Female genital mutilation (FGM) encompasses a number of traditional operations that involve cutting away parts of the female external genitalia or other injury to the female genitals, whether for cultural or any other nontherapeutic reason (534). Where FGM takes place, it is often performed during infancy, childhood, or adolescence. FGM has traditionally been called "female circumcision." Recognition of its harmful physical, psychological, and human rights consequences, however, has led to use of the term "female genital mutilation," a term that more accurately describes the consequences of the procedure and distinguishes it from the much milder male circumcision.

FGM is known to be practiced in one form or another in 28 nations in the African continent, in a few countries on the Arab Peninsula, among some minority communities in Asia, and among migrants from these areas who have settled in Europe, Australia, and North America (139, 213, 477). The historical roots of the practice are not well known, but they appear to date back 2,000 years to ancient Egypt. FGM also is thought to have been practiced at one time or other in many Western countries (213, 296, 547). It is estimated that 100 million to 132 million women now living have undergone the procedure, and another 2 million procedures are done each year (213, 477, 492).

- Types of FGM

In an effort to standardize terminology, the World Health Organization (WHO) has categorized FGM into four main groupings (534). In Type I the prepuce (clitoral hood) is removed, sometimes along with part or all of the clitoris. In Type II both the clitoris and part or all of the labia minora (inner vaginal lips) are removed. In Type III (infibulation) the clitoris is removed, some or all of the labia minora are amputated, and incisions are made on the labia majora (outer lips) to create a raw surface. These raw surfaces are either stitched together and/or kept in contact until they seal as a "hood of skin" covering the urethra and most of the vaginal opening. A small opening (sometimes the size of a match head or the tip of the small finger) is created to allow the flow of urine and menstrual blood. Experts estimate that infibulations (Type III) comprise roughly 15% of FGM. In some countries, such as Sudan, Somalia, and Djibouti, however, 80% to 90% of all FGM is infibulation (478). Type IV is a new category that encompasses a group of other operations on the external genitalia including introcision (e.g., gishiri cuts), piercing or incising the clitoris and/or labia, stretching the clitoris and/or labia, cautery, scraping and/or cutting of the vagina, introduction of corrosive substances and herbs into the vagina, and similar practices (534).
FGM is usually carried out by traditional practitioners, often lay persons with only rudimentary training. It is increasingly performed by trained medical personnel, however, sometimes at high cost, on the assumption that this is more hygienic. This medicalization of the procedure has been strongly condemned by WHO (533).

Complications and Consequences

The health consequences of FGM are both immediate and lifelong. Because FGM is often carried out with no anesthesia, an immediate effect of the surgery is excruciating pain. In some cases of infibulation, thorns are used to hold together the severed vaginal lips, and the girl's legs are tied to limit motion so that a scar forms, closing the opening of the vagina. Depending on the proficiency of the circumciser, the bluntness of the instruments, and the struggles of the young girl, cutting can sever major blood vessels and cause trauma to adjacent organs. Bleeding can lead to shock and in some cases death. Infection is common (139, 148, 213, 452). There is also a risk of HIV transmission if the same equipment is used for several individuals, although this has not been the subject of research (534).

Continuing and long-term effects of FGM, particularly infibulation, can include formation of tough scar tissue, keloids, and cysts around the wound and stitch line, as well as shrinking of the artificial opening over the vagina. Other lasting effects include pain during urination. A girl may take as long as half an hour to urinate or may not be able to urinate for days (213, 296, 477). Infection of the wound can lead to reproductive tract infections and chronic pelvic pain. Women who become pregnant endure additional agony since the artificial vaginal opening is too small for normal delivery. Often the opening must be cut to allow exit of the fetal head without tearing the tough tissue. This process may have to be repeated with each pregnancy (213, 478). Prolonged labor can lead to damage of the bladder and surrounding organs, resulting in vesicovaginal and rectovaginal fistulas (tears between the vagina and the bladder, or the vagina and rectum). Women who have these fistulas leak urine and/or feces and are often ostracized by their families and communities (213, 477). For the infant, obstructed labor can lead to brain damage or death. When a girl marries young, as is often the case in regions where FGM is most common, FGM further aggravates the elevated risk of obstructed labor inherent in childbirth before a young girl has matured physically.

