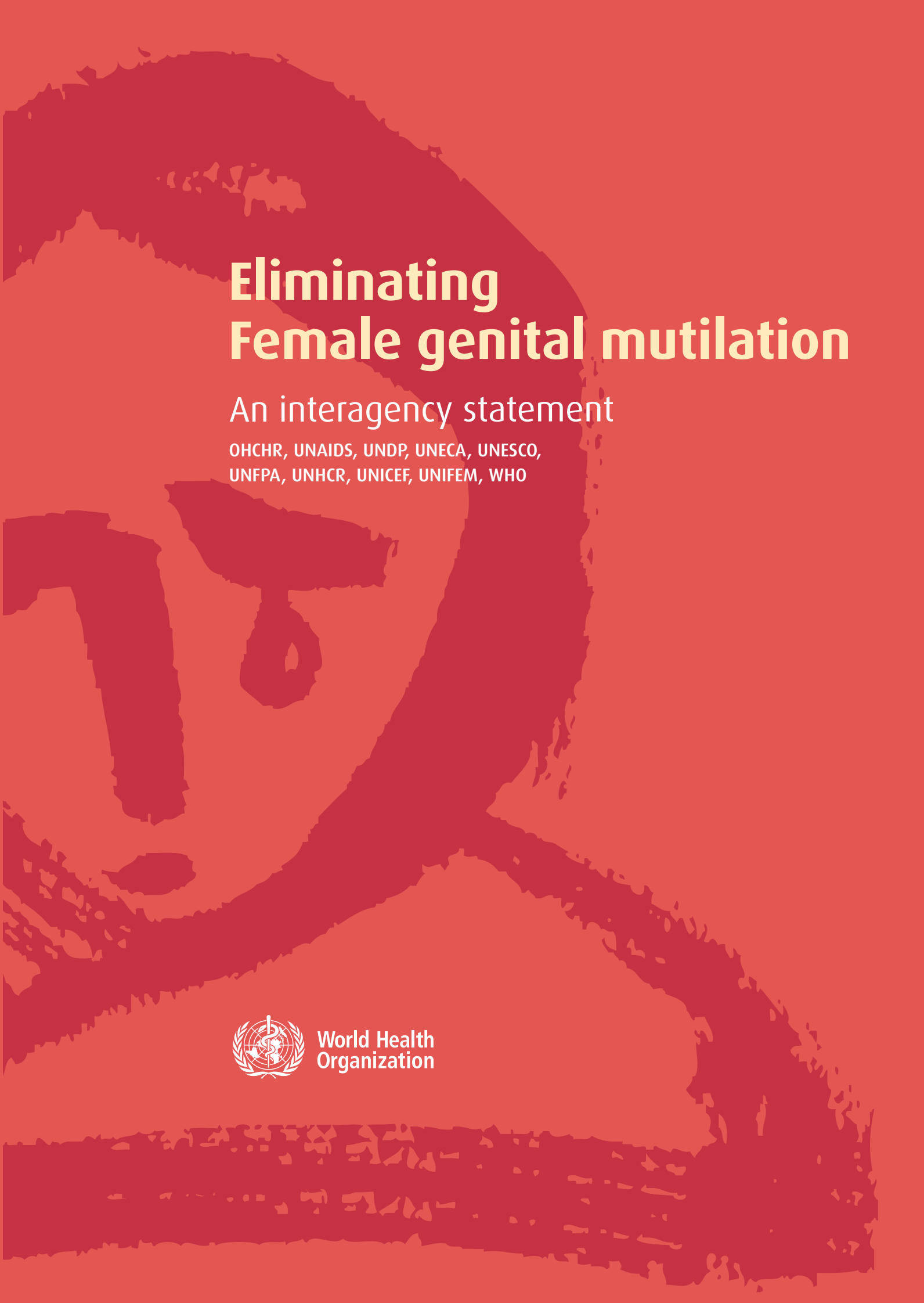

Eliminating Female genital mutilation

An interagency statement

OHCHR, UNAIDS, UNDP, UNECA, UNESCO,
UNFPA, UNHCR, UNICEF, UNIFEM, WHO

World Health Organization

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United Nations Human Rights
OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS

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Contents

Eliminating female genital mutilation: the imperative

The term 'female genital mutilation' (also called 'female genital cutting' and 'female genital mutilation/cutting') refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. Between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and 3 million girls are estimated to be at risk of undergoing the procedures every year. Female genital mutilation has been reported to occur in all parts of the world, but it is most prevalent in: the western, eastern, and north-eastern regions of Africa, some countries in Asia and the Middle East and among certain immigrant communities in North America and Europe.

Female genital mutilation has no known health benefits. On the contrary, it is known to be harmful to girls and women in many ways. First and foremost, it is painful and traumatic. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences. For example, babies born to women who have undergone female genital mutilation suffer a higher rate of neonatal death compared with babies born to women who have not undergone the procedure.

Communities that practise female genital mutilation report a variety of social and religious reasons for continuing with it. Seen from a human rights perspective, the practice reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. Female genital mutilation is nearly always carried out on minors and is therefore a violation of the rights of the child. The practice also violates the rights to health, security and physical integrity of the person, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

Decades of prevention work undertaken by local communities, governments, and national and international organizations have contributed to a reduction in the prevalence of female genital mutilation in some areas. Communities that have employed a process of collective decision-making have been able to abandon the practice. Indeed, if the practising communities decide themselves to abandon female genital mutilation, the practice can be eliminated very rapidly. Several governments have passed laws against the practice, and where these laws have been complemented by culturally-sensitive education and public awareness-raising activities, the practice has declined. National and international organizations have played a key role in advocating against the practice and generating data that confirm its harmful consequences. The African Union's *Solemn Declaration on Gender Equality in Africa*, and its Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa constitute a major contribution to the promotion of gender equality and the elimination of female genital mutilation.

However, despite some successes, the overall rate of decline in the prevalence of female genital mutilation has been slow. It is therefore a global imperative to strengthen work for the elimination of this practice, which is essential for the achievement of many of the Millennium Development Goals.

This Statement is a call to all States, international and national organizations, civil society and communities to uphold the rights of girls and women. It also call on those bodies and communities to develop, strengthen, and support specific and concrete actions directed towards ending female genital mutilation.

On behalf of our respective agencies, we reaffirm our commitment to the elimination of female genital mutilation within a generation.

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Why this new statement?

In 1997, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) issued a Joint Statement on Female Genital Mutilation (WHO, UNICEF, UNFPA, 1997) which described the implications of the practice for public health and human rights and declared support for its abandonment.

Since then, much effort has been made to counteract female genital mutilation, through research to generate further evidence on which to base interventions, through working with communities, through advocacy and by passing laws. Progress has been made at both international and local levels. More United Nations agencies are involved; human rights treaty monitoring bodies and international resolutions have condemned the practice; legal frameworks have improved in many countries; and political support for ending female genital mutilation is growing. Most significantly, in some countries the prevalence of female genital mutilation has declined, and an increasing number of women and men in practising communities are declaring their support for its abandonment.

In spite of these positive signs, prevalence in many areas remains high and there is an urgent need to intensify, expand and improve efforts if female genital mutilation is to be eliminated within one generation. To reach this goal, both increased resources and coordination and cooperation are needed.

This new Interagency Statement is written and signed by a wider group of United Nations agencies than the previous one, to support advocacy for the abandonment of female genital mutilation. It is based on new evidence and lessons learnt over the past decade. It highlights the wide recognition of the human rights and legal dimensions of the problem and provides current data on the prevalence of female genital mutilation. It summarizes findings from research on the reasons why the practice continues, highlighting that the practice is a social convention which can only be changed through coordinated collective action by practising communities. It also summarizes recent research on its damaging effects on the health of women, girls and newborn babies. Drawing on experience from interventions in many countries, the new statement describes the elements needed, for both working towards complete abandonment of female genital mutilation, and caring for those who have suffered, and continue to suffer, from its consequences.

Note on terminology

The term 'female genital mutilation' is used in this Statement as it was in the 1997 Joint Statement. The word 'mutilation' emphasizes the gravity of the act. Some United Nations agencies use the term 'female genital mutilation/cutting' wherein the additional term 'cutting' is intended to reflect the importance of using non-judgemental terminology with practising communities. Both terms emphasize the fact that the practice is a violation of girls' and women's human rights. For further explanation on this terminology, see Annex 1.

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).

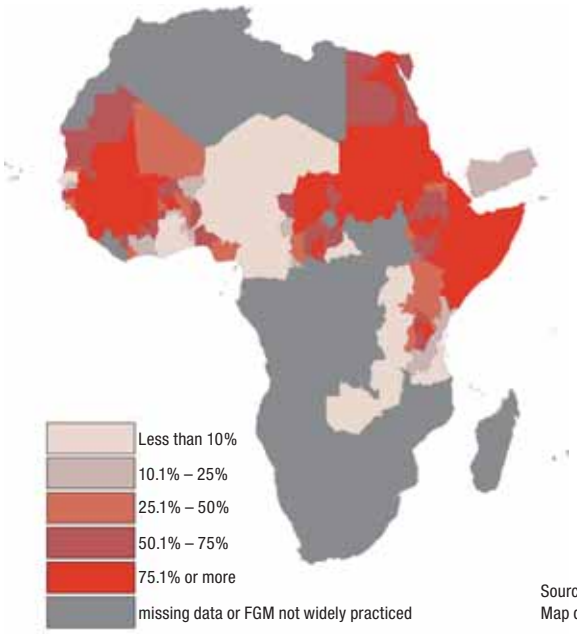
How widely it is practiced

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 map shows the areas where FGM is practised, and since that can vary markedly in different parts of any country, no national boundaries are shown.

Data at the sub-national level are not available for Zambia. Due to a discrepancy between the regional divisions used by DHS and the one adopted by DevInfo, it was not possible to include data at the sub-national level for Yemen.

