Why take action against female genital mutilation (FGM)?

Dr Heli Bathija, 2012

(using materials from various presentations, including those of Elise Johansen and Charlotte Kuhlbrandt)

Training Course in Sexual and Reproductive Health Research
Geneva 2012

World Health Organization

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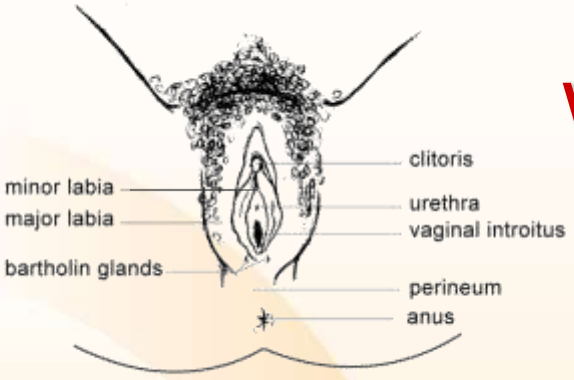
Key issues to be considered

- FGM prevalence and distribution
- Issues relating to medicalization of FGM
- Need for research
- Strategies and actions and collaborative efforts for elimination of FGM



WHO classification of FGM (2008)

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 by creating a covering seal through the cutting and apposition of the labia minora and/or labia majora, with or without excision of the clitoris (infibulation).

Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incision, cauterization and scraping.

Amended typology, with comments

Type I

Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)

Type Ia, removal of clitoral hood or prepuce only

Type Ib, removal of clitoris with prepuce

90%

Type II

Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)

Type IIa, removal of labia minora only

Type IIb, partial or total removal of clitoris and labia minora

Type IIc, partial or total removal of clitoris, labia minora and labia majora

Type III

10%

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 IIIa, removal and apposition of the labia minora; (most in west-African countries)

Type IIIb, removal and apposition of the labia majora. (most in Sudan, Somalia, Eritrea)

Re-infibulation falls under this type.

Type IV

Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.

No prevalence data

Each year 3 million girls are forced to undergo female genital mutilation

(Source: WHO,1997)

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Total estimates

Number of girls and women subjected to FGM in the African countries

Girls and women from 10 years of age and above:

91.5 million

Girls 10-14 years of age:

12.4 million

Girls at risk of FGM every year:

3 million

Country prevalence

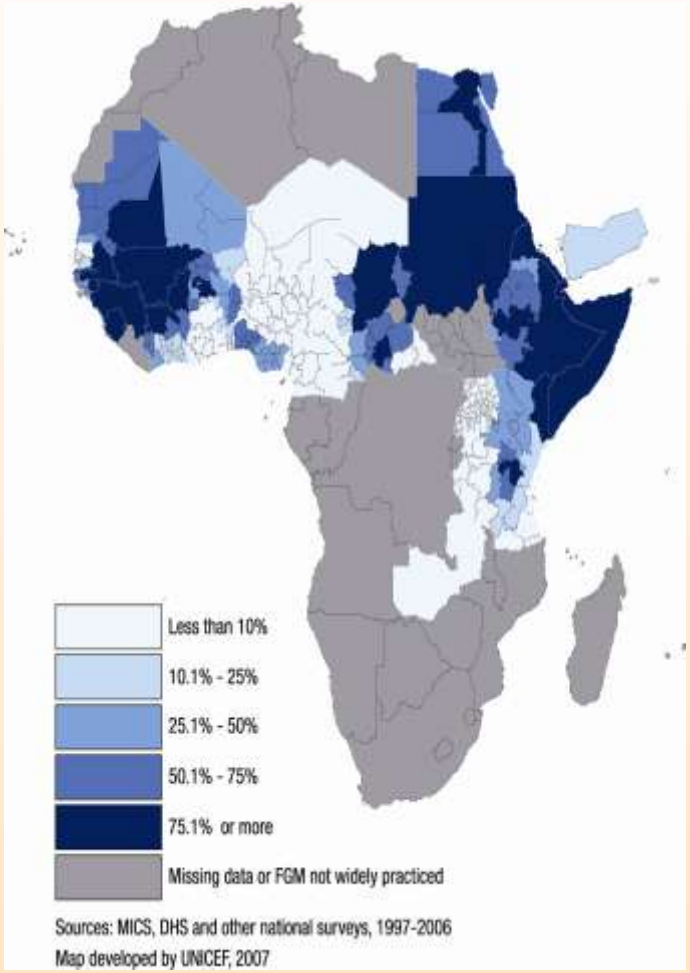
Somalia	98
Egypt	96
Guinea	96
Sierra Leone	94
Djibouti	93
Mali	92
Sudan	90
Eritrea	89
Gambia	78
Ethiopia	74
Burkina Faso	73
Mauritania	72
Liberia	58
Chad	45
Guinea-Bissau	45
Côte d'Ivoire	36
Kenya	32
Senegal	28

Yemen	23
Nigeria (19)	30
Tanzania	15
Benin	13
Togo	6
Ghana	4
Niger	2
Cameroon	1
Uganda	1
Zambia	1

Outside Africa

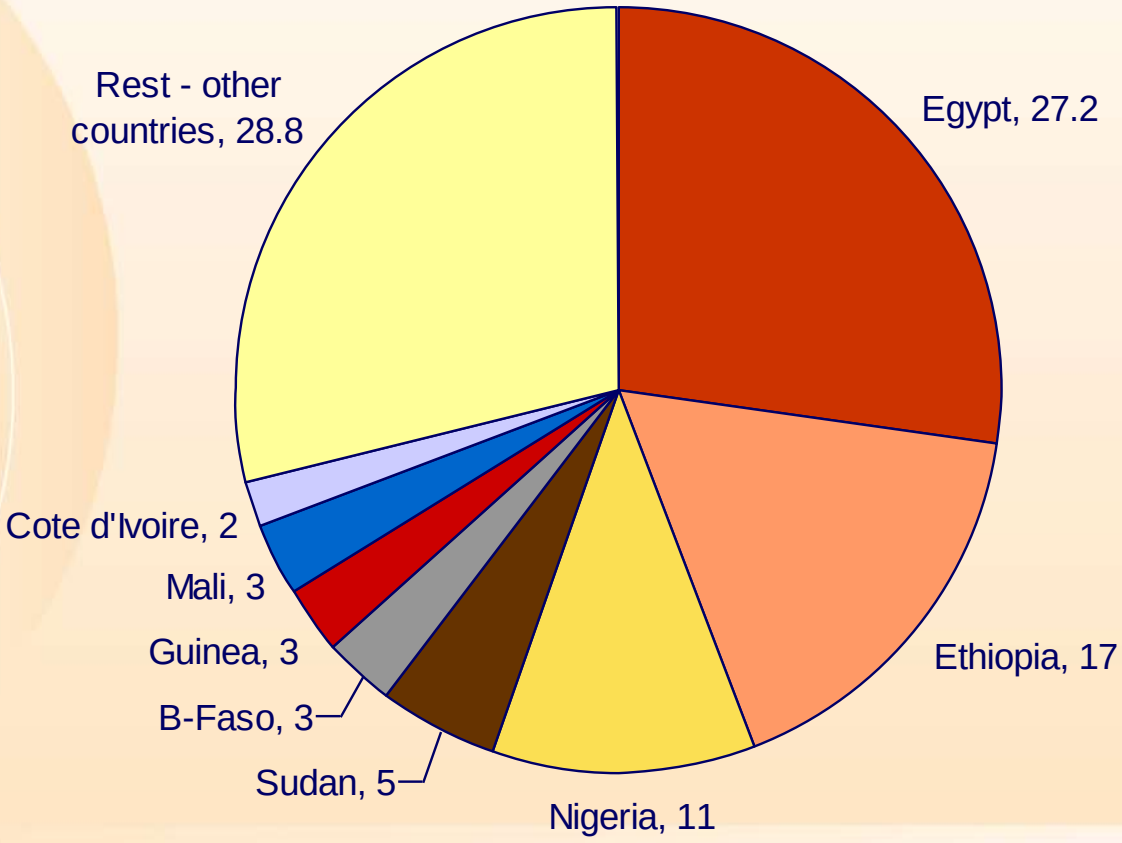
Indonesia
India
Sri Lanka
Iraq
Latin-America

