TOPIC GUIDES
PIMUN 2018

United Nation Women

Table of Contents

INTRODUCTION LETTER 3
Introduction to the Committee 4
UN Women 4
Topic A: The Rights of Women doing Low-Cost Labour 5
Introduction 5
Insight into the topic 5
Case A: Cambodia 6
Case B: Bangladesh 6
Case C: The Persian Gulf 7
Bloc positions 7
- Developed Countries 7
- GCC Countries 8
- South Asian and Asian Pacific Countries 8

Points for Further Research 8
TOPIC B: Health Risks of Female Genital Mutilation/Cutting 9
Introduction 9
History of the topic 10
Timeline of Past UN Events 10
Discussion of the Topic 11
Bloc Positions 13
- Europe and North America 13
- African and Middle-Eastern countries 13
- Asia 14

Points for further research 14
Sources 15

INTRODUCTION LETTER

Dear Delegates,

We are Sahajanya Balaganesh and Raphaëlle Ripoche, and we are super excited to be serving as your Directors for UN Women at PIMUN 2018. A little about us - Sahajanya, although originally Indian, just has to cross the border from Brussels to come to Paris. She has been involved in various public speaking scenarios for the past decade and currently heads up the Model UN team of her university as President. Saha takes all-in-or-nothing too seriously as PIMUN 2018 would be her sixth conference of the year. Raphaëlle has been been involved in Model United Nations for the past three years and recently took over the society of her university. She didn't have to travel too far to come to PIMUN as she is currently studying in Paris, so she's very much looking forward to welcoming you in her adopted city.

We eagerly look forward to this committee because of its extremely important and interesting topics. Minimum wage itself is a particularly controversial topic, but we will be specifically looking at some instances of low-cost labour that disproportionately affect women and talk about a minimum wage and better labour conditions for them. Additionally, Female Genital Mutilation is a widely discussed but sadly still prominent issue in today's world, and we will be delving deeper into the health aspects of it, for the after effects it causes are substantial impediments to gender equality. Both topics will require a great deal of cultural competency, diplomacy, and pragmatism from delegates. With that said, we look forward to witnessing some great debate.

If you have any questions, feel free to reach out to us on Facebook or email us. See you in May!

Sincerely yours,

Sahajanya and Raphaëlle

Introduction to the Committee

UN Women

The United Nations Entity for Gender Equality and the Empowerment of Women, also called UN Women, is the UN organization dedicated to gender equality and the empowerment of women. A global champion for women and girls, UN Women was established to accelerate progress on meeting their needs worldwide. The Entity was created in 2010 with the adoption of Resolution 64/289 on July 2nd, and became operational in January 2011. It results from the merging of four different institutes, offices, and bodies related to women and gender equality issues. UN Women is also part of the United Nations Development Group (UNDG).

UN Women supports UN Member States as they set global standards for achieving gender equality, and works with governments and civil society to design laws, policies, programmes and services needed to ensure that the standards are effectively implemented and truly benefit women and girls worldwide. It works globally to make the vision of the Sustainable Development Goals a reality for women and girls and stands behind women's equal participation in all aspects of life, focusing on five priority areas:

- increasing women's leadership and participation;
- ending violence against women;
- engaging women in all aspects of peace and security processes;
- enhancing women's economic empowerment;
- making gender equality central to national development planning and budgeting.

UN Women also coordinates and promotes the UN system's work in advancing gender equality, and in all deliberations and agreements linked to the 2030 Agenda. The entity works to position gender equality as fundamental to the Sustainable Development Goals, and a more inclusive world.

Topic A: The Rights of Women doing Low-Cost Labour

Introduction

The wage gap between men and women is a pressing issue in all parts of the world and is a hotly contested topic. However, often brushed under the rug is how much women working low-cost labour jobs in developing and underdeveloped countries are often not paid a livable wage. The global fashion industry is one of the older and largest not only in its size but also in terms of exports. Naturally, that gives rise to a lot of challenges associated with global manufacturing and outsourcing: low wages, the lack of labour contracts and laws, and sweatshop conditions. This disproportionately affects poor women because 80% of garment workers are women.

