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Promotion and protection of all human rights, civil political, economic, social and cultural rights, including the right to development

Expert group meeting on the elimination of female genital mutilation

Report of the United Nations High Commissioner for Human Rights

Summary

The present report is submitted pursuant to Human Rights Council resolution 38/6 on the elimination of female genital mutilation, in which the Council requested the Office of the United Nations High Commissioner for Human Rights to organize a two-day expert meeting in Addis Ababa and submit a report on the outcome of the meeting at its forty-fourth session.

The expert meeting took place on 17 and 18 July 2019. Participants discussed progress, gaps and challenges in the application of human rights norms, standards and principles to the prevention and elimination of female genital mutilation in various contexts, including at community and national levels, and in migration and displacement contexts.

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I. Introduction

1. In its resolution 38/6, the Human Rights Council reiterated that female genital mutilation was a harmful practice that violated, abused and undermined the human rights of women and girls, posed a serious threat to their well-being and was linked to other forms of harmful practices. Like other harmful practices, female genital mutilation is driven by gender inequality and patriarchal social norms or factors that perpetuate or condone ideas and practices around the subordinate position of women with respect to men and their stereotyped roles. In resolution 38/6, the Council also expressed its concern about some emerging trends, such as the medicalization of the practice and cross-border instances, despite increased efforts to put an end to the practice at all levels and a decline in its global prevalence.

2. Through resolution 38/6, the Human Rights Council requested the Office of the United Nations High Commissioner for Human Rights (OHCHR) to organize a two-day expert meeting, preferably in Addis Ababa, in close cooperation with other United Nations entities, in particular the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women) and the World Health Organization (WHO). The purpose of the meeting was to discuss progress, gaps and challenges in the application of human rights norms, standards and principles to the prevention and elimination of female genital mutilation in various contexts, including at community and national levels, across borders and in the context of population movements. The Council also requested OHCHR to submit a report on the outcome of the meeting at its forty-fourth session.

3. The expert meeting took place on 17 and 18 July 2019. Twenty-five experts and practitioners from 15 countries and different backgrounds, including scholars and researchers, medical and judicial actors, civil society and United Nations representatives participated in the meeting and shared diverse experiences relating to the elimination of female genital mutilation. The discussions were guided by four major topics, namely comprehensive and rights-based policy frameworks to end female genital mutilation; enforcement of legislative measures and accountability, including across borders and in the context of population movements; countering the medicalization of female genital mutilation; and innovative approaches at the community level and scaling-up of interventions to address social norms and strengthen social accountability and data collection. Each of these topics is discussed below.

II. Comprehensive and rights-based policy frameworks to end female genital mutilation

4. In accordance with resolution 38/6, participants in the expert meeting affirmed that female genital mutilation was a human rights concern. It represented a manifestation of gender-based discrimination anchored in social and cultural norms by which women and girls were placed in a subordinate role in society. As such, it should not be addressed as a stand-alone issue. It was also closely related to other harmful practices, including child, early and forced marriage. The effective prevention and elimination of female genital mutilation required States to address the underlying systemic and structural causes in which the practice was rooted. That involved the establishment by States of a well-defined, comprehensive, rights-based and locally relevant holistic strategy that would include supportive legislation and policy measures, combined with political commitment and accountability at all levels.[1] Such a holistic strategy must be coordinated both vertically and horizontally and integrated into national efforts to prevent and address all forms of harmful practices. It was stressed that the human rights obligations of States outlined particularly in the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child provided the basis for the development of such a holistic strategy.

[1] See joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2014) on harmful practices..

5. In the discussions participants highlighted the need for such holistic strategies to simultaneously activate measures aimed at tackling the root causes of female genital mutilation, protecting and assisting women and girls, and ensuring the accountability of perpetrators, while engaging all relevant State and non-State actors. Leadership, long-term vision and political commitment were emphasized as key components to effectively address female genital mutilation. It was also mentioned that as a human rights and development issue, interventions on female genital mutilation should be connected to national development and poverty plans and strategies, to avoid the issue becoming siloed and ensure that its socioeconomic dimensions, affecting especially the most marginalized communities, were adequately prioritized and budgeted. One expert stated that in Kenya, for instance, efforts had been made to ensure that strategic interventions on female genital mutilation be included in the country's development plan.