Immigrants from these areas



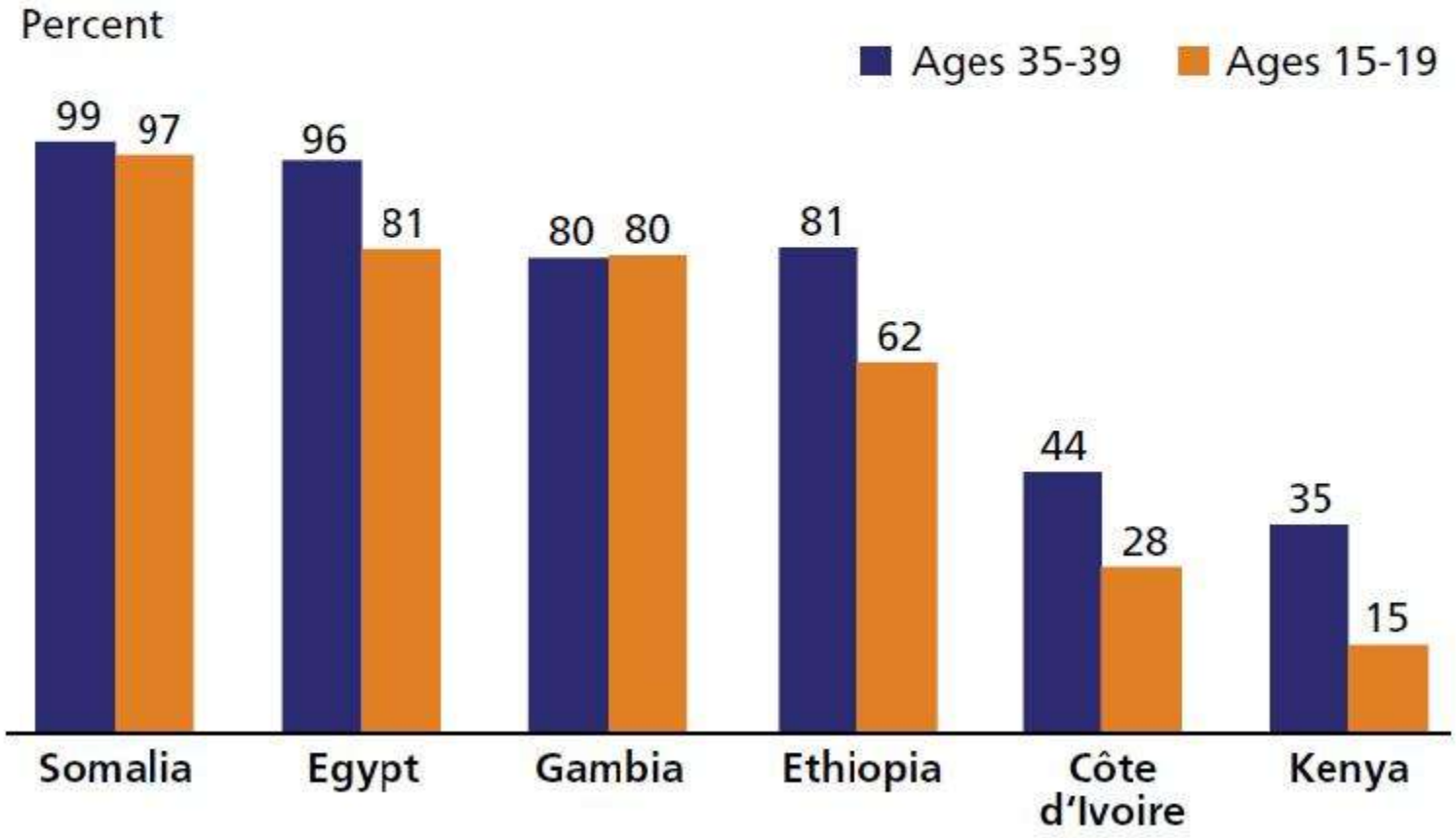
Where girls and women with FGM live

% of the 91.5 million girls and women with FGM



Prevalence of FGM/C Among Younger and Older Women

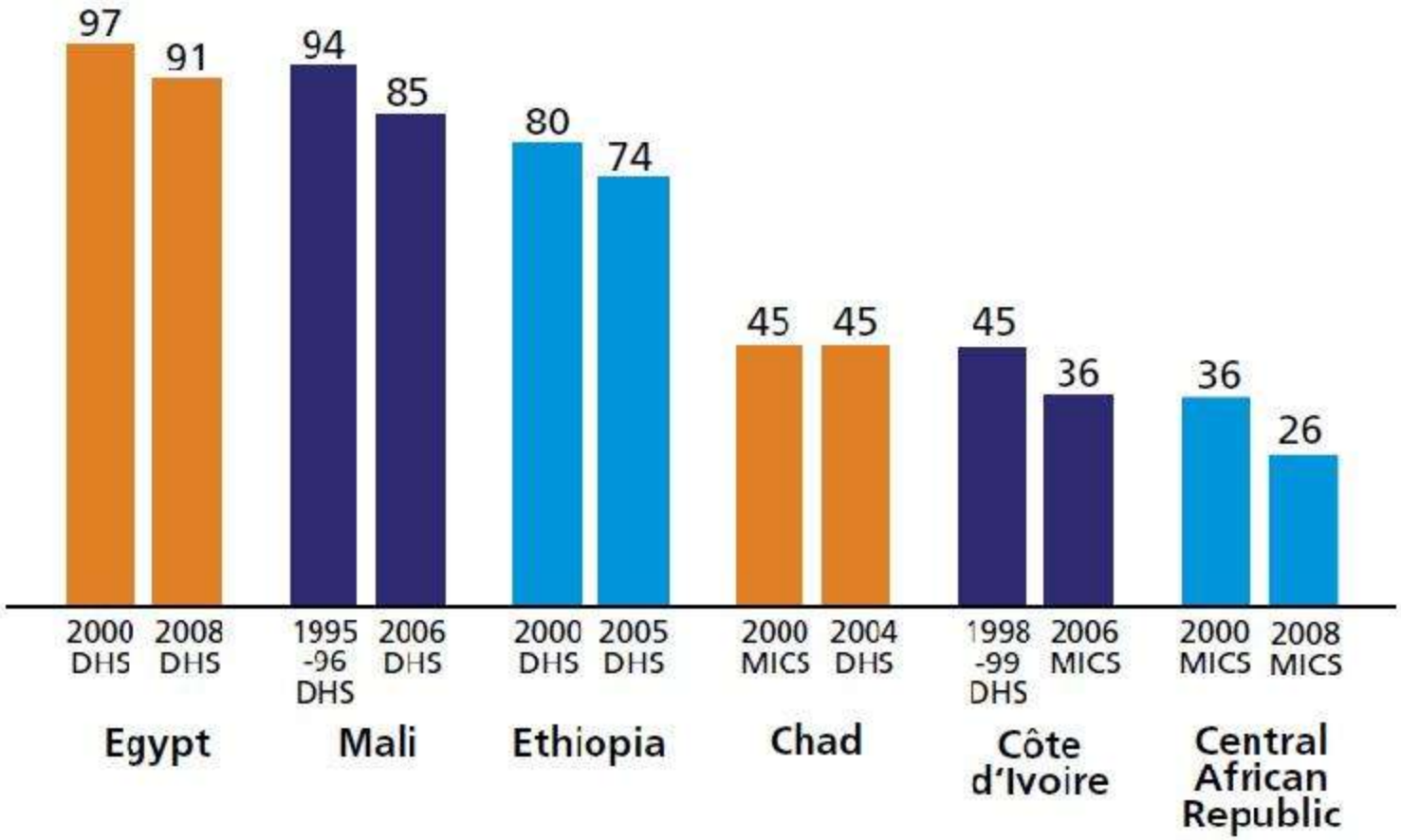
While in some countries there is little difference in prevalence between older women (ages 35 to 39) and younger women (ages 15 to 19), in others—such as Ethiopia, Côte d'Ivoire, and Kenya—the difference is significant. This may be a sign that the practice is being abandoned.



Trends in FGM/C Prevalence

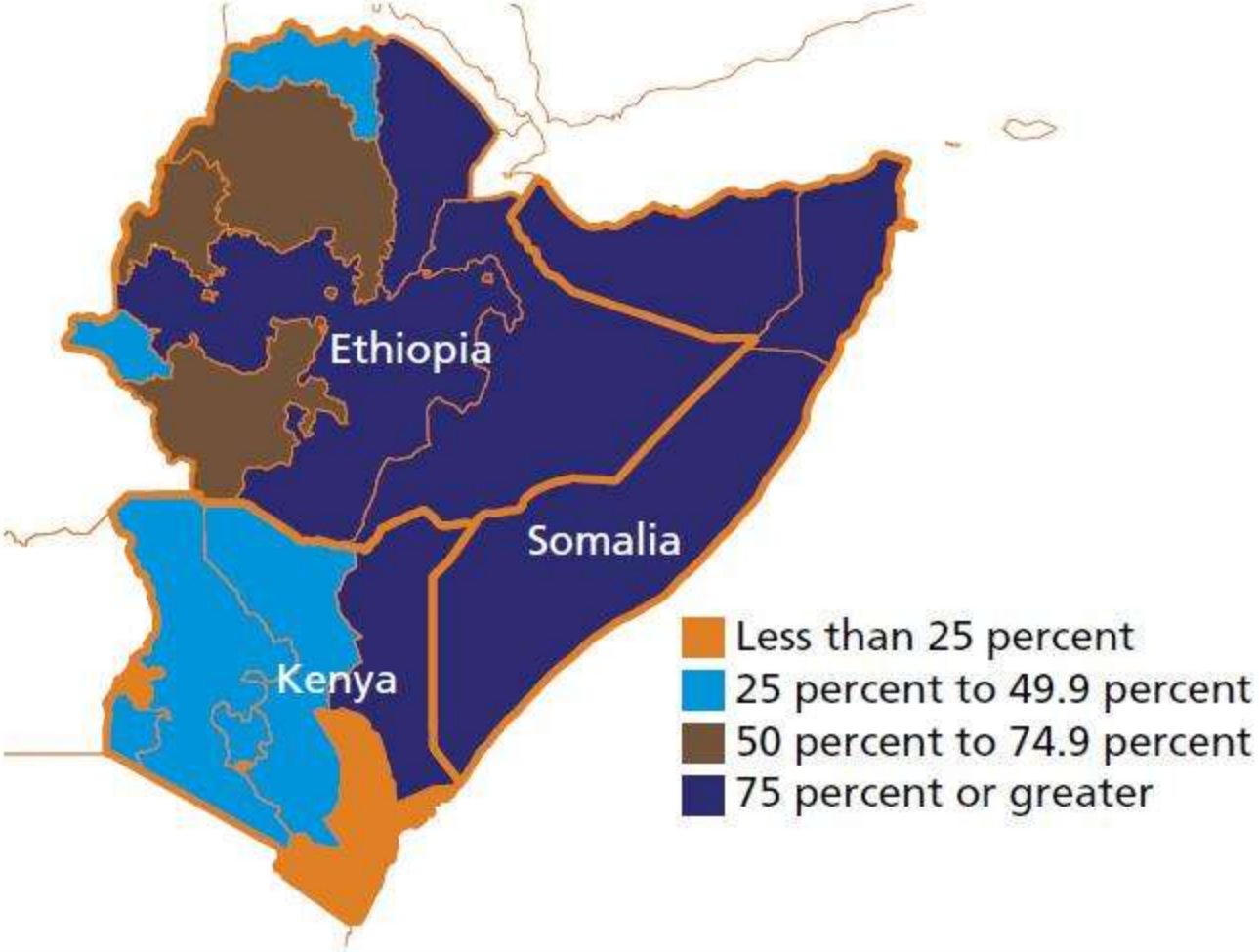
Over the last decade, a downward trend in percent of women cut in some countries indicates that abandonment of FGM/C seems to be taking hold, although in others there still is little or no apparent change.

