Female genital mutilation—what it is and why it continues

Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, UNICEF, UNFPA, 1997).

The WHO/UNICEF/UNFPA Joint Statement classified female genital mutilation into four types. Experience with using this classification over the past decade has brought to light some ambiguities. The present classification therefore incorporates modifications to accommodate concerns and shortcomings, while maintaining the four types (see Annex 2 for a detailed explanation and proposed sub-divisions of types).

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.

Female genital mutilation is mostly carried out on girls between the ages of 0 and 15 years. However, occasionally, adult and married women are also subjected to the procedure. The age at which female genital mutilation is performed varies with local traditions and circumstances, but is decreasing in some countries (UNICEF, 2005a).

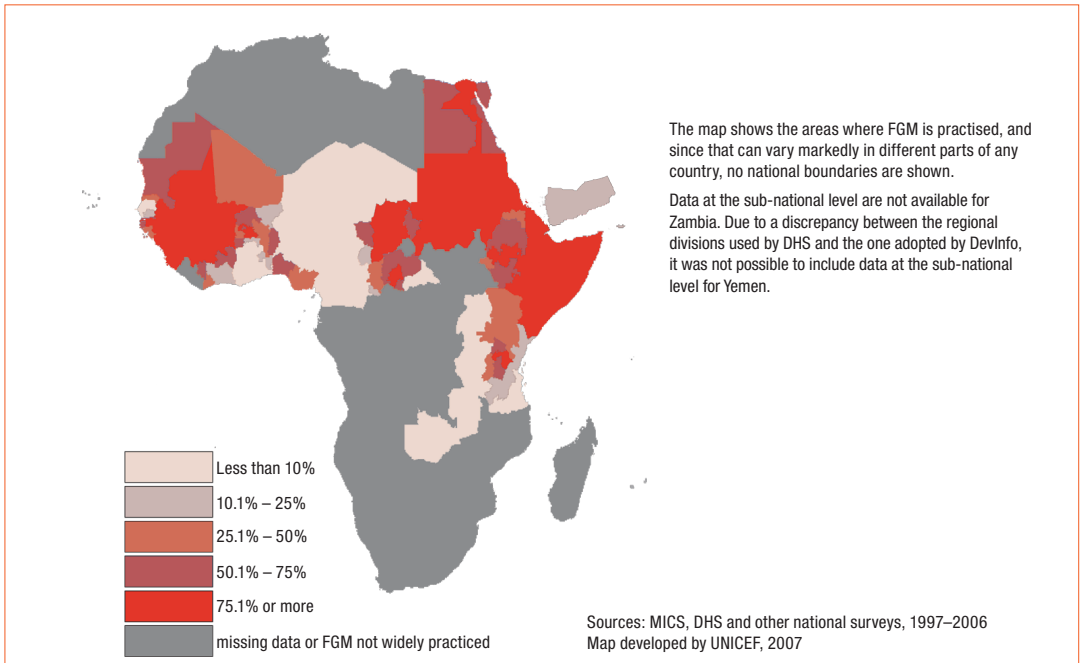
How widely it is practiced

WHO estimates that between 100 and 140 million girls and women worldwide have been subjected to one of the first three types of female genital mutilation (WHO, 2000a). Estimates based on the most recent prevalence data indicate that 91,5 million girls and women above 9 years old in Africa are currently living with the consequences of female genital mutilation (Yoder and Khan, 2007). There are an estimated 3 million girls in Africa at risk of undergoing female genital mutilation every year (Yoder et al., 2004).

Types I, II and III female genital mutilation have been documented in 28 countries in Africa and in a few countries in Asia and the Middle East (see Annex 3). Some forms of female genital mutilation have also been reported from other countries, including among certain ethnic groups in Central and South America. Growing migration has increased the number of girls and women living outside their country of origin who have undergone female genital mutilation (Yoder et al., 2004) or who may be at risk of being subjected to the practice.

The prevalence of female genital mutilation has been estimated from large-scale, national surveys asking women aged 15–49 years if they have themselves been cut. The prevalence varies considerably, both between and within regions and countries (see Figure 1 and Annex 3), with ethnicity as the most decisive factor. In seven countries the national prevalence is almost universal, (more than 85%); four countries have high prevalence (60–85%); medium prevalence (30–40%) is found in seven countries, and low prevalence, ranging from 0.6% to 28.2%, is found in the remaining nine countries. However, national averages (see Annex 3) hide the often marked variation in prevalence in different parts of most countries (see Figure 1).

Figure 1. Prevalence of female genital mutilation in Africa and Yemen (women aged 15–49)



The type of procedure performed also varies, mainly with ethnicity. Current estimates indicate that around 90% of female genital mutilation cases include Types I or II and cases where girls' genitals were "nicked" but no flesh removed (Type IV), and about 10% are Type III (Yoder and Khan, 2007).

Why the practice continues

In every society in which it is practised, female genital mutilation is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures. Like the now-abandoned foot-binding in China and the practice of dowry and child marriage, female genital mutilation represents society's control over women. Such practices have the effect of perpetuating normative gender roles that are unequal and harm women. Analysis of international health data shows a close link between women's ability to exercise control over their lives and their belief that female genital mutilation should be ended (UNICEF, 2005b).

Where female genital mutilation is widely practised, it is supported by both men and women, usually without question, and anyone departing from the norm may face condemnation, harassment, and ostracism. As such, female genital mutilation is a social convention governed by rewards and punishments which are a powerful force for continuing the practice. In view of this conventional nature of female genital mutilation, it is difficult for families to abandon the practice without support from the wider community. In fact, it is often practised even when it is known to inflict harm upon girls because the perceived social benefits of the practice are deemed higher than its disadvantages (UNICEF, 2005a).

