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Introduction

All societies have norms of care and behaviour based on age, life stage, gender and social class. These norms, often referred to as traditional practices, may be beneficial or harmless, but some may be harmful. Those traditional practices relating to female children, relations between women and men, and marriage and sexuality often have a harmful effect on women and girls. There are many examples of this. Son preference or the high value placed on sons may lead to discrimination against girls with serious health consequences for them. In extreme cases it may lead to prenatal sex selection or the infanticide of female infants. Traditional payments made by a husband to obtain a wife serve to strengthen the attitude that women are property and can lead to physical abuse, intimidation, or even death. Marriage and childbearing before girls have reached physical and psychosocial maturity also create many health risks for young women.

One deeply rooted traditional practice that has severe health consequences for girls and women is female genital mutilation, sometimes referred to as female circumcision. Female genital mutilation reinforces the inequity suffered by girls and women in the communities where it is practised and must be addressed if their health, social and economic development needs are to be met. The arguments against female genital mutilation are based on universally recognized human rights, including the rights to integrity of the person and the highest attainable level of physical and mental health. The health consequences of the practice vary according to the procedure used. Nevertheless, female genital mutilation is universally unacceptable because it is an infringement on the physical and psychosexual integrity of women and girls and is a form of violence against them.

In presenting this statement, the purpose is neither to criticize nor to condemn. Even though cultural practices may appear senseless or destructive from the standpoint of others, they have meaning and fulfil a function for those who practise them. However, culture is not static; it is in constant flux, adapting and

reforming. People will change their behaviour when they understand the hazards and indignity of harmful practices and when they realize that it is possible to give up harmful practices without giving up meaningful aspects of their culture. The role of the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) is to support global, national and community efforts for the elimination of female genital mutilation in order to achieve health and well-being for women, girls, their families and communities.

What is female genital mutilation?

Definition

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.

Classification

The different types of female genital mutilation known to be practised are as follows:

Type I Excision of the prepuce, with or without excision of part or all of the clitoris.

Type II Excision of the clitoris with partial or total excision of the labia minora.

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

The procedures described above are irreversible and their effects last a lifetime.

Practitioners

In cultures where it is an accepted norm, female genital mutilation is usually performed by a traditional practitioner with crude

instruments and without anaesthetic. Among the more affluent sectors of society it may be performed in a health care facility by qualified health personnel.

Age and reasons for female genital mutilation

The age at which female genital mutilation is carried out varies from area to area. Reports indicate that it is performed on infants a few days old, on children between 6 and 10 years of age, in adolescence and occasionally in adulthood. The reasons for the practice have been reported in a number of research papers, interviews and statements. These reasons fall into five groups:

- *psychosexual reasons* — reduction or elimination of the sensitive tissue of the outer genitalia, particularly the clitoris, in order to attenuate sexual desire in the female, maintain chastity and virginity before marriage and fidelity during marriage, and increase male sexual pleasure;
- *sociological reasons* — identification with the cultural heritage, initiation of girls into womanhood, social integration and the maintenance of social cohesion;
- *hygiene and aesthetic reasons* — the external female genitalia are considered dirty and unsightly and should be removed to promote hygiene and provide aesthetic appeal;
- *myths* — enhancement of fertility and promotion of child survival;
- *religious reasons* — female genital mutilation is practised by Muslims, Christians (Catholics, Protestants, Copts), animists and nonbelievers in a range of communities. It has, however, frequently been carried out by some Muslim communities in the genuine belief that it is demanded by the Islamic faith. However, the practice of female genital mutilation predates Islam and there is no substantive evidence that it is a religious requirement of Islam.

Prevalence and distribution

Most of the girls and women who have undergone genital mutilation live in 28 African countries, although some live in Asia. They are also increasingly found in Europe, Australia, Canada and the USA, primarily among immigrants from Africa and southwestern Asia. It is estimated that over 130 million girls and women in Africa have undergone some form of female genital mutilation. The map *(overleaf)* shows the areas of the world in which female genital mutilation has been reported to occur.

The commonest type of female genital mutilation is excision of the clitoris and the labia minora, accounting for up to 80% of all cases. The most extreme form is infibulation, which constitutes about 15% of all procedures. The incidence of infibulation is much higher in Djibouti, Somalia and northern Sudan, with a consequent higher rate of complications. Infibulation is also reported in southern Egypt, Eritrea, Ethiopia, northern Kenya, Mali and Nigeria. At current rates of population increase, and with slow decline in these procedures, it is estimated that at least 2 million girls are at risk of genital mutilation every year.

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.

Health complications

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

Immediate complications

The immediate complications include severe pain, shock, haemorrhage, tetanus or sepsis, urine retention, ulceration of the genital region and injury to adjacent tissue. Haemorrhage and infection can be of such a magnitude as to cause death. More recently, concern has arisen about possible transmission of the human immunodeficiency virus (HIV) due to the use of one instrument in multiple operations, but this has not been the subject of detailed research. In some cases where infibulation prevents or impedes vaginal intercourse, anal intercourse may be used as an alternative. The resulting damage to tissue is also a possible route of infection by HIV.

Long-term complications

Reported long-term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction. Infibulation can cause severe scar formation, difficulty in urinating and during menstruation, recurrent bladder and urinary tract infection and infertility. Because infibulation often makes intercourse difficult, it is sometimes necessary to cut open the bridge of skin created by the labia majora. Cutting may also be necessary when giving birth. Although few reliable data exist, it is likely that the risk of maternal death and stillbirth is greatly increased, particularly in the absence of skilled health personnel and appropriate facilities. During childbirth, the risk of haemor-

rhage and infection is greatly increased. Female genital mutilation may also be associated with long-term maternal morbidity (e.g. vesicovaginal fistula).