6. Experts agreed that ensuring that policies and plans were fully costed and resourced was critical to pursuing a comprehensive approach to female genital mutilation. That should be coupled with adequate technical capacity of personnel, which would go beyond nominating focal points and imply investment to build capacities within different relevant ministries and institutions. It was also mentioned that countries that had made progress were those that had invested in the elimination of female genital mutilation, such as Burkina Faso and Kenya.

7. The meeting acknowledged the value of coordination mechanisms in advancing the elimination of the practice. Beyond ensuring coordination among all actors, those mechanisms were critical to building ownership and monitoring progress. Some experts, however, warned about challenges in achieving horizontal coordination between different ministries (for example, the Ministry of Women and the Ministry of Health), within ministries (for example, different persons dealing with women's human rights and female genital mutilation), as well as vertical coordination at the central and local levels, especially in the context of devolution, as a disconnect with centralized ministries was common.

8. During the discussions it was recognized that social change needed to come from within the community. The transformation of social norms was only possible through sustained action at all levels, for instance at school and other formal education settings, in informal education, through work with communities and their leaders, including religious leaders, and through different means of communication. Examples were shared of the important role played by traditional communicators in West Africa in convincing members of the community of the harmful nature of female genital mutilation, as well as the use of social media to inform the population about the harmful consequences of the practice. Similarly, experts repeatedly referred to the need for concerted efforts to empower women and girls affected by the practice and ensure their meaningful participation in the development of interventions to address it. That was recognized as a critical element to ensure that the legitimate responses were effective and acceptable. Experts stressed that assumptions about the needs of women and girls should be avoided and that engaging in a dialogue with them was critical to understanding what an acceptable response meant for them.

9. It was also stressed that responses to female genital mutilation should be contextualized and adapted to the needs of different communities. For example, in migration contexts it was important to understand to what extent support for the practice was linked to identity and the need to belong to a certain group, while in other contexts social coercion might influence the choice of or consent to the practice for fear of rejection by the community. Some of the challenges to social change that were identified included difficulties in translating the human rights messaging around female genital mutilation in communities often deprived of their basic rights and the need to build better responses to arguments supporting the practice as a means to thrive and gain access to social capital resources.

10. The importance of comprehensive high-level initiatives at the global or regional levels to galvanize political commitment and action at the national level was also highlighted during the meeting. In that regard, the African Union initiative on eliminating female genital mutilation, "Saleema", was mentioned as a promising initiative. Saleema was launched in the margins of the African Union summit of Heads of State and Government in 2019. It aimed to accelerate the elimination of female genital mutilation by transforming social norms and the cultural dimension of the practice; addressing cross-

border female genital mutilation and strengthening the enforcement of legislation; allocating domestic financial resources to address the practice; investing in and promoting data collection, including regular reporting; and increasing engagement with civil society and community groups to end it.

11. The participants in the meeting acknowledged that the current pushback on women's human rights could represent a threat to progress in ending female genital mutilation and recognized the need to consider it along with other challenges when discussing policies and framing narratives aimed at the elimination of the practice. Some experts reported that in some communities, in India for example, civil society organizations engaged in ending female genital mutilation had faced resistance from religious and political leaders. Another example given was the backlash arising from a proposal to enact a law prohibiting female genital mutilation in the Sudan, resulting in girls being subjected to the practice on a massive scale in anticipation of the adoption of that piece of legislation. Other challenges discussed included the tendency to frame female genital mutilation as a social, cultural or religious, rather than a human rights, issue to avoid linking it to gender-based violence. Arguments in favour of the medicalization of the practice might give the impression that it was medically sound or beneficial simply because health-care providers were involved.

