

## **Female genital mutilation**

### **Report by the Secretariat**

1. Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural functioning of girls' and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including an increased risk of maternal morbidity and an increased perinatal mortality rate among babies born to women who have undergone the practice.

2. It is estimated that between 100 million and 140 million girls and women worldwide<sup>1</sup> have been subjected to type I, II or III procedures,<sup>2</sup> and that about three million girls and women are at risk of undergoing one of these types every year in Africa. Female genital mutilation has been documented in 28 countries in Africa and in several countries in Asia and the Middle East. Some forms of the practice have also been reported from other countries, including among certain ethnic groups in Central and South America. Although no prevalence data are available, there is evidence of increasing numbers of girls and women living outside their place of origin, including in North America and Western Europe, who have undergone or may undergo female genital mutilation in their host country.

3. Over the past two or three decades, local, national and international actors have significantly increased their efforts to eliminate female genital mutilation, and have made progress on several fronts. The practice is internationally recognized as a violation of human rights, and many countries have put in place policies and legislation to ban it. Many communities are, it seems, showing less support for the practice. Research findings have increased knowledge about the practice itself and the reasons for its continuation, as well as experience with interventions that can contribute to its abandonment. Advocacy at the international level has created a momentum suggesting that it is possible to significantly reduce the prevalence of female genital mutilation within one generation.

4. Following the adoption of resolution WHA47.10 by the Health Assembly in 1994, on traditional practices (including female genital mutilation) harmful to the health of women and children, the Secretariat has provided increased technical support to Member States for preventing the practice and managing its consequences. Such support has included the elaboration and dissemination of a series of

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<sup>1</sup> Extrapolated from estimates that 92 million girls and women currently aged 10 and over have undergone the practice in Africa.

<sup>2</sup> Type I – excision of the prepuce, with or without excision of part or all of the clitoris; Type II – excision of the clitoris with partial or total excision of the labia minora; Type III – excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

guidance documents on the prevention and management of the practice's health complications for use at policy, programmatic and pre-service training levels.

5. The results of a WHO study in six African countries on the obstetric sequelae of female genital mutilation<sup>1</sup> showed that deliveries among women who had undergone the practice (compared with deliveries among women who had not) were significantly more likely to be complicated by caesarean section, post-partum haemorrhage, episiotomies and prolonged stay in hospital. In addition, babies born to mothers who had undergone the practice (compared with babies born to mothers who had not) had a greater risk of dying during birth or of needing resuscitation immediately after birth.

6. WHO's ongoing support for research on female genital mutilation includes assessments of how community-based interventions that are successful can be replicated elsewhere, of the elements in decision-making that contribute to continuation or abandonment of the practice, and of the role played by perceptions of women's sexuality in the continuation of the practice. The Secretariat intends, over the next few years, to evaluate the economic costs of female genital mutilation, both immediate medical costs and long-term costs of morbidities and psychological consequences. It will also appraise the effects of legal measures. It plans to develop web-based and other audiovisual media for the training of health professionals to prevent female genital mutilation where possible, and to successfully manage its health consequences in women, girls and newborn babies.

7. All the WHO regional offices in regions where the practice is prevalent are engaged in activities aimed at eliminating it. Since 1989, when the Regional Committee for Africa in resolution AFR/RC39/R9 called on Member States to adopt appropriate policies and strategies to eliminate female circumcision, that Regional Office has supported its Member States in programmes for the elimination of the practice, in line with its 20-year Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa. In South-East Asia, the Regional Office works with the Ministry of Health in Indonesia, which is concerned about the increasing tendency for female genital mutilation to be practiced by health professionals. In Europe, there are concerns about female genital mutilation among immigrant populations, and the Regional Office is providing guidance to Member States with regard to health care and the law governing female genital mutilation. The Regional Office for the Eastern Mediterranean has produced guidelines on the elimination of female genital mutilation.

8. Nonetheless, the rate of progress towards a significant decline in the practice is slow. In some countries there appears to be an increasing tendency for female genital mutilation to be carried out by health professionals, a development that is of particular concern. Thus, there is an urgent need to reinforce actions, commitment and resources to achieve the goal of eliminating the practice within one generation.

9. WHO is therefore coordinating the revision of the 1997 WHO/UNFPA/UNICEF joint statement on female genital mutilation to reinforce international commitment in the fight to eliminate the practice. Officially launched in February 2008 during the Fifty-second session of the United Nations Economic and Social Council's Commission on the Status of Women, the revised interagency statement reflects new evidence and incorporates lessons learnt over the past decade. It highlights the now-extensive recognition of the human rights and legal dimensions of the problem. It also summarizes findings from recent research on the prevalence of female genital mutilation, the reasons why the practice continues, and its damaging effects on the health of women, girls and newborn

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<sup>1</sup> *Lancet*, 2006; 367:1835–1841.

babies. It points to a series of actions that need to be undertaken by a variety of different actors. The joint statement is the result of extensive consultation with different international, regional and national partners, and 10 other United Nations bodies have signed the statement (UNESCO, WHO, UNICEF, United Nations Economic Commission for Africa, UNDP, UNHCR, UNFPA, Office of the High Commissioner on Human Rights, United Nations Development Fund for Women, and UNAIDS).

10. At its 122nd session,<sup>1</sup> the Executive Board strongly supported strengthening efforts at national, regional and international levels to eliminate female genital mutilation, a practice that violates women's and girls' human rights. Several members expressed particular concern about the increasing tendency for female genital mutilation to be done by health professionals and underlined WHO's role in working to reverse and halt this medicalization of the practice. Although the Board was unanimous in its support of the draft resolution, members could not agree on the final wording of some of the proposed amendments. Therefore two paragraphs in the draft resolution submitted to the Health Assembly for its consideration contain bracketed text.

## **ACTION BY THE HEALTH ASSEMBLY**

11. The Health Assembly is invited to consider the draft resolution contained in resolution EB122.R13.

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<sup>1</sup> See document EB122/2008/REC/2, summary record of the sixth, ninth and tenth meetings.