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An update on WHO's work on female genital mutilation (FGM)

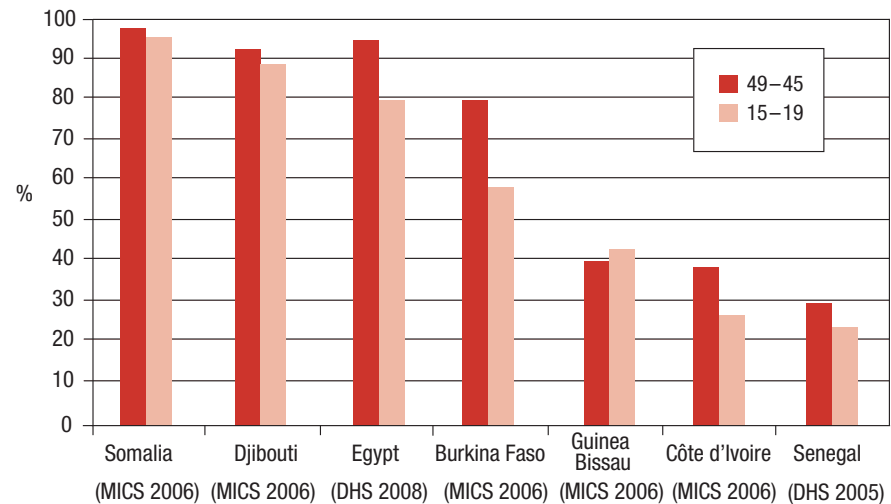
Progress report

Introduction

Female genital mutilation (FGM) – defined by WHO and the United Nations (UN) agencies as “the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons” is a deeply rooted tradition in many communities in 28 countries in Africa and in some countries in Asia and the Middle East. In the world today there are an estimated 130–140 million girls and women who have been subjected to the operation and 3 million girls are at risk of undergoing the practice every year (1).

Studies indicate that the practice of FGM has changed in a number of ways. Most encouragingly, the practice is declining. This can be observed when looking at data from countries in which at least two surveys are available, showing advanced prevalence in a number of countries. This can also be observed by comparing the youngest and oldest age-group in one survey, showing that women aged 15–19 years are less likely to have been subjected to FGM than are women in older age groups (see Figure 1).

Figure 1. Prevalence of FGM in oldest and youngest age groups



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Abbreviations

FGM	female genital mutilation
DHS	Demographic and Health Surveys
HRP	UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
MICS	UNICEF Multiple Indicator Cluster Surveys
RHR	Department of Reproductive Health and Research (WHO)
WHO	World Health Organization

There are, however, other trends of change as well. One widespread trend is a lowering of the average age at which girls are subjected to the procedure, in all centres except one. Another change is an increasing degree to which parents seek out health-care providers to perform FGM for their daughters. This is referred to as the medicalization of FGM.

This progress report reviews current information on FGM based on recent studies in the field supported by WHO. The first section includes information about the prevalence, the human rights implications and the health risks associated with the practice. It also explores some of the factors that account for its persistence despite growing awareness of its dangers to health and its infringement of human rights. The second section focuses on the efforts to abandon the practice, as well as the challenge of its “medicalization”.

The final section of this progress report summarizes the results of some of the most recent WHO-supported studies that have been initiated by HRP in Burkina Faso, Egypt, Gambia, Ghana, Kenya, Nigeria, Senegal, Sierra Leone and Sudan.

Female genital mutilation violates the human rights of girls and women

FGM of any type has been recognized as a harmful practice and a violation of the human rights of girls and women. Human rights – civil, cultural, economic, political and social – are codified in several international and regional treaties. The legal regime is complemented by a series of political consensus documents, such as those resulting from the UN world conferences and summits, which reaffirm human rights and call upon governments to strive for their full respect, protection and fulfilment. Many of the UN human rights treaty monitoring bodies address FGM in their concluding observations on how States are meeting their treaty obligations. The Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child, and the Human Rights Committee have been active in condemning the practice and recommending measures to combat it, including the criminalization of the practice (2).

Female genital mutilation – a factual overview

Prevalence

Estimates based on survey data suggest that in Africa 91.5 million girls and women aged 10 years and above have been subjected to the practice. Of these, 12.4 million are between 10 and 14 years of age (3). In most cases, the procedure is carried out on girls under the age of 15 years, although obtaining data on FGM prevalence in that age group poses several methodological challenges (3). In some communities, and in some situations, women are subjected to FGM later in life; including when they are about to be married, or after marriage, during pregnancy and after childbirth, or when their own daughters undergo the procedure (4).

