**Input from UNHCR to OHCHR report on Female Genital Mutilation and Cutting (Dec 2014)**

# Call for submission FGM/Cutting

* UNHCR’s policy on harmful traditional practices is in line with the recently-issued Policy Paper on UNHCR and Human Rights and the guiding principles outlined in UNHCR’s Policy on Refugee Children, namely: “In all action taken concerning refugee children, the human rights of the child, in particular his or her best interests, are to be given primary consideration”.
* UNHCR fully endorses the Joint Statement of WHO, UNICEF and UNFPA on Female Genital Mutilation which expresses a common purpose in supporting the efforts of governments and communities to promote and protect the health and development of women and children. The joint statement also provides useful strategies for national and community action and international approaches and actions to eradicate FGM.
* Actions to eradicate harmful traditional practices unavoidably conflict with strong cultural norms. UNHCR should promote and implement, where possible, the “Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children”, adopted by the Sub-Commission on Prevention of Discrimination and Protection of Minorities in 1994
* Field staff is advised to plan their strategy to address the occurrence of these practices carefully, in conjunction with the refugee community, implementing partners and any other relevant UN organisations. Working with the refugee community is important to ensure measures taken are as effective as possible. In addition, local NGOs and the government, who may already have active campaigns in the country, and host communities, could be involved. Field staff should also become familiar with the national laws, if any, of the countries of origin and asylum which address these issues; in some countries where FGM takes place, laws prohibit the practice. Staff should consult Headquarters for advice where necessary.

**Key response strategies: What UNHCR and partners can do**

The highly sensitive nature of dealing with harmful traditional practices, especially FGM, is appreciated. While there are no hard and fast rules for eradicating these practices, the following may provide some guidance for field workers:

**Legal & Policy Framework**

* Join efforts to criminalize Harmful Practices such as FGM in host country when it is not yet the case. Assess the capacity of host country to implement and enforce the legal framework within refugee and displaced contexts.
* Work with and through religious and traditional leadership in country to involve them in legal change process as well as the elaboration of policies and guidelines protecting women and girls from harmful practices like FGM.
* Contribute to legal implementation as well as development strategies and action plans, in coordination with government and other agencies such as UNICEF and NGOs. Those plans can be developed even when no legal provision is in place. Legal change is a long-term process.
* Growing immigrant populations in industrialised countries have brought FGM with them to states where it was not usually practised. Canada, the US, Australia and many European countries now have laws prohibiting the practice. France has prosecuted a number of parents for subjecting their daughters to the procedure in France. UNHCR discourages informing refugees about the criminalisation of the practice in resettlement countries prior to departure, as this may result in mass FGM operations before resettlement occurs. Instead, the authorities of the resettlement country should be encouraged to inform refugees of these laws upon their arrival.

**Knowledge & Data**

* It is necessary to have a thorough understanding of the nature and extent of the particular practice, including its roots and the social consequences it entails. The analysis of push and pull factors leading families and girls to undergo FGM, as well as of circumcisers to perform FGM, is also crucial. This will obviously involve discussions with the refugees themselves, underscoring the importance of understanding the culture and habits of the refugees.
* The systematic collection of data on FGM remains a challenge. Harmful Practices are often hidden phenomenon, as they often relate to the family private sphere and therefore difficult to quantify. Support research in magnitude in harmful practices within persons of concern and use evidence base to inform advocacy and programme strategies to address these issues.

**Coordination**

* Encourage collaboration and coordination in country with UNICEF, UNFPA, UN Women as well as governments and agencies mandated with the protection of women and girls to join forces in the prevention and response to Harmful Practices such as FGM. Integrate Harmful Practices in SOPs and inter-agency protocols depending on prevalence of issues.

