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# Female Genital Mutilation

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Report of a WHO Technical Working Group

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## 1 INTRODUCTION

A Technical Working Group on Female Genital Mutilation met in Geneva from 17 to 19 July 1995. Opening the meeting on behalf of the Director-General, Dr T. Türmen, Director, Division of Family Health, affirmed that WHO recognizes that female genital mutilation – the partial or total removal of or injury to the external female genitalia performed for non-therapeutic reasons – in addition to causing pain and suffering, represents a serious health hazard for women, and is a violation of internationally accepted human rights. **WHO condemns all forms of female genital mutilation and calls for the abolition of the practice. WHO also states unequivocally that no form of female genital mutilation should be practised by any health professional in any setting, including hospitals and other health establishments.**

It is estimated that there are at present over 120 million<sup>1</sup> girls and women who have undergone some form of genital mutilation and that at least 2 million girls per year are at risk of mutilation.<sup>2,3</sup> It is known that the physical and psychological effects of the practice are often very extensive, affecting health, in particular sexual, reproductive and mental health and well-being. The damage done to the female sexual organs and their functions is extensive and irreversible. These effects persist throughout the lives of those who experience them. Furthermore, female genital mutilation reinforces the inequities suffered by women in the communities where it is practised. Despite recognition of the importance of this sensitive issue, and a realization that it must be addressed if the health, social and economic development needs of women are to be met, there are still major gaps in knowledge about the extent and nature of the problem and the kinds of intervention that can be successful in eliminating it. Current information on types of mutilation and their prevalence is derived from inadequate, fragmentary data. Moreover, although there is a growing body of data on the physical consequences, little sound research has been conducted on the psychological effects on children, on the psychosexual impact on women, or on how to care for those who experience these problems.

In recent years, WHO's governing bodies have adopted a number of resolutions urging Member States *inter alia* to establish clear national policies to end traditional practices harmful to the health of women and children and requesting WHO to strengthen its technical and other support to the countries concerned (Annex). The Organization is seeking to develop its activities in this area in a holistic way, bringing together the work of different programmes in order to draw up recommendations that are consistent with the provision of integrated reproductive health programmes. WHO's four main strategies are:

- to play an advocacy role by emphasizing the importance of action against harmful practices at international, regional and national levels;
- to initiate and to coordinate the research and development being undertaken by international agencies, nongovernmental organizations and national authorities;
- to support national networks or organizations and groups involved in developing relevant policies, strategies and programmes;
- to support the training of health professionals in the prevention of female genital mutilation and the management of its health consequences.

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<sup>1</sup> Except for the Sudan, there are no reliable national prevalence data on FGM. Current national estimates are based on estimates from small-scale studies and anecdotal information. This figure has been rounded off from estimates of national prevalence by the two authors cited in notes 2 and 3 below.

<sup>2</sup> Hosken FP. *Female genital mutilation, estimate: total number of girls and women mutilated in Africa*. Lexington, Women International Network (WIN News), 1995.

<sup>3</sup> Toubia N. *Female genital mutilation: a call for global action*. New York, Rainbg, 1995.



The next steps are to increase available knowledge and develop a sound technical basis for policy and action. This includes developing instruments for use at country level for research on female genital mutilation and on interventions that are successful in abolishing the practice. Such research should be based on standard definitions and protocols, and interventions should be properly monitored and evaluated for their effectiveness.

## **1.1 Objectives of the Technical Working Group**

The Technical Working Group was convened to draw attention to female genital mutilation and its health consequences, to begin the process of developing standards and norms and to make recommendations for further activities. Its specific objectives were:

- to review existing knowledge about female genital mutilation;
- to recommend for adoption standard definitions and a classification for the different types of female genital mutilation;
- to consider appropriate research methodologies and formulate guidelines for data collection and analysis;
- to discuss the effectiveness of different types of intervention for the prevention and elimination of female genital mutilation; and
- to identify needs and intervention strategies for future action.

## **1.2 Female genital mutilation practices**

Female genital mutilation encompasses a range of procedures including the excision of the prepuce (the fold of skin above the clitoris), the partial or total excision of the clitoris (clitoridectomy) and labia, and the stitching and narrowing of the vaginal orifice (infibulation). Excision of the clitoris or of the clitoris and labia minora is performed in approximately 80% of girls and women who undergo genital mutilation. Infibulation – the most extreme form of mutilation – involves the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora. The two sides of the vulva are then stitched together with thorns or silk or catgut sutures, so that when the skin of the remaining labia majora heals a bridge of scar tissue forms over the vagina. A small opening is preserved, by the insertion of a foreign body, to allow the passage of urine and menstrual blood. The legs are sometimes bound together for several weeks to allow the scar tissue to form. Since a physical barrier has been created during sexual intercourse, the infibulated woman has to undergo gradual dilation by her husband over a period of days, weeks or even months. This painful process does not always result in successful vaginal penetration and the opening may have to be re-cut. At childbirth the woman has to be cut once more (defibulation) to allow the passage of the baby. After birth the raw edges are again sutured (re-infibulation). Other mutilation procedures include introcision (the enlargement of the vaginal opening by tearing or cutting the perineum), the pricking, piercing, incising or cauterizing by burning of the clitoris and/or labia, and the scraping of surrounding tissue of the vaginal orifice (angurya cuts) or cutting of the anterior and sometimes posterior vaginal wall (gishiri cuts).

The age at which female genital mutilation is performed varies widely, depending on the ethnic group and geographical location. In some groups it is performed on babies; more commonly it is undertaken between the ages of 4 and 10 years but it may also be carried out in adolescence or even at the time of marriage or during a first pregnancy. The operations, which last about 15–20 minutes, are carried out with special knives, scissors, scalpels, pieces of glass or razor blades. The instruments may be reused without cleaning. Operations are usually undertaken by an elderly woman in the community specially designated for this task or by traditional birth attendants, although in some cases, the services of health personnel such as midwives and doctors are called upon. Anaesthetics and antiseptics are not generally used, and pastes containing herbs, local porridge or ashes are frequently rubbed on the wounds to stop bleeding. Unintended additional

damage is often caused because of the crude tools, poor light, poor eyesight of the practitioner, and septic conditions, or because of the struggles of the girls or women during the procedure.

It is not known when or where the tradition of female genital mutilation originated and a variety of reasons (sociocultural, psychosexual, hygienic, aesthetic, and religious) are given for maintaining it. Female genital mutilation is practised by followers of a number of different religions, including Muslims and Christians (Catholics, Protestants and Copts), by animists, and also by non-believers in the countries concerned. The practice is deeply embedded in local traditional belief systems. It is important to note that neither the Bible nor the Koran prescribe to the practice, although it is frequently carried out in some Muslim communities in the genuine belief that it forms part of Islam.