Percent of women ages 15–49, by survey year



Variations Within and Across Borders

Looking only at national prevalence rates can hide the regional variations within a country. FGM/C often reflects ethnicity or social interactions of communities across national borders.



Short-term complications of FGM

- Occur during the operation itself and the healing period.
- Severe pain is the most common immediate consequence of all forms of FGM.
- The degree of pain and trauma is such that a woman or girl is often left in a state of medical shock after the operation.

Short-term complications of FGM (continued)

- Urine retention:
  - Especially in the case of FGM Type III when skin is stitched over the urethra.
  - Also in the case of other types due to pain, tissue swelling and inflammation.
- In extreme cases: death due to severe and uncontrolled bleeding or to infection.
- All these risks are repeated in cases where women have to go through re-infibulation.

Short-term complications of FGM (continued)

Infection:

- Varies widely, including potentially fatal septicaemia and tetanus.
- Risk of infection is increased by traditional practices such as binding the legs of a girl after infibulation or applying traditional medicines to the wound.

Long term health complications, other than obstetric

- **Dermoid cysts and abscesses**. Chronic pelvic infections that cause chronic back and pelvic pain, and repeated urinary tract infections in both girls and adults.
- ***Psychological consequences:*** Documented effects include post-traumatic stress disorder, anxiety and depression.
- **Sexual consequences:** Documented effects include more frequent painful sex, reduced sexual satisfaction and reduced desire.

- **Additional risks after infibulation**
- **Repeated surgery:** Immediate and long-term for sexual intercourse and childbirth.
- **Urinary and menstrual problems**, particularly prior to defibulation at first marriage.
- **Painful sexual intercourse**: Due to tight introitus that is insufficient for intercourse.
- **Infertility**.

HYDRONEPHROSIS

Long-term complications associated with FGM

Infertility

- Infertility has been found to be more prevalent in women with Type III female genital mutilation.
- In a study in Sudan the anatomical extent of FGM was associated with primary infertility.

Investigating the link between FGM and HIV/AIDS

- FGM might be a risk factor in the transmission of HIV.
- Potential sources of HIV transmission:
  - haemorrhaging subsequent to the operation,
  - bleeding during sexual intercourse as a result of damage to the genital area,
  - anal intercourse where infibulation prevents or impedes vaginal intercourse.
- No conclusive research have been carried out so far.

Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries

*WHO study group on female genital mutilation and obstetric outcome**

Summary

Background Reliable evidence about the effect of female genital mutilation (FGM) on obstetric outcome is scarce. This study examines the effect of different types of FGM on obstetric outcome.

Methods 28 393 women attending for singleton delivery between November, 2001, and March, 2003, at 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan were examined before delivery to ascertain whether or not they had undergone FGM, and were classified according to the WHO system: FGM I, removal of the prepuce or clitoris, or both; FGM II, removal of clitoris and labia minora; and FGM III, removal of part or all of the external genitalia with stitching or narrowing of the vaginal opening. Prospective information on demographic, health, and reproductive factors was gathered. Participants and their infants were followed up until maternal discharge from hospital.

Findings Compared with women without FGM, the adjusted relative risks of certain obstetric complications were, in women with FGM I, II, and III, respectively: caesarean section 1·03 (95%CI 0·88–1·21), 1·29 (1·09–1·52), 1·31 (1·01–1·70); postpartum haemorrhage 1·03 (0·87–1·21), 1·21 (1·01–1·43), 1·69 (1·34–2·12); extended maternal hospital stay 1·15 (0·97–1·35), 1·51 (1·29–1·76), 1·98 (1·54–2·54); infant resuscitation 1·11 (0·95–1·28), 1·28 (1·10–1·49), 1·66 (1·31–2·10), stillbirth or early neonatal death 1·15 (0·94–1·41), 1·32 (1·08–1·62), 1·55 (1·12–2·16), and low birthweight 0·94 (0·82–1·07), 1·03 (0·89–1·18), 0·91 (0·74–1·11). Parity did not significantly affect these relative risks. FGM is estimated to lead to an extra one to two perinatal deaths per 100 deliveries.

Interpretation Women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. Risks seem to be greater with more extensive FGM.

Lancet 2006; 367: 1835–41

See Comment

*Group members listed at end of report

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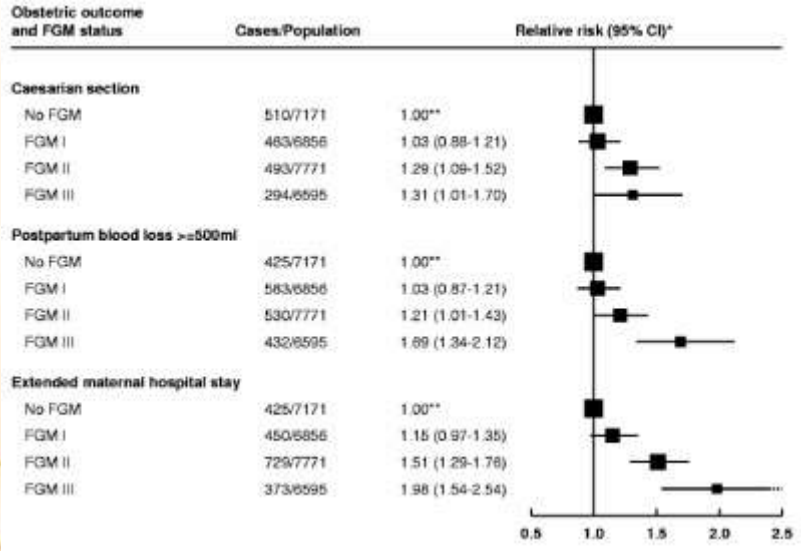
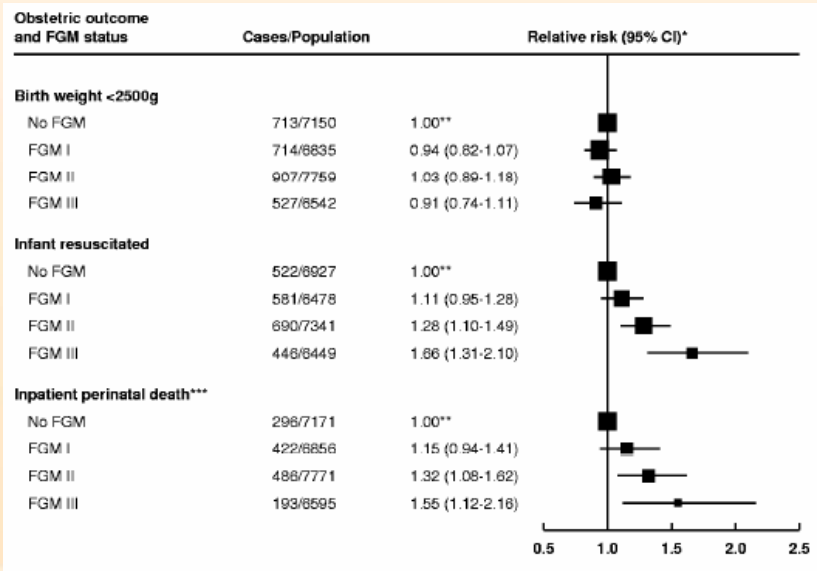
Women with FGM run greater risks during childbirth…



