February 2026

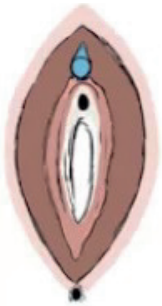
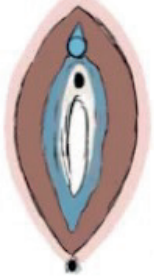
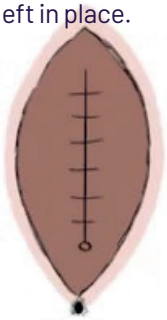
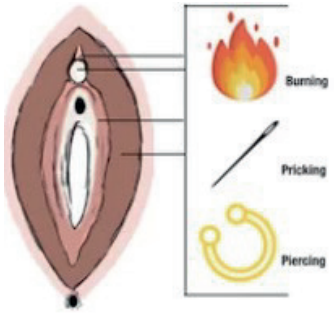
IMAP Statement on Preventing Female Genital Mutilation

Introduction

Female genital mutilation (FGM) refers to procedures involving partial or total removal of the external female genitalia or other injury for cultural or other non-medical reasons. It is a human rights violation, a form of child abuse and an extreme form of gender-based violence (GBV) which affects more than 230 million people globally **(1)**. FGM is practiced in more than 90 countries across Africa, Asia and the Middle East, with significant mortality and morbidity as a direct consequence. One study estimates 44,320 excess deaths per year due to FGM across countries where it is practised. Studies have shown that FGM is a leading cause of death of girls and young women in countries where it is practised **(2)**. FGM also occurs in diaspora communities, making it a truly global concern **(3,4)**.

Despite being a cultural practice in certain countries, FGM has no health benefits and can result in long-term and irreversible physical and mental health consequences. Its short-term complications may include severe pain, haemorrhage, shock, infection or death. The long-term consequences may include adverse neonatal and maternal outcomes during pregnancy and childbirth, chronic pelvic pain, urinary incontinence, menstrual irregularities, mental health disorders, and sexual dysfunction (5). The practice is illegal in over 80 countries, either through domestic legislation that specifically prohibits the practice of female genital mutilation within its borders, prohibits it to its expatriate citizens or allows it to be prosecuted through other laws **(6–8)**.

According to the WHO there are four types of FGM (9,10):

Type 1	Type 2	Type 3	Type 4
Partial or total removal of the clitoral glans or the external part of the clitoris. This is also called "clitoridectomy".	Partial or total removal of the clitoral glans or external part of the clitoris and the labia (the inner and outer "lips" that surround the vagina). This is also called "excision".	Partial or total removal of the clitoral glans and labia minora and sewing the labia together to make the vaginal opening smaller (infibulation). The clitoris may also be left in place.	All other harmful procedures to the female genitalia for nonmedical purposes, including pricking, piercing, cutting, scraping, and cauterization (burning).
 TYPE 1	 TYPE 2	 TYPE 3	 TYPE 4

Purpose of the statement and intended audience:

This statement was prepared by the International Medical Advisory Panel (IMAP) and approved in February 2026.

This statement provides guidance to Member Associations and Collaborative Partners across the Federation on delivering holistic programming to prevent, respond to and mitigate the impact of FGM. The statement provides an update on FGM prevalence and emerging issues including medicalisation, and specific considerations related to humanitarian settings, migration, and displacement. The statement synthesises the latest evidence on effective prevention strategies and survivor-centred service delivery models to guide IPPF affiliates response. Finally, the statement advocates for the elimination of all forms of FGM, including when performed by medically qualified health workers, and supports clinicians' adherence to human rights principles and professional ethical standards. It supports stakeholders working towards ending FGM, including health providers, policymakers, civil society organisations, and international organisations and funding agencies.