### 1.3 Geographical distribution

There have been no comprehensive global surveys of the prevalence of female genital mutilation. Most of the girls and women who have undergone mutilation live in 28 African countries (Figure 1). It is practised by many ethnic groups, from the east to the west coast of Africa, in the southern parts of the Arabian peninsula and along the Persian Gulf, and increasingly amongst some immigrant populations in Europe, Australia, Canada and the United States of America. It has also been reported to be practised by Daudi Bohra Muslims who live in India and amongst Muslims in Malaysia and Indonesia. Infibulation is widespread in Somalia, northern Sudan and Djibouti and has been reported in Ethiopia, Eritrea, northern Kenya, some parts of Mali and northern Nigeria. Introcision has only been documented in some Aboriginal communities of Australia, but is not considered to be a current practice amongst this group.

On the basis of government reports, anecdotal evidence and limited surveys with non-representative samples, the prevalence of mutilation in countries where it is practised is estimated to range from 5% to 98% (Hosken, 1995,<sup>2</sup> Toubia, 1995<sup>3</sup>). Sudan is the only country to have carried out nationwide surveys (El Dareer, 1980,<sup>4</sup> the Sudan Fertility Survey 1979<sup>5</sup>; Sudan Demographic and Health Survey, 1989/1990<sup>6</sup>). They were based on a national sample which excluded the three southern provinces, where the practice is unknown (except by adoption through marriage with members of northern groups where mutilation is practised), and indicated an initial prevalence of 89% which subsequently declined by 8%. A study by the Nigerian Association of Nurses and Nurse-midwives conducted in 1985–1986 using a sample of 400 women and men in each state showed that 13 out of the 21 states had populations practising some form of female genital mutilation, prevalence ranging from 35% to 90%.<sup>7</sup> However, the data could not be extrapolated to give a national picture. Similar surveys exist for Chad, Ethiopia, Gambia, Ghana, Kenya and Senegal.

In 1989–1990, a series of questions on female genital mutilation were incorporated in the Demographic Health Survey (DHS I) in Sudan. The Central African Republic and the Ivory Coast have also incorporated a few questions on the practice in their national Demographic and Health

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<sup>4</sup> El Dareer A. *An epidemiological study of female circumcision in the Sudan*. Khartoum, Thesis Department of Community Medicine, Faculty of Medicine, University of Khartoum, 1980.

<sup>5</sup> *The Sudan Fertility Survey*. Department of Statistics, Ministry of Economic and National planning, Khartoum, 1979.

<sup>6</sup> *Sudan Demographic and Health Survey*. Department of Statistics, Ministry of Economic and National Planning, Khartoum, 1989/1990.

<sup>7</sup> Adebajo CO. Female circumcision and other dangerous practices to women's health. In: Kisekka MN. *Women's Health Issues in Nigeria*. Zaria, Tamaza Publishing Co., 1992.

Survey (1994 and 1994-1995 respectively). A full module on female genital mutilation containing 20 questions (DHS III) was field tested in Mali and in Eritrea in 1995, and Egypt integrated 34 questions on female genital mutilation in its national Demographic and Health Survey in the same year.<sup>8</sup> It is hoped that these attempts will generate more reliable incidence and prevalence data in future years.

## 2 DEFINITION AND CLASSIFICATION

### 2.1 Background

Female genital mutilation is the term now generally accepted for the traditional practices that entail removal of part or all of or injury to the external genitalia of girls and women. It does not include genital surgery performed for medically prescribed reasons.

This term was first used by feminists, women's health advocates and human rights activists and was subsequently adopted by the Inter African Committee at a meeting in Addis Ababa, Ethiopia (1990). Since then, it has also been adopted by the United Nations and is increasingly being used by the public. Prior to its adoption, the practices were referred to as "female circumcision", a term still in common use.

The terminology used to describe the different forms of female genital mutilation varies widely among the population groups where they are practised and among researchers, health personnel, health advocates and others. Removal of the prepuce has been called "true circumcision", in that it is equivalent to male circumcision. Clitoridectomy is sometimes referred to as "mild circumcision" and is also known as "Sunna circumcision" by some Muslim communities. However, the Koran does not recommend any form of female genital mutilation and it is suggested that, in order to prevent any misunderstanding that there is such a link, the term "Sunna" should be discouraged. Infibulation may be termed "severe circumcision" and is also known as "Pharaonic circumcision" in Sudan and "Sudanese circumcision" in Egypt. A modified form of infibulation has been called "intermediate circumcision".

Attempts to classify female genital mutilation also vary considerably, since the different types of procedure have never been clearly defined. The classifications in current use generally distinguish three main types:

- excision of the prepuce and clitoris
- excision of the prepuce, clitoris and labia minora
- infibulation.

Some classifications also include other procedures such as introcision.

### 2.2 Proposed definition and classification

The Technical Working Group agreed that the adoption of a standardized definition and classification is a necessary step in the abolition of female genital mutilation, as they are essential tools for research, training, planning policies and formulating appropriate legislation and for all those working on this issue at all levels. The participants stressed that the definition of female



genital mutilation should encompass the physical, psychological and human rights aspects of the practice.

There was an extensive discussion on the use of the term "female circumcision". The term is used in different ways. Some people consider it to be equivalent to the term "male circumcision". This would be a rather narrow definition, covering only the removal of the prepuce. Others consider that it refers to more extensive removal of the external genitalia and therefore cannot be likened to male circumcision. The use of the term might also indicate that there is a case for medicalization (involvement of health professionals) in some types of procedure, which is not desirable. It was agreed that the term "female genital mutilation" is preferable. However, it was recognized that this term can be offensive to some groups, including women who have undergone the procedure. In addition, many communities use local terms. Language used at the community level should therefore be chosen with care. For research and data collection it is important to match local terminology to the agreed classification set out in the box on the next page in order to ensure comparability.

It was also agreed that, in addition to the three main forms of female genital mutilation (clitoridectomy, excision of the clitoris and labia, and infibulation), other practices involving the stretching, pricking, piercing, cauterization, scraping or cutting of any part of the external genitalia or the insertion of herbs or any other substances into the vagina for the purpose of tightening should also be included in the classification.

The Technical Working Group recommended the adoption of the definition and classification of female genital mutilation set out in the box on the next page.

### 3 PHYSICAL CONSEQUENCES

Female genital mutilation causes grave damage to girls and women and frequently results in short- and long-term health consequences. The effects on health depend on the extent of cutting, the skill of the operator, the cleanliness of the tools and the environment, and the physical condition of the girl or woman concerned. Girls and women undergoing the more severe forms of mutilation are particularly likely to suffer serious and long-lasting complications. Documentation and studies are available on the physical short-term and long-term complications described below, but there has been little study of the sexual or mental effects (see section 4) or of the frequency with which complications occur. The mortality of girls and women undergoing genital mutilation is unknown, as few records are kept and deaths due to the practice are rarely reported.

#### 3.1 Short-term complications

*Pain.* The majority of mutilation procedures are undertaken without anaesthetic and cause severe pain. Even in a medical setting where local anaesthesia is available, it is difficult to administer as the clitoris is a highly vascular organ with a dense concentration of nerve endings; to anaesthetize the area completely, multiple painful applications of the needle are required.

*Injury to adjacent tissue* of the urethra, vagina, perineum and rectum can result from the use of crude instruments, poor light, poor eyesight of the practitioner or careless technique. This is even more likely if the girl is screaming or struggling because of pain or fear. Damage to the urethra can result in incontinence.

