FINDING HUMANITY PODCAST EDUCATION TOOLKITS
Season 2: Seeking Justice on the Frontlines

EPISODE 3
Gender-Based Violence: A Raging Pandemic | Maryum Saifee

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Our goal is to share our insights, research, policy analysis and key findings with hopes to inspire continued engagement and learning around the podcast episodes and the substantial content and topics unearthed in each episode.

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About the Finding Humanity Podcast | Season 2:
For some, fighting for change means risking it all, one's own life. As history has taught us, fighting grave injustice requires courage, perseverance and grit. In season 2 of Finding Humanity Podcast, we unpack the stories of people on the frontlines of change. People who put their bodies on the line to create an equitable and just world. Learn More

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EPISODE INFORMATION

Main topics in Episode: female genital mutilation, gender-based violence

Short Description of Episode:
This episode highlights the issue of female genital mutilation or FGM, a form of physical gender-based violence against women. Affecting 1 in 3 women, FGM is a practice prevalent among girls and women in Western, Eastern, and North-Eastern regions of Africa, in some countries in the Middle East and Asia, as well as among migrants from these areas. It is a social convention, associated with cultural ideas of femininity and cleanliness and promoted in many areas as a form of supposed protection (of premarital virginity and marital fidelity). FGM is a hidden form of violence. Often victims are unaware that they have been cut. But its impacts are significant in the form of long-term physical, mental and sexual trauma. Although condemned internationally, FGM is firmly rooted in societal and cultural norms on the role of women and their bodies. Therefore, shifting the dial on the issue and abandoning it must be community led, non-judgmental and integrated with efforts to empower girls and women.

Female Genital Mutilation/Cutting

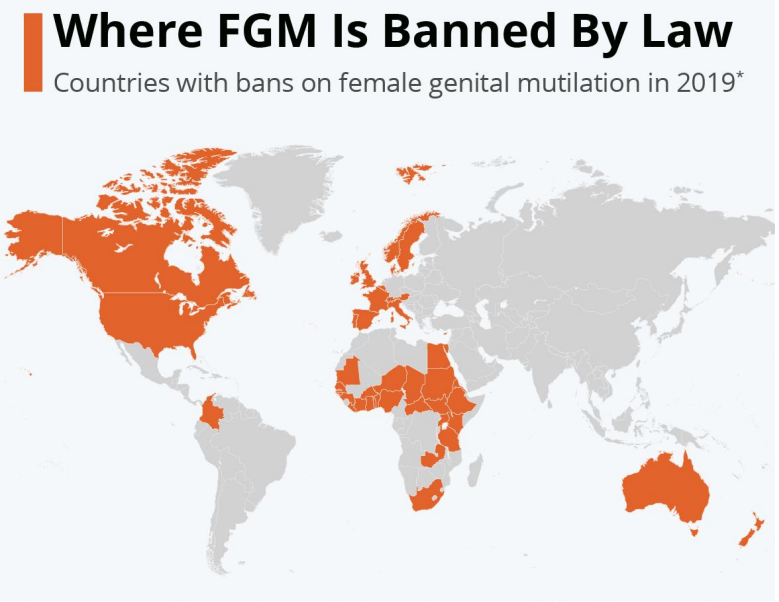
Overview:
Source: Statista

Female genital mutilation/cutting (FGM/C)[1] comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. This practice transcends race, religion, geography, and class.

The history of FGM/C is not well known, but the practice dated back at least 2000 years. Many commentators believe that the practice evolved from earliest times in primitive communities that wished to establish control over the sexual behaviour of women. The Romans performed a technique involving slipping of rings through the labia majora of female slaves to prevent them from becoming pregnant.

[1] FGM/C is referred to by a variety of names. See below the discussion about the language of FGM/C. In this toolkit the FGM/C terminology is applied, due to the fact that FGM abbreviation is widely-known, and the term "cutting" is respectful and best reflects the procedure

The practice is supported by traditional beliefs, values and attitudes. In some communities it is valued as a rite of passage to womanhood. Others value it as a means of preserving a girl's virginity until marriage. In some countries FGM/C is a pre-requisite to marriage and marriage is vital to a woman' s social and economic survival.



FGM/C is rooted in culture and some believe it is done for religious reasons, but it has not been confined to a particular culture or religion. FGM has neither been mentioned in the Quran nor Sunnah.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM due to the belief that the procedure is safer when medicalized1. WHO strongly urges health care providers not to perform FGM/C.

FGM/C is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Several countries have passed national legislation banning FGM/C. Penalties range from a minimum of six months to a maximum of life imprisonment. Several countries also include monetary fines in the penalty.