FGM is rooted in systems of gender inequality and social norms

FGM has been deeply rooted in some communities for thousands of years. At the core of the practice are social expectations that reinforce control and abuse of female bodies and include modesty, chastity, purity and obedience. The practice is often enforced by older women and rooted in patriarchal norms surrounding marriageability and honour, often accompanied by stigma and isolation for those who do not conform **(4,11,12)**. All international and many regional human rights instruments denounce the practice as a form of gender-based violence and a violation of human rights, including rights to bodily autonomy, health, and freedom from torture **(8)**.

IPPF's 2025 charter of values asserts bodily autonomy and freedom of violence as preconditions for human dignity **(13)**. FGM and other harmful practices that contravene one's right to pleasurable and fulfilling sexuality should be universally condemned.

FGM is on the rise despite global commitments to eliminate the practice by 2030

As part of Sustainable Development Goal 5 on achieving gender equality and empowering women and girls, countries have committed to eliminating all harmful practices, including FGM, by 2030 **(14)**. Despite global efforts to eliminate FGM, it is still rising. According to UNFPA and UNICEF, ongoing insecurity and humanitarian crises, including the setbacks from the COVID-19 pandemic responses as well as Mpox, could contribute an estimated four million new FGM cases annually. Africa will account for 144 million, followed by Asia (80 million cases), and the Middle East (six million cases). Women and girls in countries of highest FGM prevalence (more than 90%) such as Djibouti, Somalia and Guinea, would be most impacted by the projected increase in FGM cases **(15)**. Additionally, rapid population growth contributes to the rise in the absolute number of girls at risk. Most countries with high FGM prevalence also have higher fertility rates, meaning that the population of girls at risk of FGM continues to increase. For example, in Somalia, the total fertility rate is 6.13 births per woman, and FGM prevalence is nearly universal (99%) **(16,17)**. A recent study of factors associated with FGM prevalence among daughters in Somalia found that adolescent girls (15-19 years) living in rural areas are more likely to undergo FGM compared to older girls, those with mothers having primary education, and girls living in urban areas (16). The projected increase in girls affected by FGM in countries with high prevalence and high fertility rates will increase the demand for community outreach, education, and protection services in low-resource settings with already stretched health and social care services.

FGM medicalisation

Contributing to the lack of progress in eliminating FGM is the increasing medicalisation of the practice **(18)**. WHO reports that as of 2020, 52 million women and girls—about 1 in 4 FGM cases

globally—were cut by health workers including doctors, nurses, and midwives in clinics, hospitals or private homes in a trend that risks legitimising the practice **(19)**.

Other actions of medicalisation which attempt to minimise the health risks associated with FGM are: a) providing access to sterile medical equipment and products; b) offering medical training to traditional cutters or others who perform the procedure; and c) promoting less severe forms of FGM to reduce the health complications associated with Type III/ infibulation **(20)**. However, medicalisation of FGM does not eliminate the long-term physical, psychological or sexual harm endured by the survivors. Medicalisation is therefore not a harm reduction strategy and constitutes a clear violation of human rights and medical ethics **(5,21)**.

What is the medicalisation of FGM?

Medicalisation refers to the situations where FGM regardless of its type is practised by any category of health provider, whether in a public or a private health setting, at home or elsewhere. It also includes the procedure of re-infibulation by a healthcare provider at any point in time in a woman's life (17).

Additionally, evidence suggests that medicalisation could encourage performing FGM at younger ages, exposing girls to severe health risks earlier in life. In contrast to the arguments put forward by the FGM medicalisation advocates, evidence indicates that it leads health professionals to cut more severely. For example, in Indonesia, where over 60 million women have been affected by FGM mainly performed by medical professionals, 26 studies showed that health professionals were more likely to remove the clitoral hood (46%) compared with traditional cutters (23%)(22).

Among the key motivations of health workers to medicalise FGM is the perception that it helps maintains cultural expectations of the practice while reducing the immediate health risks, such as infection, pain, or death **(23)**. For healthcare providers, their belief in medicalisation as harm reduction, financial incentives from performing FGM, and responding to community pressure or insufficient training on FGM as a human rights violation and a form of gender-based violence continues to sustain the practice **(12,24)**. Moreover, the inconsistent enforcement of anti-FGM laws allows medicalised FGM to occur in clinics and homes, with detection and prosecution difficult **(19)**.

