

IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY

No. S43 of 2019
No. S44 of 2019
No. S45 of 2019

BETWEEN:

The Queen
Appellant

and

A2

Kubra Magennis

Shabbir Mohammedbhai Vaziri

Respondents



10

**RESPONDENTS' JOINT NOTE ON WORLD HEALTH ORGANISATION
RECOMMENDATIONS**

Part I:

- 20 1. This Note is in a form suitable for publication on the internet.

Part II:

2. This Note addresses the World Health Organisation's ("WHO") recommendations in existence at the time the Crimes (Female Genital Mutilation) Amendment Bill 1994 (NSW) ("the Bill") was introduced as referred to in the second reading speech. In particular, this Note addresses the definitions of female circumcision/female genital mutilation used by the WHO at certain points in time including leading up to the introduction of the Bill. An appreciation of the definitions of the term used by the WHO is necessary to understand the recommendations made by it. The material referred to in this Note is annexed to it.
- 30
3. In the second reading speech, the Minister referred to the WHO's recommendation that governments adopt clear national policies to abolish the practice (Joint Book of

Armstrong Legal
Level 35, 201 Elizabeth St
Sydney NSW 2000
Telephone: (02) 9261 455
Fax: (02) 9261 4165

Ref: John Sutton – A2 and Vaziri
Email: jsutton@armstronglegal.com.au
Ref: Trudie Cameron - Magennis
Email: tcameron@armstronglegal.com.au

Authorities (“JBA”) 762). It appears such a recommendation was made by the WHO first in 1979 and, in substantially the same terms, again in 1982, 1984 and 1994 (see Appellant’s Note (“AN”) at [4]-[9]).

4. In 1979 the WHO held a seminar in Khartoum on Traditional Practices Affecting the Health of Women and Children (WHO Seminar on Traditional Practices Affecting the Health of Women and Children, Khartoum 1979, Annexure A). One paper presented at that seminar described the three types of circumcision as: (1) sunna type where the clitoris is snipped; (2) second type in which the labia minora and part of the clitoris are removed; (3) total removal of clitoris and labia (Annexure A p.10). Another paper presented described four types of circumcision: (1) mild sunna; (2) modified sunna; (3) total or partial clitoridectomy; (4) infibulation (pharaonic female circumcision) (Annexure A p.14). The respondents have been unable to locate the papers presented and cannot identify any further description of these types of circumcision.
5. The recommendations from the 1979 Khartoum Seminar in relation to female circumcision included intensification of education efforts (to both the public and traditional midwives/healers/birth attendants) to demonstrate the dangers and harmful effects of female circumcision (Annexure A p.25).
6. In 1992 the WHO published an article “Female Circumcision” in the *European Journal of Obstetrics & Gynecology and Reproductive Biology* 45 (1992) 153-154 (Annexure B). The same article was published in the *International Journal of Obstetrics and Gynecology* in 1992 (Annexure B, footnote 2). The Family Law Council Discussion Paper and subsequent Report refer to this article (see JBA 593, 601, 649, 662). In the article, the WHO stated:

“Female circumcision in any of its three forms, is a painful fact of life...

In its mildest form, female circumcision involves only the removal of the foreskin of the clitoris. But in the majority of cases the clitoris itself is removed, together with all or part of the labia minora and in the most severe form the labia majora.” (Annexure B p.153).
7. The article then discussed the “lifelong physical and psychological debilities resulting from female genital mutilations” (Annexure B p.153).

8. In his January 1994 Report “Maternal and child health and family planning: Current needs and future orientation” the Director General of the WHO invited the Executive Board of the WHO to consider a draft resolution calling for the establishment of “national policies and programmes that will effectively abolish female genital mutilation” (Annexure C). The resolution was ultimately adopted by the Executive Board on 25 January 1994 (Annexure D) and adopted by the World Health Assembly on 10 May 1994 (6 days after the second reading speech) (Annexure E). In his report, the Director General said (emphasis added):

10

“Female genital mutilation is a collective name given to a series of traditional surgical operations performed on female genitals in several countries in the world. . . . Its physical and psychological effects on girls and women, particularly on normal sexual function, affect their reproductive health in a way which lasts all their lives, since none of the procedures are reversible. In all types of female circumcision part or the whole of the clitoris is removed. More severe forms, such as excision and infibulation, remove larger parts of the genitals and close off the vagina, leaving areas of tough scar tissue, permanent damage and dysfunction.” (Annexure B at [21]).

20

9. The available WHO material in existence at the time the Bill was introduced indicates that the WHO considered that female circumcision/female genital mutilation involved the removal of tissue and was concerned with the irreversibility of such procedures.

30

10. The resolution of the Executive Board of the WHO in January 1994 appears to be the most proximate in time to the introduction of the Bill (AN at [11]). The resolution refers to the harmful practices that “cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children” and the abolition of “other harmful practices affecting the health of women and children” (see extract at AN [9]; see also the Khartoum 1979 recommendations above at [5]). This suggests that the WHO was concerned with procedures with enduring adverse effects.

11. It was not until 1997 that the WHO adopted a specific definition of female genital mutilation along with four classifications of the types of female genital mutilation including the broader Type IV category. This followed after recommendations made

in 1995 by the WHO Technical Working Group on Female Genital Mutilation (WHO, *Female Genital Mutilation: An Overview* (1998) Annexure F p.6, 62). The WHO adoption of this definition of female genital mutilation and the four classifications post-dated the second reading speech and introduction of s45 of the *Crimes Act*. This suggests that as at 1994 there was no generally accepted meaning of the term female genital mutilation that included the broader Type IV category.

10 12. The change in terminology from “female circumcision” to “female genital mutilation” was proposed in 1990 by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (Annexure F p.60). This appears to have been adopted by the WHO in 1992 and the World Health Assembly in 1993 (Annexure E p.61). In the WHO Report of 1998 it was observed that “It is because of the severity and irreversibility of the damage inflicted on the girl’s body that the procedure has been termed “female genital mutilation”” (p.3).

20 13. The four categories of female genital mutilation referred to in the Family Law Council Discussion Paper and Report do not appear to have come from the WHO material. It is noted that where the four categories are discussed, there is reference to an article in *New Scientist* authored by Sue Armstrong, a freelance journalist in South Africa, (Annexure G). Ms Armstrong makes limited reference to the WHO’s involvement in abolishing female genital mutilation. She makes no reference to ritualised circumcision. Her description of female circumcision accords with the description of the term by the WHO as at 1994 (p1.5):

“... female operation nearly always involves the removal of healthy (and highly sensitive) organs ...

30 ... The mildest form – known to Muslims as ‘sunna’ and the least common – involves the removal of the prepuce or hood of the clitoris. It is the only operation analogous to male circumcision. Excision involves the removal of the clitoris and labia minora; while infibulation, the most drastic form ... involves the removal of all the external genitalia and the stitching up of the two sides of the vulva...”

14. The passage cited by the Family Law Council stated “In reality the distinction between the types of circumcision is often irrelevant since it depends on the sharpness of the instrument used, the struggling of the child, and the skill and

eyesight of the operator”. The reference is to the distinction between the types of circumcision Ms Armstrong refers to in her article, not risks associated with ritualised circumcision.

- 10 15. It is apparent that other countries acted consistently with the WHO’s recommendations to abolish female circumcision/female genital mutilation prior to 1994. For example, in the United States, federal legislation introduced in 1993, made it an offence where a person “knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years” (extracted at JBA 881, see also definition of “female genital mutilation” at JBA 882). The New York State legislation was in similar terms (extracted at JBA 883). The Swedish legislation provided that an operation must not be “carried out on the outer female sexual organs with a view to mutilating them or of bringing about some other permanent change in them (circumcision), of whether consent has been given for the operation or not” (extracted at JBA 885). The second reading speech refers to the legislation from these countries (JBA 762).
- 20 16. As noted at the oral hearing, the legislation was derived from the UK legislation, enacted in 1985 (over 10 years before the WHO adopted a definition of female genital mutilation and the four classifications). The UK second reading speech does not refer to the WHO recommendations.

Dated: 26 June 2019

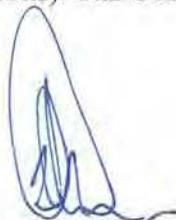


Tim Game



Georgia Huxley

Counsel for Magennis



Hament Dhanji

David Randle

Counsel for A2 and Vaziri

IN THE HIGH COURT OF AUSTRALIA
SYDNEY REGISTRY

No. S43 of 2019
No. S44 of 2019
No. S45 of 2019

BETWEEN:

The Queen
Appellant

and

A2

Kubra Magennis

Shabbir Mohammedbhai Vaziri

Respondents

10

INDEX – MATERIAL ANNEXED TO RESPONDENTS’ JOINT NOTE

20	Annexure A	World Health Organisation (“WHO”) – Seminar on Traditional Practices Affecting the Health of Women and Children, Khartoum, 1979
	Annexure B	WHO - Female Circumcision, <i>European Journal of Obstetrics & Gynecology and Reproductive Biology</i> 45 (1992) 135-154
	Annexure C	WHO – Report by Director General – Maternal and child health and family planning: Current needs and future orientation, January 1994
	Annexure D	WHO – Executive Board resolution - Maternal and child health and family planning: Current needs and future orientation, January 1994
	Annexure E	World Health Assembly resolution – Maternal and child health and family planning: traditional practices harmful to the health of women and children, May 1994
30	Annexure F	WHO – Female Genital Mutilation: An Overview, 1998
	Annexure G	Sue Armstrong – Female circumcision: Fighting a cruel tradition, <i>New Scientist</i> , February 1991

**WORLD HEALTH
ORGANIZATION**

**Regional Office
for the Eastern Mediterranean**



**ORGANISATION MONDIALE
DE LA SANTÉ**

**Bureau régional
pour la Méditerranée orientale**

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HTH.WM/44

March 1979

**SEMINAR ON TRADITIONAL PRACTICES AFFECTING
THE HEALTH OF WOMEN AND CHILDREN**

KAHARTOUM, 10 - 15 February 1979

The views expressed in this Report do not necessarily reflect the official policy of the World Health Organization.

The Seminar was inaugurated by H.E. Sayed Khalid Hassan Abbas, Minister of Health, Sudan, at the Friendship Hall. (Annex I).

Dr R.A. Khan, WHO Programme Coordinator welcomed the participants on behalf of WHO and Dr T.A. Baasher, WHO Regional Adviser on Mental Health and Secretary of the Seminar, read the message of Dr A.H. Taba, WHO Director, Eastern Mediterranean Region. (Annex II).

The following Seminar Officers were elected:

- Dr Hamid Rushwan, Associate Professor, Gynaecology and Obstetrics Department, Faculty of Medicine, University of Khartoum and Chairman of the National Preparatory Committee for the Seminar, was elected Chairman of the Seminar.
- Dr (Mrs) B.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital Yaba, Nigeria, and
- Dr Afaf Attia Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, were elected Vice Chairpersons.
- Dr Yahia Ownallah Younis, University of Khartoum, Department of Community Medicine, Sudan, was elected as General Rapporteur for the Seminar.
- Mrs Awatif Osman, Director, College of Nursing, Ministry of Education, Khartoum, and representing the International Confederation of Midwives, was elected as Rapporteur for the first session.

It was agreed that for each day's sessions a rapporteur would be elected.

The Seminar was welcomed by Dr Rushwan, who introduced the speakers.

Following the election of Officers, members moved to the adoption of the Agenda which was presented by the Chairman. Dr B.C.A. Johnson suggested the addition of Menopause to the Agenda. This was given consideration. The Agenda was then adopted by the members. Dr Baasher introduced the programme and the presentation scheduled for each session under items IV to VIII to be discussed during the five days meeting, hoping that the participants would be able to cover most of the topics on the Agenda. Dr Baasher also asked contributors to hand in their working papers and written suggestions and recommendations to be given to the Secretariat or Chairman of the Seminar. He also pointed out that before the closing session, a summary report will be given on the scientific contributions and the deliberations including the recommendations which will come out of the meeting. Twenty minutes (approximately) was the time given for the presentation of each paper.

Dr R.H.O. Bannerman, Programme Manager, Traditional Medicine, WHO Central Office, Geneva, suggested his willingness to present the paper on "Traditional Practices on Confinement and After Childbirth (in the Chinese culture)" by Dr B.L.K. Pillsbury who could not attend the meeting and this was accepted by the members.

The first topic "Nutritional Taboos and Traditional Practices in Pregnancy and Lactation Including Breast-feeding Practice" was then introduced by the Chairman and the first speaker Dr Hafiz El Shazali, Senior Paediatrician, Ministry of Health, Sudan, presented his paper on "Breast and Supplementary Feeding during Early Childhood".

Dr El Shazali pointed out that his main emphasis is on the child. He highlighted the nutritional taboos and traditional practices in pregnancy and lactation in the Sudan. Dr El Shazali classified traditional practices in three categories: harmful, harmless and useful.

Among the harmful practices he listed:

- restriction of food intake during pregnancy;
- failure to remove dirt from the house (infections);
- breast-feeding while lying down (colic);
- using only one breast in nursing (decreases milk formation);
- weaning done suddenly;
- cauterization of children with a big hot needle for diarrhoea, cough, fever, etc.;
- stopping breast-feeding during diarrhoea;
- supplementary foods introduced too late;
- boys should not be fed at sunset or by mother with head uncovered;
- wearing beads and scented necklace to prevent vomiting.

Among good practices were listed:

- neighbours bringing food to nursing mothers;
- breast-feeding for a long period;
- during last month of pregnancy, eating raw liver.

"Dietary Practice and Aversions during Pregnancy and Lactation Among Sudanese Women" was presented by Dr Ali Karrar Osman, Director of Nutrition Division, Ministry of Health, Sudan. Dr Karrar indicated that his paper was more concerned with the child.

Low birth weight is a problem affecting some 20 million newborn infants annually, mainly among the low socio-economic groups of the population.

A survey in MCH centres in Khartoum Province to investigate the nutritional knowledge, attitudes and practices among pregnant women showed that pregnant women of the low socio-economic class are not aware of the importance of the consumption of a balanced diet during pregnancy (67%). This situation is aggravated by vomiting during early pregnancy and by dietary aversions, since 57.4% of the respondents dislike meat, fish and poultry. The effect of under-nutrition, especially low protein intake, is discussed in the light of the results of global research results demonstrating the effect of this on the mental and physical development of the foetus.

93% of the respondents believe that diet should be changed during post-partum while 45% believe this should take place during lactation. High-protein, high-energy diets are consumed. The reasons cited for this change were: to regain strength, to compensate for loss during delivery and to increase milk production. This represents sound nutrition knowledge, attitudes and dietary practices. One food item which is consumed by all respondents is the fenugreek Nasha (Fenugreek + Milk + Ghee + Sugar). This is a high energy recipe and fenugreek is shown to contain a lactogenic factor.

The next paper was on "Traditional Feeding Practices in Pregnancy" - Mrs A.N. Mikhail, Director of Nursing Services, Alexandria Health Directorate, Egypt.

Urban sector and rural sector habits for housewives were examined, showing that economic aspects and education had a major influence as to whether or not the diet was balanced. During puerperium the majority of housewives preferred protein-rich food regardless of income. Reasons given for food consumption patterns showed lack of awareness about nutrition. Breast-feeding was shorter and supplementary feeding better among educated housewives. In the rural areas and among poorly educated mothers, prolonged breast-feeding is customary in the belief that it protects against pregnancy.

Discussion:

A number of important issues emerging from the papers were discussed, as follows:

- morning sickness;
- prevalence of breast-feeding in the rural areas more than in urban areas;

- contraceptive tablets and mothers' complaints of reduced milk output;
- how to deal with harmful practices, e.g. cauterization of children;
- mass media;
- advertisement of powdered milk and advice given to mothers in reference to breast-feeding of babies suffering from diarrhoea, especially within the first 24 hours;
- traditional medicine with reference to puerperal psychosis and its effect on the nutritional condition of the lactating mother and child;
- the emphasis on health education and assistance of mass-media in nutritional health education;
- native drugs during puerperium;
- breast-feeding on demand;
- overweight during lactation;
- traditional cultural ways of thinking in using red-ribbons, shells and beads to protect the child from the evil eye, infection, etc.;
- the practices of excision of the uvula, canines and cauterization of the epiglottis and the micro-organisms in reference to coughing, talking and certain diseases;
- nurseries and breast-feeding problems of working mothers, etc.

On 11 February the meeting opened with a presentation on: "Nutritional Taboos and Traditional Practices in Pregnancy and Lactation Including Breast-feeding Practices" by Dr L.J. Ghulam, Senior Public Health Officer, Ministry of Health, Muscat, Oman.

Two communities of Oman were studied. It was found that most women change their diet during pregnancy and lactation. The reason for diet changes are varied but the most important is the misunderstanding of the proper location of the unborn child. It is believed that the child is located in the stomach and as it grows, the size of the stomach is reduced.

women eat less fish because they believe that the bones and scales of fish will harden the bones of the foetus and lead to a difficult delivery. A large number of women eat more during breast-feeding to increase their milk and to have better health.

The study shows some bad habits such as women abstaining from cold food such as rice, stew, citrus fruit, salted and fried fish, lamb, veal and sweet potatoes. In both communities some foods were recommended more than other kinds of food.

Breast-feeding Practices

The pattern of demand feeding continues from infancy until weaning. 90% of the children are breast-fed up to two years of age. Early weaning is against customs and religious beliefs. Breast-feeding is practised to avoid pregnancy; however, even when the mother is pregnant she continues to feed the baby until the fifth month of her pregnancy.

"Traditional Practices on Confinement and After Childbirth" by Dr B.L.K. Pillsbury, Medical Anthropologist, Bureau for Programme and Policy, Washington, USA, was presented on her behalf by Dr R.H.O. Bannerman, Programme Manager, Traditional Medicine, WHO Central Office, Geneva.

The paper is based on Dr Pillsbury's study in China. The woman is confined to the house for one month after delivery. She is said to be "doing the month". During this period she is expected to refrain from certain practices e.g. washing, domestic work. Regarding diet, she is expected to have a "hot" liberal diet with abundance of protein. At the end of the resting month relatives are invited to drink the full moon wine. In rural China deliveries are undertaken in the home by a midwife. 90% of the obstetricians and gynaecologists are women.

A very interesting discussion followed the presentation of the paper. Similarities between the Chinese experience and various African countries in traditional practices related to confinement were noted, e.g. length of period of confinement after delivery, washing practices, dietary habits etc.

The next paper was on the subject of: "Traditional Practices in Relation to Childbirth in Kenya" presented by Miss Margaret Njoki, Psychiatric Nurse, Nairobi.

Practices vary from one part of Kenya to another, but in essence they are similar. A woman who does not do work is thought of as a lazy person, so even during pregnancy women continue to do hard work with the risk of miscarriage and ill health. Traditional midwives have harmful practices which may lead to infection in both the mother and her child. Some of the useful practices include the good nutrition secured for the mother during confinement and after delivery, and the domestic help offered by neighbours.

Dr O. Modawi presented the next paper on: "Traditional Practices in Child Health in Sudan".

Dr Modawi gave a historical review of the cultural heritage in the Sudan which is a mixture of African, Eastern, Ancient Egyptian and religious cultures - both Islamic and Christian. The common elements forming the traditional practices were discussed. These included spirits and myths, the cultural heritage, the religious background and the supernatural powers represented by the river, the sun, the moon, colours, etc. He explained that the type of food eaten by the pregnant women is determined by social practices and beliefs. He presented a cultural description of food as prestige food, celebration food, food for special groups - especially pregnant women - and religiously defined food. Traditionally, infertility is attributed to various causative factors depending on the part of the country e.g. spirits, religious reasons, witchcraft and the evil eye and the Mushara. Traditional practices in the treatment of infertility were discussed. Dr Modawi explained the different traditional contraceptive methods, described the various positions in labour, the practices during confinement and after delivery and the beliefs about multiple pregnancies and births. Slides were shown.

The topic of the following paper was "Traditional Practices in Pregnancy and Childbirth in Ethiopia" presented by Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa, Ethiopia.

Traditional practices during pregnancy, labour and post-natal periods were described, e.g. good practices such as taking nutritious food and being at home for long periods during puerperium; and harmful ones such as carrying heavy things during pregnancy. Also practices concerning the newborn and children were described, such as cutting the cord with an unclean razor and cutting eyelids to treat conjunctivitis and avoiding sunshine for fear of the evil eye.

"Traditional Practices Affecting the Health of Women in Pregnancy and Childbirth" was the topic of the next paper presented by Dr (Mrs) M.O. Aromasodu, Assistant Director, Public Health Services, Federal Ministry of Health and Social Welfare, Nigeria.

Traditional care of the pregnant women in Nigeria is described. The traditional healer, through means of certain rituals, claims to be able to forecast the outcome of

a pregnancy. If there is going to be difficulty, he can consult the "gods" through his oracle to find out what sacrifices are to be performed. He also claims to have the means by which he "ties down" the pregnancy and thus ensures that it is carried to full term.

The traditional healer, apart from consulting the "gods", through his oracle, also treats the pregnant woman with herbs. In addition, there are certain taboos which the pregnant woman must observe or else all efforts will be useless. Thus she must not go out at night or at midday to avoid meeting evil spirits, she must also not eat snails or bananas so that her baby will be healthy with no congenital abnormality.

When the woman is in labour, the pregnancy which was "tied down" is released. If it is not vertex presentation, the baby is turned round by supernatural means. Vertex delivery is preferable, although at times breech delivery is undertaken. The woman is delivered on her knees. After delivery the placenta is carefully buried because it is a bad omen for the baby if its placenta is eaten by any animal especially a dog.

After childbirth, the woman is kept indoors for 40 days. During this period, she is massaged every morning with very hot herb water to aid uterine contractions and expulsion of all remaining "bad blood" in the uterus. Sitting on top of a pot with hot herb water also has the same effect.

Twins and other multiple births are said to be a bad omen which is accepted as being the fault of the woman as well as any congenital abnormality.

In order to improve the standard of obstetric practice, traditional healers and birth attendants are now trained. During training emphasis is laid on identifying any deviation from normal and prompt referral to health institutions where patients will be taken over. With intensified health education, even the community now prefers to use non-traditional healers and birth attendants who have been trained by the experts from the Ministry of Health.

Mrs D.V. Kuteyi, Principal Nursing Officer, PH, Federal Ministry of Health and Social Welfare, Lagos, Nigeria, continued where Dr Aromasodu left off by describing

the naming ceremonies for girls and boys. The mother is kept indoors for 40 days after delivery. The naming ceremony traditionally includes tribal remarking, shaving of head and circumcision.

The baby is forcefully fed immediately after delivery with a special herbal concoction which is continued sometimes for one year and is the only food given besides mother's milk. The baby is fed with bap after sixth or seventh month (millet and corn).

Twins: If a mother has twins she must go in the street and sing and dance as well as beg for alms in order that the twins survive.

The diet of the pregnant woman is without eggs or meat and no beans or milk are given. Protein intake is lacking.

Dr S. Coleman, Staff Research Associate, Johns Hopkins Population Information Programme, Baltimore, USA, presented the next paper on: "Tobacco and Reproductive Health: Practices and Implications in Traditional and Modern Societies".

Few women in many developing countries smoke, but the tendency is for an increase; the tobacco market is growing and increased use follows increased income and spending power. Cigarettes are being promoted by tobacco corporations in developing countries, where the prospects for market expansion are greatest and where there are rarely restrictions on advertising and no antismoking educational campaigns. With increasing urbanization and emancipation, more women will soon be smoking in many countries.

Tobacco use during pregnancy lowers birth weight. This has been proven in more than forty-five studies examining over half a million births, in a number of countries. The infant's reduced weight is independent of maternal weight gain during pregnancy, and is not due to reduced length of gestation. More women who smoke, however, give birth before the full gestation period than do non-smokers. The reduced weight of smokers' infants may be due to an attempt to adapt to lack of oxygen. Carbon monoxide and nicotine are two agents in tobacco smoke that may be affecting birth weight. Increased intake of calories during pregnancy cannot counteract their effects.

The woman who smokes during pregnancy is in the greatest danger of losing her newborn infant or having a stillbirth:

- if she has experienced perinatal loss previously;
- if she is older in age;
- if she has had many previous births (high parity);
- if she is anaemic.

The more any woman smokes, the greater is the risk of perinatal mortality. Tobacco use also increases the risk of pregnancy complications. Antepartum bleeding, placental abruptions, placenta previa and premature rupture of membranes have all been found in increased frequency among smokers. Thus, the life of the woman as well as that of her offspring may be threatened, especially if medical facilities are not immediately available.

The third session was devoted to the discussion of female circumcision.

The Chairman introduced the first speaker in this session, Miss F. Hosken, Editor, Women's International Network, Lexington, USA and WHO Temporary Adviser on "Female Circumcision in the World of Today: A Global Review".

Information about genital operations performed on female children, mostly at an age too young to be able to make any decisions on their own, have been concealed for more than 2000 years. As a result these practices have spread all over Africa and are now also practised in the modern sector.

In other parts of the world genital mutilations no longer exist though they have been reported also in the medical literature (Shandall, Verzin, Mustafa, Sequeira and others) up to the present time though no clinical observations are available. In Australia genital mutilations among the indigenous population have been abandoned decades ago. In South America no clinical evidence has ever been available and the few cases reported in the ethnographic literature go back more than 100 years with no medical evidence. All the reports of genital operations on females go back to 1885 (first edition of Ploss Das Weib = Woman).

There is no present day clinical evidence that any form of genital operations are practised anywhere except in Africa and among the Moslem population of Malaysia and Indonesia, where the mildest form of circumcision is reported.

Leading Moslem gynaecologists in Malaysia and Indonesia have offered to make studies concerning any health damage.

In Africa and the Middle East a survey of 36 countries has provided the beginning of a systematic collection of data which should be continued and amplified as more information becomes available. Due to population growth more female children are operated on now than ever before. The operations are performed at a younger age because parents are afraid their daughters will refuse to submit to them when they are able to decide for themselves.

A cost analysis of genital mutilations is supplied showing that the economic costs of doing nothing about these operations are going to increase rapidly and will become a major drain for governments. Prevention campaigns could obviate many expenditures as well as improve the health of females.

This "expenditure" or cost may be listed as follows:

1. The costs due to loss of life.
2. The costs due to making childbirth more hazardous including many added services needed.
3. Costs of work time lost, health insurance and social security.
4. Costs of operations performed in hospitals.

Relevant recommendations include the education of traditional midwives, which should be undertaken on the national scale, keeping the traditional system in place but re-educating the practitioners.

Following the presentation and discussion of Miss Hosken's paper several country reports were presented. Dr Afaf Attia Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, presented a paper on "The Practice of Circumcision in Egypt". She said the practice of female circumcision is illegal in Egypt and so there are no confirmed data, but from field work done recently, three types of circumcision could be delineated:

1. Sunna type in which the clitoris is snipped.
2. Second type in which the labia minora and part of clitoris are removed.
3. Total removal of clitoris and labia.

The first type is done in both urban and rural areas and the third one mostly in Upper Egypt. Dr Salem also cited the various complications that may follow the operation.

A second presentation from Egypt on "Mental Aspects of Circumcision" was made by Dr A.S. El Hakim, Head of Mental Health Department, Ministry of Health, Cairo. Dr El Hakim indicated that sex before marriage is taboo and the female's virginity before marriage is identified with the dignity of the family. Circumcision is believed to ensure the girl's chastity, hence the man's concern with the circumcision of the female. But the operation leaves a psychological scar in the woman. It is thought that circumcision causes delayed sexual arousal in the female, but there are no direct data on this matter, only indirect information from opium addicts who claim that they resorted to the drug after frustrations from delayed sexual arousal in their circumcised wives.

A third presentation from Egypt was given by Mrs Marie B. Assaad, Senior Research Assistant, The American University, Cairo, who is also representing UNICEF. Mrs Assaad presented a very voluminous document on "Female Circumcision in Egypt". She attempted in her paper to give a critical review of written and oral information on female circumcision in Egypt and to suggest areas where systematic study is needed. Also, she summarized a pilot study which she carried out recently in Egypt with the objective of testing a set of questions and to have insight into the present extent of the practice and how, where and by whom it is done.

Circumcision in Egypt is practised by both Moslem and Christians and there is no religious basis for the practice. It fits into the people's value system about virginity and family honour. The practice existed in Egypt long before Christianity and Islam. The pilot study showed that women of low socio-economic class submit their daughters to the same fate which they themselves underwent when circumcised. Interestingly, the study does not show any correlation between excision and sexual dissatisfaction.

Mrs Assaad concluded by stating that concerted effort is needed now to accomplish the following:

- Multi-disciplinary action - research should be undertaken by psychologists, gynaecologists and social scientists - men and women - with the purpose of defining what information will be persuasive to men and women in eradicating the practice.

- health practitioners, social workers, nurses, family planning workers, feminists engaged in education and outreach programmes, and educated people in general should form the first audience of instruction. They should be informed about the practice, its extent, reasons for its perpetuation, and how traditional and erroneous beliefs of women on women's health and sexuality can be modified. It is important to engage this group first because of their prospective leadership role.
- We need to be creative and imaginative, finding ways to convince the daya (traditional birth attendant) to work with us and not against us. In view of her influential role as a traditional leader we need to exert special efforts to involve her in the new concerns, whether in relation to female circumcision or family planning. We must care for her as a person and guarantee for her other sources of livelihood and importance.
- We should begin now with the knowledge that is already available and experiment with it for educational programmes in family planning centres and health services.

Ongoing evaluations of different approaches will be useful in finding out what is feasible and effective within service constraints.

Then followed a paper from Ethiopia on "Female Circumcision In Ethiopia" presented by Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa. Sister Beddada presented a short report and said that female circumcision is mainly done at home by a traditional midwife and never in a hospital. The main reason given to rationalize the operation is that circumcision lessens the sexual desire in the female and so protects the young girl from any promiscuity.

A report from Kenya on "Female Circumcision in Kenya" was presented by Miss N. Njoki, Psychiatric Nurse, Nairobi. Miss Njoki said she would add an intimate personal experience to the report. The operation is done by a traditional healer and usually done in groups in warm weather, about August. Reasons given for the practice are: to reduce sexual desire in the girl and to initiate the young girl into womanhood. The operation is usually performed on the girl between the ages of 7 and 10 years. Though the practice is still being carried out by some groups of people, it is certainly dying out.

A report from Nigeria on Female Circumcision in Nigeria was presented by Dr (Mrs) D.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital, Yaba. Dr Johnson said that there is no official attitude to the practice and there are no reliable data. The practice is dying out. When it is done it is done as early as the seventh day after birth and as late as just before marriage. It gives a sense of belonging to the girl, being thus initiated into adulthood. Dr Johnson also cited many of the physical and psychological complications that follow the operation.

A paper was then presented by Ms Raziya Haji Dualeh, Representative of Somali Women's Democratic Organization on "Female Circumcision in Somalia".

Women are victims of outdated customs and attitudes and male prejudice. This results in negative attitudes by women about themselves.

There are many forms of sexual oppression. These are rooted in the family, society and religion.