**Human & Financial Capacity**

* Contribute to efforts to scale up funding and resource allocation to the prevention and response of FGM and its integration into other sectors to maximize impact and efficiency on interventions. Most interventions are often fragmented and impact on small catchment population and therefore are unlikely to be sustainable
* Promote, provide technical support, and mobilise resources for national and local groups that will initiate community-based activities aimed at eliminating harmful traditional practices. National Committees to eradicate harmful traditional practices exist in many countries and their expertise should be mobilised. Hum res

**Prevention & Response**

* Link with other sectors especially education/sexual and reproductive health (SRH) to integrate harmful practices in staff curricula and local prevention and response strategies. Tackling sensitive issues such as FGM within a wider education/SRH initiative has proven more successful than stand-alone sensitization work about those issues eg. in Burkina Faso, the National Committee has already piloted training for teachers as well as the incorporation of FGM into the natural sciences curriculum within schools.
* The importance of educating girls and women cannot be underestimated. The incidence of harmful traditional practices, such as FGM and early childhood marriage, decreases with gains in female literacy. Therefore, promoting and supporting female education, both for adults and by the enrolment of girls in schools, should be a priority.
* Support the establishment of safe spaces for girls to be able to share their issues and foster decision-making and access to reliable information related to their rights including sexual and reproductive rights.
* Support specialized services to young girls who have reproductive health complications including fistula.
* It is important that alternative income generating activities are found for those carrying out harmful practices such as FGM. Additionally, the community’s respect for traditional practitioners must be maintained. The “medicalization” of harmful practices such as FGM (i.e. supporting health care professionals to perform practices in health facilities under more hygienic conditions) should not be supported. Health workers in refugee situations must be aware that their involvement in such practices will not be tolerated and will lead to immediate termination of employment. In countries where FGM is practised, this should be stipulated in the employment contracts of health personnel.
* Focus on educating target populations (both men and women), namely religious leaders, traditional leaders such as chiefs, tribal elders and political leaders, traditional birth attendants, other health workers and the refugee women, men and children themselves on the harmful health consequences of these practices. In particular, it is very important to educate young girls on these issues.

**Advocacy & Awareness**

* Train and build awareness among decision makers and key groups involved (traditional and religious leaders, women’s groups, law enforcement bodies, medical staff including midwifes and TBAs etc.).
* Campaigns to eliminate these practices are more likely to succeed and be accepted by the target population where they emphasise harmful healthconsequences rather than the legal or human rights aspects.
* Videos have proved an excellent way of demonstrating the harmful effects of some traditional practices. Videos depicting FGM actually being performed or a woman who has not undergone FGM giving birth have proved effective.
* Build the capacity of anti-FGM activists and local organization in high level advocacy techniques.
* Support community based mechanisms to integrate FGM prevention among their outreach and sensitization work, provide community volunteers with the right arguments and advocacy strategies to foster behaviour change.

**Examples from the field**

***Regional Project to Address FGM in Somali Refugee Communities - Kenya, Yemen and Ethiopia***

98% of all Somali women and girls are estimated to have undergone FGM and most of them (90%) have experienced “Pharaonic” or Type III FGM. To take one example of Somali refugees, UNHCR estimates that 97% of girls under the age of eight in Dadaab camp in Kenya have had FGM performed on them. Somalis constitute the third largest group of refugees worldwide (after Afghans and Iraqis). The three countries with the largest number of Somali refugees are Kenya, Yemen and Ethiopia, with some 490,000 in Kenya, 65,000 in Yemen and 185,000 in Ethiopia. Substantial influxes of refugees from Somalia to these countries continue due to armed conflict and serious human rights violations.

In all three of these countries, UNHCR has worked on FGM eradication or abandonment efforts; however, programmes are developed differently. In Kenya, there has been considerable activity, especially in Dadaab where the refugee population is almost exclusively ethnic Somali, originating from Somalia and Ethiopia. Since the social norms concerning FGM tend to be very strongly linked to culture, lessons learned with one group of Somali refugees on what works in terms of FGM abandonment will be relevant to other Somali refugees as well.

In 2012 UNHCR launched a regional project on FGM focusing on the three countries in which the number of Somali refugees is the largest. Activities include: Discussion-tool documentary film on FGM abandonment among Somali refugees; Improved women’s health services, including FGM-related services; Livelihood support in Somali refugee camps (in Ethiopia and Kenya only), including FGM “agents of change”; Awareness-raising activities (in Yemen only); “Go and See” visits (Ethiopia and Kenya for sending and receiving; Yemen only for receiving)

During the awareness raising campaign in Yemen, challenges were faced with posters displayed as they were destroyed by people who found it unacceptable. However, the posters displayed indoors (e.g. clinics, IPs offices) were fine and in addition leaflets were distributed. With regard to providing legal assistance, UNHCR Yemen, partners and Government were able to convey a strong message to the community that legal action will be taken against FGM.

