



## Provisional version

## Committee on Equality and Non-Discrimination

## Female genital mutilation in Europe

### Report<sup>1</sup>

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#### *Summary*

Female genital mutilation is a serious violation of women's and children's rights. 200 million women and girls in the world have been subjected to genital mutilation, including women and girls who are nationals of or resident in European countries.

No religious text prescribes female genital mutilation, but the practice is rooted in the culture and beliefs of the practising communities. Prevention must lie at the heart of all efforts and involve all stakeholders: women and men in the practising communities, grassroots organisations, social and education services, the police, the justice system, healthcare professionals and asylum services.

The Assembly calls on the member States to strengthen their legislation, to develop awareness-raising, information and education campaigns, as well as training programmes for professionals working with women and girls who have been subjected to or are at risk of being subjected to genital mutilation. The Assembly encourages parliaments to take action to combat this harmful practice and invites member States to contribute to the achievement of the United Nations Sustainable Development Goals.

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<sup>1</sup> Reference to committee: Doc. 13736, Reference 4126 dated 24 April 2015.

## A. Draft resolution<sup>2</sup>

1. As of 2016, some 200 million women and girls in the world have undergone genital mutilation. These practices take place primarily in certain countries of Africa and Asia, but they also occur in Europe. Every day, women and girls who are nationals of or resident in Council of Europe member States are at risk of being subjected to genital mutilation.
2. The Parliamentary Assembly first condemned these practices back in 2001, in Resolution 1247 (2001) on Female genital mutilation and again in 2013 in Resolution 1952 (2013) on Children's right to physical integrity. However, despite growing international awareness of the seriousness of female genital mutilation, the practice persists and remains rooted in the cultures and traditions of the practising communities. The Assembly points out in this connection that no religious text prescribes female genital mutilation.
3. The Assembly underlines the fact that female genital mutilation is an act of violence against women and children and a flagrant violation of human rights. It causes serious physical and mental harm, and is a violation of the prohibition of cruel, inhuman or degrading treatment and of the right to health. As mutilation is practised in most cases during childhood, it also constitutes a violation of children's rights.
4. The Assembly is convinced that prevention must lie at the heart of all efforts to eradicate female genital mutilation and must involve all the players concerned, whether the practising communities, grassroots organisations, social and education services, the police, the justice system or healthcare professionals. Awareness-raising, information and education campaigns must include both women and men in the communities concerned and dissociate these practices from religion, gender stereotypes and the cultural beliefs which perpetuate discrimination against women.
5. In the light of the above, the Assembly calls on Council of Europe member States to:
  - 5.1. recognise female genital mutilation as violence against women and children and systematically include this issue in national procedures and policies to combat violence;
  - 5.2. run public awareness-raising and information campaigns on combating female genital mutilation, provide information in the languages mostly spoken by the communities practising female genital mutilation, and support, including financially, the initiatives of non-governmental organisations in this field;
  - 5.3. criminalise the fact of subjecting or coercing a woman or girl to undergo genital mutilation, and the fact of inciting a girl to undergo such an act, including where this is practised by healthcare professionals, or providing her with the means required for this purpose;
  - 5.4. take all necessary measures to prevent girls from being subjected to genital mutilation when travelling to their parents' countries of origin and, to this end, step up international judicial and police co-operation;
  - 5.5. ensure extraterritorial jurisdiction for domestic courts so that criminal prosecutions can be initiated when mutilation has been committed abroad on, or by, nationals or residents of Council of Europe member States;
  - 5.6. sign and/or ratify the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention, CETS No. 210), fully apply its provisions and co-operate to the closest possible extent with the Group of Experts on action against violence against women and domestic violence (GREVIO) and the Committee of the Parties in monitoring implementation of this Convention;
  - 5.7. provide women and girls who have been subjected to or at risk of being subjected to genital mutilation with access to emergency services, such as free helplines and shelters, and to healthcare and advice services;
  - 5.8. arrange for and co-ordinate the collection, at national level and in line with a common methodology, data on cases of female genital mutilation, ensure they are disseminated to the authorities involved in the fight against these practices, with due regard for international data

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<sup>2</sup> Amended draft resolution, unanimously adopted by the Committee on 9 September 2016.

protection and confidentiality standards, and on this basis, frame appropriate and targeted policies to bring an end to female genital mutilation;

- 5.9. train healthcare professionals, teachers, the police, social workers and those working in reception centres for asylum-seekers in how to detect female genital mutilation and set up mechanisms making it possible to identify girls at risk or those having been subjected to genital mutilation;
- 5.10. provide training for healthcare professionals to enable them to diagnose female genital mutilation and provide appropriate care for women and girls suffering from the physical and psychological consequences of this mutilation;
- 5.11. recognise female genital mutilation as persecution within the meaning of the 1951 Geneva Convention relating to the status of refugees, introduce gender-sensitive asylum procedures and incorporate the female genital mutilation issue in individual interviews with women coming from countries where this is practised;
- 5.12. include the fight against female genital mutilation in international co-operation and development aid activities.

6. The Assembly encourages national parliaments to support action to prevent female genital mutilation at national level and through their international co-operation activities.

7. The Assembly welcomes and supports the Sustainable Development Goals adopted by the United Nations which include the eradication of female genital mutilation by 2030 and encourages all Council of Europe member States to make an active contribution to the implementation of the Goals.

8. Lastly, the Assembly recognises that female genital mutilation is linked to other harmful traditional practices, in particular early and forced marriages, a subject which warrants separate consideration.