Sources/Extracted from:
WHO, FGM Key facts, link
UNFPA, FGM FAQ, link
FGM National Group, History FGM, link

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Quick Facts & Data

Gender based violence:

- 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. [1]
- Globally, 7% of women have been sexually assaulted by someone other than a partner. [1]
- Globally, as many as 38% of murders of women are committed by an intimate partner. [1]
- 137 women are killed by a member of their family every day. [2]
- In 2019, one in five women, aged 20–24 years, were married before the age of 18. [2]
- Less than 40 per cent of the women who experience violence seek help of any sort. In the majority of countries with available data on this issue, among women who do seek help, most look to family and friends and very few look to formal institutions, such as police and health services. Less than 10 per cent of those seeking help appealed to the police. [2]
- Calls to helplines have increased five-fold in some countries, as rates of reported intimate partner violence increase because of the COVID-19 pandemic. [2]
- By September 2020, 48 countries had integrated prevention and response to violence against women and girls into COVID-19 response plans, and 121 countries had adopted measures to strengthen services for women survivors of violence during the global crisis, but more efforts are urgently needed. [2]

Female Genital Mutilation:

- 200 million women have experienced female genital mutilation/cutting. [1]
- FGM is not the same as male circumcision (the male equivalent of FGM is castration) [1]
- CDC estimates 513,000 women and girls in the US have undergone FGM or are at risk of undergoing FGM [1]
- In 2015, an estimated 3.9 million girls had FGM globally. [3]
- The number of girls to have FGM each year is projected to rise to 4.6 million by 2030. [3]

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- 15 million will have FGM by 2030 in Indonesia. [3]

Sources/Extracted from:
[1] WHO, Fact sheets, link
[2] UN Women, Facts and figures, link
[3] UNFPA, FGM Data, link

Topical Background Information & Context

GENDER BASED VIOLENCE

Gender based violence (GBV) is violence directed against a person because of that person's gender or violence that affects persons of a particular gender disproportionately. Violence against women is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in: physical harm, sexual harm, psychological or economic harm or suffering to women.

GBV can take various forms:

Physical: it results in injuries, distress and health problems. Typical forms of physical violence are beating, strangling, pushing, and the use of weapons. In the EU, 31 % of women have experienced one or more acts of physical violence since the age of 15
Sexual: it includes sexual acts, attempts to obtain a sexual act, acts to traffic, or acts otherwise directed against a person's sexuality without the person's consent. It's estimated that one in 20 women (5 %) has been raped in EU countries since the age of 15
Psychological: includes psychologically abusive behaviours, such as controlling, coercion, economic violence and blackmail. 43% of women in the 28 EU countries have experienced some form of psychological violence by an intimate partner.

Examples of gender-based violence: domestic violence, sex-based harassment, female genital mutilation/cutting, forced marriage, online violence.

INTERNATIONAL NORMS ON VIOLENCE AGAINST WOMEN

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, is often described as an international bill of

rights for women. Consisting of a preamble and 30 articles, it defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination.

The 1979 Convention on the Elimination of all Forms of Discrimination against Women(CEDAW) does not explicitly mention violence against women and girls, but General Recommendations 12 and 19 clarify that the Convention includes violence against women and makes detailed recommendations to States parties.

The 1993 World Conference on Human Rights recognized violence against women as a human rights violation and called for the appointment of a Special Rapporteur on violence against women in the Vienna Declaration and Programme of Action. It contributed to the 1993 Declaration on the Elimination of Violence against Women.

The 1993 Declaration on the Elimination of Violence against Women became the first international instrument explicitly addressing violence against women, providing a framework for national and international action. It defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

In 2003, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the "Maputo Protocol") was adopted by Members of the African Union with the sole aim of upholding the rights of women and girls in Africa. The Maputo Protocol is a binding legal framework that holds African governments to account for the continued gross violation of the rights of women and girls in Africa. They set a 2020 deadline for ratification. However, with less than 6 months to go until the end of 2020, 13 countries are yet to ratify it including three that have neither signed nor ratified it. The Protocol guarantees extensive rights to African women and girls and includes progressive provisions on:

- Harmful traditional practices, eg child marriage and FGM/C
- Reproductive health and rights
- Roles in political processes
- Economic empowerment
- Ending violence against women

The 2011 Council of Europe Convention on preventing and combating violence against women and domestic violence became the second legally binding regional instrument on violence against women and girls but, unlike other regional agreements, it can be signed and ratified by any State.

FGM is practised on girls usually in the range of 0-15 years. Hence, the practice of FGM violates children's rights as defined in the Convention on the Rights of the Child (CRC):

- The right to be free from discrimination (Article 2);
- The right to be protected from all forms of mental and physical violence and maltreatment (Article 19(1));
- The right to highest attainable standard of health (Article 24);
- The right of freedom from torture or other cruel, inhuman or degrading treatment or punishment (Article 37).
- According to the UN Committee on CRC, "discrimination against girl children is a serious violation of rights, affecting their survival and all areas of their young lives as well as restricting their capacity to contribute positively to society" (2005).

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

Because it is performed without the consent of the girls, it also breaches the right to express one's view (Article 12). Even if the girl child is aware of the practice, the issue of consent remains, as girls are usually too young to be consulted and have no voice in the decision made on their behalf by members of their family. On the other hand, adolescent girls and women very often agree to undergo FGM because they fear the non-acceptance of their communities, families and peers, according to 2008 Report of the Special Rapporteur on Torture.

FGM also impacts on the right to dignity and directly conflicts with the right to physical integrity, as it involves the mutilation of healthy body parts.

The Committee on the Convention on the Rights of the Child has said that States party to the Convention have an obligation "to protect adolescents from all harmful traditional practices, such as early marriages, honour killings and female genital mutilation" (2003).

