Annex 2: Note on the classification of female genital mutilation

A classification of female genital mutilation was first drawn up at a technical consultation in 1995 (WHO, 1996b). An agreed classification is useful for purposes such as research on the consequences of different forms of female genital mutilation, estimates of prevalence and trends in change, gynaecological examination and management of health consequences, and for legal cases. A common typology can ensure the comparability of data sets. Nevertheless, classification naturally entails simplification and hence cannot reflect the vast variations in actual practice. As some researchers had pointed out limitations in the 1995 classification, WHO convened a number of consultations with technical experts and others working to end female genital mutilation to review the typology and evaluate possible alternatives. It was concluded that the available evidence is insufficient to warrant a new classification; however, the wording of the current typology was slightly modified, and sub-divisions created, to capture more closely the variety of procedures.

Clarifications and comments

Although the extent of genital tissue cutting generally increases from Type I to III, there are exceptions. Severity and risk are closely related to the anatomical extent of the cutting, including both the type and amount of tissue that is cut, which may vary between the types. For example, Type I usually includes removal of the clitoris (Type Ib) and Type II both the clitoris and the labia minora (Type IIb)[1]. In this case, Type II would be more severe and associated with increased risk. In some forms of Type II, however, only the labia minora are cut and not the clitoris (Type IIa), in which case certain risks such as for haemorrhage may be less, whereas other risks such as genital infections or scarification may be the same or greater. Similarly, Type III is predominantly associated with more severe health risks than Type II, such as birth complications. A significant factor in infertility, however, is the anatomical extent of the cutting, i.e. whether it includes the labia majora rather than the enclosure itself. Hence, Type II that includes cutting the labia majora (Type IIc) is associated with a greater risk for infertility than Type IIIa infibulation made with the labia minora only (Almroth et al., 2005b). As the clitoris is a highly sensitive sexual organ, Type I including the removal of the clitoris may reduce sexual sensitivity more than Type III in which the clitoris is left intact under the infibulation (Nour et al., 2006).

The severity and prevalence of psychological (including psychosexual) risks may also vary with characteristics other than the physical extent of tissue removal, such as age and social situation (McCaffrey, 1995).

Challenges for classification

The questionnaire used currently in the Demographic and Health Surveys does not differentiate between Types I and II, but only between whether a girl or woman has been cut, whether tissue has been removed and whether tissue has been sewn closed. Most studies on types, including the Demographic and Health Surveys, rely on self-reports from women. Studies that include clinical assessment have documented large variations in the level of agreement between self-reported descriptions and clinically observed

[1] "Clitoris" is used here to refer to the clitoral glans, i.e. the external part of the clitoris; it does not include the clitoral body or the crura, which are situated directly beneath the soft tissue and not visible from outside. The clitoral prepuce (hood) is the fold of skin that surrounds and protects the clitoral glans.

WHO modified typology, 2007	WHO typology, 1995
Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of **Type I** mutilation, the following subdivisions are proposed: **Type Ia**, removal of the clitoral hood or prepuce only; **Type Ib**, removal of the clitoris with the prepuce.	**Type I:** Excision of the prepuce, with or without excision of part or the entire clitoris.
Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: **Type IIa**, removal of the labia minora only; **Type IIb**, partial or total removal of the clitoris and the labia minora; **Type IIc**, partial or total removal of the clitoris, the labia minora and the labia majora. Note also that, in French, the term "excision" is often used as a general term covering all types of female genital mutilation.	**Type II:** Excision of the clitoris with partial or total excision of the labia minora.
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). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: **Type IIIa:** removal and apposition of the labia minora; **Type IIIb:** removal and apposition of the labia majora.	**Type III:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.	**Type IV:** Unclassified: 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 purpose of tightening or narrowing it; and any other procedure that falls under the broad definition of female genital mutilation.

types of female genital mutilation (Morison et al., 2001; Msuya et al., 2002; Snow et al., 2002; Klouman et al., 2005; Elmusharaf et al., 2006a). The commonest discrepancy is that a large percentage of women in areas where Type III is traditionally practised declare that they have undergone Type I or II, even though clinical assessment indicates Type III (Elmusharaf et al., 2006a). In addition, the reliability of clinical observation can be limited by natural anatomical variations and difficulty in estimating the amount of clitoral tissue under an infibulation.