## Definition and Classification of Female Genital Mutilation

### *Preamble*

Female genital mutilation is a deeply rooted, traditional practice. However, it is a form of violence against girls and women that has serious physical and psychosocial consequences which adversely affect health. Furthermore, it is a reflection of discrimination against women and girls.

WHO is committed to the abolition of all forms of female genital mutilation. It affirms the need for the effective protection and promotion of the human rights of girls and women, including their rights to bodily integrity and to the highest attainable standard of physical, mental and social well-being.

WHO strongly condemns the medicalization of female genital mutilation, that is, the involvement of health professionals in any form of female genital mutilation in any setting, including hospitals or other health establishments.

### *Definition*

Female genital mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

### *Classification*

- |          |   |
|----------|---|
| Type I   | Excision of the prepuce with or without excision of part or all of the clitoris;  |
| Type II  | Excision of the prepuce and clitoris together 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);  |
| Type IV  | Unclassified: <ul style="list-style-type: none"><li>- pricking, piercing or incision of the clitoris and/or labia</li><li>- stretching of the clitoris and/or labia</li><li>- cauterization by burning of the clitoris and surrounding tissues</li><li>- scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina</li><li>- introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina</li><li>- any other procedure that falls under the definition of female genital mutilation given above</li></ul> |

*Haemorrhage.* Excision of the clitoris involves cutting the clitoral artery which has a strong flow and high pressure. Packing, tying or stitching to stop bleeding may not be effective and this can lead to haemorrhage. Secondary haemorrhage may occur after the first week as a result of sloughing of the clot over the artery due to infection. Cutting of the labia causes further damage to blood vessels and Bartholin glands. Haemorrhage is the most common and life-threatening complication of female genital mutilation. Extensive acute haemorrhage or protracted bleeding can lead to anaemia or haemorrhagic shock and in some cases death.

*Shock.* Immediately after the procedure, the girl may develop shock as a result of the sudden blood loss (haemorrhagic shock) and severe pain and trauma (neurogenic shock), which can be fatal.

*Acute urine retention* can result from swelling and inflammation around the wound, the girl's fear of the pain of passing urine on the raw wound, or injury to the urethra. Retention is very common; it may last for hours or days, but is usually reversible. This condition often leads to urinary tract infection.

*Fracture or dislocation.* Fractures of the clavicle, femur or humerus or dislocation of the hip joint can occur if heavy pressure is applied to the struggling girl during the operation, as often occurs when several adults hold her down during the mutilation.

*Infection* is very common for a number of reasons: unhygienic conditions; use of unsterilized instruments; application of substances such as herbs or ashes to the wound, which provide an excellent growth medium for bacteria; binding of the legs following type III female genital mutilation (infibulation), which prevents wound drainage; or contamination of the wound with urine and/or faeces. Infections can result in failure of the wound to heal, abscess, fever, ascending urinary tract infection, pelvic infection, tetanus, gangrene or septicaemia. Severe infections can be fatal. Group mutilations, in which the same unclean cutting instruments are used on each girl may give rise to a risk of transmission of bloodborne diseases such as HIV and hepatitis B although transmission has not been confirmed. The consequences of type III mutilation, such as repeated cutting and stitching during labour, and the higher incidence of wounds and abrasions during vaginal intercourse and increased anal intercourse because of the difficulties of vaginal penetration, may also potentially increase the risk of HIV transmission.

*Failure to heal.* The wounds may fail to heal quickly because of infection, irritation from urine or rubbing when walking, or an underlying condition such as anaemia or malnutrition. This can lead to a purulent, weeping wound or to a chronic infected ulcer.

### 3.2 Long-term complications

*Difficulty in passing urine* can occur due to damage to the urethral opening or scarring of the meatus.

*Recurrent urinary tract infection.* Infection near the urethra can result in ascending urinary tract infections. This is particularly common following type III mutilation, when the normal flow of urine is deflected and the perineum remains constantly wet and susceptible to bacterial growth. Stasis of urine resulting from difficulty in micturition can lead to bladder infections. Both types of infection can spread to the ureters and kidneys. If not treated, bladder and kidney stones and other kidney damage may result.

*Pelvic infections* are common in infibulated women. They are painful and may be accompanied by a discharge. Infections may spread to the uterus, fallopian tubes and ovaries, and may become chronic.

*Infertility* can result if pelvic infection causes irreparable damage to the reproductive organs.

*Keloid scar.* Slow and incomplete healing of the wound and post-operative infection can lead to the production of excess connective tissue in the scar. This may obstruct the vaginal orifice, leading to dysmenorrhoea (painful menstrual period). Following infibulation, scarring can be so extensive that it prevents penile penetration and may cause sexual and psychological problems (see section 4).

*Abscess.* Deep infection resulting from faulty healing or an embedded stitch can result in the formation of an abscess, which may require surgical incision.

*Cysts and abscesses on the vulva.* Implantation dermoid cysts are the commonest complications of infibulation. They vary in size, sometimes reaching the size of a football, and occasionally become infected. They are extremely painful and prevent sexual intercourse.

*Clitoral neuroma.* A painful neuroma can develop as a consequence of trapping of the clitoral nerve in a stitch or in the scar tissue of the healed wound, leading to hypersensitivity and dyspareunia.

*Difficulties in menstruation* can occur as a result of partial or total occlusion of the vaginal opening. These include dysmenorrhoea and haematocolpos (accumulation of menstrual blood in the vagina). Haematocolpos may appear as a bluish bulging membrane in the vaginal orifice and can prevent penetrative sexual intercourse. It can also cause distension of the abdomen which, together with the lack of menstrual flow, may give rise to suspicions of pregnancy, with potentially serious social implications.

*Calculus formation in the vagina* can occur as a result of the accumulation of menstrual debris and urinary deposits in the vagina or the space behind the bridge of scar tissue formed after infibulation.

*Fistulae* (holes or tunnels) between the bladder and the vagina (vesico-vaginal) and between the rectum and vagina (recto-vaginal) can form as a result of injury during mutilation, defibulation or re-infibulation, sexual intercourse or obstructed labour. Urinary and faecal incontinence can be lifelong and may have serious social consequences.

*Development of a "false vagina"* is possible in infibulated women if, during repeated sexual intercourse, the scar tissue fails to dilate sufficiently to allow normal penetration.

*Dyspareunia* (painful sexual intercourse) is a consequence of many forms of female genital mutilation because of scarring, the reduced vaginal opening and complications such as infection. Vaginal penetration may be difficult or even impossible and re-cutting may be necessary. Vaginismus may result from injury to the vulval area and repeated vigorous sexual acts; the vaginal opening closes by reflex action causing considerable pain and soreness.

*Sexual dysfunction* can result in both partners because of painful intercourse, difficulty in vaginal penetration, and reduced sexual sensitivity following clitoridectomy (see section 4).

*Difficulties in providing gynaecological care.* The scarring resulting from type III mutilation may reduce the vaginal opening to such an extent that an adequate gynaecological examination cannot be performed without cutting. For example, it may not be possible to insert a speculum to allow a cervical smear to be taken, or to fit an intrauterine contraceptive device.