Most women who have experienced FGM live in one of the 28 countries in Africa and the Middle East – nearly half of them in just two countries: Egypt and Ethiopia. Countries in which FGM has been documented include: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen. The prevalence of FGM ranges from 0.6% to 98% of the female population (5).

Incidences of FGM have been documented in some other countries, including India, Indonesia, Iraq, Israel, Malaysia, Thailand and the United Arab Emirates, but no national estimates have been made (5). In addition, the practice of FGM and its harmful consequences also concerns a growing number of women and girls in Europe, North America, Australia and New Zealand as a result of international migration. The exact number of women and girls living with FGM in Europe is unknown, but is estimated to be around 500 000, and 180 000 girls are estimated to be at risk of being subjected to the practice (6).

Impact on health

The most common short-term consequences of FGM include severe pain, shock caused by pain and/or excessive bleeding (haemorrhage), difficulty in passing urine and faeces because of swelling, oedema and pain, as well as infections. Death can be caused by haemorrhage or infections, including tetanus and shock. A study from one country

that practises Type I and II FGM, and in which 600 women were questioned about their daughters' complications after FGM Type I and II, reported a death rate of 2.3% (7).

FGM of any type is also associated with a series of long-term health risks. The most common complications are dermoid cysts and abscesses. Chronic pelvic infections that can cause chronic back and pelvic pain, and repeated urinary tract infections have been documented in both girls and adults. A recent WHO-led study showed that FGM is associated with increased risk for complications for both mother and child during childbirth. Rates of caesarean section (29% increase for Type II and 31% increase for Type III FGM) and postpartum haemorrhage (21% for Type II and 69% for Type III FGM) were both more frequent among women with FGM compared with those without FGM. In addition, there was an increased probability of tearing and recourse to episiotomies. The risk of birth complication increases with the severity of FGM.

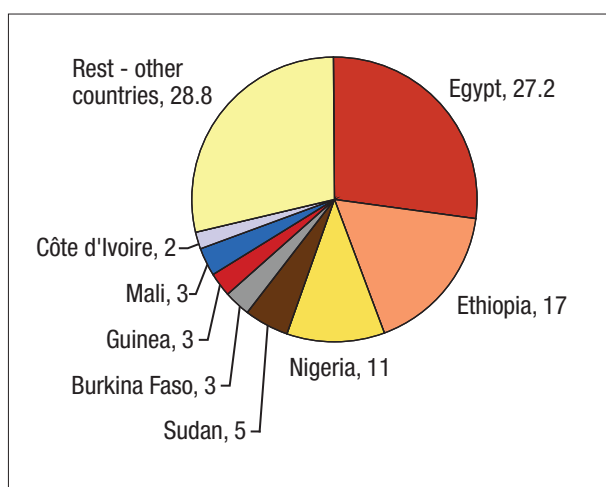
FGM of the mother is also a risk factor for the infant. The study found significantly higher death rates (including stillbirths) among infants born from mothers who have undergone FGM than women with no FGM. The increase was 15% increase for Type I FGM, 32% increase for Type II FGM and 55% increase for Type III FGM (8).

FGM can also lead to negative psychological consequences. Documented effects include post-traumatic stress disorder, anxiety, depression, and psychosexual problems. A recent study shows that women who have undergone FGM may be more likely than others to experience psychological disturbances (psychiatric diagnosis, suffer from anxiety, somatization, phobia and low self-esteem) (9).

Research has shown that sexual problems are also more common among women who have undergone FGM. Women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire (9).

Additional risks have been documented for the most extensive form of FGM (Type III). Further surgery is usually necessary later in women's lives when infibulations must be opened to enable sexual intercourse and further again in childbirth. In some countries this is followed by re-closure (reinfibulation), and hence the need for repeated defibulation later.

Figure 2. Where girls and women with FGM live (% of the 91.5 million girls and women with FGM)



Urinary and menstrual problems are not uncommon, particularly prior to defibulation at first marriage. For many women sexual intercourse is painful during the first few weeks after sexual initiation, as the infibulation must be opened up either surgically or through penetrative sex. The male partner can also experience pain and complications. Type III FGM is also associated with infertility. Evidence suggests that the more tissue is removed, the higher the risk for infection (6).

Why FGM is still practised

The continuation of FGM in a practising community is motivated by a complex mix of interlinked sociocultural factors, which vary from region to region, within single countries, between and even within practicing communities.