Even in the cases of garment companies in developed countries, the production is outsourced to emerging economies around the world. A quick look at the tag on the outfit you are wearing right now will tell you which part of the world it was made in. As with many manufacturing jobs, there was a notable shift of garment manufacturing to China. Guangdong, a small province in China, is even known as the "world's workshop". Tags on popular everyday clothing brands will say India, Cambodia, Afghanistan, Bangladesh, Pakistan, Vietnam, and so on. High end labels go to places like Morocco, Turkey, and Central America.

In this study guide, you will find two case studies on the garment industry and one focusing on another pressing issue in low (or no) cost labour done by women - domestic work in Gulf countries. 99.6% and 94.8% domestic workers and personal assistants in Saudi Arabia and the UAE, respectively, are migrant workers. This informal labour in this region exemplifies some of the same challenges faced by garment workers, but with the additional risk of being migrants.

Insight into the topic

Whilst the global fashion industry turns over USD 3 trillion annually[1], the garment workers who uphold the industry work for barely a couple of dollars a day, live in poor conditions and often do not earn enough to cover the basics including rent, food, medical bills and education for their children. About 80% of garment workers are women, due to enforced stereotypes. They live and work in extremely unsuitable conditions without making a living wage to provide for themselves and their family. They often do not get sick leave, no overtime pay, no bathroom breaks, etc. International fashion labels including H&M and Marks and Spencer have their clothes made in countries like Bangladesh, India, Cambodia, and Pakistan, where these conditions are known to exist.

Beyond this, South Asian girls and women are very often tricked or trafficked into the Middle East. A lack of labour laws in the Gulf Cooperation Council (GCC) has allowed this to happen especially in oil-rich countries in the Persian Gulf. This allows for girls and women to be sold into involuntary servitude, or even sexual enslavement. These women are not only not paid a livable wage, however if at all they are paid anything, they live in poor conditions and their passports are also confiscated from them, thus ridding them of any way out. The International Labour Organisation estimates around 230,000 people to be in forced labour in the Middle East and North Africa.

[1] Strijbos, B. (2018). Global fashion industry statistics - International apparel. Fashionunited.com. Retrieved 30 March 2018, from https://fashionunited.com/global-fashion-industry-statistics

Case A: Cambodia

An average female garment worker in Phnom Penh lives in a tightly spaced single room built in housing blocks that costs about 120,000 reils, or roughly USD 30. Steffi Eckelmann, a German photographer, did portraits on many of these women[2]. She observes, "Three to six women share just one room, not bigger than 8 square metres, often even without a window or any fresh air. No furniture, simple plastic sheets on the floor to sleep on, a toilet and portable gas stove with some pots for cooking. The women share the cost of the room, of water and electricity which amounts to about US$ 30-40 per person per month."

Every morning, the women leave early to walk to work. Dystopian looking concrete blocks with walled compounds and iron gates for factories is definitely unpleasant, but more importantly, has various safety concerns. In a workday that lasts somewhere between 9-12 hours, they get a short lunch break where they have to buy their own lunches, just like they have to do breakfast and dinner. Often, these women also have children and other family members to provide for. Women in Ecklemann's portraits share their woes about the extremely low wages they receive. All of them hope that the minimum wage will be increased as they find a wage of about USD 65 per month is unable to cover their costs and send money home. Ren Eim, 42, has been working in the industry for the past 12 years and her health suffers dearly from it. However, she has no medical insurance, so she has to work overtime to try to cover her medical costs, which only increases with the overtime[3].

On December 24th, 2013, many garment workers took to the streets to demand an increase in minimum wage up to USD 160. The police and military responded with violence, killing 4 people and injuring up to 40. This sort of oppression is commonplace in Cambodia, women often arise in protest asking for their right to a livable wage, only to be ignored and attacked mercilessly.

Case B: Bangladesh

In Bangladesh, 85% of the 3.5 million workers in 4,825 garment factories which produce goods for export to the global market are women[4]. Although the Bangladeshi garment industry generates 80% of the country's total export revenue, the wealth generated by this sector has led to few improvements in the lives of garment workers. The women in this industry face the same challenges similar to those in Cambodia, as discussed above.

