



## **ENDING FEMALE GENITAL MUTILATION TO PROMOTE THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS**

The Millennium Declaration represents the international community's commitment to further development in line with an agreed framework of eight Millennium Development Goals (MDGs) to be achieved by 2015.

In the UN General Assembly's High Level Forum on 20-22 September 2010, the progress on these goals will be reviewed. The European Union has stated a strong commitment to this framework in the European Consensus on Development, which represents the common values and principles held by the European Commission and the EU Member States.

### **HUMAN RIGHTS AND THE MDGs**

The UN has taken significant steps to develop tools for mainstreaming human rights into poverty reduction strategies, yet there still exist crucial gaps between the recognition of the importance of human rights for development and the practical application of human rights into all MDG efforts. Human rights require that poverty reduction efforts address discrimination; advance equality and gender equality; give adequate focus to the most marginalised and vulnerable people and communities; prioritise the realisation of minimum essential levels of economic, social and cultural rights for all; and provide for participation of all people in decisions affecting their rights. Human rights have mobilising potential and help build support for the action required to meet the MDGs, as such actions are required by international human rights law.

As stated in the UN Commission on Population and Development Resolution on Health, Morbidity, Mortality and Development: "advances in health depend on the effective protection of human rights, the promotion of gender equality and the empowerment of women, and the elimination of gender-based discrimination [...] by instituting zero tolerance regarding violence against women and girls, including harmful traditional practices such as female genital mutilation or cutting".

MDG based strategies often fail to reflect internationally recognised and legally binding human rights standards, thus missing an important opportunity to enhance their effectiveness. There further continues to be insufficient attention given to human rights violations that undermine efforts towards the MDGs and to addressing discrimination - including gender discrimination and inequality - in MDG strategies. The UN recognises that violence against women, in all its forms, presents a serious obstacle to the achievement of the MDGs. The practice of female genital mutilation (FGM) is a threat to the achievement of several MDGs and this negative impact should be highlighted in the upcoming High Level Review of the MDGs in September 2010.

## **FEMALE GENITAL MUTILATION**

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

FGM can take diverse forms and have different effects on women and girls. In every case it entails the cutting, stitching or removal of part or all of the female external genital organs for non-therapeutic reasons. The mutilation of healthy body parts has a detrimental impact on the health and well-being of women and girls. There are several forms of FGM and these differ from community to community.

The most recent World Health Organisation (WHO) classification from 2008 divides FGM into four types:

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

Immediate consequences of FGM include excessive bleeding and septic shock, difficulty in passing urine, infections and sometimes death. In addition to the severe pain during and in the weeks following the cutting, women who have undergone FGM experience various long-term effects - physical, sexual and psychological.

Long-term consequences include chronic pain, chronic pelvic infections, and development of cysts, abscesses and genital ulcers. There can be excessive scar tissue formation, infection of the reproductive system, decreased sexual enjoyment and painful intercourse. Although the scientific research addressing the psychological consequences of FGM is limited, documented psychological consequences include fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss.

## **FGM AND HUMAN RIGHTS**

FGM, in any form, is recognised internationally as a gross violation of human rights of women and girls. The practice denies women and girls their right to: physical and mental integrity; freedom from violence; the highest attainable standard of health; freedom from discrimination on the basis of sex; freedom from torture, cruel, inhuman and degrading treatments; life (when the procedure results in death).

These rights are protected in several international instruments, treaties and consensus documents, including:

- UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- UN Convention on the Elimination of all Forms of Discrimination against Women
- UN Convention on the Rights of the Child
- UN Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees
- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa (Maputo Protocol)
- African Charter on the Rights and Welfare of the Child
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- Charter of Fundamental Rights of the European Union
- Beijing Declaration and Platform for Action of the Fourth World Conference on Women
- UN General Assembly Declaration on the Elimination of Violence against Women
- Programme of Action of the International Conference on Population and Development

## **FGM AND THE MILLENNIUM DEVELOPMENT GOALS**

- **MDG 3 - Promote Gender Equality and Empower Women**

The target of MDG 3 is to eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. The technical indicators agreed for the monitoring of progress focus on: the ratios of girls to boys in primary, secondary and tertiary education; the share of women in wage employment in the non-agricultural sector; and the proportion of seats held by women in national parliament.

Violence against women is one of the most serious and damaging structural disadvantages that impede gender equality and women's empowerment. The practice of FGM and other harmful traditional practices perpetuate these structural disadvantages and effectively hinder the full empowerment of women in all areas of society. In relation to the technical indicators agreed for MDG 3: the physical and psychological consequences of FGM cause girls to miss school thereby putting them in a distinct disadvantage in all levels of education; women's participation in wage employment and political life is hampered by the continued physical difficulties that they often experience as a result of FGM.

- **MDG 4 - Reduce Child Mortality**

The target of MDG 4 is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. The technical indicators agreed for the monitoring of progress focus on:

under-five mortality rate; infant mortality rate; and the proportion of 1 year-old children immunised against measles.