> **Medicalisation of female genital mutilation is strongly condemned, is illegal in many countries, and health care providers must be prohibited from performing the procedure through laws, policies, or codes of conduct.**

In 2010, the World Health Organisation, with seven other United Nations agencies and six professional organisations, issued a global strategy to stop healthcare providers from performing FGM **(25)**. IPPF endorsed the strategy and is committed to intensifying efforts to eliminate FGM **(26)**.

FGM in humanitarian settings

During humanitarian responses, health systems and protection services are often disrupted, increasing the risk of FGM. Additionally, with societal breakdown, there is greater reliance on cultural norms and FGM is viewed as a cultural expression to be preserved. Out of the 15 countries with the highest FGM prevalence, nine are affected by armed conflicts, displacement and climate crises **(27)**. UN agencies and partners report considerable challenges in integrating FGM prevention into humanitarian programmes due to limited SGBV funding, rising medicalisation and cross-border practices. During emergency responses, FGM may be a secondary issue for donors and policymakers involved in programming and humanitarian work **(28)**. Strategies for eliminating FGM in humanitarian responses may include creating networks of community leaders to help in the early detection of cases and to ensure multi-sectoral response protocols are in place.

The reasons behind the increase in FGM persistence in the humanitarian context are summarised as follows:

Factors	Description
High-risk environment	Of the 15 countries with the highest FGM prevalence, nine are affected by armed conflicts, displacement and climate crises
Disrupted protection systems	Crises often weaken legal enforcement, education and health services, key deterrents to FGM
Increased vulnerability	Displacement heightens girls' exposure to gender-based violence due to breakdown in community structures and protections **(18)**

Evidence of FGM prevention and elimination interventions

The available evidence on successful strategies to prevent and eliminate FGM comprise of the following: **A) Multi-level, multi-sectoral approaches** include **system-level interventions,** such as multifaceted legislation, including codes of conduct for health workers, work most effectively when aligned with service-level interventions that effectively prevent and respond to FGM **(29)**. **B) Community mobilisation** that creates behavioural and attitudinal shifts away from FGM, through collaboration with religious and cultural leaders, as well as by engaging men and boys to denounce the practice, tend to be most effective **(19,29,30)**. Additionally, interventions are increasingly leveraging health workers as opinion leaders in FGM prevention and to influence mothers and family members through person-centred communication **(31,32)**. **C) Individual-level** strategies, such as girls' formal education, are important long-term priorities because they promote agency, economic independence and exposure to life without FGM. Evidence suggests that mothers with at least primary-level education are 40% less likely to subject their daughters to FGM **(16,30)**. **D) Digital and media interventions** including radio, television and social media campaigns, play a crucial role in reshaping public perceptions and driving social change regarding FGM. By actively involving communities in the creation and dissemination of content, these initiatives help challenge existing beliefs and promote new attitudes towards eliminating the practice. Successful campaigns featuring survivors and community members who denounce the practice ensure the messages are authentic and impactful **(30)**. Additionally, culturally resonant narratives are critical for making the communication relatable and non-offensive and for avoiding romanticising FGM (using soft metaphors such as flower-cutting) that reinforce the practice rather than challenge it **(33)**. **E)** Among the successful **legislative measures** is the adoption of multi-faceted legal instruments, such as integration into child protection, GBV, and health laws to support a holistic approach to FGM **(29)**. UNFPA and UNICEF recommend aligning anti-FGM laws with international human rights and child protection standards and obligations to instruments such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child, and the Maputo Protocol, among others **(8)**.