In 2013, Rana Plaza, a five-storey commercial building in Dhaka, collapsed due to a structural failure. Over a thousand people were killed and approximately 2500 were injured. It housed a number of garment factories where over 5000 people worked, as well as banks, and shops. The causes included shoddy construction, illegally built floors, and more heavy machinery than the structure could have held. The banks and shops on the lower floors were immediately evacuated when cracks appeared on the building. However, the garment workers were ordered to go back to work, and they were not in a position to refuse as they would lose wages that they dearly required. Unfortunately, the building collapsed in the rush hour the next morning. Innocent people who just wanted a day's wage died, and their families lost both a loved one and a major wage earner - all because of how little a concern the workers' safety was.

---

[2] Real lives of Cambodian workers. (2018). Clean Clothes Campaign. Retrieved 30 March 2018, from https://cleanclothes.org/livingwage/real-lives-of-cambodian-workers

[3] Ren Eim, 42 — Clean Clothes Campaign. (2018). Cleanclothes.org. Retrieved 31 March 2018, from https://cleanclothes.org/livingwage/living-wage-images/steffi-eckelmann-photos/ren-eim-42/view

[4] 4 Years After Rana Plaza Tragedy, What's Changed for Bangladeshi Garment Workers? (2018). NPR.org. Retrieved 31 March 2018, from https://www.npr.org/sections/parallels/2017/04/30/525858799/4-years-after-rana-plaza-tragedy-whats-changed-for-bangladeshi-garment-workers

Case C: The Persian Gulf

Globalisation, demographic changes, warfare, poverty, and variations in the supply and demand of labourers across regions contribute to the flow of migrant workers from origin to destination countries. In recent times, migration trends have been rising in many parts of the world. Between South Asia and the oil-rich Gulf countries - migrants from Bangladesh, India, Pakistan, Nepal, and Sri Lanka, migrate to Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates. While the men engage in construction labour or so, women make up half of these migrants, a majority of them moving alone as domestic workers in hopes of a pay that will allow them to provide for their families back home.

Recruitment agencies entice vulnerable women with these jobs, giving false promises of high wages and good working conditions. And while some employers maintain their promises, there are numerous cases of worker and human rights violations in these homes against these workers. In a Human Rights Watch report[5], these women recalled that they were subjected to excessively long hours of work without breaks, adequate food and water, or medical treatment. On top of not being paid the full wages due to the workers, they endured physical, and often sexual, abuse. A common complaint was also that their passports were confiscated by their employers, thus allowing them no way out.

In the region, the *kafala* system provides extraordinary power to employees over those that they employ. They are the 'visa sponsors' of these migrant workers and can revoke it at their whim, this makes it impossible to find work elsewhere in the country. With the exception of Bahrain[6], all GCC countries explicitly exclude domestic workers from their labour law and from the basic protections that are enjoyed by other workers, such as a minimum wage, safety conditions, or limited working hours.

In the Gulf region, gender discrimination in public life and employment is commonplace and generally visible. These countries defend it as their culture. However, the plight of migrant workers working behind closed doors, especially female domestic workers, are often "invisible" and are therefore particularly vulnerable to abuse and exploitation. There are several cases of them being trafficked into employment, physically and sexually abused by both labour agents and employers. They are not protected by labour laws and are effectively subjected to conditions of involuntary servitude.

Bloc positions

- Developed Countries

This bloc consists of members of the Western European and Others Group (WEOG) and their supporters. Their focus will be on the issue of human right abuses and call for a blanket solution of the issue. As countries with strict labour laws, they value upholding human rights. Thus, they will call for harsh measures against these abuses. However, thus far they have also failed to take steps to ensure mega-corporations registered in their countries enforce ethical corporate governance when they operate abroad through garment factories and so on. The members of this bloc should ensure that the human rights of migrant domestic workers are not further violated, but look towards solutions within their industries.

---

[5] "I Already Bought You" | Abuse and Exploitation of Female Migrant Domestic Workers in the United Arab Emirates. (2018). Human Rights Watch. Retrieved 31 March 2018, from https://www.hrw.org/report/2014/10/22/i-already-bought-you/abuse-and-exploitation-female-migrant-domestic-workers-united

[6] (2018). Fidh.org. Retrieved 31 March 2018, from https://www.fidh.org/IMG/pdf/bchrbahrain42.pdf

- GCC Countries

This bloc consisting of the GCC states and their supporters who wish to continue the practice of migrant workers, especially the domestic ones, without much change. While some of them have loose laws, the lack of enforcement of those laws and the existence of loopholes that conveniently escape domestic workers, severely weakens them. It is not within their interests to lose the access to the expat workforce, they do however have severe problems with their public to grant them more rights. This bloc will have to decide whether it wishes specific or blanket solutions and debate respectively. They should remember their dependence on the expats while remembering their public opinion during the whole debate.