In the space of nine years the Somali Revolution has achieved a great deal by building a new generation free of traditional prejudice against women's rights and needs.

Infibulation (Pharaonic circumcision) is still widely practised. It is a horrible practice, fraught with ordeal and danger and is in fact the result of the inability of women to find other ways of establishing virginity.

Children are the centre of life of the Somali family and the whole community. Somali society does everything possible to make sure that a bride is a virgin because of payment of the bride price. Families do not put a stop to the custom, out of fear of the older generation and fanatic religious leaders. The custom can only be abolished through education.

A National Committee coordinated by the Somali Women's Democratic Organization composed of representatives of various Ministries, Unions, Youth Organizations, doctors, etc. has been formed. The Committee is now developing a nationwide campaign.

A report was submitted on "Female Circumcision - Physical and Mental Complications" by Mrs Edna A. Ismail, WHO Temporary Adviser and Director, Department of Training, Ministry of Health, Somalia. Mrs Ismail cited the different forms of circumcision as:

1. Mild Sunna
2. Modified Sunna
3. Partial or total clitoridectomy
4. Infibulation (Pharaonic female circumcision).

The operation is carried out by a woman who earns her living by the performance of such operations or it may be done by paramedical personnel or by the traditional woman - the operated girls are between the ages of 5 and 8. After the operation the child is bound from the waist to her toes and is made to lie still on a mat. The child's diet is restricted and after the seventh day the thorns used to hold the wound together are removed. After the nineteenth day the child may begin to take some steps with a stick.

The physical and mental complications are delineated. The physical complications include the immediate shock from pain and haemorrhage; lacerations due to the struggling of the child, sepsis, retention of urine, closing of the urethra and failure of the infibulation. Usually in this case another operation is done on the child and sometimes a third. Also at the time of marriage more lacerations are inflicted on the woman by her husband and additional cuts have to be made at the time of childbirth.

Mental complications begin to affect the female child from an early age and remain with her throughout her life. Well before the child is circumcised she sees others who have been recently circumcised or hears tales of horror relating to the pain of infibulation. At the same time girls who themselves have been circumcised insult others with insults and call them unclean.

Each stage of her older life will only add further to her mental injuries: the onset of the menarche with its accompanying discomfort and odors; marriage, the opening up of the infibulation and the agony of intercourse; the birth of the first child and the knowledge that subsequent deliveries are not going to be any easier on her scar-riddled vulva.

A survey was made in 1978 by 3 male medical students including interviews of 290 women in hospitals and among university students.

The report also has tables giving the result of the survey which shows the reasons given, the age of the girls, the complications, the hospital records of complications and much more.

The Histological Study of Normal Vulval tissue (Clitoris, labia majora and labia minora) removed at circumcision from 13 children, showed abundance of nerve fibres and touch organs especially in the clitoris.

Fibrous scar tissue of circumcised vulvae of 10 adult women removed at gynaecological repair operations showed very few nerve endings which were trapped in abundance of fibrous tissue.

Circumcision and infibulation (Pharaonic circumcision) results in destruction of the nerve supply of the vulva, thus rendering it into a sheet of fibrous tissue with minimum function.

This paper will present the normal anatomical layout with special reference to innervation and its loss following circumcision and infibulation.

In the fourth session, Dr Suleiman Modawi, Ministry of Health, Khartoum, gave the first presentation under the country profiles of the Sudanese experience. In his paper "The Obstetrical and Gynaecological Aspects of Female Circumcision" Dr Modawi presented the Sudan profile of female circumcision. He reviewed the world history, the entry of circumcision into Sudan and its distribution and then made a critical review of the social impact of socio-economic factors and the changing aspects of circumcision.

Dr S. Mirghany El Sayed (Sudan) from the Centre Hospitalier de Villeneuve, Saint Georges, Villeneuve Saint Georges, France, presented a paper on female circumcision. The paper was read in French. It is part of an M.D. thesis submitted to the Faculty of Medicine in Paris. The material was collected over two years and the aim of the study was to find out the reasons and motives for female circumcision. These were discussed.

After the paper was read, a film was shown. The film was photographed in Central Africa and it shows how the operation is performed and the ceremonies and celebrations which are performed for the occasion.

A very lively discussion followed the presentation of the first two papers.

1. Mrs Amal Arbab, Ministry of Social Affairs, Sudan, took up the point about the effectiveness of the law in abolishing female circumcision and said that probably the law was not effective earlier because those who introduced it did not take into consideration the social circumstances and did not provide alternatives, but if legislation is passed with due consideration to these factors, then they will help in reducing the harmful consequences of the practice.

2. Dr R.A. Khan, WHO Programme Coordinator in Sudan said that Moslems in the world number about 600 million, while female circumcision is only practised by about one fifth of them, so if it had any religious basis it would have been practised by a larger proportion. He suggested that it is probable that those who would like to perpetuate the practise give it a religious quality.

3. Dr R.H.O. Bannerman, Programme Manager, Traditional Medicine, WHO Geneva, said that the pattern of circumcision in all country reports was similar and the reasons for it were multiple. He stated that it is clear that our aim here is to abolish the practice; so he suggested that it might be more useful if the participants would dwell a little more on what to do to abolish the practice. He said it may be worthwhile to look into the experience gained in the field of family planning and try to make use of it here.

Dr Mohammed Shaalan, Assistant Professor and Chairman, Department of Neuro-psychiatry, Faculty of Medicine, Al-Azhar University, Cairo, Egypt, then presented his paper "Clitoris Envy: A Psychodynamic Construct Instrumental in Female Circumcision". Dr Shaalan said that the prevalence of the practice of circumcision over so many centuries and in so many areas, indicates that it is no accidental occurrence. Yet its lack of ubiquity and its declining prevalence indicate that the hypothetical belief on which it was based is uncertain and/or that it is ceasing to be verified.

On the basis of clinical psychotherapeutic experience and other sources, this hypothesis may be speculated to be as follows:

Sexuality was associated with reproduction; reproduction required surplus male labour to provide for the offspring; surplus male labour was provided in exchange for female chastity and fidelity; reduction of female sexual desire and excitability was conducive to chastity and fidelity; this reduction was achieved by excision of erogenous genital areas (essentially the clitoris) or circumcision.

With present social changes reproduction is losing primacy in favour of relation and recreational sexuality. Female chastity and fidelity are declining as exclusively female virtues and circumcision is becoming redundant.

Conscious evolution coupled with rapid social change necessitate active intervention to limit circumcision.

Dr T.A. Baasher, WHO Regional Adviser on Mental Health, then presented his paper: "Psycho-Social Aspects of Female Circumcision". Dr Baasher gave a general introduction on psycho-social aspects of female circumcision. He spoke about the psycholinguistics in female circumcision, the meaning and psychological background of the practice, the psychiatric problems of it and its political associations. He said that words to describe female genitalia in our culture are few and they mainly describe the shape of them. Studying the linguistics will help in understanding the psychology of female circumcision. He said that psychological reactions depend on many factors e.g. defence mechanisms, personality factors, past experience, psychological and social support during and after the operation, and described the psychiatric disturbances resulting from the inflicted psychological trauma or manifesting as a sequelae to the physical complication. He further added that there is paucity of prospective studies about psycho-social disorders following female circumcision and the findings are conflicting. Dr Baasher gave two examples from Kenya and Sudan in relation to politics and female circumcision, where the early efforts to abolish the practice were met with resistance from nationals who thought that the colonizers wanted to destroy the code of modesty and national solidarity when they interfere with such practices.

Dr Malik Badri, Dean, Faculty of Education, University of Khartoum, Sudan, in his paper "Sudanese Children's Concepts About Female Circumcision" stated that any wide range programme to effectively change deep rooted customs and children's

attitudes should be studied. Bearing this in mind a pilot study was made with two groups of girls who were also asked to make some drawings. The two groups of 24 and 19 girls respectively had definite concepts of circumcision as their drawings also indicated. The children expressed a variety of reactions including fear of surgical instruments.

"Opinions about female Circumcision" was a paper delivered by Dr Gasim Badri, Ahfad University College, Omdurman, Sudan. The study group consisted of 60 Sudanese gynaecologists, 24 midwives and 190 female college students. A questionnaire including questions about complications of circumcision, attitudes towards the practice, methods suggested for its eradication, if any, was distributed to all participating in the study group. There was a good response. All gynaecologists who responded said that circumcision has bad physical and psychological complications. They said that the factors perpetuating the practice are multiple. 10% of the midwives thought that circumcision is a good practice. 152 of the 190 female college students said that they will not circumcise their daughters. All of them said that they do not think their grand-daughters are going to be circumcised.

Dr Asma Abdel Rahim El Dareer, Project Director, Department of Community Medicine, Faculty of Medicine, Khartoum, presented a preliminary report on "A Study on Prevalence and Epidemiology of Female Circumcision in Sudan Today" particularly in the White Nile province. This is a part of a broad study, assisted by WHO, on female circumcision. The objectives of the study are to determine the extent of the practice, people's attitudes towards it, health problems encountered, impact of socio-economic factors and possible ways of dealing with the problem. 90% of women interviewed were illiterate and of the lower socio-economic class. There are 3 types of circumcision: pharaonic - 84%, intermediate - 4% and sunna 1%. 4% do not practise circumcision and they belong to the Falata tribe. 81% of husbands approved the practice and 14% of them said it is prohibited by religion. Health education seems to be the most effective method to stop the practice.

Ms Rachel Mayanja - Special Assistant Secretary General for Social Development and Humanitarian Affairs, United Nations, New York, USA, stated that the question of women's health is a very important one, and the United Nations is interested in co-operating with WHO to ensure that this matter is given adequate attention. With regard

to female circumcision she urged the participants to consider whether or not this is a desirable practice. She stressed the need for the participants to make concrete proposals with a view to either abolishing it or providing it under better conditions. She appealed to the media when presenting the views expressed to the public at large to report accurately placing this sensitive topic in its proper context.

The first morning session was devoted to the discussion of the previous day's papers.

Dr B.C.A. Johnson, Chief Consultant Neuro-Psychiatrist, Psychiatric Hospital, Yaba, Nigeria, chaired this session. At the start she welcomed to the meeting Mrs Alice Tiendregeogon, President, Federation of Women of Upper Volta and Representative of the International Alliance of Women, Ouagadougou, Upper Volta, who arrived the previous day. Then she invited the previous day's speakers to give brief summaries of their presentations to refresh the memories of the participants before starting the discussion. After that was done, the Chairman opened the floor for discussions. At the end of the discussion the Chairman invited Mrs Triendregeogon to give her country report. Mrs Triendregeogon addressed the meeting in French.

Commencing with the background of her country Mrs Triendregeogon stated that the Mossi, the largest ethnic groups, have a patriarchal culture, while other population groups have a matriarchal system where the children belong to the mother's family. About 30% of the population is Moslem, 20% Catholic and the rest animist: all groups practise excision, without infibulation. The operation is done when the girls are 10 - 12 years old and are isolated for four weeks afterwards and taught about their adult responsibilities.

Cultural customs are beginning to disappear, however, excision continues also in the cities and is performed under very bad hygienic conditions. The Voltaic Women's Organization started a campaign against excision through a radio broadcast, after asking women why they practised the operation. Most of the women responded "because it is the custom". The women who oppose the excision are the educated ones. Although the Women's Organization dealt only with health problems, the campaign caused an adverse reaction from men as well as women. Therefore the campaign was stopped. This campaign was in 1975; since 1979 is the International Year of the Child abolition of the practice is necessary.

Various points were raised in the discussions; finally it was agreed that a Sub-Committee be formed to draw up resolutions and recommendations in the light of the presentation on female circumcision and the discussion that followed. The following were elected for the Sub-Committee: Dr S. Modawi (Sudan); Dr Afaf A. Salem (Egypt); Sister B. Beddada (Ethiopia); Miss Grace Mbevi (Kenya) and Ms Raziya Haji Dualah (Somalia). They were assisted by Dr R.H.O. Bannerman (WHO Central Office, Geneva) and Ms Rachel Mayanja (United Nations, New York).

In the late morning session Dr Afaf A. Salem, Director, General Directorate Maternity and Child Health, Ministry of Health, Cairo, took the chair.

Dr Salem introduced the first speaker, Mrs Mehani Saleh, Maternal and Child Health Supervisor, Ministry of Health, Aden, who presented her statement on "Traditional Practices during Pregnancy - Female Circumcision and Child Marriage in Yemen Democratic Republic". Mrs Saleh gave a general introduction about the country and an account of traditional practices during pregnancy and labour. She said that during the post-natal period the nursing mother does not take cold drinks and she is not allowed to take certain food like fish and beans because it is thought that this will pass with the mother's milk and cause abdominal pain in the child. The duration of confinement after delivery is 40 days. She said that circumcision is usually done by the traditional midwife and can take place as early as the seventh day after birth. She also stated that the marriage age for the female is between 15 and 16 years.

Mrs Saleh suggested some measures - such as general education, health education - be taken to abolish practices dangerous for women's health. She made a plea for women's organizations to take a leading role.

Then Dr L.J. Ghulam, Senior Public Health Officer, Ministry of Health, Oman, presented her paper on "Early Teenage Childbirth and its Consequences for both Mother and Child". Dr Ghulam indicated that in Oman both sexes, especially females, get married when very young, and as a result the infant mortality rate is very high. She presented a summary of a study conducted in Nizwa and Soher communities in Oman regarding early teenage childbirth. 2% of women interviewed in Nizwas were married at the age of 11 and 86% were married by the age of 15. In Soher 9% were married by

the age of 11 and 80% by the age of 15. There is a trend towards marrying at a later age in Soher. Dr Ghulam then listed the complications that result from early marriage, e.g. risk of operative delivery, low birth weight. She ended by recommending a design of a health education programme and passing some legislation to stop the practice.

The third speaker was Sister B. Beddada, Instructor, Health Assistant School, Menelik II Hospital, Addis Ababa and she gave a brief communication on child marriage in Ethiopia. She stated that the marriage age for the female is between 12 - 15 years. The main reason for that in the mind of the people is to prevent pre-marriage pregnancy.

Miss Grace Mbevi, Public Health Nurse, Kenya, presented a paper on "Child Marriage and Early Teenage Childbirth". As mentioned in the past, children were counted as wealth. This was because, for the female children, a brideprice was paid (dowry) and this was a source of income to the family. Child-marriage was also a custom; the main function of a woman was to bear children, hence the custom of early marriage, but this practice is dying out in Kenya. The Government and religious leaders are playing a very significant role on this issue. Miss Mbevi explained how the child is exposed to early responsibility which is difficult to cope with and this leads to mental stress and many other complications. Due to early marriage the female child is deprived of education and this is essential for the developing countries since, as everyone knows, to educate women is to educate the nation.

The fifth paper was presented by Dr M. Warsame, Director, Benadir Hospital, Mogadishu, on "Early Marriage and Teenage Deliveries in Somalia". Dr Warsame stated that the country is divided into 3 economic groups: the nomadic (about 70%), the agricultural (about 15%) and the urban who are the minor component. He said in the nomadic areas a man is not considered mature before the age of 20 years and in these areas marriage is decided by the elder male relatives. Polygamy is practised in this nomadic sector. The nomadic prefer to have children at intervals of 2 years.

In agricultural communities early marriages occur usually at the age of 15. In these communities there is no spacing of pregnancies and the birth rate is very high.

In the urban community only a few still practise child marriage, sometimes at the age of 12, and in this community polygamy is very rare. The average age of marriage is 20 years.

The Chairman expressed her regret for the absence of Dr Haddad O. Karoun, Head, Department of Obstetrics and Gynaecology, Faculty of Medicine, Khartoum, who was expected to present a paper on "Adolescent Pregnancy and Childbirth". She then introduced Dr O. Modawi, Senior Gynaecologist and Obstetrician, Ministry of Health, Sudan, who made a brief comment on teenage pregnancy. Dr Modawi said that generally early marriage is the mode in many parts of the country. Several factors play their role here e.g. tradition, religion, few chances for education. He said that there are no social difficulties as a result of this early marriage, but mainly health problems to the young primigravidae. He also said that, except for very few tribes in the Southern part of the country, early teenage pregnancy in the unmarried is a stigma and is unwanted.

After the presentations, the floor was open for discussion and valuable comments were made.

Mrs Edna Adan Ismail, WHO Temporary Adviser and Director of Department of Training, Ministry of Health, Somalia, presented a paper on "Child Marriage and Early Teenage Childbirth". Mrs Ismail stated that although child marriages sometimes take place among nomadic and agricultural communities, the practice is very rare now in Somalia. No accurate statistics can be obtained since these communities conduct their marriages and deliveries themselves. Statistics on deliveries at the Mogadishu Maternity Hospital during the last six months show that there have been no deliveries of females under the age of fourteen years. It is not known if the practice was reduced because of the law which was passed on 11 January 1975 which makes it illegal for a female below the age of 16 to be married and a male below the age of 18, or whether the practice is dying out because of economic reasons. In any case, the practice of child marriage no longer presents problems in Somalia.

RECOMMENDATIONS

Three categories of traditional practices - useful, harmless and harmful - were discussed by the participants in the Seminar. The following recommendations were proposed in support of useful practices and to abolish harmful ones. Special recommendations were made to correct harmful practices and to replace them with positive actions to promote better health.

National policies should be formulated to promote useful practices and to abolish harmful ones.

Useful practices

- Governments should recognize the need for adequate breast-feeding for the health of the child, which reflects on the total well-being of the family and the nation.
- Feeding of expectant mothers should be promoted.
- Day nurseries and crèches for working mothers should be a matter of priority.
- More part-time professional as well as non-skilled jobs should be available for women.
- Intensive nutrition education programmes should be launched by all those involved in the health of mothers and children.
- Nutrition education for women through MCH centres, schools and rural health units should be encouraged.
- Nutrition education should be propagated by the mass media with the widest possible coverage.

In summary, traditional breast-feeding patterns should be supported by giving women the opportunity to continue breast-feeding and by providing them with information on healthful feeding patterns for themselves as well as for their children.

Harmless practices

A variety of harmless practices were discussed, such as fumigation and certain charms, amulets etc. to ward off evil spirits. It is envisaged that with health education and socio-economic changes, such practices will disappear and the community will make appropriate use of available modern medical technology.

Harmful practices

- (a) Harmful practices, customs and traditions, for example restrictive feeding patterns during pregnancy or abrupt weaning, should be exposed; special educational programmes should be designed concerning the harmfulness of such practices; and positive attitudes towards nutrition, involving useful, locally available foods, should be promoted.
- (b) Other harmful practices, for example the restriction of high-protein diets including fish, chicken, eggs and camel meat in certain communities, should be discouraged because of their ill effects.
- (c) It is the belief among some communities that the milk of pregnant mothers is harmful to the child she is nursing and consequently breast-feeding is abruptly stopped, with ill effects on the child. Hence, special educational programmes for pregnant women and mothers should be developed and promoted to stop these harmful practices.
- (d) Special attention should be focused on the insufficiency of appropriate nutritional ingredients of supplementary foods for infants, the tendency to feed low protein-calorie diets to babies, the ill effects of the promotion of artificial and manufactured milk and food substitutes for babies.
- (e) Other harmful practices and remedies were discussed, e.g. cauterization (the application of hot iron sticks to certain parts of the body as a curative and preventive measure for diarrhoeal diseases and respiratory infections; cauterization of children's gums at the time of teething, etc.).
- (f) Noting the harmful effects associated with the use of tobacco, khat, alcohol, etc. in some countries on pregnancy, it is recommended that concerted efforts be made for the prevention of the use of these toxic agents.

Female circumcision

The following recommendations were made:

- (i) Adoption of clear national policies for the abolition of female circumcision.

- (ii) Establishment of national commissions to coordinate and follow up the activities of the bodies involved including, where appropriate, the enactment of legislation prohibiting female circumcision.
- (iii) Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of female circumcision.
- (iv) Intensification of education programmes for traditional birth attendants, midwives, healers and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision, with a view to enlisting their support along with general efforts to abolish this practice.

Childhood marriage and early teenage childbirth

It was recommended to:

- Conduct further research concerning child marriage and early teenage childbirth in all its aspects, i.e. medical, social, psychological, etc., to find out the possible complications.
- Design health education programmes in order to discourage childhood marriage.
- Introduce legislation to stop childhood marriage when and where appropriate.

ANNEX I

ADDRESS OF HIS EXCELLENCY SAYED KHALID HASSAN ABBAS,
MINISTER OF HEALTH, SUDAN, TO THE SEMINAR ON TRADITIONAL
PRACTICES AFFECTING THE HEALTH OF WOMEN HELD IN THE FRIENDSHIP
HALL, KHARTOUM
FROM 10-15 FEBRUARY 1979

Distinguished participants, Ladies and Gentlemen,

Greetings of our eternal and "God Given" victorious revolution. I bring you greetings from our brother President Gaafar Mohammed Numeiry wishing to express our extreme happiness that you have chosen the Sudan as the venue of this important Seminar. I wish to thank the participating brothers and sisters and I greet the institutions and the international, regional and local organizations who have participated in this Seminar, especially the World Health Organization and United Nations Development Programme and their representatives in Alexandria and the Sudan.

Women constitute half the society, carrying the burden of building the family and the society. It is therefore imperative for governments and organizations to protect her in order to ensure development. For this reason it has been our policy in the national health programme to give priority to maternal and child health within the preventive and medical services, thus following what has already been provided for in the Constitution towards the protection of women. Since the mother is the very foundation of the family, to protect her means to provide happiness and peace to the whole family and to the ideal society for which we aim. Despite our ambitions and dreams to provide the best for her, we find that our resources are limited and we, therefore, seek for help from the international organizations in order that they may assist us in achieving our goals and ambitions.

We, as a country with its own history, customs and traditions, originating from the environment must give these customs and traditions much attention. We must also study them to benefit from them. At the same time must study the harmful practices in order that we may avoid them and try and eradicate them and, protect the health and happiness of the women and the family.

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HTH.WM/ 44
Annex I
page ii

The cadres working in the health fields, and especially midwives and dayas, are accepted and respected by mothers. We, therefore, train them and prepare them in the fields of health education in order that they may carry out this role. We hope that the Women's Associations will carry out their active and effective roles in spreading health knowledge.

We, therefore, hope that this Seminar will collect the necessary information concerning the traditional practices, especially in the case of circumcision, traditional nutritional practices, early marriage and traditional practices in the field of pregnancy and child bearing, in order to find the best ways and means to develop and spread the beneficial practices and to eradicate the harmful ones.

We have made many previous efforts to eradicate some of these harmful practices through the legal system, but many of these methods have failed. We must, therefore, turn to health education as the means of spreading health knowledge hoping that we may thus influence the people and make them want to act in a correct and healthy way. These new trials and approaches have shown some hopeful results and we are convinced that health education will be our means to change these harmful traditions to better and beneficial customs.

I wish all success to your Seminar in order that you may reach effective decisions and recommendations and we, in the Ministry of Health, will give your recommendations all our support and will see that they are carried out, and together we hope to reach our aim in building our modern society without forgetting our good and beneficial traditions which may help assist us in growth and development.

WHO EMRO

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HDD.WM/44
Annex II
page i

ANNEX II

MESSAGE FROM DR A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION
TO THE
SEMINAR ON TRADITIONAL PRACTICES
AFFECTING THE HEALTH OF WOMEN
Khartoum, 10-15 February 1979

Dear Colleagues, Ladies and Gentlemen,

It gives me particular pleasure, and indeed happiness, to welcome you all, on behalf of WHO, to this important Seminar on Traditional Practices Affecting the Health of Women. Much as I would have liked to be in person with you, due to other official commitments this was not possible. However, I wish your meeting fruitful deliberations and successful discussions.

I am particularly grateful to the Government of the Democratic Republic of the Sudan for hosting this Seminar, and to the Ministry of Health, under the leadership of H.E. Sayed Khalid Hassan Abbas, Minister of Health, for unfailing support and excellent collaboration in the preparation of this meeting.

Furthermore, I am appreciative of the keenness and interest shown by various countries and by a number of UN agencies, non-governmental organizations, institutions and the mass media. This interest is not new nor surprising for, as you are aware, the UN and its Member States have been increasingly concerned with the promotion of the status of women and their role in economic and social development. This was formally acknowledged by declaring 1975 International Women's Year, and by proclaiming the ensuing decade the United Nations Decade for Women. Similarly, the World Health Assembly in 1975 passed a resolution urging governments to widen the range of opportunities for women in all aspects of health and to ensure the further integration of women in health activities.

Furthermore, special attention was given to traditional practices and their effects on the health of women, with the primary objective of fostering a realistic approach to promote useful and proven practices and do away with harmful ones.

In this respect, I am pleased to point out that concerted efforts have recently been made by the WHO Eastern Mediterranean Regional Office to systematically collect information and stimulate interest in this subject. It has also been advocated that the consequences of traditional practices, be they healthy or adverse, be highlighted, wherever appropriate, in training programmes and scientific meetings.

At the international level, it is important to recall that in 1976 the Director-General of WHO drew the attention of the World Health Assembly to the need to "combat taboos, superstitions and practices that are detrimental to the health of women and children, such as female circumcision and infibulation". It has also been considered appropriate to include the latter topic as well as others among the agenda items of this Seminar.

It is obvious that the topics with which you will be dealing are intricately culture-bound and deeply enmeshed in the customs and beliefs of the people and have, therefore, to be appropriately studied within their local contexts and social perspectives.

I feel confident that the distinguished participants in this Seminar, with their multi-disciplinary professional backgrounds and wide experience, will competently contribute to its success and I will, therefore, be looking forward to the recommendations emanating from you, which I sincerely hope will be helpful in the promotion of the health of women and in the proper care of children.

ANNEX II

MESSAGE FROM DR A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION
TO THE
SEMINAR ON TRADITIONAL PRACTICES
AFFECTING THE HEALTH OF WOMEN
Khartoum, 10-15 February 1979

Dear Colleagues, Ladies and Gentlemen,

It gives me particular pleasure, and indeed happiness, to welcome you all, on behalf of WHO, to this important Seminar on Traditional Practices Affecting the Health of Women. Much as I would have liked to be in person with you, due to other official commitments this was not possible. However, I wish your meeting fruitful deliberations and successful discussions.

I am particularly grateful to the Government of the Democratic Republic of the Sudan for hosting this Seminar, and to the Ministry of Health, under the leadership of H.E. Sayed Khalid Hassan Abbas, Minister of Health, for unfailing support and excellent collaboration in the preparation of this meeting.

Furthermore, I am appreciative of the keenness and interest shown by various countries and by a number of UN agencies, non-governmental organizations, institutions and the mass media. This interest is not new nor surprising for, as you are aware, the UN and its Member States have been increasingly concerned with the promotion of the status of women and their role in economic and social development. This was formally acknowledged by declaring 1975 International Women's Year, and by proclaiming the ensuing decade the United Nations Decade for Women. Similarly, the World Health Assembly in 1975 passed a resolution urging governments to widen the range of opportunities for women in all aspects of health and to ensure the further integration of women in health activities.

Furthermore, special attention was given to traditional practices and their effects on the health of women, with the primary objective of fostering a realistic approach to promote useful and proven practices and do away with harmful ones.

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HTH.WM/44
Annex II
page ii

WHO EMRO

In this respect, I am pleased to point out that concerted efforts have recently been made by the WHO Eastern Mediterranean Regional Office to systematically collect information and stimulate interest in this subject. It has also been advocated that the consequences of traditional practices, be they healthy or adverse, be highlighted, wherever appropriate, in training programmes and scientific meetings.

At the international level, it is important to recall that in 1976 the Director-General of WHO drew the attention of the World Health Assembly to the need to "combat taboos, superstitions and practices that are detrimental to the health of women and children, such as female circumcision and infibulation". It has also been considered appropriate to include the latter topic as well as others among the agenda items of this Seminar.

It is obvious that the topics with which you will be dealing are intricately culture-bound and deeply enmeshed in the customs and beliefs of the people and have, therefore, to be appropriately studied within their local contexts and social perspectives.

I feel confident that the distinguished participants in this Seminar, with their multi-disciplinary professional backgrounds and wide experience, will competently contribute to its success and I will, therefore, be looking forward to the recommendations emanating from you, which I sincerely hope will be helpful in the promotion of the health of women and in the proper care of children.

