The following information is sensitive in nature and suited for mature readers only. Furthermore, this material should not be regarded as medical or legal advice.

Anterior
Clitoris
Labia minora
Urethra opening
Labia majora
Vagina
Posterior

A. Normal

A. Prepuce removal only or
B. Prepuce removal and partial or total removal of the clitoris

B. TYPE I

Removal of the clitoris plus part or all of the labia minora.

C. TYPE II

Removal of part or all of the labia minora, with the labia majora sewn together, covering the urethra and vagina and leaving a small hole for urine and menstrual fluid.

D. TYPE III

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Frequently Asked Questions:

Q: What is female genital cutting (FGC)?

A: Female genital cutting (FGC) is the collective name given to traditional practices that involve the partial or total cutting away of the female external genitalia or other injury to the female genitals, whether for cultural or other non-therapeutic reasons. Historically, it has been also called “female genital mutilation” or “female circumcision.”

Q: When is FGC carried out?

A: The age at which FGC is performed on women and girls varies. It may be performed during infancy, childhood, marriage or during a first pregnancy. FGC is typically performed on young girls who are between 4 and 12 years old, however, by a medically untrained person (often an older woman) from the local culture or community. Increasingly FGC is also performed by trained health personnel, including physicians, nurses and midwives.

Q: Where is FGC practiced?

A: FGC is practiced predominantly in 28 Countries in Africa. Eighteen African countries have prevalence rates of 50 percent or higher, but these estimates vary from country to country and within various ethnic groups. FGC also occurs in some Middle Eastern Countries—Egypt, the Republic of Yemen, Oman, Saudi Arabia and Israel—and is found in some Muslim groups in Indonesia, Malaysia, Pakistan and India. Some immigrants practice various forms of FGC in other parts of the world, including Australia, Canada, New Zealand, and the United States and in European nations.

Q: How many women and girls in the world have been affected by FGC in the United States?

A: It is estimated that 130 million girls and women have undergone FGC. Approximately 2 million are subjected to this practice each year worldwide. According to the Centers for Disease Control and Prevention (CDC), an estimated 168,000 women and girls in the United States had either

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undergone FGC or were at risk for FGC in 1990. Of these, 48,000 were girls younger than 18 years old.

Q: Why are other terms used for female genital cutting, such as female circumcision (FC) or female genital mutilation (FGM)?

A: FGC has traditionally been called "female circumcision," which implies that it is similar to male circumcision. The recognition of FGC's harmful physical, psychological and human rights consequences, however, has led to the use of the term "female genital mutilation" or "FGM," which distinguishes this practice from the much milder practice of male circumcision. Many women who have undergone FGC do not consider themselves to be mutilated and have become offended by the term "FGM." Recently, other terms such as "female genital cutting" (FGC) have increasingly been used.

Q: Where and when did FGC originate?

A: Practices involving the cutting of female genitals have been found throughout history in many cultures, but there is no definitive evidence documenting when or why this ritual began. Some theories suggest that FGC might have been practiced in ancient Egypt as a sign of distinction, while others hypothesize origins in ancient Greece, Rome, pre-Islamic Arabia and Tsarist Russia. Up until the mid-20th century, some physicians in the United States wrongly performed clitoridectomies for a variety of clinically unsound reasons.

Q: Who performs FGC?

A: FGC is usually carried out by traditional practitioners or lay persons who use a variety of instruments, which range from a scalpel to a piece of glass, to conduct the procedure. Harsh, unsterile conditions under which FGC occurs are not conducive to accurate, hygienic cutting. With the increasing awareness of the health consequences of FGC, health providers have erroneously utilized more hygienic techniques to conduct FGC

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and "improve" the practice. However, this medicalization of FGC has been condemned by the World Health Organization and is considered to perpetuate and promote FGC rather than to prevent or reduce its practice.

Q: What are the consequences of FGC?

A: The potential physical complications resulting from the procedure are numerous. Because FGC is often carried out without anesthesia, an immediate effect of the procedure is pain. Short-term complications, such as severe bleeding, which can lead to shock or death, are greatly affected by the type of FGC performed, the degree of struggle by the woman or girl, unsanitary operating conditions, and inexperienced practitioners or inadequate medical services once a complication occurs. There is a very high risk of infection, with documented reports of ulcers, scar tissue and cysts. Female genital cutting may also interfere with a woman's pregnancy or labor. Other lasting effects that commonly result from FGC procedures include urine retention, resulting in repeated urinary infections and obstruction in menstrual f low, which may lead to frequent reproductive tract infections, infertility, and chronic pelvic pain. FGC is also thought to facilitate the transmission of HIV through several mechanisms. Significant psychological and psychosexual consequences of FGC exist, but these factors have not been adequately studied.

Q: Why is FGC still practiced?

A: Female genital cutting is done for many complex, poorly understood reasons. In some cultures, the practice is based on love and the desire to protect because it is viewed as a culturally normal practice that has social significance for females. Some societies support FGC because they consider it a "good tradition" or a necessary rite of passage to womanhood. In many cultures that practice FGC, a woman achieves recognition and economic security through marriage and childbearing, and FGC is often a prerequisite for

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qualifying for wifehood. Therefore, FGC affords economic and social protection. Other rationale for FGC include belief that FGC enhances male sexuality; curbs female sexual desire; has aesthetic, purifying or hygienic benefits; and prevents promiscuity and preserves virginity and that the clitoris is an unhealthy, unattractive and/or lethal organ. Some argue that FGC has religious significance, but the custom cuts across religions and is practiced by Muslims, Christians, Jews and followers of indigenous religions. FGC is considered an important part of gender identity, which explains why many women and family members identify with and defend the practice. However, FGC is conducted in the broader context of gender discrimination. In cultures where FGC is practiced, men often control and perpetuate FGC by paying for their daughters to undergo the practice. They also may refuse to marry women who have not undergone FGC. These explanations for FGC do not justify its practice. Whatever the reason, the end result of FGC is that a female is subjected to an unnecessary, painful and health-compromising procedure.