III. Enforcement of legislative measures and accountability, including across borders and in the context of population movements

12. A human rights-based approach to addressing female genital mutilation requires the recognition that it is a form of gender-based violence and thus there should be specific legal rules to ensure that it is prohibited. The practice of female genital mutilation should be considered a crime that must be investigated, prosecuted and punished. The participants in the expert meeting reached a consensus on the importance of enacting legislation prohibiting female genital mutilation as a critical element to signal that the practice was not acceptable and to ensure protection and remedies for women and girls. The practice could also constitute a criminal offence subject to criminal law. The process of developing such legislation should include meaningful consultations with the community to avoid misconceptions, ensure ownership and legitimacy, and ultimately enforceability. However, the experts recalled that the adoption of legislation alone was insufficient to address the practice effectively. In that regard, it was stressed that the Committee on the Rights of the Child and other human rights mechanisms had made it clear that any anti-female genital mutilation legislation should be part of a comprehensive approach, including measures aimed at addressing social norms and the cultural context.[2]

13. In that context, experts identified some of the key elements of any potential legislation on female genital mutilation, which would facilitate its enforcement, such as: (a) the comprehensive nature of a law that would address both the prohibition and the criminalization of the practice (encompassing prevention, punishment and remedies); (b) a proper definition of the elements of the crime, including attempting to commit or aiding and abetting female genital mutilation and a clear definition of offenders; (c) clauses dealing with the issue of extraterritoriality; (d) no time limitation for reporting and simplified reporting procedures (for example through anonymous hotlines); (e) adequate sentencing and a coherent application of the law; (f) proper dissemination of the law for it to be known and implemented; (g) adequate training for judges and lawyers; (h) capacity-building of women and girls on how to seek remedies; (i) gender and child-sensitive prosecutions, including protection systems for victims and witnesses; (j) guidance to ensure that the application of an informal legal system was supervised by the formal legal system with the aim of condemning the practice.

14. During the meeting, it was acknowledged that the criminalization of female genital mutilation and the imposition of heavy sentences and fines were generating increasing discussion on whether such laws were achieving their intended objective of reducing the

[2] See, for example, CEDAW/C/KEN/CO/8; CEDAW/C/GBR/CO/8; CRC/C/CMR/CO/3-5; CCPR/C/BFA/CO/1; and E/C.12/MLI/CO/1.

incidence of the practice. For instance, reports from several countries indicated that securing prosecutions under such laws was difficult, especially taking into account the potential liability of parents and relatives of the victim for performing or organizing the procedure and consequently being reluctant to report it. That was further complicated by the difficulties in collecting evidence, as it was often not readily apparent if a girl had undergone female genital mutilation. Experts reported that some of the barriers faced by the authorities in the United Kingdom of Great Britain and Northern Ireland in collecting evidence on female genital mutilation were due to a number of issues, including the underground nature of the practice and the difficulty of obtaining medical evidence. Furthermore, children of parents facing the consequences of criminal sanctions might be left in a dire situation, especially where there were no social protection systems. The need to regularly assess the impact of legal frameworks to identify possible adverse consequences was therefore stressed.

15. In addition, some experts raised concerns about the disproportionate impact of punitive approaches on women and girls, as they might, for example, push the practice underground, making it even more dangerous for the girls concerned and resulting in the stigmatization of communities, in particular women and girls, in the context of migration and movement of populations (for example in Europe). In that respect, some experts emphasized the need to complement legislation with measures aimed at encouraging a change in social norms and understanding the other factors supporting the practice.

16. Another related challenge, identified during the meeting, related to gaps in the enforcement of legislation owing to its narrow conceptualization and interpretation by judges. An experience shared from Kenya was illustrative in that regard: three adult women who had agreed to undergo female genital mutilation were sentenced to three years in prison for not having reported their cases to the authorities, since the legislation stated that consent could not be used as a defence for performing female genital mutilation and stipulated mandatory reporting.[3] While discussing this issue, the experts noted that terms such as consent, bodily autonomy, choice and harm challenged the implementation of punitive approaches to female genital mutilation. Experts agreed on the need for more research on those issues and on the human rights implications of different policy and legal approaches to female genital mutilation, in particular concerning adult women. Furthermore, those issues should also inform the much-needed supplementary efforts to monitor the impact of legislation against female genital mutilation, for example who was being prosecuted and the impact of prosecutions on those prosecuted, always having at its core the human rights of the women and girls concerned. Analysis and monitoring of the human rights impact should inform the work of human rights mechanisms and their recommendations concerning the elimination of female genital mutilation.

17. Concerns were raised over the issue of mandatory reporting of female genital mutilation by health-care professionals and the ethical dilemmas that entailed in terms of confidentiality and the potential harm to the patient-doctor relationship and public trust, as without the assurance of confidentiality, survivors of female genital mutilation (and their families) might avoid seeking medical help in general practice, even for non-gynaecological conditions.[4] While data was limited as to whether mandatory reporting, in the manner that it was applied, was successful in safeguarding girls and women at risk of female genital mutilation,[5] experts considered that the issue required further research and clarification.