ANNEX III

LIST OF PARTICIPANTS

Eastern Mediterranean Region

DEMOCRATIC YEMEN

Mrs Mehani Saleh
Maternal and Child Health Supervisor
Ministry of Health
Aden

DJIBOUTI

Dr Said Salah Youssouf
Médecin Chef du Centre médical de Brousse
Tadjourah

Dr Alain David
Médecin Chef du Centre médical de Brousse
Ali-Sabieh

EGYPT

Dr Afaf Attia Salem
Director
General Directorate Maternity and Child Health
Ministry of Health
Cairo

Dr Ahmed Saad El Dine El Hakim
Director
Mental Health Department
Ministry of Health
Cairo

Mrs Angèle Naguib Mikhail
Director of Nursing Services
Alexandria Health Directorate
Alexandria

OMAN

Dr Layla Jassim Ghulam
Senior Public Health Officer
Maternal and Child Health Section
Ministry of Health
Muscat

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.MTH.WM/ 44
Annex III
page ii

WHO EMRO

SOMALIA

Dr Mohamed Warsame
Director
Benadir Hospital
Mogadishu

Dr Faduma Haji Mohamed Hussein
Gynaecologist
Benadir Hospital
Mogadishu

SUDAN

Dr Hamid Rushwan
Associate Professor
Gynaecology and Obstetrics Department
Faculty of Medicine
Khartoum

Dr O. Modawi
Senior Gynaecologist and Obstetrician
Ministry of Health
Khartoum

Dr Hafiz El Shazali
Consultant Paediatrician
Medani Hospital
Wad Medani

Dr Ali Karrar Osman
Director
Nutrition Division
Ministry of Health
Khartoum

Dr Suliman Modawi
Gynaecologist Obstetrician
Ministry of Health
Khartoum

Dr Hassab El Rasoul Suleiman
Director-General
Mental Health Department
Khartoum

Mrs Amal Sayed Arbab
Sudan Family Planning Association
Ministry of Social Affairs
Khartoum

WHO EMRO

EM/MCH/137
EM/MENT/91
EM/SEM.TR.IR.AFF.MTH.EM/44
Annex III
page iii

SUDAN
(cont'd)

Dr Mohamed Ahmed Ali El Sheikh
Lecturer
Obstetrics/Gynaecology
University of Khartoum
Khartoum

Dr Asma Abdel Rahim El Dareer
Project Director
Department of Community Medicine
Faculty of Medicine
Khartoum

Dr Sanaa Abu Samra
Medical Officer
Ministry of Health
Khartoum

Dr Mirghani El Sayed
Centre Hospitalier de Villeneuve
Saint Georges
Villeneuve Saint Georges - FRANCE

Dr Yahia Ownallah Younis
Department of Community Medicine
Faculty of Medicine
Khartoum

African Region

ETHIOPIA

Sister B. Beddada
Instructor
Health Assistant School
Menelik II Hospital
Addis Ababa

KENYA

Miss Grace Mbevi
Public Health Nurse
Kitui District Hospital
Kitui

Miss Margaret Njoki
Psychiatric Nurse
Machakos Provincial General Hospital
Nairobi

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HTh.WM/44
Annex III
page iv

WHO EMRO

NIGERIA

Dr (Mrs) B.C.A. Johnson
Chief Consultant Neuro-Psychiatrist
Psychiatric Hospital
Yaba

Dr (Mrs) M.O. Aromasodu
Assistant Director
Public Health Services
Federal Ministry of Health and Social Welfare
Lagos

Mrs D.Y. Kuteyi
Principal Nursing Officer, PH
Federal Ministry of Health and Social Welfare
Lagos

OBSERVERS
FROM SUDAN

Mrs Hawa Mohamed Salih
Nurse/Midwife
Ministry of Health
Khartoum

Dr Abu Obeida El Magzoub
Health Education Department
Ministry of Health
Khartoum

Dr Malek Badri
Ministry of Health
Khartoum

Dr Samia El Azharia Jahn
Water Purification Project
Khartoum

Sister Fatma O. Killa
Khartoum Nursing College
Khartoum

Sister Soad Ahmed El-Sharifi
Khartoum Nursing College
Khartoum

Miss Miranda Munro
Medical Social Worker
Terre des hommes
Khartoum

WHO EMRO

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.NTH.WM/ 44
Annex III
page v

OBSERVERS
FROM SUDAN (cont'd)

Miss Awatif Bashir Hamid
Khartoum Nursing College
Khartoum

Sister Lisbeth Boberg
Health Educator
Khartoum

Miss Angela Chell
Nomadic Community Health Project
El Obeid

Miss Ann Rose
Department of Social Anthropology
University of Khartoum
Khartoum

Dr Salah Abu Bakar
Director
Buluk Hospital
Omdurman

Dr Mahmoud Abbakar Suleiman
Department of Psychiatry
Faculty of Medicine
Khartoum

Dr Yousif Mahdi
Amarat
Khartoum

Miss Zeinab Salih Fadi El Mool
Khartoum Nursing College
Khartoum

Miss Awatif Ahmed Farag
M.S.A.I.D.
Khartoum

Dr Ahmed Osman Ahmed
Faculty of Medicine
Khartoum

Dr Gail Price
Ahfad University College
Omdurman

Dr Gasim Badri
Ahfad University College
Omdurman

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HTH.WM/44
Annex III
page vi

WHO EMRO

REPRESENTATIVES FROM OTHER UNITED NATIONS BODIES

UNITED NATIONS	Ms Racnel Mayanja Special Assistant Secretary General for Social Development and Humanitarian Affairs United Nations <u>New York</u> USA
UNITED NATIONS DEVELOPMENT PROGRAMME	Mr C. H. La Munière Resident Representative United Nations Development Programme <u>Khartoum</u> SUDAN
UNICEF	Mr Henry M. Kasiga UNICEF Project Officer Sudan Country Office <u>Khartoum</u> SUDAN
	Mrs Marie B. Assaad Senior Research Assistant The American University in Cairo Representing UNICEF <u>Cairo</u> EGYPT

OBSERVERS FROM OTHER ORGANIZATIONS

FEDERATION OF WOMEN OF UPPER VOLTA AND INTERNATIONAL ALLIANCE OF WOMEN	Mrs Alice Tiendregeon President, Federation of Women of Upper Volta and Representative, International Alliance of Women <u>Ouagadougou</u> UPPER VOLTA
INTERNATIONAL PLANNED PARENTHOOD FEDERATION	Dr Mohammad Shaalan Assistant Professor and Chairman Department of Neuropsychiatry Faculty of Medicine Al Azhar University <u>Cairo</u> EGYPT

WHO EMRO

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.RTH.WM/44
Annex III
page vii

INTERNATIONAL
UNION FOR CHILD
WELFARE

Dr Mahmoud Mohamed Hassan
Senior Paediatrician
Khartoum Civil Hospital
Khartoum
SUDAN

INTERNATIONAL
CONFEDERATION OF
MIDWIVES

Mrs Awatif Osman
Director
College of Nursing
Ministry of Education
Khartoum
SUDAN

JOHNS HOPKINS
POPULATION INFORMATION
PROGRAMME

Dr Samuel Coleman
Staff Research Associate
Baltimore, Maryland
USA

MEDICAL WOMEN'S
INTERNATIONAL
ASSOCIATION

Dr Muna Husain Hassan
University Eye Hospital
Khartoum
SUDAN

NATIONAL BOARD OF
HEALTH AND WELFARE -
SWEDEN

Dr Marianne Cederblad
Head
Clinic for Child and Adolescent Psychiatry
Regional Hospital
Linköping
SWEDEN

SOMALI DEMOCRATIC
WOMEN'S ORGANIZATION

Ma Raqiya Haji Dualeh
Education Secretary
Somali Democratic Women's Organization
Mogadishu
SOMALIA

Miss Mariam Farah Warsame
Foreign Relations Secretary
Somali Democratic Women's Organization
Mogadishu
SOMALIA

WHO SECRETARIAT

Dr T.A. Saasher	Regional Adviser on Mental Health and Secretary of the Seminar	WHO Regional Office for the Eastern Mediterranean, <u>Alexandria, EGYPT.</u>
Dr R. Khan	WHO Programme Coordinator, SUDAN	WHO Eastern Mediterranean Regional Office
Dr K.H.O. Bannerman	Programme Manager, Traditional Medicine	WHO Central Office, <u>Geneva, SWITZERLAND.</u>
Mrs Edna Adan Ismail	WHO Temporary Adviser	Director, Department of Training, Ministry of Health, <u>Mogadishu, SOMALIA</u>
Mrs F. Hosken	WHO Temporary Adviser	Editor, Women's International Network, <u>Lexington, USA.</u>
Mrs C. Cartoudis-Démétrio	Conference Officer	WHO Regional Office for the Eastern Mediterranean, <u>Alexandria, EGYPT.</u>
Mrs S. Banoub	Secretary	WHO Regional Office for the Eastern Mediterranean, <u>Alexandria, EGYPT.</u>

NATIONAL PREPARATORY COMMITTEE

Dr Hamid Rushwan	Chairman of the National Preparatory Committee	Associate Professor, Gynaecology and Obstetrics Department, Faculty of Medicine, <u>Khartoum, SUDAN.</u>
------------------	---	--

WHO EMRO

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HTH.WM/ 44
Annex III
page ix

MEDIA REPRESENTATIVES

Mr Mohammad Moussa
Information Officer
Ministry of Health
Khartoum

Miss Willemien Klarenberg
Author
Sara Publishing Firm
Amsterdam
HOLLAND

Mr Mostafa Fathi
Information Officer
Ministry of Health
Khartoum

Mr Abdel Moneim Mohamed Aly
Press Information Officer
Ministry of Information
Khartoum

Miss Claire Brisset
Le Monde
Paris
FRANCE

Mr Pierre Lanfranchi
French Newspapers (Free Lance)

Mrs Eva Hoffmann
German Television
Mainz
FEDERAL REPUBLIC OF GERMANY

Mr Giuseppe Josca
Cairo Correspondent
Swiss Radio and Television
Cairo

Miss Clarisse Lucas
Reuters
London
ENGLAND

Miss Betsy Udink
Author
Sara Publishing Firm
Amsterdam
HOLLAND

ANNEX IV

LIST OF BASIC DOCUMENTS

Agenda	EM/SEM.TR.PR.AFF.HTH.WM/1
Programme	EM/SEM.TR.PR.AFF.HTH.WM/2 Rev.2
List of Participants	EM/SEM.TR.PR.AFF.HTH.WM/3 Rev.2
Nutritional Taboos and Traditional Practices in Pregnancy and Lactation including Breast-feeding, by Dr Hafiz El Shazali	EM/SEM.TR.PR.AFF.HTH.WM/4
Dietary Practices and Aversions during Pregnancy and Lactation among Sudanese Women, by Dr Ali K. Osman	EM/SEM.TR.PR.AFF.HTH.WM/5
Traditional Feeding Practices in Pregnancy and Lactation in an Egyptian Community, by Mrs A.N. Mikhail	EM/SEM.TR.PR.AFF.HTH.WM/6
Nutritional Taboos and Traditional Practices in Pregnancy and Lactation including Breast-feeding Practices, by Dr L.J. Ghulam	EM/SEM.TR.PR.AFF.HTH.WM/7
Tobacco and Reproductive Health: Practices and Implications in Traditional and Modern Societies, by Dr S. Coleman	EM/SEM.TR.PR.AFF.HTH.WM/8
Traditional Practices on Confinement and after Childbirth, by Dr B.L.K. Pillsbury	EM/SEM.TR.PR.AFF.HTH.WM/9
Traditional Practices in Childbirth, by Dr O. Modawi	EM/SEM.TR.PR.AFF.HTH.WM/10
Female Circumcision in the World of To-Day: A Global Review, by Mrs F. Hosken	EM/SEM.TR.PR.AFF.HTH.WM/11
Female Circumcision, Physical and Mental Complications, by Mrs E. Ismail	EM/SEM.TR.PR.AFF.HTH.WM/12
The Obstetrical and Gynaecological Aspects of Female Circumcision in the Sudan, by Dr S. Modawi	EM/SEM.TR.PR.AFF.HTH.WM/14
A Study of Prevalence and Epidemiology of Female Circumcision in Sudan To-Day - Preliminary Findings, by Dr Asma A.R. El Dareer	EM/SEM.TR.PR.AFF.HTH.WM/15
Female Circumcision in Sudan, by Dr M. El Sayed	EM/SEM.TR.PR.AFF.HTH.WM/16

Psycho-social Aspects of Female Circumcision, by Dr T.A. Baasher	EM/SEM.TR.PR.AFF.HTH.WM/17
Child Marriage in Somalia, by Mrs E. Ismail	EM/SEM.TR.PR.AFF.HTH.WM/18
Traditional Practices in Relations to Pregnancy and Child Birth, by Sister Beddada	EM/SEM.TR.PR.AFF.HTH.WM/21
Clitoris Envy: A Psychodynamic Construct Instru- mental in Female Circumcision, by Dr M. Shaalan	EM/SEM.TR.PR.AFF.HTH.WM/23
Nutritional Needs of the Child especially in the First Year of Life, by Mrs P.V. Kuteyi	EM/SEM.TR.PR.AFF.HTH.WM/24
Traditional Practices affecting the Health of Women in Pregnancy and Childbirth, by Dr M.C. Aromasodu	EM/SEM.TR.PR.AFF.HTH.WM/25
Early Marriage and Teenage Deliveries in Somalia, by Dr M. Warsame	EM/SEM.TR.PR.AFF.HTH.WM/26
Female Circumcision in Egypt, by Mrs A.A. Salem	EM/SEM.TR.PR.AFF.HTH.WM/27
Traditional Practices in Relation to Child Health, by Miss Grace Mbevi and Miss Margaret Njoki	EM/SEM.TR.PR.AFF.HTH.WM/28
Early Teenage Childbirth, Consequences of this for Mother and Child, by Dr L.J. Ghulam	EM/SEM.TR.PR.AFF.HTH.WM/29
Psycho-social Aspects of Female Circumcision in the Sudan, by Dr Gasim Badri	EM/SEM.TR.PR.AFF.HTH.WM/30
Sudanese Children's Concepts about Female Circumcision, by Prof. M. Badri	EM/SEM.TR.PR.AFF.HTH.WM/31
Traditional Practices in Relation to Childbirth, Female Circumcision and Child Marriage and Early Teenage Childbirth in Democratic Yemen, by Mrs Mehani Mohammed Saleh	EM/SEM.TR.PR.AFF.HTH.WM/32
Circumcision and Infibulation in the Sudan, by Dr Salah Abu Bakr	EM/SEM.TR.PR.AFF.HTH.WM/33
Circumcision of Girls, by Dr Nawal El Saadawi	EM/SEM.TR.PR.AFF.HTH.WM/34
Traditional Practices affecting the Health of Women, by Dr B.C.A. Johnson	EM/SEM.TR.PR.AFF.HTH.WM/35
Somali Democratic Republic, Somali Women's Democratic Organizations, by Ms R. Haji Dualeh and Mrs Mariam Farah Warsame	EM/SEM.TR.PR.AFF.HTH.WM/39

WHO EMRO

EM/MCH/137
EM/MENT/91
EM/SEM.TR.PR.AFF.HTH.WM/44
Annex IV
page iii

Female Circumcision in Upper Volta,
by Mrs Alice Triendregeogon

EM/SEM.TR.PR.AFF.HTH.WM/40

Female Circumcision in Egypt: Current Research
and Social Implications, by Mrs Marie B. Assaad

EM/SEM.TR.PR.AFF.HTH.WM/41

Women and Health in East and West Africa:
Family Planning and Female Circumcision,
by Mrs F. Hosken

EM/SEM.TR.PR.AFF.HTH.WM/42

Female Circumcision in Egypt, by
Dr Ahmed Saad El Dine El Hakim

EM/SEM.TR.PR.AFF.HTH.WM/43

Final Report

EM/SEM.TR.PR.AFF.HTH.WM/44



WORLD HEALTH ORGANIZATION

Female circumcision

Female genital mutilation^{1,2}



INTERNATIONAL FEDERATION OF
GYNECOLOGY AND OBSTETRICS (FIGO)

Female circumcision in any of its three forms, is a painful fact of life for about 80 million girls and women in over 30 countries of Africa, the Middle East and South East Asia where its practice is widespread.

Although a traditional practice, female circumcision is also a health issue because it potentially affects the physical and mental well being of every woman and girl who undergoes the surgical procedure.

In its mildest form, female circumcision involves only the removal of the foreskin of the clitoris. But in the majority of cases the clitoris itself is removed, together with all or part of the labia minora and in the most severe form the labia majora.

Initial circumcision is carried out before a girl reaches puberty sometime between 1 week and 14 years, and in some societies where infibulation is practiced, women are commonly re-infibulated after each delivery, after divorce and on the death of their husband.

Because the operation is usually performed by traditional midwives, with unsterilized knives, razors or pieces of glass and without any anesthesia, it carries many health risks.

The immediate physical effects — acute infection, tetanus, bleeding of adjacent organs, shock resulting from violent pain, and hemorrhage —

can even cause death. In fact, many such deaths have occurred in continue to occur as a result of this traditional practice.

The lifelong physical and psychological debilities resulting from female genital mutilations, are manifold: chronic pelvic infections, keloids (scar tissue), vulval abscesses, sterility, incontinence, depression, anxiety and even psychosis, sexual dysfunction and marital disharmony, and obstetric complications, with risk to both the infant or fetus and the mother. Female circumcision also carries with it the possibility of AIDS infection. Finally, there is profound impairment of women's potential for development as a result of trauma and chronic suffering.

Female circumcision is significantly associated with poverty, illiteracy and low status of women, with communities in which people face hunger, ill health overwork and lack of clean water. In these settings, the woman who is not circumcised is stigmatized, ostracized and not sought in marriage. Regardless of her personal feelings, a woman who wants to remain with her own community cannot afford to rebel against or even question this tradition which remains profoundly entrenched in powerful taboos and is protected by secrecy and moral codes. If she loses her community social acceptance and support, it may mean the difference between life and death. Hence the paradox — the victims of the practice are also its strongest proponents.

Because of the difficulty and delicacy of eradicating a practice based on cultural and traditional patterns that have been traced back for over 2000 years, the issue can only be addressed effectively by promoting awareness through education of the

¹ Issued by the joint WHO/FIGO Task Force. For further information contact FIGO Secretariat, 27 Sussex Place, Regents Park, London, NW1 4RG, UK.

² This article appeared in the International Journal of Obstetrics and Gynecology 1992; 37: 19.

public, of health workers and of trained practitioners. It requires the active involvement of local communities, their leaders, women groups and organizations rather than emotional statements by outsiders, however well intentioned they may be. Experience shows that when the practice of female circumcision has been condemned by outsiders or outlawed by governments in isolation from the complex psychosocial, cultural process of which it is but one part, it has led to the exacerbation of the problem. The practice has simply been done with greater secrecy and those suffering from complications have been inhibited from seeking help.

In any effort to change prevailing attitudes towards this custom, the education of men is as critical as the wider efforts to improve the status of women including that of their reproductive health as a whole. In settings where femal circumcision represents one among many other serious problems facing women, it is these women themselves who must set their priorities and initi-

ate the steps towards the abolition of this practice in line with the religious and cultural sensitivities surrounding this subject. National and local women's organizations, governmental or not, have been distinctly identified as the most appropriate mechanism for influencing the process of change in attitudes and practice of this age old custom. Such national and local initiatives can be greatly helped by outside support to accelerate this pace of change.

Together with UNICEF, UNFPA, WHO and FIGO continue to support national efforts against femal circumcision and to collaborate in research and in the dissemination of information. WHO also collaborates with the Inter-African Committee, a regional NGO which works through its affiliates in 22 African countries.

WHO believes that integrating information on female circumcision in programs of primary health care and safe motherhood will have a far reaching effect.



Maternal and child health and family planning: Current needs and future orientation¹

Report by the Director-General

This report reviews the health situation of women and children 15 years after the introduction of primary health care and 18 years after the sixth meeting of the Expert Committee on Maternal and Child Health. Major advances in policies and programmes have occurred since then. While many of the recommendations of the Expert Committee have been implemented at a policy level and are reflected in the strategy for health for all through primary health care, there have been notable gaps between policy and programme implementation in a number of areas. Integration of the elements of maternal and child health and family planning and sustainability of programmes elude many countries, particularly the least developed, with their weak infrastructures and dependence on external support for specific components of care.

Nearly all countries have adopted policies recognizing the importance of family planning, and direct or indirect support to programmes is found in 144 countries. However, a great continuing need for the spacing and limiting of births is noted in many countries, and facilities for family planning are often limited to the maternal and child health services.

Immunization coverage shows substantial increases in all regions of the world and infant mortality rates continue to decline. New problems have emerged, and many have been reflected in policies and programmes.

Maternal health has become a high priority in most countries, underlined by the tragic figure of over 500 000 maternal deaths each year. The health of the newborn is inseparable from the health of the mother. Despite progress, significant differences in maternal and child health and family planning coverage continue to exist between countries, and differences between groups within countries may even be on the rise. Analysis of the patterns of coverage and accessibility reveals major gaps in the quality of care provided in services.

Approaches appropriate to both developed and developing countries are described in the final sections. The Executive Board is invited to consider resolutions on traditional practices that are harmful to the health and development of women and children and on quality of care in maternal and child health and family planning.

¹ For a tabular summary the reader is referred to document EB93/INF.DOC./3.

CONTENTS

	Page
Introduction	3
Policies and international instruments	3
Progress in the health status of women, children and families	4
Emerging health needs for women, children and families	5
Provision of care: accessibility, coverage and quality of care	6
Traditional practices affecting the health of women and children	7
WHO response to the persisting problems and new challenges	9
Conclusions: old needs unmet, emerging needs with new challenges	9
Action by the Executive Board	10

INTRODUCTION

1. At its ninety-first session the Executive Board requested that a report on progress in maternal and child health and family planning be prepared for the ninety-third session. Subsequently, the Health Assembly in resolution WHA46.18, *inter alia*, requested the Director-General to give particular attention in his report to traditional practices affecting the health of women and children. The last comprehensive review of maternal and child health was made at the sixth meeting of the WHO Expert Committee on Maternal and Child Health in 1975.¹ In 1978 the Thirty-first and in 1979 the Thirty-second World Health Assembly, considering the report of the Expert Committee and on the occasion of the International Year of the Child (1979), requested the Director-General *inter alia* to report on progress in maternal and child health and family planning to a future Health Assembly.² While progress in specific programme areas relevant to maternal and child health and family planning have been reviewed by subsequent Health Assemblies,³ this report is the first review of progress in nearly 15 years. The recommendations of the sixth meeting of the Expert Committee have been taken as the point of departure for this report.⁴ Since then the world has undergone monumental social, political and economic changes. The information revolution and rapid advances in technology have affected the health of women and children in nearly all countries and communities. Problems of maternal health, HIV/AIDS and the large numbers of refugees and people displaced by natural and man-made disasters, unnoticed or unimagined in 1975, came to the fore in 1993. Violence affecting women, children and adolescents is being recognized as a public health problem. Newer evaluation techniques have provided better insight into such issues as the content and quality of care, adequacy of skills and the organization of services as district systems. The new emerging needs are summarized in document EB93/INF.DOC./3.

2. This report deals with major developments in maternal and child health and family planning as they relate to the overall provision of services. Recent reports of the Director-General and reports of Technical Discussions at the Health Assembly have dealt with the Expanded Programme on Immunization, "Women, health and development", "The health of youth", "Health of the newborn", "Women and AIDS", and "Control of diarrhoeal disease". While there have been references by the Board and Health Assembly to maternal health and safe motherhood, family planning, and the need for an integrated approach to maternal and child health and family planning, the Board has not explicitly examined the needs and experience of countries with respect to these problems. Information for this review has been forthcoming from: the monitoring of the global strategy for health for all; the development of monitoring and evaluation methods within specific programmes; the data from Demographic Health Surveys; reports of regional committees; preparatory work for the International Summit for Children; the development of readily accessible databases relevant to the health of women and children; and the documents and background papers for the seventh meeting of the Expert Committee on Maternal and Child Health in December 1993.

POLICIES AND INTERNATIONAL INSTRUMENTS

3. As noted in document EB93/INF.DOC./3, there has been no dearth of policy responses to most of the matters raised by the sixth meeting of the Expert Committee on Maternal and Child Health, or to a

¹ *New trends and approaches in the delivery of maternal and child care in health services*. WHO Technical Report Series, No. 600, 1976.

² Resolutions WHA31.55 and WHA32.42.

³ Relevant Health Assembly resolutions on maternal health; women, health and development; infant and young child feeding; Expanded Programme on Immunization; diarrhoeal diseases; human reproduction research, etc. are noted in document EB93/INF.DOC./3.

⁴ Although the Expert Committee's report included recommendations on research, the subject will not be covered in this report since an earlier meeting of the Advisory Committee on Health Research dealt with this subject and because space is limited.

number of those that have arisen subsequently. Alma-Ata at the time of the International Conference on Primary Health Care represented a sea of change for policy and programme development in maternal and child health and family planning. The Declaration, *inter alia*, affirmed that family planning as part of maternal and child health was an essential element of primary health care, and that equity and participation of communities were essential in health development. Many of the goals set to meet the needs of women and children are common to WHO, UNICEF, UNFPA and UNDP. They have been reiterated and expanded upon in: the WHO/UNICEF Common Goals for the Fourth United Nations Development Decade; a series of joint policy statements by WHO and UNICEF on such subjects as immunization, control of diarrhoeal and respiratory diseases, breast-feeding, and maternal and neonatal care, and - with UNFPA - on reproductive health of adolescents, traditional birth attendants, breast-feeding and family planning, and HIV/AIDS and maternal and child health and family planning (the latter also with UNDP). The Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child, *inter alia*, establish legal frameworks for action by national authorities to give effect to many of the health goals and targets adopted by the Health Assembly and other international bodies. Target-setting as a means for guiding and providing a stimulus for national and international action has been introduced since the sixth meeting of the Expert Committee on Maternal and Child Health.

PROGRESS IN THE HEALTH STATUS OF WOMEN, CHILDREN AND FAMILIES

4. The greatest strides in this domain in the last two decades have been made in child health and family planning. Life expectancy at birth increased from 51 to 64 years between 1960 and 1990. From estimated global childhood immunization coverage of about 5% in 1975, coverage reached about 80% in 1991 (see document EB93/INF.DOC./3). Infant mortality declined from 76 per 1000 live births in 1985¹ to 68 per 1000 in 1991. Emphasis on breast-feeding and the introduction of oral rehydration therapy in the management of diarrhoeal disease have resulted in sharp declines in the case-fatality rate for this disease. For nearly all areas of the world stunting - an indicator of long-term malnutrition - declined from 40% to 34% between 1975 and 1990.

5. There is much evidence that family planning affects the health and well-being of women in many ways. Among the most significant benefits are: improvement in health status, self-esteem and educational and employment opportunities. More specifically, the possibility to avoid an unwanted pregnancy and to space out or limit childbearing enables women better to exercise their rights as women in their productive and reproductive lives. Currently 144 countries provide direct or indirect support to family planning programmes. The total number of contraceptive users in developing countries is estimated to have risen from 31 million in 1960-1965 to 381 million in 1985-1990. Progress in and unmet needs for family planning (by United Nations regions) is presented in document EB93/INF.DOC./3. To meet these needs, taking into account the United Nations projection for medium population growth, the current estimated "contraceptive prevalence" (51% of people protected) will have to increase to 59% by the year 2000.

6. Little notice was accorded to maternal health until WHO, UNFPA, UNDP and the World Bank focused world attention, at the International Conference on Safe Motherhood in 1987 in Nairobi, on the tragic figure of 500 000 maternal deaths each year. Awareness and policy commitment are widespread but progress has been slow. The negative indicators of women's health - maternal mortality, anaemia, unsafe abortion, low birth weight and perinatal mortality - remain high, and where data on trends are available they show only slow improvement or none - even a deterioration, particularly in the least developed countries or disadvantaged communities. WHO estimates that in the period from 1983 to 1988 numbers of maternal deaths remained the same but in some areas of Africa maternal mortality rates increased by 3% to 9%. The declines over that period in Asia and Latin America were in large part attributable to declining fertility. While earlier data suggested that countries with at least 70% coverage by trained birth

¹ *Implementation of the Global Strategy for Health for All by the Year 2000, Eighth report on the world health situation, Vol. 1.* Geneva, World Health Organization (1993).

attendants do not appear to have maternal mortality rates higher than 150 per 100 000 live births, more recent data from a few urban centres in Africa and Asia have shown rates ranging from 200 to 500 per 100 000. These rates are much higher than expected in areas where the coverage by prenatal care and trained attendants in childbirth were thought to be adequate. It is apparent that the content and quality of care must be assured simultaneously if maternal health is to benefit. Low birth weight and anaemia during pregnancy, two other negative indicators of newborn and maternal health, have not shown any improvement for the world as a whole in the decade from 1980 to 1990. The current global rate for low birth weight is 17%, while the rate of anaemia among pregnant women is 51%.

7. Despite the emphasis on lowering infant mortality there is only limited direct activity in countries to reduce neonatal mortality, which accounts for half of infant mortality, and to combat low birth weight, another major factor. The causes of the 4.2 million deaths in newborn infants each year are linked to complications of pregnancy and/or birth: neonatal tetanus, low birth weight and pre-term births, asphyxia/hypoxia, birth trauma and infections. The millions of newborn infants who survive the consequences of maternal ill health, poor nutrition and poor quality of care are left with poor health, increased risk of death or life-long morbidity. Infants with low birth weight or born prematurely are more likely to suffer the effects of birth trauma and asphyxia, with permanent and severe damage from seizure disorders, retardation or learning disabilities. Yet, most of the conditions that result in neonatal death and severe morbidity can be prevented or treated without resorting to sophisticated and expensive technology. The health needs of newborn infants, inseparable from those of the mother, are mistakenly thought to involve high technology and sophisticated services.

EMERGING HEALTH NEEDS FOR WOMEN, CHILDREN AND FAMILIES

8. Children and women are particularly vulnerable to the effects of poverty, disaster and displacement. Even in natural disasters they bear a disproportionate share of the morbidity and mortality. In most catastrophic situations - war, famine, refugee movements, natural disasters - children are separated from their families. Studies of children's response to extreme violence, death of those around them, abuse and hunger indicate that they are able to resist emotional stress and physical hardship as long as they remain with their parents and families; emergencies become significant in this sense as soon as separations occur and the child's primary attachments are disrupted. Sexual violence against women and sexual exploitation are all too common in mass conflicts. Mental illness is a much neglected but serious consequence of violence, social disruption, refugee situations or displacement. The behavioural implications, in adulthood, for children exposed to widespread senseless violence and death - as such events become banal - and to disruption of the social fabric, are serious. Studies of ghetto children have shown that violent conditions at home and in the environment tend to breed violence.

9. Child labour and the phenomenon of street children persist as economic crisis deepens. The International Labour Organisation conservatively estimates that over 18% of children between 10 and 14 years of age in developing countries are working: at least 7% in Latin America, 18% in Asia and 25% in Africa. Hazards to health include malnutrition (as energy for growth is diverted to work), exposure to toxic substances, and occupational illness and injury, and they can be fatal.

10. Families, and especially the women members, have been seen as the "under-utilized" resource for care. Yet, the family needs internal support if it is to function, providing for the basic requirements of its members. Very little information is available on family functioning and the health of families. The burden of maintaining a family as a functioning entity is on women in much of the world, and often they have limited decision-making authority. There are few indicators of the health of families.

(Emerging needs related to HIV/AIDS must not be forgotten. They have been and must continue to be considered by the Board in another context - see provisional agenda item 9.)

PROVISION OF CARE: ACCESSIBILITY, COVERAGE AND QUALITY OF CARE

11. Adequate coverage is the aim of programmes, and it is often used as an unofficial indicator for the effect of care; however, it is imprecise and of limited use managerially. For example, low levels of coverage could be attributed to inaccessibility (in terms of delays, or distance from services), or to lack of motivation to use services, a more complex factor with economic and cultural aspects, perception of need and belief that the services will meet the need, as well as the acceptability of the services and those providing them. Even when coverage is reported to be high, the system may not be working according to expectations because of lack of equipment or supplies, or health workers may fail to perform tasks correctly.

12. Accessibility of care has not been considered methodologically except in isolated studies and in recent Demographic and Health Surveys (DHS) in a limited number of countries. A wide discrepancy between the population considered to have access to services and those actually using services provides programme managers with an indicator of problems in terms of communities' knowledge, perceived needs or motivation. An analysis of the accessibility of different components of maternal and child health and family planning care provides a measure of the degree to which services are functionally integrated within a community. Data from the DHS during the period 1988-1991 showed a wide variation in accessibility and degree of integration of the different components of maternal and child health and family planning; the widest discrepancy between accessibility and use concerned family planning activities and the use of oral rehydration salts. There is also a wide gap between rates of diphtheria/pertussis/tetanus (three doses) in children and tetanus toxoid vaccination (two doses) for women at risk. An analysis of the use of services in relation to distance from the services provides a useful measure of the importance of the latter. Among 10 countries in which this was examined in DHS studies, distance was not a factor in five while in two it was a severe constraint, and in three a lesser constraint.

13. Significant improvement in maternal health is not possible in the absence of the essential obstetric care generally found at the level of a district or small rural hospital. Yet even in developing countries with well developed health infrastructures, only a minority of the rural population has access to such facilities. As noted in the WHO/World Bank analysis for the 1993 World Development Report, many of the essential obstetric functions could be provided at the level of the health centre where staff had the necessary midwifery skills and supplies and equipment to deal with emergency treatment of haemorrhage, infection, etc. The DHS comparative analysis indicated that in most countries the majority of rural women live within eight kilometres of a health centre.