- South Asian and Asian Pacific Countries

This bloc consists of countries with both the low-cost sweatshops and the citizens who migrate to the Gulf. These are developing or underdeveloped countries that are stuck in catch-22 situations, they dearly need outsourced manufacturing but also need to protect their citizens. These countries often have loose labour laws that are exploited by big corporations. Given the difference in the countries and the measures they have already taken it is very difficult to guess how this bloc will develop. We urge the members of this bloc to closely work together to ensure the safety of their citizens.

Points for Further Research

1. Is the current international framework sufficient to protect labour rights vulnerable situations as the ones we discussed above?
2. What measures can UN Women implement in order to guarantee a more equal and fair integration of female migrants and to tackle gender-based discriminations?
3. What can UN Women do to examine and provide redressal to the problems with recruitment practices and the deficiencies of the legal framework in both the GCC countries and developing countries that are low-cost manufacturing hubs?
4. How can it be ensured that workers may bring their cases before objective and effective courts?
5. Should international law differentiate between the state of development of different countries, i.e. should there exist different conventions for different phases of economic development of states?

TOPIC B: Health Risks of Female Genital Mutilation/Cutting

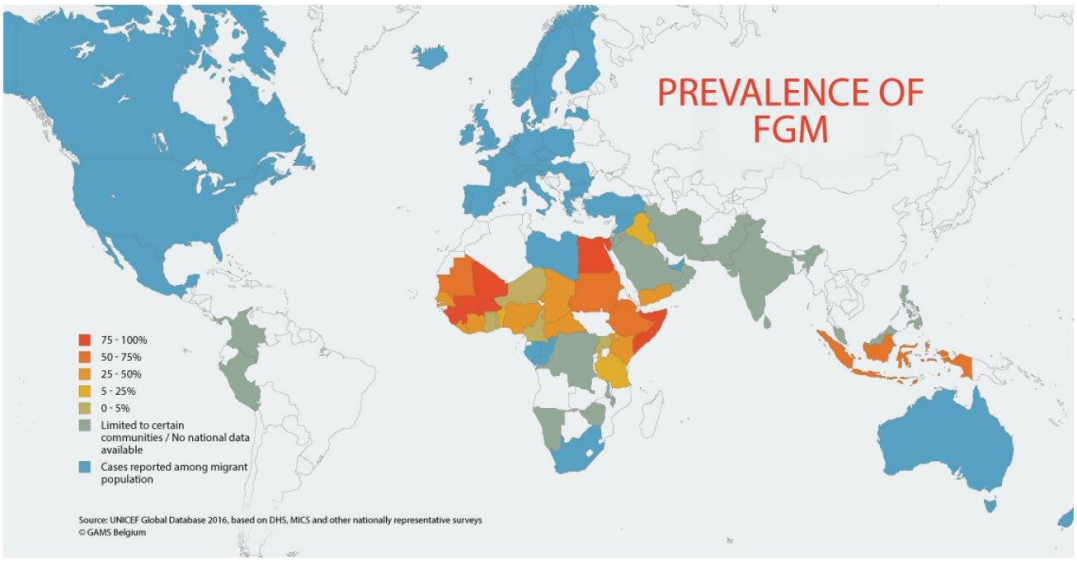
Introduction

The United Nations Population Fund defines Female Genital Mutilations/Cutting (FGM/C) as all procedures that involve partial or total removal of the external female genitalia, or other injury to female genital organs for non-medical reasons (WHO, 2018). It is recognised as a violation of human rights throughout the world, as it clearly violates the right to health, security and physical integrity of an individual, as well as the right to be free from torture and cruel, inhumane and degrading treatment. FGM/C is nearly always carried out on underaged girls and it occurs most of the time without their consent. According to UNICEF, in half of the countries with available data, the majority of girls were cut before age 5 (UNICEF, 2013). Consequently, such a practice also goes against the rights of children.