18. Some experts also mentioned that where legislation was in place it was often inadequate in its scope or suffered from weak implementation owing to numerous factors. For instance, despite the fact that cross-border female genital mutilation was taking place in both East and West Africa, failure to address the cross-border dimensions of the practice was a critical gap in most African laws against female genital mutilation.[6] Girls and young

[3] See the Prohibition of Female Genital Mutilation Act (2011), arts. 19 (6) and 24.

[4] See Joel Naftalin and Susan Bewley, "Mandatory reporting of FGM", *British Journal of General Practice*, vol. 65, No. 638 (September 2015).

[5] Yusuf Malik and others, "Mandatory reporting of female genital mutilation in children in the UK", *British Journal of Midwifery*, vol. 26, No. 6 (June 2018).

[6] See for example: UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, *How to Transform a Social Norm: Reflections on Phase II of the UNFPA-UNICEF Joint*

women living in Europe usually underwent the practice in their country of origin, which gave rise to the question of how laws against female genital mutilation could apply extraterritorially. A large majority of European countries had included the principle of extraterritoriality in their general criminal law, which allowed its application to female genital mutilation.

19. Efforts to address cross-border female genital mutilation that were shared during the expert meeting included the use of protection orders in the United Kingdom to minimize the risk of exposure of women and girls as an alternative option by preventing women and girls at risk from travelling outside the country. Experts however warned about the potentially disproportionate targeting of specific communities in implementing the protection orders. Another initiative that was shared during the meeting referred to an East African cross-border meeting to end female genital mutilation, at which representatives from Ethiopia, Kenya, Somalia, Uganda and the United Republic of Tanzania discussed the enactment of the East African community bill on female genital mutilation (2016) and adopted a plan of action on cross-border female genital mutilation,[7] which included four results areas, namely the improvement of legislative and policy frameworks and the environment; effective and efficient coordination and collaboration between national Governments; communication and advocacy on prevention and response; and increasing capacities to generate and use evidential data to address the practice. It was stressed, however, that more research on the impact of cross-border female genital mutilation on the human rights of women and girls affected was needed to better inform interventions.

20. The role of the Optional Protocol to the Convention on the Rights of the Child on a communications procedure was highlighted as a tool to enhance the protection of girls at risk of female genital mutilation. In that regard, it was mentioned that in March 2018 the Committee on the Rights of the Child had adopted its first decision on the matter, in which it stated that the risk of being subjected to female genital mutilation was a ground for non-refoulement and that when assessing this risk an individualized assessment that took the best interest of the child as a primary consideration should be conducted (see CRC/C/77/D/3/2016).

IV. Countering the medicalization of female genital mutilation

21. WHO defines the medicalization of female genital mutilation as situations in which the practice is performed by any category of health-care provider, whether in a public or private clinic, at home or elsewhere.[8] That also includes the procedure of reinfibulation at any time in a women's life.

22. Under international human rights law, female genital mutilation is considered a form of gender-based violence and a harmful practice, regardless of whether it is performed in a medical setting. Article 5 (b) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa specifically requires States to prohibit all forms of female genital mutilation, including its "medicalisation and para-medicalisation". In addition, in a number of resolutions the General Assembly has called upon States to condemn all forms of female genital mutilation "whether committed within or outside a medical institution" (see, for example, resolutions 67/146 and 71/168). Furthermore, several treaty bodies, inter alia the Committee on the Elimination of Discrimination against Women, have called upon countries to eliminate the medicalization of female genital mutilation. Similarly, the Human Rights Council discussed medicalized female genital mutilation at its thirty-eighth session and stressed that the trend towards medicalization did not make the practice any more acceptable. In resolution 38/6, the Council called upon

Programme on Female Genital Mutilation (2018), p. 25; and Samuel Kimani and Caroline W. Karibu, "Shifts in female genital mutilation/cutting in Kenya: perspectives of families and health care providers", Population Council (December 2018), p. ix.

[7] UNFPA-UNICEF, "Ending cross-border FGM" (April 2019),available at https://drive.google.com/file/d/1X48bGPutBbiYuFGtJQOg3stvmTLsJ6o_/view.