14. Access to services does not ensure the availability of service or the necessary quality of care. Evaluations of the performance of the maternal and child health and family planning services in several countries have confirmed that essential tasks, such as testing for anaemia or measuring blood pressure, cannot be performed because equipment and supplies are not available or are out of order. Even when they are available, they may be misused; in one evaluation 40% of the health workers did not perform their tasks correctly or did not perform them at all. Thus, while countries may report reasonably high levels of maternal and child health and family planning coverage, *effective* coverage should be the criterion by which to judge progress. Less effective coverage may account for the contradictory data on the effect of antenatal care on pregnancy outcome, as it is also likely to explain the very wide discrepancy between claimed numbers of trained delivery attendants and high rates of maternal mortality. Some countries with maternal mortality rates of 500 per 100 000 live births, or higher, reported that 50% to 70% of birth attendants were trained. Similar discrepancies are observed in data from at least two African urban settings. Before extending maternal and child health and family planning services, the content and quality of care provided remain among the highest priorities.

15. A critical method for the evaluation of quality is maternal and perinatal death audit. In one recent national study, failure in diagnosis or incorrect case management by the obstetrician was noted in over 40% of the instances where the mother died, shortcomings in the facilities were noted in over 10% of the instances and "self-neglect" when women failed to seek care was noted in over 50%. Only 7% of the deaths

were considered unavoidable, and over 50% of the problems could have been detected during antenatal care.

16. In many countries, particularly those with weak infrastructures, new maternal and child health and family planning programme components, such as the Expanded Programme on Immunization and diarrhoeal disease control, were introduced with their own structures and procedures for planning, management, training, information and evaluation. Often they were strongly supported by external resources in contrast to other aspects of maternal and child health care. By 1990 immunization programmes had made spectacular progress, but - in Africa at least - there was a 10% decline in immunization coverage between 1990 and 1991; countries with the best overall maternal and child health coverage maintained high levels.¹

17. The deployment of maternal and child health personnel is inequitable; midwifery is the backbone of maternal and child health and family planning services; many countries have enough trained midwives in theory but most are located in the urban areas, some in private practice. Rural clinics are often not provided with the equipment and skills to handle the common complications of pregnancy. Rural areas have to make do with traditional birth attendants who, while a useful adjunct to the modern midwife, are not an adequate substitute alone and without the supervision or referral services essential to prevent maternal mortality.² Some countries have no alternative but to train traditional birth attendants. In some countries in Africa and Latin America maternity waiting homes have been established close to the referral hospital. Malawi, Mozambique and Zaire are among countries that have upgraded the obstetric and surgical skills of medical assistants and midwives to provide essential obstetric care.

TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN

18. All societies have evolved norms of care, feeding and related behaviour with variations according to age and sex. These "norms", often referred to as traditional practices, have social or cultural origins or are based on empirical observation of individuals or society and their well-being. The health effects of traditional practices may be beneficial, harmful or benign. Many of the traditional practices of childbirth are beneficial, including delivery in an upright position, the presence of a companion during labour and delivery, and measures to ensure a warm, draught-free environment.

19. While many traditional practices have no health rationale they may have a profound health effect, particularly those relating to female children, relations between males and females, including marriage, and sexuality. The socially disadvantaged position of women and girls is manifested in feeding patterns, health care, work, play and schooling. The effects are often cumulative, the most severe consequence being death in childbirth. The last to be fed, the least educated, in many societies the girl child is kept indoors, out of the sun and without other sources of vitamin D, and her pelvic bones are apt to become deformed. Because of menses and later pregnancies and lactation, the adolescent girl requires, but rarely gets, 18% more iron per kg body weight than male adolescents. Globally, 37% of women, and 51% of pregnant women, suffer from anaemia. In developing countries, up to 7% of pregnant women suffer from severe anaemia (below 7 gm% haemoglobin). The common practice of drinking tea with meals interferes with the biological availability of whatever quantity of limited iron may be present in the diet. The practice of eating less or doing without certain nutritious foods during pregnancy is widely described but poorly documented (ACC Subcommittee on Nutrition, 1988). It is presumably thought to guarantee a small infant, thus reducing the chance of obstructed labour due to cephalopelvic disproportion. No published research results confirm or disprove the concern that food supplementation before and during pregnancy might increase such risks while reducing the risk of low birth weight of the baby and malnutrition of the mother.

¹ UNICEF, *Progress of Nations*, 1993.

² World Bank, *Better Health in Africa*, 1993; Joint WHO/UNFPA/UNICEF Statement, 1992.

20. Child marriage persists in many communities. With marriage comes the pressure to bear a child, preferably a son. Unfortunately for the girl, the capacity for reproduction is attained about three years before full growth and, more importantly, before the pelvic bones reach adult dimensions. Pregnancy, without nutritional supplementation, before completion of growth will retard or stop further growth, leaving the girl-cum-woman at high risk of obstructed labour, vesiculo- or ano-vaginal fistula, infection and death. In Ethiopia, for example, the maternal mortality rate in the age group 15-19 years is three times higher than that in the age group 20-24 years. In northern Nigeria, in the absence of antenatal care, 5% to 7% of girls under 17 years may die. When such "children bearing children" survive and are still fertile, they face the prospect of repeated complications in future childbearing. If the girls have had the misfortune to undergo one or another form of genital mutilation, and have survived, they are doubly endangered.

21. Female genital mutilation is a collective name given to a series of traditional surgical operations performed on female genitals in several countries in the world. It is a cultural practice and not a disease. Its physical and psychological effects on girls and women, particularly on normal sexual function, affect their reproductive health in a way which lasts all their lives, since none of the procedures are reversible. In all types of female circumcision part or the whole of the clitoris is removed. More severe forms, such as excision and infibulation, remove larger parts of the genitals and close off the vagina, leaving areas of tough scar tissue, permanent damage and dysfunction.

22. Although it is practised in many societies with diverse cultures and religions there is no definitive proof that circumcision of girls is required by any religion. At present, it is estimated that between 85 million and 114 million girls and women in the world are genitally mutilated (Table 1). Most of them live in 26 African countries, a few in Asian countries and increasing numbers in Europe, Australia, Canada and the United States of America. It is estimated that at least two million girls every year are at risk of genital mutilation. The information on total prevalence and rates by type of operation is incomplete (Toubia, 1993). It is estimated, for example, that more than 80% of women in Somalia, Djibouti and North and Central Sudan have undergone the more severe procedure, infibulation. Most of the studies and reports contain inadequate or biased samples and use unclear or faulty methods of data collection. The only country with nationwide data is Sudan, where three countrywide surveys included questions on female genital mutilation.¹

23. The immediate and long-term consequences will vary depending on the procedure performed. The immediate consequences may include: haemorrhage, tetanus or sepsis, vesiculo-vaginal fistula and most recently, HIV transmission from the performer of the operation or when the procedure is part of a group ritual among older girls. Other consequences include cysts and abscesses, keloid and severe scar formation, difficulty voiding and during menstruation, bladder and urinary tract infection, etc. For the most severe form, infibulation, difficulties in intercourse may lead to the cutting open of the vagina, which usually becomes necessary in any event in the course of delivery. Though no data exist, it is likely that the risk of maternal death and a stillbirth is greatly increased by these factors, particularly in the absence of skilled personnel and appropriate facilities. During childbirth the risk of haemorrhage and infection is certainly greatly increased, and long-term morbidity becomes cumulative and chronic.

24. For several years increased attention has been focused on female genital mutilation by women's organizations, human rights groups, and national and international media. National authorities in many countries in Africa, working with the network of nongovernmental organizations, the Inter-African Committee for the Elimination of Harmful Traditional Practices and others, have developed programmes to educate and inform women and persuade them to abandon mutilation. Combined efforts have been made to convert men in order to ensure a positive effect for the campaign by women. Many lessons have been learned, resulting in the present approach through national and/or local organizations and using as

¹ University of Khartoum Survey 1979, World Fertility Survey [WFS] 1979/80, and Demographic and Health Survey [DHS], 1990. Comparison of WFS and DHS data shows an overall decline of about 6%-8% and a shift from infibulation to clitoridectomy affecting 12% of those mutilated.

far as possible the skills and experience of those whose work is among villagers, such as teachers, social workers and health personnel.

25. Although it is now generally accepted that the initiative for abolition of female circumcision must be taken by women from the societies that practise it, it is also recognized that national and local initiative can benefit greatly by outside support. For the past 15 years, WHO's role has included technical and financial support for national surveys, for the relevant training of health workers, and for grassroot initiatives. A joint task force of nongovernmental organizations and WHO is also being established to strengthen coordination between the various agencies and organizations active in this field.

WHO RESPONSE TO THE PERSISTING PROBLEMS AND NEW CHALLENGES

26. The health of women and children is among the highest priorities for all regions of the Organization. The governing bodies at global and regional levels have discussed the majority of previously identified and emerging needs in maternal and child health and family planning, although they have yet to respond to some of the critical problems of management and performance in programmes. At all levels WHO has attempted to maintain its leadership in supporting Member States in the development of policy and of technical programmes. However, too often, its presence and coordinating role in many countries is limited by material and human resources; resources, and not reason, often have the greater influence on health development priorities. The Organization's development and application of a number of methods for "empowerment" to improve the quality of care, programme performance and training, have been effective in pinpointing many of the questions raised in this report.

27. Regional and global programmes have asserted policy and technical leadership in support of Member States to tackle the most glaring manifestation of inequity and years of neglect for women's health, namely maternal mortality. With the support of a number of major agencies, a global programme on maternal health and safe motherhood has been launched. Activities are focused on national programme development and the global support necessary for that process. Particular attention has been given to the role of health centres, midwifery skills and essential obstetric care in the programme's strategy. A "mother-baby package" of measures to be implemented in any country within the context of national health development has been prepared.

CONCLUSIONS: OLD NEEDS UNMET, EMERGING NEEDS WITH NEW CHALLENGES

28. WHO has been increasingly successful in monitoring the health situation of women and children, documenting global and regional progress and spotting situations requiring urgent attention. The strategies and tools for improving maternal and newborn health have been found. The urgency with which the Organization has taken the lead in this field has in large part been matched by the commitment of many, if not most, countries. Many more countries must take the next step of adapting the global and regional policies, strategies and technology for national programmes. Maternal and newborn health and family planning require even higher commitment of the donor community, governments and WHO. Strengthening of country coordination, and cooperation with nongovernmental organizations, together with rapid exchange of country experience, will facilitate the attainment of the global target of reducing by half the 1990 level of maternal mortality by the year 2000.

29. Considering the analysis reflected in this report and recognizing that the goals of health for all and the Child Summit will not be realized without sustained support for the health of women, children and adolescents, a concerted effort must be made:

- to improve the quality of care and programme performance as a prerequisite for any major investment in extending the coverage of services for maternal and child health and family planning;

- to strengthen the understanding, training and commitment of staff of the entire health system regarding the importance of family planning and their contribution to related services;
- to ensure the functional integration of all the elements of maternal and child health and family planning services, their planning, management and evaluation, to serve not only women and children but young people and families, and including activities for the prevention of sexually transmitted diseases and HIV/AIDS;
- to focus on and plan the elimination of harmful traditional practices affecting the health and development of women and children, in close cooperation with governments and nongovernmental organizations, and stress the public health implications of violence and abuse of women and children, and the need for action to prevent them;
- to increase sustainability of maternal and child health and family planning programmes through decentralization and integration of services and appropriate delegation of responsibility for care within the community, relying on people's involvement and participation, and improve the quality of care.

ACTION BY THE EXECUTIVE BOARD

30. After reviewing this report, submitted in accordance with resolution WHA46.18, and the complementary document EB93/INF.DOC./3, and noting the action of WHO in response to country needs, the Board may wish:

- (a) to recommend that the programme's financing should be allocated distinctly within WHO's overall accounts in order to give the necessary attention to the activities and the need for increased external funding, and approve the establishment of a Special Account for the Maternal Health and Safe Motherhood Programme within the Voluntary Fund for Health Promotion as from 1 January 1994;
- (b) to consider the following two draft resolutions:

(1) Traditional practices harmful to the health of women and children

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;
2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;
3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 251 of 1992 on traditional practices affecting the health of women and children;

Recognizing that although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early marriage and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES all Member States:

(1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;

(2) to establish national policies and programmes that will effectively abolish female genital mutilation, marriage and childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;

(3) to collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;

3. REQUESTS the Director-General:

(1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;

(2) to continue global and regional collaboration with the networks of nongovernmental organizations and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;

(3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

(2) Quality of care in maternal and child health and family planning

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;
2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;
3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA32.30 on primary health care and monitoring health for all; and WHA46.18 on maternal and child health and family planning for health;

Noting that the Organization has successfully developed and adapted a number of management and evaluation methods that involve the participation of all levels of the health system and community, that can be rapidly applied to a wide range of service delivery problems, and that may provide guidance on action needed to improve the functioning and performance of maternal and child health and family planning services;

Recognizing that enormous progress has been made in many aspects of maternal and child health, as evidenced by the great increase in immunization coverage, accessibility and use of family planning services and numbers of trained attendants at childbirth;

Concerned nonetheless that in many countries such increases in coverage are not having the expected effect because of poor quality of care and performance of health systems;

Emphasizing that rapid progress in the health of mothers and the newborn and in family planning can be assured by improving the quality of care and the performance of the existing services and staff,

1. URGES all Member States:
 - (1) to give priority to assessing and improving the quality of care for women and children in district-based health systems;
 - (2) to adapt and apply standard protocols for the diagnosis and clinical management of the common problems encountered in services for the health of mothers, infants and children;
 - (3) to strengthen health centres so as to ensure a high level of midwifery care, and to provide regular supervisory, managerial and logistic support to peripheral health posts, community health workers and trained traditional birth attendants applying local strategies for the health of mothers and the newborn;
 - (4) to reorient training curricula to community-based and problem-solving approaches, and to ensure that health workers are made aware of the attitudes and needs of women and other members of the community;
2. REQUESTS the Director-General:
 - (1) to continue to provide technical support and guidance to Member States in the further development, adaptation and application of indicators of quality of care in maternal and child health and family planning and other aspects of primary health care;

(2) to continue to prepare guidelines and training material and devise approaches that improve the quality of care through standardized case definition, diagnosis and case management for the major health problems affecting mothers, the newborn, infants and children, and providing the necessary supervisory support;

(3) to ensure that the components of maternal and child health care and family planning are promoted and provided to Member States in a coherent and integrated manner, and that they correspond to national priorities and demand.

TABLE 1. PREVALENCE OF FEMALE GENITAL MUTILATION (FGM)

Benin*	50%	1 200 000	
Burkina Faso*	70%	3 290 000	
Cameroon*	-	-	Information on prevalence not available.
Central African Republic*	50%	750 000	
Chad	60%	1 530 000	Prevalence based upon 1990 and 1991 studies in three regions.
Côte d'Ivoire*	60%	3 750 000	
Djibouti	98%	196 000	Infibulation almost universally practised. The Union Nationale des Femmes de Djibouti (UNFD) runs a clinic where a milder form of infibulation is performed under local anaesthesia.
Egypt	50%	13 625 000	Practised throughout the country by both Muslims and Christians. Infibulation reported in areas of south Egypt closer to Sudan.
Ethiopia and Eritrea ¹	90%	23 940 000	Common among Muslims and Christians and practised by Falahas (Jewish population, most of whom now live in Israel). Clitoridectomy is more common, except in areas bordering Sudan and Somalia, where infibulation seems to have spread.
Gambia*	60%	270 000	
Ghana	30%	2 325 000	A 1987 pilot survey in one community showed that 97% of interviewed women above age 47 were circumcised, while 48% of those under 20 were not.
Guinea*	50%	1 875 000	
Guinea-Bissau*	50%	250 000	
Kenya	50%	6 300 000	Decreasing in urban areas, but remains strong in rural areas, primarily around the Rift Valley. 1992 studies in four regions found that the age for circumcision ranged from eight to 13 years, and traditional practitioners usually operated on a group of girls at one time without much cleaning of the knife between procedures.
Liberia*	60%	810 000	
Mali	75%	3 112 500	
Mauritania*	25%	262 500	
Niger*	20%	800 000	
Nigeria	50%	30 625 000	Two national studies conducted, but not released. A study of Bendel state reported widespread clitoridectomy among all ethnic groups, including Christians, Muslims, and animists.
Senegal	20%	750 000	Predominantly in the north and south-east. Only a minority of Muslims, who constitute 95% of the population, practise FGM.

Sierra Leone	90%	1 935 000	All ethnic groups practise FGM except for Christian Krios in the western region and in the capital, Freetown.
Somalia	98%	3 773 000	FGM is general; approximately 80% of the operations are infibulation.
Sudan	89%	9 220 400	A very high prevalence, predominantly infibulation, throughout most of the northern, north-eastern and north-western regions. Along with a small overall decline in the 1980s, there is a clear shift from infibulation to clitoridectomy.
United Republic of Tanzania	10%	1 345 000	Clitoridectomy reported only among the Chagga groups near Mount Kilimanjaro.
Togo*	50%	950 000	
Uganda*	5%	467 500	
Zaire*	5%	945 000	
Total		114 296 900	

* Anecdotal information only; no published studies. (By Donna Sullivan and Nahid Toubla for the World Conference on Human Rights, Vienna, June 1993.)

¹ Reported jointly in the absence of separate statistics.

= = =



世界衛生組織執行委員會決議

قرار المجلس التنفيذي لمنظمة الصحة العالمية

RESOLUTION OF THE EXECUTIVE BOARD OF THE WHO
RÉSOLUTION DU CONSEIL EXÉCUTIF DE L'OMS
РЕЗОЛЮЦИЯ ИСПОЛНИТЕЛЬНОГО КОМИТЕТА ВОЗ
RESOLUCION DEL CONSEJO EJECUTIVO DE LA OMS

Ninety-third Session

EB93.R10

Agenda item 8

25 January 1994

Maternal and child health and family planning: Current needs and future orientation

Traditional practices harmful to the health of women and children

The Executive Board,

Having considered the report by the Director-General on maternal and child health and family planning: current needs and future orientation,

1. WELCOMES the report;
2. NOTES that the full report of the seventh meeting of the Expert Committee on Maternal and Child Health is expected to be presented to the ninety-fifth session of the Board;
3. RECOMMENDS to the Forty-seventh World Health Assembly the adoption of the following resolution:

The Forty-seventh World Health Assembly,

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 251 of 1992 on traditional practices affecting the health of women and children;

Recognizing that although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early marriage and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES all Member States:

- (1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;
- (2) to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, marriage and childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;
- (3) to collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;

3. REQUESTS the Director-General:

- (1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;
- (2) to continue global and regional collaboration with the networks of nongovernmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;
- (3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

Thirteenth meeting, 25 January 1994
EB93/SR/13

= = =



世界衛生大會 決議

قرار جمعية الصحة العالمية

RESOLUTION OF THE WORLD HEALTH ASSEMBLY
RÉSOLUTION DE L'ASSEMBLÉE MONDIALE DE LA SANTÉ
РЕЗОЛЮЦИЯ ВСЕМИРНОЙ АССАМБЛЕИ ЗДРАВООХРАНЕНИЯ
RESOLUCION DE LA ASAMBLEA MUNDIAL DE LA SALUD

FORTY-SEVENTH WORLD HEALTH ASSEMBLY

WHA47.10

Agenda item 19

10 May 1994

Maternal and child health and family planning: traditional practices harmful to the health of women and children

The Forty-seventh World Health Assembly,

Noting the report by the Director-General on maternal and child health and family planning: current needs and future orientation;

Recalling resolutions WHA32.42 on maternal and child health, including family planning; WHA38.22 on maturity before childbearing and promotion of responsible parenthood; and WHA46.18 on maternal and child health and family planning for health;

Reaffirming its support for the United Nations Convention on the Rights of the Child, and United Nations Economic and Social Council resolution 1992/251 on traditional practices affecting the health of women and children;

Recognizing that, although some traditional practices may be beneficial or harmless, others, particularly those relating to female genital mutilation and early sexual relations and reproduction, cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding, creating risks of rickets and anaemia;

Acknowledging the important role that nongovernmental organizations have played in bringing these matters to the attention of their social, political and religious leaders, and in establishing programmes for the abolition of many of these practices, particularly female genital mutilation,

1. WELCOMES the initiative taken by the Director-General in drawing international attention to these matters in relation to health and human rights in the context of a comprehensive approach to women's health in all countries, and the policy declarations to the United Nations Special Rapporteur on traditional practices by governments in countries where female genital mutilation is practised;

2. URGES all Member States:

(1) to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group;

(2) to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, childbearing before biological and social maturity, and other harmful practices affecting the health of women and children;

(3) to collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment;

3. REQUESTS the Director-General:

- (1) to strengthen WHO's technical support to and cooperation with Member States in implementing the measures specified above;
- (2) to continue global and regional collaboration with the networks of nongovernmental organizations, United Nations bodies, and other agencies and organizations concerned in order to establish national, regional and global strategies for the abolition of harmful traditional practices;
- (3) to mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels.

Twelfth plenary meeting, 10 May 1994
A47/VR/12

= = =



Female genital mutilation

.....

An overview



World Health Organization
Geneva
1998

The World Health Organization was established in 1948 as a specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health, a responsibility that it fulfils in part through its extensive programme of publications.

The Organization seeks through its publications to support national health strategies and address the most pressing public health concerns of populations around the world. To respond to the needs of Member States at all levels of development, WHO publishes practical manuals, handbooks and training material for specific categories of health workers; internationally applicable guidelines and standards; reviews and analyses of health policies, programmes and research; and state-of-the-art consensus reports that offer technical advice and recommendations for decision-makers. These books are closely tied to the Organization's priority activities, encompassing disease prevention and control, the development of equitable health systems based on primary health care, and health promotion for individuals and communities. Progress towards better health for all also demands the global dissemination and exchange of information that draws on the knowledge and experience of all WHO's Member countries and the collaboration of world leaders in public health and the biomedical sciences.

To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures the broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease throughout the world, WHO's books contribute to achieving the Organization's principal objective – the attainment by all people of the highest possible level of health.

WHO Library Cataloguing in Publication Data

Female genital mutilation : an overview.

1. Circumcision, Female 2. Public policy 3. Human rights

ISBN 92 4 156191 2

(NLM Classification: WP 200)

The World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full. Applications and enquiries should be addressed to the Office of Publications, World Health Organization, Geneva, Switzerland, which will be glad to provide the latest information on any changes made to the text, plans for new editions, and reprints and translations already available.

© **World Health Organization, 1998**

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The authors alone are responsible for the views expressed in this publication.

Designed by WHO Graphics
Typeset and printed in Switzerland
98 / 11931 - Strategic / Schuler - 9500

Contents

Foreword	v
Acknowledgements	vi
Introduction	vii
1. Definitions and classifications	1
Background	1
Early classifications	3
Current WHO classification	5
Description of the different types of female genital mutilation	6
2. Prevalence and epidemiology	9
Background	9
Africa	10
Refugee and immigrant populations	18
Evidence of prevalence in other regions	21
3. Health consequences	23
Development and functional anatomy of the external female genitalia	23
Physical consequences and complications	25
Psychological and sexual effects	31
4. Research	37
Past research	37
Suggested research agenda	38
5. International, regional and national agreements and actions	50
International	50
Regional	55

National	56
Ethical considerations	57
6. WHO policies and activities	59
7. Conclusion	63
References	66
Recommended further reading	73

Foreword

Female genital mutilation, a traditional practice that can have serious health consequences, is of great concern to the World Health Organization (WHO). In addition to causing pain and suffering, it is a violation of internationally accepted human rights.

In the last few years, WHO's governing bodies have adopted a number of resolutions urging Member States to establish clear national policies to end traditional practices that are harmful to the health of women and children and requesting WHO to strengthen its technical support and other assistance to the countries directly concerned. Activities are being carried out to combat this practice as part of WHO's broader programmes on women's and children's health.

WHO has consistently and unequivocally advised that female genital mutilation, in any of its forms, should not be practised by any health professionals in any setting — including hospitals or other health establishments. While recognizing that female genital mutilation is an important reproductive health issue, it is also a sensitive topic. The issue must be approached with an understanding of the context of the cultural practice and its meaning for communities that practise it.

Much has already been achieved in the last decade in lifting the veil of secrecy from female genital mutilation and developing a strategy to bring about changes. However, there are still major gaps in understanding the extent of the problem, its health impact and the kinds of interventions that can be successful in eliminating it.

Lack of information hampers work in this area. This is why WHO is focusing on increasing knowledge and promoting technically sound policies and approaches to eliminate female genital mutilation.

This review, which includes an assessment of the epidemiological status and health complications of female genital mutilation and past and present policies at international, regional and national levels, aims to assist government agencies and nongovernmental organizations that are working to eliminate this practice. We hope that the book will help to turn this challenge into an opportunity for change in the lives of women.



Dr Tomris Türmen

Executive Director

Family and Reproductive Health

World Health Organization

Acknowledgements

This publication has been prepared by N. Toubia and S. Izett of RAINBØ Research, Action and Information Network for Bodily Integrity of Women.

The authors wish to acknowledge the contribution of Ms Elizabeth Kiberger who researched and helped draft legal and policy information. The contribution of the staff of the World Health Organization Family and Reproductive Health programme is also gratefully acknowledged.

Introduction

The traditional practice of female genital mutilation, sometimes referred to as female circumcision, has attracted increasing international attention in the past 20 years. Activists and nongovernmental organizations (NGOs) have used the opportunity provided by world conferences organized by the United Nations,¹ together with associated nongovernmental forums, to establish a strong global consensus against this practice and to consolidate the will and resources of national, regional and international institutions to stop it. WHO has been the leading United Nations specialized agency to take a position against female genital mutilation, starting in the 1960s. It is coordinating action in this area with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). In April 1997, WHO, UNICEF and UNFPA issued a joint statement expressing their common purpose in supporting the efforts of governments and communities to promote and strengthen action for the elimination of female genital mutilation. In recent years, increasing recognition of the human rights of women and children has brought additional calls for the practice to be stopped.

This book is intended primarily to document the medical and health facts about female genital mutilation together with related information as it appeared in the published literature, both formally in peer-reviewed journals and informally in country reports and publications resulting from workshops and conferences over the years. The book also considers legislation, human rights declarations and other action relevant to efforts to combat this practice. A special effort has been made to review past research in order to identify gaps in knowledge and make recommendations for future research priorities.

¹ World Conferences on Women, Copenhagen, 1980, Nairobi, 1985, Beijing, 1995; World Conference on Human Rights, Vienna, 1993; International Conference on Population and Development, Cairo, 1994; World Summit for Social Development, Copenhagen, 1995.

This is not a comprehensive review of all aspects of female genital mutilation. Many organizations and countries have developed projects to educate communities or to change attitudes and behaviours towards this practice. These projects are not adequately documented and any attempt to list them would be an arduous task. Evaluation of the success or failure of these efforts is also extremely difficult at this stage. However, the walls of silence surrounding the practice have been broken. There is more willingness by all concerned to face the problem. This is the first step towards creating conditions conducive to behavioural change with regard to female genital mutilation and is a major breakthrough. Although more work needs to be done, this achievement should be acknowledged. Some communities known to practise female genital mutilation have migrated to other countries. However, little is known about the numbers of girls who have undergone female genital mutilation or who are at risk of female genital mutilation in the new communities. Although several countries have passed laws against the practice, many now recognize that laws alone are not effective and are increasingly supporting preventive education programmes within the communities directly concerned. The increasing involvement of WHO and other technical agencies in this complex area of women's health will not only add to the visibility of the issue but will strengthen work that has already begun.

This book is intended primarily to address many of the scientific and medical questions related to female genital mutilation. It is hoped that it will prove useful not only to health professionals as they consider their role in relation to this practice but also to other individuals and groups active in combating female genital mutilation or in a position to develop policies and take action to stop it. Readers may not find all the answers to their questions or concerns here. However, the list of references gives direction for further investigations.

The review has been prepared by Nahid Toubia and Susan Izett of RAINB♀ — Research and Information Network for Bodily Integrity of Women. This nongovernmental body is well known for its commitment to the protection and promotion of the health of women and girls, and in particular to the elimination of female genital mutilation.

1.

Definitions and classifications

Background

Both traditional and modern genital surgery is performed in different societies for a variety of medical, cosmetic, psychological or social reasons. The surgical procedures included in the definition of female genital mutilation used in this book are limited to cutting rituals performed exclusively for cultural and traditional reasons on girls or young women, often without their approval or full understanding of the consequences of the procedures.¹ The procedures are outlined in the current WHO definition and classification of female genital mutilation which is reproduced on page 6. Surgeries described in the medical literature as circumcision for treatment of sexual disorders² and sex-determining surgeries for hermaphroditism³ are

¹ The issue of consent by an individual of majority age (adult) to non-therapeutic surgery or any physical or psychological act by another, which may be perceived by some as a violation, is a widely debated and controversial issue which is not considered in depth in this review. The authority and limitation of parents and guardians to consent or withhold consent on behalf of a minor for treatment or surgery, whether medical or ritualistic, is a subject that requires more comprehensive discussion in the future. For further reading on these issues see, for example, Katz, 1984 (1) and Anderson, 1993 (2). Also refer to principles established in the World Medical Association Declarations of Geneva (1948), Helsinki (1964) and Tokyo (1975) (3-5).

² Medically prescribed "circumcisions" allegedly treat women for decreased sexual response or "frigidity". These operations usually involve the removal of the prepuce or foreskin from around the glans clitoris of adult women to increase exposure of the sensitive area. This procedure may be categorized as plastic surgery and is therefore beyond the scope of discussion of this review. Other genital cosmetic surgeries, involving trimming of the labia or repositioning of the clitoris, are reported in parts of Europe and North America (6, p.107). Such operations were performed in Norway in the recent past on women with wide inner lips colloquially termed "bat lips". The law against female genital mutilation which was passed in Norway in 1995 also outlawed this operation. Apart from this one exception, such operations are legal in most countries on the basis that, like all cosmetic surgeries, they are requested by adult women legally capable of consent. The question of the nature of consent when culture is a major determining factor in women's choices is an important one but is also beyond the scope of this work.

³ In sex-determining surgeries for hermaphroditism, one set of gonads is removed and there is some form of plastic reconstruction of the external genitals, which may involve amputation of some parts. One of the objections to such procedures is that they are performed on non-consenting children.

excluded. However, the limitations set for the purposes of this book should not preclude future discussions and appropriate scientific debate to expand or limit criteria for what constitutes female genital mutilation.

Female genital mutilation is mostly performed as a rite of passage from childhood to adulthood and is undertaken in most communities between the ages of four and 14 years. However, the age varies from area to area. For example, in southern Nigeria female genital mutilation is performed on babies in the first few months of life while in Uganda it is performed on young adult women. It is difficult to summarize the cultural significance of the practice in a few sentences because the cultures in which it occurs are very diverse. The reasons and meaning mostly revolve around social definitions of femininity and attitudes towards women's sexuality. A common feature is the social conditioning of women to accept female genital mutilation within social definitions of womanhood and identity. This leads them to perpetuate and defend the practice. Although many of these societies acknowledge the dampening effect of genital mutilation on women's sexual pleasure, preservation of chastity is not always the goal. In Egypt, Somalia and Sudan, for example, extramarital sex is completely unacceptable and female genital mutilation is used to ensure that it does not occur. In Kenya, Uganda and west African countries such as Sierra Leone, a girl may have a child out of wedlock to prove her fertility, then undergo genital mutilation and be married afterwards. For a mother in a society where there is little economic viability for women outside marriage, ensuring that a daughter undergoes genital mutilation as a child or teenager is a loving act to make certain of her marriageability. Because of the very private nature of the practice, the operation is performed at the request of the family and condoned by society as part of its cultural identity. The roots of the practice run deep into the individual's psychology, sense of loyalty to family and belief in a value system. These aspects are discussed further in section 3.