## **B. Explanatory memorandum by Ms Béatrice Fresko-Rolfo, rapporteur**

### **1. Introduction**

*Worldwide, one girl is subject to genital mutilation every five minutes (WHO)*

1. Every day, women and girls who are nationals of or resident in our countries are at risk of being subjected to genital mutilation. It is believed that there are some 180,000 girls in the European Union in this position.<sup>3</sup> Such practices, far from occurring exclusively in certain countries of Africa, are also to be found in Asia and in Europe. Female genital mutilation is carried out in most cases traditionally, but there is justifiable fear of the medicalisation of the practice.

2. According to a European Parliament estimate, 500,000 women and girls are believed to be living with genital mutilation in the European Union.<sup>4</sup> Figures published in 2015 reveal that in the United Kingdom alone, 137 000 women and girls permanently resident in England and Wales had been subjected to genital mutilation.<sup>5</sup> In certain districts of London, it is believed that this has affected almost one woman in 20.

3. Worldwide, although the long-standing estimate put forward was of 130 million women and girls having been subjected to genital mutilation, UNICEF reported in February 2016 that the real figure was at least 200 million women and girls in the 30 countries for which data were available.<sup>6</sup> Somalia, Guinea, Djibouti, Sierra Leone, Mali, Egypt and Sudan are amongst those countries most affected.<sup>7</sup> This significant increase can be partly explained by the growth in the world population, but also by the fact that countries such as Indonesia have begun to collect data at national level. International action is therefore more necessary than ever and I am delighted that the elimination of genital mutilation by 2030 was included as one of the targets in the Sustainable Development Goals adopted by the United Nations in September 2015.

4. The figures are alarming and reveal, if indeed evidence were necessary, that we are directly affected. We must acknowledge that this practice takes place worldwide and must take action to ensure prevention, protection and appropriate punishment, and to remedy and deal effectively with the long-term consequences on the lives of these women. In so doing, we must remember that behind these figures, there are women and girls and that they are the ones who have to endure these practices and their consequences and must be the focus of our attention. When preparing this report, I met women who have been subjected to genital mutilation. I would like to thank them for having agreed to share their personal histories with me and express to them my admiration for their courage. They have helped me understand what figures or the best experts can never tell us, namely the suffering and incomprehension vis-à-vis this violence inflicted upon them.

### **2. Harmful traditional practices**

5. The United Nations defines female genital mutilation (hereafter “FGM”) as “harmful traditional practices, grounded on discrimination, on the basis mainly of gender, often involving violence and causing physical or psychological harm or suffering, prescribed or kept in place by social norms that perpetuate male dominance and inequality of women”.<sup>8</sup> The term “harmful traditional practices” also appears in the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the Maputo Protocol) which requires states to prohibit all forms of FGM by means of legislative measures, together with sanctions.<sup>9</sup>

#### *2.1. A violation of the rights of women and children*

6. FGM is a flagrant violation of human rights as recognised in many international texts. It causes serious physical and mental harm, is a violation of the right to life, of the prohibition of cruel, inhuman or degrading

<sup>3</sup> European Parliament, Resolution of 14 June 2012 on ending female genital mutilation.

<sup>4</sup> There are unfortunately no figures enabling the extent of this problem across all Council of Europe member States to be assessed.

<sup>5</sup> Alison Macfarlane, Efuia Dorkenoo, Prevalence of Female Genital Mutilation in England and Wales: National and local estimates, City University London, July 2015, 32p.

<sup>6</sup> UNICEF, Female Genital Mutilation/Cutting: A Global Concern, 5 February 2016.

<sup>7</sup> UNICEF, *Ibid.* In these countries, over 85% of women and girls aged 15 to 49 have been subjected to genital mutilation.

<sup>8</sup> Joint general recommendation/general comment No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices, 4 November 2014.

<sup>9</sup> The Maputo Protocol, adopted in 2003 by the member States of the African Union, entered into force on 25 November 2005. It has been ratified by 36 states and signed by 15 others. Three states have neither signed nor ratified it: Botswana, Egypt and Tunisia (state of signatures and ratifications as at 1 July 2016).

treatment,<sup>10</sup> of the prohibition of discrimination – in particular gender-based discrimination – and of the right to health.

7. Children's rights are also violated by the practice of FGM since in most cases it is carried out on girls under the age of 15. UNICEF has observed that in half the countries where FGM is practised, girls are subjected to it before they are five years old. The personal testimonies are especially shocking.<sup>11</sup> Each one highlights the physical constraint endured by the child to be subjected to this mutilation, the extreme physical suffering and mental anguish of the child whose trust has been betrayed by her family, and the psychological after-effects.

8. FGM can also be practised on adult women. This would apply, for example, to women who had not been excised during their childhood but who will be prior to their marriage. Similarly, reinfibulation is practiced on women after childbirth or sexual intercourse in some cases.

9. FGM must be recognised as a serious form of violence against women and children, dealt with as such by the member States of the Council of Europe and fully incorporated into national policies to combat violence against women and children.

## 2.2. Terminology

10. In preparing this report, I had several discussions on the terminology used to describe both the women and the practice. The term "cutting" is sometimes employed in the United Kingdom, either to comply with the terminology used by international institutions such as UNICEF, or out of a concern to protect the sensibilities of the women concerned. Yet most people we spoke to felt that the term should be avoided, as it tended to minimise the seriousness of the practice. Moreover, in French-speaking countries, some people preferred the term "sexual mutilation" which underlined the desire to control women's sexuality by means of FGM. Personally, I believe the term "female genital mutilation" is preferable as it is the one used in the Council of Europe Convention on preventing and combating violence against women and domestic violence, and by the vast majority of non-governmental organisations active in this field.