Sources: MICS, DHS and other national surveys, 1997–2006
Map developed by UNICEF, 2007

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).

Female genital mutilation is a violation of human rights

Female genital mutilation of any type has been recognized as a harmful practice and a violation of the human rights of girls and women. Human rights—civil, cultural, economic, political and social—are codified in several international and regional treaties. The legal regime is complemented by a series of political consensus documents, such as those resulting from the United Nations world conferences and summits, which reaffirm human rights and call upon governments to strive for their full respect, protection and fulfilment.

Many of the United Nations human rights treaty monitoring bodies have addressed female genital mutilation in their concluding observations on how States are meeting their treaty obligations.

The Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child and the Human Rights Committee have been active in condemning the practice and recommending measures to combat it, including the criminalization of the practice. The Committee on the Elimination of All Forms of Discrimination against Women issued its General Recommendation on Female Circumcision (General Recommendation No 14) that calls upon states to take appropriate and effective measures with a view to eradicating the practice and requests them to provide information about measures being taken to eliminate female genital mutilation in their reports to the Committee (Committee on the Elimination of All Forms of Discrimination against Women, 1990).

International and regional sources of human rights

Strong support for the protection of the rights of women and girls to abandon female genital mutilation is found in international and regional human rights treaties and consensus documents. These include, among others:

International treaties

- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Covenant on Civil and Political Rights
- Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)
- Convention on the Rights of the Child
- Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees

Regional treaties

- African Charter on Human and Peoples' Rights (the Banjul Charter) and its Protocol on the Rights of Women in Africa
- African Charter on the Rights and Welfare of the Child
- European Convention for the Protection of Human Rights and Fundamental Freedoms

Consensus documents

- Beijing Declaration and Platform for Action of the Fourth World Conference on Women
- General Assembly Declaration on the Elimination of Violence against Women
- Programme of Action of the International Conference on Population and Development (ICPD)
- UNESCO Universal Declaration on Cultural Diversity
- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on Ending Female Genital Mutilation. E/CN.6/2007/L.3/Rev.1.

(See Annex 4 for full details of treaties and consensus documents).

Human rights violated by female genital mutilation

Female genital mutilation violates a series of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment as well as the rights identified below. As it interferes with healthy genital tissue in the absence of medical necessity and can lead to severe consequences for a woman's physical and mental health, female genital mutilation is a violation of a person's right to the highest attainable standard of health.

The rights of the child

Because of children's vulnerability and their need for care and support, human rights law grants them special protection. One of the guiding principles of the Convention on the Rights of the Child is the primary consideration of 'the best interests of the child'. Parents who take the decision to submit their daughters to female genital mutilation perceive that the benefits to be gained from this procedure outweigh the risks involved. However, this perception cannot justify a permanent and potentially life-changing practice that constitutes a violation of girls' fundamental human rights.

The Convention on the Rights of the Child refers to the evolving capacity of children to make decisions regarding matters that affect them. However, for female genital mutilation, even in cases where there is an apparent agreement or desire by girls to undergo the procedure, in reality it is the result of social pressure and community expectations and stems from the girls' aspiration to be accepted as full members of the community. That is why a girl's decision to undergo female genital mutilation cannot be called free, informed or free of coercion.

Legal instruments for the protection of children's rights specifically call for the abolition of traditional practices prejudicial to their health and lives. The Convention on the Rights of the Child makes explicit reference to harmful traditional practices and the Committee on the Rights of the Child, as well as other United Nations Human Rights Treaty Monitoring Bodies, have frequently raised female genital mutilation as a violation of human rights, calling upon State Parties to take all effective and appropriate measures to abolish the practice.

Female genital mutilation has been recognized as discrimination based on sex because it is rooted in gender inequalities and power imbalances between men and women and inhibits women's full and equal enjoyment of their human rights. It is a form of violence against girls and women, with physical and psychological consequences. Female genital mutilation deprives girls and women from making an independent decision about an intervention that has a lasting effect on their bodies and infringes on their autonomy and control over their lives.

The right to participate in cultural life and freedom of religion are protected by international law. However, international law stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental rights and freedoms of others. Therefore, social and cultural claims cannot be evoked to justify female genital mutilation (International Covenant on Civil and Political Rights, Article 18.3; UNESCO, 2001, Article 4).

Female genital mutilation has harmful consequences

Female genital mutilation is associated with a series of health risks and consequences. Almost all those who have undergone female genital mutilation experience pain and bleeding as a consequence of the procedure. The intervention itself is traumatic as girls are usually physically held down during the procedure (Chalmers and Hashi, 2000; Talle, 2007). Those who are infibulated often have their legs bound together for several days or weeks thereafter (Talle, 1993). Other physical and psychological health problems occur with varying frequency. Generally, the risks and complications associated with Types I, II and III are similar, but they tend to be significantly more severe and prevalent the more extensive the procedure. Immediate consequences, such as infections, are usually only documented when women seek hospital treatment. Therefore, the true extent of immediate complications is unknown (Obermeyer, 2005). Long-term consequences can include chronic pain, infections, decreased sexual enjoyment, and psychological consequences, such as post-traumatic stress disorder. (See Annex 5 for details of the main health risks and consequences).

Dangers for childbirth

Findings from a WHO multi-country study in which more than 28,000 women participated, confirm that women who had undergone genital mutilation had significantly increased risks for adverse events during childbirth. Higher incidences of caesarean section and post-partum haemorrhage were found in the women with Type I, II and III genital mutilation compared to those who had not undergone genital mutilation, and the risk increased with the severity of the procedure (WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006).

A striking new finding from the study is that genital mutilation of mothers has negative effects on their newborn babies. Most seriously, death rates among babies during and immediately after birth were higher for those born to mothers who had undergone genital mutilation compared to those who had not: 15% higher for those whose mothers had Type I, 32% higher for those with Type II and 55% higher for those with Type III genital mutilation. It was estimated that, at the study sites, an additional one to two babies per 100 deliveries die as a result of female genital mutilation.

The consequences of genital mutilation for most women who deliver outside the hospital setting are expected to be even more severe (WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006). The high incidence of post-partum haemorrhage, a life-threatening condition, is of particular concern where health services are weak or women cannot easily access them.

Note

In contrast to female genital mutilation, male circumcision has significant health benefits that outweigh the very low risk of complications when performed by adequately-equipped and well-trained providers in hygienic settings Circumcision has been shown to lower men's risk for HIV acquisition by about 60% (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007) and is now recognized as an additional intervention to reduce infection in men in settings where there is a high prevalence of HIV (UNAIDS, 2007).

Health professionals must never perform female genital mutilation

"It is the mission of the physician to safeguard the health of the people."
World Medical Association Declaration of Helsinki, 1964

Trained health professionals who perform female genital mutilation are violating girls' and women's right to life, right to physical integrity, and right to health. They are also violating the fundamental medical ethic to 'Do no harm'. Yet, medical professionals have performed and continue to perform female genital mutilation (UNICEF, 2005a). Studies have found that, in some countries, one-third or more of women had their daughter subjected to the practice by a trained health professional (Satti et al., 2006). Evidence also shows that the trend is increasing in a number of countries (Yoder et al., 2004). In addition, female genital mutilation in the form of reinfibulation has been documented as being performed as a routine procedure after childbirth in some countries (Almroth-Berggren et al., 2001; Berggren et al., 2004, 2006). Among groups that have immigrated to Europe and North America, reports indicate that reinfibulation is occasionally performed even where it is prohibited by law (Vangen et al., 2004).

A range of factors can motivate medical professionals to perform female genital mutilation, including prospects of economic gain, pressure and a sense of duty to serve community requests (Berggren et al., 2004; Christoffersen-Deb, 2005). In countries where groups that practise female genital mutilation have emigrated, some medical personnel misuse the principles of human rights and perform reinfibulation in the name of upholding what they perceive is the patient's culture and the right of the patient to choose medical procedures, even in cases where the patient did not request it (Vangen et al., 2004; Thierfelder et al., 2005; Johansen, 2006a)

Some medical professionals, nongovernmental organizations, government officials and others consider medicalization as a harm-reduction strategy and support the notion that when the procedure is performed by a trained health professional, some of the immediate risks may be reduced (Shell-Duncan, 2001; Christoffersen-Deb, 2005). However, even when carried out by trained professionals, the procedure is not necessarily less severe, or conditions sanitary. Moreover, there is no evidence that medicalization reduces the documented obstetric or other long-term complications associated with female genital mutilation. Some have argued that medicalization is a useful or necessary first step towards total abandonment, but there is no documented evidence to support this.

There are serious risks associated with medicalization of female genital mutilation. Its performance by medical personnel may wrongly legitimize the practice as medically sound or beneficial for girls and women's health. It can also further institutionalize the procedure as medical personnel often hold power, authority, and respect in society (Budiharsana, 2004).

Medical licensing authorities and professional associations have joined the United Nations organizations in condemning actions to medicalize female genital mutilation. The International Federation of Gynecology and Obstetrics (FIGO) passed a resolution in 1994 at its General Assembly opposing the performance of female genital mutilation by obstetricians and gynaecologists, including a recommendation to "oppose any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals" (International Federation of Gynecology and Obstetrics, 1994).

Taking action for the complete elimination of female genital mutilation

Action taken at international, regional and national levels over the past decade or more has begun to bear fruit. Increasing numbers of women and men from practising groups have declared support for discontinuing the practice and, in some areas, the prevalence of female genital mutilation has decreased. The reduction in prevalence is not, however, as substantial as hoped for. Therefore, it is vital that the work against female genital mutilation be intensified to more effectively counteract the underlying reasons behind continuation of the practice.