*Problems in pregnancy and childbirth* are common, particularly following type III mutilation, because the tough scar tissue that forms causes partial or total occlusion of the vaginal opening and prevents dilation of the birth canal. Difficulty in undertaking an examination during labour can lead to incorrect monitoring of the stage of delivery and fetal presentation. Prolonged and obstructed labour can lead to tearing of the perineum, haemorrhage, fistula formation and uterine

inertia, rupture or prolapse. These complications can lead to neonatal harm (including stillbirth) and maternal death. In the event of a miscarriage, the fetus may be retained in the uterus or birth canal. The infibulated woman must be defibulated to allow passage of the baby. Defibulation increases the risk of bleeding and wound infection and may lead to damage to neighbouring organs if performed incorrectly. There is also a risk of subsequent complications following re-infibulation. Where midwives and doctors are not familiar with defibulation procedures, Caesarian section may be performed.

### **3.3 Association of female genital mutilation with its health consequences**

Many women appear to be unaware of the relation between female genital mutilation and its health consequences, in particular the complications affecting sexual intercourse and childbirth which occur many years after mutilation has taken place. Moreover, in many cases, women have been conditioned socially to accept the practice and the pain it causes. However, traditional practitioners are often aware of the health problems of female genital mutilation and may perpetuate various myths to make women believe that these are normal. In Sierra Leone, for example, they know that the scar tissue will not usually yield for the first child and therefore promote the belief that it is usual to lose this child at birth.

## **4 SEXUAL, MENTAL AND SOCIAL CONSEQUENCES**

Female genital mutilation can have lifetime effects on the minds of those who experience it. Unfortunately, there is little systematic information on the sexual, mental and social effects of the practice on girls and women. Current information is based on field observations and preliminary pilot studies.

### **4.1 Sexual consequences**

#### **4.1.1 Functions of the female external genitalia**

The clitoris is a key to the normal functioning and mental and physical development of female sexuality. Arousal and pleasure associated with clitoral erection are discovered by female infants in their first year of life. Subsequent wilful clitoral stimulation (mental or physical), plays a major role in the development of female sexuality.

The clitoris and labia minora are supplied with a large number of sensory nerve receptors and fibres, with a particularly high concentration in the tip of the clitoris. These are connected to the brain, affecting sensory perception, which in return affects the muscle and secretory activities of the body, particularly the pelvic muscular and glandular activities. Clitoral erection releases chemicals in the brain (endorphins, dopamine and serotonin) that reduce pain and stress.

#### **4.1.2 Effects of mutilation**

Many women who have undergone genital mutilation experience various forms and degrees of sexual malfunction.

Genital mutilations that involve injury to or removal of the clitoris, particularly the clitoral tip and the labia minora, result in damage to the concentrated nerve complex responsible for clitoral erection, pelvic muscular and secretory activities, and for the transmission of sensory information to the central nervous system.

Erection of a partially mutilated clitoris stretches scarred erectile tissue and stimulates damaged clitoral nerve tissues, which can be a painful and mentally inhibiting ordeal. Loss or interruption of spontaneity of clitoral erection and damage to sensory perception impair arousal, which may inhibit sexual foreplay and affect the development of sexuality. Vaginal penetration, through damaged genital nerve and scar tissues, can be difficult or impossible without further tissue damage (tears) and bleeding. Orgasm is lost in many genitally mutilated women. Despite such sexual malfunctions, women with mutilated genitals seem to experience sexual desire and fantasy no less than women with intact genitals, and some degree of sexual enjoyment may be possible. This ability to compensate for lack of clitoris and other erogenous areas, and the emotional and physical propensity for the sexual act need to be further investigated to guide management of the sexual malfunctions of genitally mutilated women.

Male attitudes to sex and sexual pleasure in communities practising female genital mutilation may reinforce the practice. For example, anecdotal reports suggest that in some communities practising infibulation, achievement of difficult penetration of a tight vagina has become a proof of virility following marriage.

## **4.2 Mental and social consequences**

Genital mutilation is commonly performed when girls are quite young and uninformed and is often preceded by acts of deception, intimidation, coercion, and violence by trusted parents, relatives and friends. Girls are generally conscious when the painful operation is undertaken – no anaesthetic or other medication is used – and they have to be physically restrained as they struggle. In some instances they are also made to watch the mutilation of other girls.

For many girls, genital mutilation is a major experience of fear, submission, inhibition and suppression of feelings and thinking. This experience becomes a vivid landmark in their mental development, the memory of which persists throughout life. Older women have reported that nothing they have subsequently gone through, including pain and stress in pregnancy, childbirth, painful sexual intercourse and periods, has come close to the painful experience of genital mutilation. Some girls and women are unable or have difficulty recalling and describing the experience but their tension and tears reflect the magnitude of emotional pain they silently endure at all times. Although they may receive family support immediately following the procedure, girls may have feelings of anger, bitterness and betrayal at having been subjected to such pain. The resulting loss of confidence and trust in family and friends can affect the child-parent relationships and has implications for future intimate relationships with adults and with their own children. Other girls and women are expressive about the humiliation, submission and fear entrenched in their lives as a result of enduring the experience of genital mutilation. For many girls and women, the mental experience of genital mutilation and its mental aftermath, are very similar to those following rape.

The experience of genital mutilation is commonly associated with psychosomatic and mental problems, symptoms and disorders which affect a wide range of brain functions. Girls have reported disturbances in eating, sleep, mood and cognition. These were manifested in sleeplessness, nightmares, appetite or weight loss or excessive gain, post-traumatic stress, panic attacks, mood instability and difficulties in concentration and learning. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobia, panic or even psychotic disorders. These are compounded by the development of the serious long-term physical health effects of mutilation described in section 3. Many women traumatized by their experience of genital mutilation have no acceptable means of expressing their fears and pains and suffer in silence.



## **5 RESEARCH AND DEVELOPMENT**

### **5.1 Principles to guide research**

Research efforts on female genital mutilation should be designed to avoid waste and duplication, to make maximum use of the limited funds likely to become available given the current economic climate and the long-term investment needed to ensure the elimination of the practice. Where possible, collaboration with other international organizations, scientific institutes, governments, professional and nongovernmental organizations and community groups should be encouraged. Studies pioneered by nongovernmental organizations at local level should be evaluated and followed up where relevant. Because the practice of female genital mutilation is based on the deep-rooted traditions and cultural norms of ethnic groups, a multidisciplinary approach to research on female genital mutilation will be needed. The welfare of girls and women who have undergone mutilation should be of paramount concern.

Research on female genital mutilation should build on the experience gained in similarly sensitive areas, such as fertility control, and attitudes to sexual behaviour in relation to interventions to control the spread of HIV/AIDS. New approaches and innovative tools will be needed. As much of the thinking and decision-making about female genital mutilation, and even the procedure itself are undertaken in privacy and often in secrecy, access to information will necessitate winning the confidence of all those involved. An example of the kind of difficulties to be overcome is provided by the mythology surrounding female genital mutilation in some communities in Burkina Faso. If complications arise following the procedure, it is thought to mean that the family has sinned. Thus even when the complications lead to death, relatives do not come forward and admit their loss to people outside the family.