Controversy continues over the use of the terms "female circumcision" and "female genital mutilation" to describe the procedures employed. "Female circumcision" appeared in the reports of explorers and missionaries in Africa as early as the late nineteenth century and continued to be used until the 1980s. The term "female genital mutilation", used in the 1980s mostly by western writers (7), was endorsed by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) during its regional meeting in 1989 (unpublished report).

The most common argument over the term "female circumcision" relates to whether or not the procedure is analogous to male circumcision. In the medical literature, "circumcision" is used specifically to mean removing the prepuce or foreskin of the penis or the clitoris. In young girls

this procedure is extremely difficult to perform. However, in general use the term is not so precise and merely describes ritualistic cutting of the genitals for cultural or religious reasons. In the latter sense, "female circumcision" is no different from male circumcision, as both are cutting rituals performed on a child with no demonstrated positive impact on health. One difference between the two practices is that male circumcision is a clear requirement of some religions while "female circumcision" is not. The most important difference, however, is that even the most minimal form of "female circumcision" can affect a girl's normal sexual function. Evidence in the medical literature on the effect of circumcision on male sexual function is not as yet well established.¹

The most common types of female genital cutting rituals involve amputation of part or all of the clitoris and the labia minora resulting in irreparable physical damage and increased risk of health complications (the anatomy of the external female genitalia and the effects of female genital mutilation on health are described in section 3). It is because of the severity and irreversibility of the damage inflicted on the girl's body that the procedure has been termed "female genital mutilation", often abbreviated to FGM. This is currently the term used in all official documents of the United Nations and in the documents of world conferences such as the Programme of Action of the International Conference on Population and Development, 1994 (9), and the Declaration and Platform for Action of the Fourth World Conference on Women, 1995 (10). Its use has also been endorsed by WHO (11). In this book "female genital mutilation" is used except when quoting a source in which the term "female circumcision" is used.

Early classifications

A review of the literature reveals a wide range of terminology and descriptions of types and classifications of female genital mutilation. The first recorded attempt at classification was put forward by Daniell in 1847 (12). He described four types of clitoridectomy and excisions of labia in West Africa but did not mention any stitching of the vulva. Roles (13) in his review of anthropological literature of the nineteenth century described the ritual in East Africa as comprising three types: clitoridectomy, clitoridectomy and removal of the labia minora, and clitoridectomy with removal of the labia minora and majora.

¹ For further discussion of this subject, please see, for example, Taylor, Lockwood & Taylor, 1996 (8).

Worsley (14), who worked in a maternity hospital in Sudan in the 1930s, also wrote of three types:

“a) introcision, or cutting into the vagina at an early age; b) the circumcision of women, paring the edges of the labia, together with excision of the clitoris; and c) infibulation proper, which is the aforementioned circumcision, but followed by almost complete closure of the vulval orifice”.

Introcision was described by the British, when they entered Australia, as being a part of the complex initiation rituals of both sexes among some Aboriginal tribes. These rituals varied by region and introcision was not uniformly present among all subgroups. Worsley reported (14) that it was practised among the Petta-Petta tribe in the following manner:

“When the girl reaches puberty, the whole tribe, of both sexes, is assembled. The operator, an elderly man trained for the purpose, enlarges the vaginal orifice by tearing it downwards with three fingers bound round with opossum string. In other districts the perineum is split up with a stone knife. This is usually followed by compulsory intercourse with a number of young men, and... [other practices] for the rejuvenation of the tribal aged and infirm.”

In contemporary literature, Shandall (15) put forward a much-quoted classification in 1967, based on one of the earliest clinical studies of a large sample of “circumcised” women, which describes four types:

“Type 1: Circumcision proper. This is the circumferential excision of the clitoral prepuce and is clearly analogous to male circumcision. In Muslim countries it is known as Sunna circumcision.

Type 2: Excision. Besides the prepuce, this involves the removal of the glans clitoridis or even the clitoris itself and may include part, or the whole, of the labia minora.

Type 3: Infibulation. This is also called Pharaonic circumcision. It involves partial closure of the vaginal orifice after excision of a varying amount of vulval tissue. In its drastic form, all or part of the mons veneris, labia majora and minora, and the clitoris are removed and the raw areas left to heal across the lower end of the vagina. After the operation, the thighs are strapped together and kept so for 40 days, complete occlusion of the introitus being prevented by the insertion of a small sliver of wood commonly a match-stick.

Type 4: Introcision. This is the cutting into the vagina or splitting of the perineum, either digitally or by means of a sharp instrument, and is the severest form of circumcision.”

These types correspond to those put forward by Verzin (16) in 1975. This classification was more accurate than the previous ones but still had several drawbacks, namely:

- The existence of a ritual operation which can be classified as type 1 or “true circumcision” has never been adequately documented. What is locally referred to as Sunna circumcision in many countries often includes removal of part or all of the clitoris, as is the case in Egypt and Sudan.
- The term “Pharaonic” is a Sudanese colloquial reference to infibulation and also implies a historical origin which is still open to question. The same type of female genital mutilation is referred to as “Sudanese circumcision” in Egypt. The use of colloquial terminology in the literature without reference to a standardized scientifically-based classification has resulted in confusion when comparing reports from different countries.
- Including introcision in a formal classification is not useful. There is no evidence of this practice outside Australia, either in Sudan or other African countries that practice female genital mutilation. A recent inquiry to the Australian government revealed that there are no known reports of the practice currently among the indigenous population (unpublished communication).

Many modifications of the Shandall classifications followed, adding further to the confusion (16-22).

Current WHO classification

Recognizing the need for a standardized classification, WHO convened a Technical Working Group on Female Genital Mutilation in Geneva, Switzerland, in July 1995. That Technical Working Group described the practice, and WHO's attitude to it, as follows (11):

“Female genital mutilation is a deeply rooted, traditional practice. However, it is a form of violence against girls and women that has serious physical and psychosocial consequences which adversely affect health. Furthermore, it is a reflection of discrimination against women and girls.

WHO is committed to the abolition of all forms of female genital mutilation. It affirms the need for the effective protection and promotion of the human rights of girls and women, including their rights to bodily integrity and to the highest attainable standard of physical, mental and social well-being.

WHO strongly condemns the medicalization of female genital mutilation, that is, the involvement of health professionals in any form of female genital mutilation in any setting, including hospitals or other health establishments.”

The joint statement on female genital mutilation issued in April 1997 by WHO, UNICEF and UNFPA gave the following definition to the practice (23):

“Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.”

The three agencies classified the different types of female genital mutilation as follows:

Type I Excision of the prepuce, with or without excision of part or all of the clitoris.

Type II Excision of the clitoris with partial or total excision of the labia minora.

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

Description of the different types of female genital mutilation

Female genital mutilation is usually performed by traditional practitioners, generally elderly women in the community specially designated for this task, or traditional birth attendants. In some countries, health professionals—trained midwives and physicians—are increasingly performing female genital mutilation. In Egypt, for example, preliminary results from the 1995 Demographic and Health Survey indicate that the proportion of women who reported having been “circumcised” by a doctor was 13%. In contrast, among their most recently “circumcised” daughters,

46% had been "circumcised" by a doctor. Further aspects of this development are considered in section 5.

The procedures employed in each type of female genital mutilation are described below.

Type I

In the commonest form of this procedure the clitoris is held between the thumb and index finger, pulled out and amputated with one stroke of a sharp object. Bleeding is usually stopped by packing the wound with gauzes or other substances and applying a pressure bandage. Modern trained practitioners may insert one or two stitches around the clitoral artery to stop the bleeding.

Type II

The degree of severity of cutting varies considerably in this type. Commonly the clitoris is amputated as described above and the labia minora are partially or totally removed, often with the same stroke. Bleeding is stopped with packing and bandages or by a few circular stitches which may or may not cover the urethra and part of the vaginal opening. There are reported cases of extensive excisions which heal with fusion of the raw surfaces, resulting in pseudo-infibulation even though there has been no stitching (24-26).

Types I and II generally account for 80-85% of all female genital mutilation (27), although the proportion may vary greatly from country to country.

Type III

The amount of tissue removed is extensive. The most extreme form involves the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora. The raw edges of the labia majora are brought together to fuse, using thorns, poultices or stitching to hold them in place, and the legs are tied together for 2-6 weeks (28, 29). The healed scar creates a "hood of skin" (17) which covers the urethra and part or most of the vagina, and which acts as a physical barrier to intercourse. A small opening is left at the back to allow for the flow of urine and menstrual blood. The opening is surrounded by skin and scar tissue and is usually 2-3 cm in diameter but may be as small as the head of a matchstick (14, 18).

If after infibulation the posterior opening is large enough, sexual intercourse can take place after gradual dilatation, which may take weeks, months or, in some recorded cases, as long as two years (21). If the opening is too small to start the dilatation, recutting (defibulation) before intercourse is traditionally undertaken by the husband or one of his female relatives using a sharp knife or a piece of glass. Modern couples may seek the assistance of a trained health professional, although this is done in secrecy, possibly because it might "undermine the social image of the man's virility" (30).

In almost all cases of infibulation (15, 17, 18) and in many cases of severe excision (26), defibulation must also be performed during childbirth to allow exit of the fetal head without tearing the surrounding scar tissue. If no experienced birth attendant is available to perform defibulation, fetal and/or maternal complications may occur because of obstructed labour or perineal tears.

Traditionally, "re-infibulation" is performed after the woman gives birth. The raw edges are stitched together again to create a small posterior opening, often the same size as that which existed before marriage. This is done to create the illusion of virginity, since a tight vaginal opening is culturally perceived as more pleasurable to the man (30). Because of the extent of both the initial and repeated cutting and suturing, the physical, sexual and psychological effects of infibulation are greater and longer-lasting than for other types of female genital mutilation.

Although only an estimated 15–20% of all women who experience genital mutilation undergo type III, in certain countries such as Djibouti, Somalia and Sudan the proportion is 80–90%. Infibulation is practised on a smaller scale in parts of Egypt, Eritrea, Ethiopia, Gambia, Kenya and Mali, and may occur in other communities where information is lacking or still incomplete.

Type IV

Type IV female genital mutilation encompasses a variety of procedures, most of which are self-explanatory. Two procedures are described here (13).

The term "angurya cuts" describes the scraping of the tissue around the vaginal opening.

"Gishiri cuts" are posterior (or backward) cuts from the vagina into the perineum as an attempt to increase the vaginal outlet to relieve obstructed labour. They often result in vesicovaginal fistulae and damage to the anal sphincter.

2.

Prevalence and epidemiology

Background

Documentation of the prevalence of different types of female genital mutilation began in the early twentieth century with reports by European travellers and missionaries. Since the 1950s, small studies have been undertaken by physicians and gynaecologists in some countries, using clinical records or direct interviews with patients (15, 16, 31).

The first national survey ever to be undertaken was conducted by the Faculty of Medicine of the University of Khartoum in Sudan in 1979 (19). The Sudan Fertility Survey, also conducted in 1979 (32), and the Demographic and Health Survey of Sudan in 1990 (33), also included questions on female genital mutilation. Sudan is the only country with comprehensive and reliable national prevalence data over time.

In 1993, the inclusion of a basic module questionnaire on female genital mutilation in the Demographic and Health Surveys¹ was approved (J. Sullivan, Demographic and Health Surveys, personal communication), and has since been used in several countries in Africa. Demographic and Health Survey data on female genital mutilation have recently become available for Central African Republic, Côte d'Ivoire, Egypt, Eritrea, Mali and Yemen. The United Republic of Tanzania has also included questions on female genital mutilation in its current Demographic and Health Survey. It is hoped that if the module is adopted by other countries as well, more accurate data on national prevalence of female genital mutilation will become available.

The first comprehensive article on the epidemiology of female genital mutilation worldwide was published by Hosken in 1978 (7). In 1979, the first edition of *The Hosken report* was published, in which the author presented a global review and country-by-country estimates of the prevalence of the practice (34). Although the report did not specify the exact

¹ The national Demographic and Health Surveys are prepared and organized by Macro International Inc., 11785 Beltsville Drive, Calverton, MD 20705, USA.

methodology by which the data were collected, these figures remain a major source for global estimates of female genital mutilation. A literature review of available studies by Toubia published in 1993 (35) made modifications to Hosken's figures on the basis of more recent country studies and reports. These figures were updated again in 1995 (27) and 1996 (36).

Current estimates of prevalence are presented in Table 1 and are based on an extensive review of the most recent published literature and unpublished reports and on the most recent results from completed Demographic and Health Surveys. For countries for which results of studies with adequate sample size or regional representation were available, the estimates are based on such studies. However, the majority of published studies and surveys had sample sizes that were too small, not representative or clinically based. In addition, some reports did not state clearly how the samples were selected. The authors are also aware of a number of other studies, including several Demographic and Health Surveys and a comparative study of the results obtained using the Demographic and Health Survey module in African countries, which are currently under way or whose results became available too late for inclusion. For countries where no specific or reliable studies were found, Hosken's latest estimates are used. On the basis of these figures it is estimated that over 132 million women and girls have experienced female genital mutilation. It is also estimated that some two million girls are at risk of undergoing some form of the procedure every year.

Africa

Benin (estimated prevalence 50%)

A study undertaken by the National Committee on Harmful Traditional Practices in 1993 indicated a prevalence of 50% (39). Female genital mutilation is practised mainly in the northern region, in the provinces of Atacora, Borgou and Zou. It is virtually non-existent in the provinces of Atlantic and Mono. The main ethnic groups practising female genital mutilation include the Bariba, Boko, Nago, Peul and Wama. The procedure is most commonly carried out between the ages of 5 and 10, although among the Nago it is often undertaken in adult women after they have already given birth several times. Type II is the most common form reported.

Table 1. Current estimates of female genital mutilation

Country	Female population ^a	Prevalence ^b	Number
Benin	2 730 000	50	1 365 000
Burkina Faso	5 224 000	70	3 656 800
Cameroon	6 684 000	20	1 336 800
Central African Rep.	1 767 000	43	759 810
Chad	3 220 000	60	1 932 000
Côte d'Ivoire	7 089 000	43	3 048 270
Democratic Republic of the Congo	22 158 000	5	1 107 900
Djibouti	254 000	98	248 920
Egypt	28 769 000	97	27 905 930
Eritrea	1 777 000 ^c	90	1 599 300
Ethiopia	2 087 000	85	24 723 950
Gambia	496 000	80	396 800
Ghana	8 784 000	30	2 635 200
Guinea	3 333 000	60	1 999 800
Guinea-Bissau	545 000	50	272 500
Kenya	13 935 000	50	6 967 500
Liberia	1 504 000	60	902 400
Mali	5 485 000	94	5 155 900
Mauritania	1 181 000	25	295 250
Niger	4 606 000	20	921 200
Nigeria	64 003 000	40	25 601 200
Senegal	4 190 000	20	838 000
Sierra Leone	2 408 000	90	2 167 200
Somalia	5 137 000	98	5 034 260
Sudan	14 400 000	89	12 816 000
Togo	2 089 000	50	1 044 500
Uganda	10 261 000	5	513 050
United Republic of Tanzania	15 520 000	10	1 552 000
Total			136 797 440

^a *The world's women*. New York, NY, United Nations, 1996 (37).

^b Prevalence expressed as a percentage. Prevalences for Central African Republic, Côte d'Ivoire, Egypt, Mali and Sudan from Demographic and Health Survey results.

^c *World population prospects: the 1994 revision*. New York, NY, United Nations, 1994 (38).

Burkina Faso (estimated prevalence 70%)

A limited study in 1993 of 805 female genital mutilations indicated prevalence of 73% among girls aged 12–14 years and 88% among women aged 20–24 (40). There was little difference between rural and urban areas. However, among girls whose mothers had received secondary education, prevalence was significantly lower (48%) than among those whose mothers had not (78%). Subsequently, the national committee working to control the practice (Comité National de Lutte contre la Pratique de l'Excision)

reported that it was widespread among Christians, Muslims and animists in the provinces of Comeo, Ganzourgou, Houet, Kenedougou, Kossi, Kadiogo, Mouhoun, Nahouri, Yatenga and Zounweogo. All groups practise types I and II. The Gourounsi, Leo and Tiebele do not practise female genital mutilation. A limited survey in 1995 showed that prevalence of type I in girls aged 2–3 years was 70.6%. Prevalence of type II in the age group 12–14 was 70.5% and in the age group 20–24 was 80.1% (41). This report provides the basis for the current prevalence estimate.

Cameroon (estimated prevalence 20%)

Female genital mutilation is prevalent in certain areas of Cameroon. There are no published studies of national prevalence, but a study by the National Committee on Harmful Traditional Practices in 1994 covered the southwest and far north provinces where the practice is known to occur (42). The sample was not stratified and was selected randomly from primary schools, maternity units, traditional birth attendants and communities. In this highly selected population, female genital mutilation was practised by 100% of Muslims and by 63.6% of Christians. Only types I and II were reported. The total prevalence rate for the country, estimated by observers to be 20%, is based on anecdotal evidence.

Central African Republic (estimated prevalence 43%)

The 1994–1995 national Demographic and Health Survey provided the first comprehensive data on female genital mutilation in the country (43), indicating an overall prevalence of 43%. However, the rate varies by region and ethnic group. Région Sanitaire IV was found to have the highest prevalence at 91% and, among ethnic groups, prevalence was greatest among the Banda and Mandjia at 84% and 71% respectively. While there was no significant difference between rural and urban dwellers, there was a strong difference between women with no education or with primary schooling (47%) and those with secondary education (23%). There is some indication that prevalence is declining, as it was found to be 53% among women aged 45–49 years and only 35% among women aged 15–19. However, the lower figure in the latter group may be partly due to the fact that nearly 10% of genital mutilations are undertaken after the age of 15, so this age group may include women who have not yet undergone the procedure. In general, however, the majority of girls undergo genital mutilation between the ages of 7 and 15. The survey provided no information on the types practised.

Chad (estimated prevalence 60%)

A UNICEF-supported study was undertaken in the south, east and central regions and in N'Djamena, covering nine communities (unpublished data, 1991). Types I and II were found to predominate; type III was not reported. This partial study is the basis of the current prevalence estimate.

Côte d'Ivoire (estimated prevalence 43%)

The 1994 national Demographic and Health Survey provided the first reliable data (44) and indicated an overall prevalence of 43%. This varied from 31% in Abidjan to 57% in the rural savannah region; however, overall prevalence in the rural areas was 45%. Female genital mutilation was found to be much more prevalent among the Muslim population (80%) than among Catholics and Protestants (16%). The most striking difference was between women with no education (55%) and those with primary or secondary education (24%). There does appear to be a slight trend toward reduced prevalence, as the rates for age groups 25–29 and 30–34 were 47% while the rate for those aged 15–19 was 35%. While some women in the latter group may not yet have undergone the procedure, the majority of girls have done so before the age of 10. The survey provided no information on the types of genital mutilation performed.

Democratic Republic of the Congo (estimated prevalence 5%)

No report by a national group or published study was found. The current prevalence estimate is based on previous estimates by Hosken.

Djibouti (estimated prevalence 98%)

There have been no official studies on prevalence in Djibouti, but the Ministry of Health and the national women's union (Union National des Femmes de Djibouti) have reported that female genital mutilation is almost universal, with type III the most common procedure (45).

Egypt (estimated prevalence 97%)

The preliminary results of the 1995 national Demographic and Health Survey show a surprisingly higher rate than previously estimated. A validation study is currently being conducted by the Egyptian Fertility Care Society on a subsample, comparing self-reporting and clinical examination. The final results of the survey and the validation study should yield valuable information, as the survey included extensive questions on the

procedure, complications, "circumcision" of women's daughters, and attitudes and beliefs.

Female genital mutilation is practised throughout the country by Muslims and Christians. Type I is the common procedure, although type III is reported in areas of south Egypt closer to Sudan (46, 47).

Eritrea (estimated prevalence 90%)

In 1993, Eritrea gained independence from Ethiopia. Female genital mutilation is known to be practised by Eritrean Christians and Muslims. The Eritrean People's Liberation Front, which is the governing party, and the National Union of Eritrean Women, have taken a position against the practice since the 1970s. There are no published statistics on prevalence in Eritrea following independence from Ethiopia. While two surveys conducted in Ethiopia in 1985 and 1990 (see section on Ethiopia, below) did not produce statistics specific to Eritrea, which was a war zone at the time, they give the general impression that female genital mutilation is as widespread in Eritrea as it is in Ethiopia. Results from the recent Demographic and Health Survey in Eritrea will provide the first reliable data on prevalence.

Ethiopia (estimated prevalence 85%)

Female genital mutilation is common among Christians and Muslims, and was practised by Ethiopian Jews, who now live in Israel. Types I and II are common except in the areas bordering Somalia, particularly Hararghe, where type III is practised. In 1984, the Ethiopian Ministry of Health together with UNICEF conducted a prevalence survey in five regions — Addis Ababa, Arssi, Eritrea, Gojjam and Hararghe (48). The findings suggest that the practice is almost universal in the areas studied, although no overall prevalence rates are cited. A further survey in 1990, sponsored by IAC, included 20 of the 31 administrative regions, covering 73% of the population of the country (49). This showed that 85% of the women surveyed had undergone genital mutilation. There is some regional overlap between the two surveys. However, high prevalence regions such as Diredawa, Eastern Hararghe and Ogaden were not included in the 1990 survey. Two ethnic groups, the Begas and the Wellega, do not practise female genital mutilation.

Gambia (estimated prevalence 80%)

A study by Singhatoh published in 1985, covering several regions in Gam-

bia, indicated a prevalence rate of 79% (50). However, the sample was not representative of the total population. The study reported different prevalence rates for different ethnic groups (100% for the Mandinga and Serehule, 93% for the Fula, 65.7% for the Jola and only 1.9% for the Wollof). All groups practise types I and II.

Ghana (estimated prevalence 30%)

According to Kadri (51), female genital mutilation is practised in two secluded regions of Ghana — in the Upper East region by the Bussansi, Frafra, Kantonsi, Kassena, Kussasi, Mamprushie, Moshie and Nankanne ethnic groups and in the Upper West region by the Dargarti, Grunshie, Kantonsi, Lobi, Sissala and Walas ethnic groups. Adherence to the practice in these regions ranges from 75% to 100%. A study by Twumasi (52) in Accra and Nsawam in the south found female genital mutilation only among migrant communities from the northern part of Ghana and from neighbouring countries.

Guinea (estimated prevalence 60%)

No studies have been conducted on prevalence and estimates are based on reporting by the National Committee on Harmful Traditional Practices (Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Femme et l'Enfant, CPTAFE; unpublished data, 1991).

Guinea-Bissau (estimated prevalence 50%)

A limited non-representative survey by the national women's union (Union Démocratique des Femmes de la Guinée-Bissau) reported type II female genital mutilation in almost 100% of Muslim women (unpublished data, 1990). Muslims constitute about 50% of the population.

Kenya (estimated prevalence 50%)

Types I, II and III have all been reported in Kenya, where they are practised by several ethnic groups. The Maendeleo ya Wanawake Organization, the largest women's organization in Kenya, conducted a survey in 1991 in four districts in which female genital mutilation is known to be widely practised — Kisii, Meru, Narok and Samburu (53). The overall prevalence in these districts was 89.6%. There are no surveys of other districts in Kenya. Given that female genital mutilation is not practised in some major districts and that it is being abandoned by the increasing

urban population, prevalence is currently estimated at 50% for the country as a whole.

Liberia (estimated prevalence 60%)

According to a 1984 report (54), female genital mutilation is practised in most parts of Liberia and only three ethnic groups do not perform it. The estimated prevalence, based on a limited survey, is between 50% and 70%. The practice, type II only, is part of the initiation into the secret Sande or bush school.

Mali (estimated prevalence 94%)

The results from the 1995–1996 national Demographic and Health Survey indicate an overall prevalence of 94% (55). Female genital mutilation is practised throughout Mali, except for the regions of Gao and Tombouktou. Types I and II are predominant (52% and 47% respectively), with type III representing less than 1%. There are no significant differences in prevalence between women from rural areas and those from urban areas, or between women with no education or primary education (94%) and those with secondary education (90%). Female genital mutilation is practised by all religious groups, ranging from 85% among Christians to 94% among Muslims, and across all ethnic groups. The two groups with lower prevalence rates are the Tamacheck (16%) and the Sonrai (48%), both of which reside mainly in the regions of Gao and Tombouktou.

Mauritania (estimated prevalence 25%)

According to the Director of Social Affairs in the Ministry of Health of Mauritania, 20–25% of the population undergo female genital mutilation (unpublished data, 1987).

Niger (estimated prevalence 20%)

While there are no published studies on national prevalence, two published reports indicate that female genital mutilation is practised in three provinces: Diffa, Niamey and Tillabery (56, 57). The ethnic groups concerned who perform mainly types I and II are the Arabes (Shuwa), Gourmanche, Kourtey, Peulh, Songhai and Wogo. These reports from 1992 and 1993 are the basis of the current prevalence estimate.

Nigeria (estimated prevalence 40%)

Female genital mutilation is acknowledged to be widely practised in Nigeria and particularly among the three major tribes — the Hausa, Ibo and Yoruba. The practice is said to be declining in large urban centres. In 1985, the Nigerian Association of Nurses and Nurse-midwives conducted a national but non-representative survey and found that 13 out of 21 states had populations who practise female genital mutilation (58). Types I, II and III were all reported, as were gishiri cuts (type IV). Based on this limited sample, the average prevalence for the areas surveyed was 39.2%. This is considered low by many observers given that major ethnic groups practise female genital mutilation.

Senegal (estimated prevalence 20%)

A national study by Mottin-Sylla (59) reported prevalence in 1990 at around 18%, revising the 1976 estimate of 35%.

Sierra Leone (estimated prevalence 90%)

According to a 1984 study by Koso-Thomas (20), all Christian and Muslim ethnic groups in the country practise female genital mutilation, except for the Krios who live in the western region and in the capital of Freetown. Only types I and II are performed as part of the initiation rituals of the Bundo and Sande secret societies. The current prevalence estimate is based on the reporting by Koso-Thomas.

Somalia (estimated prevalence 98%)

Two documents published in 1982 and 1989 indicate that female genital mutilation is almost universal in Somalia with over 80% of procedures being of type III and the remainder type I (60, 61).

Sudan (estimated prevalence 89%)

The 1990 Sudan Demographic and Health Survey reported that 89% of ever-married women in the northern, eastern and western provinces had been "circumcised" (33). This is a 7% drop from the 96% found in the Sudan Fertility Survey of 1979 (32). The majority of women (85%) had undergone type III and only 15% had undergone type I. There was little variation in the distribution of types of female genital mutilation between rural and urban areas but there were differences in type by region. Twice as many women under 25 years (20%) as those over 40 years (10%) had

Of the 65 local social work departments canvassed, 10 reported case-work intervention because of suspected female genital mutilation (64). The Department of Health is sponsoring FORWARD to map out the profiles of communities for whom female genital mutilation is a deep-rooted traditional practice and to review all the programmes implemented to date on female genital mutilation in the United Kingdom. The outcome of this project will be published.

North America

The African Resource Centre in Ottawa, Canada, has reported 12 000 African immigrants in the city but did not indicate whether they came from countries where female genital mutilation is practised (unpublished data, 1993). Canada receives immigrants and refugees from all over Africa but the numbers of Eritreans, Ethiopians and Somalis have increased significantly in the past 10 years.

The United States of America receives immigrants and refugees from all African countries. The 1990 census, which does not carry detailed information on the country of origin of citizens and residents, indicated that the total African-born population was 363 819 and that 10 357 African-born immigrants were admitted to the country between 1991 and 1994. According to preliminary statistics collected by the Research, Action and Information Network for Bodily Integrity of Women (RAINB♀), women constitute 40.7% of the African-born population in the country. The 11 largest groups come from the following countries: Egypt, Ethiopia, Ghana, Kenya, Liberia, Nigeria, Sierra Leone, Somalia, Sudan, Uganda and the United Republic of Tanzania. The prevalence of female genital mutilation varies widely among populations from these countries. RAINB♀ is currently undertaking a study of African immigrants in the New York metropolitan area, *inter alia* collecting population statistics and conducting a needs assessment for health and social services. The aim of this study is to assist women who have suffered from genital mutilation and to prevent its occurrence among immigrant children.

Israel

Between 1984 and 1990, the Government of Israel undertook a major resettlement programme for the entire Jewish population of Ethiopia. This group is known to practise female genital mutilation (65). A preliminary report (66) did not find evidence of a continuation of the practice following immigration but a more thorough investigation is needed to substantiate this. A recent study by Asali et al. (67), which included interviews with 21 Bedouin women, indicated that female genital mutilation has

been practised in this ethnic group. Girls are most commonly "circumcised" between the ages of 12 and 17. However, physical examination of 37 young women from these tribes revealed only small scars on the prepuce of the clitoris or on the upper labia minora, indicating that the procedure may have been modified to a non-cutting ritual in more recent years.

Evidence of prevalence in other regions

Arabian peninsula

A limited inquiry on female genital mutilation conducted in the city of Sana'a, Yemen (S. Thadeus, unpublished data, 1992), found that the practice was localized to a few ethnic groups, and was predominantly of type I. The primary groups involved had historically been traders across the Red Sea and some had settled in East Africa. The recent national Demographic and Health Survey included two questions on female genital mutilation. These questions did not refer to prevalence in Yemen, but asked whether women approved or disapproved of the practice and what their reasons were for approval or disapproval.

Bahrain, Oman, Saudi Arabia and United Arab Emirates are listed in some publications as having female genital mutilation. No national reports or documented evidence were found regarding the practice in these countries.

South and South-East Asia

According to reports by Ghadially (68) and Srinivasan (69), female genital mutilation is practised in India by the small ethno-religious minority, the Daudi Bohra of the Ismaili Shia sect of Islam. The total population concerned is around half a million in the Bombay area and in small immigrant communities in Africa and North America.

According to Pratiknya of Gadjah Mada University in Indonesia, genital cutting operations took place in that country in the past but are no longer performed in the country (70). However, various non-cutting rituals involving the clitoris still persist in Indonesia. These include cleaning with herbal juice, symbolic cutting and light puncture of the clitoris. According to the 1997 WHO/UNICEF/UNFPA classification, symbolic cutting and light puncture of the clitoris are considered to be type IV female genital mutilation.

Several writers have reported genital mutilation practices among some Muslims in Malaysia but no reports by national groups or documented evidence of the practice have been found.

minora (equivalent to the shaft of the penis), the labia majora (equivalent to the scrotum), and the opening to the vagina.