Bringing an end to female genital mutilation requires a broad-based, long-term commitment. Experience over the past two or three decades has shown that there are no quick or easy solutions. The elimination of female genital mutilation requires a strong foundation that can support successful behaviour change and address the core values and enforcement mechanisms that support the practice (WHO, 1999; UNICEF, 2005a; Population Reference Bureau, 2006; Donor Working Group, 2007). Even though there have been few systematic evaluations of the many programmes being run by nongovernmental organizations, governments and others, there are reviews that provide some overall lessons (WHO, 1999; Population Reference Bureau, 2001, 2006; UNICEF, 2005a, 2005b; UNFPA, 2007c). Key among these lessons is that actions and interventions must be:

- ***Multisectoral:*** Concerted action from many sides and at different levels is needed, from local to global and involving sectors such as education, finance, justice, and women's affairs as well as the health sector; and many different kinds of actors must be engaged, from community groups and nongovernmental organizations including health professional groups and human rights groups to governments and international agencies.
- ***Sustained:*** As behaviour change is complex, sustained action is essential to have a lasting impact. Although change may occur rapidly, the process leading to change can be slow and long.
- ***Community-led:*** Programmes that are led by communities are, by nature, participatory and generally guide communities to define the problems and solutions themselves. Programmes that have demonstrated success in promoting abandonment of female genital mutilation on a large scale build on human rights and gender equality and are non-judgmental and non-coercive. They focus on encouraging a collective choice to abandon female genital mutilation.

A process of positive social change at community level

New insights from social science theory and the analysis of programme experiences indicate that abandonment of female genital mutilation on a large scale results from a process of positive social change (Mackie, 2000; Yount, 2002; Hayford, 2005; Shell-Duncan and Hernlund, 2006). The conventional nature of the practice requires a significant number of families within a community to make a **collective, coordinated choice** to abandon the practice so that no single girl or family is disadvantaged by the decision (UNICEF, 2005b). The decision to abandon must be collective and explicit so that each family will have the confidence that others are also abandoning the practice. The decision must be widespread within the practising community in order to be sustained. In effect, it will bring into place a new social norm that ensures the marriageability of daughters and the social status of families that do not cut their girls; a social norm that does not harm girls or violate their rights.

Programmes that include 'empowering' education, discussion and debate, public pledges and organized diffusion have been shown to bring about the necessary consensus and coordination for the sustained abandonment of female genital mutilation at community level. The activities encourage communities to raise problems and define solutions themselves regarding a variety of concerns, including sensitive ones such as female genital mutilation, without feeling coerced or judged. Different methods can be used to create a space for open and reflective dialogue, including intercultural dialogue that investigates cultural variations within and between communities as well as aspects of cultural change. Such methods have shown to be particularly effective when they raise and stimulate discussion on human rights principles. Programmes using these elements and principles have demonstrated a significant reduction in prevalence seven years after the original programmatic intervention (Ndiaye et al., in press).

Empowering education helps people to examine their own beliefs and values related to the practice in a dynamic and open way, that is not experienced or seen as threatening. Educational sessions will be empowering if they serve not only to impart new knowledge but also to provide a forum for participants to exchange experiences, and help them reveal and share complex inner feelings and examine conflicting attitudes towards female genital mutilation in the community Empowering education can be undertaken through various forms of training, including literacy training, analytical skills and problem-solving as well as through the provision of information on human rights, religion, general health and sexual and reproductive health. Classes and workshops can include the use of traditional means of communication such as theatre, poetry, story telling, music and dance, as well as more modern methods, such as computer-based applications and mobile phone messages.

Educational activities must be sensitive to local cultural and religious concerns or run the risk that the information provided will be regarded as morally offensive and result in negative reactions in communities. Information provided should be based on evidence, but at the same time build on local perceptions and knowledge. Community-based educational activities can also build on and expand their work with the mass media such as drama, video and local radio. 'Champions' against female genital mutilation, such as public personalities, can also be used to relay information and messages about female genital mutilation (Population Reference Bureau, 2006).

As female genital mutilation is a manifestation of gender inequality, a special focus on women's empowerment is important (see box below). However, educational activities must reach all groups in the community with the same basic information to avoid misunderstandings and to inspire inter-group dialogue. The format must be adapted so as to suit the realities of each specific group. It is also important to include young people - both girls and boys - as they are often more open to change, and can themselves be important change agents.

Schools can offer a forum for learning and discussion about female genital mutilation if they can create an environment of confidence, trust and openness. Artists and others who provide positive role models can be brought into schools, and materials can be developed for teachers and integrated into school curricula and teacher training on subjects such as science, biology and hygiene as well as those in which religious, gender and other social issues are addressed (UNICEF, 2005b).

Nevertheless, schools may not always be the ideal setting for learning about sensitive and intimate issues and, as many girls and boys are not enrolled in school, other outreach activities for young people are needed. As it is advisable to reach all groups of the community with the same basic information, all forms and spaces of learning, including intergenerational dialogue should be explored when designing initiatives to address female genital mutilation.

To reach the collective, coordinated choice necessary for sustained abandonment of female genital mutilation, communities must have the opportunity to discuss and reflect on new knowledge in public. Such **public dialogue** provides opportunities to increase awareness and understanding by the community as a whole on women's human rights and on national and international legal instruments on female genital mutilation. This dialogue and debate among women, men and community leaders often focuses on women's rights, health, and female genital mutilation, and brings about recognition of the value of women in the community, thus fostering their active contribution to decision-making and enhancing their ability to discontinue the practice. Intergenerational dialogue is another example in which communication between groups that rarely discuss such issues on an egalitarian basis is encouraged (GTZ, 2005). Most importantly, such public discussions can stimulate discussions in the private, family setting where decisions about genital mutilation of girl children are made by parents and other family members (Draege, 2007).

The collective, coordinated choice by a practicing group to abandon female genital mutilation should be made visible or explicit through a **public pledge** so that it can be trusted by all concerned. Indeed, many of the approaches adopted by community-based initiatives lead towards a public declaration of social change (WHO, 1999; Population Reference Bureau, 2001, 2006). This creates the confidence needed by individuals who intend to stop the practice to actually do so and is therefore a key step in the process of real and sustained change in communities.

Empowerment of women

As female genital mutilation is a manifestation of gender inequality, the empowerment of women is of key importance to the elimination of the practice. Addressing this through education and debate brings to the fore the human rights of girls and women and the differential treatment of boys and girls with regard to their roles in society in general, and specifically with respect to female genital mutilation. This can serve to influence gender relations and thus accelerate progress in abandonment of the practice (WHO, 2000b; Population Reference Bureau, 2001, 2006; UNICEF, 2005b; UNFPA, 2007a). Programmes which foster women's economic empowerment are likely to contribute to progress as they can provide incentives to change the patterns of traditional behaviour to which a woman is bound as a dependent member of the household, or where women are loosing traditional access to economic gain and its associated power. Gainful employment empowers women in various spheres of their lives, influencing sexual and reproductive health choices, education and healthy behaviour (UNFPA, 2007a).

Different mechanisms have been used to make public the pledge to abandon the practice. In some contexts, public pledges have taken the form of written declarations, publicly posted, which are signed by those who have decided to abandon female genital mutilation. In West Africa, pledges are typically made in the form of inter-village declarations involving as many as 100 villages at a time. These are festive occasions that bring together individuals who have participated in the educational sessions, religious, traditional and government leaders and a large number of other community members. Often, people from communities that have not been directly involved in promoting abandonment are invited as a way of spreading the abandonment movement. Media are typically present and serve to disseminate information about the fact that communities are abandoning the practice and to explain the reasons why.

Among some populations where female genital mutilation is traditionally accompanied by a 'coming of age' ritual, **alternative rituals** that reinforce the traditional positive values but without female genital mutilation, have been pursued. Such approaches have added new elements in the rituals, including education on human rights and sexual and reproductive health issues. Alternative rites have been found to be effective to the extent that they foster a process of social change by engaging the community at large, as well as girls, in activities that lead to changing beliefs about female genital mutilation (Chege et al., 2001).

As with individual families, it is difficult for one community to abandon the practice if those around it continue. Activities at community level therefore must include an explicit strategy for spreading the decision to abandon the practice throughout the practising population. This is typically done by passing information and engaging in discussion with influential members of other communities that are part of the same social network. Through a strategy of **organized diffusion,** communities that are abandoning the practice engage others to do the same, thereby increasing the consensus and sustainability of the new social norm that rejects female genital mutilation.

National-level actions

Social change within communities can be hindered or enhanced by activities at national level and across national boundaries. As at community level, activities at national level should promote a process of social change that leads to a shared decision to end female genital mutilation. Activities must engage traditional, religious and government leaders, parliamentarians and civil society organizations.

Promoting the decision to abandon female genital mutilation includes national activities that bring the practice into the public discussion and debate. The **media** can play a crucial role both in bringing correct information to households and in informing people about positive social change that may be taking place in communities. This is particularly important when discussion of female genital mutilation is considered taboo. Information activities should target local needs and concerns as well as provide information on a wide range of issues, such as human rights including child and women's rights, facts on female sexual organs and functions and consequences of female genital mutilation, as well as the ways in which individuals and communities can combat the practice.

Activities must include the review and reform of **laws and policies** as well as sectoral measures especially within the health, education, social and

legal protection systems. A number of countries have enacted specific laws or applied existing legal provisions for prohibiting the practice (see box below). The effectiveness of any law depends, however, on the extent to which it is linked to the broader process of social change. Legal measures are important to make explicit the government's disapproval of female genital mutilation, to support those who have abandoned the practice or wish to do so, and to act as a deterrent. However, imposing sanctions alone runs the risk of driving the practice underground and having a very limited impact on behaviour (UNICEF, 2005b). Legal measures should be accompanied by information and other measures that promote increased public support for ending the practice.

The amendment, adoption and enforcement of laws should be done in consultation with community and religious leaders and other civil society representatives. Mechanisms should be established to review and assess the enforcement of the laws regularly (UNFPA, 2006, 2007c).