IPPF FGM Centre of Excellence

To accelerate coordinated responses to FGM, in 2022, IPPF launched a Centre of Excellence (CoE), based in Mauritania. The centre's comprehensive Theory of Change (ToC) from 2023 involves these key areas:

- **Shifting Social Norms:** This includes community-based efforts, engaging men and community leaders, promoting alternative rites of passage, and using media campaigns to challenge harmful gender norms and misperceptions surrounding FGM.
- **Advocacy and Policy Change:** IPPF advocates for the enactment and enforcement of legislation to prohibit FGM, including the medicalisation.

IPPF FGM Centre of Excellence

- **Providing Integrated Services:** Strengthening IPPF Member Associations' provision of comprehensive sexual and reproductive health (SRH) services and psychological support to FGM survivors, to serve as the first point of contact for affected women.
- **Building Partnerships:** The framework emphasizes collaboration with a wide range of stakeholders, including other civil society organizations, government ministries, and UN agencies.
- **Evidence Generation and Data Collection:** IPPF promotes research and collection of data on FGM prevalence and effective interventions to inform evidence-based policies and programs.
- **Education:** Comprehensive sexuality education (CSE) is used to inform young people about bodily autonomy and the harms of FGM, empowering them to become agents of change.

More information is available here: https://awr.ippf.org/resource/accelerating-elimination-female-genital-mutilation-comprehensive-framework

Integrated FGM health responses

Among the key steps in FGM prevention and elimination from a health sector perspective is the strong condemnation of FGM medicalisation through law enforcement, providers' education, values clarification and behaviour change, and capacity building on person-centred communication on FGM prevention and commitment to ethical care **(34)**. Health responses to FGM need to shift from siloed sexual and reproductive health (SRH) and sexual and gender-based violence (SGBV) services to integrated models that embed prevention and response across the health system **(29)**. Taking an intersectional gender-transformative approach to service delivery is important for challenging harmful gender norms and promoting equity. Finally, multisectoral collaboration is essential among social, justice and health services to ensure linkages, continuity of care and support, consistent messaging, and sustainability **(35)**.

Integration of FGM prevention services entails tailoring interventions at health system entry points, through primary care and maternal health where midwives, nurses, general practitioners, OB-GYNs, and paediatricians identify FGM as a risk and provide trauma-informed person-centred care. Another crucial entry point is to align the health system with safeguarding protocols, such as national child protection protocols, to ensure timely referrals and legal compliance **(19)**.

Specific clinical interventions have been demonstrated to prevent immediate and delayed complications resulting from FGM, as assessed by health outcomes and survivor preferences

and needs. WHO strongly recommends deinfibulation[1] for women and girls with type 3 FGM, either antepartum or intrapartum, during the third stage of labour or at the time of an abortion, to improve health outcomes and reduce risks during delivery **(19)**. As of 2026, there is no clear evidence on the optimal timing of deinfibulation. Different factors determine the timing of the procedure such as health worker's competency, women's preferences, and antenatal care access and uptake, which are all essential to ensuring quality and rights-based care. The Royal College of Obstetricians & Gynaecologists recommends deinfibulation be offered prior to pregnancy and preferably before first intercourse **(36)**. WHO recommends that decisions about FGM include adequate counselling and informed consent, which can include family members, where appropriate, who might resist deinfibulation or promote reinfibulation **(19)**.

Evidence on clitoral reconstruction[2] surgeries remain limited as per the latest WHO guideline based on 13 studies **(19)**. Among them is the 2024 review of 40 studies which found that of 7,274 women who underwent the surgery, 94% reported post-operative improvement, including enhanced sexual function and reduced pain. The review also revealed a low complication[3] rate - only 3% (207 cases), suggesting the procedures are generally safe when performed by trained professionals **(37)**. However, this evidence was not sufficient to recommend clitoral reconstruction routinely for FGM survivors due to limitations in study design, the lack of treatment standardisation (surgical techniques, patient selection and outcome measurements varied) and the short-term outcomes reported **(19)**. The WHO recommends clitoral reconstruction only for women living with FGM with sexual dysfunction, whose expectations align with the outcomes of this surgical intervention, due to low-certainty evidence and potential surgical risks. The implementation requires that women undergoing surgery also receive sexual health counselling and psychosocial support in conjunction with the surgery, that it is performed by a surgeon with specialized training, and that adequate informed consent procedures are followed. In some cases, sexual health counselling might be sufficient for some women to overcome sexual dysfunction following FGM without risks of surgery, including risk that the surgery does not achieve the desired outcome as sexual health is a combination of psychological, social, biological, and relational factors **(19)**.