11. To denote the women, the term "survivor" is used very frequently instead of "victim". In the United Kingdom, all the people I spoke to said that their position was to use the term preferred by the women concerned themselves, and that was often "survivor". That seems the right approach to me, and I will seek to use the term as far as possible in my report. Lastly, it was also stressed during the fact-finding visit to the United Kingdom, in March 2016, that using terms such as "barbaric" or "horrendous" should be avoided so as not to offend or stigmatise members of the communities which practised FGM.

## 2.3. Definition and consequences of female genital mutilation

*"A 'life sentence'"<sup>12</sup>*

12. In medical terms, FGM encompasses all procedures that involve partial or complete removal of the external female genitalia or other injury caused to the female genital organs for non-medical reasons.

13. The World Health Organisation (WHO) has established a classification of FGM, to which frequent reference is made, divided into four types.<sup>13</sup> However, some people oppose its use, in particular as it is seen as establishing a scale of gravity which fails to take into account the long-term consequences on the lives of women, or indeed could prevent criminal prosecution of type-4 FGM for which the WHO definition does not correspond to mutilation, in the commonly accepted legal sense.<sup>14</sup> Dr Pierre Foldès, a French urological

<sup>10</sup> In 2007, the European Court of Human Rights held that subjecting a woman to FGM amounted to ill-treatment contrary to Article 3 of the European Convention on Human Rights which prohibits torture and inhuman or degrading treatment (*Collins and Akaziebie v. Sweden* (dec.), Application No. 23944/05, 8 March 2007).

<sup>11</sup> See, for example, Khady, "Mutilée", Oh! Editions, Paris, 2005.

<sup>12</sup> Personal testimony by Hibo Wandere reported by Lydia Smith: "FGM: I was 6 years old and I screamed because I wanted to die", IBTimes, 5 February 2015.

<sup>13</sup> Type 1 is clitoridectomy, the partial or total removal of the clitoris and, more rarely, only the prepuce (the fold of skin surrounding the clitoris). The most common type of female genital mutilation is excision (Type 2): partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Infibulation (Type 3) is the narrowing of the vaginal opening through the creation of a covering seal, formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris. Lastly, Type 4 covers all other harmful procedures to the female genitalia for non-medical purposes (pricking, piercing, incising, scraping and cauterising).

<sup>14</sup> European Commission, Female genital mutilation in Europe: an analysis of court cases, 2015, p.21.

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surgeon, argues that “there is no such thing as a minor excision”.<sup>15</sup> He believes that any excision is a mutilation affecting the woman’s sexual organ which may or may not, depending on traditions, be accompanied by additional practices.

14. As the WHO points out, FGM offers no health benefits.<sup>16</sup> In contrast, it entails serious medical consequences for the women subjected to it, not only at the time of the mutilation, but also throughout their lives. The risks include pain, bleeding and haemorrhaging which are sometimes fatal, urinary and gynaecological infections, obstetric complications, including losing the baby and the risk of vesicovaginal fistulae, and psychological consequences, associated with the trauma of the mutilation.

15. At a hearing held by the Parliamentary Network Women Free from Violence on 24 June 2015, Dr Pierre Foldès said that in 15% of cases the practice of FGM led to immediate death. However, it would appear that there was very little awareness of the risks both in the countries most concerned and among emigrant communities.

16. A further effect of FGM is that in the majority of cases, sexual intercourse is made painful for the women survivors. The sexual consequences of mutilation also include the absence of pleasure during intercourse, with the suppression of erogenous zones causing a reduction or total absence of sexual sensations. This aspect of FGM symbolises a form of control by men over the sexuality of women: by lowering women’s sexual desire, men reinforce their domination and in this way ensure that their wives remain faithful to them and that their daughters will remain virgins until they marry. In this connection, it should be emphasised that any parallel between male circumcision and FGM must be dismissed out of hand, if only because the clitoris, whose sole function is sexual pleasure, has no equivalent in males.

#### 2.4. *The many origins of female genital mutilation*

17. In order to put forward precise and appropriate recommendations about ways of protecting and assisting women, according to the needs they express, it is in my view of prime importance to consider the question of the origins of FGM. I am convinced that this is a prerequisite to the adoption of both relevant measures to combat it and effective information policies aimed at the communities which practise it.

18. There are many origins of FGM and the personal testimonies of survivors provide valuable insight. At a hearing in 2013 jointly organised by the Parliamentary Network Women Free from Violence, Ms Djenabou Teliwel Diallo explained that “Guinean Muslim men do not marry an un-excised girl as they are convinced that the clitoris brings about male impotence and that a child may die if it touches its mother’s clitoris”.<sup>17</sup> She also said that her mother “had been indoctrinated by tradition like all the other mothers” and that “they do it in spite of themselves, they feel bound to do it because they think it is for the good of their child”.

19. The social acceptance engendered by continuity of the practice is seen as one of the main beneficial effects of FGM, among both women and girls, and men and boys. Social norms play a key role here: it is the mark of a culture and a tradition, with which failure to comply necessarily entails social rejection and marginalisation. The power of tradition and social order is therefore decisive in the continuation of such practices. Surveys show that women who carry out FGM do not know why they do it, other than it has always been the practice and must continue to be so. This was also highlighted by Ms Naana Otoo-Oyortey, Director of FORWARD UK and President of the Board of the European network End FGM, at the hearing of the Parliamentary Network Women Free from Violence in June 2015.

20. Religious grounds are often cited to justify FGM, particularly by Muslim communities. However, it is essential to point out that FGM is much older than Islam and although it is also practised by Muslims, it is not a precept of Islam. In point of fact, there are countries where Islam is the majority religion where the practice is not carried out, such as Turkey, Albania, Bosnia and Herzegovina, Azerbaijan, Algeria, Morocco and Tunisia. In addition, within the same country, these practices may be observed in certain regions but not in others. In Iraq, for example, FGM is practised only in the region of Kurdistan. Many religious leaders have spoken out in condemnation of FGM and have recommended that the practice be abandoned. Moreover,

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<sup>15</sup> Statement by Dr Pierre Foldès to the Parliamentary Network Women Free from Violence, Strasbourg, 24 June 2015.