Comments on the modifications to the 1995 definition of Type I

The reference to the clitoral prepuce is moved to the end of the sentence. The reason for this change is the common tendency to describe Type I as removal of the prepuce, whereas this has not been documented as a traditional form of female genital mutilation. However, in some countries, medicalized female genital mutilation can include removal of the prepuce only (Type Ia) (Thabet and Thabet, 2003), but this form appears to be relatively rare (Satti et al., 2006). Almost all known forms of female genital mutilation that remove tissue from the clitoris also cut all or part of the clitoral glans itself.

Comments on the modifications to the 1995 definition of Type II

Removal of the clitoris and labia minora is the commonest form documented for Type II, but there are documented variations. Sometimes, tissue from the labia majora is also removed (Almroth et al., 2005b; Bjälkander and Almroth, 2007), and in other cases only the labia minora are cut, without removal of the clitoris. It should be noted that what appears to be Type II might sometimes be an opened Type III. Furthermore, scarring after Type II can lead to closure of the vaginal orifice, and therefore the result will mimic Type III. As such, it will be defined as Type III, although this was not the intended outcome.

Comments on the modifications to the 1995 definition of Type III

The key characteristic of Type III is the cutting and apposition—and hence adhesion—of the labia minora or majora, leading to narrowing of the vaginal orifice. This is usually accompanied by partial or total removal of the clitoris. The words "Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora" replace the 1995 formulation of "stitching/narrowing of the vaginal opening". The new formulation makes it clear that it is generally not the vagina itself that is narrowed or stitched, but rather that it is partly covered by a seal of skin created by the scar tissue from the adhesion of the labia. This skin tissue also covers the clitoris and urethra. The term "apposition" is used in preference to "stitching" because stitching (with thorns or sutures) is only one of the ways to create adhesion. Other common techniques include tying the legs together or the use of herbal pastes.

New studies have found significant variations in Type III, particularly a major distinction between infibulation of the labia minora and of the labia majora (Satti et al., 2006). For research on certain health complications, and to document tendencies of change, it may be important to distinguish between these two types of infibulation (Almroth et al., 2005b; Elmusharaf et al., 2006a). Labia minora infibulation may include what in some countries is described as "sealing". As mentioned under the

comments on Type II, this can be an accidental adhesion resulting from a procedure intended as a Type II. In many cases of Type III, no clitoral tissue has been removed (Nour et al., 2006).

Reinfibulation is covered under this definition. This is a procedure to recreate an infibulation, usually after childbirth in which defibulation was necessary. The amount of re-closure varies. If reinfibulation is performed to recreate a "virginal" appearance, it is often necessary not only to close what has been opened but also to perform further cutting to create new raw edges for more extensive closure. Recent studies have also documented that, in some cases, women who were not infibulated prior to childbirth underwent sutures that reduced their vaginal orifices after delivery (Almroth-Berggren et al., 2001; Berggren et al., 2004). WHO guidelines recommend permanent defibulation, including suturing the raw edges separately to secure a permanent opening and to prevent adhesion formation, in order to avoid future complications associated with infibulation (WHO, 2001a,b).

Comments on the modifications to the 1995 definition of Type IV

Type IV is a category that subsumes all other harmful, or potentially harmful, practices that are performed on the genitalia of girls and women. Therefore, the modified typology begins with the broad definition. The different practices listed are examples, and the list could be shortened or lengthened with increasing knowledge.

The reasons, context, consequences and risks of the various practices subsumed under Type IV vary enormously. As these practices are generally less well known and studied than those under Types I, II and III, the following clarifications derived from available evidence are provided.

Pricking, piercing, incising and scraping

Pricking, piercing and incision can be defined as procedures in which the skin is pierced with a sharp object; blood may be let, but no tissue is removed. Pricking has been described in some countries either as a traditional form of female genital mutilation (Budiharsana, 2004) or as a replacement for more severe forms of female genital mutilation (Yoder et al., 2001; Njue and Askew, 2004). Incision of the genitals of young girls and infants has been documented (Budiharsana, 2004), as has scraping (Newland, 2006).