Ending female genital mutilation and treatment and care of its adverse health consequences should be an integral part of relevant health programmes and services, such as safe motherhood and child survival programmes, sexual health counselling, psycho-social counselling, prevention and treatment of reproductive tract infections and sexually transmitted infections including HIV and AIDS, prevention and management of gender-based violence, youth health programmes and programmes targeting traditional birth attendants (who may also be traditional circumcisers).

Medical ethics standards must make it clear that the practice of female genital mutilation upon children or women violates professional standards as well as a patient's human rights, in line with international human rights and ethical standards. Medical practitioners who engage in the practice should be subject to disciplinary proceedings and have their medical licenses withdrawn.

Health service providers must be trained to identify problems resulting from female genital mutilation and to treat them. This includes procedures to treat immediate complications, and to manage various long-term complications including defibulation. Defibulation should be offered as soon as possible (not only during childbirth) since it may reduce several health complications of infibulation, as well as providing impetus for change. Evidence suggests that improved birth care procedures according to WHO guidelines (WHO, 2001a, 2001b, 2001c) can contribute to reducing the risks associated with female genital mutilation for both the mother and the child during childbirth.

Responsibility of actors

The responsibility for action lies with many players, some of whom are mentioned below; but the accountability ultimately rests with the government of a country, to prevent female genital mutilation, to promote its abandonment, to respond to its consequences, and to hold those who perpetrate it criminally responsible for inflicting harm on girls and women.

Governments have legal obligations to respect, protect and promote human rights, and can be held accountable for failing to fulfil these obligations. Accordingly, governments need to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources. These measures include ensuring that all domestic

Laws for the elimination of female genital mutilation

Constitutional recognition of the rights of girls and women

Constitutional measures to uphold the rights of women and girls, such as equality, non-discrimination and protection from violence, are critical and can shape the response of governments to eliminating female genital mutilation. Examples applicable to female genital mutilation include: 'women's protection from harmful practices'; prohibition of customs or traditions that are 'against the dignity, welfare or interest of women or which undermine their status', and abolition of 'traditional practices' injurious to people's health and well-being. Such constitutional protections can provide guidance for drafting laws and policies and for implementing them. They can also require the revision or abolition of laws and policies that are not compatible with these principles.

Criminal laws

In some countries, the existing general provisions of criminal codes have been, or can be, applied to female genital mutilation. These may include: 'intentional wounds or strikes', 'assault occasioning grievous harm', 'attacks on corporal and mental integrity' or 'violent acts that result in mutilation or permanent disability'. Some governments have enacted laws that specifically prohibit the practice of female genital mutilation, many of which specify the categories of people who are potentially liable under the law. Accordingly, traditional practitioners, medical personnel, parents, guardians and persons who fail to report a potential or already committed crime can be subject to prosecution. The type of penalty also varies and includes imprisonment, fines or, in the case of medical personnel, the confiscation of professional licenses. The penalty may differ according to the form of the mutilation, and often increases when this crime is committed against minors or results in death.

Child protection laws

A number of countries have declared the applicability of child protection laws to female genital mutilation, while others have enacted and applied specific provisions for the elimination of harmful practices, including female genital mutilation. Child protection laws provide for state intervention in cases in which the State has reason to believe that child abuse has occurred or may occur. They may enable authorities to remove a girl from her family or the country if there is reason to believe that she will be subjected to female genital mutilation. These laws focus on ensuring the best interests of the child.

Civil laws and remedies

In countries with adequate mechanisms for adjudicating civil claims and enforcing judgements, female genital mutilation can be recognized as an injury that gives rise to a civil lawsuit for damages or other redress. Girls and women who have undergone female genital mutilation can seek redress from practitioners and/or others who participate in such an act. Other laws may be available and utilized to prevent the procedure from occurring in the first place, such as child protection laws.

Asylum and immigration regulations

It has been widely recognized that gender-based violence, including female genital mutilation, can amount to persecution within the meaning of the refugee definition of the 1951 Refugee Convention and its 1967 Protocol. Regional resolutions and specific national regulations require that women and girls who are at risk of undergoing female genital mutilation in other countries are granted refugee status or complementary forms of protection. Furthermore, in some cases, immigration authorities are required to provide information to immigrants about the harmful effect of female genital mutilation and the legal consequences of the practice. Some of these regulations contain instructions that such information should be provided in a sensitive and culturally appropriate manner.

legislation is compatible with the international and regional human rights treaties they have ratified. Governments are also responsible for drawing up plans of actions and strategies to ensure that health facilities are available and accessible to girls and women for their sexual and reproductive health needs. They should organize public awareness campaigns and education initiatives and ensure that sufficient resources are allocated for prevention and response. Several ministries should cooperate in such efforts, including ministries of health, finance, education and information, social services and women's affairs.

Parliamentarians have a critical role to play in bringing the issue of female genital mutilation into policy debates as do the legal and judicial sectors in setting and enforcing norms.

Professional organizations, such as medical associations and nursing councils, can promote ethical guidelines in medical training and in practice. Associations for teachers, lawyers, social workers and others can also contribute towards eliminating female genital mutilation within their respective fields through activities such as lobbying, advocacy and conducting appropriate training activities.

National and international **nongovernmental organizations** have been key actors in designing and implementing programmes for the abandonment of female genital mutilation. The most successful programmes have been community-based with strong support from and involvement of the government and development cooperation agencies (WHO, 1999). **Faith-based and inter-faith based organizations** have also been important actors using established networks and structures to deliver advocacy messages within the community and influence the attitudes and behaviour of their fellow community members (UNFPA, 2005, 2007b).

Experience shows that it is especially important to ensure that the governments and nongovernmental organizations work in cooperation with the local practising communities in formulating and implementing programmes. This is true in countries of origin as well as in countries where female genital mutilation is practised by immigrant communities.

Inclusion of **leaders**, both religious and secular, in interventions is important to secure a supportive environment for change. This is true at the level of the community as well as at national level. Such leaders who are at the forefront in advocating the abandonment of female genital mutilation play an important role in both providing arguments against the practice and generating social support for change.

Health care providers can play a key role in preventing female genital mutilation and in supporting and informing patients and communities about the benefits of eliminating it. This can be done by providing women with information about their own sexual and reproductive health, making it easier for them to understand natural body functions and the harmful consequences of female genital mutilation. Health care providers can also play an important role in community outreach, such as through school programmes and public health education programmes.

Traditional circumcisers are also key actors as their role will have to change. They might be resistant to such change as it can threaten their position, and use their influence within the community to continue to promote the practice

or undermine efforts for abandonment. On the other hand, if they decide to abandon the practice they can be very forceful in convincing others to abandon it also.

Although female genital mutilation has traditionally been seen by many men as a 'women's issue', **men** are important for change. In some settings they support the practice; however, research has shown that some men are concerned by the effects of female genital mutilation and would prefer to marry women who have not undergone the procedure (Almroth et al., 2001; Herieka and Dhar, 2003; Draege, 2007). Young men in particular are more likely to oppose the practice (Herieka and Dhar, 2003; Draege, 2007).

The **United Nations** plays a crucial role in providing international standards and promoting and undertaking research, in collaboration with academic and development partners, to ensure that standards are grounded in sound evidence. United Nations agencies are particularly well placed to promote cooperation and coordination among all actors. Several United Nations bodies are tasked with monitoring the implementation of international legal commitments to protect and promote human rights for all without discrimination on any basis.

The role of **development cooperation agencies** in supporting international and national initiatives by providing technical and financial support is also essential to achieve the common goal of ending female genital mutilation.

Capacity building, research, monitoring and evaluation

Lessons from the past decade show that strong and competent organizations are required to sustain programmes for the abandonment of female genital mutilation. This requires both financial resources and considerable capacity building.

Training must be comprehensive both in the range of people trained and in the range of topics covered. In some places, three- to four-week courses have been held for programme implementers, health care providers and others to give them the information and skills required to plan, implement and evaluate a community-based intervention.

As effective programme design and implementation must be based on sound data, continuous monitoring is required to document trends in prevalence and changes in the type and justifications for the practice. There is international agreement on the use of five indicators in surveys on female genital mutilation: prevalence by age cohorts 15–49 years; status of daughters (as declared by mothers aged 15–49 years); percentage of "closed " (infibulation, sealing) and open (excision) female genital mutilation; the performer of female genital mutilation; and support of, or opposition to, female genital mutilation by women and men aged 15–49 years (UNICEF, 2005b). Consistency in the use of indicators enables comparative analysis at national and international levels across different surveys. Evaluation, including base- and end-line studies as well as process evaluation, is essential for measuring feasibility and effectiveness (Askew, 2005).

Research continues to be needed on aspects that will contribute to the elimination and prevention of female genital mutilation and better care for girls and women who have been subjected to the practice. Topics that require further study

include: the dynamics of social and cultural change that lead to the abandonment of the practice, the prevalence of immediate health complications, girls' experiences of the practice, psychological consequences of female genital mutilation, care procedures for girls and women and birth care procedures that might reduce the harmful consequences of female genital mutilation for mothers and their babies, the impact of legal measures to prevent the practice, and its medicalization.

Conclusion

This Interagency Statement expresses the common commitment of these organizations to continue working towards the elimination of female genital mutilation. Female genital mutilation is a dangerous practice, and a critical human rights issue.

Progress has been achieved on a number of fronts: female genital mutilation is internationally recognized as a violation of human rights; a global goal to end the practice has been set by the United Nations General Assembly Special Session on Children (UN General Assembly, 2002); policies and legislation to prohibit the practice have been put in place in many countries; and, most importantly, there are indications that processes of social change leading to abandonment of the practice are under way in a number of countries.