### **5.2 Collection of baseline information**

As indicated in section 1, there is little reliable information on the prevalence, incidence and recurrence rates of the different forms of female genital mutilation or its health and social consequences. Reliable and accurate data are essential to provide a baseline for subsequent evaluations and to inform policy-makers and national decision-making processes. At the local level, a rapid pre-intervention survey may be the most appropriate step. At the national level, more detailed incidence and prevalence rates can be obtained by incorporating modules on female genital mutilation in existing surveys or census questionnaires. In this context, the module being tested in the Demographic and Health Survey (DHS III) mentioned in section 1.3 should soon provide comparable national data from several countries. National surveys to collect data specifically on female genital mutilation alone should be discouraged for reasons of the costs involved.

Where studies of female genital mutilation are conducted, the magnitude of the practice should be reported for different sociodemographic groups and for each type of genital mutilation. The magnitude of the problem should be expressed in terms of prevalence, incidence and recurrence rates. Repeat surveys of prevalence, incidence and recurrence rates over time will help to determine trends in genital mutilation in a given community or nation.

Further descriptive research providing quantitative and qualitative information is needed to characterize the different forms of genital mutilation and the sociodemographic features of those who practise female genital mutilation compared with those who do not. Other sociological variables such as the age at which girls undergo genital mutilation, the location where the procedure is performed and the persons involved in performing and executing the practice are essential information for planning interventions and health education programmes targeted at certain locations (e.g. schools or homes) or among specific populations (e.g. nurses, midwives, doctors and traditional birth attendants) with the aim of eliminating genital mutilation at the source.

## 5.3 Intervention research

### 5.3.1 Sociobehavioural research

The aim of studying the behaviour and attitudes of individuals, the family and the community towards the practice of female genital mutilation is to determine the motivation behind the practice and the factors that influence it. In attempting to do this, it is necessary to differentiate between reasons and rationalization. The former are the true behavioural motivations for an act while the latter are what an individual repeats to herself or himself because they are accepted wisdom. Providing information that addresses rationalization will not bring about behavioural change unless the true reasons are dealt with. For example, rationalization that female genital mutilation is "clean" and "healthy" can be countered by facts about complications that prove the opposite. However, if the family's real reason is fear that relatives and neighbours will think a girl immoral or not a virgin unless she undergoes the procedure, addressing this underlying concern is the only way behavioural change can be achieved. Reasons and rationalizations vary widely in different communities and careful investigation at local level is needed to distinguish between them.

Studying those who willingly express their dissent may prove to be a valuable means of understanding the dynamics of behavioural change. Small-scale studies undertaken so far indicate opposition to the practice in 10-30% of respondents. While this may indicate widespread support for the practice, it also shows that there are people inclined towards change. With further questioning, they may reveal useful information about motivations for change, sources of information, decision-making hierarchies and an insight into what measures might prove effective. For example, a study is planned in a village in Upper Egypt where the practice was stopped three years ago following an intervention by the Coptic-Evangelical Church Society. It is hoped that the study will indicate the reasons for the change. It might also be useful to study subcultures where female genital mutilation has never taken place within a larger culture where it is practised. For example, 90% of the Yoruba ethnic group who live in south-west Nigeria practise female genital mutilation, but the Ijebus, a major group within the Yorubas have never done so. Reasons for this could be used to counter myths about female genital mutilation among the Yoruba group.

It is important to identify the sources of knowledge and information in each community and for each social group, and to determine who are the most influential members of society. For example, women may trust leaders of their own networks more than male political leaders or the educated elite. Youth may be more influenced by members of their own peer group. All such assumptions are based on impressions and need to be tested. It is important to remember that many of these variables are community-specific, and generalizations must be made with extreme care. This is particularly true of female genital mutilation, reasons for which may vary widely between districts within the same country.

Investigations are also needed to gain a better understanding of the sociocultural factors that influence female genital mutilation, including beliefs, class differences, power structures within the society, the social/festive character that has built up around mutilation rituals and the links of the practice with marriageability. Some beliefs recur in a number of population groups, but there are also notable differences and some themes are exclusive to certain areas. Efforts are needed to analyse these factors within countries so that information, education and communication materials can be adapted to take account of local conditions. Similarly, an accurate analysis of the existing economic incentives that promote the continuation of the practice will suggest measures to counteract them and indicate appropriate areas for intervention. An analysis of the cost of treatment of the complications arising from female genital mutilation to health services might help to convince governments of the cost-effectiveness of investing in prevention measures.

### 5.3.2 Clinical and rehabilitation research

The physical complications of female genital mutilation are well known, establishing the harmful effects of the practice (see section 3) and making a case for the development of policies for its elimination. What is not clear, however, is the actual prevalence of complications and their long-term sequelae in relation to infertility, gynaecological morbidity, pregnancy outcome and maternal and childhood mortality. Given the scale of the practice of female genital mutilation in many communities, this information is most important for developing clinical support for girls and women who are suffering from the health complications of female genital mutilation. Greater use of the standard definition and classification and greater involvement of the medical profession in research on female genital mutilation would increase the reliability and diminish some of the bias in reported information.

As indicated in section 4, the nature and degree of psychological and sexual damage caused by female genital mutilation in different groups and its effect on self-esteem are still largely unexplored. Psychological adjustment mechanisms, including denial, loss of memory, and perpetuation of the act to affirm its normalcy, should be investigated with the aim of helping survivors to cope with their situation and to resist the perpetuation of the practice on the next generation including their own daughters. Studies should be carried out to address the counselling needs of female genital mutilation survivors to enable them and their partners to enjoy a more satisfactory sexual relationship. The experience of women's support groups in these areas should be taken into account in planning interventions.

## 5.4 Monitoring and evaluation of interventions and programmes

Monitoring and evaluation should be an integral part of all research and intervention programmes on female genital mutilation, although difficulties may be encountered in establishing accurate outcome measures, particularly for attitude changes and the effectiveness of education programmes. The crucial indicator is, of course, the incidence of female genital mutilation. Adequate reporting is an important aspect of monitoring and evaluation. Interventions must be well documented to ensure that lessons can be learned and that successful experiences can be shared with others.

## 6 FRAMEWORK FOR ACTIVITIES: LESSONS LEARNED

Lessons learned from the experiences of nongovernmental organizations in combating female genital mutilation in Egypt, Ethiopia, Gambia, Kenya, the United Kingdom and the United States of America are summarized below.

### 6.1 Breaking the silence

There are strong taboos regarding the discussion of reproductive organs and sexual behaviour in many countries. Furthermore, talking about female genital mutilation can be very difficult for women who have memories of deep pain and shame going back to the very early age at which the procedure was performed. Yet many women in communities where the practice continues would like to discuss the importance of sex in their lives and how genital mutilation has affected their sexuality. The right approaches must be found to enable them to do so. Breaking the silence and encouraging people and the media to talk about female genital mutilation can help to dismantle the taboos and all the false beliefs shrouding the practice. Women and girls need to learn about their bodies, particularly their reproductive system, the function of each organ and the harm incurred by genital mutilation.