Q: Why does FGC occur in the United States?

A: Because significant numbers of females continue to emigrate from countries where FGC is practiced, the population of females in the United States who have undergone FGC or who are at risk for FGC is increasing. Immigrants and refugees often establish social support systems and networks in the West that reflect the social and cultural diversity of their country or origin or ethnic group. Cultural activities and family obligations such as FGC may be unaltered by the geographic location of an individual. Furthermore, the problem of FGC in the United States is compounded by complex barriers that immigrants and refugees may face difficulties with cultural adaptation, immigration status, economic issues, isolation and access to education and healthcare services for populations who have undergone FGC or who are at risk for FGC. Under federal law,

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FGC is illegal in the United States for girls under the age of 18. But if FGC is still performed, it is unlikely that the girl would be brought to a health care facility for the treatment of complications because the fear of legal repercussions would be too strong.

Q: Why is female genital cutting considered to be a human rights violation?

A: FGC is deeply rooted in the traditions of a number of societies, but it is a form of violence against women and girls. In order for this practice to be understood, FGC must be placed within the broader context of discrimination against women across cultures and as a symptom of the greater problem of women's subordination and compromised dignity. The documented complications of FGC constitute a violation of a person's right to physical and mental health. Such fundamental freedoms are protected by several universal human rights instruments, including the Universal Declaration of Human Rights (UDHR).

Q: What laws against female genital cutting exist in the United States?

A: Since 1998, 16 states have instituted criminal sanctions against the practice of FGC: California, Colorado, Delaware, Illinois, Maryland, Minnesota, Missouri, Nevada, New York, North Dakota, Oregon, Rhode Island, Tennessee, Texas, West Virginia and Wisconsin. A federal law criminalizing the practice was passed in 1996 and became effective in April 1997. The law provides that the practice of FGC on a person(s) under the age of 18 is a federal crime, unless the procedure is necessary to protect the health of a young person or for medical purposes connected with labor or birth. The penalty for violating this law is a fine or imprisonment for up to five years, or both. This law specifically exempts cultural beliefs or practices as a defense for conducting FGC. In addition to criminalizing the practice, Congress passed three other legislative measures relating to FGC. In 1996, Congress directed the Secretary of the U.S. Department of

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Health and Human Services to carry out educational outreach to affected communities, develop and disseminate recommendations for students in medical and osteopathic schools, and undertake a study on FGC in the U.S. to determine the population who was at risk (statistics cited earlier). That same year, the second legal measure directed the Immigration and Naturalization Service (INS), in cooperation with the Department of State, to provide information to immigrants and refugees entering the United States from countries where FGC is practiced about the adverse health consequences associated with FGC and the legal consequences of performing the procedure in the United States. Finally, as part of fiscal year 1997, Congress enacted legislation requiring U.S. executive directors of international financial institutions to oppose non-humanitarian loans to countries where FGC is practiced and whose governments have not implemented educational programs to prevent the practice of FGC.

Q: What international efforts exist to stop FGC?

A: Within the past decade, the silence that has surrounded FGC has faded. FGC has become one of the most talked about subjects among women's groups, especially in Africa. International and professional organizations as well as many governments have recognized that FGC is a violation of the human rights of women and girls. Many communities, governments and organizations recognize that gender discrimination underlies the practice of FGC and that the most effective strategies for dealing with FGC involve helping women and girls to become educated and empowered within their own communities and cultures. In addition, these groups recognize that the support of men, community leaders and other cultures is vital to stopping the practice. Advocacy by women's groups has placed FGC on the agenda of governments and has contributed to the formation of FGC programs, laws and policies worldwide. The influx of immigrants

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and refugees from countries where FGC is prevalent has led global governments and organizations to examine and take action on FGC in host countries. For example, the U.S. Department of Health and Human Services has worked to fulfill Congress' mandate on GC by collecting and compiling FGC data, holding community meetings, and educating health professionals on FGC through the development and distribution of the technical manual called Caring for Women with Circumcision.

For more information . . .

National Women's Health Information Center
Internet Address: www.4woman.gov
Phone Number: (800) 994-WOMAN
(800) 994-9662 or contact one of the following organizations:

Amnesty International
Internet Address:
http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm

Center for Reproductive Rights
Internet Address: http://www.crlp.org/

The World Health Organization
Internet Address:
http://www.who.int/health_topics/female_genital_mutilation/en/

For legal information regarding FGC, contact: Center for Reproductive Law and Policy (CRLP), International Program
120 Wall Street
New York, New York 10005
Phone number: (212)-514-5534
Fax: (212)-514-5538
Internet Address: http://www.crlp.org

To obtain a list of published and unpublished literature on FGC, contact:
The Population Information Program of the Johns Hopkins Center for Communications Programs
The FGM Resource Group, POPLINE,
111 Market Place, Suite 310
Baltimore, MD 21202-4012
Website: http://www.jhuccp.org
Phone Number: (410) 659-6300
Fax: (410) 659-6266

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