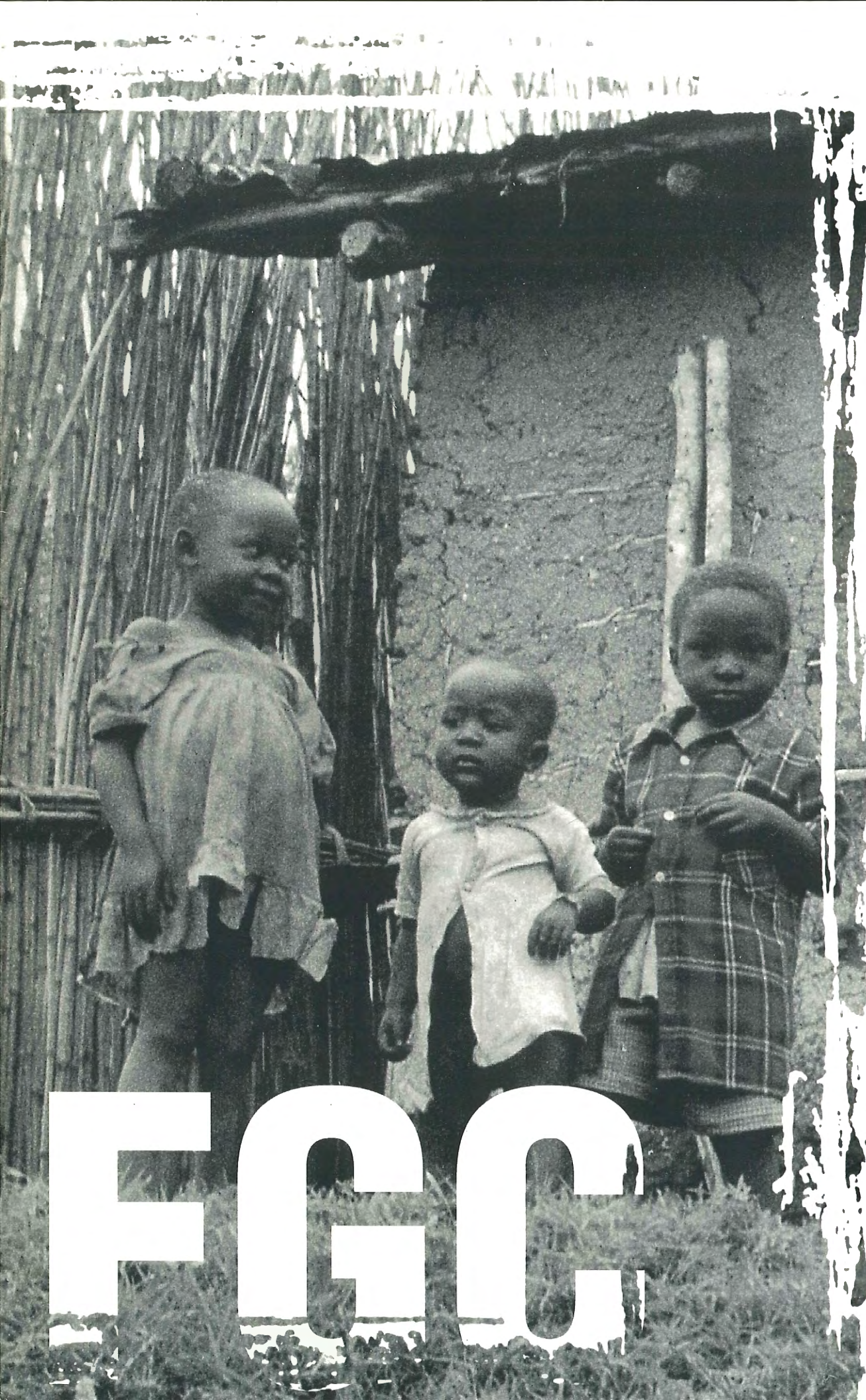


FEMALE GENITAL CUTTING
World Health Organization Fact Sheet



FFC

Female genital mutilation (FGM), sometimes referred to as female circumcision, comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.



What is Female Genital Mutilation?

There are different types of female genital mutilation known to be practised today. They include:

- excision of the prepuce, with or without excision of part or all of the clitoris;
- excision of the clitoris with partial or total excision of the labia minora;
- excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue;
- scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts);
- introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it;
- any other procedure that falls under the definition given above.

All these procedures are irreversible, harmful to the health of women and girls, and their effects last a lifetime.

The commonest type of female genital mutilation is excision of the clitoris and the labia minora, accounting for up to 80% of all cases; the most extreme form is infibulation, which constitutes about 15% of all procedures.

Health Consequences

The immediate and long-term health consequences of female genital mutilation vary according to the type and severity of the procedure performed.

Immediate complications include severe pain, shock, haemorrhage, urine retention, ulceration of the genital region and injury to adjacent tissue. Haemorrhage and infection can cause death.

More recently, concern has arisen about possible transmission of the human immunodeficiency virus (HIV) due to the use of one instrument in multiple operations, but this has not been the subject of detailed research. In some cases where infibulation prevents or impedes vaginal intercourse, analintercourse is known to be used as an alternative. The damage to tissue from anal intercourse is also a possible route of infection by HIV.

Long-term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction.