Obstetric outcome and FGM status	Cases/Population	Relative risk (95% CI)*
Caesarian section		
No FGM	510/7171	1.00**
FGM I	463/6856	1.03 (0.88-1.21)
FGM II	493/7771	1.29 (1.09-1.52)
FGM III	294/6595	1.31 (1.01-1.70)
Postpartum blood loss >=500ml		
No FGM	425/7171	1.00**
FGM I	583/6856	1.03 (0.87-1.21)
FGM II	530/7771	1.21 (1.01-1.43)
FGM III	432/6595	1.69 (1.34-2.12)
Extended maternal hospital stay		
No FGM	425/7171	1.00**
FGM I	450/6856	1.15 (0.97-1.35)
FGM II	729/7771	1.51 (1.29-1.78)
FGM III	373/6595	1.98 (1.54-2.54)

0.5 1.0 1.5 2.0 2.5

… and so do their babies



Obstetric outcome and FGM status	Cases/Population	Relative risk (95% CI)*
Birth weight <2500g		
No FGM	713/7150	1.00**
FGM I	714/6835	0.94 (0.82-1.07)
FGM II	907/7759	1.03 (0.89-1.18)
FGM III	527/6542	0.91 (0.74-1.11)
Infant resuscitated		
No FGM	522/6927	1.00**
FGM I	581/6478	1.11 (0.95-1.28)
FGM II	690/7341	1.28 (1.10-1.49)
FGM III	446/6449	1.66 (1.31-2.10)
Inpatient perinatal death***		
No FGM	296/7171	1.00**
FGM I	422/6856	1.15 (0.94-1.41)
FGM II	486/7771	1.32 (1.08-1.62)
FGM III	193/6595	1.55 (1.12-2.16)

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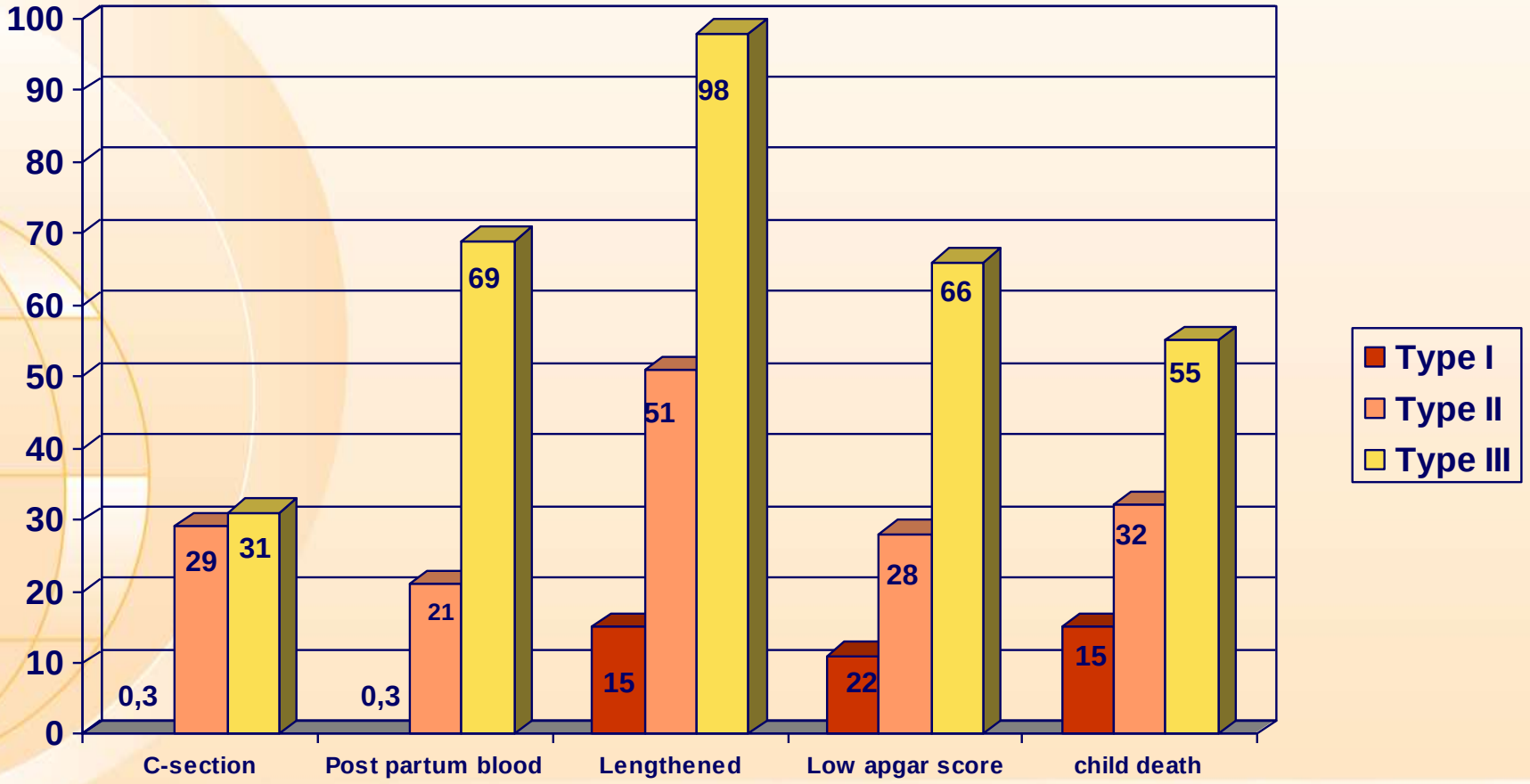
Increased risk of obstetric complications of women with, compared to women without FGM



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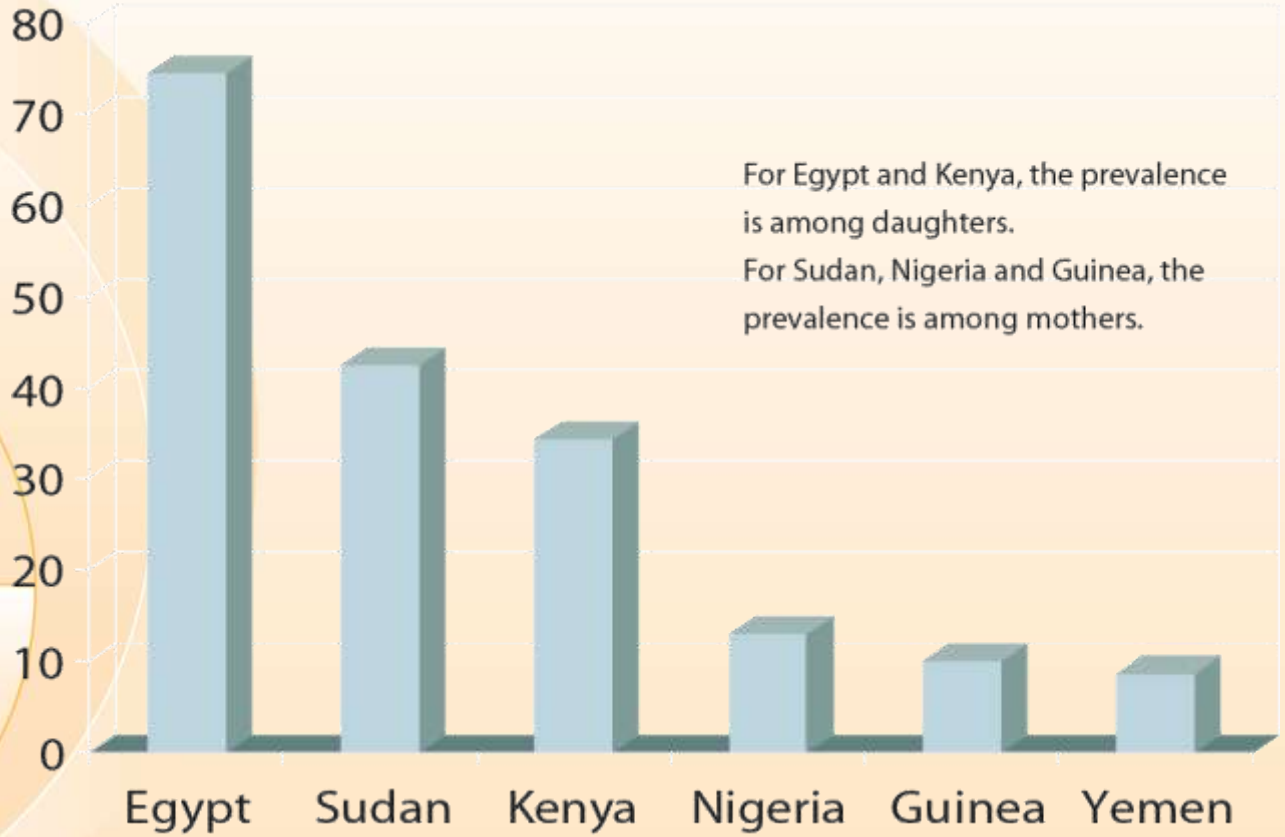
Proportion of FGM carried out by health professionals (Total +18%)



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Motivations of health care providers

- Part of the culture, share lay people's motivations
- Perception or legitimization as medical necessity
- See it as harmless, do not realise risk and human rights implications
- Harm reduction (reduce, replace or avoid unqualified performer)
- Financial gain
- Respect for "patients" socio-culturally motivated request

Most common "forms" of medicalized FGM, and common motivation

When health care providers

- **perform any type of FGM**
  - (part of culture, respect culture, financial gain, harm reduction)
- **perform what is perceived as "minor" or "modified" forms of FGM**
  - (harm reduction in extent and performance)
- **Reinfibulation**
  - ("respect" for socio-culturally demanded/expected request/expectation)