[8] WHO, *Care of Girls and Women Living with Female Genital Mutilation: a Clinical Handbook* (Geneva, 2018), p. 392, and WHO and others, "Global strategy to stop health-care providers from performing female genital mutilation" (2010), p. 1.

States, the international community and the United Nations system to stop the medicalization of female genital mutilation.

23. Against that background, participants in the expert meeting discussed some of the arguments made in support of the medicalization of female genital mutilation, including that it reduced harm for women and girls and that it was a first step towards the elimination of the practice. According to WHO, health-care providers performing medicalized genital mutilation are in violation of the fundamental medical ethical principle of non-maleficence ("do no harm") and the fundamental principle of providing the highest quality health care possible.[9] Experts noted that in the absence of evidence, it was unclear how medicalization reduced harm and health risks for women and girls. By contrast, there were documented long-term complications associated with female genital mutilation, particularly regarding sexual and reproductive rights and psychological and obstetric complications. Several experts also stressed that instead of contributing to its elimination, medicalization could contribute to the normalization or institutionalization of the practice, rendering it a routine procedure and perhaps even encouraging it. Others referred to the trauma that undergoing female genital mutilation entailed for girls, irrespective of who performed it, and how that trauma might affect their future relationships, including with medical practitioners.

24. Based on existing experience, the experts discussed a number of promising practices to better address the trend towards the medicalization of female genital mutilation. In the context of Burkina Faso, for example, it seemed that a strong legal framework with large penalties for medical practitioners had been effective in reducing medicalization, as fear of incurring a prison term or losing the licence to practice had acted as a deterrent. For its part, the Sudan had developed in 2016 an accountability framework for midwives to ensure the quality of services provision and to address medicalized female genital mutilation. The adoption of a medical code and the integration of female genital mutilation issues in the curricula of medical schools as well as in pre- and in-service training for medical professionals and midwives was mentioned as necessary for building the capacities of the medical sector. Rights-based training material for medical doctors and midwives by United Nations agencies, in particular WHO, were mentioned as critical to building awareness of the unacceptability of female genital mutilation. The need for guidelines for medical practitioners on how to respond to the pressure to which they might be subjected to perform medicalized female genital mutilation and equip them with key messages for communities on reasons to abandon the practice was also stressed.

25. Other experiences shared included the work currently undertaken with the media and communities by health-care professionals, including "Doctors against Female Genital Mutilation" in Egypt, to raise awareness of the issue and with students in medical schools to mobilize them against the practice. Similarly, the lead role of professional medical associations in condemning actions to medicalize female genital mutilation was mentioned as an important contribution to reducing the prevalence of the practice. For instance, the Arab syndicates of doctors from Egypt, Somalia, the Sudan and Yemen and midwives from Djibouti and the Sudan had adopted public statements in 2017, in which they recognized the practice as a violation of the rights of women and girls and further committed to take action to eliminate the practice. At the national level, similar public statements had been made by different professional associations (nurses, midwives practitioners of obstetrics and gynaecology and paediatric associations) during their annual professional meetings, for example in the Sudan since 2016.

26. Research has shown that the medicalization of female genital mutilation may lead to some health-care providers developing a financial interest in upholding the practice, although it is not always the primary motivating factor.[10] Material gains are mostly in the form of money, but also in the form of gifts.[11] In that respect, experts acknowledged the challenges associated with addressing the issue of economic gain, especially in contexts

[9] WHO, *Care of Girls and Women Living with Female Genital Mutilation: a Clinical Handbook*, p. 392.

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

[11] See Marie-Hélène Doucet, Christina Pallitto and Danielle Groleau, "Understanding the motivations of health-care providers in performing female genital mutilation: an integrative review of the literature", *Reproductive Health*, vol. 14 (March 2017).

where it might be the only income for doctors, and indicated that a possible way to address the issue would be to include female genital mutilation in poverty reduction strategies and plans.

