

CAH Team



Female genital mutilation is a human rights violation: Let's stop it by 2030

Rationale

More than 200 million girls and women alive today have undergone female genital mutilation (FGM) in countries where the practice is concentrated. Female genital mutilation has no health benefits. It can lead to immediate health risks and long-term complications for women's physical, mental and sexual health and well-being. As part of the Sustainable Development Goals, the global community has set a target to end the practice of female genital mutilation by 2030. This fact sheet provides an overview of the status of female genital mutilation in the African Region.

Key messages

- For the period 2012–2020, about 35% of girls and women aged 15–49 years had undergone FGM in the African Region, including about 16.7% of girls aged 0–14 years.
- Over the period 2013–2021, approximately 72% of girls and women aged 15–49 years in the African Region reported their opposition to the continuation of FGM.
- In more than half of the countries in the African Region where information is available, more than 50% of the boys, girls, women and men surveyed (period 2013–2021) were opposed to the continuation of FGM.
- The top 10 affected countries (for girls and women aged 15–49 years) in the Region are Guinea (94.5%), Mali (88.6%), Sierra Leone (83%), Eritrea (83%), Burkina Faso (75.8%), Gambia (72.6%), Mauritania (66.6%), Ethiopia (65.2%), Guinea-Bissau (52.1%) and Côte d'Ivoire (36.7%).
- The most common risk factors for either undergoing FGM or forcing a girl to undergo the procedure are cultural, religious and social.
- Health-care providers should not perform any type of FGM in any setting – neither should they perform infibulation after delivery or in any other situation. They should provide care for girls and women suffering from complications associated with FGM, including special care during childbirth for women who have already undergone FGM.

1. Women and girls who have undergone female genital mutilation

FGM refers to “all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons” (WHO).

The practice of FGM is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending births. However, more than 18% of all FGM is performed by health care providers, and the trend towards medicalization is increasing. FGM is internationally recognized as a violation of the human rights of girls and women. It reflects deep-seated gender inequality and is an extreme form of discrimination against women. The practice also violates a person's right to health, safety and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life if the procedure results in death.

- Over the period 2012–2020, forty-nine per cent (23 out of 47) of countries in the African Region reported information on FGM.
- For the period 2012–2020, about 35 % of girls and women (aged 15–49 years) had undergone FGM in the Region (Figure 1).
- Guinea (94.5%), followed by Mali (88.6%) and Sierra Leone (83%) recorded the highest number of girls and women who had undergone FGM over the period 2012–2020.
- Uganda (0.3%), Cameroon (1.4%) and Niger (2.6%) had the lowest FGM prevalence among girls and women in the Region for the period 2012–2020.

Figure 1: Prevalence of female genital mutilation (%) among girls and women (15–49 years) in the African Region, 2012–2020 (Source: WHO)