Sources/Extracted from:
UN, Women Watch, CEDAW, link ; UN, CEDAW, link

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On the language of FGM/C

Female Genital Mutilation (FGM) is the current terminology used by the World Health Organisation (WHO) and is familiar to most Health Care Professionals. The term "female circumcision" is inappropriate as it implies that the procedure is analogous to male circumcision when in fact a much more extensive amount of tissue is removed. Women themselves may however refer to it as circumcision. The word "mutilation" although accurate can be seen as judgemental and can be offensive and in some situations the term Female Genital Cutting is a more sensitive term to use.

Gannon Gillespie, Tostan's former Director of Strategic Development explains for the Orchid Project that:

'most importantly, we should be very cautious in labeling and stigmatizing the girls and women who have been cut. We do not believe it is our place to tell them that they are "mutilated." As with other victims of violence, we believe they have the human right to self-identify in whatever manner they choose. Some prefer to call themselves mutilated, others simply "cut," many others say less, or nothing, as they are not yet comfortable being public about this very private matter. We believe women should be free to choose the term that best defines them, and that the term "mutilated" should not be forced upon them'

Sources/Extracted from:
Orchid project, Term FGC, link
FGM National Group, Terminology, link

TYPES OF FGM

Female genital mutilation is classified into 4 major types.

Type 1: partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans).

Type 2: partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).

Type 3: also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans (Type I FGM/C).

Type 4: includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Types 1 and 2 are most prevalent, but variation exists within countries and communities. Type 3 – infibulation – is experienced by about 10% of all affected women.

Sources/Extracted from:
WHO, FGM Key facts, link

PREVALENCE OF FGM/C

The practice predates the rise of Christianity and Islam. It is said that some Egyptian mummies display characteristics of FGM/C. Historians such as Herodotus claim that, in the fifth century BC, the Phoenicians, the Hittites and the Ethiopians practised circumcision.

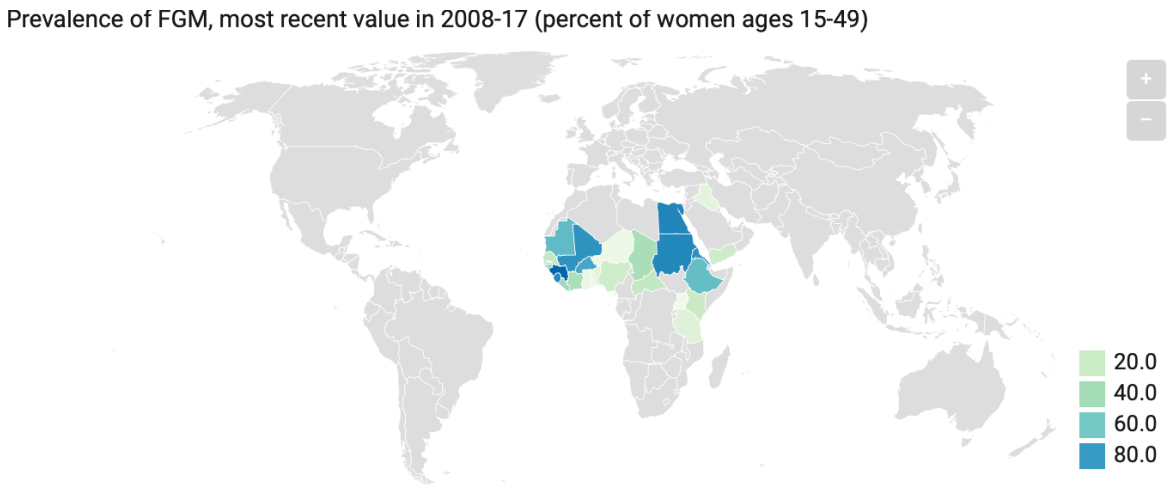
It is also reported that circumcision rites were adopted in tropical zones of Africa, in the Philippines, by certain tribes in the Upper Amazon, by women of the Arunta tribe in Australia, and by certain early Romans and Arabs. As recent as the 1950s, clitoridectomy was practised in Western Europe and the United States to treat perceived ailments, including mental and sexual disorders.

Today, the practice can be found in communities around the world. A**nd while it is often thought to be connected to Islam, it is not endorsed by Islam, and many non-Islamic communities practice FGM/C.** Yet no religion promotes or condones it, and many religious leaders have denounced it.

FGM is known to be practised in:

- 27 countries in Africa and Yemen, especially in the eastern, north-eastern and western regions;
- some countries in Asia and the Middle East;
- immigrants from these countries wherever they live, including in Australia, Canada, Europe, New Zealand and the USA; and

- a few population groups in Central and South America (2)



Demographic and Health Surveys; Multiple Indicator Cluster Surveys; UNICEF Data

In the 28 countries in Africa and the Middle East for which data are available, national prevalence among women aged 15 years and older ranges from 0.6% (Uganda, 2006) to 97.9% (Somalia, 2006) (2). There are some regional patterns in FGM prevalence. According to Demographic Health Surveys done during 1989–2002, within north-eastern Africa (Egypt, Eritrea, Ethiopia and northern Sudan), prevalence was estimated at 80–97%, while in eastern Africa (Kenya and the United Republic of Tanzania) it was estimated to be 18–38%. However, prevalence can vary strikingly between different ethnic groups within a single country. FGM has been documented in several countries outside Africa but national prevalence data are not available.