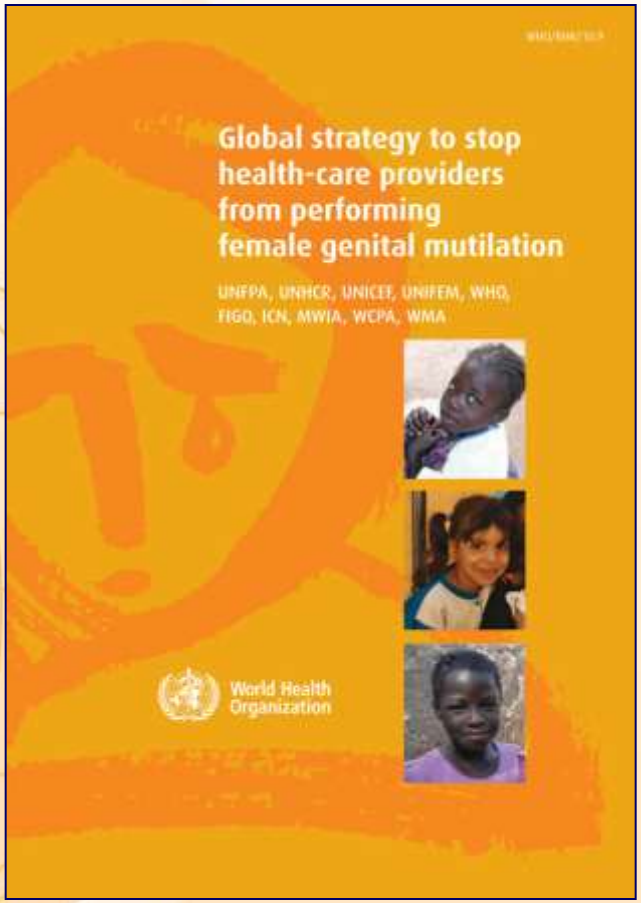
Why medicalization of FGM must be stopped

- Violation of human rights
- Gives legitimacy to the practice
- Contribute to institutionalisation of FGM and spread
- Health professionals can develop professional and financial interest in upholding the practice
- Overall: Undermines the overall efforts to eliminate FGM

Medicalized "modified" FGM

- **When health care providers perform what is perceived as "minor" or "modified" forms of FGM**
- **Motivated by belief in doing** harm reduction in extent and performance
- **Some of the challenges**
  - Can a "mild" FGM replace a more invasive FGM?
  - Does it fulfil the cultural requirement? (removal of clitoris to reduce desire and/or closure to physically hindrance to intercourse)
  - Any guarantee that procedure is "minor"? Who will control? Who will define?
  - Any guarantee that not seek more severe FGM later (repeated FGM documented to be rather common)

Global strategy to stop health care providers from performing female genital mutilation



Developed in collaboration with key stakeholders; UN organizations, international professional organizations, national governments and NGOs.

Target group: policy-makers in governments, parliamentarians, international agencies, professional associations, community leaders, religious leaders, NGOs and other institutions.

The adoption and implementation of this strategy is essential to secure the elimination of all forms of FGM.

Strategy against the medicalization of female genital mutilation/cutting

a) Mobilize political will and funding

b) Strengthen the understanding and knowledge of health care providers

c) Create supportive, legal and regulatory frameworks

d) Strengthen monitoring, evaluation and accountability

a) Mobilize political will and funding

- Build support for investment among key stakeholders and leaders
- Mobilize and coordinate efforts to support a national policy
- Advocate sustained and coordinated planning, budgeting and actions
- Advocate for public and private partnership in financing

b) Strengthen the understanding and knowledge of health-care providers

- **National guidelines in dealing with FGM, including care and how to resist pressure to perform, including reinfibulation**
- **Training modules for pre- and in-service training and refresher courses**
- **Training of health-care providers should be integrated at the community level with other community-based activities promoting the abandonment of FGM**

c) Create supportive legislative and regulatory frameworks

- **Information to health professionals**
- **National policy statements**
- **Train legal staff to deal with medicalization**
- **Professional organisations give clear standards and guidelines, backed by strict sanctions**
- **Performing FGM, including reinfibulation should give rise to legal and professional sanctions**
- **Women and girls supported to bring civil action, and health-care provides to assist by providing evidence**

d) Strengthen monitoring, evaluation and accountability

- Monitor training and implement lessons learned
- Mechanisms to increase accountability at facility and district levels
- Routine data collection on FGM
- Monitor providers of FGM, including legislative measures
- Report to UN human rights treaty bodies and other international and regional human rights bodies
- Institutionalize feedback mechanisms to the communities

CALL TO ACTION

All health-care providers take an oath of practice in line with the Hippocratic Oath and other relevant statements of ensuring no harm against any patient. Health-care providers should know and respect the health and human rights aspects of FGM and refrain from supporting or performing any form of the practice.

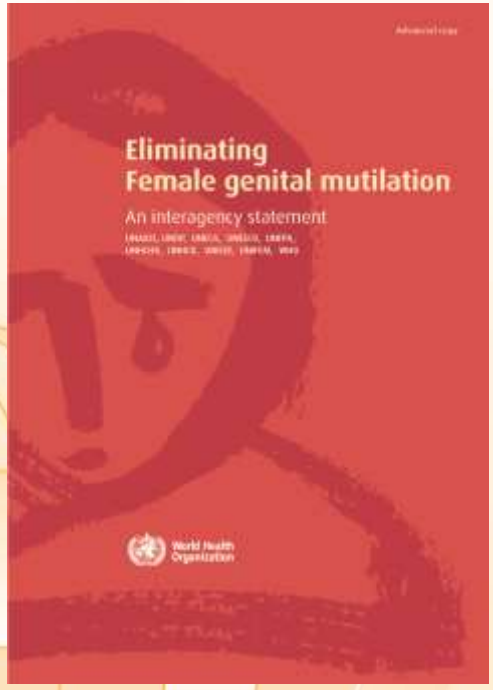
Governments must create a supportive legal and educational framework with corresponding national guidelines and policies that can guide the work of all categories of health-care providers, including reporting and monitoring routines and providing the necessary budget to discourage medicalization of FGM within the overall framework of total elimination of the practice. They should also ensure that health-care providers are given comprehensive training and acquire the necessary knowledge and competencies to provide care for girls and women suffering from complications caused by FGM and strengthen their capacity to act as advocates for abandonment of the practice.

Health professionals should 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

Interagency Statement 2008



Many organizations of the United Nations family are stakeholders (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO)

Why an interagency statement?

In spite of positive signs in a number of regions, 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.

The Sixty First World Health Assembly, **May 2008, Resolution WHA61.16**

- concerned about emerging evidence of an increase in carrying out female genital mutilation by medical personnel in all regions where it is practised;
- emphasizing that concerted action is needed in sectors such as education, finance, justice and women's affairs as well as in the health sector, and that many different kinds of actor must be engaged, from governments and international agencies to nongovernmental organizations.

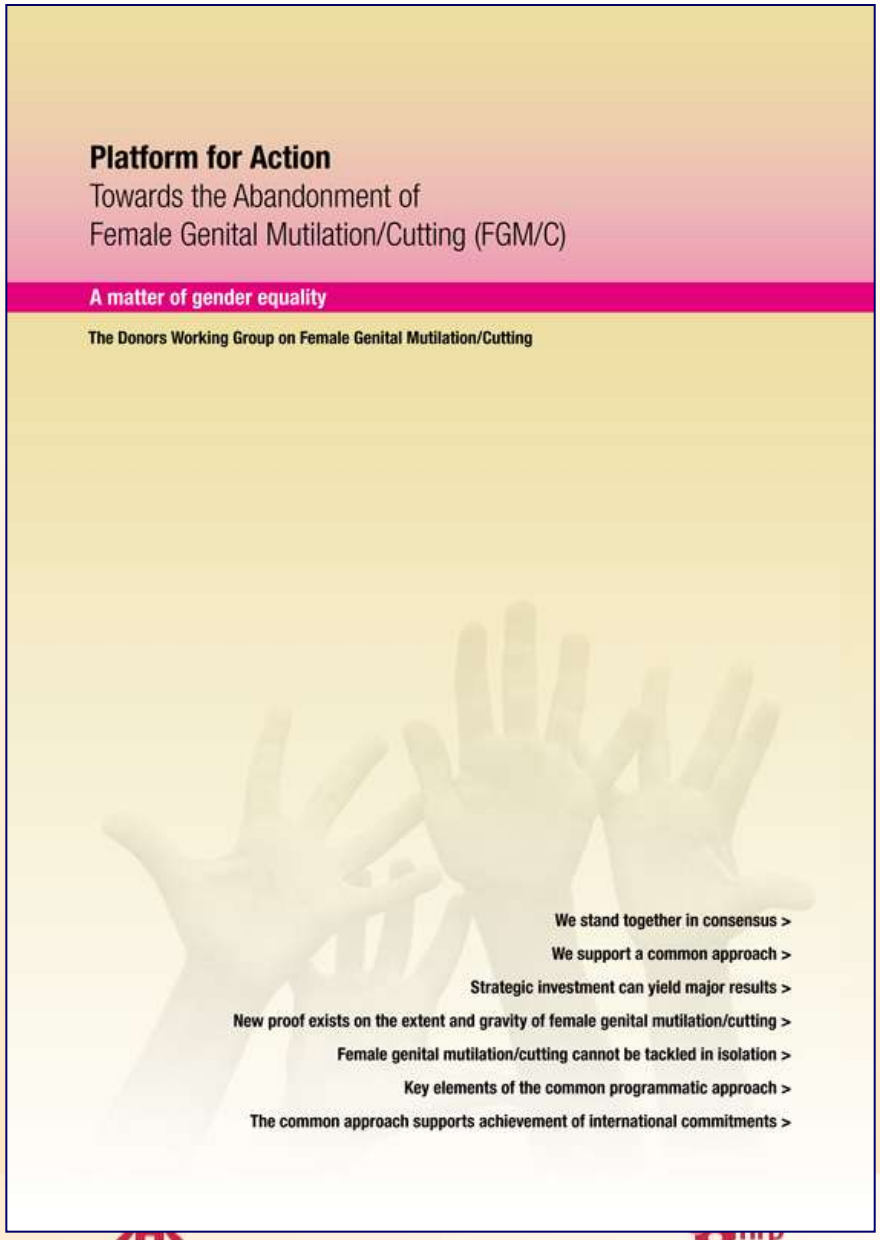
61st World Health Assembly, May 2008 , Resolution