We now have more knowledge about the practice itself and the reasons for its continuation, as well as experience with interventions that can more effectively lead to its abandonment. Application of this knowledge through a common, coordinated approach that promotes positive social change at community, national and international levels could lead to female genital mutilation being abandoned within a generation, with some of the main achievements obtained by 2015, in line with the Millennium Development Goals.

The United Nations agencies confirm their commitment to support governments, communities and the women and girls concerned to achieve the abandonment of female genital mutilation within a generation.

Annex 1: Note on terminology

The terminology used for this procedure has undergone various changes. During the first years in which the practice was discussed outside practising groups, it was generally referred to as 'female circumcision'. This term, however, draws a parallel with male circumcision and, as a result, creates confusion between these two distinct practices.

The expression 'female genital mutilation' gained growing support from the late 1970s. The word mutilation establishes a clear linguistic distinction from male circumcision, and emphasizes the gravity and harm of the act. Use of the word 'mutilation' reinforces the fact that the practice is a violation of girls' and women's rights, and thereby helps to promote national and international advocacy for its abandonment.

In 1990, this term was adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, in Addis Ababa, Ethiopia. In 1991, WHO recommended that the United Nations adopt this term. It has subsequently been widely used in United Nations documents and elsewhere and is the term employed by WHO.

From the late 1990s the terms 'female genital cutting' and 'female genital mutilation/cutting' were increasingly used, both in research and by some agencies. The preference for this term was partly due to dissatisfaction with the negative association attached to the term 'mutilation', and some evidence that the use of that word was estranging practising communities and perhaps hindering the process of social change for the elimination of female genital mutilation.
To capture the significance of the term 'mutilation' at the policy level and, at the same time, to use less judgemental terminology for practising communities, the expression 'female genital mutilation/cutting' is used by UNICEF and UNFPA. For the purpose of this Interagency Statement and in view of its significance as an advocacy tool, all United Nations agencies have agreed to use the single term 'female genital mutilation'.

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.

Annex 3: Countries where female genital mutilation has been documented

Listed below are countries in which female genital mutilation of Types I, II, III and 'nicking' Type IV has been documented as a traditional practice. For countries without an asterisk the prevalence is derived from national survey data (the Demographic and Health Surveys (DHS) published by Macro, or the Multiple Cluster Indicator Surveys (MICS), published by UNICEF).

Country	Year	Estimated prevalence of female genital mutilation in girls and women 15 – 49 years (%)
Benin	2001	16.8
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Côte d'Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea-Bissau	2005	44.5
Kenya	2003	32.2
Liberia*		45.0
Mali	2001	91.6
Mauritania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19.0
Senegal	2005	28.2
Sierra Leone	2005	94.0
Somalia	2005	97.9
Sudan, northern (approximately 80% of total population in survey)	2000	90.0
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6
Yemen	1997	22.6

* The estimate is derived from a variety of local and sub-national studies (Yoder and Khan, 2007).

In some other countries, studies have documented female genital mutilation, but no national estimates have been made. These countries include:

- India (Ghadially, 1992)
- Indonesia (Budiharsana, 2004)
- Iraq (Strobel and Van der Osten-Sacken, 2006)
- Israel (Asali et al., 1995)
- Malaysia (Isa et al., 1999)
- United Arab Emirates (Kvello and Sayed, 2002)

There are anecdotal reports on female genital mutilation from several other countries as well, including Colombia, Democratic Republic of Congo, Oman, Peru and Sri Lanka. Countries in which female genital mutilation is practised only by migrant populations are not included in these lists.

Annex 4: International and regional human rights treaties and consensus documents providing protection and containing safeguards against female genital mutilation

International treaties

- Universal Declaration of Human Rights, adopted 10 December 1948. General Assembly Resolution 217. UN Doc. A/810.
- Convention relating to the Status of Refugees, adopted 28 July 1951 (entry into force, 22 April 1954).
- Protocol relating to the Status of Refugees, adopted 31 January 1967 (entry into force, 4 October 1967).
- International Covenant on Civil and Political Rights, adopted 16 December 1966 (entry into force, 23 March 1976).
- International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966 (entry into force, 3 January 1976).
- Convention on the Elimination of all Forms of Discrimination against Women, adopted 18 December 1979 (entry into force, 3 September 1981).
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984 (entry into force, 26 June 1987).
- Convention on the Rights of the Child, adopted 20 November 1989. General Assembly Resolution 44/25. UN GAOR 44th session, Supp. No. 49. UN Doc. A/44/49 (entry into force, 2 September 1990).
- Committee on the Elimination of All Forms of Discrimination against Women. General Recommendation No. 14, 1990, Female circumcision; General Recommendation No. 19, 1992, Violence against women; and General Recommendation No. 24, 1999, Women and health.
- Human Rights Committee. General Comment No. 20, 1992. Prohibition of torture and cruel treatment or punishment.
- Human Rights Committee. General Comment No. 28, 2000. Equality of rights between men and women. CCPR/C/21/rev.1/Add.10.
- Committee on Economic, Social and Cultural Rights. General Comment No. 14, 2000. The right to the highest attainable standard of health. UN Doc. E/C.12/2000/4.
- Committee on the Rights of the Child. General Comment No. 4, 2003. Adolescent health and development in the context of the Convention on the Rights of the Child. CRC/GC/2003/4.

Regional treaties

- European Convention for the Protection of Human Rights and Fundamental Freedoms, adopted 4 November 1950 (entry into force, 3 September 1953).
- American Convention on Human Rights (entry into force, 18 July 1978).
- African Charter on Human and Peoples' Rights (Banjul Charter), adopted 27 June 1981. Organization of African Unity. Doc. CAB/LEG/67/3/Rev. 5 (1981), reprinted in 21 I.L.M. 59 (1982) (entry into force, 21 October 1986).
- African Charter on the Rights and Welfare of the Child, adopted 11 July 1990. Organization of African Unity. Doc. CAB/LEG/24.9/49 (entry into force 29 November 1999).
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, Assembly of the African Union (entry into force 25 November 2005).

Consensus documents

- United Nations General Assembly, Declaration on the Elimination of Violence against Women, UN Doc. A/RES/48/104 (1993).

- World Conference on Human Rights, Vienna Declaration and Plan of Action, June 1993. UN Doc. DPI/ 1394-39399 (August 1993).
- Programme of Action of the International Conference on Population and Development, Cairo, Egypt, 5–13 September 1994. UN Doc. A/CONF.171/13/Rev. 1 (1995).
- Beijing Declaration and Platform for Action of the Fourth World Conference on Women, Beijing, China, 4–15 September 1995. UN Doc. A/CONF.177/20.
- UNESCO Universal Declaration on Cultural Diversity, adopted 2 November 2001.
- Convention on the Protection and Promotion of the Diversity of Cultural Expressions, adopted October 2005 (entry into force March 2007).
- United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on the Ending of Female Genital Mutilation. March 2007. E/CN.6/2007/L.3/Rev.1.

Annex 5: Health complications of female genital mutilation

Where available data allow, variations by type are specified. Generally speaking, risks increase with increasing severity of the procedure. As there are limited data on the different practices included in Type IV female genital mutilation, information on these forms is not included.

Immediate risks of health complications from Types I, II and III

Severe pain: Cutting the nerve ends and sensitive genital tissue causes extreme pain. Proper anaesthesia is rarely used and, when used, not always effective. The healing period is also painful. Type III female genital mutilation is a more extensive procedure of longer duration (15–20 minutes), hence the intensity and duration of pain are more extensive. The healing period is extended and intensified accordingly. [1]

Shock can be caused by pain and/or haemorrhage.[2]

Excessive bleeding (haemorrhage) and septic shock have been documented.[3]

Difficulty in passing urine, and also passing of faeces, can occur due to swelling, oedema and pain.[4]

Infections may spread after the use of contaminated instruments (e.g. use of same instruments in multiple genital mutilation operations), and during the healing period.[5]

Human immunodeficiency virus (HIV): Use of the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo female genital mutilation together.[6] In one study an indirect association was found,[7] but no direct association has been documented,[8] perhaps because of the rarity of mass genital cutting with the same instrument, and the low HIV prevalence among girls of the age at which the procedure is performed.

Death can be caused by haemorrhage or infections, including tetanus and shock.[9]

Psychological consequences: The pain, shock and the use of physical force by those performing the procedure are mentioned as reasons why many women describe female genital mutilation as a traumatic event.[10]

Unintended labia fusion: Several studies have found that, in some cases, what was intended as a Type II female genital mutilation may, due to labia adhesion, result in a Type III female genital mutilation.[11]

Repeated female genital mutilation appears to be quite frequent in Type III female genital mutilation, usually due to unsuccessful healing.[12]

1. Type I and II: El-Defrawi et al., 2001; Dare et al., 2004; Malmström, 2007. Type III: Boddy, 1989; Dirie and Lindmark, 1992; Chalmers and Hashi, 2000; Gruenbaum, 2001; Johansen, 2002

2. Type I and II: Egwuatu and Agugua, 1981; Agugua and Egwuatu, 1982. Type III: Dirie and Lindmark, 1992; Almroth et al., 2005a

3. Dirie and Lindmark, 1992; Jones et al., 1999; Chalmers and Hashi, 2000; Dare et al., 2004; Yoder et al., 2004

4. Type I and II: El-Defrawi et al., 2001; Dare et al., 2004; Yoder et al., 2004. Type III: Dirie and Lindmark, 1992; Chalmers and Hashi, 2000; Yoder et al., 2004; Almroth et al., 2005a.