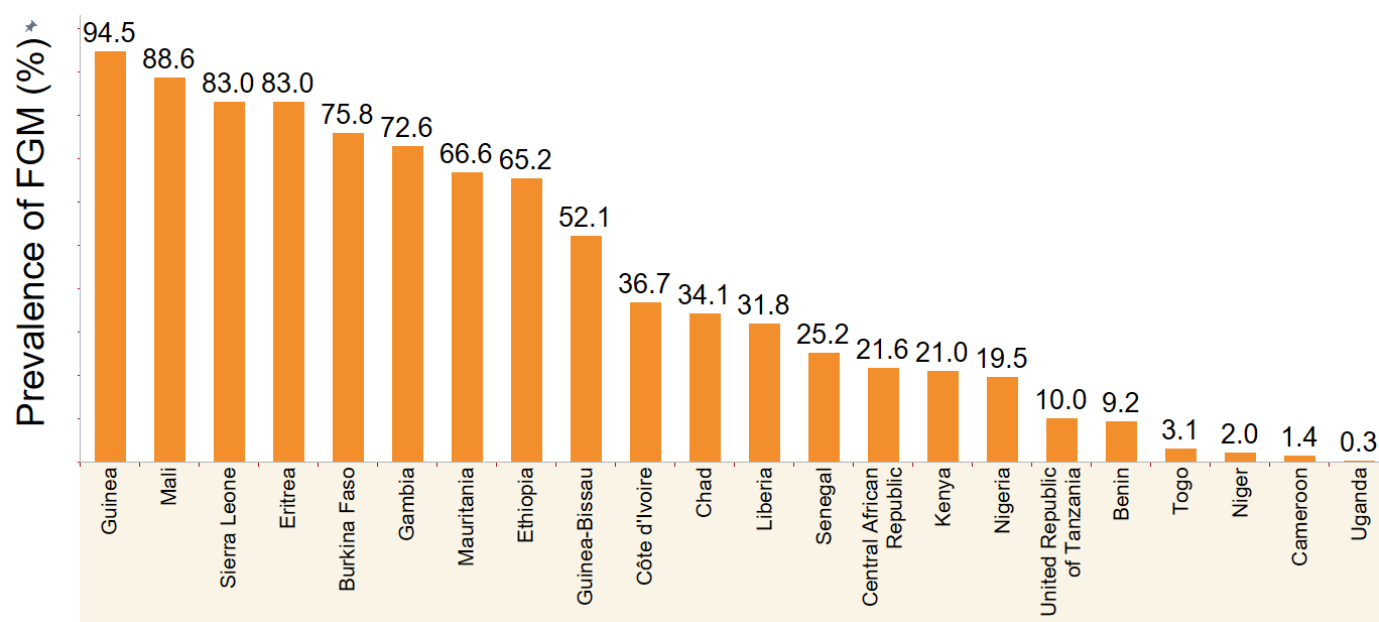


Figure 2: Prevalence of female genital mutilation (%) among girls (0–14 years) in the African Region, 2012–2020
(Source: WHO)

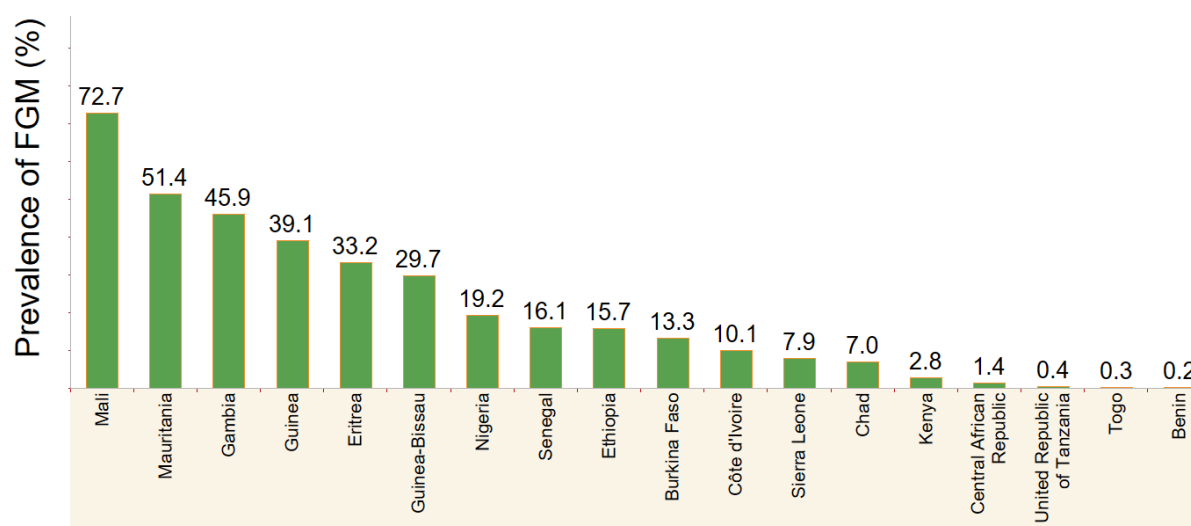
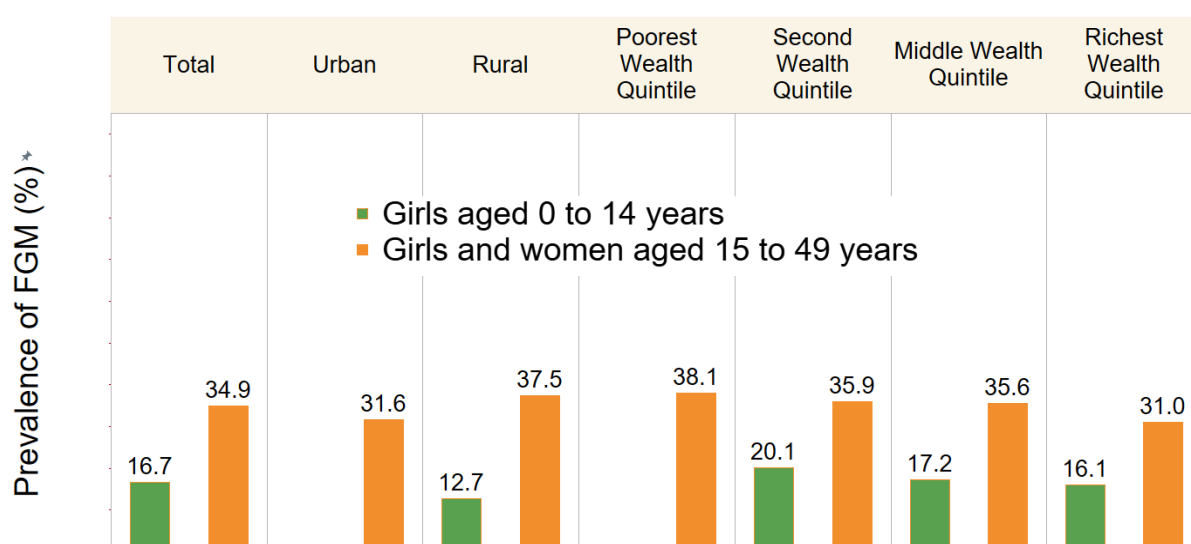