- **Resolution WHA61.16**
  - ✓ **Urges all Member States to, among others, enact and enforce legislation, support and enhance community-based efforts, develop and promote guidelines for care of victims**
  - ✓ **Requests Director-General to, among others, assist Member States to implement action towards elimination, increase support to research, report regularly to Assembly, at least every three years (next time in 2011)**

Platform for action towards the abandonment of Female Genital Mutilation/Cutting (FGM/C)

The Donors Working Group on Female Genital Mutilation/Cutting

www.fgm-cdonor.org



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Platform for action towards the abandonment of Female Genital Mutilation/Cutting

Principal elements of the common programmatic approach

- District development activities are essential to achieve a positive social change
- A massive abandonment takes place after the decision not to perform FGM/C is publicly accepted
- A favorable national environment accelerates the changing process

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

- We stand together in consensus
- We support a common approach
- Strategic investment can yield major results
- New proof exists on the extent and gravity of female genital mutilation/cutting
- Female genital mutilation/cutting cannot be tackled in isolation
- Key elements of the common programmatic approach
- The common approach supports achievement of international commitments

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

We stand together in consensus

The Donors Working Group on FGM/C (DWG) has, since 2001, brought together key governmental and intergovernmental organizations and foundations committed to supporting the abandonment of FGM/C. Thanks to the sharing and systematic analysis of experiences, we have reached a consensus on a common programmatic approach to support the abandonment of the practice and make a major difference for girls and women worldwide.

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

We support a common approach

The common programmatic approach is the result of the in-depth analysis and evaluations of programme experiences supported by national governments and non-governmental organizations working on the ground. The analysis has been informed by social science theory and a human rights perspective and has highlighted what works and why it works. It has shown that a process of positive social transformation can occur when programmes and policies focus on enabling communities to make a coordinated, collective choice to abandon FGM/C.

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

Strategic investment can yield major results

UNICEF has estimated that community oriented programmes costing about US$24 million each year over the next 10 years can lead to major reductions in the prevalence of FGM/C in 16 sub-Saharan African countries with high or medium prevalence. The World Health Organization estimates that an additional US$4 million is needed over six years to support governments and other partners to generate the knowledge needed to set global standards for the care of women who have undergone FGM/C and to improve programme effectiveness.

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

New proof exists on the extent and gravity of female genital mutilation/cutting

With more and better data, we now estimate that 3 million girls on the African continent (Egypt, Sudan and sub-Saharan Africa) are subjected to the practice each year, 1 million more than previously estimated.
In addition, FGM/C has recently been found to be more prevalent than formerly believed in some countries in Asia and the Middle East.
2006 World Health Organization study provided clear evidence that complications during delivery are significantly more likely to occur among women with FGM/C. The study also found that FGM/C is harmful to babies, leading to an extra 1 to 2 perinatal deaths per 100 deliveries.

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

Female genital mutilation/cutting cannot be tackled in isolation

Mothers and other family members organize the cutting of their daughters even though they may be aware that it can bring physical and psychological harm to the girls. They consider it part of what they must do to raise a girl properly and prepare her for adulthood and marriage. From their perspective, not conforming to this obligation would bring greater harm, and would result in shame and social exclusion. This type of behaviour is in line with what social scientists refer to as a self-enforcing social convention. Changing this type of social convention requires that a significant number of families within a community make a collective and coordinated choice to abandon the practice so that no single girl or family is disadvantaged by the decision.

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

Key elements of the common programmatic approach

- Community empowerment activities are essential for positive social change
- Major abandonment occurs following a public pledge of the decision to abandon FGM/C
- A supportive environment at national level accelerates the process of change

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

The common approach supports achievement of international commitments

- Universal Declaration of Human Rights
- Convention on the Elimination of All Forms of Discrimination Against Women
- Convention on the Rights of the Child
- International Conference on Population and Development
- Fourth World Conference on Women
- 2002 United Nations General Assembly Special Session on Children.
- African Charter on the Rights and Welfare of the Child and the Protocol on the Rights of Women in Africa, also called the 'Maputo Protocol' and part of the African Charter on Human and Peoples' Rights. African states further commit to take all appropriate measures to eliminate harmful social and cultural practices.

Platform for Action Towards the Abandonment of Female Genital Mutilation/Cutting (FGM/C)

- Austria – Austrian Foreign Ministry
- Germany – Federal Ministry for Economic Development (BMZ), Gesellschaft für Technische Zusammenarbeit (GTZ), Kreditanstalt für Wiederaufbau (KfW)
- Ireland – Irish Aid
- Italy – Direzione Generale Cooperazione allo Sviluppo of the Ministry of Foreign Affairs
- Netherlands – Ministry of Foreign Affairs
- Norway – Ministry of Foreign Affairs, Norwegian Agency for Development Cooperation (NORAD)
- Sweden – Swedish International Development Cooperation Agency (SIDA)
- United Kingdom – Department for International Development (DFID)
- United States – United States Agency for International Development (USAID)
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- Office of the High Commissioner for Human Rights (OHCHR)
- United Nations Children's Fund (UNICEF)
- United Nations Development Fund for Women (UNIFEM)
- United Nations Development Programme (UNDP)
- United Nations Economic Commission for Africa (UNECA)
- United Nations Educational, Scientific and
- Cultural Organization (UNESCO)
- United Nations Population Fund (UNFPA)
- United Nations High Commissioner for Refugees (UNHCR)
- United Nations Volunteers (UNV)
- World Health Organization (WHO)
- International Organization for Migration (IOM)
- European Commission (EC)
- World Bank
- United Nations Foundation (UNF)
- Wallace Global Fund

Development of Training Tools: three short videos

- **Demonstration of a model technique for counselling a pregnant woman with FGM** and their partners/families on how FGM can affect their pregnancy, what specific interventions might be needed during childbirth, the process of defibulation and avoidance of re-infibulation and how to prevent submission of daughters to any kind of FGM.

- Videos contain important information as well as tips on how to present and tackle specific questions and concerns. Although they are primarily targeted at health-care providers, the videos can also be shown to any woman or man to raise and illustrate various themes related to FGM, pregnancy and childbirth and healthcare for women with FGM Type III, infibulation. The videos do not contain any offensive or disturbing words or images.

Estimating the Obstetrical Costs of Female Genital Mutilation (FGM) in Six African Countries

FGM Cost Study Group on behalf of WHO

World Health Organization

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Estimating the Economic Costs of Female Genital Mutilation

Conclusion

Beyond the immense psychological trauma it entails,

FGM imposes large financial costs and loss of life.

The cost of government efforts to prevent FGM will be offset by savings from preventing obstetric complications.

Continuing research into determinants and consequences of FGM and ways of eliminating the practice:

- how successful, community-based interventions can be replicated elsewhere,
- the elements in decision-making that contribute to continuation or abandonment of the practice,
- the role that perceptions of women's sexuality play in the continuation of the practice.

FGM and sexuality

- Sexual consequences of FGM for physical reasons
- Psychosexual consequences of FGM
- Sexuality as motivation for continuation of FGM
- Sexuality as motivation for abandoning FGM

Sexuality as motivation: WHO call for studies on FGM and women's sexuality

- 2006 WHO call for proposals to examine how desire for sexual morality, "proper" sexual behaviour, and femininity is associated with women's decision to practice or stop FGM.
- The reason for this call was the limited reduction in the prevalence of FGM, and the lack of success of many popular approaches.
- If sociocultural beliefs regarding the relationship between female sexuality and FGM is an important motivator for the continuation of FGM, more knowledge is needed on this aspect.
- The studies are supported by the European Commission.

Three WHO sponsored studies on FGM and sexuality as motivation, and outputs from other studies

- **Egypt**: Investigating women's sexuality in relation to FGM (slum area in Cairo, and Minya governorate).
- **Senegal** (1): The role of biological, sexual and reproductive determinants in the continuity of FGM among Al pulaar, Laobé and Diola women in Senegal.
- **Senegal** (2) Sociological determinants of FGM; Matrimonial strategies, familial incentives and religious justification among the Al pulaar and Soninke of the River valley in northern Senegal.
- **Burkina Faso** & **Sudan**: Data on sexuality from a study of community based interventions.
- **Senegal** & The **Gambia**: Data on sexuality from study of decision-making.