FGM/C in Europe

It is estimated that over 600,000 women are living with the consequences of FGM in Europe and that a further 180,000 girls and women are at risk of undergoing the harmful practice in 13 European countries alone. Moreover UNHCR estimates that every year for the past five years at least 20,000 women and girls asylum seekers coming to Europe might be affected by FGM. This number is taken summing different studies done at national level with the numbers from an overall study based on the 2011 European Census to fill the research gaps where needed. FGM exists in Europe and has been around for a long time. While data does

exist on FGM in Europe, obtaining the figures has always proven to be difficult and hindered by many challenges. Research has shown that there are still many gaps that need to be addressed in order to develop adequate evidence-based national and European policies on FGM.

FGM/C in the USA

More detailed statistics on FGM are needed. In January 2016, in response to advocacy by Equality Now, Safe Hands for Girls, and other civil society partners, the Centers for Disease Control and Prevention (CDC) published a study on the number of women and girls in the U.S. who are at risk of or have been subjected to FGM. According to it, the number is estimated to be 513,000, more than three times higher than an earlier estimate based on 1990 data.

Equality Now was founded in 1992 to address the lack of attention FGM received from international human rights organizations and in 1996 launched a campaign in the U.S. against the detention of 17-year-old Fauziya Kassindja, who had escaped from Togo fleeing FGM and a forced marriage in 1994. In a landmark decision, Fauziya was granted asylum in the U.S. and her case helped establish FGM as a form of gender-based persecution on the basis of which women could receive asylum in the U.S.

More recently, news articles have highlighted cases of girls born in the U.S. being subjected to FGM, sometimes while on vacation in their parents' countries of origin, referred to as "vacation cutting."

WHY IS FGM/C PERFORMED

In every society in which it is practiced, female genital mutilation is a manifestation of deeply entrenched gender inequality. Where it is widely practiced, FGM is supported by both men and women, usually without question, and anyone that does not follow the norm may face condemnation, harassment and ostracism. It may be difficult for families to abandon the practice without support from the wider community. In fact, it is often practiced even when it is known to inflict harm upon girls because the perceived social benefits of the practice are deemed higher than its disadvantages.

The reasons given for practicing FGM fall generally into five categories:

1. **Psychosexual reasons**: FGM is carried out as a way to control women's sexuality, which is sometimes said to be insatiable if parts of the genitalia, especially the clitoris, are not removed. It is thought to ensure virginity before marriage and fidelity afterward, and to increase male sexual pleasure.

2. **Sociological and cultural reasons:** FGM is seen as part of a girl's initiation into womanhood and as an intrinsic part of a community's cultural heritage. Sometimes myths about female genitalia (e.g., that an uncut clitoris will grow to the size of a penis, or that FGM will enhance fertility or promote child survival) perpetuate the practice.

3. **Hygiene and aesthetic reasons:** In some communities, the external female genitalia are considered dirty and ugly and are removed, ostensibly to promote hygiene and aesthetic appeal.

4. **Religious reasons:** Although FGM is not endorsed by either Islam or by Christianity, supposed religious doctrine is often used to justify the practice.

5. **Socio-economic factors:** In many communities, FGM is a prerequisite for marriage. Where women are largely dependent on men, economic necessity can be a major driver of the procedure. FGM sometimes is a prerequisite for the right to inherit. It may also be a major income source for practitioners.

SOCIO-CULTRAL ASPECTS OF FGM/C

The reasons why female genital mutilations are performed vary from one region to another as well as over time, and include a mix of sociocultural factors within families and communities. The most commonly cited reasons are:

- Where FGM is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice. In some communities, FGM is almost universally performed and unquestioned.
- FGM is often considered a necessary part of raising a girl, and a way to prepare her for adulthood and marriage.

- FGM is often motivated by beliefs about what is considered acceptable sexual behaviour. It aims to ensure premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist extramarital sexual acts. When a vaginal opening is covered or narrowed (Type 3), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage extramarital sexual intercourse among women with this type of FGM.
- Where it is believed that being cut increases marriageability, FGM is more likely to be carried out.
- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are clean and beautiful after removal of body parts that are considered unclean, unfeminine or male.
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice. Likewise, when informed, they can be effective advocates for abandonment of FGM.
- In most societies, where FGM is practised, it is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.

VULNERABLE GROUPS AND PERPETRATORS

The risk faced by women and adolescent girls aged 15–19 of undergoing FGM is highly dependent on context, with ethnicity playing a particularly strong role in determining whether they will be cut.

In Kenya, where the practice has been banned under law since 2011, 4 in 10 women and adolescent girls have undergone FGM, although the variation across ethnic groups is dramatic; the practice is still prevalent among some ethnicities(for example, among the Somali population, where it is estimated to be 94%), but almost non-existent among others (including both the Luhya and Luo ethnicities, where it is less than 1%).