27. With respect to the prevention of the medicalization of female genital mutilation, the common responsibility of Governments, policymakers, medical professionals, lawyers and religious leaders at all levels was emphasized. It was also mentioned that WHO, in collaboration with key stakeholders, had developed a global strategy to stop female genital mutilation, which included a component to strengthen the understanding and knowledge of health-care providers as they were key agents of change in preventing the practice. WHO was currently supporting countries to develop and implement national health sector strategies. In the Sudan, the Ministry of Health had taken the lead since 2015 to operationalize the national strategy. Eight other countries were in different phases in terms of operationalization of the strategy.[12] Participants welcomed the strategy and stressed the need to learn from the processes and evaluate its impact on medicalized female genital mutilation.

28. The discussions also touched upon whether adult women could consent to female genital mutilation in medical settings and, if so, how to support medical practitioners in assessing their full, free and informed consent. Some experts felt that the practice should never be allowed, even when requested by adult women, given the social pressure to which they might have been exposed that could vitiate consent. Other experts, however, warned about double standards when other medically unnecessary, potentially harmful surgical interventions on female genitalia, such as female medical cosmetic surgery, were allowed and reasons to perform them might also be attributed to social pressure. While the meeting did not come to a conclusion on the most desirable approach, experts agreed on the need for further discussions on how women's choice and consent was understood in the context of patriarchal societies.

V. Innovative approaches at the community level in scaling up interventions to address social norms and strengthen social accountability and data collection

29. Throughout the expert meeting, the notion of accountability for female genital mutilation was discussed. Human rights accountability meant more than ensuring criminal liability. It encompassed a broad range of other measures that States should take to ensure the full realization of the human rights of women and girls, inter alia through comprehensive and rights-based legislation and policies that were well resourced and the establishment of monitoring mechanisms.

30. In that context, the concept of social accountability was recognized as a useful and complementary framework as it relied on the engagement of members of the community and/or civil society organizations who participated directly or indirectly in demanding accountability from duty bearers. It referred to the broad range of actions and mechanisms that could be initiated and supported by the State, citizens or both, but were very often demand-driven and operated from the bottom up. They were meant to hold public officials accountable through, for example, public expenditure tracking tools, participatory budgeting, community scorecards to assess the satisfaction of service users and providers of services.[13] Mechanisms of social accountability entailed the participation of citizens and community groups in project planning, budgeting and monitoring.

31. In particular, the participants discussed how social accountability initiatives on female genital mutilation might benefit from the use of technology to gain access to information; monitor the implementation of legislation and policies; scale up budget

[12] Those countries are Burkina Faso, Egypt, Ethiopia, Gambia, Guinea, Kenya, Nigeria and Somalia. Yemen was originally targeted as the tenth country to operationalize the WHO global strategy, but the work has not yet been initiated because of the conflict situation.

[13] See Carmen Malena, Reiner Forster and Janmejay Singh, "Social accountability: an introduction to the concept and emerging practice", World Bank social development papers No. 76, (December 2004), p. 3.

tracking; and potentially hold Governments accountable. Experiences shared in that regard included, for instance, "U-Report", a free SMS-based platform launched in Uganda in 2011 with the support of UNICEF, which allowed people to report on issues affecting them and their communities, as well as get real-time information and feedback on new initiatives.[14] The reporting system of the platform has been supporting the UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation to initiate dialogue with the youth on female genital mutilation as a means to further engage partners and communities in the effort to end the practice. In addition, it was being used to collect real-time data on female genital mutilation cases that had been recorded by other management information systems that reach the relevant communities, follow up programme achievements and monitor the implementation of activities in real time. It had also served as a tool to measure trends in perceptions of female genital mutilation.[15]

32. During the meeting, participants also analysed the benefits of using digital technology at the community level to address female genital mutilation. Examples of innovative approaches in this regard included "Crowd2Map" in the United Republic of Tanzania, which since 2015 had been improving the mapping of rural Tanzania into "OpenStreetMap" (a free open-source mapping application) and building the capacity of local civil society organizations to use those maps to inform their protection interventions for girls at risk of female genital mutilation.[16] Better and detailed mapping had facilitated access for these organizations to remote villages to locate girls at risk, with the purpose of placing them in safe houses during the "cutting season".[17]

33. Another issue that was discussed throughout the meeting was the importance of data collection on female genital mutilation to make the practice visible and inform planning, management and decision-making. While recognizing the various efforts made to support country-level initiatives to improve data collection by UNFPA and UNICEF through their joint programme,[18] the expert meeting noted with concern the lack of accurate and reliable data on female genital mutilation in many countries where the practice continued to exist. That was due to, among others, the absence of female genital mutilation indicators in health information systems; the absence of robust monitoring and evaluation frameworks; the lack of capacity of relevant officials; and the absence of standard guidelines on the collection of data.