<sup>16</sup> WHO, “Female genital mutilation. Understanding and addressing violence against women”, 2012.

<sup>17</sup> “The cutting of the hundred girls”, personal testimony by Djenabou Teliwel Diallo in “Refugee women and the Istanbul Convention”, Proceedings of the hearing of 23 January 2013 on “Preventing and combating sexual and gender-based violence” organised by the Parliamentary Network Women Free from Violence, the Committee on Migration, Refugees and Displaced Persons of the Parliamentary Assembly of the Council of Europe and the United Nations High Commissioner for Refugees, pp.17-18.

while the majority of groups practising FGM are Muslim, many other religious groups, including Christians,<sup>18</sup> animists and Falasha Jews, continue to subject their women and girls to this practice.

21. The practice of FGM is also based on the belief that men will marry only women who have been subjected to excision or infibulation. For example, “the desire for a proper marriage, which is often essential for economic and social security as well as for fulfilling local ideals of womanhood and femininity, may account for the persistence of the practice”.<sup>19</sup> Family honour then comes into play and is protected by the practice of FGM of girls before they reach marrying age. This is also what can give rise to re-excision: if the first excision is not deemed to have been sufficiently well carried out, it can be done again on the young woman. In this context, such mutilation is seen as a sign of chastity and purity, and above all, of high moral values for the whole family. From this perspective, FGM clearly represents a form of control over women and in particular their sexuality. Among boys and men, the preservation of virginity is regarded as one of the main reasons for the practice of FGM.<sup>20</sup> Similarly, it can be seen as going through a rite of passage and entering adulthood.

22. The diversity of practices and reasons put forward to explain or justify FGM shows the extent to which these derive from cultural practice and not religious precepts. It is imperative to underline that no religious text prescribes FGM. I firmly believe that the only common point linking all these practices is the desire to control women and their sexuality.

### 3. Legal, social and medical responses to female genital mutilation

#### 3.1. Criminalisation of practices

23. The Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention) requires States Parties to criminalise subjecting or coercing a woman or a girl to FGM and also inciting a child to undergo FGM (Article 38).<sup>21</sup> Several Council of Europe member states have introduced into their criminal code a specific offence relating to FGM, sometimes even before ratifying the Istanbul Convention.<sup>22</sup> In other states, FGM is covered by other general criminal provisions, for example grievous bodily harm (Greece, Slovakia), mutilation (Estonia), malicious injury (Turkey) and violence resulting in death, permanent disability or mutilation (France).<sup>23</sup> Generally speaking, these offences are punishable by a prison sentence of up to 10 years, or indeed 20 years in the most serious cases (mutilation resulting in death or performed on a minor).

24. Whatever the legal classification, the important thing is that such practices can be prosecuted. Some countries believe that they do not have a FGM problem, but I feel that this must be demonstrated. I would encourage all member States to ensure that they have the legal means of prosecuting and punishing instances of FGM. The first step would be to establish a specific offence which includes all injuries to the female genital organs for non-medical reasons.

25. One cause for concern is the fact that criminalisation of this practice fails to result in prosecutions and convictions. In the European Union, up to February 2012, only 41 cases had been brought before the courts, mainly in France (29 cases).<sup>24</sup> Since then, other cases have been registered, but are very few and far between compared with the estimated number of women and girls who have been or are at risk of being subjected to FGM. This low prosecution and conviction rate is problematic, as it prevents the prohibition of FGM to be taken seriously by members of the communities concerned.

26. In the United Kingdom, FGM was made a criminal offence in 1985 (Prohibition of Female Circumcision Act) and the legislation was strengthened in 2003 (Female Genital Mutilation Act). However, up to 2014, no prosecutions involving FGM were brought before the UK courts. There are several reasons for this. On the

<sup>18</sup> UNICEF, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, July 2013, p.73. In Ethiopia FGM is practised by 70% of Christians, who represent 60% of the population.

<sup>19</sup> “Eliminating female genital mutilation” An interagency statement – OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, p.6.

<sup>20</sup> UNICEF, *op. cit.*, 2013, p. 68.

<sup>21</sup> For a detailed presentation of the Istanbul Convention with regard to FGM, see Council of Europe, Amnesty International, “The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence – A tool to end female genital mutilation”, November 2014, 62p.

<sup>22</sup> For example, Austria, Belgium, Croatia, Cyprus, Denmark, Germany, Ireland, Italy, Malta, Monaco, Norway, the Netherlands, Portugal, Spain, Sweden, Switzerland and the United Kingdom.

<sup>23</sup> For further information see the replies from the Council of Europe member States to the questionnaire on FGM and forced marriage, CDDH-MF (2016)03, 14 April 2016, pp.105-114.

<sup>24</sup> EIGE, *Estimation of girls at risk of female genital mutilation in the European Union*, 2015, p.19.

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one hand, very few victims report the offence, primarily because it is difficult for them to report their own parents or to identify the persons responsible when the mutilation has been committed abroad and when the victims were very young, and social pressure may also come into play. On the other, the fact that healthcare professionals, social services and educational staff rarely report FGM is seen as a further reason for the lack of prosecutions.