The psychological and psychosexual consequences of FGM have not been well studied. Clearly, the agony endured during the operation must remain with many women for years, if not a lifetime. Pain during intercourse is common. Especially with severe forms of the procedure, the woman sometimes has to be cut open to allow penetration (27, 148, 296). There are reports of problems with potency among some men who fear that they cannot penetrate the woman, and initial penetration can take as long as two to three months of repeated attempts (276, 296, 547).

Why Is FGM Still Practiced?

The purpose and importance of FGM varies from community to community and, very often, from family to family. Proponents contend that FGM is justified as part of socialization into womanhood or because it has religious significance (especially among Muslims), curbs female sexual desires, or has aesthetic, purifying, or hygienic benefits (20, 213, 452, 477). There is no doctrinal basis for FGM in either Islam or Christianity, however (29, 139, 477). FGM does reward its practitioners if they charge for services or receive social recognition and status (29, 148, 492).

One of the main factors behind the persistence of FGM is its social significance for females. In most regions where it is practiced, a woman achieves recognition mainly through marriage and childbirth, and many men refuse to marry a woman who has not undergone FGM. Therefore to be uncircumcised is to have no access to status or a voice in these communities. Thus, as a joint report of WHO and the International Federation of Gynecology and Obstetrics (FIGO) observes, the victims of the practice are often its strongest proponents (550).

Preventing FGM

Advocacy by women's groups has placed FGM on the agenda of governments as well as regional and international organizations. WHO, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the United...
States Agency for International Development (USAID), and FIGO, among others, have condemned the practice (492, 501, 533, 550). The 1994 International Conference on Population and Development (ICPD), held in Cairo, spotlighted the matter in the conference recommendations:

Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate the practice. (486)

Many heads of state including those of Benin, Burkina Faso, Egypt, Kenya, and Senegal have spoken out against the practice. There are specific laws against FGM in Belgium, Ghana, Sweden, and the United Kingdom (52, 138, 222). In France and Canada the operation is illegal under existing child abuse laws (168, 213, 214, 222). The governments of Sudan and Djibouti have laws that allow clitoridectomies but not infibulation. There is some type of regulation against FGM in Burkina Faso, Kenya, Uganda, and possibly other African countries (138). Legal options are under review in Australia and the US (213, 222, 332). In Eritrea recent civil reforms have banned FGM and early marriage (139).

Because FGM is so entrenched in some societies, legal decrees and policy statements alone are unlikely to abolish it. For example, resolutions against the practice were signed in Egypt in 1959 and a law was passed by the British colonial government in Sudan in 1946, and yet the practice persists (284). Changes in social norms are necessary for long-lasting results.

Grassroots community education and advocacy groups have taken the lead in ongoing reform efforts. Although these groups often are small and staffed primarily by volunteers, they make up for these limitations by their commitment. The largest of them, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), received the 1995 United Nations Population Award in recognition of its work (494). There are national IAC committees in 25 African countries (213), and it is chiefly the efforts of this group that have led to adoption of the term “female genital mutilation.” The IAC has courageously championed anti-FGM work through regional conferences, educational efforts, advocacy, and research at the national, regional, and community levels all over Africa.

**Educating the public.** Education has been an important component of efforts to eradicate FGM. For example, in Burkina Faso the government's National Committee Against Excision has used broadcast media, video, film, and other educational materials to reach the public (213). In Kenya the largest women's organization, Mawandeo Ya Wanawake Organization (MYWO), is at the forefront of anti-FGM activities. With assistance from the Program for Appropriate Technology in Health (PATH) and Population Action International (PAI), MYWO has conducted research on FGM in various areas and is now mounting a public education campaign (331, 389). Similar anti-FGM activities have taken place in Mali (213), Tanzania, Sudan (139, 213), and Somalia (332). In Nigeria the local IAC affiliate spearheads anti-FGM work, training traditional birth attendants who in turn train their colleagues all over the country. The National Association of Nigerian Nurses and Midwives (NANNM) has mobilized its members to educate the public through plays, skits, and other live performances (173, 213, 400).

