

# Understanding and addressing violence against women

## Female genital mutilation

**Female genital mutilation<sup>1</sup> (FGM) is internationally recognized as a violation of the human rights of girls and women, reflecting deep-rooted inequality between the sexes. Since FGM is almost always carried out on minors, it is also a violation of the rights of children.**

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 (**Box 1**).

### BOX 1. TYPES OF FEMALE GENITAL MUTILATION

**Type 1 – Clitoridectomy:** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and/or in very rare cases only, the prepuce (the fold of skin surrounding the clitoris).

**Type 2 – Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the ‘lips’ that surround the vagina).

**Type 3 – Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

**Type 4 – Other:** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Families, communities and cultures in which FGM is performed have different reasons for doing so. A major motivation is that the practice is believed to ensure the girl conforms to key social norms, such as those related to sexual restraint, femininity, respectability and maturity.

FGM differs from most forms of violence against girls and women in that women are not only the victims but also involved in perpetration. A girl’s female relatives are normally responsible for arranging FGM, which, in turn, is usually performed by traditional female excisers. FGM is also increasingly being done by male and female health-care providers. This feature of FGM illustrates how both women and men can be complicit in reinforcing gender norms and practices that support violence against women (1,2).

FGM also differs from most other forms of violence against women in that, in practising communities, it is done routinely on almost all girls, usually minors, and is promoted as a highly valued cultural practice and social norm.

<sup>1</sup> Also referred to as ‘female genital cutting’ or ‘female circumcision’.

## How prevalent is female genital mutilation?

There are population-based data on FGM prevalence from all African countries in which the practice has been documented. Estimates suggest that:

- 100–140 million girls and women worldwide are living with the consequences of FGM;
- approximately 3.3 million girls are at risk of FGM each year; and
- in the 28 countries from which national prevalence data exist (27 in Africa and Yemen), more than 101 million girls aged 10 years and older are living with the effects of FGM (3).

FGM is known to be practised in:

- 27 countries in Africa and Yemen, especially in the eastern, north-eastern and western regions;
- some countries in Asia and the Middle East;
- immigrants from these countries wherever they live, including in Australia, Canada, Europe, New Zealand and the USA; and
- a few population groups in Central and South America (2)

In the 28 countries in Africa and the Middle East for which data are available, national prevalence among women aged 15 years and older ranges from 0.6% (Uganda, 2006) to 97.9% (Somalia, 2006) (2). There are some regional patterns in FGM prevalence. According to Demographic Health Surveys done during 1989–2002, within north-eastern Africa (Egypt, Eritrea, Ethiopia and northern Sudan), prevalence was estimated at 80–97%, while in eastern Africa (Kenya and the United Republic of Tanzania) it was estimated to be 18–38%. However, prevalence can vary strikingly between different ethnic groups within a single country (4). FGM has been documented in several countries outside Africa but national prevalence data are not available (2).

FGM is classified according to the anatomical extent of the procedure (**Box 1**) and prevalence by type varies by location and ethnic group. An estimated 90% of FGM cases involve clitoridectomy or excision, and around 10% involve infibulation, which has the most severe negative consequences (3).

Estimates on FGM prevalence among communities living outside their native countries have also been made. Since national population survey data are not available for destination countries, estimates of the occurrence of FGM in migrant populations are based on documented prevalence in the country of origin. For example, an estimated 66 000 women in England and Wales have undergone FGM and an estimated 32 000 girls under the age of 15 years have a high probability of having undergone the procedure or are at high risk of it being done (5). Documents from the European Parliament suggest that more than half a million women and girls have undergone, or are at risk of, the procedure in the European Union (6); it is thought that variations in laws and approaches to FGM across the region are leading to cross-border movements of girls so that the procedure can be done (7).

## What are the consequences of female genital mutilation?

### Health consequences

FGM has no health benefits. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. Traditional excisers use a variety of tools to perform FGM, including razor blades and knives, and do not usually use anaesthetic. An

estimated 18% of all FGM is done by health-care providers, who use surgical scissors and anaesthetic (8). All forms of FGM can cause immediate bleeding and pain and are associated with risk of infection; the risk of both immediate and long-term complications increases with the extent of the cutting. **Table 1** lists some of the commonly documented complications.

Research into the health effects of FGM has progressed in recent years. A WHO-led study of more than 28 000 pregnant women in six African countries found that those who had undergone FGM had a significantly higher risk of childbirth complications, such as caesarean section and postpartum haemorrhage, than those without FGM. In addition, the death rate for babies during and immediately after birth was higher for mothers with FGM than those without. The risks of both birth complications and neonatal death increased relative to the severity of type of FGM (9). Sexual problems are also more common among women who have undergone FGM. They are 1.5 times more likely to experience pain during sexual intercourse, have significantly less sexual satisfaction and are twice as likely to report a lack of sexual desire (10).