27. As a result of this, in 2015, the United Kingdom further strengthened its legislation by means of the Serious Crime Act, comprising four key measures:

- Anonymity of victims which is intended to make it easier for victims to report FGM. However, some of the people I spoke to in the UK pointed out that the persons responsible for FGM are usually parents or family members, which makes it very difficult if not impossible to apply anonymity in practice.
- Parental responsibility means that if a person has responsibility for a girl who has suffered FGM, that person may be held criminally liable unless they can prove that the child was not under their supervision at the relevant time. This measure makes it possible to get round the difficulty in identifying the person who actually performed the FGM, which in most cases takes place abroad.
- Mandatory reporting which requires members of the regulated professions in the social, medical and education sectors to notify the police in cases where FGM appears to have been carried out on girls aged under 18 where there are physical signs that an act of FGM has been committed or where the child reports the fact.
- Protection orders which may be issued by family law courts if there are serious grounds for believing that a girl may be sent to her family's country of origin to undergo FGM. The measures ordered may include bans on leaving the country or confiscation of passports. The courts must decide which measures to order and for how long depending on the individual circumstances. In the first nine months of the implementation of such orders (July 2015-March 2016), 60 applications were lodged and 46 protection orders were issued. This measure raises some concern among the non-governmental organisations I met in London insofar as it could be seen as interference with the freedom of movement of people from countries where FGM is carried out. The point is that the definition of girls who are at risk is not very clear-cut, and a girl will generally be regarded as being at risk if her mother herself had undergone FGM. However, this could result in a woman being regarded not as a victim or a survivor but as a potential offender, thereby stigmatising an entire community. Moreover it places the emphasis on mothers alone, ignoring the fact that in some cases it is the fathers who come from communities affected by FGM, not the mothers. Likewise, a child being seen as the responsibility of the wider community, a girl may undergo FGM even if her parents are against it.

28. UK legislation also grants domestic courts extraterritorial jurisdiction in respect of acts committed abroad both on and by UK nationals or residents. This provision is vital insofar as FGM is in most cases carried out during holidays in the parents' countries of origin. Extraterritorial jurisdiction is also enshrined in the Istanbul Convention (Article 44). Regrettably, this is one of the rare provisions for which states can make a reservation at the time of ratifying the Convention. I call on states not to make use of this possibility or, where appropriate, to withdraw as soon as possible their reservation to this provision which is essential for protecting girls against FGM.

29. The fight against FGM also requires enhanced international co-operation, between both the courts and police forces. However, the police representatives in London whom I met said that there was currently no police co-operation at borders to prevent families circumventing protection orders by travelling to their countries of origin from other European countries. In the UK, Operation Limelight is currently conducted in the main airports three times a year, during school holidays. During the operation, two flights a day are chosen and families with girls returning from countries where FGM is practised are questioned by two officers to see whether FGM has taken place. The stated goal is to demonstrate that the national authorities take the fight against FGM seriously. I regret however that this operation is not also conducted at the time of departure for these countries, in order to strengthen its preventive dimension.

30. Lastly, I would stress that alongside tougher legislation there must be arrangements to help victims. It is imperative for girls fearing they could be subjected to FGM or those who have been subjected to it to have access to legal services, healthcare, including psychological care, emergency helplines and shelters when they flee from their families.

### 3.2. Training for professionals, medical care and information exchange

31. Training for professionals is vital not only to detect instances of FGM and flag up girls at risk, but also to deal with the consequences of FGM. In the meetings I had when preparing my report, I was often told that FGM was sometimes detected only at the time of childbirth, even though the woman had been under a gynaecologist during her pregnancy. This reveals a lack of training among the medical profession, or indeed a lack of attention given to these women, which is all the more problematic as childbirth for women who have undergone FGM can lead to very serious complications which will not have been properly anticipated.

32. In the United Kingdom, it has been estimated that roughly 1.5% of women giving birth in England and Wales have been subjected to FGM.<sup>25</sup> Accordingly, it is essential that professionals have the proper training so that these women can be given appropriate care. The training of midwives is decisive in this regard because they are sometimes the only medical personnel to whom FGM survivors have access.

33. There are 16 clinics in the UK which specialise in FGM care and I was pleased to be able to visit one of them during my fact-finding visit, the African Well Women's Clinic, in Guy's and St Thomas' Hospital, which was established in 1997 by Dr Momoh. The maternity unit takes in at least one woman a day who has suffered FGM. The women are provided with care, counselling and information about the legislation applicable to FGM. Dr Momoh spoke to me of the need to provide access to such care throughout the country. The UK's policy of "dispersing" asylum seekers throughout the country means that it is necessary for such care to be available nationwide, including in sometimes remote areas where the women live. In this connection, I was told that a study is being carried out to identify the standard costs of this care so that in future it will be made available in all National Health Service clinics.

34. In the UK, deinfibulation operations are available on the National Health Service. However, repair and reconstruction operations are not. The reason put forward is that there is no medical proof of the benefits of such operations. However, research is being carried out. Women who wish to undergo such operations therefore travel abroad, for instance to France or Germany. I believe that survivors should be eligible for repair and reconstruction operations. Given its importance, psychological support should be available for survivors before and, if applicable, after the operation. In France, a reconstructive surgery protocol was drawn up and these operations have been fully covered by health insurance since 2003. In Paris and London, I met women who had had reconstructive surgery and was struck by the effect these operations had on them, enabling them to feel whole and women. I firmly believe that survivors should be given this choice and it is for each woman to decide for herself, depending on her own personal history, whether or not to go down that path.

35. When preparing this report, I was also very moved by the words of the activist Nimco Ali who said that when she was a child, she had confided in a female teacher that she had undergone FGM and the teacher had replied "that is what happens to girls like you".<sup>26</sup> Such a reaction shows how important it is for FGM to be considered a criminal offence and gender-based violence against children. Accordingly, it is essential to raise the awareness of professionals in contact with children. As can be seen from this testimony, professionals' lack of training, the fear of stigmatising a community, prejudices and the difficulty of addressing a taboo subject, all prevent instances being reported and make prevention work impossible.