The clitoris has four distinct parts: a small glans or head, a short body of two incompletely separated corpora cavernosa, continuous posteriorly with a pair of crura (72). All the parts are made of spongy, vascular, erectile tissue. The mature clitoris (glans and body) is about 2–2.5 cm in length with the crura twice as long. The size varies widely between individuals, depending on genetic and endocrine influence. Its prominence outside the lips varies with the development of the adjacent vulva.

The prepuce (foreskin) is a fold of epithelium above the clitoris which may or may not cover the entire glans. In young girls it is not well developed (2–3 mm in length) and difficult to separate from the glans. This is important to remember when comparing type I female genital mutilation to male circumcision.

The labia majora are two prominent longitudinal cutaneous (skin) folds extending from the mons veneris to the anterior boundary of the perineum. Their outer surface is pigmented and covered with hair and the inner surface is smooth and contains large sebaceous (lubricating) follicles.

The labia minora are made of cavernous erectile tissue with a high concentration of sensory nerve endings.

Lowry (73) summarizes the histological evidence regarding the sensitivity of the female external genitalia as follows:

“In summary, the clitoris contains, in most women, a large number of receptor nerve endings; in some women, other areas may contain more. In almost all women, the labia minora are also highly sensitive.”

The vagina is the least sensitive area, with sensory nerve endings limited to a ring around the inlet.

The above descriptions indicate the importance of the clitoris and labia minora as the primary sensory organs in the female sexual response. Cutting part or all of them will undoubtedly interfere with, though not necessarily abolish, the physical receptivity of sexual stimulation in women. Human sexual arousal is also brought about by other sensory and non-sensory stimulants. The secondary organs include the lips, breasts and other areas of heightened sexual sensitivity. Non-tactile physical senses, such as smell, vision and hearing, can transmit sexually stimulating messages. Individuals vary in terms of their psychological predisposition towards sexual arousal as well as in their ability to achieve sexual satisfaction. Emotions, as part of the psychological milieu within which sexual arousal occurs, are known to be a strong factor, particularly in women. Finally, social conditioning with regard to appropriate sexual behaviour plays a crucial role in both sexual arousal and the ability to seek and

attain sexual pleasure. The impact of female genital mutilation on sexual response is discussed in more detail below.

Physical consequences and complications

All types of female genital mutilation involve removal or damage to the normal functioning of the external female genitalia and can give rise to a range of well documented physical complications. Psychological effects are less well documented in the scientific literature but descriptions are abundant in anecdotal evidence and in women's stories of their experiences (74).

The occurrence of physical complications depends on several factors, including the extent of cutting, the skill of the operator, the cleanliness of the tools used on the surrounding area, and the physical condition of the child. Although serious complications are possible following all types of female genital mutilation, those resulting from type III occur more frequently, tend to be more serious and last longer. Complications may be fewer when the procedure is undertaken by a skilled operator, although cases of death from uncontrolled bleeding from the clitoral artery have occurred even when it was performed by a trained physician (75).

The physical complications listed below are summarized from the published literature and focus on the short-term and long-term problems that occur with types I, II and III.

Immediate complications — all types

Death

While anecdotal evidence is frequently mentioned (18, 21), no study has ever been undertaken to determine the proportion of female child mortality that is attributable to female genital mutilation. Death can result from severe bleeding (haemorrhagic shock), from the pain and trauma (neurogenic shock) or from severe and overwhelming infection (septicaemia). Asuen reported a case of a 23-year-old multiparous Nigerian woman who was "circumcised" one day prior to admission for delivery. A live baby girl was delivered but the woman's circumcision wound became infected and four days later she became comatose and died (76).

Haemorrhage

Severe bleeding (haemorrhage) is the most common immediate complication and evidence of its high incidence is abundant in the literature (18, 21, 77). In El Dareer's study, bleeding accounted for almost one-quarter (22%) of all reported complications (19, 78). Amputation of the clitoris

cuts across the clitoral artery in which blood flows at high pressure. To stop the bleeding, the artery must be packed tightly or tied with a running stitch, either of which may slip and lead to haemorrhage (79). Secondary haemorrhage can occur after the first week as a result of sloughing of the clot over the artery owing to infection. An acute episode of haemorrhage or protracted bleeding can lead to anaemia (80) or, if very severe, to death.

Shock

Immediately after the procedure the child may enter a state of shock from the pain, psychological trauma and exhaustion from screaming. The short-term and long-term effects of this state of physical and psychological shock have not been reported.

Injury to neighbouring organs

As the procedure is commonly performed with no anaesthesia or with local anaesthesia only, the girl screams and wriggles from fear and pain. The cutting instrument may be crude and the practitioner may be inexperienced or have failing eyesight. Any of these can result in injury to the urethra (18), the vagina, the perineum or the rectum and can lead to the formation of fistulae through which urine or faeces will leak continuously (81).

Urine retention

Pain, swelling and inflammation around the wound and subsequent infection can lead to urine retention, which may last for hours or days, but is usually reversible. Intervention with a catheter or removal of stitches may be necessary before urine can be passed normally.

Infection

Infection is very common and can be caused by unsterile instruments. It can also occur within a few days of the operation as the area becomes soaked in urine and contaminated by faeces (21). The degree of infection varies widely from a superficial wound infection to a generalized blood infection or septicaemia. Unsterilized tools and faecal matter can cause infection with tetanus spores or bacteria that will cause gangrene.

Severe pain

The majority of procedures are performed without anaesthetic. When local anaesthesia is used, pain in the highly sensitive area of the clitoris

returns within 2–3 hours of the operation. Applying the local anaesthesia is itself extremely painful because the area of the clitoris and labia minora has a dense concentration of nerves and is highly sensitive. The use of general anaesthesia adds to the risk of death since it is usually not applied by a specialist with paediatric experience.

Long-term complications of types I and II

Failure to heal

Infection, separation by the urine flow and movement during walking may prevent the wound edges from healing. A weeping wound oozing pus or a chronic infected ulcer may result, which will require proper dressing and expert handling. Even if healing is complete, the rigid vulnerable scar over the clitoris may split open during childbirth. This may lead to renewed profuse bleeding from the clitoral artery.

Abscess formation

In cases where the infection is buried under the wound edges or an embedded stitch fails to be absorbed, an abscess can form which will usually require surgical incision and repeated dressing over a period of time.

Dermoid cyst

This is the most common long-term complication of all types of female genital mutilation. It results from the embedding of skin tissue in the scar. The gland which normally lubricates the skin will continue to secrete under the scar and form a cyst or sac full of cheesy material. The reported size of dermoid cysts ranges from that of a small pea to that of a grapefruit or football. Although not a serious threat to physical health these cysts are extremely distressing (82). Small dermoid cysts should be left alone to avoid further damage to the area, and the woman should be reassured. If cysts become very large or infected, surgical removal may be unavoidable.

Keloids

There is a genetic susceptibility to keloids (excessive growth of scar tissue) in many of the ethnic groups that practice female genital mutilation. Vulval keloids are disfiguring and psychologically distressing. Treatment is often unsuccessful since surgical removal frequently provokes further growth.

Stenosis of the artificial opening to the vagina

With infibulation, the artificial opening to the vagina can be so small that it closes almost completely over time. This may cause incomplete voiding of urine or haematocolpos (retained menstrual blood) and make sexual intercourse impossible (21). Products of miscarriage could also be retained in the vaginal canal leading to severe infection. A case of a primary stone in the vagina due to obstruction in a 33-year-old woman from the Ibo ethnic group in Nigeria has been reported (87). The stone caused severe pain, infertility and dribbling of urine. Although the Ibo are known to practise type II genital mutilation, in this case the vaginal opening was narrowed by fused labia which created an infibulation-like occlusion.

Complications of labour and delivery

During childbirth, the infibulated woman must be defibulated to allow the fetal head to emerge from the vagina. This increases the risk of bleeding and wound infection. If an experienced attendant is not available to perform defibulation (anterior episiotomy), labour may become obstructed (88). Prolonged obstructed labour can cause moderate-to-severe complications for the mother and the child. No studies have been undertaken on the precise impact of infibulation on perinatal outcome. However, cases of ruptured vulval scar, perineal tears, fetal distress and vesicovaginal and vesicorectal fistulae have been reported (81). There have also been reports of severe lacerations, including third-degree tears involving the anal musculature and injuries to the urinary tract including avulsion (tearing away) of the urethra from the bladder (89). Although female genital mutilation may contribute to maternal mortality there is no evidence of the extent of that contribution. It has been claimed that female genital mutilation doubles the rate of maternal mortality (90). This allegation has not been substantiated by any published study. One well documented study was undertaken by DeSilva on 173 mostly infibulated Sudanese women living in Saudi Arabia and delivering in a well-equipped hospital (88). There was significant delay in the second stage of labour, increased haemorrhage and increased occurrence of severe fetal asphyxia. There was no increase in maternal or neonatal mortality, which may be the result of the availability of resuscitation facilities in the hospital. Similar effects on labour occurring in rural areas may yield different outcomes. Evidence from Somalia (77) regarding the effect of infibulation on fetal and maternal outcome is weak because of small sample size, absence of information on other characteristics of the mothers and no control group. Moreover, the high rates of vesicovaginal and vesicorectal fistulae in Africa occur primarily as a result of pregnancy in very young girls whose

pelvises are not well developed. The true contribution of female genital mutilation to this condition has still not been verified.

Injury to neighbouring organs

This can occur during defibulation performed crudely to enable sexual intercourse to take place or during labour. Spontaneous injury or tearing of the perineum can also occur as a result of strong uterine contractions during labour (81).

Psychological and sexual effects

The few studies and reports available on the psychological and sexual effects of female genital mutilation are qualitative, in the form of case studies, rather than quantitative in nature, and therefore do not indicate the prevalence of such complications.

Effect on the psychological health of girls

There is only one published case of psychopathology in a child resulting from “fear of circumcision” in the medical literature (91).¹ This scarcity probably reflects the lack of attention by the research community to documenting these problems rather than the rarity of the condition. Other evidence suggests that the perception of the incident by the girl is not simply negative, despite the pain and trauma. The desirability of the ceremony for the child, with its social advantages of peer acceptance, personal pride and material gifts is strongly juxtaposed to the physical suffering in the stories of many women (77, 92). One description of the opposing forces acting on the child is provided from Burkina Faso (25):

“In areas where excision is practised, unexcised girls are constantly mocked by friends who have undergone the operation. Those yet to be excised may be terrified by older girls’ description of what is in store for them.”

The balance between the positive and the negative in the girl’s experience is what will shape her reaction and will determine how she remembers the incident. A study in Somalia asked 159 girls aged 8–16 to draw their experience of the moment of their “circumcision” and the period of convalescence afterwards (93). All the girls remembered the exact day and time they were “circumcised”, their age, who the “circumciser” was and where the procedure took place. Psychological analysis of the girls’

¹ This study also documented two cases of psychopathology directly related to female genital mutilation in adult women.

young Ibo women in Nigeria (97). He found no difference in what he termed "levels of promiscuity" between "circumcised" (type II) and "uncircumcised" women. He also reported that only 58.8% of the former experienced orgasm in contrast to 68.7% of the latter. This study also showed that when the clitoris is removed the labia minora and the breasts take over as the most erotic organs in the body.

Shandall studied 4024 women from his outpatient clinic in northern Sudan and reported that over 80% of those with type III (infibulation) did not know of or experience orgasm, compared to around 10% of those with type I or who were "uncircumcised" (15). El Dareer conducted a national survey, also in north Sudan, and reported similar results (19). In her study, 50% of women reported no sexual pleasure, 23% were indifferent to sexual intercourse and the remainder experienced pleasure all or some of the time. It is important to remember that in northern Sudan over 90% of women undergo type III genital mutilation. Another study, by Lightfoot-Klein, contradicted this evidence; out of 300 Sudanese women with infibulation, 90% reported pleasurable sex with frequent orgasm (95). The author does not adequately describe her methodology but admits to using two senior nurses, both with a thriving "circumcision" practice on the side, as her translators. In fact this study contradicts the findings of a previous study by the same author which reported severe pain and suffering with sexual intercourse and lack of pleasure with sex by infibulated women in Sudan (98).

Karim and Ammar studied 331 "circumcised" women who attended their outpatient clinic in Cairo (99). Of these, 29% did not experience any sexual satisfaction during intercourse, 30% experienced some satisfaction but did not reach orgasm and 41% experienced satisfaction and orgasm frequently. Although the sample contained women with types I, II and III genital mutilation, no clear conclusion was reached as to the difference in sexual experience of women with the different types. Also given possible confounding variables, such as social conditioning and the quality of the marital relationship, these numbers could be meaningful only if compared to the experiences of women with no genital mutilation in the same society. Another study of Egyptian women (133 who had undergone types I and II female genital mutilation and 26 who were "uncircumcised") was conducted by Badawi who reported that a greater proportion of the latter had sexual excitement in response to stimulation of the genitals compared to those with genital mutilation (100). The study also found that 50% of the "uncircumcised" women and 25% of those with genital mutilation experienced orgasm with manual stimulation of the clitoris/clitoral area. However, the size of the sample of uncircumcised women was very small.

Koso-Thomas reported on the experience of arousal, sexual feelings from genital stimulation and possibility of reaching climax among "circumcised" women in Sierra Leone (20). Her sample included 47 women with clitoridectomy (type I) and 93 women with clitoridectomy and excision of labia (type II). An interesting finding was the difference between 14 women with sexual experience before the procedure and 33 who experienced sex only afterwards. All respondents were fully conscious of themselves as sexual beings, a perception that the experience of genital mutilation did not seem to alter. With regard to their response to male sexual advances, those who had experienced sex before had positive reactions and those who experienced it only afterwards had a neutral response. When asked about the level of arousal experienced, no woman in either group reported intense arousal but those with previous experience were better able to detect a mild stimulation. None of the women experienced orgasm, but the women with no previous sexual experience remained neutral while those with previous experience became aroused but unfulfilled.

From Burkina Faso, Kere and Tapsoba reported on the sexual experience of several women and men whom they interviewed and who live with the consequences of female genital mutilation (26). Many of the women reported pain and discomfort with intercourse; some experienced a degree of sexual arousal but most did not experience orgasm.

From the evidence cited, it is clear that all types of female genital mutilation interfere to some degree with women's sexual response but do not necessarily abolish the possibility of sexual pleasure and climax. As explained on page 24, some of the sensitive tissues of the body and the crura of the clitoris are embedded deeply near the pubic symphysis and are not removed when excision of the protruding parts take place. Even women with infibulation often have parts of the sensitive tissue of the clitoris and labia left intact. Some studies suggest that, apart from the external genitals, other erogenous zones in the body may become more sensitized in women with genital mutilation, particularly when the overall sexual experience is pleasurable with a caring partner. Also, the psychological and cortical components of the sexual experience in women with genital mutilation are influenced by various factors that are not always predictable. Better designed studies are needed before more light can be shed on the effects of female genital mutilation on women's sexuality.

Effect on men's sexuality

For men who have to live with the genital mutilation of their wives and sexual partners, the experience can also be unpleasant. A woman from Burkina Faso has described how she feels about sex (27):

to stop the practice. Methodologies for monitoring and evaluating different interventions are also lacking. A study from Sudan moves in this direction by assessing the effects of past campaigns and identifying which media and messages were most successful (109). The researchers were partially successful in achieving their stated goals.

Given the social and behavioural factors involved in female genital mutilation it is reasonable to suggest that future research should be focused on behavioural and programmatic aspects of combating the practice. Epidemiological studies are needed to establish baseline prevalence rates. The inclusion of questions on the practice in more Demographic and Health Survey questionnaires will ensure that such baseline data are available for most countries in the near future. Clinical research to quantify the contribution of female genital mutilation to the mortality and reproductive morbidity of girls and women could be useful in influencing policy decisions, and would provide the information base needed for developing clinical support for girls and women who suffer from the health complications of female genital mutilation.

Suggested research agenda

There is clearly a lack of data on the extent, types and effects of female genital mutilation throughout the world, and little research has been undertaken on ways of combating the practice and managing its consequences. This section highlights gaps in current knowledge and provides suggestions for appropriate future research in the following main areas: epidemiology, health effects, behavioural determinants, and programme design and evaluation.¹

Epidemiology

Epidemiological research should address two sets of questions:

- Is there sufficient evidence that female genital mutilation is practised in the particular country or community to justify taking action?
- What is the scale of the problem: what groups in the country practise female genital mutilation; at what age is it performed; who performs the procedure; and what different methods are used?

¹ An in-depth discussion of research issues can be found in *Inroads to behavioral change: a research agenda for female genital mutilation and other reproductive and sexual health issues* (110).

Prevalence rate

Prevalence rates can be reported by type of procedure, ethnic group, religious following, income, education, age at which female genital mutilation is undertaken etc. Researchers who study female genital mutilation should familiarize themselves with the WHO four-type classification on page 6. Local terminologies and practices should be investigated and matched to this classification. Local variations as to who, how, when and why communities practise female genital mutilation are considerable. Research designed to inform people/organizations carrying out interventions, will therefore need to take into consideration the local factors that influence continuation and those that are the most likely to bring about change in each community. For example, in some countries, ethnic and religious affiliations are currently the most significant causes of continuation, while emerging variables such as parents' level of education, income level, mother's employment, nuclear family structure and female-headed households may influence future decision-making in the family.

Measuring trends over time

Studying the prevalence of female genital mutilation among different age groups through multiple cross-sectional surveys or longitudinal multigenerational studies is the most definitive means of measuring change. However, both of these types of studies, especially the latter, are expensive and require major investments in human and material resources. Since behavioural change in relation to such a deeply rooted practice is expected to be slow, measurable change will be detected only over long periods.

Establishing population at risk at local level

Given the wide variations in the practice of female genital mutilation, exact knowledge of the age at which it is carried out at any particular time and place and of how social trends may shift the practice to a younger or older age is important in order to identify who has escaped the practice and who is still at risk. Such detailed information is useful for the design of interventions to promote behavioural change.

Age-specific prevalence rates

This indicator could measure the incidence of female genital mutilation among an identified population at risk and could be used as a faster measure of trend than multigenerational studies. For example, if the age at

which female genital mutilation is performed in a particular community is known to be 4–8 years, the prevalence of genital mutilation among girls in that age group who attend school can be documented. A community-based intervention can be implemented, prevalence in the same age group measured every 2–3 years in the same schools and changes in prevalence rates noted.

The advantage of using age-specific indicators is that the population to be studied may be found in a defined location such as a primary school. Its major drawback is that, unless the age at which genital mutilation is performed and the proportion of girls who attend school remain constant, the measure is not reliable. Another consideration is that the behaviour of families who send their girls to school may be different from that of families who do not, so that the prevalence rate in school may not match that of the general population. In addition, varying school enrolment rates must be taken into consideration.

Despite the limitations, age-specific prevalence rates from the same setting may still prove useful as measures of change over a relatively short period of time.

Health effects

In this category five questions should be addressed. The first relates to the short-term health effects of female genital mutilation, the remaining four to the long-term consequences, namely:

- (1) What is the contribution of genital mutilation to the mortality and morbidity of girls?
- (2) Do complications of genital mutilation increase the risk of maternal mortality?
- (3) What is the contribution of the practice to reproductive morbidity?
- (4) What are the effects of genital mutilation on women's psychological and sexual health?
- (5) How does genital mutilation affect women's fertility and use of family planning?

To date, the majority of studies on the health consequences of female genital mutilation have been carried out among clients of gynaecology clinics. What is missing is measurement of the contribution of the practice and its complications to the overall morbidity and mortality of girls and women. Although such studies are no longer necessary to justify action against female genital mutilation, they may influence the decisions

of policy-makers towards starting programmes and passing professional regulations or legislation to combat the practice.

Measuring the burden of disease due to female genital mutilation is important and can be used in calculating the cost of this unnecessary practice to the beleaguered economies of Africa and in convincing governments to support abolition programmes.

Mortality in girls

Although some studies and reports document the occurrence of death among girls who have recently undergone genital mutilation (111), and there is considerable anecdotal evidence to suggest that it is by no means rare, there has been no systematic investigation of the scale of the problem. Death may be caused by neurogenic shock, immediate severe bleeding or overwhelming infection, and can therefore be easily linked to the procedure. However, later deaths due to slower bleeding, heart failure from severe anaemia or secondary infection may not be attributed to the operation. Several methodologies can be used to measure mortality from genital mutilation in girls, including an adaptation of the "sisterhood method" used for maternal mortality and secondary analysis of survey data collected using questions on the age at which the procedure is undertaken and child mortality. Reliable data on mortality would be most useful to all concerned in designing policies and programmes to combat female genital mutilation.

Morbidity in girls and effect on education

Various degrees of bleeding amounting to haemorrhage are known to be common to all types of female genital mutilation. By the time a girl undergoes the procedure at age 4–16, she may already be anaemic from inadequate nutrition and/or from menstrual blood loss. The acute bleeding following the operation may initiate or exacerbate an already existing anaemia (102). Anaemia is known to be a major debilitating condition for girls. Its effects are particularly relevant in the pre-pubertal and early reproductive years, as anaemic children have reduced learning abilities. As a result, genital mutilation may contribute to reduced educational achievement of girls.

Genital mutilation may also affect a girl's education more directly. The ritual may be performed during school days, healing may take a long time or the girl may develop infection or other complications which cause her to miss school. In parts of Kenya, girls are removed from school to undergo the procedure and are then married immediately and not allowed

to return to school (53). In such communities, stopping female genital mutilation may reduce the numbers of early marriages. School absenteeism or drop-out due to female genital mutilation needs to be documented through research. Studying the effect of the practice on girls' health and educational achievements is important to programmes for children.

Maternal mortality

Although some correlation between female genital mutilation and maternal mortality probably exists, no studies have provided conclusive evidence to substantiate this. In fact, few studies adequately document the effect of genital mutilation on pregnancy outcomes. In Somalia, it has been observed that some women deliberately starve themselves to reduce the size of the fetus in an attempt to avoid the complications of infibulation (22). However, research on women with malnutrition has shown that the condition has little effect on the incidence of prolonged or obstructed labour. One study reports the possibility of higher incidence of fetal distress among infibulated women. However, the mechanism by which this may occur if the woman has been adequately defibulated is not scientifically obvious nor was any explanation suggested by the study (88). There have been anecdotal reports of stillbirths.

Retention of the products of miscarriage in the vaginal canal has been reported with types II and III female genital mutilation. Obstructed second stage of labour due to tough scars around the vaginal exit is often mentioned but no documented evidence has been found. In fact, since the elasticity of the birth canal itself is not affected by any type of female genital mutilation there should be no reason for obstructed labour. In infibulated women, the most likely outcome would be severe perineal tearing around the narrowed outlet beyond the vaginal introitus if defibulation is not performed. The scar is unlikely to be too tough to be torn by uterine contraction.

Female genital mutilation may contribute to maternal mortality and morbidity through increased risk of bleeding or infection. However, incidents of intrapartum or postpartum haemorrhage or septicaemia solely attributable to it have not been reported. Female genital mutilation and its complications are more likely to add incrementally to other causes of maternal mortality and morbidity than to be the sole causative factor. More detailed information is needed before definitive statements on this subject can be made. Whatever the possible mechanisms, the contribution of genital mutilation to the alarmingly high rates of maternal mortality in Africa needs to be scientifically documented.

Reproductive morbidity

The list of immediate and long-term complications of female genital mutilation, both common and rare, is a directory of reproductive morbidity. Case reports are abundant in the literature and further studies can only add to this information by quantifying its contribution to common conditions, such as reproductive tract infections and infertility.

Psychological effects

The psychological effects are the least explored area of clinical research on female genital mutilation. It is therefore important to investigate the relationship between female genital mutilation, gender inequality and women's subordination. It is also important to look at the role the experience plays in shaping the personal identity and self-image of young women in terms of their right to control their bodies, as their sexuality may influence their reproductive decisions later in life. Understanding the psychosocial dynamics of female genital mutilation may therefore enhance understanding of other reproductive health decisions women make, including health-seeking behaviour and decisions related to child-bearing. Other important psychological questions are:

- What are the mechanisms of internalization of social roles which make women accept and defend female genital mutilation?
- Why is it difficult and painful for women to realize the damage done to them through female genital mutilation?
- What counselling and/or support systems do women need to reject the practice and protect their daughters from it?

Finding ways to heal women psychologically will not only benefit them individually, but may be essential to stop them from perpetuating the practice. Unless women recognize and accept the damage done to them and find the means to cope with their own pain they will not attempt to stop female genital mutilation.

It would also be useful to determine whether there is a difference in the social, educational and personal achievement of girls who have undergone genital mutilation compared with those who have not. This question could be answered through case-control studies, with careful attention to possible confounding factors, such as wealth, family status, and rural or urban dwelling.

Sexual effects

More attempts have been made to study sexual effects of female genital

chastity is more valuable than her life, health risks become irrelevant. For this reason, it is important to separate chastity as a moral attribute from physical cutting of the genitals. This is a prime strategy of the Egyptian task force on female genital mutilation. Public testimonies by non-circumcised women who are highly respected as role models may be more effective in these communities than health or religious messages (112).

Identifying causes of behavioural change

No studies have been undertaken to investigate the reasons why certain individuals, families or communities have stopped practising female genital mutilation. There is a need to study the profile of these social pioneers so they are identified, targeted and recruited as agents of change in their communities. Researchers are currently looking into the experience of a village in the socially conservative region of upper Egypt, where the population stopped practising female genital mutilation because of an intervention implemented by an NGO affiliated to the church. Case studies of families can provide useful information for the design of appropriate interventions and the development of new, more effective messages.

Where a measurable decline in the practice has occurred, it is important to study the role of direct and indirect causes of that decline. Examples of direct causes are specific education and training efforts, media campaigns or personal counselling by health care providers. Indirect causes may include increased levels of female education, improvement in women's economic autonomy, and the effects of urbanization or modernization in shifting the decision-making process to the nuclear family. An attempt should be made to assess the role each factor plays in the ultimate decision to stop the practice.

Programme design and evaluation

Some of the questions to be answered in this regard are:

- Who are the key groups in the family or the community who are likely to change their attitude more readily and how powerful are they in the decision-making hierarchy?
- Who are the best messengers to persuade individuals and communities against the practice? What training do they need and where should they be located?
- How should messages and interventions against female genital mutilation be designed and how can their effectiveness best be evaluated?

-
- How can changes in the prevalence of the practice best be monitored over time?

Designing effective messages to motivate change

In the past, messages developed for interventions against female genital mutilation were based on the knowledge and untested instincts of members of the community. While these are prerequisites for any such intervention, it is also important to analyse systematically the content and effect of different messages.

Change can be motivated by challenging the perceived benefits of female genital mutilation to those who hold power, such as fathers, uncles, elderly women and other family members. The perceived benefit for girls' morality and health also has to be challenged. Developing messages on the benefits of not practising female genital mutilation to all parties concerned may be a good counter-tactic. These and many other strategies need to be tried and tested.

Operational research

No research has been undertaken on the operational aspects of implementing interventions against female genital mutilation. The desirability, feasibility and means of integrating messages against the practice into school curricula, professional training and individual counselling within the health services is uncharted territory. Educational materials should be developed according to identified needs and their impact should be assessed. Examples of materials developed for these purposes are available, but there has to be more systematic testing of their design and impact.

Economic research

For policy decisions as well as programme priorities, some research on the economic aspects of female genital mutilation is needed. Firstly, it is important to determine whether attempts to persuade practitioners, who benefit both socially and economically, to seek alternative employment have been successful. Some evidence suggests that this approach in relation to a service that is highly in demand may benefit the supplier but may not improve the overall situation since the same suppliers may continue despite alternative training or, even if they stop, other suppliers will step in to fill the demand. In some countries, such as Egypt, the profile of practitioners has changed — current mothers mainly experienced genital

mutilation at the hands of traditional practitioners while in the case of their daughters the procedure was undertaken primarily by doctors. Patterns of modernization of the practice have also been reported among affluent families in Nigeria, Somalia and Sudan. While legislation may not affect traditional practitioners who operate outside the formal system, physicians and trained health personnel may be more responsive to legislative measures through fear of losing their license or reputation.

A second area of research is to calculate the economic costs of treating complications and of the burden of disease and disability attributable to female genital mutilation. This could be important in persuading governments to support programmes and legislation to combat the practice.

Evaluation and monitoring

If the abolition of female genital mutilation is to become a reality, each investment in research and each intervention should have a built-in means of measuring its contribution to the ultimate goal of stopping the practice. Evaluation of the efficacy of a particular project and monitoring of the effectiveness of the overall programme against the practice are different exercises which need different approaches and techniques.

Project evaluation is a shorter-term exercise that looks at how a particular project is moving towards its stated goals. For example, a mass education campaign with messages directed at men could be evaluated quantitatively by finding out the number of men who were reached and how many times they heard the message. It can be evaluated qualitatively by finding out how much of the information in the message they retained and whether it had any effect on their attitudes and intended behaviour. Such an assessment may be made at the end of the intervention or at intervals during it.

A project designed to convince the public and policy-makers of the need to pass legislation against female genital mutilation should be evaluated on the basis of its ability to show an effect on public opinion, the views of government officials and the direction of the debate. These are intermediate indicators, while the ultimate measure for this effort is the passing of legislation.

Programme monitoring refers to the effectiveness of all the efforts concerned in reducing the incidence of the practice. As discussed above, the monitoring of change could be partially achieved by measuring the decline in age-specific prevalence rates. Other short-term community monitoring techniques, such as a register of girls who have not undergone genital mutilation, could be developed with the assistance of health workers and community leaders. This type of monitoring was used successfully in

one project in Nigeria (58). Monitoring of programmes would also include the documentation of progress of policies, changes in legislation and professional regulations designed to combat the practice, and the amount of financial and human resources invested in abolition efforts. The ultimate monitoring indicator is the decline of female genital mutilation prevalence rates over time. Such monitoring is possible with the integration of questions on female genital mutilation into repeated national surveys, such as the Demographic and Health Survey, which is undertaken approximately every 10 years.

5.

International, regional and national agreements and actions

Female genital mutilation has recognized implications for the human rights of women and children. It is also considered to be a form of violence against the girl, which affects her life as an adult woman. A summary of the international and regional legal instruments which relate to female genital mutilation is available from WHO.¹ These instruments are elaborated further in this section.

International

A series of human rights instruments dating from 1948, which are legally binding on States Parties, contain language concerning the rights to health, non-discrimination on the basis of sex or gender, and physical and mental integrity. Female genital mutilation violates each of these precepts. More recently, language in international conference declarations has directly addressed harmful traditional practices in general and, in some cases, female genital mutilation specifically.

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948, established a number of basic human rights principles, among them, the inherent freedom and equality of all human beings (114, Article 1). Starting from these principles, it sets out a number of basic human rights to which each person is entitled. Article 3 guarantees the right to life, liberty and security of person. This principle has come to be articulated as providing the basis for the right to physical and mental integrity. The Declaration prohibits torture and "cruel, inhuman or degrading treatment or punishment" (Article 5).