### Social consequences

While there are few rigorous studies on the social impact of FGM, some research has identified the potential negative consequences for families, girls and women of refraining from FGM. The practice is performed in response to strong social conventions and supported by key social norms; thus failure to conform often results in harassment and, exclusion from important communal events and support networks, as well as discrimination by peers. Unless there is a joint agreement within a larger group, individuals and families are likely to consider the social risks to be greater than the physical and mental health risks to girls of FGM. Even legal restrictions against FGM may be seen as less important than the restrictions that can be imposed by the community for non-compliance with the practice (11,12).

TABLE 1

**Immediate and long-term health consequences of female genital mutilation (9,10)**

| Immediate health risks   | Longer-term health risks  |
|--|---|
| <ul style="list-style-type: none"> <li>• Severe pain</li> <li>• Shock</li> <li>• Haemorrhage (i.e. excessive bleeding)</li> <li>• Sepsis</li> <li>• Difficulty in passing urine</li> <li>• Infections</li> <li>• Death</li> <li>• Psychological consequences</li> <li>• Unintended labia fusion</li> </ul> | <ul style="list-style-type: none"> <li>• Need for surgery</li> <li>• Urinary and menstrual problems</li> <li>• Painful sexual intercourse and poor quality of sexual life</li> <li>• Infertility</li> <li>• Chronic pain</li> <li>• Infections (e.g. cysts, abscesses and genital ulcers, chronic pelvic infections, urinary tract infections)</li> <li>• Keloids (i.e. excessive scar tissue)</li> <li>• Reproductive tract infections</li> <li>• Psychological consequences, such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression</li> <li>• Increased risk of cervical cancer (although more research is needed)</li> </ul> |
| Known obstetric complications/risks  | Conditions often considered to be associated with FGM but for which evidence is equivocal or shows no link  |
| <ul style="list-style-type: none"> <li>• Caesarean section</li> <li>• Postpartum haemorrhage</li> <li>• Extended maternal hospital stay</li> <li>• Infant resuscitation</li> <li>• Stillbirth or early neonatal death</li> </ul>   | <ul style="list-style-type: none"> <li>• HIV (in the short term)</li> <li>• Obstetric fistula</li> <li>• Incontinence</li> </ul>  |

## Economic costs

FGM is a potential financial burden to health systems. A study based on data from six African countries found that costs associated with the medical management of obstetric complications resulting from FGM were equivalent to 0.1–1% of total government spending on women of reproductive age (13). The cost to families is largely unknown; a study from Nigeria estimated the cost of treating post-FGM complications in a paediatric clinic to be US\$120 per girl (14). A recent study from the Gambia found that one out of three gynaecological complications women sought help for was the direct result of FGM. In many cases, surgery was required, indicating that FGM complications are a significant cost for gynaecology services (15).

## What are the risk factors for female genital mutilation?

The most common risk factors for either undergoing FGM or forcing a girl to undergo the procedure are cultural, religious and social (2). These influences include:

- social pressure to conform with peers;
- the perception of FGM as necessary to raise a girl properly and prepare her for adulthood and marriage;
- the assumption that FGM reduces women's sexual desire, and thereby preserves premarital virginity and prevents promiscuity;
- the association of FGM with ideas of cleanliness (hygienic, aesthetic and moral), including the belief that, left uncut, the clitoris would grow excessively;
- women's belief, in some rare cases, that FGM improves male sexual pleasure and virility and, in even rarer cases, that FGM facilitates childbirth by improving a women's ability to tolerate the pain of childbirth through the pain of FGM;
- the belief that FGM is supported or mandated by religion, or that it facilitates living up to religious expectations of sexual constraint;
- the notion that FGM is an important cultural tradition that should not be questioned or stopped, especially not by people from outside the community.

Young age is a key risk factor for undergoing FGM, with most procedures carried out on girls aged between infancy and 15 years. Factors associated with subjecting a girl to undergo FGM vary. For example, a study in Ethiopia found that desire to continue the practice of FGM was linked to being aged 15–24 years, living in a rural area, being Muslim, married or uneducated, having undergone FGM and having no exposure to mass media (16).

Research also suggests that if a mother has more education, her daughter is less likely to undergo FGM (17). Notably, this protective effect of education has also been seen in other forms of violence against women (1). Research in Kenya has shown that secondary education is associated with a four-fold increase in disapproval of FGM (18). However, this link has not been found in all countries, and in some instances the association is negative (19).