36. In the UK, the introduction of mandatory reporting by professionals in contact with children highlighted the need for better information and training for professionals now required to report cases of FGM. In particular, it is very important to reassure them about the action taken by the police following notification, in particular the proportionality of the responses in relation to the risk factor. Some professionals may be very reluctant to file a report out of fear of disproportionate measures, such as the parents being arrested and their children being placed in institutions. It is therefore important to explain to professionals the procedure followed in such cases and to bring about a change in culture among medical personnel, in particular general practitioners who are sometimes believed to hide behind medical secrecy.

37. Data collection and the sharing of information between medical staff, social services, schools, the police and, where relevant, asylum services are vital for identifying the girls at risk of being subjected to FGM and also for having accurate statistics about the number of women and girls affected by these practices. As the Parliamentary Assembly recently stated in Resolution 2101 (2016), systematic and comprehensive data collection in this field is a precondition for efficient and effective action to combat violence against women.<sup>27</sup>

<sup>25</sup> Macfarlane, Dorkenoo, op. cit., p. 24.

<sup>26</sup> Nimco Ali's war to end FGM, Anne Summers Reports, No. 13, August-September 2015, p. 21.

<sup>27</sup> Resolution 2101 (2016) of 4 March 2016, "Systematic collection of data on violence against women" (see also Doc. 13988, report of the Committee on Equality and Non-Discrimination, rapporteur: Ms Maria Edera Spadoni, Italy, NR).

#### 4. Asylum policy and female genital mutilation

38. According to the UN High Commissioner for Refugees (UNHCR), roughly 16,000 women and girls who sought asylum in an EU member state in 2013 could have already been subjected to FGM prior to their arrival. This equates to 62% of the total number of women and girls coming from countries in which FGM is practised who have requested asylum.<sup>28</sup> Requests for asylum also come from women and girls who are at risk of suffering FGM, a second operation (re-excision, re-infibulation upon marriage or at child birth) or who have had reconstructive surgery and who fear being subjected once again to mutilation upon return, from parents wishing to protect their daughters, and from women who refuse to practise FGM in their countries of origin or who campaign against it.<sup>29</sup>

##### 4.1. Recognition of female genital mutilation as a form of persecution

39. The UNHCR regards FGM as a form of gender-based violence exposing women to serious harm, both physical and psychological, and amounts to persecution within the meaning of Article 1 of the 1951 Geneva Convention relating to the status of refugees.<sup>30</sup> In Resolution 1765 (2010) on Gender-related claims for asylum, the Assembly called on member States to take account of the problems encountered by the victims or potential victims of FGM in the asylum process and to “recognise female genital mutilation and the risk of female genital mutilation as potential grounds for an asylum claim”.

40. This requirement is found in Articles 60 and 61 of the Istanbul Convention which calls on states to interpret the 1951 Geneva Convention in a gender-sensitive way, to recognise gender-based violence as a form of persecution and of serious harm giving rise to subsidiary protection and not to return anyone to a country where his or her life would be at risk and where he or she could be subjected to torture or inhumane or degrading treatment or punishment. Since the definition of refugee given by the Geneva Convention does not take account of gender, the international protection afforded by the Istanbul Convention is of paramount importance. It has made it possible to take a major step forward in the protection of women refugees who have been victims of violence by introducing a gender-sensitive interpretation of the definition of refugee.

41. At this point, an adverse effect of the recognition of FGM as a form of persecution has to be mentioned. Women wishing to emigrate are occasionally encouraged to undergo excision on the ground that this could help them obtain a residence permit. Incitement to undergo or have someone else undergo genital mutilation should be severely punished.

##### 4.2. The introduction of gender-sensitive asylum procedures

42. There is a clear need to put in place specific procedures to deal with asylum requests so as to improve the quality of processing and to eliminate as far as possible the procedural difficulties for women and girls seeking asylum. This means reviewing reception procedures, which must also be gender-sensitive, and women’s support services.

43. Moreover, there is a pressing need to train and raise the awareness of staff in connection with FGM so that they can be more understanding of and receptive to asylum-seekers who relate their story to them and in this way be in a better position to take their requests into consideration. The United Kingdom issued an asylum policy instruction containing guidance for caseworkers on how to address gender-based violence issues, and especially issues relating to FGM, including the need to utilise gender-sensitive procedures.<sup>31</sup>

44. On 23 October 2015, I attended a conference on FGM organised by GAMS-Belgium and Intact, during which Ms Geetui Daem from the Belgian Refugee Council explained that in Belgium, asylum-seekers can ask for the protection officer in charge of their file and the interpreter, where there is one, to be of the same sex as the applicant. She underlined the importance of complying with these requests and, in the case of couples, offering an individual interview with the women. In point of fact, when a couple was seen together, the woman’s specific situation often receded into the background. Experience had shown that women did not immediately talk about violence they had suffered, including domestic violence. Often, it was only once an

<sup>28</sup> UNHCR, Too much pain, Female Genital Mutilation and Asylum in the European Union, A Statistical Update, March 2014, 36 p.

<sup>29</sup> UNHCR, Too much pain, Female Genital Mutilation and Asylum in the European Union, A Statistical Overview, February 2013, p.33.

<sup>30</sup> UNHCR, “Guidance note on refugee claims relating to female genital mutilation”, May 2009. At European Union level, under Article 9 of the EU “Qualification” Directive (Directive 2011/95/EU of the European Parliament and the Council of 13 December 2011) an act of persecution can take the form of an act of a gender-specific nature and comprise acts of physical or mental violence, including acts of sexual violence.