WHO classified FGM/C in 4 different types, all in varying degrees of severity:

Type 1 - clitoridectomy	Partial or total removal of the clitoris and/or the prepuce.
Type 2 - excision	Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.
Type 3 - infibulation	Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together. The adhesion of the labia results in near complete covering of the urethra and the vaginal orifice.
Type 4	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

Types 1 and 2 account for 80 % of the cases (WHO, 2018). A joint study made by the WHO and UNICEF estimates that 200 million girls and women alive have been cut in 28 African countries, in the Middle East (Yemen, Saudi Arabia, Oman) and in Asia (India, Indonesia, Malaysia, Sri Lanka, Brunei, Thailand) where FGM/C is concentrated. It also found that five percent of all affected girls and women are estimated to be living in Western countries, and that another 30 million girls are at risk of being cut in the next decade (UNICEF, 2013).



The reasons why FGM/C is performed vary from a place to another. In most societies where it occurs, the practice is seen as a cultural tradition and this is often used as a reason for its perpetuation. It might also be seen as a social norm, meaning people feel a pressure to conform to what is seen as a widespread custom in order not to be rejected or marginalised. In some communities, FGM/C is seen as a necessary part of raising a girl so as to prepare her for her adult life and her marriage. It may be motivated by the belief of what is considered acceptable sexual behaviour and what is not, as it is sometimes believed FGM/C helps ensure premarital virginity and marital fidelity.

FGM/C reflects deep-rooted inequality between sexes for it constitutes an extreme form of discrimination against girls and women. It reflects attempts to control women's sexuality and behaviour, consequently preventing Goal 4 of the Sustainable Development Goals to be achieved. The UN views it as a form of torture and a cruel, inhumane and degrading treatment as it causes an irreversible violation of girls' and women's bodies. Indeed, the degree discrepancy between the high prevalence of the practice and the low support for FGM/C confirms that it is a social obligation: even in countries where most girls and women are cut, a great share of the population is against the practice. By being denied the opportunity to choose for themselves, girls and women are opposed the rights to well-being and self-determination. Moreover, as FGM/C was proven to have no health benefits and to simply cause both physical and mental damage, it makes it impossible for girls who are affected to have the same chances and the same opportunities as boys.

« FGM is a practice that must end (…). It is an act that cuts away equality »
Phumzile Mlambo-Ngcuka, UN Under-Secretary-General and Executive Director of UN Women

History of the topic

The first step against the FGM/C was taken in 1997: WHO, together with UNICEF and UNFPA issued a joint statement against the practice. Great efforts elaborated on research, work within communities and changes in public policy have been made ever since in order to counter FGM/C at international, national and regional levels. The involvement to tackle the issue widened among the international community and as political support grew, the legal framework around FGM/C was reformed in 26 African and Middle-Eastern countries where the practice is common. As a result, the prevalence of FGM/C dropped in most countries where it was broadly carried out and the number of people, men and women, in practicing communities who support ending it also increased.

Timeline of Past UN Events

2007: UNFPA and UNICEF launched the Joint Programme on Female Genital Mutilation/Cutting to speed up the abandonment of the practice.

2008: WHO, together with 9 UN partners (UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UN Women), released a statement called "Eliminating female genital mutilation: an interagency statement", which aim was to support increased advocacy to contribute to the abandonment of the practice. It emphasised the need for concerted action in various sectors (health, education, finance, justice and women's affairs) to achieve significant results.

2010: The "Global strategy to stop health care providers from performing female genital mutilations", drafted by UNFPA, UNHCR, UNICEF, UN Women, WHO, the International Federation of Gynaecology & Obstetrics,

the International Council of Nurses, the IOM, The Medical Women's International Association, the World Confederation for Physical Therapy and the World Medical Association, is published. This document brings the challenges posed by the practice to the achievement of the SDGs. It also touches on the way to engage health professionals to support the abandonment of the practice and discusses strategies to speed up process.

2012: Resolution 67/146 on Intensifying global efforts for the elimination of female genital mutilations was adopted by the UN General Assembly in December. It reflects an international agreement on the fact that FGM/C does constitute a violation of basic human rights that should be addressed all over the world by "all necessary measures, including enacting and enforcing legislation to prohibit FGM and to protect women and girls from this form of violence, and to end impunity".

