in People' where "good health for all" and "gender equality" form two of the programme's four main pillars.¹⁶⁸

The **European Neighbourhood and Partnership Instrument (ENPI)**¹⁶⁹ is the framework for EC assistance to Algeria, Armenia, Azerbaijan, Belarus, Egypt, Georgia, Israel, Jordan, Lebanon, Libya, Moldova, Morocco, the Pal-

"We condemn the practice of Female Genital Mutilation which still occurs in a number of countries. This practice causes a great deal of suffering and is a serious threat to the health of women and girls. We are encouraged that some partner countries have already introduced legislation against this harmful practice but we would stress that the Commission continues to take every opportunity to convince other partners to do the same".

Louis Michel, Former EU Commissioner for Development and Humanitarian Aid¹⁷⁰

estinian Authority, Russia, Syria, Tunisia and Ukraine. While there is no direct reference to FGM, gender equality and women's rights are referred to in Article 2 on the scope of the regulation. Furthermore reproductive and infant health of women and girls is mentioned.

The **European Instrument for Democracy and Human Rights (EIDHR)**¹⁷¹ is created to complement and reinforce the other frameworks for development cooperation. It makes several references to gender equality and women's rights, and further states that measures which combat FGM should be supported by community assistance.

In the **EU guidelines** on "Violence against women and girls and combating all forms of discrimination against them" (2008), FGM is included in the definition of violence against women and girls. It is further stated as an operational guideline that the "EU reiterates the three indissociable aims of combating violence against women: prevention of violence, protection of and support for victims and prosecution of the perpetrators of such violence".¹⁷²

The document '**Towards an EU Strategy on the Rights of the Child**' lists FGM as one of the global challenges facing children today. It further makes the commitment that the Commission will "address children's rights in political dialogue with third countries, including civil society and social partners, and use its other

166 The revised version that entered into force in 2008 can be found on European Commission website

167 Regulation (EC) No 1905/2006 of the European Parliament and the Council of 18 December 2006 establishing a financing instrument for development cooperation

168 Development Programmes, European commission website on development and relations with ACP states

169 Regulation (EC) No 1638/2006 of European Parliament and the Council of 24 October 2006 laying down general provisions establishing a European Neighbourhood and Partnership Instrument

170 Press Release IP/08/182 for the International Day of Zero Tolerance against Female Genital Mutilation 6 February 2008,

171 Regulation (EC) No 1889/2006 of the European Parliament and the Council of 20 December 2006 on establishing a financing instrument for the promotion of democracy and human rights worldwide

172 Guidelines available on Europa website

policy instruments and cooperation programmes to promote and address children's rights worldwide".¹⁷³ The commitment to create a comprehensive strategy for the protection and promotion of children's rights in EU external policies is reiterated in the Commission Communication 'A Special Place for Children in EU External Action'.¹⁷⁴ It lists six ways in which the EU can use its available instruments in its external action: in development cooperation, in trade policy, in the political dialogue, through regional and global actions, through empowerment of children and adolescents and in humanitarian aid.¹⁷⁵ In the accompanying Commission staff working paper, it is specifically noted that EU actions should focus on preventing FGM. It also states that the EU should pay special attention to children's rights in their country programming, and it is in the process of developing a Children's Rights Toolkit in liaison with UNICEF.¹⁷⁶ Both documents call for EU support to the implementation of the 2002 UN Plan of Action 'A World Fit for Children' which amongst other objectives includes the ending of FGM.¹⁷⁷ In the EU guidelines on the Promotion and Protection of the rights of the Child (2007), FGM is included in the section on 'All Forms of Violence against Children'.¹⁷⁸

The EU has stated a strong commitment to support the achievement of the **Millennium Development Goals** (MDG) in the European Consensus on Development.¹⁷⁹ This statement represents the common values and principles held by the European Commission and the EU Member States. According to UNFPA, FGM is a threat to the achievement of several MDGs:

- **MDG 3** Promote Gender Equality and Empower Women, is linked to structural disadvantages for women in societies including violence against women and girls. The practice of FGM and other harmful traditional practices perpetuate these structural disadvantages and effectively hinder the full empowerment of women in all areas of society.
- **MDG 4** Reduce Child Mortality, aims to reduce under-five child mortality. FGM is often practiced on infants and young girls with possible severe health consequences, sometimes death. Women who have been subjected to FGM often experience increased diffi-

culties in child delivery and studies have shown that FGM contributes to still births and neonatal deaths.