Psychosexual and psychological health

Almost all types of female genital mutilation involve the removal of part or all of the clitoris, which is the main female sexual organ, equivalent in its anatomy and physiology to the male penis. The more severe types, such as infibulation, remove larger parts of the genitals and close off the vagina, leaving areas of tough scar tissue in place of the sensitive genitalia, thus creating permanent damage and dysfunction. Sexual dysfunction in both partners may result from painful intercourse and reduced sexual sensitivity following clitoridectomy and narrowing of the vaginal opening.

Genital mutilation may leave a lasting mark on the life and mind of the woman who has undergone it. The psychological complications may be submerged deep in the child's subconscious and may trigger behavioural disturbances. The loss of trust and confidence in care-givers has been reported as a possible serious effect. In the longer term, women may suffer feelings of incompleteness, anxiety, depression, chronic irritability and frigidity. They may experience marital conflicts. Many girls and women, traumatized by their experience but with no acceptable means of expressing their fears, suffer in silence.

The medicalization of female genital mutilation

WHO has consistently and unequivocally advised that female genital mutilation in any form should not be practised by health professionals in any setting — including hospitals or other health establishments. WHO's position rests on the basic ethics of health care whereby unnecessary bodily mutilation cannot be condoned by health providers. Genital mutilation is harmful to

girls and women and medicalization of the procedure does not eliminate this harm. Medicalization is also inappropriate as it reinforces the continuation of the practice by seeming to legitimize it. In communities where infibulation is the norm, it has been noted that many families revert to clitoridectomy when health education programmes commence. However, the formal policy messages must consistently convey that all forms of female genital mutilation must be stopped.

International agreements

International human rights covenants underscore the obligations of United Nations Member States to respect and to ensure the protection and promotion of human rights, including the rights to non-discrimination, to integrity of the person and to the highest attainable standard of physical and mental health. In this regard, most governments in countries where female genital mutilation is practised have ratified several United Nations Conventions and Declarations that make provision for the promotion and protection of the health of girls and women, including the elimination of female genital mutilation, as indicated in the box.

1948 The Universal Declaration of Human Rights proclaimed the right of all human beings to live in conditions that enable them to enjoy good health and health care.

1966 The International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights condemned discrimination on the grounds of sex, and recognized the universal right to the highest attainable standard of physical and mental health.

1979 The Convention on the Elimination of All Forms of Discrimination against Women can be interpreted to require States Parties to take action against female genital mutilation, namely:

- "to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women" (Art. 2.f);
- "to modify the social and cultural patterns of conduct of men and women, with a view to

achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women" (Art. 5.a);

1990 The Convention on the Rights of the Child protects the right to equality irrespective of sex (Art. 2), to freedom from all forms of mental and physical violence and maltreatment (Art. 19.1), to the highest attainable standard of health (Art. 24.1), and to freedom from torture or cruel, inhuman or degrading treatment (Art. 37.a). Article 24.3 of the Convention explicitly requires States to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children.

1993 The Vienna Declaration and the Programme of Action of the World Conference on Human Rights expanded the international human rights agenda to include gender-based violations which include female genital mutilation.

1993 The Declaration on Violence Against Women expressly states in its article 2:

"Violence against women shall be understood to encompass, but not be limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including . . . dowry-related violence . . . female genital mutilation and other traditional practices harmful to women . . ."

1994 The Programme of Action of the International Conference on Population and Development (ICPD) included recommendations on female genital mutilation which commit governments and communities to:

"urgently take steps to stop the practice of female genital mutilation and to protect women and girls

from all such similar unnecessary and dangerous practices".

1995 The Platform for Action of the Fourth World Conference on Women included a section on the girl child and urged governments, international organizations and nongovernmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including female genital mutilation.

In order to make these agreements meaningful, mechanisms must be developed to implement them at grassroots level and concerted efforts must be made to protect the rights of girls and women.

National and community action

In the last decade, many organizations and individuals have attempted community-based activities aimed at the elimination of female genital mutilation. Much experience has been gained in bringing the problem to the attention of political, religious and community leaders and in creating an atmosphere of political support for the elimination of the practice. There is increasing recognition that the cultural purpose of female genital mutilation varies as widely as the type of procedure performed and that a full understanding of women's position and of gender relations within the particular sociocultural and economic context is required in order to eliminate the practice. Efforts to stop it must therefore not be limited to the medical model of disease eradication but must be part of a multidisciplinary approach. While there is not a great body of successful experience, those involved in action against female genital mutilation concur in the overall approaches to be taken, as follows:

- adoption of clear national policies for the abolition of female genital mutilation including, where appropriate, the enactment of legislation to prohibit it;
- establishment of interagency teams that bring together representatives of relevant government ministries, non-governmental organizations and professional organizations and associations to ensure action to eliminate female genital mutilation;
- support for research into all aspects of female genital mutilation, including incidence, prevalence, the main reasons why it continues to be practised, and health consequences, as well as operations research on interventions for eliminating it;
- organization of strong community outreach and family life education programmes that involve village and religious leaders and address the main reasons for continuing the practice (experience shows that, where leadership is enlightened and committed, information and education activities are more successful);