**Legislative change and advocacy.** Although laws alone will not end FGM, they demonstrate critical governmental commitment and can create an avenue for legal action. In Burkina Faso the national government campaign to eliminate FGM began in 1988 (213). In Tanzania the Gender Health Risks Project has conducted workshops for community and religious leaders (213). In Egypt a television documentary about the circumcision of a 10-year-old girl, broadcast during the ICPD after the president of Egypt had denied that FGM existed in Egypt, led to re-examination of its legality. Governmental commitment to eliminate the procedure was restrained by a fatwa issued by the Grand Sheikh of Cairo, declaring FGM a duty for all women. In search of a compromise, the Ministry of Health reversed its 35-year ban on FGM in government hospitals and established special days when health care providers could perform the procedure. Providers were instructed to counsel parents and try to talk them out of the procedure (150, 171, 576). Human rights groups and women's organizations objected to this policy, however, and in late 1995 the Ministry of Health re-imposed the ban. FGM remains legal in Egypt, nevertheless, and private practitioners can still perform the pro-
In Nigeria NANNM, with assistance from PATH, works to keep the attention of the news media focused on the issue (173, 213, 400). In Sudan the Babikir-Badri Association for Women's Studies and the local IAC affiliate lead advocacy efforts (139, 213, 412).

**Working with health care providers.** In Egypt anti-FGM initiatives are led by the Egyptian Task Force Against FGM and the Egyptian Society Against Practices Harmful to Woman and Child, which have programs in nursing schools, women's associations, health care facilities, and the mass media (213, 475). Similar activities have been undertaken in Sudan (139, 213).

**Alternatives to FGM.** Some groups are encouraging communities to find healthy alternatives to genital mutilation without giving up its social and ritual aspects. For example, in Kenya a MYWO project will provide a rite of passage for adolescent girls, including the celebration, gift-giving, and recognition that are key to traditional passage into womanhood, while omitting the actual operation (412). In Sierra Leone the Kenema Project worked with opinion leaders of the secret circumcision societies to educate them about the harmful effects of FGM and to encourage allowing adolescents to go through the ceremonies without the harmful operations. This project also encouraged young men to pledge that they would not insist on marrying only circumcised women and young women to pledge that they will not circumcise their daughters (173, 332). To reduce opposition from practitioners by giving them alternative employment, one project in Ghana trains circumcisers to become traditional birth attendants, while another in Ethiopia trains them in sandal-making and bread-baking (27).

**Working with immigrant and refugee communities.** Organizations in Western countries are dealing with FGM among recent immigrants. In London the government-funded Foundation for Women's Health, Research and Development and the London Black Women's Health Action Project and, in France, Groupe Femmes pour l'Abolition des Mutations Sexuelles (GAMS) and Commission pour l'Abolition des Mutations Sexuelles (CAMS) have put the issue of FGM on the agenda for national and international discussion. Along with public information and advocacy campaigns, they are active among migrant communities, providing information and counseling families (27, 138, 139). The UK has incorporated FGM prevention into its child protection laws, and this has been used successfully in the courts to protect some girls from genital mutilation (52). There is no special law against FGM in France, but CAMS has successfully used existing sections of the penal code on violence against children to prosecute circumcisers or parents who have submitted their girls to FGM (138, 168). In Canada a strong campaign supported by medical and health personnel is underway (214).

**Research.** Research is essential to understanding FGM and designing effective reforms. Recently, the Sudan and Yemen Demographic and Health Surveys have included FGM modules. Other countries including Central African Republic, Côte d'Ivoire, Egypt, Eritrea, Mali, and Tanzania are including questions on FGM in surveys (269). The IAC calls for research as part of any FGM intervention (223). Several US groups have studied FGM and supported efforts to eradicate it. Women's International Network (WIN), headed by Fran Hosken, was among the first and has published newsletters on FGM prevention activities since 1975 (213). The late Gordon Wallace of Population Action International Special Projects Fund supported many advocacy, research and FGM eradication programs at the country level. The New York-based Research Action Information Network for Bodily Integrity of Women (RAINBO) has recently undertaken a comprehensive review of FGM and gives technical assistance in FGM research (477, 478). As programs expand, it will be crucial to include formative research and impact evaluation and to conduct operations research to identify what determines programmatic success or failure so that further efforts can be made more effective.

The practice of FGM is complex. Its prevalence, severity, and social rationale vary widely. For this reason grassroots organizations lead the way in fighting FGM and need the support of governments as well as national and international organizations. Because FGM is often at the heart of a community's beliefs, the community first must acknowledge FGM as a detrimental and sometimes dangerous procedure before it will begin to change it. It is crucial, therefore, that members of the community be involved in designing and conducting any FGM eradication campaign.