The International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights, comple-

¹ *Female genital mutilation*. Geneva, World Health Organization, 1996 (unpublished document WHO/FRH/WHD/96.26; available on request from Family and Reproductive Health, World Health Organization, 1211 Geneva 27, Switzerland).

mentary human rights treaties adopted by the United Nations General Assembly in 1966 and legally binding on States Parties, have provisions applicable to the practice of female genital mutilation (115, 116). The first is the right to self-determination, set out in Article 1.1 of the International Covenant on Economic, Social and Cultural Rights. This guarantees to all persons, *inter alia*, the right to “freely determine their ... social and cultural development”. Article 12 of the International Covenant on Economic, Social and Cultural Rights expands the right to health set out in Article 25.1 of the Universal Declaration of Human Rights, declaring that all persons have a right “to the enjoyment of the highest attainable standard of physical and mental health”, specifying that States Parties should create conditions amenable to ensuring the provision of prevention as well as treatment of adverse health conditions. The International Covenant on Civil and Political Rights supplements the above, adding that, “Every human being has the inherent right to life”, which “should be protected by law” (Article 6). With regard to health and the individual person, it proscribes “torture or ... cruel, inhuman or degrading treatment or punishment” (Article 7). It also expressly prohibits the non-consensual subjection of persons to medical or scientific experimentation (Article 7).

The 1979 Convention on the Elimination of All Forms of Discrimination against Women, legally binding on States Parties, strongly promotes the rights of women and specifically addresses discriminatory traditional customs and practices (117). It calls on States Parties to take immediate steps towards eliminating such discrimination by refraining from future discriminatory acts or practices, as well as “to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women” (Article 2f). Article 5 obligates States Parties to “modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women”. States Parties are obligated in Article 10 to ensure that women have “access to specific educational information to help to ensure the health and well-being of families”. Finally, in Article 12, States Parties are obligated to “take all appropriate measures to eliminate discrimination against women in the field of health care...”. The provisions of the Convention, although they do not expressly refer to female genital mutilation, establish a strong international legal basis for the institution of measures to eliminate the practice.

The 1985 Nairobi Forward-Looking Strategies for the Advancement of Women suggest a number of ways in which the international community could promote the rights of women (118). Several provisions are

applicable to female genital mutilation, although there is no specific reference to the practice. Paragraph 148 calls on governments to establish plans for the promotion of women's health and development to "identify and reduce risks to women's health and to promote the positive health of women at all stages of life". There is a more direct statement against harmful practices in paragraph 150 which states that "health education should be geared towards changing those attitudes and values and actions that are discriminatory and detrimental to women's and girls' health". The same paragraph goes on to state that "steps should be taken to change the attitudes and health knowledge and composition of health personnel so that there can be an appropriate understanding of women's health needs".

The 1993 United Nations Declaration on Elimination of Violence Against Women (119) expressly states in its Article 2: "Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including ... dowry-related violence ... female genital mutilation and other traditional practices harmful to women..." (119).

The 1989 Convention on the Rights of the Child, ratified by all states where female genital mutilation is practised, specifically sets out human rights principles applicable to children (120). Among other things, the Convention on the Rights of the Child establishes the child's right to develop physically, mentally and socially to his or her fullest potential, to freely express his or her opinion, and to participate in decisions concerning his or her future. Article 19, which protects children from "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation", is applicable to female genital mutilation. More specifically, however, the Convention on the Rights of the Child refers to harmful traditional practices in Article 24.3 which states that "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children".

A World Medical Association statement on Condemnation of Female Genital Mutilation was adopted by the 45th World Medical Assembly in Budapest, Hungary, in 1993 (121). The statement condemns both female genital mutilation and the participation of physicians in the practice.

Building on growing human rights precepts, the 1993 Vienna Declaration and Programme of Action strongly supports the rights of women and girls (122). It is applicable to female genital mutilation not only in this way, but also in its specific mention of harmful traditional practices and in its condemnation of them. Reflected in this Declaration is the acceptance by the international community that women's rights are human rights

and that violence against women is a human rights violation, even if the perpetrator is a private individual or family member. Paragraph 9 states that “the human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights”. It goes on to state that “the human rights of women should form an integral part of the United Nations human rights activities including the promotion of all human rights instruments relating to women”. Further, the same paragraph declares as priority objectives of the international community the “full and equal participation of women in the political, civil, economic, social and cultural life”, as well as “the eradication of all forms of discrimination on grounds of sex”. Paragraph 9 then calls for the elimination of gender-based violence and sexual exploitation, including acts and practices “resulting from cultural prejudice”, since such acts and practices are “incompatible with the dignity and worth of the human person”. It suggests that the international community may achieve the above goals through legal means and other national action, and through cooperation among nations in programmes of economic and social development, including education, health and social support. Finally, the paragraph “urges governments, institutions, intergovernmental and nongovernmental organizations to intensify their efforts for the protection and promotion of human rights of women and the girl-child”. Paragraph 10, which addresses the issues of sexual violence and gender bias, expressly calls for “the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices, cultural prejudices and religious extremism”.

The 1994 Declaration and Programme of Action of the International Conference on Population and Development (ICPD), which strongly advocates gender equity and equality and women’s empowerment as well as directly addressing reproductive health and rights issues, make five specific mentions of female genital mutilation and calls for its prohibition (9). The document represents a shift at the international level away from thinking about female genital mutilation primarily as a health issue and towards considering it as an issue of women’s health and rights. It also specifically calls for the abolition of female genital mutilation in paragraph 4.22: “Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among nongovernmental and community organizations and religious institutions to eliminate such practices”. Paragraph 5.5 characterizes female genital mutilation as coercive and discriminatory, calling for the adoption and enforcement of measures to eliminate it. Paragraph 7.35 characterizes it as both a “violation of basic rights” and “a major lifelong risk to women’s health”. This paragraph includes female genital mutilation in a class of

harmful practices which were "meant to control women's sexuality" and which have "led to great suffering". Reflecting the status of female genital mutilation as a violation of the right to health, paragraph 7.40 specifically delineates ways in which governments and communities can eliminate the practice. This paragraph emphasizes the urgency of such action and suggests that "steps to eliminate the practice should include strong community outreach programmes involving village and religious leaders, education and counselling about its impact on girls' and women's health, and appropriate treatment and rehabilitation for girls who have suffered mutilation". It adds that such services "should include counselling for women and men to discourage the practice". Finally, paragraph 7.6 states that "active discouragement of harmful practices such as female genital mutilation should also be an integral component of primary health care including reproductive health care programmes".

The 1995 Report of the World Summit for Social Development held in Copenhagen makes specific provisions for the rights of women (Commitment 5) and of the girl child (Commitment 6) (123). It also specifically refers to female genital mutilation, reinforcing the ICPD language condemning the practice. In keeping with this, Commitment 6(y) calls for increased international support and cooperation "for education and health programmes based on respect for human dignity and focused on the protection of women and children, especially against exploitation, trafficking and harmful practices, such as child prostitution, female genital mutilation and child marriages".

The Declaration and Platform for Action of the Fourth World Conference on Women, held in Beijing in September 1995, builds on all of this prior action. In addition to strong statements supporting women's and girls' rights, it reinforces the ICPD language calling for an end to the practice of female genital mutilation (10). In paragraph 39, which refers to the rights of girls, the document lists female genital mutilation as one of the various forms of sexual and economic exploitation to which girls are often subjected. Paragraph 93 refers to female genital mutilation in the context of social discrimination. It recognizes that conditions "that subject [girls] to harmful practices, such as female genital mutilation" which "pose grave health risks" are common. It goes on to recognize the need for girls to have access to health services, including counselling, as well as access to sexual and reproductive health information. Additionally, this paragraph recognizes that "a young woman's right to privacy, confidentiality, respect and informed consent is often not considered" with respect to health services, and the need for young men to be educated "to respect women's self-determination and to share responsibility with women in matters of sexuality and reproduction".

Female genital mutilation also receives specific mention in the Platform's section on the strengthening of preventive programmes that promote women's health. The document calls for the United Nations and other relevant international organizations, governments, NGOs, the mass media and the private sector to respect women's health programmes. In paragraph 107(a), which calls for prioritization of various educational programmes for women, the Platform calls for the placement of "special focus on programmes for both men and women that emphasize the elimination of harmful attitudes and practices, including female genital mutilation..."

In the section on equality and non-discrimination, the Platform issues a particularly strong call to governments to ensure, via national constitutions or appropriate legislation, women's equality as well as the elimination of discrimination on the basis of sex (paragraph 232, (a) et seq.). According to section (d) of this paragraph, governments should remove legal provisions not in accord with these principles. Paragraph 232(g) calls for urgent government action to "combat and eliminate violence against women, which is a human rights violation, resulting from harmful traditional or customary practices, cultural prejudices and extremism". Along these same lines, paragraph 232(h) calls for the prohibition of "female genital mutilation wherever it exists", as well as for the "support of efforts among non-governmental and community organizations and religious institutions to eliminate such practices". More generally, various provisions of paragraph 232 call for the implementation of legal and educational measures to ensure the rights of women. Finally, in the section on the girl child, paragraph 259 lists female genital mutilation as an example of gender discrimination, and paragraph 277 calls for the development of "policies and programmes, giving priority to formal and informal education programmes that support girls" as well as placing emphasis on programmes to educate "women and men, especially parents, on the importance of girls' physical and mental health and well-being, including the elimination of discrimination against girls in food allocation, early marriage, violence against girls, female genital mutilation, child prostitution..."

Regional

The African Charter on the Rights and Welfare of the Child, adopted by the Organization of African Unity (OAU) in 1990, protects many of the rights ensured by the Convention on the Rights of the Child (124). Article III of the Charter ensures the right to "equality between the sexes". Also applicable to female genital mutilation are Article XIV.1, which

on legal minors with no power or faculties to consent. Consent by parents or guardians is not acceptable when the act performed is damaging rather than beneficial to the child. The argument that female genital mutilation performed under hygienic and medically controlled conditions is a lesser evil compared to the greater risk of severe complications is also not acceptable, since the cause of the risk is human behaviour, which can be changed, and not an uncontrollable pathology such as malignancy. Since all medical research and clinical efforts aim at making uncontrollable causes of damage to the human body more controllable, it would be unethical for a health professional to damage a healthy body in order to prevent more destructive human behaviour. It is therefore difficult to find a medico-legal justification for the performance of female genital mutilation on children by health professionals.

6.

WHO policies and activities

WHO started its efforts to promote the elimination of harmful traditional practices in the 1970s. These efforts included gathering information on female genital mutilation, especially regarding its epidemiology and health consequences. These efforts, which are still continuing, include advocacy at international, regional and national levels for the elimination of female genital mutilation. On the basis of research findings, WHO works to promote technically sound policies and approaches to the prevention of female genital mutilation and the management of its health consequences, and to provide support to national networks or organizations and groups involved in developing relevant policies, strategies and programmes. Since the early 1980s, WHO has issued several statements and adopted resolutions on female genital mutilation. These activities and policies are considered below in more detail.

The Seminar on Traditional Practices held in Khartoum, Sudan, in February 1979, which was sponsored by the WHO Regional Office for the Eastern Mediterranean, was the first international forum on female genital mutilation. It took the unprecedented step of formulating recommendations on the elimination of female genital mutilation by governments, including the setting up of national commissions for the coordination of activities aimed at doing this.

In August 1982, WHO made a formal statement of its position to the United Nations Commission on Human Rights, endorsing the recommendations of the Khartoum seminar. WHO's main points were:

- that governments should adopt clear national policies to abolish the practice of female genital mutilation, and to inform and educate the public about its harmfulness;
- that programmes designed to combat the practice should recognize its association with extremely adverse social and economic conditions, and should respond sensitively to women's needs and problems;

- that the involvement of women's organizations at the local level should be encouraged, since awareness and commitment to change must begin with them.

In the same statement, WHO expressed its unequivocal opposition to any medicalization of the operation, advising that under no circumstances should it be performed by health professionals or in health establishments. Together with UNICEF, WHO also stated its readiness to support national efforts against female genital mutilation and continued collaboration in research and dissemination of information.

In the ensuing years, WHO's role included providing technical and financial support for national surveys, for the training of health workers and for grassroots initiatives. For example, WHO supported the NGO Working Group on Female Circumcision which was established in 1977 under the auspices of the Commission on Human Rights to coordinate the actions of NGOs in this area. In 1983, WHO and the NGO Working Group on Female Circumcision convened an informal meeting on the subject with African delegates to the Thirty-sixth World Health Assembly.

In 1984, WHO headquarters and its Regional Offices for Africa and for the Eastern Mediterranean joined UNICEF and UNFPA in providing technical and administrative support and financial assistance to a seminar in Dakar organized by the NGO Working Group on Female Circumcision and sponsored by the Government of Senegal. The Dakar seminar gave further impetus to the establishment of national committees in all countries where female genital mutilation is practised. It set up the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) to act as a bridge between the groups working among the people and those providing support for their activities.

The efforts of IAC and the NGO Working Group on Traditional Practices Affecting the Health of Women and Children (formerly the NGO Working Group on Female Circumcision) have led to the formation of 24 national committees in Africa that carry out activities for the elimination of this practice with the support of the United Nations and other international funding agencies. WHO continued its support to IAC by cosponsoring the IAC regional seminars on traditional practices affecting the health of women and children in Africa, held in Ethiopia in 1987 and in 1990. The outcome of the 1990 IAC seminar was a proposal for a change in terminology from "female circumcision" to "female genital mutilation". WHO also provided funding to IAC to undertake a comparative study of female genital mutilation and contraceptive use among women in Djibouti and Sierra Leone.

The subject of female genital mutilation, along with other harmful practices, was also discussed during a Regional Workshop on Women, Health

and Development, jointly sponsored by WHO, UNICEF and UNFPA in November 1984 in Damascus, Syrian Arab Republic.

In September 1988, the Thirty-fifth session of the WHO Regional Committee for the Eastern Mediterranean passed a resolution on maternal and infant mortality (socioeconomic implications) which stated that women's health must be safeguarded by ensuring the elimination of harmful traditional practices, including female genital mutilation. The WHO Regional Office for the Eastern Mediterranean has also supported the establishment of a regional network of national focal points on women's health through which it supports various activities aimed at the prevention of harmful traditional practices including female genital mutilation.

At its Thirty-ninth session in 1989, the WHO Regional Committee for Africa adopted Resolution AFR/RC39/R9 on traditional practices affecting women and children, recommending that Member States: "(1) prohibit the medicalization of female circumcision and discourage health personnel from performing the operation; (2) include in training programmes for health and traditional birth attendants relevant information on the dangers of female circumcision; and (3) encourage research projects to identify the most effective means of controlling these practices."

WHO participated in a Regional Seminar on Traditional Practices Affecting the Health of Women and Children, organized by the United Nations Centre for Human Rights in Ouagadougou in 1992. The seminar recommended that the terminology "female genital mutilation" be used in the future. In the same year WHO issued a joint statement on female genital mutilation with the International Federation of Gynecology and Obstetrics drawing attention to its harmful effects on health and suggesting approaches for action to abolish the practice (90).

In 1993, the Forty-sixth World Health Assembly adopted Resolution WHA46.18 on maternal and child health and family planning for health which stated that harmful traditional practices such as female genital mutilation "further restrict the attainment of the goals of health, development and human rights for all members of society". Notable here are the changes in language. The stronger and arguably more accurate term "female genital mutilation" is substituted for the term "female circumcision" and there is a recognizable shift from addressing the practice only in terms of a health issue towards acknowledging it as both a health and a human rights issue. The resolution urged Member States to continue the monitoring and evaluation of their efforts to eliminate the practice and requested the Director-General to "collaborate with other organizations and bodies of the United Nations system, governmental and nongovernmental organizations in contributing to the preparation of a plan of action for eliminating harmful traditional practices affecting the

health of women, children and adolescents”.

The Forty-seventh World Health Assembly in 1994 adopted Resolution WHA47.10 which recognized that traditional practices such as female genital mutilation and early sexual relations and reproduction “cause serious problems in pregnancy and childbirth and have a profound effect on the health and development of children, including child care and feeding”. The resolution went on to urge Member States “to assess the extent to which harmful traditional practices affecting the health of women and children constitute a social and public health problem in any local community or sub-group” and “to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation”. It also requested the Director-General to “mobilize additional extrabudgetary resources in order to sustain the action at national, regional and global levels”.

In 1995, WHO convened a Technical Working Group on Female Genital Mutilation, which met in Geneva, Switzerland from 17 to 19 July, to draw attention to female genital mutilation and its health consequences, to begin the process of developing standards and norms in relation to the practice and to make recommendations for future action. On the basis of its recommendations, the WHO definition and classification of female genital mutilation reproduced on page 6 was drawn up.

The WHO Regional Office for Africa and UNFPA co-funded the IAC training seminar aimed at strengthening the operational capacity of its national committees, which was held in Burkina Faso in July 1995.

The WHO Regional Office for Africa launched a regional plan of action for accelerating the elimination of female genital mutilation in the countries of the Region in March 1997. WHO also published a joint statement on female genital mutilation together with UNICEF and UNFPA in April 1997 (23).

7.

Conclusion

The centuries-old practice of female genital mutilation used to be shrouded in silence. However, in the past five years that shroud has been removed and female genital mutilation has become one of the most talked about subjects among women's groups, especially in Africa. It is a topic of national and international media attention and most international assistance agencies have developed policies or programmes to combat it. It was an important issue at the World Conference on Human Rights in 1993, a clearly stated violation of reproductive and health rights at the International Conference on Population and Development in 1994 and one of the major issues exposed at the United Nations Fourth World Conference on Women in 1995. Many have reached the conclusion that, recognizing the imbalance of power between men and women that underlies the practice, the most effective strategies for dealing with female genital mutilation include helping women to empower themselves within their own culture and community. Essentially this means that the struggle to stop the practice as a health risk and a violation of women's rights must be led by women from the communities where it occurs. Since Africa is the region where this practice predominates it is natural that African women have been at the forefront of exposing it locally and internationally.

This does not mean, however, that others have no role to play. The support of men and of people from other cultures who are sympathetic to the views of African women opposed to the practice is vital. A number of groups have the potential to provide assistance in this regard.

The international development aid community

International organizations working in Africa and other communities where female genital mutilation is practised have a major role to play. Such organizations can respond to requests for resources (both technical and financial) from local NGOs and government programmes that are opposed to the practice. The limitations of this review do not permit a full

report on the policy and funding trends in programmes to combat female genital mutilation over the past 10 years but the overall picture suggests a rapidly rising political interest in the issue with a much slower, and often non-existent, rise in budget for grants or activities. If this trend continues, the current interest in the topic may eventually fade and the practice may once again be shrouded in silence.

International women's groups

Women's groups can help by monitoring progress towards eliminating female genital mutilation and by helping to make sure that resources continue to be available when needed. Women's groups can support the promotion and protection of the health and development of women and girls by listening to what women affected by this practice have to say and by following their lead.

National governments

Some national governments have made a clear and public commitment to stop female genital mutilation through laws, professional regulations and programmes and by signing international declarations that condemn the practice. The launching of the WHO African Region's "Plan of action for accelerating female genital mutilation elimination in Africa" in March 1997 has contributed to a growing interest in the subject among governments. Some have begun developing national policies and plans of action for eliminating female genital mutilation, including setting targets for elimination and developing national-level and district-level indicators for monitoring and evaluating programmes. There is more emphasis on integrating efforts to prevent female genital mutilation into existing health and education programmes and on building partnerships with nongovernmental groups and communities in order to bring about change. Although passing laws to criminalize female genital mutilation may not be appropriate in view of the current stage of development of the movement against the practice in certain countries, it is still important to consider doing so in due course.

National groups

National NGOs, universities and other institutions, and professional associations can help to draw attention to the need to promote and protect reproductive health and to eliminate female genital mutilation. Governments are more likely to take action against the practice when greater numbers of citizens oppose it.

It is essential to document, review and evaluate approaches and programmes. If activities to combat female genital mutilation are to be successful, the needs and concerns of national groups cannot be ignored.

Finally, it is now possible to believe that the beginning of the end of female genital mutilation is here. Women in Africa and elsewhere, perhaps for the first time ever, have a serious chance of abolishing this humiliating practice while at the same time addressing other problems of discrimination and inequality that they face. With the right approaches locally and sensitive international support, female genital mutilation can and will be defeated.

References

1. Katz J. *The silent world of doctor and patient*. New York, NY, Free Press, 1984.
2. Anderson P. *Children's consent to surgery*. Buckingham, Open University Press, 1993.
3. Declaration of Geneva, 1948. In: *Handbook of declarations*. Ferney-Voltaire, World Medical Association, 1996.
4. Declaration of Helsinki, 1986. In: *Handbook of declarations*. Ferney-Voltaire, World Medical Association, 1996.
5. Declaration of Tokyo, 1975. In: *Handbook of declarations*. Ferney-Voltaire, World Medical Association, 1996.
6. Wolkoff AS. Surgery of the clitoris. In: Lowry, TP et al. *The clitoris*. St Louis, MO, Warren H. Green Inc., 1976:104–110.
7. Hosken F. The epidemiology of female genital mutilation. *Tropical doctor*, 1978, 8:150–156.
8. Taylor JR, Lockwood AP, Taylor AJ. The prepuce: specialized mucosa of the penis and its loss to circumcision. *British journal of urology*, 1996, 77:291–295.
9. *Programme of action*. Cairo, International Conference on Population and Development, 1994.
10. *Declaration and platform for action*. Beijing, Fourth World Conference on Women, 1995.
11. *Female genital mutilation. Report of a WHO Technical Working Group, Geneva, 17–19 July 1995*. Geneva, World Health Organization, 1996 (unpublished document WHO/FRH/WHD/96.10; available on request from Family and Reproductive Health, World Health Organization, 1211 Geneva 27, Switzerland).
12. Daniell WF. On the circumcision of females in West Africa. *Medical gazette of London, England*, 1847:374–378 (Cited in: Huelsman BR. An anthropological view of clitoral and other female genital mutilations. In: Lowry TP et al. *The clitoris*. St Louis, MO, Warren H. Green Inc., 1976:111–161).
13. Roles RC. Tribal surgery in East Africa during the 19th century: Part two — Therapeutic surgery. *East Africa medical journal*, 1967, 44:17–30 (Cited in: Huelsman BR. An anthropological view of clitoral and other female genital mutilations. In: Lowry TP et al. *The clitoris*. St Louis, MO, Warren H. Green Inc., 1976:111–161).

14. Worsley A. Infibulation and female circumcision: a study of a little-known custom. *Journal of obstetrics and gynaecology of the British Empire*, 1938, 45:686–691.
15. Shandall AA. Circumcision and infibulation of females: a general consideration of the problem and a clinical study of the complications in Sudanese women. *Sudan medical journal*, 1967, 5:178–212.
16. Verzin JA. Sequelae of female circumcision. *Tropical doctor*, 1975, 5:163–169.
17. Daw E. Female circumcision and infibulation complicating delivery. *The practitioner*, 1970, 204:559–563.
18. Aziz FA. Gynecologic and obstetric complications of female circumcision. *International journal of gynaecology and obstetrics*, 1980, 17:560–563.
19. El Dareer A. *Women, why do you weep?* London, Zed Press, 1982.
20. Koso-Thomas O. *The circumcision of women: a strategy for eradication*. London, Zed Press, 1987.
21. Dirie MA, Lindmark G. The risk of medical complications after female circumcision. *East African medical journal*, 1992, 69:479–482.
22. Johnson KE, Rodgers S. When cultural practices are health risks: the dilemma of female circumcision. *Holistic nursing practice*, 1994, 8:70–78.
23. *Female genital mutilation: a joint WHO/UNICEF/UNFPA statement*. Geneva, World Health Organization, 1997.
24. Iregbulem LM. Post-circumcision vulval adhesions in Nigerians. *British journal of plastic surgery*, 1980, 33:83–86.
25. Diejomaoh FME, Faal MKB. Adhesions of labia minora complicating circumcisions in the neonatal period in a Nigerian community. *Tropical geographical medicine*, 1981, 33:135–138.
26. Kere LA, Tapsoba I. Charity will not liberate women. In: *Private decisions, public debate*. London, Panos Press, 1994.
27. Toubia N. *Female genital mutilation: a call for global action*, 2nd ed. New York, NY, RAINBQ, 1995.
28. Dirie MA. Female circumcision in Somalia: medical and social implications. In: *Proceedings of the SOMAC/SAREC (Sweden) Conference, Mogadishu, Somalia, 1985*.
29. Mustafa AZ. Female circumcision and infibulation in the Sudan. *Journal of obstetrics and gynaecology of the British Commonwealth*, 1966, 73:302–306.
30. Van der Kwaak A. Female circumcision and gender identity: a questionable alliance. *Social science and medicine*, 1992, 35:777–787.
31. Modawi S. The impact of social and economic changes in female circumcision. In: *Proceedings of the Third Congress of Obstetrics and Gynaecology, Khartoum*. Khartoum, Sudan Medical Association, 1973:242–254 (Sudan Medical Association Congress Series, No. 1).
32. *Sudan fertility survey*. Khartoum, Department of Statistics, Ministry of Economic and National Planning, 1979.
33. Sudan Ministry of Economic and National Planning & Institute for Resource Development/Macro International. *Sudan demographic and health survey, 1989/1990*. Calverton, MD, Macro International, 1991.

34. Hosken F. *The Hosken report*, 1st ed. Lexington, MA, Women's International Network News, 1979.
35. Toubia, N. *Female genital mutilation: a call for global action*. New York, NY, RAINBQ, 1993.
36. Toubia N. Two million girls a year mutilated. In: *The progress of nations*. New York, NY, UNICEF, 1996.
37. *The world's women*. New York, NY, United Nations, 1995.
38. *World population prospects: the 1994 revision*. New York, NY, United Nations, 1994.
39. *Enquête et témoignages sur la pratique de l'Excision en République du Bénin (Survey and evidence of the practice of excision in the Republic of Benin)*. Porto-Novo, National Committee on Harmful Traditional Practices, 1993 (unpublished report).
40. Nitiema PA. *Les mutilations génitales féminines dans la ville de Ouagadougou: épidémiologie — évolution. (Female genital mutilations in the town of Ouagadougou: epidemiology — evolution)*. Ouagadougou, University of Ouagadougou Faculty of Health Sciences, 1993 (unpublished thesis).
41. Lamizana M, Comité National de Lutte contre la Pratique de l'Excision. Update on female genital mutilation in Burkina Faso. In: *Report of the Second Annual Inter-agency Working Group Meeting on female genital mutilation*. New York, NY, RAINBQ, 1995.
42. Njock Nje Y et al. *Research on female genital mutilation in Cameroon*. Yaoundé, National Committee on Harmful Traditional Practices, 1994 (unpublished report).
43. Central African Republic, Ministry of Economics, Planning and International Cooperation/Macro International. *Enquête démographique et de santé, République Centrafricaine 1994-95. (Demographic and health survey, Central African Republic 1994-95)*. Calverton, MD, Macro International, 1995.
44. Côte d'Ivoire Ministry of Economics, Finance and Planning/Macro International. *Enquête démographique et de santé, Côte d'Ivoire, 1994 (Demographic and health survey, Côte d'Ivoire, 1994)*. Calverton, MD, Macro International, 1995.
45. Warzazi A. *Report of the Working Group on Traditional Practices Affecting the Health of Women and Children*. New York, NY, United Nations Economic and Social Council, Commission on Human Rights, 1991.
46. Saadawi N. *The hidden face of Eve*. London, Zed Press, 1977.
47. Assaad M. Female circumcision in Egypt: social implications, current research and prospects for change. *Studies in family planning*, 1980, 11:3-16.
48. Gebere Selassie A, Desta M, Negesh Z. *Harmful traditional practices affecting the health of women and children in Ethiopia*. Addis Ababa, Ministry of Health/UNICEF, 1984.
49. Meskal FH, Dijene A, Yuduhfa A. *Perceptions and attitudes regarding harmful traditional practices in Ethiopia*. Addis Ababa, National Committee on Harmful Traditional Practices/Ministry of Health, 1990.

50. Singhateh SK. *Female circumcision, the Gambian experience: a study on the social, economic and health implications*. Banjul, The Gambia Women's Bureau, 1985.
51. Kadri J. *The practice of female circumcision in the upper east region of Ghana: a survey report*. Accra, Ghanaian Association for Women's Welfare, 1986.
52. Twumasi PA. *Female circumcision in selected areas in southern Ghana*. Accra, Ghanaian Association for Women's Welfare, 1987.
53. *Report on harmful traditional practices that affect the health of the women and their children in Kenya*. Nairobi, Maendeleo ya Wanawake Organization, 1991.
54. Marshall R et al. Traditional practices affecting the health of women and children in Liberia. In: *Seminar on traditional practices*. Dakar, Inter-African Committee on Harmful Traditional Practices Affecting the Health of Women and Children, 1984.
55. Republic of Mali, Ministry of Health, Solidarity and Aged Persons/Macro International. *Enquête démographique et de santé, Mali, 1995-96: Rapport préliminaire. (Demographic and health survey, Mali, 1995-96, preliminary report)*. Calverton, MD, Macro International, 1996.
56. Salamatou T et al. *Enquête primaire sur les pratiques traditionnelles ayant effets néfastes sur la santé de la mère et de l'enfant au Niger. (Primary survey of traditional practices with harmful effects on mothers and children in Niger)*. Niamey, Comité Nigerien de lutte contre les pratiques traditionnelles néfastes, 1992.
57. Issa B. *Communication concernant l'excision au Niger (Communication on excision in Niger)*. In: *Réunion préparatoire de la conférence régionale sur l'excision. (Preparatory meeting for the regional conference on excision)*. Ouagadougou, National Committee on Harmful Traditional Practices, 1993 (unpublished document).
58. Adebajo C. Update on female genital mutilation in Nigeria. In: *Report of the Global Action Against Female Genital Mutilation first inter-agency working group meeting on female genital mutilation*. New York, NY, RAINBQ, 1994.
59. Mottin-Sylla M-H. *L'excision au Sénégal: éléments d'information pour l'action. (Excision in Senegal: elements of information for action)*. Dakar, Environnement et Développement du Tiers-Monde (ENDA), 1990.
60. Abdalla R. *Sisters in affliction: circumcision and infibulation of women in Africa*. London, Zed Press, 1982.
61. *Female circumcision: strategies to bring about change. Proceedings of the International Seminar on Female Circumcision, Mogadishu, Somalia, 13-16 June 1988*. Rome, Somali Women's Democratic Organization/Italian Association for Women in Development, 1989.
62. *Female genital mutilation in Uganda*. Geneva, Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, 1993 (IAC video).
63. *Report of the IAC Regional Conference, Tanzania, 1990*. Geneva, Inter-African Committee on Harmful Traditional Practices Affecting the Health of Women and Children, 1991 (unpublished document).

