TOPICS

WHAT IS FEMALE GENITAL MUTILATION

Introduction

African activists, women groups and intellectuals have opposed female genital mutilation (FGM) in their home countries for many decades. This is testified by the large active scene of local non-governmental organisations (NGOs) and regional networks. It was them who introduced the issue in the global discourse on women's health and human rights with regard to FGM. Women activists who hold positions in relevant institutions in the USA and Europe have taken action in order to raise awareness and promote the movement against FGM in western countries. "For many years I have been outspoken about [FGM] in my own country, Sudan, […] but talking about this issue in the West felt like revealing my family's dysfunctional behaviour to their in-laws", says Dr. Nahid Toubia (Rainbo). Meanwhile, she is at the forefront of the struggle against FGM in the UK. Whilst Somali Waris Dirie, author of *Desert Flower,* heads the campaign to eliminate FGM at UNFPA.

Definition

Female circumcision (FC), female genital mutilation (FGM) or female genital cutting (FGC) are overarching terms used for several different traditional practices that involve the partial or total removal of the external female genitalia and/or injury to the female genital organs.

The term FC is often seen as an understatement due to its analogy to male circumcision. Without making judgements on the consequences of male circumcision, female circumcision represents a serious violation of a girl's health and human rights; the most minimal form can affect her wellbeing in a negative way. To denote the severity of the damage inflicted, activists and international development discourse use the term mutilation. This is also endorsed by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). However, some prefer the term FGC as being less derogatory. While it is recommended that terminology and classification be internationally standardised to maintain a professional communication, in the respective setting indigenous words should be favoured for international terms to avoid humiliation or stigmatisation.

Classification

Recognising the need for a standardisation WHO, UNICEF and UNFPA classified the different forms of FGM into four types. Even though it is not always possible to clearly allocate a practice to any one category.

WHO Classification

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.*

Prevalence

FGM is prevalent in 28 African countries, in a few Arab and Asian countries (e.g. Yemen, a few ethnic groups in Oman, Indonesia and Malaysia), and among certain African immigrants in the West. An estimated 130 million girls and women worldwide have undergone the practice, with another three million girls being affected each year. Types I and II account for 80 to 85% of all cases, although the proportion may vary greatly from country to country. For instance in Djibouti, Somalia and Sudan most women undergo Type III. In-

gtz

As of 1 January 2011:
giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

fibulation is practised on a smaller scale in parts of Egypt, Eritrea, Ethiopia, Gambia, Kenya and Mali.

Motives

FGM tends to be justified among others by the following reasons: The apparent need to control women's sexuality, an alleged medical advantage of genital cutting, the belief that female circumcision constitutes a religious obligation, and/or the desire to adhere to customary traditions. Implicitly underlying these is the social construction of female sexuality and identity. It is social conditioning or social pressure that leads women to accept and perpetuate the practice. Traditional circumcisors often enjoy high prestige in their communities. Familiarity with the respective justification(s) for the practice in a given community is essential for a sensitive and effective intervention strategy.

Practice

FGM is often performed as a rite of passage from childhood to womanhood. It tends to be undertaken on girls between the ages of four and 14 years. Though the age varies from one community to another, and can be as young as a few days or as late as prior to marriage or the birth of the first child. Generally, age at circumcision is decreasing. Reasons for this include a slow yet perceptible dissociation with a rite of passage, the attempt to avoid coming into conflict with existing legislation, or to avoid resistance on the part of (older) children. FGM is usually performed by traditional circumcisers, normally elderly women, or traditional birth attendants. They tend to use unsterilised, often blunt utensils, like razor blades, knives, scissors or broken glass, without anaesthetics. The procedure takes usually place in secluded and private places in the absence of men.

Health Complications

All types of FGM are irreversible and can lead to a range of psychological and physical complications, most serious and lasting in Type III operations. The occurrence of health hazards depends on the nature of the cutting, the skill of the practitioner, the hygiene condition, and the girl's general well-being. Acute risks include severe pain, haemorrhage, urine retention, infection and death. In the longer term, women may experience damage to the sexual and reproductive health, augmented risk of HIV infection, and psychological scars. In almost all cases of infibulation and in many cases of severe excision, defibulation must be performed during child-birth. If no experienced birth attendant is available to perform defibulation, the life of the foetus or the mother may be at risk because of obstructed labour or tissue tears.

Medicalisation

In some areas there is a slight trend towards medicalisation of FGM (i.e. the operation being performed by health professionals in health structures). The idea is to benefit from more hygienic conditions and modern medicine in order to avoid side-effects. Many health-care providers not only support the continuation and medicalisation of the practice, but also regard it as a source of income. However, medicalisation does not preclude medical complications; moreover, it leaves untouched FGM as a violation of human rights. Therefore, international development bodies strongly condemn the medicalisation of FGM.

GTZ subscribes to the WHO stance that medicalisation should never be considered as an option.

Human Rights

FGM offends various human rights of women and girls, civil and political rights, as well as social and cultural rights: Most importantly, the right to security and personal liberty, to life and bodily integrity, and the right to health, including reproductive health. FGM was an important topic at the World Conference on Human Rights in 1993, the International Conference on Population and Development in 1994, and the United Nations Fourth World Conference on Women in 1995. Given that culture is a constantly contested and negotiated set of social practices, the fact that FGM is a cultural tradition should not deter from asserting that it violates universally recognised rights. However, it is necessary to save the positive (aspects of) traditional practices. The human rights framework represents a powerful tool for affecting political processes at international and national levels, and provides a means for governments to establish official sanctions for practising FGM. Furthermore, it obliges the international community to assume its share of responsibility for the protection of the human rights of women and girls.

Published by
Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ) GmbH

Dag Hammarskjöld-Weg 1-5
65760 Eschborn

Supra-regional project
Ending Female Genital Mutilation

Tel. +49(0)6196-79-1578, -1579, -1553
Fax +49(0)6196-79-7177
E-Mail bianca.schimmel@gtz.de
Web www.gtz.de/fgm

July 2007