Families, communities and cultures in which FGM is performed have different reasons for doing so. A major motivation is that the practice is believed to ensure the girl conforms to key social norms, such as those related to sexual restraint, femininity, respectability and maturity.

FGM differs from most forms of violence against girls and women in that women are not only the victims but also involved in perpetration. A girl's female relatives are normally responsible for arranging FGM, which, in turn, is usually performed by traditional female excisers. FGM is also increasingly being done by male and female health-care providers. This feature of FGM illustrates how both women and men can be complicit in reinforcing gender norms and practices that support violence against women.

Medicalization of FGM/C

A major trend is that health-care providers, such as physicians, nurses and midwives (21,22), are increasingly providing FGM in place of traditional excisers, a phenomenon known as 'medicalization' (8,24). FGM is still carried out primarily by traditional excisers in most countries, but, for example, survey data suggest that girls in Egypt are three times more likely to undergo FGM at the hands of a health-care provider than did their mothers. There are no documented cases of medicalization leading to a reduction in the practice of FGM (24). WHO and other agencies believe that medicalization actually contributes to upholding the practice, by legitimizing it as a health procedure.

HEALTH RISKS

Immediate consequences of FGM include severe pain and bleeding, shock, difficulty in passing urine, infections, injury to nearby genital tissue and sometimes death. The procedure can result in death through severe bleeding leading to haemorrhagic shock, neurogenic shock as a result of pain and trauma, and overwhelming infection and septicaemia, according to Manfred Nowak, UN Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. Almost all women who have undergone FGM experience pain and bleeding as a consequence of the procedure. The event itself is traumatic as girls are held down during the procedure. Risk and complications increase with the type of FGM and are more severe and prevalent with infibulations.

Source: WHO

Immediate health risks	Longer-term health risks
• Severe pain • Shock • Haemorrhage (i.e. excessive bleeding) • Sepsis • Difficulty in passing urine • Infections • Death • Psychological consequences • Unintended labia fusion	• Need for surgery • Urinary and menstrual problems • Painful sexual intercourse and poor quality of sexual life • Infertility • Chronic pain • Infections (e.g. cysts, abscesses and genital ulcers, chronic pelvic infections, urinary tract infections) • Keloids (i.e. excessive scar tissue) • Reproductive tract infections • Psychological consequences, such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression • Increased risk of cervical cancer (although more research is needed)
Known obstetric complications/ risks	**Conditions often considered to be associated with FGM but for which evidence is equivocal or shows no link**
• Caesarean section • Postpartum haemorrhage • Extended maternal hospital stay • Infant resuscitation • Stillbirth or early neonatal death	• HIV (in the short term) • Obstetric fistula • Incontinence

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.

A multi-country study by WHO in six African countries, showed that women who had undergone FGM, had significantly increased risks for adverse events during childbirth, and that genital mutilation in mothers has negative effects on their newborn babies. According to the study, an additional one to two babies per 100 deliveries die as a result of FGM.

Sources/Extracted from:
UNFPA, FAQ FGM, link
Orchid Project, About FGC, link
End FGM, FGM in Europe, link
WHO, FGM Fact Sheet, link
End FGM, What is FGM, link
WHO, Understanding FGM, link

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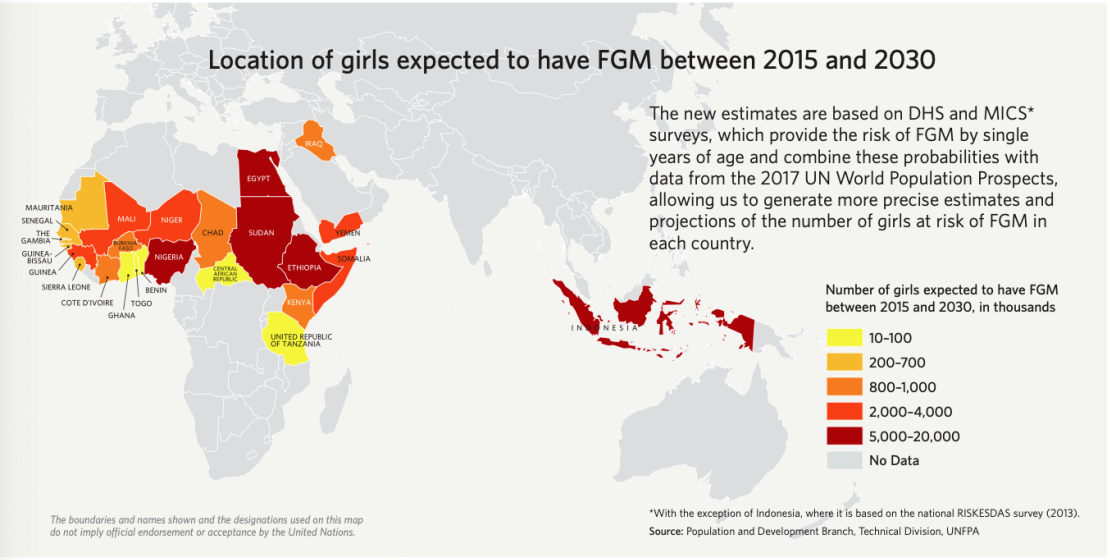
FGM/C - FUTURE PROSPECTS

FGM has drawn increasing international attention in recent decades, including new laws against the practice in countries within and outside Africa (6). While there has been little change in the frequency of FGM in some countries, there is evidence of:

- a large prevalence reduction among younger generations (aged 15–19 years) in a few countries;
- lower prevalence among daughters of educated mothers in some countries;
- less support for FGM among some women in practising communities;
- increasing research and policy change to address FGM among immigrant populations in higher-income countries;
- a reduction in the average age at which a girl is subjected to the procedure in most countries; and
- an increase in the extent to which FGM is being carried out by health-care providers.