Members of the extended family are usually involved in decision-making about female genital mutilation, although women are usually responsible for the practical arrangements for the ceremony. Female genital mutilation is considered necessary

to raise a girl properly and to prepare her for adulthood and marriage (Yoder et al., 1999; Ahmadu, 2000; Hernlund, 2003; Dellenborg, 2004). In some societies, the practice is embedded in coming-of-age rituals, sometimes for entry into women's secret societies, which are considered necessary for girls to become adult and responsible members of the society (Ahmadu, 2000; Hernlund, 2003; Behrendt, 2005; Johnson, 2007). Girls themselves may desire to undergo the procedure as a result of social pressure from peers and because of fear of stigmatization and rejection by their communities if they do not follow the tradition. Also, in some places, girls who undergo the procedure are given rewards such as celebrations, public recognition and gifts (Behrendt, 2005; UNICEF, 2005a). Thus, in cultures where it is widely practised, female genital mutilation has become an important part of the cultural identity of girls and women and may also impart a sense of pride, a coming of age and a feeling of community membership.

There is often an expectation that men will marry only women who have undergone the practice. The desire for a proper marriage, which is often essential for economic and social security as well as for fulfilling local ideals of womanhood and femininity, may account for the persistence of the practice.

Some of the other justifications offered for female genital mutilation are also linked to girls' marriageability and are consistent with the characteristics considered necessary for a woman to become a "proper" wife. It is often believed that the practice ensures and preserves a girl's or woman's virginity (Talle, 1993, 2007; Berggren et al., 2006; Gruenbaum, 2006). In some communities, it is thought to restrain sexual desire, thereby ensuring marital fidelity and preventing sexual behaviour that is considered deviant and immoral (Ahmadu, 2000; Hernlund, 2000, 2003; Abusharaf, 2001; Gruenbaum, 2006). Female genital mutilation is also considered to make girls "clean" and beautiful. Removal of genital parts is thought of as eliminating "masculine" parts such as the clitoris (Talle, 1993; Ahmadu, 2000; Johansen, 2007), or in the case of infibulation, to achieve smoothness considered to be beautiful (Talle, 1993; Gruenbaum, 2006). A belief sometimes expressed by women is that female genital mutilation enhances men's sexual pleasure (Almroth-Berggren et al., 2001).

In many communities, the practice may also be upheld by beliefs associated with religion (Budiharsana, 2004; Dellenborg, 2004; Gruenbaum, 2006; Clarence-Smith, 2007; Abdi, 2007; Johnson, 2007). Even though the practice can be found among Christians, Jews and Muslims, none of the holy texts of any of these religions prescribes female genital mutilation and the practice pre-dates both Christianity and Islam (WHO, 1996a; WHO and UNFPA, 2006). The role of religious leaders varies. Those who support the practice tend either to consider it a religious act, or to see efforts aimed at eliminating the practice as a threat to culture and religion. Other religious leaders support and participate in efforts to eliminate the practice. When religious leaders are unclear or avoid the issue, they may be perceived as being in favour of female genital mutilation.

The practice of female genital mutilation is often upheld by local structures of power and authority such as traditional leaders, religious leaders, circumcisers, elders, and even some medical personnel. Indeed, there is evidence of an increase in the performance of female genital mutilation by

medical personnel (see box "Health professionals must never perform female genital mutilation", page 12). In many societies, older women who have themselves been mutilated often become gatekeepers of the practice, seeing it as essential to the identity of women and girls. This is probably one reason why women, and more often older women, are more likely to support the practice, and tend to see efforts to combat the practice as an attack on their identity and culture (Toubia and Sharief, 2003; Draege, 2007; Johnson, 2007). It should be noted that some of these actors also play a key role in efforts to eliminate the practice.

Female genital mutilation is sometimes adopted by new groups and in new areas after migration and displacement (Abusharaf, 2005, 2007). Other communities have been influenced to adopt the practice by neighbouring groups (Leonard, 2000; Dellenborg, 2004) and sometimes in religious or traditional revival movements (Nypan, 1991). Preservation of ethnic identity to mark a distinction from other, non-practising groups might also be important, particularly in periods of intensive social change. For example, female genital mutilation is practised by immigrant communities living in countries that have no tradition of the practice (Dembour, 2001; Johansen, 2002, 2007; Johnson, 2007). Female genital mutilation is also occasionally performed on women and their children from non-practising groups when they marry into groups in which female genital mutilation is widely practised (Shell-Duncan and Hernlund, 2006).

Decisions to perform female genital mutilation on girls involve a wide group of people who may have different opinions and varying degrees of influence (Shell-Duncan and Hernlund, 2006; Draege, 2007). This is even true for the practice of reinfibulation in adult women (Berggren et al., 2006). In periods of change, female genital mutilation can give rise to discussions and disagreement, and there are cases in which some family members, against the will of others, have organized the procedure (Draege, 2007). Furthermore, both individuals and communities can change ideas and opinions several times (Nypan, 1991; Shell-Duncan and Hernlund, 2006). Decision-making is complex and, to ensure that families who wish to abandon the practice can make and sustain their decision so that the rights of girls are upheld, a wide group of people have to come to agreement about ending the practice (see section on "Taking action for the complete elimination of female genital mutilation", page 13).