2013: UNICEF published a report entitled "Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change". It is based on more than 70 national surveys over a twenty-year period that analyses prevalence and trends in FGM/C in 29 countries and thus promotes a better understanding of the practice.

2016: UNICEF updated the report it published in 2013: it relies on an increased number of national surveys and compiles statistics and prevalence rates. It also documents beliefs, attitudes, trends, and programmatic and policy responses to the practice.

In **May 2016**, the first evidence-based guidelines on how to manage complications from FGM/C are launched thanks to a collaboration between UNICEF, UNFPA and WHO. It aims at improving the way women living with FGM/C are taken in charge by health care professionals throughout their life.

Discussion of the Topic

Health complications

WHO makes the difference between the types of health complications engendered by FGM/C:

- Immediate risks include pain -at the time of the cutting and during the healing process, bleeding-that may lead to severe haemorrhage, shock -resulting from the violence of the act and the trauma it causes, infections and HIV transmission -depending on the conditions the operation was performed.
- Long term risks are not systematic but extremely frequent. They are more difficult to attribute directly to FGM/C but may include damage to adjacent organs, recurring urinary tract infections, the formation of dermoid cysts, childbearing difficulty and sterility. (WHO, 2018)

Consequences of FGM/C on health are only known retrospectively and approximately, and focus mainly on adult life. The aftereffects of the practice on health during childhood and puberty still need to be studied in a deeper way. Numerous conditions affecting girls at a young age are probably still ignored although they must be impeding those affected from growing up in the best conditions possible (Berg et al, 2014). Therefore, it is obvious that such complications, which result from a non-therapeutic procedure, are many obstacles that prevent girls and women to live up to their aspiration and to their full capacity. As such, the very nature of FGM/C anchors gender inequality.

Long term risks were mentioned above, and they also include conditions related to pregnancy. In fact, a study made in 28 hospitals in 6 African countries that involved close to 28 400 women who gave birth brought tangible evidence concerning obstetric aftereffects of FGM/C. Caesarean-section were proven to be riskier as usual, post-partum haemorrhage were more frequent, and so were infant's reparatory distress and neonatal mortality (Wuest et al., 2009). This study was based on women giving birth in hospitals; yet countries where FGM/C prevalence rates are high are also places where birth is given outside a medical setting. This questions

the chance for women to recover unharmed from their childbirth, consequently being able to enjoy the same opportunities as other members of their society, be it men or other women who were not cut.

Psychological consequences

« Invisible » wounds should not be left aside when addressing the issue of FGM/C. The psychological stress that results from the procedure may trigger behavioural disturbances and attention deficit disorders in little girls. They may also be linked to a loss of trust and confidence in caregivers. Girls are therefore impaired in their development as human beings with a full potential for such troubles may prejudice their education. In the longer run, women may suffer feelings of anxiety and depression. Moreover, sexual dysfunction and incapacity to have children may also contribute to marital conflicts or divorce. This leaves girls and women in precarious conditions as they become vulnerable individuals.

Aftereffects' mapping

The information on health consequences of FGM/C that is available today comes from large-scale population-based surveys, but they count numerous bias. First, as they are based on self-reported retrospective data, those surveys suffer from selection bias since they only include women who survived FGM/C. Second, they are based on testimonies of women who have mostly undergone the procedure in their infancy or early childhood (UNICEF, 2013). Consequently, it may be impossible for them to remember all the details concerning the experience. Rethinking the way surveys are thought and run needs to be taken into account in order for evidence to be more comprehensive and for an answer that meets all the detrimental effects on health to be addressed.

Medicalisation

The question of medicalisation of the practice is also at the centre of vigorous debates. It aims at minimising health risks associated with the procedure by having it performed by healthcare professionals or medically trained personnel, using sterile equipment supposedly in order for the cutting to take place in a more hygienic and less painful way (Josse, 2013). For instance, that is the case in Egypt or in Sudan where one in three women was operated on by a doctor or a midwife in 2016. The argument here is that it is a safer manner to conduct the procedure in areas where a complete eradication has not been achieved yet. However, although medicalisation may contribute to reducing immediate risks (i.e. infection or pain if an anaesthetic is used), it fails to take into account long-term gynaecological and obstetrical complications, as well as invisible damages that are life-long emotional and psychological problems. It is also rather unlikely that girls and women living in poor or rural communities, where prevalence rates are high, would have access to such settings. Additionally, the illegal status of the practice also causes it to often be performed outside healthcare facilities. Focusing strictly on medicalisation draws the attention away from the actual priority that is the complete elimination of FGM/C, which will only happen thanks to intergovernmental collaboration alongside international organisations and NGOs.