FGM is generally practised as a matter of social convention, and is interlinked with social acceptance, peer pressure, the fear of not having access to resources and opportunities as a young woman and to secure prospects of marriage (10,11). Therefore individuals' actions are

Classification of female genital mutilation
Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

interdependent on those of others. This social convention is connected to different concrete sociocultural perceptions, most of which are linked to local perceptions of gender, sexuality and religion.

With regards to gender, there is often a perception that women's bodies need to be "carved" to become fully female. Often the clitoris is seen as "male-like" organ that needs to be removed to ensure pure femininity.

FGM is also frequently associated with sexual morality, and the perception of the clitoris as the origin of sexual desire. Hence the clitoris is removed in order to reduce women's sexual drive, in the belief that this will improve the prospect of premarital virginity, and marital fidelity, and to ensure "decent behaviour" (6).

The practice is often also linked to a ritual marking of the coming of age and initiation to womanhood. In many communities FGM is often perceived to be prescribed by the locally common religion, which includes Islam, Christianity and traditional faith systems.

Ending the practice

Action taken at international, regional and national levels over the past decade or more has begun to bear fruit. Increasing numbers of women and men from practising groups have declared support for discontinuing the practice and, in several countries the prevalence of FGM has decreased significantly.

However, in many countries the reduction in prevalence is not as substantial as hoped for, and in a few, no decline can be noted.

To sustain and stimulate further reduction in changing countries, and to stimulate change in countries where the prevalence has remained stable, it is therefore vital that the work against FGM be intensified to counteract more effectively the underlying reasons behind continuation of the practice. Action areas to support the abandonment of FGM focuses around three focus areas: social, legal and political commitment.

Social measures

Experience and evidence over the past three decades shows that bringing FGM to an end requires broad-based, long-term commitment. It needs to support successful behaviour change and address core values and enforcement mechanisms that support the practice. Interventions require action from many sectors such as education, finance, justice, social and women's affairs as well as the health sector, and from many levels. Actors from community groups and nongovernmental organizations need to be engaged, including health professional groups, human rights groups and international agencies.

Programmes are best led by communities in a participatory way, supporting the communities to define the problems and solutions themselves. Programmes that have demonstrated success in promoting abandonment of FGM on a large scale build on human rights and gender equality and are nonjudgmental and noncoercive. They focus on encouraging a collective choice to abandon FGM (12).

Survey data (Demographic and Health Surveys (DHS) and UNICEF Multiple Indicator Cluster Surveys (MICS)) have shown that in many countries, the numbers of women who state they want practice of FGM to end is much higher than the number who have actually discontinued the practice. This points to the significance of the social norm and social convention, in that even some women and men who would like to discontinue FGM, still subject their daughters to this practice due to social pressure.

Furthermore, this finding supports qualitative studies showing that in many communities it is not unusual for women, girls and men to question and be critical towards the practice of FGM, even when this opposition has not yet been publicly discussed. Some projects use methods that intend to draw specifically on this silent opposition to great effect, for example by encouraging opponents to speak out and engage their communities in a debate on the subject.

Social change within communities can be hindered or enhanced by activities at national level and across national boundaries. As at community level, activities at national level should promote a process of social change that leads to a shared decision to end FGM. Activities must engage traditional, religious and government leaders, parliamentarians and civil society organizations.

Legal and political measures

Governments have legal obligations to respect, protect and promote human rights, and can be held accountable for failing to fulfil these obligations. Legislative measures to protect future generations of women from FGM include constitutional recognition of the rights of girls and women, criminal laws, child protection laws, civil laws and remedies and asylum and immigration legislations. Today, 21 countries in Africa, and several states of two additional countries, have laws against FGM.¹

Legal measures are important to make explicit the government's disapproval of FGM, to support those who have abandoned the practice or wish to do so, and to act as a deterrent. The effectiveness of any law depends, however, on the extent to which it is linked to the broader process of social change. Therefore legal measures should be accompanied by information and other measures that promote increased public support for ending the practice, including work within practicing communities (6,13).

WHO contributions

Advocacy for the abandonment of FGM

To strengthen and update the international commitment, WHO coordinated a new interagency statement on the elimination of FGM, which was launched in February 2008. Co-signed by ten UN agencies, the new interagency statement highlights the various dimensions and approaches to elimination of FGM, and provides updates on factual knowledge as well as legal and human rights tools. It argues that the practice is a social convention and describes elements needed for its prevention and for caring for those who are suffering from its consequences, and presents a reviewed classification of the practice.