***Stockholm Regional Office***

UNHCR systematically meet with asylum-seeking and refugee women during monitoring visits to reception centres, detention centres and municipalities. In seminars, case studies involving girls at risk of forced marriage and FGM and women at risk of domestic violence are included.

UNHCR also promoted the study ‘Too Much Pain’ on FGM and asylum, especially towards its counterparts in Sweden and Finland, and paved the way for capacity building in 2014 on the identification and response to applicants at risk of FGM.

***Brussels (Regional Representation for Western Europe)***

UNHCR wrote to State Secretary for Asylum Migration expressing concern about a COI report on Guinea, its methodology findings on FGM; intervened in FGM cases at appeal spoke at a colloquium on FGM, asylum Guinea. Belgium’s new regular resettlement programme gave priority to vulnerable refugees from the subcategories of women-at-risk LGBTI refugees.

***Ethiopia***

In Eastern Ethiopia, UNHCR is in partnership with a community-based NGO, Mother and Child Development Organization (MCDO), to raise awareness on FGM. In 2008-2009, MCDO conducted weekly group discussions, referred to as “coffee ceremonies”, and mobilized youth clubs against FGM in three Somali refugee camps. They identified role models against FGM within the refugee community and provided support to those who choose not to perform FGM on their children. They trained health staff on how to respond to FGM and conducted vocational skills training targeted at former FGM practitioners and groups at risk in the camps. MCDO has also established a women’s centre in Aw-bare refugee camp where women talk exclusively about their economic, social and domestic problems. Organized discussions related to FGM are held in the centre to raise awareness.

***Kenya***

In Dadaab refugee camp in Kenya, which hosts Somali refugees, UNHCR is raised awareness of the serious health risks of FGM through community dialogue. Inter-generational debates were held between older persons and youth to discuss the negative aspects of the culture. Support groups to fight FGM have been created, including religious leaders’ committees which support the abolition of FGM and emphasize the distinction between FGM and religion. Men against FGM, a group of three hundred individuals, was mobilizing the refugee community, conducting peer education activities, acting as role models, and working in close cooperation with the police and agencies. There are support groups for families who have abandoned FGM, groups of former FGM practitioners, Youth against FGM and groups for girls who have not undergone FGM. The awareness on FGM among the youth in the camp has greatly improved, through a project using sports to address FGM. Teachers, sports coaches and FGM survivors have been trained and the sports activities are used as a safe environment to discuss and create awareness on FGM. Radio communication has also been used to share information on the consequences of FGM.

***Chad***

In the context of the fight against FGM, the Chadian Government adopted law SR/06 (prevention and condemnation of FGM, early marriage) in 2006. However, it is still awaiting promulgation. UNHCR together with other UN agencies concerned advocates for the promulgation of the above-mentioned law and is fully supported by the Government of Chad.

***Egypt***

UNHCR, in partnership with Cairo Family Planning & Development Association, continues to implement awareness-raising sessions for refugee women on SGBV prevention and response, and the issue of FGM has been included in these sessions. The activity reaches around one hundred refugee women yearly. Moreover, discussions on community mechanisms to address SGBV and FGM regularly feature in UNHCR’s work with community-based refugee organizations.

***Uganda***

In Uganda, support for conducting the “rites of passage” ceremony is emphasised while stopping the harmful practices of FGM. Programmes encourage the continuation of the ceremonial aspects of the “coming of age” for young women, but eradicate the “cutting”.

***Sierra Leone***

In Sierra Leone, FGM is part of an initiation process for women’s secret societies. These societies can be very important for women’s self-empowerment because they provide a support network and contacts for income generating activities. While it is important to encourage groups that empower women, it is equally important to encourage initiations which do not require FGM.

**Sources:**

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