5. Dirie and Lindmark, 1992; Chalmers and Hashi, 2000; Almroth et al., 2005a,b

6. Klouman et al., 2005; Morison et al., 2001

7. Yount and Abraham, 2007

8. Morison et al., 2001; Okonofua et al., 2002; Klouman et al., 2005

9. Mohamud, 1991

10. Boddy, 1989; Johansen, 2002; Talle, 2007; Behrendt and Moritz, 2005; Malmström, 2007

11. Egwuatu and Agugua, 1981; Agugua and Egwuatu, 1982; Dare et al., 2004; Behrent, 2005

12. Dirie and Lindmark, 1992; Chalmers and Hashi, 2000; Johansen, 2006b

Long-term health risks from Types I, II and III (occurring at any time during life)

Pain: Chronic pain can be due to trapped or unprotected nerve endings.[13]

Infections: Dermoid cysts, abscesses and genital ulcers can develop, with superficial loss of tissue.[14] Chronic pelvic infections can cause chronic back and pelvic pain.[15] Urinary tract infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk for repeated urinary tract infections is well documented in both girls and adult women.[16]

Keloid: Excessive scar tissue may form at the site of the cutting.[17]

Reproductive tract infections and sexually transmitted infections: An increased frequency of certain genital infections, including bacterial vaginosis has been documented.[18] Some studies have documented an increased risk for genital herpes, but no association has been found with other sexually transmitted infections.[19]

Human immunodeficiency virus (HIV): An increased risk for bleeding during intercourse, which is often the case when defibulation is necessary (Type III), may increase the risk for HIV transmission. The increased prevalence of herpes in women subjected to female genital mutilation may also increase the risk for HIV infection, as genital herpes is a risk factor in the transmission of HIV.

Quality of sexual life: Removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual pleasure and pain during sex. Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems.[20]

Birth complications: The incidences of caesarean section and postpartum haemorrhage are substantially increased, in addition to increased tearing and recourse to episiotomies. The risks increase with the severity of the female genital mutilation.[21] Obstetric fistula is a complication of prolonged and obstructed labour, and hence may be a secondary result of birth complications caused by female genital mutilation.[22] Studies investigating a possible association between female genital mutilation and obstetric fistulas are under way.

Danger to the newborn: Higher death rates and reduced Apgar scores have been found, the severity increasing with the severity of female genital mutilation.[23]

Psychological consequences: Some studies have shown an increased likelihood of fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss.[24] The cultural significance of the practice might not protect against psychological complications.[25]

13. Akotionga et al., 2001; Okonofua et al., 2002; Fernandez-Aguilaret and Noel, 2003

14. Egwautu and Agugua 1981; Dirie and Lindmark, 1992; Chalmers and Hashi, 2000; Rouzi et al., 2001; Okonofua et al., 2002; Thabet and Thabet, 2003

15. Rushwan, 1980; Klouman et al., 2005

16. Ismail, 1999; Knight et al., 1999; Almroth et al., 2005a

17. Jones et al., 1999; Okonofua et al., 2002

18. Morison et al., 2001; Okonofua et al., 2002; Klouman et al., 2005; Elmusharaf et al., 2006b

19. Morison et al., 2001; Okonofua et al., 2002; Klouman et al., 2005; Elmusharaf et al., 2006b

20. Knight et al., 1999; Thabet and Thabet, 2003; El-Defrawi et al., 2001; Elnashar and Abdelhady, 2007; Johansen, 2007

21. Vangen et al., 2002; WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006

22. Tahzib, 1983; Rushwan, 2000

23. Vangen et al., 2002; WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006

24. Whitehorn, 2002; Behrendt and Moritz, 2005; Lockhat, 2006

25. Behrendt and Moritz, 2005; Lockhat, 2006; Nour et al., 2006; Elnashar and Abdelhady, 2007

Additional risks for complications from Type III

Later surgery: Infibulations must be opened (defibulation) later in life to enable penetration during sexual intercourse and for childbirth. In some countries it is usual to follow this by re-closure (reinfibulation), and hence the need for repeated defibulation later. Re-closure is also reportedly done on other occasions.[26]

Urinary and menstrual problems: Slow and painful menstruation and urination can result from the near-complete sealing off of the vagina and urethra.[27] Haematocolpus may need surgical intervention.[28] Dribbling of urine is common in infibulated women, probably due to both difficulties in emptying the bladder and stagnation of urine under the hood of scar tissue.[29]

Painful sexual intercourse: As the infibulation must be opened up either surgically or through penetrative sex, sexual intercourse is frequently painful during the first few weeks after sexual initiation.[30] The male partner can also experience pain and complications.[31]

Infertility: The association between female genital mutilation and infertility is due mainly to cutting of the labia majora, as evidence suggests that the more tissue that is removed, the higher the risk for infection.[32]

26. Berggren, 2004, 2006; Nour et al., 2006

27. Akotionga et al., 2001; Knight et al., 1999; Almroth et al., 2005a; Nour et al., 2006

28. Dirie and Lindmark ,1992

29. Egwautu and Agugua, 1981; Agugua and Egwautu, 1982; Dirie and Lindmark, 1992 ; Ismail, 1999; Chalmers and Hashi, 2000; Njue and Askew, 2004

30. Talle, 1993; Akotionga et al., 2001; Gruenbaum, 2006; Nour et al., 2006

31. Dirie and Lindmark, 1992; Almroth et al., 2001

32. Almroth et al., 2005b

References

Abdi MS (2007). *A religious oriented approach to addressing FGM/C among the Somali community of Wajir*. Nairobi, Population Council.

Abusharaf RM (2001). Virtuous cuts: female genital circumcision in an African ontology. Differences, a J*ournal of Feminist Cultural Studies*, 12:112–140.

Abusharaf R (2005). Smoke bath: renegotiating self and the world in a Sudanese shantytown. *Anthropology and Humanism*, 30:1–21.

Abusharaf R, ed. (2007). *Female circumcision: multicultural perspectives*. Philadelphia, University of Pennsylvania Press.

Agugua NE, Egwuatu VE (1982). Female circumcision: management of urinary complications. *Journal of Tropical Pediatrics*, 28:248–252.

Ahmadu F (2000). Rites and wrongs: an insider/outsider reflects on power and excision In: Shell-Duncan B, Hernlund Y, eds. *Female 'circumcision' in Africa: culture, controversy and change*. Boulder, Colorado, Lynne Rienner: 283–312.

Akotionga M, Traore O, Lakonde J, Kone B. (2001). Séquelles génitales externes de l'excision au centre hospitalier national Yalgado Uuedraogo (CHN-YO): épidémiologie et traitement chirurgical. *Gynécologie Obstétrique et Fertilité*, 29:295–300.

Almroth L, Almroth-Berggren V, Hassanein OM, Al Said SS, Hasan SS, Lithell UB (2001). Male complications of female genital mutilation. *Social Science and Medicine*, 53:1455–1460.

Almroth L, Bedri HA, Elmusharaf S, Satti A, Idris T, Hashim MS (2005a). Urogenital complications among girls with genital mutilation: A hospital based study in Khartoum. *African Journal of Reproductive Health*, 9:127–133.

Almroth L, Elmusharaf S, El Hadi N, Obeid A, El Sheikh MAA, Elfadil SM (2005b). Primary infertility after genital mutilation in girlhood in Sudan: a case–control study. *Lancet*, 366:385–391.

Almroth-Berggren V, Almroth L, Bergstrom S, Hassanein OM, Hadi NE, Lithell UB (2001). Reinfibulation among women in a rural area in central Sudan. *Health Care Women International*, 22:711–721.

Asali A, Khamaysi N, Aburabia Y, Letzer S, Halihal B, Sadovsky M (1995). Ritual female genital surgery among Bedouin in Israel. *Archives of Sexual Behavior*, 24:571–575.

Askew I (2005). Methodological issues in measuring the impact of interventions against female genital cutting. *Culture, Health and Sexuality*, 7:463–477.

Assembly of the African Union (2003). Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. Adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 11 July 2003. Available at: http://www.achpr.org/english/_info/women_en.html (accessed on 16 October 2007).

Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A (2005). Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. *PLoS Med*, 2:e298.

Bagnol B, Esmeralda M. (in press). Closing the vagina through elongation of the labia minora and use of vaginal products to enhance eroticism: Can these practices be considered FGM? *Finnish Journal of Ethnicity and Migration(FJEM)*. www.etmu.fi/fjem.

Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN (2007). Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. *Lancet*, 369:643–656.

Behrendt A (2005). *The practice of excision in Moyamba and Bombali districts of Sierra Leone: perceptions, attitudes and practices*. Dakar, Plan West Africa Regional Office.

Behrendt A, Moritz S (2005). Posttraumatic stress disorder and memory problems after female genital mutilation. *American Journal of Psychiatry*, 162:1000–1002.

Berggren V, Abdel Salam G, Bergstrom S, Johansson E, Edberg AK (2004). An explorative study of Sudanese midwives' motives, perceptions and experiences of re-infibulation after birth. *Midwifery*, 20:299–311.

Berggren V, Yagoub AE, Satti AM, Khalifa MA, Aziz FA, Bergstrom S (2006). Postpartum tightening operations on two delivering wards in Sudan. *British Journal of Midwifery*, 14:1–4.

Bjälkander O, Almroth L (2007). *FGM in Sierra Leone: rituals, youth, fistula and local laws*. Paper presented at the 4th FOKO conference (Nordic Network for Research on FGM), Hansaari, Finland, 7–8 September.

Boddy J (1989). *Wombs and alien spirits: women, men and the zar cult in northern Sudan*. Madison, Wisconsin, University of Wisconsin Press.

Boddy J (1998). Violence embodied? Female circumcision, gender politics, and cultural aesthetics. In: Dobash RE, Dobash RP, eds. *Rethinking violence against women*. Thousand Oaks, California, Sage Publications.

Budiharsana M (2004). *Female circumcision in Indonesia: extent, implications and possible interventions to uphold women's health rights*. Jakarta, Population Council.

Catania L, Hussen AO (2005). *Ferite per sempre Le MGF e al proposta del rito simbolico alternative*. Rome, The Casa editrice, Derive Approdi.