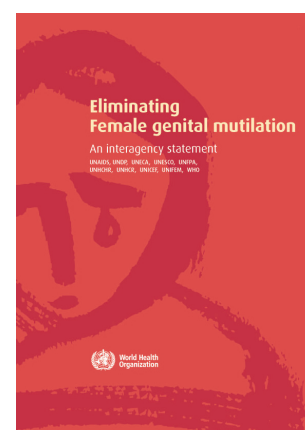
In 2008 the World Health Assembly, including all WHO Member States passed a resolution (WHA 61.16) on the elimination of FGM. Through this resolution all the countries have agreed and committed themselves to increase their efforts to support the elimination of FGM through concerted action in all sectors, followed up through triennial reporting.

Guidance to health care providers

In 2010, WHO together with seven other UN agencies and six professional organizations and others issued a global strategy to stop health-care providers from performing FGM. This was a response to a concern about the increasing rate at which FGM is becoming medicalized. An estimated 18% of all women who have undergone FGM have done so at the hands of health-care providers. There are large variations in this between countries, from less than 1% in several countries, to between 9% and 74% in six countries (14). However, the trend is increasing in all countries.

Parents are probably motivated to seek health-care providers to perform FGM due to an increased awareness of the health risks associated with the practice. The motivations of health-care providers who agree to perform FGM is varied. Most often they are themselves a part of the FGM-practicing community in which they serve. Hence, the reasons why they agree to perform FGM are often the same as those that motivate those requesting it. However, even some health-care providers, who do not themselves support FGM, still agree to perform FGM. Some consider it their duty to support the patient's (and/or the family's) socioculturally motivated request for FGM. Others see medicalization as a form of harm reduction, considering that, by performing it, they help to prevent the expected greater dangers if the procedure were to be carried out by traditional practitioners. Finally, some health-care providers are also motivated by the opportunity for financial gain (14).

However, when health-care providers agree to perform FGM, they contribute to the persistence of the practice. Their acceptance to perform FGM adds a medical legitimacy to the practice, which can further contribute to institutionalization and even spread of the practice. It can also lead some health-care providers to develop a professional and financial interest in upholding the practice.



¹ WHO Study Group on Female Genital Mutilation and Obstetric Outcome (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet*, 367:1835-1841. ([http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)68805-3/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)68805-3/abstract))

Furthermore, medicalized FGM does not necessarily contribute to harm reduction (15). While it may reduce some of the immediate risks, it ignores the long-term complications, including sexual, psychological and obstetrical complications. Studies do not suggest that FGM performed by health-care providers is systematically less extensive. Furthermore, while some argue that a medically performed FGM can be a first step to abandonment, there is no evidence supporting such an expectation.

Providing care for girls and women suffering negative health consequences from FGM is, however, a key role for health-care providers, as well as support for its abandonment. RHR contributes to capacity building in the health-care sector through a series of training courses, and technical tools, including guidance videos for counselling training.

Research to support the abandonment of FGM

During the past few years, RHR has supported research to elucidate more in-depth the reasons for the persistence as well as abandonment of the practice of FGM. A short summary of some of the studies and their key findings is presented below.

Who influences decisions on FGM, and how they do so

RHR supported a study to improve the understanding of the dynamics of decision-making and change in the practice of FGM in Senegal and the Gambia. Data were collected using a set of mixed qualitative and quantitative methods in a closely integrated fashion, looking at a range of various factors to estimate their impact on these processes.

The study found that most decisions about FGM are made by multiple family members, including mothers, fathers, grandparents and aunts. The context in which discussions and change is negotiated is marked by extensive social pressure to practice of FGM. Intergenerational peer convention and peer pressure among women is the prime motivating factor for the continuation of FGM.

Factual aspects such as health risks, particularly experience with adverse outcome and fear of HIV, as well as fear of legal sanctions were contributing factors motivation intentions to abandon the practice.

The results supported a social convention theory that highlights how actions of individuals are interdependent on those of others, and that behaviour change must be coordinated among interconnected individuals.

To grasp the interplay between individual and social factors, the study developed a model of five categories of readiness to change that involves preference and actual behaviour. A model was developed to measure readiness to change in ways that grasp differences between preference and actual behaviour, capturing the significance of a wider decision-making group as well as the significance of social pressure. The theoretical and methodological outcome from this study can be a useful tool for identifying change short of total abandonment, and provides useful metrics for monitoring and evaluation of interventions.