<sup>31</sup> EIGE, Good practices in combating female genital mutilation, 2013, p.15.

initial asylum application had been rejected that they spoke of such violence. Furthermore, as FGM was an acknowledged ground of persecution, the officers dealing with asylum applications should spontaneously conduct some research when there is a high FGM prevalence rate in the country of origin. They should be proactive and ask questions about the practice in order that prevention is raised with the applicant, in particular when daughters are present. Reception centres should also be proactive in identifying at-risk groups in order to conduct prevention.

## 5. Preventing female genital mutilation: complex challenges to be addressed

45. There are very many challenges to be addressed in the fight against FGM. Prevention is clearly the most important challenge to tackle, as it involves changing attitudes, not only among the members of the communities concerned but also among professionals in contact with women and girls from those communities. When preparing my report, three other challenges struck me as being particularly significant of the complexity of this issue.

### 5.1. Continuation of the practice in immigrant communities

46. The existence and persistence of FGM in Europe are linked to immigration. Although the available studies tend to show that the practice of FGM diminishes over time in immigrant populations,<sup>32</sup> members of communities which practise FGM continue to do so once they have settled in European countries, either in the country itself or during holidays in their country of origin.

47. There are a variety of reasons for this persistence of FGM, in particular the need to feel a sense of belonging to a community which is felt much more intensely in a migration context. For example, maintaining the practice is connected to a certain extent with upholding traditions to overcome any feeling of betrayal – towards the whole community and in particular one's ancestors.

48. In addition, the question of losing one's identity is very much present along with, once again, social pressure. In France, for example, it has been observed that parents from countries where FGM is practised "are faced with two competing views: in France, excision is regarded as sexual mutilation and a serious violation of human rights, whereas in their country of origin, anyone wishing to be seen as a good parent must have their daughters excised (and their sons circumcised). Migrants are obliged to reconcile these two contradictory imperatives. This paradoxical situation may prompt the parents to resort to strategies resulting in the excision of just one or at least not all of their daughters."<sup>33</sup>

49. So, the question is how can we prevent this practice from continuing? To answer this question we also need to consider how we can encourage a change in the social norms prevailing in immigrant communities. It is essential to get across the message that abandoning the practice of FGM does not mean abandoning one's identity. And to do that, we need to be able to foster a change of perception so that FGM is no longer seen as a positive and beneficial practice but as one that is harmful to women and girls.

50. The involvement of communities is therefore decisive for winning the fight against FGM. The best laws will not change cultural and traditional practices without the involvement of the communities themselves. To that end, exchanges and co-operation between organisations from the communities and the national authorities must constantly be stepped up. Through their grassroots knowledge, the relevant organisations can play a key role as intermediaries within immigrant communities and communities in the countries of origin. The emancipation of women, and of men who also have a role to play in convincing members of their communities to abandon these practices, is a prerequisite. Nevertheless, it is essential to keep in mind that this is a subject which remains in the private sphere and which may be difficult for the persons concerned to discuss. Singling out this practice as harmful must on no account stigmatise those who carry it out and the whole community.

<sup>32</sup> EIGE, op. cit., 2015.

<sup>33</sup> INED, *Rapport final - Volet qualitatif du projet Excision et Handicap (ExH) Comment orienter la prévention de l'excision chez les filles et jeunes filles d'origine Africaine vivant en France: Une étude des déterminants sociaux et familiaux du phénomène*, 2009, p.15.

## 5.2. *The medicalisation of the practice*

*“A doctor or carer who carries out an act of mutilation commits a crime against the women who trust them, against the spirit and ethics of medicine, and against society”<sup>34</sup>*

51. The WHO reports that information campaigns targeting communities and especially excisers, focusing on the medical consequences of these practices, have failed to stop the practice of FGM.<sup>35</sup> These campaigns have, in contrast, led to increased medicalisation of FGM, but without drastically reducing the number of genital mutilations carried out. Indeed, as the risks of infection and numerous deaths were linked to the conditions in which FGM was carried out, families were increasingly inclined to go to health-care professionals in order to reduce the health risks. The WHO states that in countries for which data are available, 18% of FGM procedures have been performed by health-care providers, although there are large variations between countries.<sup>36</sup> This is particularly the case in Egypt, where a recent analysis of data collected in 2014 among mothers showed that FGM of daughters aged 0-19 had been carried out by trained medical personnel in 82% of cases<sup>37</sup> despite the fact that they have been forbidden to do so since 1997.

52. The international organisations active in the health field have repeatedly condemned the medicalisation of FGM not only as a violation of fundamental rights and medical ethics, but also because it helps legitimise this practice among the communities concerned and, consequently, prevents it from being brought to an end. Furthermore, as Dr Pierre Foldès points out, this medicalisation of genital mutilation tends to be viewed by non-medical experts, and in particular asylum officials, as a minor procedure which therefore could not be regarded as persecution within the meaning of the 1951 Convention relating to the status of refugees.<sup>38</sup>

53. The training of doctors on the ethical and legal aspects of FGM, and its toll on the lives of women, must be stepped up. I welcome the recently published WHO guidelines on the management of health complications from FGM which clearly set out the principle that the medicalisation of FGM is never acceptable and “violates medical ethics since (i) FGM is a harmful practice; (ii) medicalisation perpetuates FGM; and (iii) the risks of the procedure outweigh any perceived benefit.”<sup>39</sup> States must ensure that doctors carrying out FGM are prosecuted and convicted. Such doctors should also be subject to disciplinary sanctions ordered by the professional organisations to which they belong.