- **MDG 5** Improve Maternal Health, aims to reduce the maternal mortality ratio. As FGM is associated with a range of health complications around pregnancy and childbirth it negatively affects the goal to reduce maternal mortality.¹⁸⁰

EU instruments

European Commission development programming for partner countries is shaped through negotiations with the partner government and outlined in Country Strategy Papers (CSPs) and National Indicative Programmes (NIPs). This strategy is largely dependent on the political will of the partner country, thereby making both the political dialogue and the subsequent policy dialogue crucial steps in addressing issues like human rights and gender equality.

This geographical development strategy can also be complemented by thematic development instruments (Investing in People, Non-State Actors and Local Authorities)¹⁸¹ as well as the European Instrument for Democracy and Human Rights (EIDHR)¹⁸². The particular strength of this initiative is that it can cooperate directly with local civil society organisations and so address sensitive political issues that partner governments may be reluctant to address. Grants in the form of 'macro-projects' are selected by EC headquarters in Brussels, while 'micro-projects' grants are launched and selected directly by the EC delegation.¹⁸³

As outlined in the Draft EU Plan of Action on Gender Equality and Women's Empowerment in Development (2010-2015), the 'three-pronged approach' to promoting gender equality in EU development cooperation consists of the political and policy dialogue, gender mainstreaming of all development activities, and special actions targeting gender inequality.

173 Ibid

174 Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, "A Special Place for Children in EU External Action", 5.2.2008, COM(2008) 55

175 Ibid

176 Commission staff working paper accompanying COM(2008)55

177 United Nations General Assembly "A world fit for children", A/RES/S-27/2

178 Europa website

179 Joint statement by the Council and the representatives of the governments of the Member States meeting within the Council, the European Parliament and the Commission on European Union Development Policy: 'The European Consensus' (2006/C 46/01)

180 Global Technical Consultation on FGM/C, UNFPA website

181 Financing instrument for development cooperation - DCI (2007-2013), Europa website

182 "Investing in people" [COM(2006) 18, Commission Communication of 25 January 2006

183 Herrero Sonia, "A decade of democracy promotion through the European Initiative for Democracy and Human Rights", The EPD Working Papers Series on Democracy Support 1/2009



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→ GOOD PRACTICE

The European Commission has promoted gender equality in Eastern Sudan by supporting the Abuhadia Association, an organisation that engages in conflict resolution and promotes women's rights. The European Commission contribution was granted during 2005-2007 and it included the objective to combat female genital mutilation at community and government level in Red Sea State (Eastern Sudan). As a result, two major awareness campaigns and training sessions were organised to combat female genital mutilation.¹⁸⁴ Another initiative to eradicate FGM was taken by the European Commission in Egypt, in collaboration with the National Council for Children and Motherhood (NCCM) and their "Children at Risk Programme". This programme supports the "FGM-Free-Village" initiative which is led by NCCM and UNDP and aims to eradicate the practice of FGM "by a bottom-top approach - by changing people's perception on the issue - and by a top-bottom approach - by instigating new legislation against FGM".¹⁸⁵

184 Promoting land and women rights in Red Sea State, Eastern Sudan, European Commission, EuropeAid website

185 EC website on the Delegation of the European Union to Egypt

→ RECOMMENDATIONS

The END FGM-European Campaign:

Urges the European Commission and the EU Member States

- to address the issue of FGM in the framework of the political dialogue with partner countries and regional organisations and discuss how to best implement the commitments taken in international and regional treaties as well as in partner countries' national legislation
- to address the issue of FGM in the policy dialogue with stakeholders relevant to this sensitive issue in the national context. It is imperative that women's civil society organisations and human rights activists already working on ending the practice of FGM be included in these dialogues, together with girls and women directly affected by the practice, community leaders, religious leaders, teachers, health workers and government officials both at local and national level
- to employ the established guidelines on human rights defenders in relation to the women and men who are threatened when speaking out against the practice
- to mainstream its commitment to combat FGM across several sectors of development assistance, including health, governance, education and culture

Urges the European Commission

- to include in its annual country reviews an assessment of FGM prevalence and efforts to end this practice, and where applicable (i.e., in coordination with other donors and in partnership with third countries) include measures to combat FGM in Country Strategy Papers (CSPs) and in National Indicative Programmes (NIPs)
- to provide grants for macro and micro projects to combat FGM through thematic instruments and programmes
- to design and develop a module on FGM, as part of a wider training programme on EU's human rights commitments, that includes relevant international, regional and national legal instruments, promotes understanding of its cross-sector dimensions and gives examples of current best practices on ending FGM. This module should form part of the core-curriculum for staff at headquarters and at partner country level



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