Infibulation, for example, can cause severe scar formation, difficulty in urinating and during menstruation, recurrent bladder and urinary tract infection and infertility. Because infibulation often makes intercourse difficult, it is sometimes necessary to cut open the bridge of skin created by the labia majora. Cutting may also be necessary when giving birth.

Although few reliable data exist, it is likely that the risk of maternal death and stillbirth is greatly increased, particularly in the absence of skilled health personnel and appropriate facilities.

Female genital mutilation may have adverse effects on a healthy reproductive life and also be associated with long-term maternal morbidity (e.g. vesico-vaginal fistula).

Genital mutilation may leave a lasting mark on the life and mind of the woman who has undergone it. The psychological complications may be submerged deep in the child's subconscious and may trigger behavioural disturbances. The loss of trust and confidence in care-givers has been reported as a possible serious effect. In the longer term, women may suffer feelings of incompleteness, anxiety, depression, chronic irritability and frigidity. They may experience marital conflicts because of sexual dysfunction in both partners resulting from painful intercourse and reduced sexual sensitivity.

Many girls and women, traumatized by their experience but with no acceptable means of expressing their fears, suffer in silence.

By Whom is it Performed, at What Age and for What Reasons?

In cultures where it is an accepted norm, female genital mutilation is usually performed by a traditional practitioner with crude instruments and without anaesthetic. Among the more affluent sectors of society it may be performed in a health care facility by qualified health personnel. In the latter case one may speak of the medicalization of female genital mutilation.

FGM is harmful to girls and women. The medicalization of the procedure does not eliminate this harm and is inappropriate for two major reasons: FGM runs against basic ethics of health care whereby unnecessary bodily mutilation cannot be condoned by health providers; and, its medicalization seems to legitimize the harmful practice.

The age at which female genital mutilation is performed varies from area to area: it is performed on infants a few days old, female children and adolescents who are not in a position to decide for themselves, and, occasionally, even on mature women.



The Known Reasons for FGM Include:

- psychosexual reasons: reduction or elimination of the sensitive tissue of the outer genitalia, particularly the clitoris, in order to attenuate sexual desire in the female, maintain chastity and virginity before marriage and fidelity during marriage, and increase male sexual pleasure;
- sociological reasons: identification with the cultural heritage, initiation of girls into womanhood, social integration and the maintenance of social cohesion;
- hygiene and aesthetic reasons: the external female genitalia are considered dirty and unsightly and are to be removed to promote hygiene and provide aesthetic appeal;
- myths: enhancement of fertility and promotion of child survival;
- religious reasons: FGM is practised by Muslims, Christians (Catholics, Protestants, Copts), animists and nonbelievers in a range of communities. Some Muslim communities, for example, practice FGM in the genuine belief that it is demanded by the Islamic faith. However, the practice predates Islam.

Prevalence and Distribution

Most of the girls and women who have undergone genital mutilation live in 28 African countries, although some live in Asia and the Middle East. They are also increasingly found in Europe, Australia, Canada and the USA, primarily among immigrants from these countries.

Today, the number of girls and women who have been subjected to female genital mutilation is estimated at over 130 million individuals worldwide, and a further 2 million girls who are annually at risk of this practice.

International Response

Several United Nations Conventions and Declarations make provision for the promotion and protection of the health of girls and women, including the elimination of female genital mutilation. Most governments in countries where it is practised have ratified these conventions. International organizations, nongovernmental organizations and other interested partners have been working towards the elimination of FGM.

Much experience has been gained in bringing the problem to the attention of political, religious and community leaders and in creating an atmosphere of political support for the elimination of the practice. Unfortunately, the overall

progress in this area has been very slow. The major reasons for this include the lack of coordination of prevention programmes and limited investment of resources in them in the countries concerned.

International experience in fighting FGM testifies to the fact that the variety of cultural reasons for female genital mutilation, including the issue of women's position and gender relations within a particular sociocultural and economic context, can be addressed only through concerted multidisciplinary interagency efforts.

The analysis of the situation made by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) — the three agencies most actively involved in the fight against FGM — has shown that a well designed and well coordinated campaign against the practice, with appropriate technical expertise and adequate levels of funding, brings about a major decline in female genital mutilation in 10 years and could lead to its elimination within three generations.

The elimination of FGM can be achieved through teamwork among different UN agencies both within the countries where female genital mutilation is practised, as well as at the regional and global levels. This teamwork must bring together governments, political and religious institutions, international organizations, nongovernmental organizations and funding agencies in their efforts to eliminate this harmful practice. WHO, UNICEF and UNFPA agreed that the basis for this cooperation at country level would be national "interagency teams" supported by international organizations.

Such teams will assist governments in developing and implementing clear national policies for the abolition of female genital mutilation, including, where appropriate, the enactment of legislation to prohibit it.

The interagency teams' efforts will be directed at changing public opinion in the countries concerned through education and awareness-raising about the harmful health effects of female genital mutilation. Their target audiences will include the general public, medical professionals, decision-makers, governments, political, religious and village leaders, as well as traditional healers and birth attendants.

For further information, please contact the Office of Health Communications and Public Relations, WHO, Geneva, Switzerland (4122) 791 2532/2584, fax (4122) 791 4858.

All WHO Press Releases, Fact Sheets and Features can be obtained on Internet on the WHO home page <http://www.who.int>.

For more information, please contact:

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