Chalmers B, Hashi KO (2000). 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth*, 27:227–234.

Chege JN, Askew I, Liku J (2001). *An assessment of the alternative rites approach for encouraging abandonment of female genital mutilation in Kenya*. Frontiers in Reproductive Health. Washington DC, Population Council.

Christoffersen-Deb A (2005). Taming tradition: medicalized female genital practices in western Kenya. *Medical Anthropology Quarterly*, 19:402–418.

Clarence-Smith WG (2007). *Islam and female genital cutting in Southeast Asia: the weight of the past*. Paper presented at 4th FOKO conference (Nordic Network for Research on FGM), 7–8 October, Hansaari, Finland.

Committee on the Elimination of All Forms of Discrimination against Women (1990).General Recommendation No. 14 (Ninth session). New York, United Nations Division for the Advancement of Women.

Convention on the Rights of the Child (1989). General Assembly Resolution 44/25. UN GAOR 44th session, Supp. No. 49. UN Doc. A/44/49.

Dare FO, Oboro VO, Fadiora SO, Orji EO, Sule-Odu AO, Olabode TO (2004). Female genital mutilation: an analysis of 522 cases in South-Western Nigeria. *Journal of Obstetrics and Gynaecology*, 24:281–283.

Dellenborg L (2004). A reflection on the cultural meanings of female circumcision: experiences from fieldwork in Casamance, southern Senegal. In: Arnfred, S, ed., *Re-thinking sexualities in Africa*. Uppsala, Nordic Africa Institute, 79–98.

Dembour M (2001). Following the movement of a pendulum: between universalism and relativism. In: Cowan J, Dembour M, Wilson, R, eds. *Culture and rights: anthropological perspectives*. Cambridge, Cambridge University Press: 56–79.

Dirie MA, Lindmark G (1992). The risk of medical complications after female circumcision. *East African Medical Journal*, 69:479–482.

Donor Working Group on Female Genital Mutilation/cutting (2007). *Toward a common framework for the abandonment of FGM/C*. Florence, UNICEF.

Draege TL (2007). *The role of men in the maintenance and change of female genital cutting in Eritrea*. Thesis, University of Bergen.

Egwuatu VE, Agugua NE (1981). Complications of female circumcision in Nigerian Igbos. *British Journal of Obstetrics and Gynaecology*, 88:1090–1093.

El-Defrawi MH, Lotfy G, Dandash KF, Refaat AH, Eyada M (2001). Female genital mutilation and its psychosexual impact. *Journal of Sexual and Marital Therapy*, 27:465–473.

Elmusharaf S, Elhadi N, Almroth L (2006a) Reliability of self reported form of female genital mutilation and WHO classification: cross sectional study. *British Medical Journal*, 333(7559):124.

Elmusharaf S, Elkhidir I, Hoffmann S, Almroth L (2006b). A case–control study on the association between female genital mutilation and sexually transmitted infections in Sudan. *British Journal of Obstetrics and Gynaecology*, 113:469–474.

Elnashar RA, Abdelhady R (2007). The impact of female genital cutting on health of newly married women. *International Journal of Gynecology and Obstetrics*, 97:238–244.

Fernandez-Aguilaret S, Noel JC (2003). Neuroma of the clitoris after female genital cutting. *Obstetrics and Gynecology*, 101:1053–1054.

GTZ-Gesellschaft für Technische Zusammenarbeit (2005). *Generation dialogue about FGM and HIV/AIDS: method, experiences in the field and impact assessment*. Eschborn.

Ghadially R (1992). Update on female genital mutilation in India. *Women's Global Network for Reproductive Rights Newsletter*, January–March.

Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S, Nalugoda F et al. (2007). Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. *Lancet*, 369:657–666.

Gruenbaum E (2001). *The female circumcision controversy: an anthropological perspective*. Pittsburgh, University of Pennsylvania Press.

Gruenbaum E (2006). Sexuality issues in the movement to abolish female genital cutting in Sudan. *Medical Anthropology Quarterly*, 20:121.

Hayford SH (2005). Conformity and change: community effects on female genital cutting in Kenya. *Journal of Health and Social Behavior*, 46:121–140.

Herieka E, Dhar J (2003). Female genital mutilation in the Sudan: survey of the attitude of Khartoum university students towards this practice. *Sexually Transmitted Infections*, 79:220–223.

Hernlund Y (2000). Cutting without ritual and ritual without cutting: female circumcision and the re-ritualization of initiation in The Gambia. In: Hernlund Y, Shell-Duncan B, eds. *Female 'circumcision' in Africa: culture, change and controversy*. Boulder, Colorado, Lynne Rienner; 235–252.

Hernlund Y (2003). *Winnowing culture: negotiating female 'circumcision' in the Gambia*. PhD thesis. University of Washington, Seattle.

International Federation of Gynaecology and Obstetrics (1994). FIGO General Assembly, Montreal, Canada 1994. London, FIGO—International Federation of Gynecology and Obstetrics.

International Covenant on Civil and Political Rights, adopted 16 December 1966 (entry into force, 23 March 1976).

Irin News (2007). Guinea-Bissau: Two thousand girls a year suffer genital mutilation. Available at: www.plusnews.org

Isa AR, Shuib R, Othman MS (1999). The practice of female circumcision among Muslims in Kelantan, Malaysia. Reproductive Health Matters, 7:137–144.

Ismail NHA. (1999). Urinary leakage and other complications of female genital mutilation (FGM) among Somali girls in Sweden. Uppsala, Institutionen för kvinnors och barns hälsa.

Johansen REB (2002). Pain as a counterpoint to culture: towards an analysis of pain associated with infibulation among Somali immigrants in Norway. Medical Anthropology Quarterly, 16:312–340.

Johansen REB (2006a). Care for infibulated women giving birth in Norway- An anthropological analysis of health workers management of a medically and culturally unfamiliar issue. *Medical Anthropology Quarterly*; 20:516–44.

Johansen REB (2006b). *Experiences and perceptions of pain, sexuality and childbirth. A study of female genital cutting among Somalis in Norwegian exile, and their health care providers*. Dissertation. University of Oslo, Faculty of medicine.

Johansen REB (2007). Experiencing sex in exile—can genitals change their gender? In: Hernlund Y, Shell-Duncan B, eds. *Transcultural bodies: female genital cutting in global context*. New Brunswick, Rutgers University Press: 248–277.

Johnson M (2007). Making mandinga or making Muslims? Debating female circumcision, ethnicity, and Islam in Guinea-Bissau and Portugal. In: Hernlund Y, Shell-Duncan B, eds. *Transcultural bodies: female genital cutting in global context*. New Brunswick, Rutgers University Press: 202–223.

Jones H, Diop N, Askew I, Kaboré I (1999). Female genital cutting practices in Burkina Faso and Mali and their negative health outcomes. *Studies in Family Planning*, 30:219–230.

Klouman E, Manongi R, Klepp KI (2005). Self-reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections. *Tropical Medicine and International Health*, 10:105–115.

Knight R, Hotchin A, Bayly C, Grover S (1999). Female genital mutilation—experience of The Royal Women's Hospital, Melbourne. *Australia New Zealand Journal of Obstetrics and Gynaecology*, 39:50–54.

Kvello A, Sayed L (2002). *Omskjering av kvinner i de forente arabiske emirater—er klitoridektomi i tradisjonell praksis et overgrep mot kvinner*? (Concerning female circumcision in the United Arab Emirates: Is clitoridectomy in a traditional context an assault against women?) Thesis, Faculty of Medicine, University of Oslo.

Leonard L (2000). Adopting female 'circumcision' in southern Chad: the experience of Myabe. In: Hernlund Y, Shell-Duncan B, eds. *Female 'circumcision' in Africa: culture, controversy, and change*. Boulder, Colorado, Lynne Rienner, 167–192.

Lockhat H (2006). *Female genital mutilation: treating the tears*. London Middlesex University Press.

Mackie G (2000). Female genital cutting: the beginning of the end. In: Hernlund Y, Shell-Duncan B, eds. *Female 'circumcision' in Africa: culture, controversy, and change*. Boulder, Colorado, Lynne Rienner: 253–282.

Malmström M (2007). *Bearing the pain as a woman or becoming ruined for life? Changing views of the meaning and morality of pain and suffering among the popular classes of Cairo*. Paper presented at 4th FOKO conference (Nordic Network for Research on FGM), Hansaari, Finland 7–8 September 2007.

McCaffrey M (1995). Female genital mutilation: consequences for reproductive and sexual health. *Sexual and Marital Therapy*, 10:189–200.

McClelland RS, Lavreys L, Hassan W, Mandaliya K, Ndinya-Achola J, Baeten JM (2006). Vaginal washing and increased risk of HIV-1 acquisition among African women: a 10-year prospective study. *AIDS*, 20:269–273.

Mohamud OA (1991). Female circumcision and child mortality in urban Somalia. Genus, 47:203–223.

Morison L, Scherf C, Ekpo G, Paine K, West B, Coleman R, Walraven G (2001). The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey. *Tropical Medicine and International Health*, 6:643–653.

Msuya SE, Mbizvo E, Hussain A, Sundby J, Sam NE, Stray-Pedersen B (2002). Female genital cutting in Kilimanjaro, Tanzania: changing attitudes? *Tropical Medicine and International Health*, 7:159–165.

Mwenda KK (2006). Labia elongation under African customary law: a violation of women's rights? *International Journal of Human Rights*, 10:341–357.

Ndiaye S, Diop NJ, Yoder PS (in press). *Évaluation à long terme du programme de Tostan au Senegal: Régions de Kolda, Thiès et Fatick*. Calverton, Macro International Inc.

Newland L (2006). Female circumcision: Muslim identities and zero tolerance policies in rural West Java. *Women's Studies International Forum*, 29:394–404.