Figure 3: Prevalence of female genital mutilation (%) among girls (0–14 years) and women (15–49 years), by residence and household wealth quintile in the African Region, 2012–2020 (Source: WHO)



FGM has no health benefits and harms girls and women in many ways. It involves the removal and damage of healthy and normal female genital tissue and disrupts the natural functions of girls' and women's bodies. Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urinary retention, open sores in the genital area and damage to nearby genital tissue. Long-term effects can include recurrent bladder and urinary tract infections, cysts, infertility, increased risk of complications during childbirth and neonatal death, and the need for subsequent surgery.

- Over the period 2012–2020, about 16.7% of girls (aged 0–14 years) had undergone FGM in the Region (Figure 3).
- Mali (72.7%), followed by Mauritania (51.4%) and Gambia (45.9%) reported the highest number of girls who had undergone FGM in the period 2012–2020 (Figure 2).
- Benin (0.2%), Togo (0.3%) and United Republic of Tanzania (0.4%) had the lowest FGM prevalence among girls in the Region for the period 2012–2020 (Figure 2).

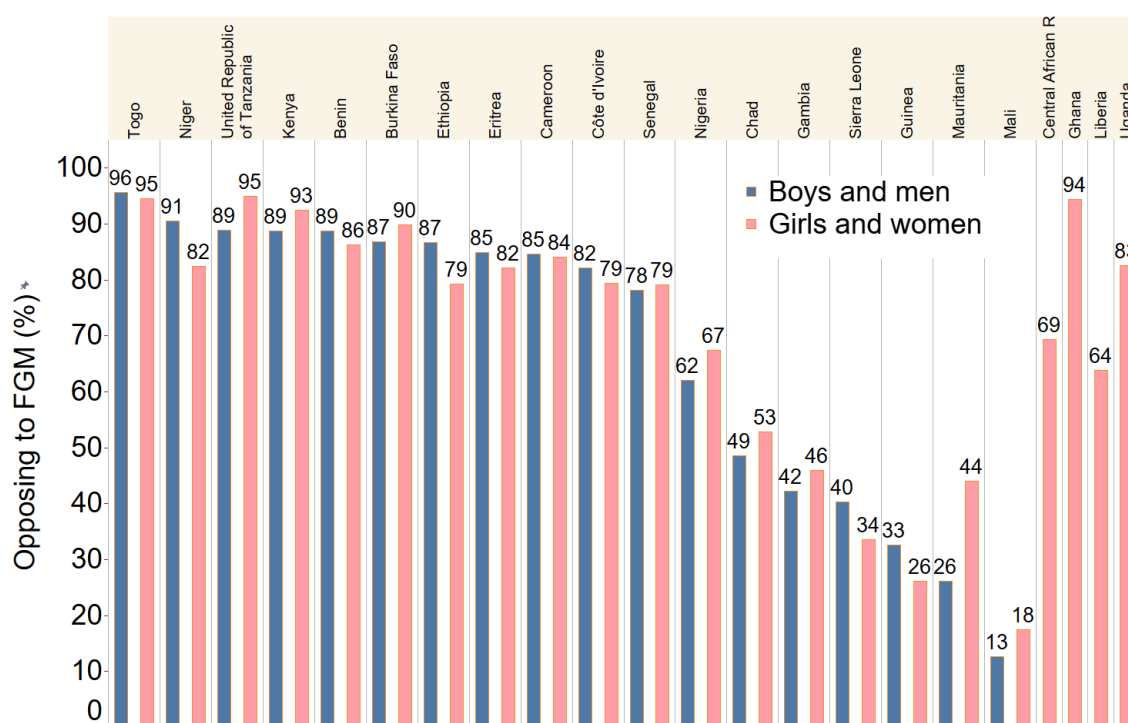
2. Perceptions of female genital mutilation by gender