## 6.2 Raising awareness

Awareness of female genital mutilation and the harm it causes should be increased in all countries and at all levels. However, this is a highly sensitive issue and it is essential not to offend or alienate potential sympathizers. Language and terminology used in information about the practice must therefore be chosen with care.

It is also important to raise awareness in men and boys. They are the partners or future partners of survivors of female genital mutilation and need to understand why their wives or girlfriends may have health and sexual problems. Men are also the fathers, uncles or grandfathers of potential victims, and can play a vital part in the prevention and abolition of the practice. Although one of the reasons given for female genital mutilation is to please men, the practice is primarily practised, enforced and controlled by women. For this reason, many men may not readily understand their current role in perpetuating the practice.

The media can play an important role in influencing public opinion, and should be encouraged to feature items on female genital mutilation and its harmful effects. Existing films and documentaries depicting harmful practices, including genital mutilation, on young, unwilling girls clearly illustrate their terror and pain and can have a powerful effect. Such existing materials, when used sensitively and in conjunction with adequate explanation and discussion, can be useful tools in raising awareness.

## 6.3 Providing information

It is vital to provide clear, accurate and consistent information on female genital mutilation and its physical and psychological consequences in ways that will be culturally acceptable. Printed materials, newspaper and magazine features, films, radio and television programmes, songs, plays, puppet shows, workshops and counselling are some of the approaches that can be used.

Different target audiences have different needs and constraints, and their values, aspirations, expectations, conflicts, abilities to make important decisions, peer group pressures, etc. vary widely. Messages must be therefore be adapted accordingly and presented using language that will not give offence.

In some communities, female genital mutilation is closely associated with culturally entrenched values of pre-marital chastity. Community recognition of a woman's virginity prior to marriage is perceived to be achieved only through the practice and the surrounding rituals. It is essential to correct the misconception that genital mutilation is synonymous with sexual chastity. There is no evidence to support the notion that girls or women who have undergone genital mutilation engage in less premarital intercourse than those who have not. Other myths surrounding the practice must also be refuted.

Governments and nongovernmental organizations should integrate appropriate information on female genital mutilation in literacy classes, health education, family planning and population education, and other public awareness programmes.

## 6.4 Advocacy

Advocacy against female genital mutilation should be undertaken at three levels, at the political level, among health and social workers, and in communities. Short and simple information pamphlets for use in lobbying at these different levels can be extremely useful.

There is a need to develop manuals for use in training advocates. An effective advocate against female genital mutilation must first come to terms with her or his own cultural conditioning and prejudices. It is particularly important to address unconscious projection of racist generalizations onto those who have undergone female genital mutilation, feelings that sexuality is shameful, and fear of personal castration.

Before women who have undergone female genital mutilation can themselves become effective advocates against the practice, they need to deal with their own pain. This may involve confronting family members with the extent of their suffering and/or in-depth and sensitive counselling.

## **6.5 Enhancing women's views of themselves**

While marriage is an important and cherished goal for most boys and girls, it is vital to empower girls and women with the understanding that they have the right to grow as equal partners with boys and men and to enjoy a variety of roles other than those of wife and mother. The importance of education and skill training for girls should therefore be emphasized.

In order to improve the self-image and self-esteem of women and to promote the fulfilment of their multifaceted roles in society, perceptions of women in many societies will have to change. Women will need support from the wider community in their battles to better their lives and protect themselves and their daughters from the many harmful effects of female genital mutilation.

## **6.6 Involving policy-makers**

There are a number of major constraints to government commitment to the prevention and abolition of female genital mutilation:

- Governments that have ratified international human rights conventions that cover female genital mutilation are bound to protect the human rights of girls and women. However, the high turnover of government officials in many countries means that many are ignorant of these conventions, and this mitigates against their implementation and any continuity.
- Governments tend to be reluctant to deal with such sensitive issues, which may be politically charged and may generate negative reactions from the electorate.
- A stable environment is essential if strategies to raise awareness about and abolish female genital mutilation are to be implemented successfully. The current climate of civil war in some of the countries where the practice is widespread does not provide this.
- It can be difficult to raise sufficient government support to ensure finance for activities to abolish female genital mutilation.
- There is a danger that female genital mutilation will be forced underground if legislation against it is inappropriate or is implemented too quickly without the complementary backup of other forms of intervention such as education.

However, the opportunities for government action against female genital mutilation outweigh these constraints. Government involvement is very helpful in facilitating coordinated approaches by allowing access to and liaison between various ministries. Furthermore, positive statements from political leaders supporting advocates for its abolition, can make a great impact.

Many countries in sub-Saharan Africa are developing national policies in a number of sectors, including health, women, agriculture and population. Action to prevent female genital mutilation can be incorporated in such policies, and should include statements clearly rejecting female genital mutilation on both health and human rights grounds.

Interventions aimed at abolishing female genital mutilation should be integrated with other health and development programmes. Programmes that incorporate a variety of approaches with an overriding holistic perspective for the general well-being of women appear to have a much greater impact. As indicated in section 1, existing government surveys (e.g. national DHS surveys and national surveys on household income and expenditure, and fertility) can, with the addition of a few extra questions, be used to provide data on female genital mutilation at a fraction of the cost of a specific survey.

The involvement of government officials in community interventions is important because it heightens their commitment and also because it lends credibility to the interventions. Government officials should be kept informed of the developments, for example, through a newsletter and/or report of research findings. In addition, local government officials should be encouraged to participate in interactions with community members.

## **6.7 Involving nongovernmental organizations**

Nongovernmental organizations have played an important role to date in projects concerned with female genital mutilation. As interest in and activities for the abolition of female genital mutilation escalate, cooperation and collaboration between nongovernmental organizations and other agencies will be essential in order to draw together the strengths of the various groups to ensure effective action, and to avoid duplication and waste of scant resources.

## **6.8 Involving the community**

The involvement of local communities in planning and participating in activities to abolish female genital mutilation is essential. Interventions are much more effective when local women and their families have a sense of ownership. In some communities, the participation of women in the organization of community workshops and in interviews about their activities by the local media has been shown to enhance their morale, self-esteem and motivation.

Communities are not static, which means that workplans and programmes must be flexible and must allow for progressive discussions. Community gatherings should be held at different times and the timing of events such as school examinations and harvesting and planting times should be taken into account in order to maximize community participation.

## **6.9 Female genital mutilation in immigrant communities in Western countries**

Countries where female genital mutilation is not a traditional practice should be aware that it may be practised in immigrant communities or that immigrant survivors who have undergone the procedure in their home countries may need special medical help. Of major concern are the possible adverse psychosocial consequences for women and girls who have moved from a country in which female genital mutilation has familial and societal acceptance to one in which it is illegal and there is general community abhorrence of the practice. Because immigrant population groups practising female genital mutilation are marginalized groups within Western nations, their needs may not be visible. State resources should be set aside for the education of immigrant groups practising female genital mutilation and for research into the health needs of immigrant women and



girls. Some activities are already under way in certain Western nations (e.g. Australia, Canada, France, Sweden and the United Kingdom).