FGM is slowly declining in some countries and subregions where the practice is prevalent. Despite recent progress, the prevalence of FGM remains alarmingly high in parts of Northern Africa, Eastern Africa and West Africa. Because COVID-19 is interrupting programmes to end FGM, progress may be threatened. Progress in the elimination of FGM is not universal, and

where it is taking place it is not fast enough. Even in countries where the practice has become less common, progress would need to be at least 10 times faster to meet the global target of its elimination by 2030.

Source: UNFPA

SUSTAINABLE DEVELOPMENT GOAL (SDG Goal 5.3)

Target 5.3 of the SDG aims to "eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation". According to the indicator 5.3.2, "proportion of girls and women aged 15-49 years who have undergone female genital mutilation/cutting".

With its inclusion under Sustainable Development Goal (SDG) target 5.3, which is aimed at the elimination of this harmful practice by 2030, FGM holds a prominent position on the global development agenda. Although the practice has persisted for centuries, it is becoming less common, with a marked decline reported in countries such as Egypt where it was once universal, as well as in countries such as Kenya, where the practice is restricted to specific ethnic communities.

UNFPA/UNICEF Joint Programme to Eliminate FGM/C

UNFPA and UNICEF jointly lead the largest global programme to accelerate the elimination of female genital mutilation (FGM). The UNFPA-UNICEF Joint Programme harnesses the complementary expertise of the two agencies, with governments and often in close collaboration with grass-roots community organizations and other key stakeholders, backed by the latest social science research.

The FGM/C Joint Programme achievements:

- *Provision of appropriate and quality services:* More than 3.2 million girls and women in the 17 countries supported by the Joint Programme have benefited from FGM-related protection and care services.
- *Increased community-led engagement*: As a result of community-led engagement through education, dialogue and consensus-building, more than 31.5 million individuals in over 21,700 communities have made public declarations on the abandonment of FGM.

- *Legal and policy frameworks:* 13 countries supported by the UNFPA-UNICEF Joint Programme have legal and policy frameworks banning FGM. Following intensive capacity development initiatives, to date, there have been more than 900 cases of legal enforcement. Public statements at all levels have announced that FGM is a human right issue and must be stopped. Such statements provide the political backing required to strengthen the community-wide efforts and initiatives.
- *Government ownership*: All 17 countries supported by the UNFPA-UNICEF Joint programme have a national coordination mechanism in place to systematically engage all actors at the national level. Twelve countries established a national budget line funding services and programmes to specifically address FGM.

Starting in 2018, UNFPA and UNICEF are continuing the joint effort, integrating complementary interventions even more systematically under a new phase of the Joint Programme. The joint action builds on valuable lessons learned and is directly linked to the Sustainable Development Goal 5.3, which aims to end all harmful practices by 2030. The focus continues to be on countries with highest FGM prevalence, with the aim of shifting social norms in affected communities while working with governments to put in place viable national response systems.

HOW TO ADDRESS FGM

Ending FGM requires a multi-sectoral approach that brings together law enforcement, child protection professionals, educators, physicians, religious leaders, government agencies, advocates, and survivors. The approach must be holistic and always keep the best interest of the girl or woman who is either at risk of or a survivor of FGM at the center of its efforts.

UNICEF established 6 elements for FGC abandonment:

1) **An approach which is not forced or judgemental with a focus to fulfil human rights and empower girls and women** Communities raise the issue of FGC when they increase their awareness and understanding of human rights and make progress towards areas of immediate concern e.g. health and education. Despite taboos, the issue emerges because the group are aware FGC causes harm. Community discussion contributes to new understanding that girls would be better off if everyone abandoned the practice.

2) **Community awareness of the harm caused by the practice.** People share experiences through non-judgemental public discussion + non-directive reflection → costs of FGC more evident

3) **The collective choice of a group that intermarries/is closely connected.** FGC a community practice, most effectively given up by the community acting together rather than individuals acting on their own. Ability of group members to organise and take collective action can result in transformation of the social convention.

4) **Explicit public affirmation of collective commitment to abandon.** Community makes clear their will to abandon FGC. Various forms – joint public declaration in a large public gathering, authoritative written statement of collective commitment to abandon.

5) **Organised diffusion to ensure the decision spreads rapidly from one community to another and is sustained. Communities engage neighbouring villages so the decision to abandon can be spread and sustained.** Engage communities exercising a strong influence. When decision is sufficiently diffused, social norms has shifted and now serves to pressure individuals to abandon the practice.

6) **An environment that enables and supports change**. Commitment of government at all levels to introduce appropriate social norm measures and legislation, complemented by advocacy and awareness efforts. Civil society is integral to enabling the environment. Media role in facilitating the diffusion process.