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1 Deinfibulation is a surgical procedure to open the sealed vaginal introitus in women with Type III FGM (infibulation) by cutting through the scar tissue that covers the vaginal opening. Source: WHO Guidelines on the Prevention of Female Genital Mutilation and Clinical Management of Complications, 2025

2 A surgical technique aimed at restoring the clitoral anatomy and function after FGM, usually for women who have undergone Type II or III FGM. Source: WHO Guidelines on the Prevention of Female Genital Mutilation and Clinical Management of Complications, 2025

3 Clitoral reconstructive surgery could have different complications ranging from immediate impacts such as hematoma and edema to long-lasting affects such as clitoral pain and clitoral burial. Source: WHO Guidelines on the Prevention of Female Genital Mutilation and Clinical Management of Complications, 2025

Survivor-centred approach to FGM

A survivor-centred approach to FGM prioritises the voices and leadership of women and girls with lived experience, while placing their dignity and healing at the core of interventions aiming to end FGM. Key principles crucial to this approach include: 1) empowering survivors to lead, advocate, to influence programming and policy change **(38)**; and 2) person-centred communication with FGM survivors and expectant women to improve FGM detection, prevention and response. To achieve these goals, providers need skills in positive communication with survivors, empathy through active listening, cultural sensitivity, appropriate language and genuine interactions **(39)**.

Addressing the psychological impact of FGM is paramount, and providing care that is trauma-informed is crucial. Services like Cognitive Behaviour Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR), are both clinically approved for trauma and anxiety treatment **(40,41)**. These approaches centre survivors' agency, voice and choice and foster trust in communities where FGM is deeply entrenched.

Recommendations for IPPF MAs on delivering FGM services within a survivor-centred and rights-based approach:

These recommendations promote shifting away from a focus on punitive laws and policies towards community-based education, empowerment, and survivor-centred approaches to FGM prevention and response. This shift is essential because current strategies have not sufficiently reduced the prevalence of FGM, and lasting progress can only be achieved by fostering understanding, resilience, and engagement with affected communities.

These recommendations build on the existing IPPF framework of action to eliminate FGM which is centred on service integration, advocacy and behaviour change to inform FGM programming with and by IPPF MAs through the IPPF's 2028 strategy and the IPPF Charter of Values, while upholding values of bodily autonomy, freedom from violence, dignity and pleasure **(13,42,43)**.

1. **Multi-level, multi-sectoral approaches to FGM prevention:**
    a. Social and behaviour change: MAs should plan long-term, multi-sectoral behaviour change campaigns that include child protection, women's empowerment, and gender-based violence prevention, among others. A monitoring and evaluation strategy should accompany such campaigns.
    b. Multifaceted laws and legislation: MAs should contribute to national-level and international advocacy movements and legal efforts to eliminate FGM without compromising the safety and security of their respective organisations and staff. MAs are encouraged to advocate for robust legislation and effective enforcement, and support survivor-centred services within national health and justice systems.

c. Community participatory digital and media interventions: MAs are encouraged to collaborate with youth leaders to create and disseminate digital content that challenges existing beliefs and promotes new, healthier attitudes towards eliminating the practice.
d. Integration of FGM prevention into formal and informal education including pre-service education: MAs should advocate for FGM prevention information in school curricula and comprehensive sexuality education. MAs should additionally advocate for the inclusion of FGM in pre-service education of healthcare providers at all levels.
e. Joint advocacy for girls' rights, choice, and agency: MAs are encouraged to collaborate with children's and girls' rights organisations to advocate for girls' access to continued formal education, as one of the most evidence-informed pathways to FGM elimination. MAs should also promote and advocate for CSE in schools.