In the United Kingdom, female genital mutilation attracted media attention in the early 1980s, when it became known that women and girls were coming from overseas to have mutilation performed in private clinics in London. This indicated the need to prevent doctors from carrying out such unnecessary and harmful operations and the necessary legislation came into force in 1985. It was soon to emerge that female genital mutilation was practised by some immigrant communities living in the United Kingdom. Lessons learned over a ten-year period of developing activities for the prevention and elimination in the United Kingdom are summarized below.

Prevention of female genital mutilation should be integrated with broader national health care policies. One approach is for a lead agency to act as a bridge between local communities and the statutory agencies to find the best possible ways of developing a sensitive system for prevention, protection of girls at risk of genital mutilation and the rehabilitation of women and girls who have already undergone it. A rapid survey can be undertaken to study the distribution of the problem and to examine the entry points within child care law, and the health care and educational systems through which prevention can be furthered. The approach should stress support to families through counselling and persuasion, with removal of children only if this fails. The following should be emphasized:

- identification of areas where immigrant children are at risk;
- systematic inter-agency cooperation;
- provision of resources to community groups for education and awareness-raising activities in the community;
- training of health and related professionals in education, counselling and monitoring; and
- protection of children by law if other measures such as education and counselling fail.

The welfare and well-being of the child should be paramount to all other considerations. In the United Kingdom, this principle is enshrined in the Children Act 1989. Every country should develop legislation to protect children either within laws related to assault or in the form of specific laws. It must be clear that the law covers female genital mutilation.

The needs of women who have undergone female genital mutilation should not be forgotten. In London, for example, a well-woman clinic has been established in a hospital (Northwick Park Hospital) specifically to enhance health service delivery for women who have undergone female genital mutilation. This project is run by a specially trained team of health professionals, with an interpretation service. It helps to promote sensitive antenatal and gynaecological care for women who have suffered from female genital mutilation. The clinic also has the potential for follow-up action with women and their families to provide education for the prevention of female genital mutilation.

## **7 RECOMMENDATIONS**

### **7.1 Research**

1. Research activities should be multidisciplinary and should focus on the well-being of women and girls.
2. Research should be based on partnerships between governments, international agencies, nongovernmental organizations, scientists, activists and practising communities. Policy-

makers should be involved at an early stage to ensure their commitment. Community involvement in the planning, design and implementation of projects and programmes is essential.

3. Results obtained from research should be reported to all interested parties, particularly the communities concerned, and made available to the media in an accessible form.
4. To establish baseline information on female genital mutilation and its consequences, a situational analysis of the country and/or community is necessary. To limit costs, this should be achieved by the addition of suitable questions to existing large-scale population-based surveys wherever possible.
5. Research is needed in the following areas:
  - the magnitude (prevalence, incidence and recurrence rates) of the different types of female genital mutilation in communities where it is practised and its physical, mental and sexual complications;
  - methods for approaches to physical and psychological care and counselling for those who have undergone female genital mutilation;
  - customs, traditions and beliefs surrounding the practice of female genital mutilation, including the attitudes, perceptions and motivations of different groups, including those who have stopped practising it and are opposed to it, reasons for continuing the practice and factors precipitating change within groups;
  - evaluation of the effectiveness of ongoing approaches to the prevention and elimination of the practice;
  - the development and pilot-testing of information, education and communication (IEC) advocacy, and training materials including pictorial information;
  - the identification and evaluation of existing systems and organizations that might be helpful in campaigns for the prevention and elimination of female genital mutilation;
  - evaluation of the effectiveness of existing legislation covering female genital mutilation and ways of integrating human and legal rights aspects into activities against female genital mutilation.

## **7.2 Advocacy and information, education and communication**

1. Coalitions of advocates should be established. These should include advocates at the family, community, national, regional and international levels.
2. Advocacy and IEC messages should be:
  - research-based, using standard definitions;
  - accurate, clear, consistent and simple;
  - formulated in consultation at local level to take account of sociocultural conditions and community concerns;
  - adjusted as necessary in the light of changing needs and new information.
3. Methods of advocacy should include the following:

### *At family and community level*

- home visits by community workers
- use of posters, leaflets, information kits, visual aids and models, songs, plays, puppet shows, radio and television programmes, and films and videos
- organization of workshops and counselling sessions

- lobbying of community and religious leaders;

*At the national level*

- organization of seminars, round-table discussions, workshops and viewing of films
- coordination of research and provision of IEC materials
- invitations to the national media to cover special events or public awareness campaigns
- lobbying of policy-makers;

*At the international level*

- sending of advocates to appropriate international forums and provision of information to delegates
- organization of international think-tanks
- use of international media.

### **7.3 National policies and legislation**

1. Policies should have a multidisciplinary and collaborative approach that permits the involvement of a variety of professionals and others working in the field including opinion leaders, politicians, and nongovernmental organizations, particularly women's groups.
2. Female genital mutilation should be perceived as a public health issue, and activities for its prevention and elimination should be incorporated into existing institutional budgets and health education curricula, including reproductive health packages, safe motherhood programmes, national AIDS programmes and school health programmes.
3. Policy development should take account of possible effects at local level.
4. Policies should set clear goals, targets and objectives, and a schedule for their attainment.
5. Policies should focus on prevention and rehabilitation, with emphasis on advocacy and IEC, and should not legitimize, institutionalize or medicalize any type of female genital mutilation.
6. Legislation should be developed and introduced in consultation with the various groups concerned, taking due account of the sensitivity of the issue. However, legislation alone is insufficient. It should be accompanied by appropriate information, education, training and other activities.
7. Laws and professional codes should prohibit the practice of female genital mutilation and the involvement in it of health professionals in any setting, including hospitals and other health establishments.

### **7.4 Training**

1. Training programmes should be based on a needs assessment and should be integrated with existing programmes.
2. Training should equip the various categories of service providers concerned, particularly nurses, midwives and traditional birth attendants and healers, with the appropriate knowledge, attitudes and skills to enable them to work for the prevention and elimination of female genital mutilation and to provide clinical and psychological care and support for

girls and women who have undergone the procedure, taking due account of cultural and personal sensitivities.

## 7.5 Recommendations to WHO

1. WHO should continue to publicize female genital mutilation and ensure its inclusion on the research agenda.
2. WHO should continue to develop standards and norms in the area of female genital mutilation. It should submit the adopted definition and classification of female genital mutilation for consideration for inclusion in the next revision of the *International Classification of Diseases*.
3. WHO, in particular through its Regional Offices for Africa and the Eastern Mediterranean, should collect and disseminate published and unpublished data related to female genital mutilation, and prepare technical papers on the subject.
4. WHO should develop and disseminate research guidelines and protocols.
5. WHO should promote and coordinate relevant research on female genital mutilation in collaboration with governments, international agencies, scientific institutions, nongovernmental organizations and other interested parties.
6. WHO should develop and test training materials suitable for use at regional and country level and promote their incorporation in training curricula.
7. WHO should provide technical support for the development of regional and national policies and programmes for the prevention and elimination of female genital mutilation.
8. WHO should consider organizing a day or year of action for the prevention and elimination of female genital mutilation and other traditional practices harmful to health as soon as possible, preferably before the year 2000.
9. WHO should allocate additional resources to activities in the area of female genital mutilation from its regular budget; it should not count solely on extrabudgetary funds.
10. WHO should seek to strengthen collaboration between French-speaking and English-speaking countries in their work against female genital mutilation. It should support the provision of research, information and training materials in English, French, Arabic and Portuguese.
11. WHO should collaborate more effectively with other United Nations agencies concerned with female genital mutilation, such as UNICEF and UNFPA.
12. WHO should promote the establishment of effective partnerships with and between relevant nongovernmental organizations.