Prevention

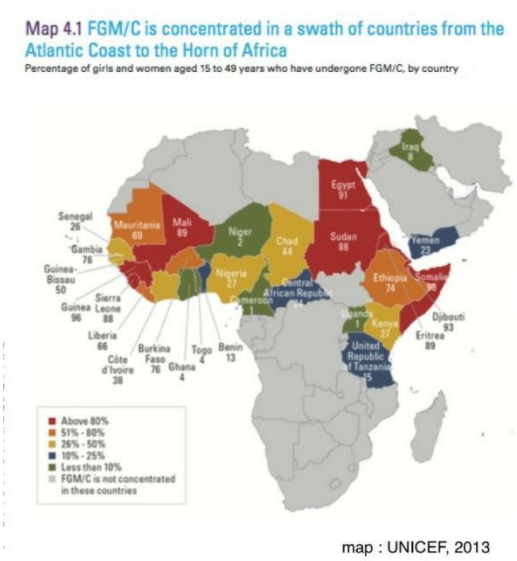
In addition to collaboration between governmental actors, international bodies and community leaders, the role of healthcare professionals will be crucial to the eradication of the practice in the next decades. Indeed, they are key actors in terms of prevention, but also experts as of how women who are affected should be taken in charge in order for FGM/C aftereffects to be reduced as much as possible (Andro, 2016). So far and as FGM/C will not be eradicated overnight, efforts should also be directed towards the follow-up of girls affected and their access to support and care facilities.

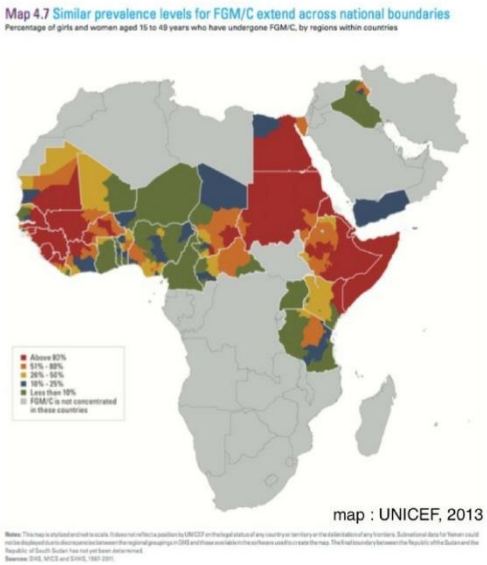
Bloc Positions

- Europe and North America

In those regions, documented cases of women suffering from FGM/C concern women of immigrant background. An estimated five percent of all the women who have undergone FGM/C live in Western nations (UNICEF, 2013). Those countries tend to adopt a more liberal view towards women's rights; yet some other countries argued that their approach is problematic as it is a way to try to perpetuate western values abroad. However, it is important to note that FGM/C does occur in the West too, and that efforts should therefore focus on how to tackle the issue at its roots in order for a full eradication to take place. At a regional level, the European Commission is currently working on methods to improve knowledge and data collection on the practice through the development of more precise estimation methods for the number of girls and women affected. It also funding national awareness campaigns directly referring to FGM/C in four of its member states.

- African and Middle-Eastern countries





Some African and Middle-Eastern countries do have a particularly high FGM/C rate, but it should also be noted that the figures may change drastically from country to country. Therefore, the labelling of FGM as an issue that is mostly "African" might be a dangerous stereotype: while FGM/C is nearly universal in Somalia, Guinea, Djibouti and Egypt, it affects only 1 percent of girls and women in Cameroon and Uganda. It is similarly important to underline that situations may vary a lot at a national scale, and this shows the issue should be focused on at a community or regional level.