2. **Partnerships and coalitions to strengthen collaboration on FGM elimination:** MAs should develop national, regional, and global partnerships wherever possible, including with UN agencies, donors and other stakeholders, to unite efforts on FGM prevention, elimination, and response. These partnerships and collaborations are also encouraged during humanitarian response efforts to ensure coordination on supporting communities affected by and at risk of FGM.

3. **Responding to the medicalisation of FGM:**
   a. IPPF MAs should participate in the national, regional, and global efforts to denounce and condemn FGM medicalisation.
   b. MAs should reinforce Professional Codes of Conduct and adopt a zero-tolerance policy towards health providers performing FGM under any circumstances.
   c. MAs are encouraged to establish and/or support national reporting mechanisms for suspected cases of medicalised FGM and monitor compliance with legal and ethical obligations.
   d. Awareness and value clarification interventions to strengthen medical staff's capacity on preventing FGM are recommended. Ensuring that providers are trained is necessary to advocate in the community against the practice, and to emphasise that medicalisation still constitutes a violation of women and girls' rights and bodily autonomy.

4. **Integrated FGM health responses:**
   a. Survivor-centred approaches should guide clinical and rehabilitation services, ensuring they are trauma-informed, integrated, and properly documented when necessary.
   b. Adherence to IPPF's Charter of Values and zero-tolerance on FGM by all medical and non-medical staff at IPPF-affiliated and partner health facilities.
   c. Address FGM's impact on menstrual health, including painful menstruation, which impacts school attendance and education, leading to higher dropout rates among girls affected. Multi-sectoral interventions involving the Ministry of Education and relevant government bodies are needed to mitigate the impact of FGM on girls' education, including by providing menstrual hygiene supplies in schools and primary health centres.

d. Provide specialised care to FGM survivors who face higher risks of pelvic and urinary tract infections due to altered anatomy, poor sanitary conditions, and scarring obstruction and who may not be able to use standard menstrual hygiene management products.
e. Deinfibulation for women with type 3 FGM is recommended, according to WHO recommendations, either antepartum or intrapartum, or during abortion provision to improve health outcomes and reduce risks during delivery (19).
f. Recognise the specific needs of women living with FGM during obstetric and abortion care, including the increased need for caesarean and assisted delivery (vacuum extraction or forceps), increased risk of obstetric haemorrhage, and increased likelihood of prolonged labour. Additionally, infibulated women are likely to need episiotomy as scarred tissue stretches insufficiently. Deinfibulation may reduce the need for episiotomy.
g. According to WHO guidelines, clitoral reconstruction is recommended as needed for women living with FGM, as a conditional recommendation based on low-certainty evidence, potential surgical risks, and limited availability in a few high-income countries. More research is needed to evaluate the long-term outcomes of reconstruction.
h. Trauma- informed services for FGM survivors are recommended, including various behavioural therapies and anxiety treatments, where trained staff employ a survivor-centred approach.

5. **Research and evidence on FGM:**
    a. Greater investment is required in effective health integration strategies for FGM prevention and treatment, as well as in evaluating existing or novel surgical options and their long-term outcomes.
    b. More evidence on the long-term impact (e.g. mental health, sexual dysfunction) of FGM on women and their partners is needed to strengthen the case for legal and policy change.
    c. More practice-based knowledge is needed on integrating FGM prevention strategies. For example, implementation research using experimental designs could help generate scalable findings from existing interventions and inform campaigns.
    d. Research and learning should be co-designed with FGM survivors or champions in highly affected countries, including studies on positive deviance from countries, communities and women leaders who have shifted norms on FGM.

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