A wealth of information of anti-FGM/C programmes from many countries exist, which can provide guidelines for good practice, as summarized by the WHO:

- **Understand the social dynamics of decision making related to FGM**

Decision-making and practices in many communities involve more than just individuals and families – they are embedded in community or group dynamics. Interventions that target individuals, families or exercises alone are therefore unlikely to be effective

- **Work with - not against - cultural and community practices and beliefs**

FGM has rarely been abandoned when programmes against the practice have been perceived by the community as attacking and criticizing local culture and values, and/or as driven by outsiders. On the contrary, defensive reactions, including mass-FGM initiatives and

proclamations in support of the practice, can result. Evaluations suggests that reinforcing positive cultural values can be more effective, as can supporting community dialogue aimed at finding ways to signify a girl's coming of age that do not involve cutting

- **Target local, national and international levels of influence**

Grass-roots-level interventions have been shown to benefit from complemen- tary national responses. In addition, ethnicity – a major predictor of the type of FGM practised – can span national borders; thus interventions targeting a particular ethnic group should consider cross-border coordination

- **Use a comprehensive and rights-based approach**

The components of a comprehensive, rights-based strategy might include approaches focused on reducing gender discrimination, improving social justice and supporting human rights, community development, and empowerment and literacy among women and girls.

Sources/Extracted from:
UN, Violence against women and the girl child, link
Orchid project, UNICEF, 6 elements, link
Equality now, FGM in the US, link
UNFPA, Joint Programme with UNICEF, link

Proposed Discussion Questions

- What is the best approach to ending FGM/C?
- Do you agree that "what may appeal to one school as torture, may be absolved or approved by another as culture" in the context of the FGM/C? If no, why not? If yes, why?
- Should alternative rites of passage be proposed in communities that practice FGM/C? If so, what kind? Who is responsible for advocating for change?
- Should men, as fathers, religious and community leaders, be included in efforts to stop FGM/C? If yes, how/why?
- How can women who perform FGM/C be stopped?
- How can the international community become more involved in the elimination of FGM/C without ignoring local and cultural norms?
- What can we do to end all forms of gender-based violence?

Additional Reading & Follow up

Learn more about:

Maryum Saifee's work:

- World Woman Foundation, link
- Malanational, link
- Medium, Storytelling, shame, the hidden costs, link
- Berkley Center, Ending FGM/C, link
- MS Magazine, FGM's #MeToo Moment, link

Natasha Latiff's work:

- SAHR, link
- Women for Justice Afghanistan, link

Yakın Ertürk work:

- Center for Women's Global Leadership, link
- Institute for Women's Leadership, link
- Turkish Antenna of Mediterranean Women's Mediation Network, link

End FGM Initiatives:

- Equality now, link
- Orchid Project, link
- End FGM, link

Initiatives to reduce gender based violence:

- Voices against violence, UN, link
- A framework to underpin action to prevent violence against women, UN Women link
- Ways to end violence against girls, Plan International, link

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Episode Speaker Biographies

[Main Story Biography] Maryum Saifee | Human Rights Advocate, Oslo Women's Rights Initiative

Maryum Saifee is a human rights advocate working with the Oslo Women's Rights Initiative and co-founder of the #FreeToBe campaign. She participated in this podcast in her personal capacity. Prior to OWRI, Saifee served as a U.S. diplomat for over a decade with overseas postings in Cairo during the early days of the Arab uprising in 2011, as well as Baghdad and Erbil, and most recently, she was spokesperson for the U.S. Consulate in Lahore. She was also a policy advisor in the Secretary's Office of Religion and Global Affairs and the Secretary's Office of Global Women's Issues. Saifee was a Council on Foreign Relations International Affairs Fellow from 2018-19. She also served as a Peace Corps Volunteer in Jordan and an AmeriCorps Volunteer in Seattle working with South Asian and Muslim immigrant survivors of domestic violence. She was a consultant at the Ford Foundation, Women Deliver, UNDP's Regional Bureau of Arab States, and Acumen Fund. Saifee is a graduate of Columbia University's School of International and Public Affairs. She is a 2019 Presidential Leadership Scholar and serves on the advisory boards of the Athena Leadership Project, Women of Color Advancing Peace and Security's New York chapter, Too Young to Wed, The US Network to End FGM/C, Sahiyo, and the Center for Women, Faith, and Leadership. Her advocacy work has appeared in the Guardian, NPR's Weekend Edition, Ms. Magazine, Al Jazeera, and the Economist. Twitter: @MaryumSaifee, @oslOWRI

[Expert Biography] Prof. Yakın Ertürk | Human Rights Lawyer at SAHR and Women for Justice Afghanistan