Njue C, Askew I (2004). *Medicalization of female genital cutting among the Abagusii in Nyanza Province, Kenya*. Washington DC, Population Council Frontiers in Reproductive Health.

Nour NM, Michels KB, Bryant AE (2006). Defibulation to treat female genital cutting. Effect on symptoms and sexual function. *Obstetrics and Gynecology*, 108:55–60.

Nypan A (1991). Revival of female circumcision: a case of neo-traditionalism. In: Stolen KA, Vaa M, eds. Gender and change in developing countries. Oslo, Norwegian University Press: 39–65.

Obermeyer CM (2005). The consequences of female circumcision for health and sexuality: an update on the evidence. *Culture, Health and Sexuality*, 7:443–461.

Obiora LA (1997). Bridges and barricades: rethinking polemics and intransigence in the campaign against female circumcision [electronic version]. *Western Reserve Law Review*, 47:275–379.

Okonofua FE, Larsen U, Oronsaye F, Snow RC, Slanger TE (2002). The association between female genital cutting and correlates of sexual and gynaecological morbidity in Edo State, Nigeria. *British Journal of Obstetrics and Gynaecology*, 109:1089–1096.

Population Reference Bureau (2001). *Abandoning female genital cutting: prevalence, attitudes, and efforts to end the practice*. Washington DC.

Population Reference Bureau (2006). *Abandoning female genital mutilation/cutting: an in-depth look at promising practices*. Washington DC, Population Reference Bureau.

Rouzi AA, Sindi O, Bandar Radhan F, Ba'aqeel H (2001). Epidermal clitoral inclusion cyst after type I female genital mutilation. *American Journal of Obstetrics and Gynecology*, 185:569–571.

Rushwan H (1980). Etiologic factors in pelvic inflammatory disease in Sudanese women. American Journal of Obstetrics and Gynecology, 138:877–879.

Rushwan H (2000). Female genital mutilation (FGM) management during pregnancy, childbirth and the postpartum period. *International Journal of Gynaecology and Obstetrics*, 70:99–104.

Satti A, Elmusharaf S, Bedri HA, Idris T, Hashim MSK, Suliman GI, Almroth I (2006). Prevalence and determinants of the practice of genital mutilation of girls in Khartoum, Sudan. *Annals of Tropical Paediatrics: International Child Health*,26:303–310.

Shell-Duncan B (2001). The medicalization of female' circumcision': harm reduction or promotion of a dangerous practice? *Social Sciences and Medicine*, 52:1013–1028.

Shell-Duncan B, Hernlund Y (2006). Are there 'stages of change' in the practice of female genital cutting? Qualitative research findings from Senegal and The Gambia. *African Journal of Reproductive Health*, 10:57–71.

Shweder RA (2003). What about female genital mutilation and why understanding culture matters in the first place. In: Shweder R, Minow M, Markus HR, eds. *Engaging cultural differences: the multicultural challenge in liberal democracies*. New York, Russell Sage Foundation: 216–251.

Snow RC, Slanger TE, Okonofua F, Oronsaye F, Wacker J (2002). Female genital cutting in southern urban and peri-urban Nigeria: self-reported validity, social determinants and secular decline *Tropical Medicine and International Health*, 7:91–100.

Strobel S, von der Osten-Sacken T (2006).Female genital mutilation in Iraqi Kurdistan. Presented at the 1ère Journée Humanitaire sur la Santé des Femmes dans le Monde, Paris, France. Gynécologie sans Frontières http://www.wadinet.de/news/dokus/fgm-conference_1ere_journee_humanitaire-en.htm.

Talle A (1993). Transforming women into 'pure' agnates: aspects of female infibulation in Somalia. In: Broch-Due V, Rudie I, Bleie T, eds. *Carved flesh, cast selves: gender symbols and social practices*. Oxford, Berg; 83–106.

Talle A (2007). Female circumcision in Africa and beyond: the anthropology of a difficult issue. In: Hernlund Y, Shell-Duncan B, eds. *Transcultural bodies: female genital cutting in global context*. New Brunswick, Rutgers University Press: 91–106.

Tamale S (2006). Eroticism, sensuality and 'women's secrets' among the Baganda. Institute of Development Studies Bulletin, 37:89–97.

Tahzib F (1983). Epidemiological determinants of vesico-vaginal fistulas. *British Journal of Obstetrics and Gynaecology*, 90:387–391.

Thabet SM, Thabet AS (2003). Defective sexuality and female circumcision: the cause and the possible management. *Journal of Obstetrics and Gynaecology Research*, 29:12–19.

Thierfelder C, Tanner M, Bodiang CM **(2005). Female genital mutilation in the context of migration: experience of African women with the Swiss health care system.** *European Journal of Public Health*;15:86–90.

Toubia NF, Sharief EH (2003). Female genital mutilation: have we made progress? *International Journal of Gynecology and Obstetrics*, 82:251–261.

UNAIDS (2007). *Safe, voluntary, informed male circumcision and comprehensive HIV prevention programming: Guidance for decision-makers on human rights, ethical and legal considerations*. Geneva, UNAIDS.

UNESCO (2001). *UNESCO Universal Declaration on Cultural Diversity*. Paris, UNESCO.

UNICEF (2005a). *Female genital mutilation/female genital cutting: a statistical report*. New York, UNICEF.

UNICEF (2005b). *Changing a harmful social convention: female genital mutilation/cutting*. Innocenti Digest. Florence, UNICEF.

UNFPA (2005). *Culture matters. Working with communities and faith-based organizations. Case studies from Country programmes*. New York, UNFPA.

UNFPA (2006). *Guide to working from within: 24 tips for culturally sensitive programming*. New York, UNFPA.

UNFPA (2007a). *Women's Economic Empowerment: Meeting the Needs of Impoverished Women*. New York, UNFPA.

UNFPA (2007b). *Engaging faith-Based organizations in HIV prevention: A training manual for programme managers*. New York, UNFPA.

UNFPA (2007c). A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting. New York, UNFPA.

UN General Assembly (2002). A world fit for children: resolution adopted by the General Assembly, 11 October 2002. New York, United Nations.

Vangen S, Johansen REB, Træen B, Sundby J, Stray-Pedersen B (2004). Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 112, 29–35.

Vangen S, Stoltenberg C, Johansen REB, Sundby J, Stray-Pedersen B (2002). Perinatal complications among ethnic Somalis in Norway. *Acta Obstetrics et Gynecologica Scandinavica*, 81:317–322.

Whitehorn J (2002). Female genital mutilation: cultural and psychological implications. *Sexual Relationships and Therapy*, 17:161–170.

WHO (1996a). *Islamic ruling on male and female circumcision*. Alexandria, World Health Organization Regional Office for the Eastern Mediterranean.

WHO (1996b). *Female genital mutilation. Report of a WHO technical working group*, Geneva,17–19 July 1996. Geneva, World Health Organization.

WHO (1999). *FGM programmes to date: what works and what doesn't. A review*. Geneva. Report No: WHO/CHS/WMH/99.5

WHO (2000a). Female genital mutilation. Fact Sheet No 241, June 2000. Geneva, World Health Organization. At: http://www.who.int/mediacentre/factsheets/fs241/en/ (accessed 3 October 2007).

WHO (2000b). *Female genital mutilation: a handbook for frontline workers*. Geneva. World Health Organization. WHO/FCH/WMH/00.5.

WHO (2001a). *Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery, a teacher's guide*. Geneva, World Health Organization. WHO/RHR/01.16.

WHO (2001b). *Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery—a student's manual*. Geneva, World Health Organization. WHO/RHR/01.17.

WHO (2001c). *Female genital mutilation: the prevention and the management of the health complications, policy guidelines for nurses and midwives*. Geneva, World Health Organization. WHO/RHR/01.18.

WHO Somalia (2002). *Female genital cutting in Somalia. Reasons for continuation and strategies for eradication*. Hergeisa, Somalia, World Health Organization.

WHO Study Group on Female Genital Mutilation and Obstetric Outcome (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet*, 367:1835–1841.

WHO, UNAIDS (2007). New data on male circumcision and HIV prevention: policy and programme implications. WHO/UNAIDS Technical Consultation, Montreux, 6–8 March 2007. Conclusions and Recommendations. Geneva, World Health Organization.

WHO, UNFPA (2006). *Towards the elimination of female genital mutilation: a training manual for the affected countries in the Eastern Mediterranean Region*. Cairo, World Health Organization Regional Office for the Eastern Mediterranean.

WHO, UNICEF, UNFPA (1997). *Female genital mutilation. A Joint WHO/UNICEF/UNFPA Statement*. Geneva, World Health Organization.

World Medical Association (1964). Declaration of Helsinki. Ethical principles for medical research involving human subjects. Adopted by the 18th World Medical Association General Assembly, in Helsinki, Finland, June 1964, and amended in 1975, 1983, 1989, 1996 and 2000.

Yoder PS, Khan S (2007). *Numbers of Women Circumcised in Africa: The production of a Total*. Calverton, Macro International Inc.

Yoder PS, Mahy M (2001). *Female genital cutting in Guinea: qualitative and quantitative research strategies* (DHS Analytical Studies No 5), Calverton: Macro International Inc.

Yoder PS, Camar PO, Soumaoro B (1999). *Female genital cutting and coming of age in Guinea*. Calverton, Macro International Inc.

Yoder PS, Abderrahim N, Zhuzhuni A (2004). *Female genital cutting in the Demographic and Health Surveys: a critical and comparative analysis*. Calverton, Macro International Inc.

Yount KM (2002). Like mother, like daughter? Female genital cutting in Minia, Egypt. *Journal of Health and Social Behaviour*. 43(3):336–358.

Yount KM, Abraham BK (2007). Female genital cutting and HIV/AIDS among Kenyan women. *Studies in Family Planning*, 30:73–88.

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