FGM is often practiced on infants and young girls with possible severe health consequences, sometimes death. Moreover, women who have been subjected to FGM commonly experience increased difficulties in child delivery and studies have shown that FGM contributes to still births and neonatal deaths. According to a WHO study conducted in six Sub-Saharan countries it is estimated that “in the African context an additional 10 to 20 babies die per 1000 deliveries as a result of the practice”.

The UN estimates that in 27 countries there has been no progress in reducing childhood death rates since the adoption of the goal in 1990 and the large majority of these countries are in Sub-Saharan Africa. While the causes of child mortality are many - including malnutrition, malaria and preventable diseases such as measles - the high prevalence of FGM in many countries in Sub-Saharan Africa cannot be ignored in this context in view of the documented negative impact of the practice on infant mortality.

- **MDG 5 - Reduce Maternal Mortality**

The first target of MDG 5 is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. The technical indicators agreed for the monitoring of progress focus on: the maternal mortality ratio and the proportion of births attended by skilled health personnel. The second target of MDG 5 is to achieve, by 2015, universal access to reproductive health. The technical indicators agreed for the monitoring of progress focus on: contraceptive prevalence rate; adolescent birth rate; antenatal care coverage; and unmet need for family planning.

FGM is associated with a range of health complications around pregnancy and childbirth, including fistulas resulting from obstructed labour and an elevated risk for emergency caesarean sections which can be a severe challenge in resource poor locations with few births attended by skilled health personnel in hospital settings. Sub-Saharan Africa is the region with the highest maternal mortality rates and where there has been little or no progress to date according to UN estimates. The causal connection of FGM to obstructed labour and pregnancy related health complication is not commonly known amongst FGM practicing communities. There is therefore a clear need for research findings to be communicated not only in international settings but also at national and local level to raise awareness of the serious health consequences connected with FGM. In view of the elevated risk for childbirth complications, improved antenatal care coverage is essential for women living with FGM.

- **MDG 6 - Combat HIV/AIDS, Malaria and other diseases**

Of the three targets defined for MDG 6, the first two have links to the prevalence of FGM. The first target of MDG 6 is to have halted by 2015 and begun to reverse the spread of HIV/AIDS. The technical indicators agreed to monitor progress focus on HIV prevalence among population aged 15-24 years; condom use at last high-risk sex; proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS and the ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years. The second target of MDG 6 is to achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. The technical indicator agreed to monitor progress focus on: the proportion of population with advanced HIV infection with access to antiretroviral drugs.

Medical research indicates that the practice of FGM increases the risks of HIV transmission to women. FGM is often carried out on several girls at the same time, using the same knife or razorblade without it being disinfected between the individual procedures thus resulting in high risk of transmitting the infection between the girls. Women who have been subjected to FGM are also at greater risk for vaginal tears during intercourse, rendering them more vulnerable to being infected with the virus. Finally, the increased risk of obstructed labour and health complications during pregnancies can lead to haemorrhaging and need for blood transfusions, again an increased risk to be taken into account in populations with high prevalence of HIV/AIDS.

## **NEXT STEPS FOR THE EUROPEAN UNION**

As stated in the report of the Secretary General of the UN General Assembly on the Girl Child, ending FGM will contribute to the achievement of the MDGs and to the implementation of the Convention of the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Hence, development of legal, policy and prevention measures at community level to end FGM is necessary to the achievement of MDG 3, 4, 5 and 6.

Respect for human rights, equality between women and men, protection of the rights of the child are founding values of the European Union. These values should be promoted and enhanced in the EU internal and external activities, policies and legislation. The EU through its Belgian Presidency needs to ensure these values are at the core of its position at the UN forum, in particular during the meeting on the revision of the MDGs in September 2010. It should ensure that comprehensive and tangible actions are taken to end violence against women and FGM as they directly challenge these values and impede progress on the MDGs.

In addition, the EU institutions need to ensure respect for human rights and coherence of EU's internal and external policies. A human rights based approach to development policies is necessary. Thus the work towards the achievement of the MDGs needs to take on board and to be strengthened by external human rights policies such as the EU guidelines on violence against women and girls and combating all forms of discrimination against them.

## **RECOMMENDATIONS:**

### **THE END FGM EUROPEAN CAMPAIGN CALLS ON:**

- The Spanish and Belgian presidencies of the EU to ensure that violence against women and in particular FGM, one important underlying cause of the lack of progress on the MDGs, is raised and given visibility during the review of the MDGs at the UN. Following from this, indicators should be reviewed and in particular indicators on violence against women and FGM should be included in the MDG 3, 4, 5 and 6.
- The European Parliament to continue linking human rights and the achievement of the MDGs -in its report on human rights in the world- and highlight the underlying factors which prevent the achievement of the MDGs such as violence against women and FGM.
- The European Commission and the EU Member States to take concrete steps to audit/review their MDG policies and strategies to ensure their consistency with international human rights standards, include indicators on violence against women and FGM and their impact on achieving the MDGs.
- The European Commission and the Donors Working Group on Female Genital Mutilation/Cutting to link their initiatives to end FGM with the MDGs, to ensure that their support to end FGM facilitates the participation of people living in poverty in planning, implementation and monitoring at all levels, and in particular focuses on the empowerment and equal participation of women.

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