Yakın Ertürk is professor emeritus of sociology, Middle East Technical University, Ankara. Her professional experiences include: consultancies for national and international agencies on rural development projects; employment as director of UNDAW (1997-99) and UNINSTRAW (1999-2001); international and regional human rights monitoring mandates: UN Special Rapporteur on Violence against Women (2003-09); member of Independent International Commission of Inquiry of the June 2010 events in the Republic of Kyrgyzstan (Oct. 2010-April 2011); member of Independent Commission of Inquiry for Syrian Arab Republic (Sept. 2011 – March 2012); member European Committee for the Prevention of Torture (CPT). From Sept 2017 to May 2018 she was a Global Visiting Associate at the Center for Women's Global Leadership (CWGL) and the Institute for Women's Leadership (IWL) Consortium, Rutgers University. She is the founding member of the Turkish Antenna of Mediterranean Women's Mediation Network. Her recent publications include: Violence without Borders: Paradigm, Policy and Praxis Concerning Violence against Women (2016); Feminist Advocacy, Family Law Reform and Violence against Women (Co-editor, Routledge 2019); "Political Economy of Peace Processes and the Women, Peace and Security Agenda," Conflict, Security and Development (2020). Yakın Ertürk holds a PhD in development sociology from Cornell University.

[Expert Biography] Natasha Latiff | Human Rights Lawyer at SAHR and Women for Justice Afghanistan

Natasha Latiff is an acclaimed human rights lawyer represents victims in cases of rape, sexual violence and torture. She is the Co-Founder and Legal Director of two legal action organisations, ""SAHR"" which operates globally and ""Women for Justice Afghanistan"" which operates in Afghanistan. Through her organisations, she takes some of the most high-profile sexual violence cases to hold States and institutions accountable. She has served as a Legal Advisor and Legal Consultant to several INGOs and UN entities. She advises on human rights issues and cases such as rape, sexual violence, political persecution, torture, virginity testing and murder. She has submitted expert opinions in the courts of Switzerland and the United States. Through her work, she has secured compensation for victims; held government officials accountable; released women from prison in Afghanistan. The former Attorney General of the United Kingdom, former President Bill Clinton and former Dean of School of Oriental and African Studies, University of London, has recognized her contribution to pro bono work globally. She holds an LL.B. from the University of Warwick and an LL.M. with Distinction from the School of Oriental and African Studies, University of London. She is admitted to practice as an advocate and solicitor of the Supreme Court of Singapore. Twitter: @SAHR_NGO, @natasha_latiff

[The Elders Special Segment Guest Biography] Graça Machel | Deputy Chair of The Elders, Founder of the Graça Machel Trust

Graça Machel is Deputy Chair of The Elders, an independent group of global leaders founded by Nelson Mandela in 2007, who work together for peace, justice and human rights. Graça Machel co-founded The Elders with her husband, Nelson Mandela in 2007. She is a renowned international advocate oversaw an increase in primary school enrolment from 40% of children in 1975 to over 90% of boys and 75% of girls by 1989. In 1994, she was appointed by the UN Secretary-General to assess the impact of armed conflict on children. Her landmark report established a new and innovative agenda for the comprehensive protection of children caught up in war. Graça Machel is Founder and President of the Foundation for Community Development (FDC) and Founder of the Graça Machel Trust.

[Host Biography] Hazami Barmada | Founder & CEO, Humanity Lab Foundation; co-Executive Producer & Host, Finding Humanity Podcast

Hazami is a social entrepreneur, thought leader, and public affairs and social impact expert recognized by Forbes as an "inspirational agent of change." She has consulted for many leading global brands including the United Nations, United Nations Foundation, Aspen Institute, and the Royal Court of the Sultanate of Oman. Among her posts at the United Nations, she served as the Coordinator for the United Nations Secretary General's World Humanitarian Summit, an Advisor to the first-ever United Nations Secretary-General's Youth Envoy, as a member of the United Nations SDG Strategy Hub for the launch of the 2030 Sustainable Development Agenda. Hazami has a Masters from

Harvard University where she was an Edward S. Mason Fellow in Public Policy and Management. She studied social and public policy at Georgetown University and has a BA in Anthropology and Sociology. Twitter: @hazamibarmada

PODCAST PRODUCTION ORGANIZATIONS & TEAM

Humanity Lab Foundation is a disruptive empathy-driven movement at the intersection of public policy and people power. As a collective of enablers, the Humanity Lab facilitates public engagement and social innovation to drive progress on human development and create an equitable and just world. Through a diverse portfolio of programs and initiatives, the Humanity Lab enhances global development systems by convening, connecting and collaborating with everyday people to solve complex challenges and drive social change. The Humanity Lab aims to: unlock human potential, break down barriers, provoke thought-leadership and knowledge sharing, facilitate partnerships, catalyze action, and democratize access to the power that shapes the world. The Humanity Lab has collaborated with a large array of partners including the Office of the President of the United Nations General Assembly, United Nations Office of Partnerships, United Nations, Qualcomm, The Elders, Warner Music, MTV and the Washington Diplomat.

Hueman Group Media ("HGM") is an award-winning podcast company for social change. HGM produces impactful and high-caliber podcasts for leading nonprofit organizations, purpose-driven companies and thought leaders, amplifying conversations around today's most important causes and issues — including gender inequality, climate change, racial injustice, and mental health. HGM podcasts cater to diverse, socially conscious, and deeply curious audiences. With the power of storytelling and expert-driven conversations, HGM activates listeners to take action and make a positive impact in their communities. HGM has worked with notable organizations including UN Women, The Elders, SAP, GoDaddy, CORE Response, and MIT Solve.

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