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- Sister A. Thompson, Maternal Health and Safe Motherhood, Division of Family Health, WHO, Geneva, Switzerland
- Dr T. Türmen, Director, Division of Family Health, WHO, Geneva, Switzerland
- Dr J. Zupan, Child Health and Development, Division of Family Health, WHO, Geneva, Switzerland

## ANNEX

### Recent World Health Assembly and Regional Committee resolutions related to female genital mutilation

#### Resolution WHA47.10

Forty-seventh World Health Assembly, May 1994

Maternal and child health and family planning: traditional practices harmful to the health of women and children

The Forty-seventh World Health Assembly,

Noting the report by the Director-General to the Executive Board on maternal and child health and family planning: current needs and future orientation;<sup>1</sup>

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Rc reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 1992/251 on traditional practices affecting the health of women and children;

Recognizing that, although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early sexual relations and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES all Member States:

(1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;

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<sup>1</sup> See document EB93/1994/REC/1, Annex 5.

(2) to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;

(3) to collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

**Resolution AFR/RC39.R9****Thirty-ninth session of the Regional Committee for Africa, September 1989****Traditional practices affecting women and children**

The Regional Committee,

Considering the adverse effects on maternal and child health in certain traditional practices such as female circumcision, early marriage, nutritional taboos and other such practices;

Considering the high priority given by WHO and Member States to maternal and child health;

Convinced that the World Health Organization has an important role to play in the control of traditional practices affecting maternal and child health;

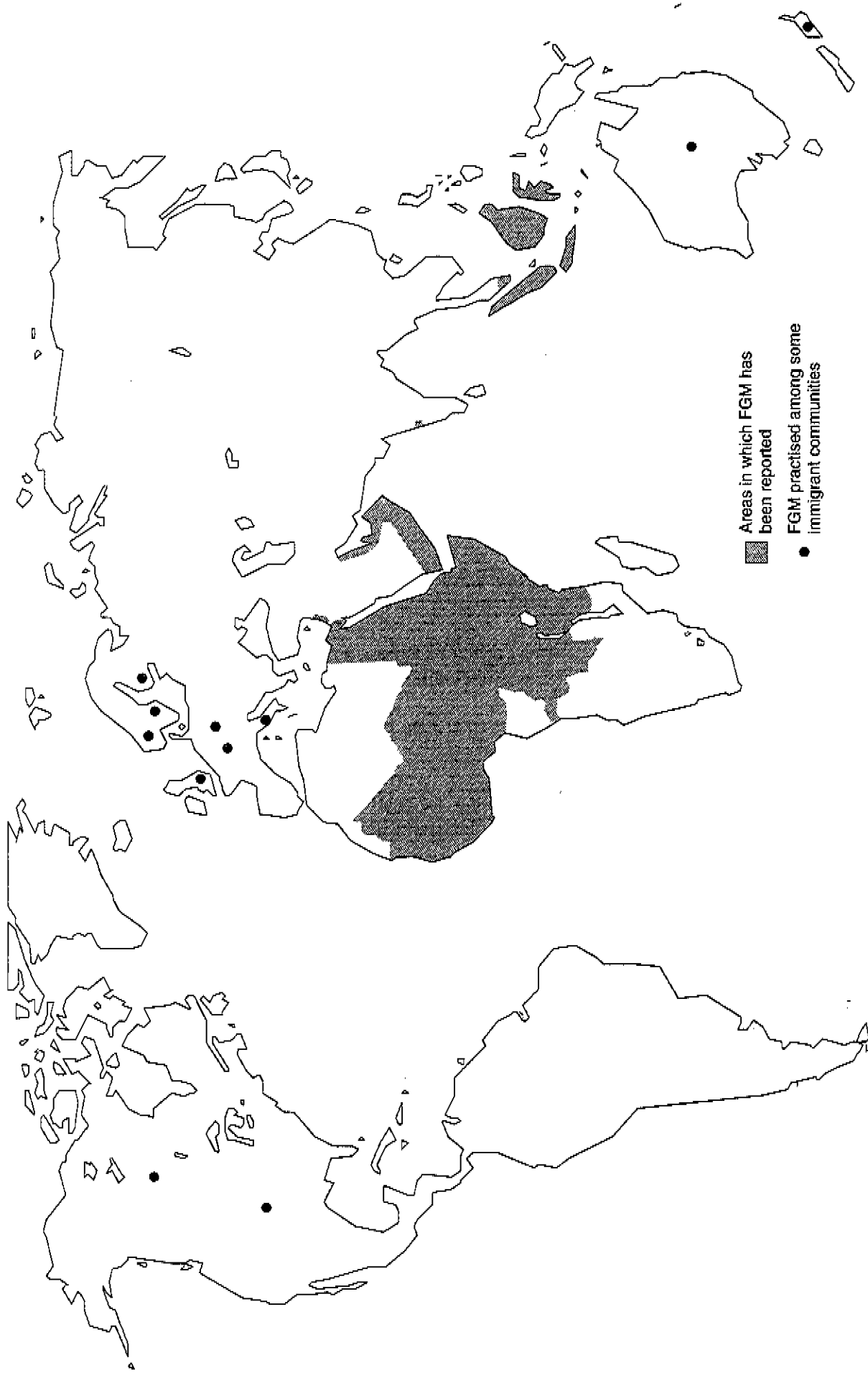
1. **RECOMMENDS** that the Member States concerned:

- (i) adopt appropriate policies and strategies to eliminate female circumcision;
- (ii) organize educational and informational activities, bearing in mind local cultural contexts, in order to:
  - create awareness among women and men of the dangers of female circumcision, early marriage, nutritional taboos and similar practices;
  - inform the general public of the possible relationship between the propagation of infectious diseases, including AIDS and female circumcision;
- (iii) prohibit the medicalization of female circumcision and discourage health personnel from performing this operation;
- (iv) include in training programmes for health personnel and traditional birth attendants relevant information on the dangers of female circumcision;
- (v) encourage research projects to identify the most effective means of controlling these practices;
- (vi) take the steps necessary to put into practice the various recommendations made at the national and international levels in this area.

2. **REQUESTS** the Regional Director:

- (i) to provide appropriate support to Member States in the implementation of this resolution;
- (ii) to include this topic in the agenda of a future session of the Regional Committee.

Figure 1: Areas of the world in which female genital mutilation has been reported to occur



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Information on the map is based mainly on partial and incomplete data.