Female genital mutilation

Fact sheet
Updated January 2020

Key facts

- Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.
- The procedure has no health benefits for girls and women.
- Procedures can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of new-born deaths.
- More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated[1].
- FGM is mostly carried out on young girls between infancy and age 15.
- FGM is a violation of the human rights of girls and women.

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.
The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM due to the erroneous belief that the procedure is safer when medicalized[1]. WHO strongly urges health professionals not to perform such procedures.
FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Procedures

Female genital mutilation is classified into 4 major types.

- **Type 1:** Often referred to as **clitoridectomy**, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Type 2:** Often referred to as **excision**, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).
- **Type 3:** Often referred to as **infibulation**, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- **Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Deinfibulation refers to the practice of cutting open the sealed vaginal opening in a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth.

No health benefits, only harm

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue and interferes with the natural functions of girls' and women's bodies. Generally speaking, risks increase with increasing severity of the procedure.
Immediate complications can include:

- severe pain

- excessive bleeding (haemorrhage)
- genital tissue swelling
- fever
- infections e.g., tetanus
- urinary problems
- wound healing problems
- injury to surrounding genital tissue
- shock
- death.

Long-term consequences can include:

- urinary problems (painful urination, urinary tract infections);
- vaginal problems (discharge, itching, bacterial vaginosis and other infections);
- menstrual problems (painful menstruations, difficulty in passing menstrual blood, etc.);
- scar tissue and keloid;
- sexual problems (pain during intercourse, decreased satisfaction, etc.);
- increased risk of childbirth complications (difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby, etc.) and newborn deaths;
- need for later surgeries: for example, the FGM procedure that seals or narrows a vaginal opening (type 3) needs to be cut open later to allow for sexual intercourse and childbirth (deinfibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks;
- psychological problems (depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.).
- Health complications of female genital mutilation

Who is at risk?

Procedures are mostly carried out on young girls sometime between infancy and adolescence, and occasionally on adult women. More than 3 million girls are estimated to be at risk for FGM annually. More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated [1].

The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries the Middle East and Asia, as well as among migrants from these areas. FGM is therefore a global concern.

Cultural and social factors for performing FGM

The reasons why female genital mutilations are performed vary from one region to another as well as over time and include a mix of sociocultural factors within families and communities. The most commonly cited reasons are:

- Where FGM is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice. In some communities, FGM is almost universally performed and unquestioned.
- FGM is often considered a necessary part of raising a girl, and a way to prepare her for adulthood and marriage.
- FGM is often motivated by beliefs about what is considered acceptable sexual behaviour. It aims to ensure premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist extramarital sexual acts. When a vaginal opening is covered or narrowed (type 3), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage extramarital sexual intercourse among women with this type of FGM.
- Where it is believed that being cut increases marriageability, FGM is more likely to be carried out.
- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are clean and beautiful after removal of body parts that are considered unclean, unfeminine or male.
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.

- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.
- In most societies, where FGM is practised, it is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.

International response

Building on work from previous decades, in 1997, WHO issued a joint statement against the practice of FGM together with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA).

Since 1997, great efforts have been made to counteract FGM, through research, work within communities, and changes in public policy. Progress at international, national and sub-national levels includes:

- wider international involvement to stop FGM;
- international monitoring bodies and resolutions that condemn the practice;
- revised legal frameworks and growing political support to end FGM (this includes a law against FGM in 26 countries in Africa and the Middle East, as well as in 33 other countries with migrant populations from FGM practicing countries);
- the prevalence of FGM has decreased in most countries and an increasing number of women and men in practising communities support ending its practice.

Research shows that, if practicing communities themselves decide to abandon FGM, the practice can be eliminated very rapidly.

In 2007, UNFPA and UNICEF initiated the Joint Programme on Female Genital Mutilation/Cutting to accelerate the abandonment of the practice.

In 2008, WHO together with 9 other United Nations partners, issued a statement on the elimination of FGM to support increased advocacy for its abandonment, called: "Eliminating female genital mutilation: an interagency statement". This statement provided evidence collected over the previous decade about the practice of FGM.

In 2010, WHO published a "Global strategy to stop health care providers from performing female genital mutilation" in collaboration with other key UN agencies and international organizations.

In December 2012, the UN General Assembly adopted a resolution on the elimination of female genital mutilation.

Building on a previous report from 2013, in 2016 UNICEF launched an updated report documenting the prevalence of FGM in 30 countries, as well as beliefs, attitudes, trends, and programmatic and policy responses to the practice globally.

In May 2016, WHO in collaboration with the UNFPA-UNICEF joint programme on FGM launched the first evidence-based guidelines on the management of health complications from FGM. The guidelines were developed based on a systematic review of the best available evidence on health interventions for women living with FGM.

To ensure the effective implementation of the guidelines, WHO is developing tools for front-line health-care workers to improve knowledge, attitudes, and skills of health care providers in preventing and managing the complications of FGM.

WHO response

In 2008, the World Health Assembly passed resolution WHA61.16 on the elimination of FGM, emphasizing the need for concerted action in all sectors - health, education, finance, justice and women's affairs.

WHO efforts to eliminate female genital mutilation focus on:

- strengthening the health sector response: guidelines, tools, training and policy to ensure that health professionals can provide medical care and counselling to girls and women living with FGM;
- building evidence: generating knowledge about the causes and consequences of the practice, including why health care professionals carry out procedures, how to eliminate it, and how to care for those who have experienced FGM;

- increasing advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM within a generation.

www.fgmelearning.co.uk

www.elearning.prevent.homeoffice.gov.uk