Concerns about women's sexuality – a key issue for the continuation of FGM

To investigate whether concerns about women's sexuality influences decisions to abandon or continue FGM, RHR supported three qualitative studies; one in Egypt and two in Senegal. In addition, information on this was collected also from other studies, including in Burkina Faso, the Gambia and Sudan.

In all countries it was found that a desire to control women's sexuality was a strong motivation for the practice of FGM. In all countries, there was a perception that it was necessary to cut the clitoris of young girls, as this was seen as the site of sexual desire, and removal of the clitoris was therefore expected to reduce women's sexual desire, and thereby improve their ability to comply with local sexual norms that generally emphasize premarital virginity, marital fidelity and sexual modesty.

However, in all the countries it was found that the reduced desire thought accomplished through cutting off the clitoris, was not generally believed to reduce women's sexual pleasure during sexual encounters. An exception was a concern over this among some, especially young groups, and study participants who had been exposed to anti-FGM messages.

In all sites, an overall focus on the importance of sexual pleasure for the man, rather than the woman, was identified. For example, for those men in Egypt who expressed concern that FGM might reduce women's sexual pleasure, their key concern was on the negative effect that could have on their own sexual pleasure. In Senegal the study looked at the widespread use of erotic products, which was mainly presented as means to enhance the sexual pleasure of men. And this thus serves as a means for women to seek men's faithfulness, marital stability and support.

The study also found that religious perceptions were more or less directly related to this. While in some communities FGM was believed by study participants to be directly supported by religion, more often the link was made indirectly, through the focus on control of women's sexuality. FGM was considered to support the religious expectation of sexual restraint in women. Often religious and community leaders were found to provide tacit support of the practice, as men in general. However, men were more likely to question the practice with increased factual information of health risks.

Community practices and interventions

An operations-research initiative was conducted in Sudan and in Burkina Faso, estimating the effects of the most successful interventions documented to date. The study seeks to understand which intervention programs to support the discontinuation of FGM work at community level.

Several of the studies on FGM and sexuality from Senegal found that not only ethnicity but also geographic vicinity are correlated to the practice or non-practice of FGM. Some subgroups of ethnic groups that generally do not practice FGM, who live in the vicinity of groups that practice FGM, had taken up the practice.

Studies on health effects of female genital mutilation

FGM and obstetric complications

In 2006, RHR published a large-scale multicountry study examining the effect of different types of FGM on obstetric outcome. Pregnant women (no. 28 393) attending for singleton delivery at 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan were examined and interviewed. The study found that women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. Deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death, than deliveries to women who have not had FGM. Risks seem to be greater with more extensive FGM.

FGM and obstetric fistula

A multicentre case–control study in Sierra Leone is examining whether there is an association between FGM and obstetric fistulae. The links that have been demonstrated between FGM and higher risks of various obstetric sequelae, indirectly support a link with obstructed labour, a known risk factor for fistula formation. Keloid formation in the vulva after FGM has also been shown to be common, and is another risk factor for obstructed labour. The pilot study indicated that there might be an association between FGM and obstetric fistula, but final results will only be ready by the end of 2013, subject to availability of funding.

Extra costs of obstetric care due to FGM

Following up the seminal study on the obstetric risks associated with different types of FGM from 2006, (6) a modelling study was set up to estimate the increased costs of obstetric care due to increased risk of obstetric complications caused by FGM. The costs were based on data from the same six African countries as the obstetric complication study: Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. The annual costs of FGM-related obstetric complications in the six African countries was estimated to be purchasing power parity dollars (I\$) 3.7 million and ranged from 0.1 to 1% of government spending on health for women aged 15–45 years.

Conclusion

Several recent reviews and studies have confirmed and deepened our understanding of the importance of working through communities, with a broad-based target, long-term investment and a focus on human rights as understood in the local context, to support collective change and public declarations that support the change of local norms. To strengthen this process, political and legal support is key, as is the education of and support to health-care services so they can contribute to the change in their communities, refrain from performing FGM, as well as providing care for those who suffer negative health outcomes from FGM.

Further research is, however, still needed. Communities vary in the extent to which interventions succeed in change, and an even deeper understanding of motivations and processes of decision-making in more communities is needed. There are also large areas of research on health care, health effects, including psychological and social consequences of FGM, that need further studies to improve the quality of care and effectiveness of preventive efforts in a wide variety of contexts.

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