## 5.3. *Secrecy*

54. The secrecy that surrounds the practice and its victims is also a major challenge. It is a barrier to the prosecution of those carrying out FGM in countries where it is a criminal offence. The social dynamics of this practice are stronger than the will to put an end to it and prosecute those who allow it to continue despite its being prohibited by law. This secrecy also means that it is extremely difficult for women and girls to talk about it and therefore to receive appropriate care, whether medical or psychological, if they so wish, or simply proper care during pregnancy or at childbirth. Moreover, it is even more complicated for the competent authorities - and indeed for anyone - to identify a girl in danger when nothing is said by those around her or by herself directly. I therefore believe that it is of paramount importance for people to speak freely and to ensure that this is no longer a taboo subject, so that women and girls can confide in each other more openly, obtain help or indeed offer help to a woman or girl they know who is at risk of being subjected to FGM.

55. The secrecy and taboo surrounding FGM significantly complicate the collection of reliable data on the number of women who have been subjected to mutilation or girls who are at risk. And yet, it is well-known that data are essential to enable states to frame appropriate policies.

56. In this context, awareness-raising, information and education campaigns are of vital importance for breaking the taboo. I would like to pay tribute to the dynamism and commitment of the non-governmental organisations tirelessly working to provide information, initiate dialogue and provide training on combating FGM, despite the lack of long-term financial resources with which they often have to cope. Their involvement

<sup>34</sup> Pierre Foldès, Frédérique Martz, “The medicalisation of female genital mutilation”, Mini-feature, Forced Migration Review, Refugee Studies Centre, University of Oxford, May 2015, p.7.

<sup>35</sup> WHO, op. cit., 2012, p. 8.

<sup>36</sup> Global strategy to stop health-care providers from performing female genital mutilation UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, MWIA, WCPA, WMA, 2010.

<sup>37</sup> Ministry of Health and Population, Egypt Demographic and Health Survey 2014, May 2015, p.191.

<sup>38</sup> Foldès, Martz, op. cit., 2015, p.6.

<sup>39</sup> WHO guidelines on the management of health complications from female genital mutilation, May 2016.

in the efforts to prevent FGM is decisive as they have access to the communities concerned. The community aspect of the persistence of FGM must be part of any campaign to bring about an end to these practices: one family on its own would be excluded and marginalised whereas several families acting together could have a real impact on their community. The action of these organisations should therefore be given financial support if we wish to win the battle against FGM.

#### 5.4. *The involvement of men*

*“Although aware of their power, [men] do not use it. Unwilling to disturb the established order, they are happy to allow FGM to remain a woman’s issue”<sup>40</sup>*

57. Prevention work must include all members of the family and the community – not only women and children but also men who too often stand back from discussions on FGM. The UN Office of the High Commissioner for Human Rights stated the following: “As fathers, brothers, husbands, community and religious leaders and politicians, men hold many of the decision-making roles that allow the practice to continue and can play a role in ending female genital mutilation and other harmful practices”.<sup>41</sup> Furthermore, a recent UNICEF study clearly showed that men can be agents for change in a number of countries insofar as there are very many who claim to be opposed to FGM, often more than women think, or more opposed to the practice than women themselves.<sup>42</sup>

58. In the course of my fact-finding visit to the UK, the importance of the part which men and fathers can play in combating FGM was underlined several times during my discussions. The EU-funded Men Speak Out project currently in progress focuses specifically on the involvement of men and I was fortunate to meet one of its representatives in the UK. Men’s views can make a difference and must be heard more clearly. I firmly believe that men must play their part in combating FGM and publicly express their opposition to a practice which is perpetuated for them.

## 6. Conclusions

59. FGM is a serious violation of human rights and the inalienable right of women and children to their physical integrity. Their body belongs to them; it does not belong to their parents or the community of which they are members. Several of the survivors I met underlined how important it was for them to feel “complete”. One of them told me, “I want to be a woman. I am empty. Our parents have ruined our lives”. These words clearly show the distress that survivors can feel and their failure to understand how this practice can still continue. We must listen to them, put them at the centre of our discussions and step up our efforts to bring an end to FGM.

60. The fight against FGM is a complex one, because it necessitates having an understanding of the cultural context of the communities which practice it, avoiding stigmatisation and coming up with a concerted, multi-disciplinary and long-term response. The only way to win this fight is to involve all the players concerned, and first and foremost the communities themselves, not only the women but also the men in these communities. States also have their share of responsibility in the fight against FGM by making diligent efforts to prevent, investigate, punish and remedy acts of violence committed against anyone under their jurisdiction, as required of them by the European Convention on Human Rights and the Istanbul Convention.

61. Lastly, I would like to mention that the fight against FGM can also be waged in the context of international co-operation and development aid. The transnational nature of FGM requires solutions which are also transnational. No country can bring an end to FGM by acting in isolation. It is therefore of paramount importance to build bridges between the countries concerned by FGM and support the action taken by local organisations. For example, countries such as the United Kingdom and Sweden invest in prevention programmes in the countries affected by FGM based on the idea that changes in cultural practices in the countries of origin will also bring about changes within the communities settled in Europe. As members of parliament, we must also, in our friendship groups and through our development aid, make every effort to support initiatives to eradicate FGM and ensure that the FGM issue remains on the political agenda as long as necessary.

<sup>40</sup> Séverine Carillon, Véronique Petit, “La pratique des mutilations génitales féminines à Djibouti: une “affaire de femmes” entre les mains des hommes”, *Autrepart* (52), 2009, p.24.

<sup>41</sup> United Nations Office of the High Commissioner for Human Rights, “Compilation of good practices and major challenges in preventing and eliminating female genital mutilation”, A/HRC/29/20, 27 March 2015, p.10.

<sup>42</sup> UNICEF, *op. cit.*, 2013, pp.57 and 62-63.