Discussion on whether pricking should be included in the typology and defined as a type of female genital mutilation has been extensive. Some researchers consider that it should be removed from the typology, both because it is difficult to prove if there are no anatomical changes, and because it is considered significantly less harmful than other forms (Obiora, 1997; Shweder, 2003; Catania and Hussen, 2005). Introduction of pricking has even some times been suggested as a replacement of more invasive procedures, as a form of harm-reduction (Shweder, 2003; Catania and Hussen, 2005). Others argue that it should be retained, either to enable documentation of changes from more severe procedures, or to ensure that it cannot be used as a "cover up" for more extensive procedures, as there are strong indications that pricking described as a replacement often involves a change in terminology rather than a change in the actual practice of cutting (WHO Somalia, 2002). When women who

claim to have undergone "pricking" have been examined medically, they have been found to have undergone a wide variety of practices, ranging from Type I to Type III. Hence the term can be used to legitimize or cover up more invasive procedures (WHO Somalia, 2002; Elmusharaf et al., 2006a). Because of these concerns, pricking is retained here within Type IV.

Stretching

Stretching or elongation of the clitoris and/or labia minora, often referred to as elongation, has been documented in some areas, especially in southern Africa. Generally, prepubescent girls are taught how to stretch their labia by using products such as oils and herbs, over a period of some months. Some also elongate again after giving birth. The elongated labia are considered an enclosure for the vagina, and to enhance both female and male sexual pleasure. Pain and laceration while pulling has been documented, but no long-term consequences have been found. The practice has been documented mainly in societies where women enjoy a relatively high social status, mostly in matrilineal societies. Labial stretching might be defined as a form of female genital mutilation because it is a social convention, and hence there is social pressure on young girls to modify their genitalia, and because it creates permanent genital changes (Mwenda, 2006; Tamale, 2006; Bagnol and Esmeralda, in press).

Cauterization

Cauterization is defined here as the destruction of tissue by burning it with a hot iron. This has been described as a remedy for several health problems, including bleeding, abscesses, sores, ulcers, and wounds, or for "counter-irritation" - that is, to cause pain or irritation in one part of the body in order to relieve pain or inflammation in another. The term "cauterization" is retained, but the specification is removed to make the description more general, as there are little data on this practice.

Cutting into the external genital organs

In the original formulation, reference was made to *gishiri* cuts and *angurya* cuts, which are local terms used in parts of Nigeria. *Gishiri* cuts are generally made into the vaginal wall in cases of obstructed labour (Tahzib, 1983). The practice can have serious health risks, including fistula, bleeding and pain. It differs from most types of female genital mutilation, as it is not routinely performed on young girls but more as a traditional birthing practice. *Angurya* cuts are a form of traditional surgery or scraping to remove the hymen and other tissue surrounding the vaginal orifice. No studies were found on the prevalence or consequences of this practice. In the modified definition, reference to these very local terms and practices has been removed and the description kept more general to cover various procedures.

Introduction of harmful substances

A number of practices of this type have been found in several countries, with a large variety of reasons and potential health hazards. Generally, they are performed regularly by adult women on themselves to clean the vagina before or after sexual intercourse or to tighten and strengthen the vagina to enhance their own or their partner's sexual pleasure. The consequences and health risks depend on the substances used, as well as the frequency and technicalities of the procedures

(McClelland et al., 2006 Bagnol and Esmeralda, in press). Insertion of harmful substances can be defined as a form of genital mutilation, particularly when associated with health risks and high social pressure.

Further considerations

The definition of Type IV raises a number of unresolved questions. Types I–III, in which genital tissue is usually removed from minors, clearly violate several human rights and are targeted by most legislation on violence, bodily harm and child abuse. It is not always clear, however, what harmful genital practices should be defined as Type IV. Generally, the natural female genitalia, when not diseased, do not require surgical intervention or manipulation. The guiding principles for considering genital practices as female genital mutilation should be those of human rights, including the right to health, the rights of children and the right to nondiscrimination on the basis of sex. Some practices, such as genital cosmetic surgery and hymen repair, which are legally accepted in many countries and not generally considered to constitute female genital mutilation, actually fall under the definition used here. It has been considered important, however, to maintain a broad definition of female genital mutilation in order to avoid loopholes that might allow the practice to continue. The lack of clarity concerning Type IV should not curb the urgent need to eliminate the types of female genital mutilation that are most prominent and known—Types I–III—which have been performed on 100–140 million girls and women and risk being performed on more than 3 million girls every year.