The social dynamics driving female genital mutilation are inherently gendered, and the practice is driven by, and reinforces norms that devalue girls. However, despite its patriarchal origins, the practice is not perpetuated by men alone. In many countries, men are just as likely as women to oppose the practice. Yet the potential influence of men in eliminating FGM is far from being realized. Men can play a pivotal role, whether as community members shaping societal expectations, as future husbands identifying the qualities they value in a partner, or as fathers welcoming daughters into the world and making the crucial decision about whether the practice will continue into the next generation. Boys and men can and should use their influence to end FGM. Those who are personally opposed to FGM may continue the practice to conform to social expectations, including those for men. Indeed, one of the most cited reasons for continuing FGM is social acceptance.

- Over the period 2013–2021, approximately 72% of girls and women aged 15–49 years reported being opposed to the continuation of FGM in the African Region.
- Mali (18%), Mauritania (26%) and Sierra Leone (34%) were the countries where girls and women were less likely to oppose the continuation of FGM in the African Region between 2013 and 2021 (Figure 4).
- Mali (13%), Mauritania (26%) and Guinea (33%) were the countries where boys and men were less likely to oppose the continuation of FGM in the African Region between 2013 and 2021.
- In more than half of the countries in the African Region where information is available, more than 50% of the boys, girls, women and men surveyed opposed the continuation of FGM for the period 2013–2021.

3. Risk factors associated with female genital mutilation

Figure 4: Percentage of population (15–49 years) opposing the continuation of female genital mutilation (%) by gender in the African Region, 2013–2021 (Source: WHO)



The most common risk factors for either undergoing FGM or forcing a girl to undergo the procedure are cultural, religious and social.

These influences include:

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

4. Global strategy to stop health-care providers from performing FGM

Health-care providers should not perform any type of FGM in any setting – neither should they perform infibulation after delivery or in any other situation. They should provide care for girls and women suffering from complications associated with FGM, including special care during childbirth for women who have already undergone FGM.

Four overarching activities are recommended to stop health-care providers from performing FGM:

- mobilize political will and funding to ensure the development and sustained implementation of policies, guidelines, and laws;
- strengthen the understanding and knowledge of health-care providers;
- create a supportive legislative and regulatory framework;
- strengthen monitoring, evaluation and accountability for improving health-care providers' approaches to FGM and for refining plans to promote abandonment of the practice.

5. Actions to stop health-care providers from performing FGM

Mobilize political will and funding to support abandonment of FGM

- Build strong advocacy support for investment to support the abandonment of FGM, involving political leaders, other leaders, parliamentarians and government ministries.
- Mobilize and coordinate the efforts of key stakeholders to support a national policy against the medicalization of FGM. This includes parliamentarians, health-care providers, legal experts, human rights groups, government ministries, political leaders and parties, professional organizations, religious and community leaders, including leaders of migrant communities, and other persons of influence.
- Advocate for sustained and coordinated planning, budgeting and actions for key stakeholders.
- Advocate for the establishment of a sustainable, coordinated public and private financing partnership.

Strengthen the understanding and knowledge of health-care providers

- The relevant national authorities should develop national guidelines for various health-care providers on how to deal with issues related to FGM.
- Training modules should be developed on FGM for inclusion in pre- and in-service curricula and training, including refresher courses and updates for all health-care providers.
- Training of health-care providers should be integrated at the community level with other community-based activities promoting the abandonment of FGM.

Craft a supportive legislative and regulatory framework

- Health-care providers should be informed without delay about human rights and ethical perspectives as well as the harmful consequences of FGM, and that performing FGM, including infibulation, would give rise to civil and criminal liability.
- The Ministry of Health and professional regulatory bodies should issue a joint policy statement against the medicalization of FGM, and laws and policies and/or the application of existing laws and policies should address the role of health-care providers in the elimination of FGM and forbid the performance of any type of FGM, including infibulation.
- Training on how to deal with medicalization of FGM should also be provided to judicial staff as well as law enforcement and security personnel.

Strengthen monitoring, evaluation and accountability

- Monitor health-sector training and implement the lessons learnt.
- Develop mechanisms to increase accountability at facility and district levels.
- Routinely collect data on FGM (such as antenatal records).
- Monitor providers of FGM, including legislative measures taken against them.
- Institutionalize feedback mechanisms to communities.
- Integrate FGM, including infibulation, into existing monitoring and evaluation systems in countries.

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Sources

Data are from WHO: [The Global Health Observatory](#) and [Integrated African Health Observatory](#)

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