Sexuality is a motivations both for the continuation and the abandonment of FGM

Sexual motivations for the continuation of FGM

FGM is believed to reduce women's sexual drive, and thereby reduce the risk of non-legitimate sexual acts.

Sexual motivations for the abandonment of FGM

FGM is feared to reduce sexual pleasure in women, which again might affect the men and the marital relationship, hence it is feared to be destructive both pleasure and moral reasons (fear increased risk of divorce, and also extra-marital sex).

Female genital mutilation, is it motivated by sexual concerns?

- FGM is believe to promote sexual morality in women: FGM considered important to reduce women's sexual drive, which is again believed to reduce her vulnerability or willingness to premarital sexual activity, or promiscuity after marriage.
- There was considerable ambivalence between the perceived benefit of FGM for sexual control of women, and the feared negative outcome in expected reduction of women's sexual pleasure also within marriage, which again was feared to negatively affect male sexual pleasure as well as marital stability.
- Women's sexual pleasure was given less significance as an end in itself, but could be seen as important if it could increase the sexual pleasure of the man.
- Infibulation (Type IIIa – apposition of labia minora) was found to be more frequent in both Senegal and the Gambia, than suggested in the DHS studies.

Some findings from a qualitative study in Egypt

(PI: Mawaheb El-Mouelhy)

Women's views

- Most women do not link between FGM and sexual pleasure, but see sexual pleasure more as an outcome of the marital relationship.
- Women exposed to anti FGM campaigns are more likely to link FGM with sexual dissatisfaction
- Women do not consider their own sexual pleasure as a priority for a happy marital life. Economic security, health of children and lack of violence is more important.

Men's views

- Young men fearing that FGM may affect women's ability in sexual engagement
- However, men believe FGM ensures fidelity in women and men's control over the sexual relationship
- Men tend to rate sexual pleasure as a higher priority in marriage.

- **On FGM and virginity:** Most people do not draw a direct link between FGM and virginity, however, they think un-cut girls get more easily sexually aroused and therefore are more prone to loose their virginity .
- **Medical necessity**: It was believed by many, lay people as well as some health professionals, that FGM is a medical necessity for the majority of women. Again linked to views of aesthetics and the belief that if genital tissue protrude it can be stimulated through clothing or walking, hence stimulation sexual desire feared to lead women to engage in sexual activity.

Some findings from the studies in Senegal
(continuing)

- **Sexual pleasure**: Was generally not expected to be affected by FGM. Erotic products was widely used within marriages to enhance pleasure of the men (and women).

- **Infibulation Type IIIa** more usual than expected (Senegal river), purposeful result, not accidental scarring. Circumcisers tradition to open at wedding.

- **Division of labour** and exchange of information (religious doctrines), goods (erotica) and labour (FGM and defibulation) between different casts.

Sexual consequences of FGM

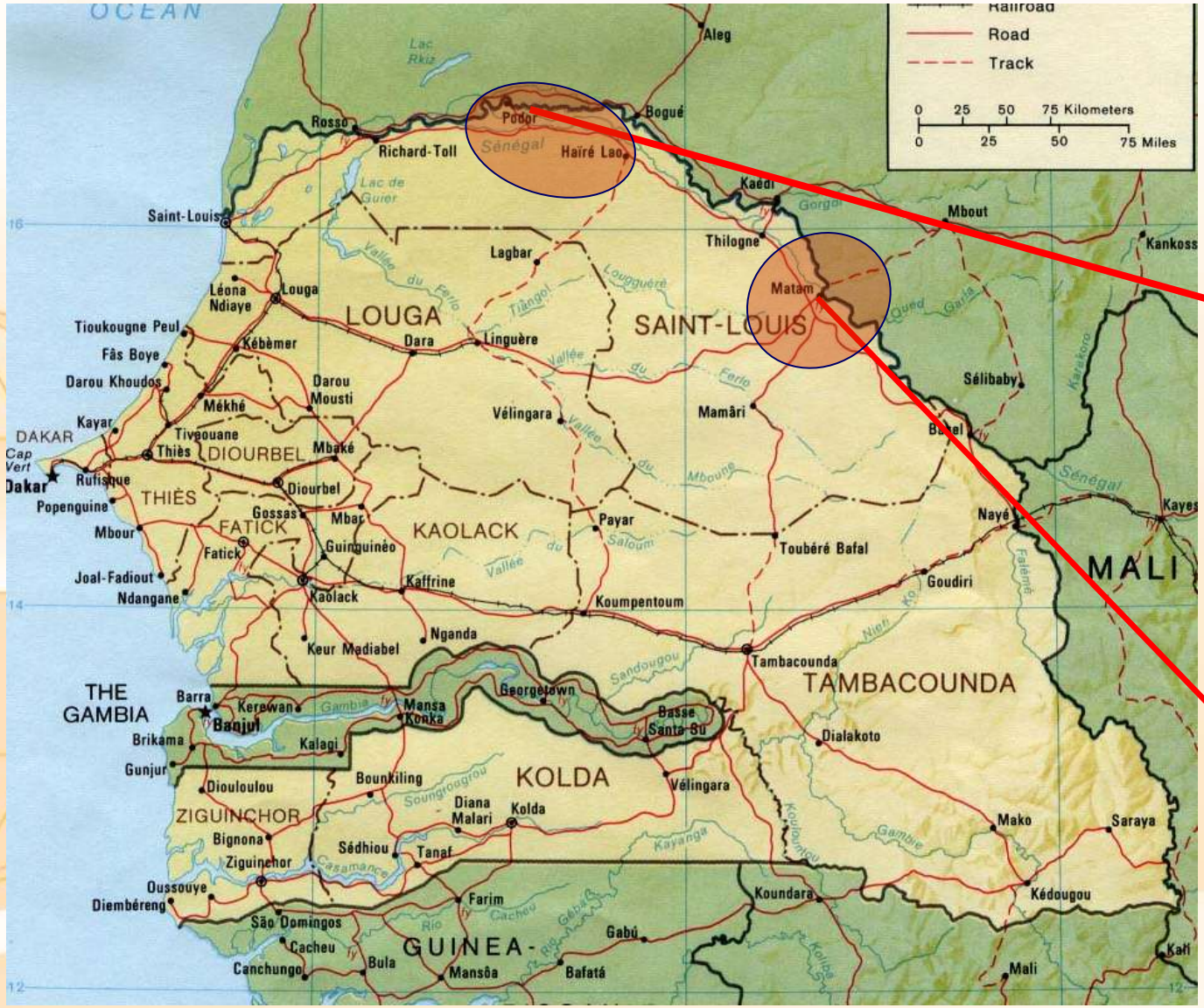
- Several studies has demonstrated that FGM does not reduce the number of sexual partners, frequency of STI, frequency of sexual intercourse. The only sexual outcome is a slightly younger age at sexual initiation among women with FGM, which may be related to other confounding socio-cultural factors (early marriage).

- Study results on women's sexual desire and pleasure varies significantly, but increased experiences of loss of libido, anorgasmia, reduced lubrication and dyspareunia have been documented.

Conclusions

- The results of these and other WHO funded studies on FGM indicate that since sexual concern is a key motivator for FGM in many, probably most, communities, these concerns must be taken into account when working against the practice.
- Sexual counselling should take the practice of FGM into account, both with regards to possible physical complications as well as psychosexual and relational problems.