Another important aspect to be highlighted is the pace at which decline may happen in some moderately low to very low prevalence countries. In Kenya and the United Republic of Tanzania, for example, women aged 45 to 49 are approximately three times more likely to have been cut than girls aged 15 to 19 (UNICEF, 2013). Conversely, no significant changes in prevalence rates were observed in Chad, Djibouti, Gambia, Guinea-Bissau, Mali, Senegal, Somalia, Sudan and Yemen in recent years. (UNFPA, 2015) Tackling the issue of FGM/C and its consequence on health at the level of the continent should be done by allowing broad access to health facilities

and assuring that every girl is able to attend school, as comprehensive education is a means of prevention (UNGA, 2013).

- Asia

FGM/C is more widespread in Asia than commonly thought. The concern is not the same as in African or Middle Eastern countries as the operation is mostly carried out by healthcare professionals in a medical context. Religious bodies often put pressure on governments in order for them to allow FGM/C so long as the operation is performed by doctors, trained nurses and midwives and provided that it abides by guidelines set out at a national scale. Most of the girls and women affected have a Muslim background, and religion is cited as a justification most of the time. This is the case, for instance, of 80% of those who undergone FGM/C in Malaysia, a country where the prevalence rate was reported to be over 90 percent according to a study run on communities in the north of the country (Batha, 2016). The age at which the operation is carried out also shows major discrepancies between countries, as it varies from infancy (between 40 and 60 days of age in Brunei) to late during childhood (between 6 and 9 years old in the Dawoodi Bohra community in India and Pakistan).

Points for further research

1. How far have we come since resolution 67/146 was passed?
2. How do we allow girls and women from all backgrounds have access to care and support structures in order to address both physiological and psychological after-effects, and to make sure the consequences on health are as limited as possible?
3. How to make sure everybody is reached, and what steps can be taken on the way to achieving total eradication?
4. Where should the biggest focus be to make sure the question is tackled effectively at a national scale, in order for the global response to be comprehensive and sustainable?
5. What is the legal framework like in your country?
6. How are religious leaders involved in the process of sensibilisation and education (if they are at all)?
7. Is there any way follow up and counselling can take place?
8. To what extent is psychological support part of the tackling of FGM/C in your country?
9. How do cultural differences come into play in the position to adopt regarding FGM/C and the way its aftereffects are handled?

Sources

Andro, Lesclingand. Les mutilations génitales féminines - État des lieux et des connaissances, Population 2016/2 (Vol. 71), p. 224-311. Available at : https://www.cairn.info/revue-population-2016-2-page-224.htm

Batha E., Oct. 13, 2016. The hidden cut: female genital mutilation in Asia. Reuters. Available at https://www.reuters.com/article/us-singapore-fgm-asia-factbox/factbox-the-hidden-cut-female-genital-mutilation-in-asia-idUSKCN12D04E

Berg, Fretheim, Odgaard-Jensen, Underland and Vist, 2014. Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. US National Library of Medicine

Josse ., 2013. Mutilations sexuelles ou mutilations génitales féminines : de quoi parle-t-on ? Grotius International. Available at : https://grotius.fr/les-mutilations-sexuelles-feminines-de-quoi-parle-t-on/#.Wrp5RmbpP4M

UNFPA, 2015. Demographic Perspectives on Female Genital Mutilation. Available at : https://sustainabledevelopment.un.org/content/documents/19961027123_UN_Demograhics_v3%20(1).pdf

United Nations General Assembly resolution, Intensifying global efforts for the elimination of female genital mutilations, UN document A/RES/67/146, 20 December 2012. Available at : http://digitallibrary.un.org/record/858574/files/A_RES_71_168-EN.pdf

UNICEF, 2013. Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. New York: UNICEF. Available at http://data.unicef.org/wp-content/uploads/2015/12/FGMC_Lo_res_Final_26.pdf

UNICEF, 2018. Female genital mutilation, current status and progress. Available at : https://data.unicef.org/topic/child-protection/female-genital-mutilation/#

World Health Organization, UNICEF & United Nations Population Fund, 1997. Female genital mutilation : a joint WHO/UNICEF/UNFPA statement. Geneva : World Health Organization. Available at http://www.who.int/iris/handle/10665/41903

WHO, 2008. Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. Available at : http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf

WHO, 2018, Female genital mutilation. Available at: http://www.who.int/mediacentre/factsheets/fs241/en/

Wuest. et al., 2009, Effects of female genital mutilation on birth outcomes in Switzerland, BJOG : An International Journal of Obstetrics and Gynaecology, 116(9), p. 1204-1209.