34. Innovative initiatives supported by the UNFPA-UNICEF Joint Programme were also shared during the meeting, including the use of demographic modelling techniques (so-called "survival analysis") to improve data collection, which were based on the risk that a girl faced of being subjected to female genital mutilation each year of her life;[19] and the ACT framework, a pilot monitoring and evaluation project in Ethiopia and Guinea, that sought to measure change in social norms on female genital mutilation and was flexible enough to be contextualized in each country.[20] It was stressed that the absence of accurate statistics undermined efforts to promote the eradication of female genital mutilation and provide services to women and girls who had undergone the practice. The need to continue supporting efforts in that regard was therefore considered critical.

VI. Conclusions and recommendations

35. **Participants in the expert meeting discussed progress and gaps in and challenges to ensuring the elimination of female genital mutilation with a focus on**

[14] See UNICEF, "U-Report: amplifying voices for young people", available from https://www.unicef.org/uganda/what-we-do/u-report.

[15] See https://ureport.ug/stories/.

[16] See https://crowd2map.org.

[17] United Nations Population Fund, "For girls escaping FGM in rural Tanzania, crowdsourced maps show the way to safety", 22 October 2018.

[18] See, for example, UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, *Accelerating Change. Annual Report 2018* (August 2019).

[19] See for example, United Nations Population Fund, "Bending the curve: FGM trends we aim to change" (2018).

[20] Ibid. See also UNFPA and UNICEF, "Changing social norms around FGM/C: the development of a macro-level M & E framework" (April 2018).

comprehensive and rights-based policy frameworks; the enforcement of legislation; cross-border female genital mutilation; the medicalization of the practice; and data collection. Innovative approaches at the community level to address social norms were discussed throughout the meeting. Leadership, political commitment, long-term vision, a participatory and inclusive approach and accountability were stressed as key requirements to advance the elimination of female genital mutilation. Set out below are a number of recommendations stemming from the meeting in addition to those included throughout the text:

(a) **Develop well-defined, comprehensive, rights-based and locally relevant holistic strategies, which tackle the root causes of the practice, protect and assist women and girls and ensure accountability for perpetrators, in line with international human rights standards;**

(b) **Hold meaningful consultations with practising communities, in particular with women and girls, to ensure ownership and the legitimacy of interventions;**

(c) **Adopt comprehensive, gender- and age-sensitive legislation on female genital mutilation, which covers the prohibition and criminalization of the practice, including prevention, punishment and remedies for victims. The human rights impact of legislation should be regularly monitored, as well as obstacles to its enforcement, in consultation with, inter alia, communities and women's human rights groups;**

(d) **Make use of the Optional Protocol to the Convention on the Rights of the Child on a communications procedure as a tool to enhance the protection of girls at risk of female genital mutilation;**

(e) **Continue strengthening coordination and collaboration at the regional level to eliminate female genital mutilation through diverse initiatives and strategies (for example the Saleema initiative);**

(f) **Conduct research on the impact of cross-border female genital mutilation on the human rights of the women and girls who are affected to better inform interventions;**

(g) **Undertake research on the meaning of consent, bodily autonomy, choice and harm in the context of patriarchy and its implications for adult women, to better inform policy and legal approaches on female genital mutilation, including in relation to the medicalization of the practice;**

(h) **Enhance efforts to address medicalized female genital mutilation, including with the support of WHO by, for example, integrating female genital mutilation issues in the curricula of medical schools and training for midwives and health-care providers, developing medical codes and guidance for medical practitioners and supporting medical professional associations and civil society organizations initiatives to raise awareness of the unacceptability of the practice;**

(i) **Document the long-term complications resulting from medicalized female genital mutilation, including sexual, psychological and obstetric complications, take measures to address its drivers, such as material gain for health-service providers, and avoid interventions which result in adverse consequences, in particular for women and girls, such as punitive approaches and mandatory reporting of the practice;**

(j) **Promote social accountability frameworks through, for example, innovative approaches and the use of technology at the community level, including with the support of the UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation.**