Study No. I - Social determinants of FGM in Senegal



Al pulaar and Soninké

Al pulaar and Soninké

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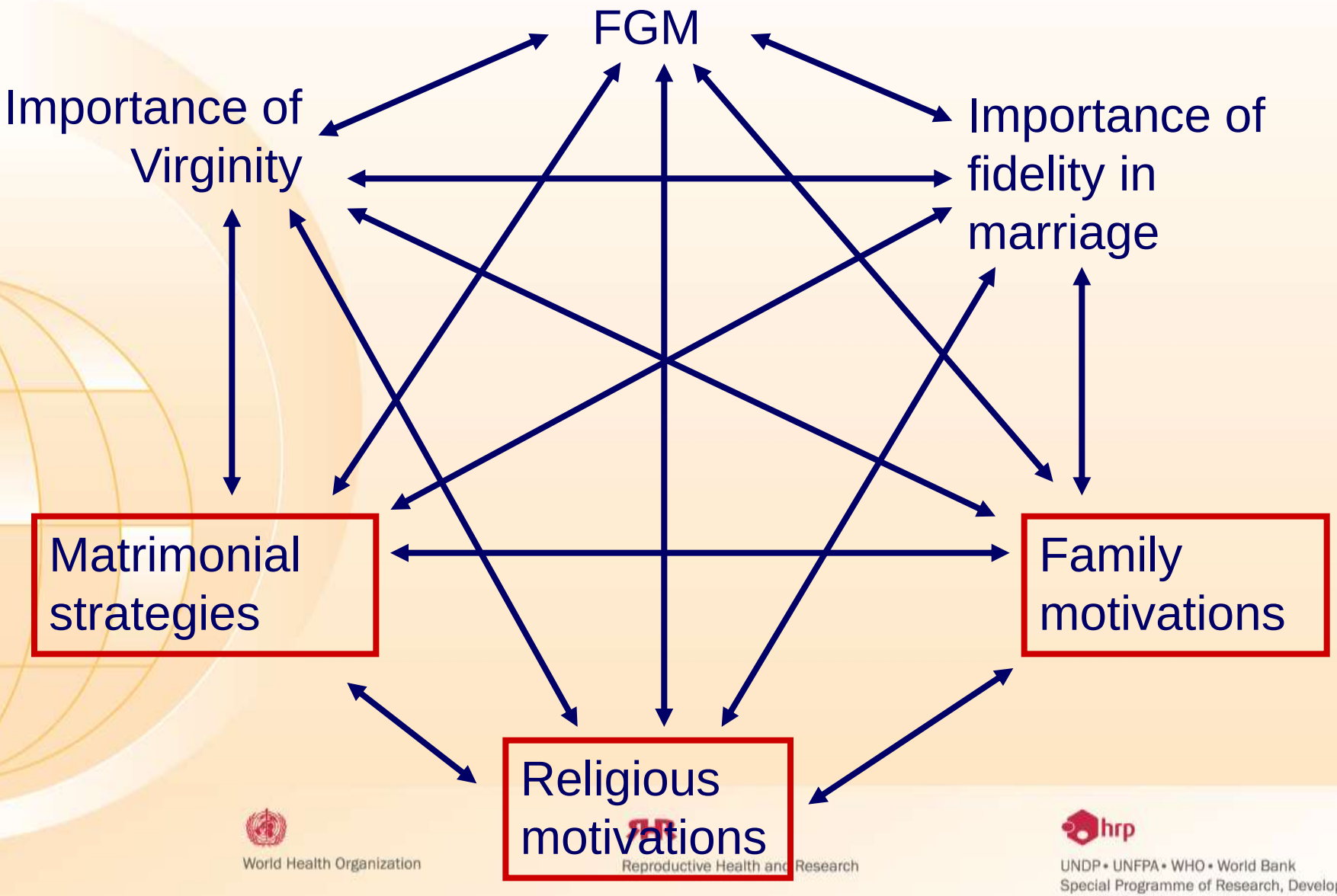
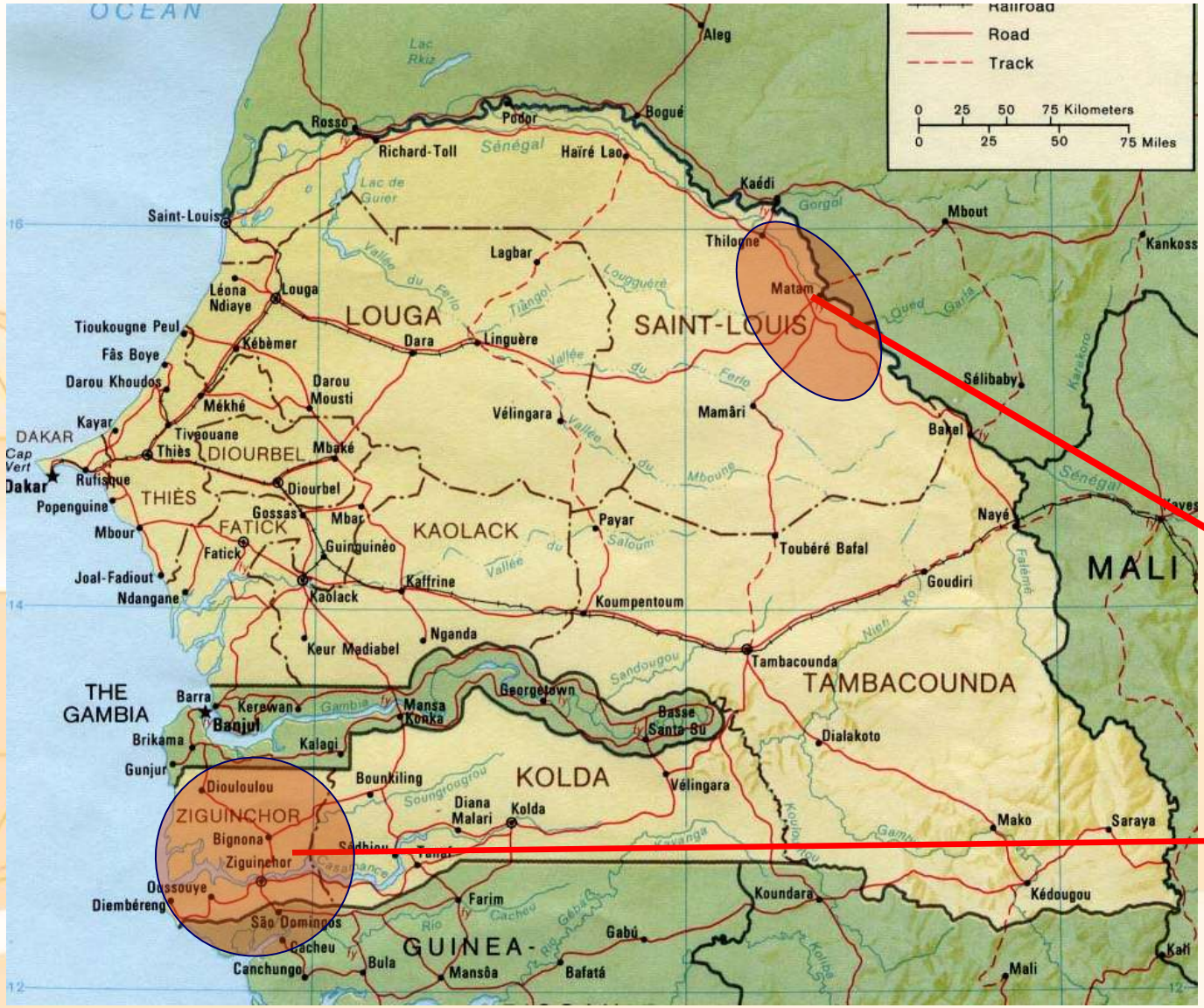
Social determinants of FGM



Study No. II - FGM and erotic products – perceptions of sexuality among three communities in Senegal



AL PULAAR Subgroups of Torrodo and Laobé

Community of Diola

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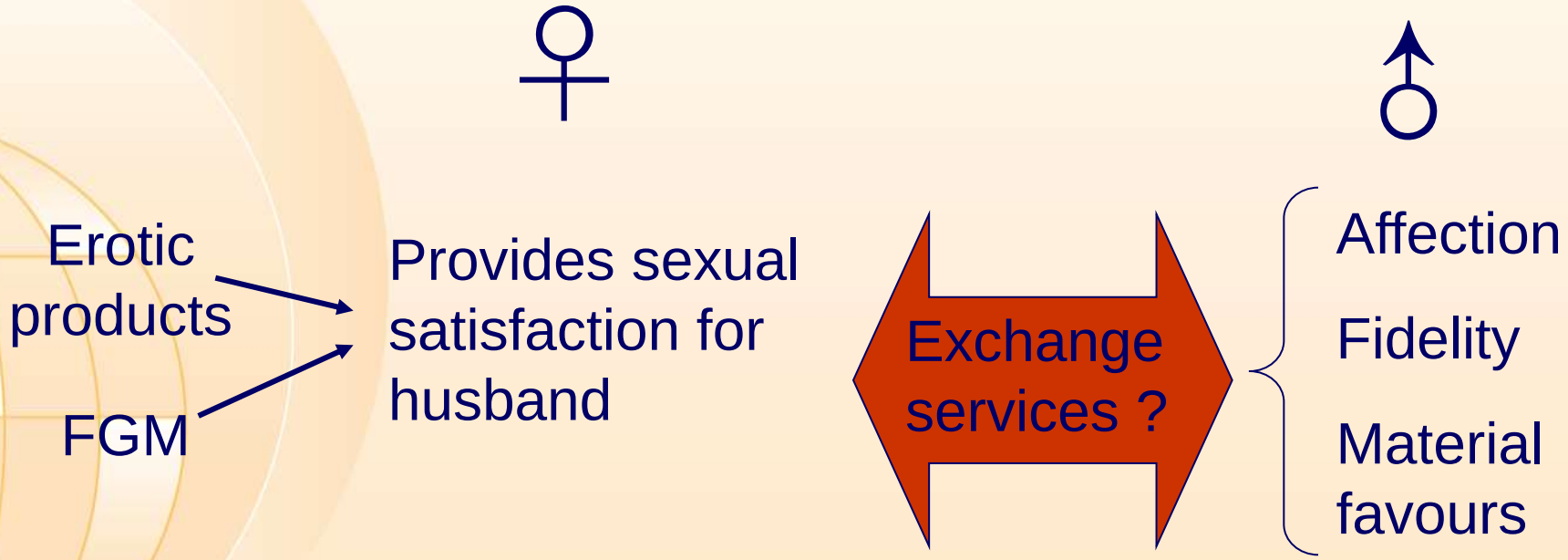
Aphrodisiacs

Chains of beads

Loincloths

Motivations for use of erotic products



Policy Implications from Study I and II

- Acknowledge complexities
- Acknowledge sexuality as a motivation
- Involve men in campaigns
- Focus on whole communities
- Discussions between religious leaders

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