## Are the prevalence, practice and approach to female genital mutilation changing?

FGM has drawn increasing international attention in recent decades, including new laws against the practice in countries within and outside Africa (6). While there has been little change in the frequency of FGM in some countries, there is evidence of:



- a large prevalence reduction among younger generations (aged 15–19 years) in a few countries (19,20);
- lower prevalence among daughters of educated mothers in some countries (19);
- less support for FGM among some women in practising communities (21,22);
- increasing research and policy change to address FGM among immigrant populations in higher-income countries (6);
- a reduction in the average age at which a girl is subjected to the procedure in most countries (4,23); and
- an increase in the extent to which FGM is being carried out by health-care providers (24).

### Medicalization of female genital mutilation

A major trend is that health-care providers, such as physicians, nurses and midwives (21,22), are increasingly providing FGM in place of traditional excisers, a phenomenon known as ‘medicalization’ (8,24). FGM is still carried out primarily by traditional excisers in most countries, but, for example, survey data suggest that girls in Egypt are three times more likely to undergo FGM at the hands of a health-care provider than did their mothers (25).

Parents may go to health practitioners instead of traditional excisers because they believe it will reduce the risk of harm from FGM (24). Some medical providers do indeed use clean equipment and drugs to reduce pain, bleeding and infection. However, medical FGM cannot eliminate immediate risks, as illustrated by media reports of deaths resulting from the practice. Furthermore, FGM performed by health-care providers cannot reduce the long-term effects (Table 1), neither does it guarantee sanitary conditions or that the procedure will be less severe (24).

There are no documented cases of medicalization leading to a reduction in the practice of FGM (24). WHO and other agencies believe that medicalization actually contributes to upholding the practice, by legitimizing it as a health procedure (8).

### What is the best approach to ending female genital mutilation?

Few interventions aimed at preventing FGM have undergone high-quality and systematic evaluation; thus much more rigorous research is needed (26,11). A systematic review by Berg and Denison (2012) found that there was little evidence of the effectiveness of interventions to prevent FGM. The review highlights that the factors related to the continuation or discontinuation of the practice varied across contexts; however, the main factors supporting the practice were tradition, religion and concern with reducing women’s sexual desire. Conversely, health complications and lack of sexual satisfaction did not favour support of the practice (11).

However, a wealth of evaluations of anti-FGM programmes from many countries exists, which can provide guidelines for good practice. These strategies are summarized below.

### Understand the social dynamics of decision-making related to FGM

Decision-making and practices in many communities involve more than just individuals and families (24) – they are embedded in community or group dynamics. Interventions that target individuals, families or excisers alone are therefore unlikely to be effective (16). For example, a three-year study in the

Gambia and Senegal found that decisions about FGM were made by more than one member of the family, including mothers, fathers, grandparents and aunts. Fathers were less supportive of FGM than mothers, and were often crucial to decisions not to subject their daughters to the procedure (21,23).

In light of these findings and other research on decision-making in relation to FGM, researchers and practitioners recommend that preventive interventions include elements of community dialogue; understanding of the importance of local rewards and punishments (22); and a method for coordinating change among social groups that includes men and women from multiple generations within the community and related communities (25).

### Work with – not against – cultural and community practices and beliefs

FGM has rarely been abandoned when programmes against the practice have been perceived by the community as attacking and criticizing local culture and values, and/or as driven by outsiders (23). On the contrary, defensive reactions, including mass-FGM initiatives and proclamations in support of the practice, can result. Evaluations suggests that reinforcing positive cultural values can be more effective (26), as can supporting community dialogue aimed at finding ways to signify a girl's coming of age that do not involve cutting (16).

### Target local, national and international levels of influence

Grass-roots-level interventions have been shown to benefit from complementary national responses. In addition, ethnicity – a major predictor of the type of FGM practised – can span national borders; thus interventions targeting a particular ethnic group should consider cross-border coordination (16).

Legal sanctions against FGM are the most common type of intervention at the national and international levels but there is strong evidence that laws alone are not enough (10,21,27). Nevertheless, legislation creates an enabling environment for interventions at the local level, as illustrated in Ghana (20) and Senegal (23).

Legislation and codes of conduct have also been shown to be important in relation to communities that practise FGM outside their countries of origin. A study in the European Union found that effective implementation of laws related to FGM is associated with better knowledge, including how to deal with an at-risk girl, and attitudes among health-care providers who are in contact with these populations (27).

### Use a comprehensive and rights-based approach

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