64. Hedley R, Dorkenoo E. *Child protection and female genital mutilation: advice for health, education and social work professionals*. London, FORWARD Ltd, 1992.
65. Harel D. Medical work among the Falashas of Ethiopia. *Israel journal of medical science*, 1967, 3:483-490.
66. Grisaru N, Lezer S, Belmaker RH. Ritual female genital surgery among Ethiopian Jews. *Archives of sexual behavior*, 1997, 26 (2):211-215.
67. Asali A et al. Ritual female genital surgery among Bedouin in Israel. *Archives of sexual behavior*, 1995, 24:573-577.
68. Ghadially R. Update on female genital mutilation in India. *Women's Global Network for Reproductive Rights newsletter*, January-March 1992.
69. Srinivasan S. Behind the veil, the mutilation. *The Independent (Times of India)*, Sunday, 14 April, 1991 (magazine section, "Vantage").
70. Pratiknya AW. Female circumcision in Indonesia: a synthesis profile for cultural, religious and health values. In: *Female circumcision: strategies to bring about change. Proceedings of the International Seminar on Female Circumcision, Mogadishu, Somalia, 13-16 June 1988*. Rome, Somali Women's Democratic Organization/Italian Association for Women in Development, 1989.
71. Gilbert SG. *Pictorial human embryology*. Seattle, WA, University of Washington Press, 1989.
72. Stilwell DL. Anatomy of the human clitoris. In: Lowry et al. *The clitoris*. St Louis, MO, Warren H. Green Inc., 1976:9-21.
73. Lowry TP. Some issues in the histology of the clitoris. In: Lowry et al. *The clitoris*. St Louis, MO, Warren H. Green Inc., 1976:91-97.
74. Sillah MM. Bundu trap. *Natural history* (the monthly magazine of the American Museum of Natural History), 1996, 105:42-51.
75. United Press International. Press notice, 25 August 1996.
76. Asuen MI. Maternal septicaemia and death after circumcision. *Tropical doctor*, 1977, 7:177-178.
77. Warsame A. Social and cultural implications of infibulation in Somalia. In: *Female circumcision: strategies to bring about change. Proceedings of the International Seminar on Female Circumcision, Mogadishu, Somalia, 13-16 June 1988*. Rome, Somali Women's Democratic Organization/Italian Association for Women in Development, 1989.
78. El Dareer A. Epidemiology of female circumcision in the Sudan. *Tropical doctor*, 1983, 13:41-45.
79. Silberstein AJ. Circoncision féminine en Côte d'Ivoire. (Female circumcision in Côte d'Ivoire). *Annales de la Société Belge de Médecine Tropicale*, 1977, 57:129-135.
80. Fleischer NKF. A study of traditional practices and early childhood anaemia in Northern Nigeria. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1975, 69:198-200.
81. Sami I. Female circumcision with special reference to the Sudan. *Annals of tropical paediatrics*, 1986, 6:99-115.

82. Hathout HM. Some aspects of female circumcision with case report of a rare complication. *Journal of obstetrics and gynaecology of the British Empire*, 1963, 70:505-507.
83. Post MTH. *Female genital mutilation and the risk of HIV*. Soutien pour l'Analyse et la Recherche en Afrique (SARA) Issue Paper, May 1995.
84. Rushwan H. Etiologic factors in pelvic inflammatory disease in Sudanese women. *American journal of obstetrics and gynecology*, 1980:877-879.
85. Brown Y, Calder B, Rae D. Female circumcision. *Canadian nurse*, 1989, 85:19-22.
86. Agugua NEN, Egwuatu VE. Female circumcision: management of urinary complications. *Journal of tropical pediatrics*, 1982, 28:248-252.
87. Onuigbo WIB, Twomey D. Primary vaginal stone associated with circumcision. *Obstetrics and gynecology*, 1974, 44:769-770.
88. DeSilva S. Obstetric sequelae of female circumcision. *European journal of obstetrics, gynaecology and reproductive biology*, 1989, 32:233-240.
89. McCaffrey M. *Female genital mutilation: consequences for reproductive and sexual health*. London, British Association for Sexual and Marital Therapy, 1995:189-200.
90. World Health Organization, International Federation of Gynecology and Obstetrics. Female circumcision, female genital mutilation. *International journal of gynecology and obstetrics*, 1992, 37:149.
91. Baasher TA. Psychological aspects of female circumcision. In: *Fifth Congress of Obstetrical and Gynaecological Society of Sudan*. Alexandria, World Health Organization Regional Office for the Eastern Mediterranean, 1977.
92. Bijleved C. *The effect of education on Sudanese women's attitudes towards female circumcision*. Leiden, University of Leiden, 1985.
93. Grassivaro Gallo P, Moro Moscolo E. Female circumcision in the graphic reproduction of a group of Somali girls: cultural aspects and psychological experiences. *Psychopathologie Africaine*, 1985, 10:165-190.
94. Sanderson LP. *Against the mutilation of women: the struggle to end unnecessary suffering*. London, Ithaca Press, 1981.
95. Lightfoot-Klein H. The sexual experience and marital adjustment of genitally circumcised and infibulated females in the Sudan. *The journal of sex research*, 1989, 26:375-392.
96. Boddy J. *Wombs and alien spirits. Women, men, and the Zar cult in northern Sudan*. Madison, WI, University of Wisconsin Press, 1989.
97. Megafu U. Female ritual circumcision of Africa: an investigation of the presumed benefits among Ibos of Nigeria. *East African medical journal*, 1983, 60:793-800.
98. Lightfoot-Klein H. Pharaonic circumcision of females in the Sudan. *Medicine and law*, 1983, 2:353-360.
99. Karim M, Ammar R. Female circumcision and sexual desire. *Ain Shams medical journal*, 1966, 17:2-39.
100. Badawi M. Epidemiology of female sexual castration in Cairo, Egypt. *The truth seeker*, July/August 1989, 31-34.
101. Karim, M. *Circumcisions and mutilations: male and female*. Cairo, The National Population Council, 1994.

SELECTED WHO PUBLICATIONS OF RELATED INTEREST

Female genital mutilation.

A joint WHO/UNICEF/UNFPA statement.
1997 (20 pages) Sw.fr. 10.–

The reproductive health of adolescents: a strategy for action.

A joint WHO/UNFPA/UNICEF statement.
1989 (18 pages) Sw.fr. 3.–

Women's health and human rights: the promotion and protection of women's health through international human rights law.

R.J. Cook.
1994 (62 pages) Sw.fr. 14.–

Women's health: across age and frontier.

1992 (107 pages) Sw.fr. 20.–

Maternal mortality: a global factbook.

Compiled by C. AbouZahr and E. Royston.
1991 (608 pages) Sw.fr. 50.–

Women, health and development in the South-East Asia Region.

SEARO Regional Health Paper, No. 22.
1992 (90 pages) Sw.fr. 7.–

The state of child health in the Eastern Mediterranean Region, 2nd ed.

EMRO Technical Publications Series, No. 9.
1995 (213 pages) Sw.fr. 20.–

Gender, women and health in the Americas.

Edited by E. Gómez Gómez.
PAHO Scientific Publication, No. 541.
1993 (280 pages) Sw.fr. 56.–

Further information on these and other WHO publications can be obtained from
Distribution and Sales, World Health Organization, 1211 Geneva 27, Switzerland.

Prices in developing countries are 70% of those listed here.

Female genital mutilation has been practised for more than 2000 years. At least 130 million women and girls alive today have undergone the procedure. Yet despite the fact that female genital mutilation is very common in some areas – and leads to serious health problems – little is known about it outside the communities where it is practised. This overview provides the information needed to understand both the social importance of this practice and the dangers it presents to the health of the women and girls who undergo it. It explains what the different types of female genital mutilation involve, what kinds of mental and physical complications result, and what research still needs to be done in order to put an end to the practice.

This book does not make for easy reading. It describes a brutal and humiliating practice that has been condemned by international agreements and national governments. Yet because that practice still persists this book has had to be written. The authors present ample evidence why, for the sake of all the women at risk, female genital mutilation must become a thing of the past.

Price: Sw.fr. 25.—
Price in developing countries: Sw.fr. 18.20
ISBN 92 4 156191 2



New Scientist uses cookies to provide you with a great user experience. By using this website, you agree to the use of cookies on your device. [Accept](#)

NewScientist

Female circumcision: Fighting a cruel tradition

0

2 February 1991

By **SUE ARMSTRONG**

When 'Joanna,' born and brought up in Britain, was eight years old she was sent home to her native Somalia for what she thought was to be a holiday with her grandparents. Instead, within days of her arrival she was taken with her older sister to a place where the village women held her down, stripped her naked, parted her legs and sliced off her genitalia.

'Because I was very young I didn't know what was happening. I had ladies holding every part of my body, even my mouth so that I couldn't scream. I remember the pain to this day,' said Joanna, now 18.

Her own operation was the first she knew of female circumcision, a traditional practice that affects an estimated 80 million women in the world today. The practice is most widespread in Africa where it occurs in 28 countries. The custom is also found among groups in the Middle East, Far East and, according to some reports, the descendants of West African slaves in Brazil. As wars and poverty scatter people around the world, female circumcision is becoming an issue wherever practising groups have settled, including Europe, America and Australia.

The term 'female circumcision' is misleading for it implies an operation similar to male circumcision – simply the removal of a piece of skin. The female operation nearly always involves the removal of healthy (and highly sensitive) organs, and delegates to a recent conference in Addis Ababa on harmful traditional practices called for it to be known henceforth as 'female genital mutilation' (FGM) which they believe reflects more accurately the cruel and radical operation so many young girls are forced to undergo.

Female circumcision entails different things in different cultures. The mildest form – known to Muslims as 'sunna' and the least common – involves the removal of the prepuce or hood of the clitoris. It is the only operation analogous to male circumcision. Excision involves the removal of the clitoris and labia minora; while infibulation, the most drastic form known also as 'pharaonic circumcision,' involves the removal of all the external genitalia and the stitching up of the two sides of the vulva to leave only a tiny opening for the passage of urine and menstrual blood.

The opening is preserved by the insertion of a sliver of wood or a reed, and often the stitching is done with Acacia thorns held in place with silk, catgut or horsehair. The wound is then dabbed with anything from alcohol or lemon juice to ash, herb mixtures or cow dung, and the child's legs bound together until it has healed. Anaesthetics are rarely used and the child is held down by a number of women, frequently including her own relatives. This form of circumcision is practised widely in only three countries – Sudan, Somalia and Mali.

In reality the distinction between the types of circumcision is often irrelevant since it depends on the sharpness of the instrument used, the struggling of the child, and the skill and eyesight of the operator. In most cultures this is an elderly woman from the village who may use a variety of instruments from a razor blade or pair of scissors to a broken bottle, depending on the setting.

The circumciser's social status varies from place to place. In Mali, the operators are usually women of the blacksmiths' caste who are thought to be in touch with the occult. In the Upper East Region of Ghana – the only part of the country where female circumcision is practised – the traditional operator enjoys high status: he or she is not allowed to farm, but is supported entirely by the community. Elsewhere an operator may be a lowly person who earns little more than pocket money for performing circumcisions as a sideline. Many are also traditional birth attendants.

In some countries medical staff have carried out circumcisions in an attempt to avoid some of the dangers of unskilled operations performed in insanitary conditions. No one is quite sure how many clinics perform circumcisions, as the sensitivity of the subject makes research extremely

difficult. But a study by Marie Assaad of the American University of Cairo, prepared for a seminar on traditional practices organised by the WHO in 1979, found that 12 per cent of the female circumcisions were performed by physicians, 53 per cent by traditional midwives (dayas), 12 per cent by barbers and less than 5 per cent by nurses. Another study carried out in Cairo found that professional midwives were performing 19 per cent of the operations and doctors 10 per cent.

Until recently, the City Hospital in Bamako, capital of Mali, employed a person exclusively to perform female circumcisions because the operation was so frequently requested by the parents of newborn girls. But this services has reportedly been discontinued because of growing opposition to the medicalisation of female circumcision – a stand taken unequivocally by the WHO.

The operation is generally performed on girls before they reach puberty. In many places it was once an initiation rite into adulthood, and accompanied by drumming, dancing, feasting and gifts. But most experts agree the operation being performed on an ever younger age and that it has less and less to do with initiation into adulthood.

The immediate and long-term risks to health are enormous. Many little girls bleed to death because clumsy operators have cut into the pudendal artery or the dorsal artery of the clitoris. Others die of post-operative shock because no one knows how to resuscitate them and the hospital is too far, or those involved are reluctant to seek help because they are ashamed of the botched operations. The use of unsterilised instruments and traditional compounds to staunch bleeding carries a high risk of tetanus, infection and septicaemia. And some children suffer acute urinary retention because they are afraid to pass urine on the raw wound.

Sometimes the hole left after infibulation is too small to allow the passage of menstrual blood which collects, instead, in the abdomen. There have been instances where girls have been beaten and even killed to preserve the honour of their families who believed that their swelling bellies and absence of periods indicated pregnancy. Dysmenorrhoea is so common among infibulated women that in northern Sudan, where the incidence of female circumcision is 90 per cent, every female is entitled to one day off school or work per month.

If the Bartholin gland, responsible for lubricating the vulva, is damaged during circumcision, secretions may accumulate in the vulva and form cysts which become painful abscesses when infected. Some girls develop a neuroma at the site of the excised clitoris – a miserable condition that renders the whole area unbearably sensitive.

Not surprisingly, such conditions, as well as the presence of thick and hard scar tissue, cause sexual difficulties. Intercourse is often difficult and the woman may tear. Sometimes penetration is impossible, and in some place notably Mali, Somalia and parts of Sierra Leone, it is the custom for the husband to take a knife to his new bride on their wedding night.

Clitoridectomy means the removal of the organ responsible for female orgasm and some women, unable to respond or receive sexual pleasure, become frigid or depressed. Some, who are aware that circumcision is not universal, realise they are mutilated. 'I felt as if I was less of a woman, as if I was abnormal' said a young woman from the Masai tribe of Kenya whose marriage to an Englishman foundered on sexual problems and who has not chosen celibacy. 'I never had any sexual feelings all the time I was with him. I just felt used. To this day I've never felt anything. (Circumcision) is something that leaves a scar in your life for a long time.'

Little has been written about the effect of circumcision on a woman's sexuality. However, interviews conducted by Olayinka Koso-Thomas, a doctor in Freetown, Sierra Leone (described in her book *The Circumcision of Women: a Strategy for Eradication*, available from Zed Press in London) offer some insights. Of the 140 women involved, 47 had undergone clitoridectomy only, while 93 had been excised. Some had experienced sexual intercourse before circumcision, and this seemed to affect their responses: they were the only women who experienced any arousal in response to male advances prior to love making. These women were also more likely than other circumcised women to experience mild sexual stimulation during intercourse. Generally, the more extreme the operation, the greater was the loss of sexual feeling. None of the women felt any intense stimulation during intercourse.

Interestingly, all Koso-Thomas's interviewees were 'proud of their feminine being and personality.' However, those who had experienced intercourse before circumcision 'expressed disappointment with the condition of their womanhood and the diminished level at which they were expected to perform as human beings.' Most others, especially those from the more conservative rural areas, 'seemed to have resigned themselves to the fate which their societies had decreed for them'.

Koso-Thomas canvassed opinion among men, too. Of the 15 she interviewed, 10 said they preferred uncircumcised women as sexual partners because they got more intense pleasure and liked to share the experience with their partners. Of the five who preferred circumcised partners, one said he believed women were not intended to enjoy sexual intercourse. All the illiterate men from rural areas believed women who were uncircumcised were unclean and oversexed.

Many circumcised women suffer infertility as a result of frequent pelvic infections or scar tissue blocking the fallopian tubes. But those who conceive are likely to experience problems in childbirth such as prolonged labour and internal laceration because of the lack of elasticity in the scarred birth canal. Paul Correa, gynaecologist and former head of maternity services at Danec Hospital in Dakar, Senegal, found that haemorrhage from internal tearing was the most common labour complication among circumcised women, and the most frequent cause of maternal death.

The origins of female circumcision are impossible to establish though it is known to be a practice that is centuries old, evident among the mummies of ancient Egypt, Efuia Forkeno, co-editor of the 1983 Minority Rights Group report on female circumcision and now director of the

London-based Foundation for Women's Health Research and Development (FORWARD), warns against dismissing this as 'just another barbaric custom out of Africa.'

'Circumcision has been practised in some form by the natives of every continent at one time or another,' she said. In 1886 an eminent London obstetrician, Isaac Baker Brown, published his book, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy and Hysteria in the Female*, in which he recommended clitoridectomy as treatment for all such 'feminine weaknesses.' He performed such operations for years before his drastic treatment was challenged by the British Medical Association and he was struck off the medical register. But clitoridectomy as a cure for various mental disorders could also be found in medical textbooks in America at the time.

There is no doubt that practice is a means of suppressing and controlling the sexual behaviour of women. Female circumcision is a physiological chastity belt: a cruel extension of the iron contraptions within which the crusaders of the 12th century locked their women's pelvises or the rings that the early Romans put through the labia majora of their female slaves to ensure their faithfulness.

It is still deeply rooted in underdevelopment and the low social status of women – which explains the paradox that those who are victims of the practice are also its strongest proponents. Circumcision is a passport to social acceptance, and people dare not challenge it while community support is the only means of individual survival.

Many explanations are put forward for supporting the custom today. Some practitioners associate it with religion, though there is no basis for it in either the Koran or the Bible – and, significantly, female circumcision is not practised in Saudi Arabia, the cradle of Islam. Some believe female genitalia are unclean and cutting them away purifies a woman; that the sex drive of an uncircumcised woman is uncontrollable; or that, unless they are cut, the clitoris and the labia will grow until they hang down between a woman's knees.

Other myths and misconceptions abound. According to the Bambaras of Mali, each baby is born with rudimentary characteristics of the opposite sex which must be cut away to make the child wholly male or female. Thus the prepuce or foreskin, of the penis (considered to be vestigial hymen) and the clitoris (considered to be a vestigial penis) are both removed. Some groups in Nigeria believe that if the head of the baby touches the clitoris during childhood, the child will die.

A researcher working in Egypt was told by qualified nurses that they would have their daughters circumcised to protect them from delinquency. And women have also admitted in interviews that they subjected their daughters to the same painful fate as themselves out of spite.

Exploding the myths does little to loosen the grip of the custom on traditional societies: they cling to it as a vital part of their cultural identity and simply find new rationales when the old ones are refuted. In Kenya and Sudan, where the missionaries and then the colonial administrations campaigned against it, female circumcision became a symbol of resistance to foreign influence. Jomo Kenyatta, then a freedom fighter and subsequently the first president of independent Kenya, championed the practice. In recent years Kenyatta's successor, President Daniel Arap Moi, has issued a decree against it. But Arap Moi is a member of the Luo tribe which does not circumcise its women and, like the colonial powers before him, he has been accused of trying to suppress the culture of tribes to which he does not belong.

For many years, African governments used a similar argument to deflect the WHO from the issue. And the same shocked and furious response greeted Western feminists when they tried to take the lid off the subject again during the United Nations Decade of Women, 1975 to 1985. They were accused of racism and cultural imperialism, and told to mind their own business. But this time African and Arab women picked up the gauntlet and they have, with great discretion, set about understanding female circumcision's role in society, and have since dictated the style of the campaign against it.

At a conference in Dakar in 1984 on 'traditional practices affecting the health of women and children,' financed largely by the WHO and UNICEF, delegates agreed that national committees should be established within each country where female circumcision was practised. They subsequently set up the Inter Africa Committee (IAC) – a shoestring operation based in Geneva – to act as a bridge between the local groups and outside supporters who fund the work. (Circumcision is an extremely low priority for national governments strapped for cash and wary of such a controversial issue).

National committees have been set up in 22 African countries. 'Our main weapon in fighting these traditions is education,' said Berhane Ras-Work, Ethiopian-born director of the IAC. 'We target women first for they have to realise the importance of their own health. In many African countries, women don't consider their health as important because they work and die taking care of others. Most women think that pain is part of their life. We have to convince them that life without pain is possible, life without disease is possible.'

This takes skill and wisdom, for information about the health hazards of female circumcision tends simply to be dismissed by people who value the practice as a mark of morality and marriageability. The personal discomfort and danger, no matter how severe, is often preferable to being an uncircumcised outcast. Abolitionists who fail to recognise and respect this fact lose credibility.

Furthermore, convincing a teenage girl or young mother of the danger and pointlessness of circumcision leads only to doubt and anxiety and changes nothing if they cannot decide their fate or that of their small daughters. Campaigners must, therefore, make efforts to reach the decision-makers, who are frequently the older women and the menfolk in a family.

They must also take into account the fact that circumcision is a source of income to traditional operators. So health education addressed to this group has to be combined with training for an alternative livelihood – and, importantly, one that carries the same social status. One campaign in Ghana, for example, offers circumcisers the chance to become traditional birth attendants, equally respected by the community. In Ethiopia, on

the other hand, a group of women who earned little for their services as circumcisers are training as bakers and sandal makers for which there is a demand.

The IAC conference, held in the Ethiopian capital of Addis Ababa in November to assess the progress of the abolition campaign so far, identified insufficient and unpredictable funding as the major handicap. The big UN donors such as UNICEF and the WHO (which were among the first to

governments. Usually they can only support country projects at the request of the government, and most governments decline to get involved. However, the WHO does offer more covert support through the IAC and as part of other health programmes.

Otherwise campaigns rely on a handful of European and American nongovernmental aid organisations for support. Lack of cash means they are run largely by volunteers whose time is limited, and who frequently lack the training and organisational skills necessary to make the most of their deep personal commitment. A Swedish evaluation team who visited projects in Kenya, Egypt and Mali prior to the Addis conference commented: 'What they all have in common is that they have gone through a period of trial and error as they have had no knowledge of how to approach this very sensitive issue. Consequently they have had little planning, and seldom defined targets or target groups.'

Evaluation teams visited six African countries and they brought back anecdotal evidence of slow change at the grassroots. In Mali, for example, a team member who attended a meeting for rural women was amused to see the campaigner come striding through the village with the IAC teaching aid – a female torso with removable genital parts – carried on her head like a pitcher of water. 'That represented a huge step forward in a country where you couldn't even mention the subject a decade ago,' she said.

In Ethiopia another evaluator found a Muslim and a Christian priest, two men of considerable influence, who had been so shocked by a film they saw on female circumcision that they had joined forces to fight it among their followers. However, the fact that no programme has been able to demonstrate sweeping change clearly exasperates some campaigners who believe the time has come for a more militant approach.

'They have had education campaigns in the Sudan since the 1940s, and where has it got them?' asked Dorkeno from the FORWARD group. 'In the north female genital mutilation is still nearly 100 per cent prevalent.' She believes it is time to start talking about sexual politics and human rights. 'This has a lot to do with how women have been conditioned to see their roles in society. We should be looking at how women are able to cope with the pressures to conform, and start developing support structures for those who want to opt out.'

Dorkeno, who works among immigrant groups in Britain, speaks for a minority of campaigners. Most of those working in male-dominated rural Africa are not ready to make such a strong challenge to the status quo. Any hint of 'feminism' or 'women's liberation,' they say, would kill their campaigns.

Whatever their chosen approach, nobody close to the action has any doubt that putting an end to female circumcision is an uphill struggle, or that the target of 'abolition by the year 2000' is more of a rallying cry than a real possibility. To give their efforts a boost, they ended their conference in Addis by calling on governments in all the countries where female circumcision still prevails to pass laws against it.

There is a danger that outlawing such a deep-rooted and valued tradition will drive it underground and make people reluctant to seek medical help when accidents happen. But many grassroots campaigners feel there is a limit to what they can achieve on their own. They need the support of people in high places to give them credibility, and a law is a practical statement of that support as well as a useful weapon.

Not only their governments but the whole international community should heed their call. For in the final analysis, the fact that millions of downtrodden women consent to their own torture and that of their daughters is one of the greatest conundrums and tragedies of our time.

Sue Armstrong is a freelance journalist based in South Africa

AN END TO 'FEMALE GENITAL MULTILATION'?

There are many international conventions that ostensibly offer women and children protection from genital mutilation, including the Universal Declaration of Human Rights adopted by the United Nations in 1948. Article 5 states that 'no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.'

Female circumcision, as a specific issue, was first put on the agenda of the UN Centre for Human Rights in 1981, when Efua Dorkeno of the Foundation for Women's Health Research and Development was allowed to address the Working Group on Slavery. It was subsequently taken on by the Centre's Sub-Commission on Prevention of Discrimination and Protection of Minorities which formed a special working group of experts, drawn widely from health and child welfare, to study harmful traditional practices and to recommend ways of eliminating them.

Throughout its history as a human rights issue, however, female circumcision has had to fight for its voice. Only constant badgering from a small core of dedicated African women has kept the subject from being swept under the carpet on numerous occasions. But despite the fact that so many governments pay only lip service to declarations, failing to give them the weight of national law, the women have won some small victories. In 1991 for example the first seminars on harmful traditional practices to be held under the auspices of the Centre for Human Rights will take place in Africa and Asia. And the campaigners say that at least the conventions give them scope to raise the issue with governments who would rather turn a blind eye to the practice.

One of the most important advances on the human rights front, however, came last September when world leaders met in New York to discuss the protection of children. Carried along by the cause and the warmth of media attention, many governments signed the resulting Convention on the

Rights of the Child without hesitation. It effectively condemns female circumcision as torture and sexual abuse, and Dorkeno is determined that this time the impetus for abolishing the practice must not be allowed to die as the spotlight moves on.

'This is one of the major social evils of our time,' she declared. 'The film screened at the Addis conference showed a six-month-old child being cut in public somewhere in Africa. At the end of the operation the child was in such a state of distress her tongue was literally hanging out. There are thousands of children undergoing this operation daily.'

'We need to look at all possible ways of combating it. That will involve not just information, but legislation, law enforcement, and active protection of children,' she said. 'It's a must. Otherwise we'll have another 3000 years waiting for traditional society to evolve, and I don't think it's fair on women or children.'

SURGICAL CHILD ABUSE, THE BATTLE TO STOP FEMALE CIRCUMCISION IN BRITAIN

Several of Britain's immigrant communities come from countries in which female circumcision is practised. For many immigrants, keeping their cultural traditions alive is vital to their sense of identity in an alien land, and over recent years it has become apparent that thousands of young girls in Britain are at risk of genital mutilation.

'Considering the groups from Somalia, Sudan, Ethiopia, West and East Africa, we're talking about up to 10,000 children at risk in the United Kingdom as a whole,' said Efua Forkeno, Ghanaian-born director of FORWARD (Foundation for Women's Health Research and Development) which is at the forefront of the eradication campaign in Britain.

The most common practice is for families to send their young daughters back to Africa for the operation, said Dorkeno. But she has had reports that traditional operators have also been brought to Britain to perform circumcisions. 'We're investigating to see if we can find some of them,' she said. 'But the community is very very secretive and very protective, so it's difficult to find out who is actually doing it.'

The psychological consequences of the operation may be more severe for a young woman living in Britain than they would be in her native country, because sooner or later she becomes aware of the fact that she is different from many of her peers. 'The black child in Britain already faces a lot of pressure, and many suffer badly from his added stigma. They're ashamed to talk to their friends, and can't talk to their parents because their parents believe it's a good thing for them,' said Dorkeno. 'Quite a number come to our project with their difficulties.'

Female circumcision has probably been practised in Britain ever since immigrant groups first settled with their families. But for a long time the extreme sensitivity of the issue caused it to be swept firmly under the carpet by those professionals who become aware of it in the course of their work. Few are prepared to step into the racial minefield, even if they were prepared to breach the taboos surrounding sexual matters.

British law has always offered protection against such a practice, but in 1985 specific legislation was passed in the form of Prohibition of Female Circumcision Act, which was introduced by MP Marion Roe. The act makes it an offence for any person to excise, infibulate or otherwise mutilate the whole or any part of the labia majora, labia minora or clitoris of another person to aid, abet, counsel or procure another person to perform such acts.

With the wall of silence breached and female circumcision declared unequivocally illegal, it soon became clear that professionals – such as health personnel, social workers, teachers – who have to confront the issue in the course of their work needed special training and support, and, most importantly a framework for action. So, in February 1989, FORWARD organised the first national conference on female genital mutilation in Britain, to explore some of the extremely complex ethical, social and legal issues involved in combating it.

Among them was the question of whether female circumcision constitutes child abuse and should thus be listed among the categories of children 'at risk' on the child abuse register. The issue is extremely controversial: some people – notably members of the London Black Women's Health Action Project which plays a strong part in the eradication campaign – argue that labelling families as child abusers, and therefore criminals, is counterproductive because it alienates immigrant groups rather than encouraging them to change.

Most such families, they say, see the circumcision of their daughters as an act of love, not cruelty. Attitudes will never change if people are put on the defensive. These objections are taken seriously by fellow campaigners, although the consensus is that female circumcision should be recognised as child abuse, thus clearly empowering professionals to take action to protect little girls at risk.

As with cases of child sexual abuse, many social workers find themselves crippled with uncertainty about the best kind of action to take. Having explored the various options, campaigners believe that making children at risk 'wards of court' is often the most appropriate course of action, because it prevents parents from making unilateral decisions about the child's welfare without subjecting the child to the misery of removal from the family.

As everywhere, education and consciousness raising are essential parts of the campaign. Following the 1989 conference, FORWARD drew up an action plan that aims to make all those who come into professional contact with immigrant families aware of the practice of female circumcision and to enlist their cooperation in combating it.

The plan suggests setting up grassroots information and counselling services, and support groups for families wanting to challenge tradition – for even in far-off Britain, many immigrants find it hard to question the values and to resist the pressure to conform to their native societies. The action plan aims, too, to create some sort of consultative body that will include members of the community and the social services and act as a vital channel of communication between the two as they feel their way through the minefield.

Despite its painstaking efforts to put the issue on the agendas of health and social services, however, the campaign to eradicate female circumcision in Britain remains hamstrung by its cultural sensitivity. On several occasions Dorken has had phone calls from distressed general practitioners who alerted to her to the fact that genital mutilation was occurring in their area but who refused to identify themselves or the children in imminent danger.

'We presume they're wary of getting involved in a culturally bound and sensitive issue,' she said. 'We understand their fears, but unless we all confront the issue, we rob these little girls of the only defence they have – the campaign against female circumcision.'

TRENDING

LATEST

VIDEO

FREE

Cause of polycystic ovary syndrome discovered at last

1

The father of all men is 340,000 years old

2

Dogs evolved a special muscle that lets them make puppy dog eyes

3

Prisoners in China are still being used as organ donors, says inquiry

4

Feeling lonely? You're not on your own

5

Magazine issue 1754 , published 2 February 1991

0



DOWNLOAD

BUY IN PRINT

Previous article

Technology: Born-again telescope will have biggest open dish

Next article

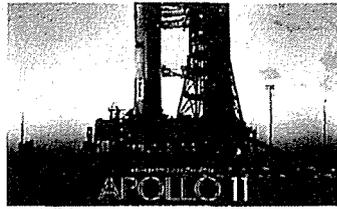
Technology: Radar plans complete tests in action

Advertisement

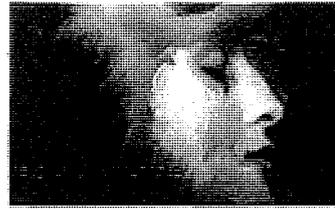
MORE FROM NEW SCIENTIST



Carbon farming scientist David Reay on repaying his emissions debt



Don't miss: men on the moon, robots in orbit and museums in the street

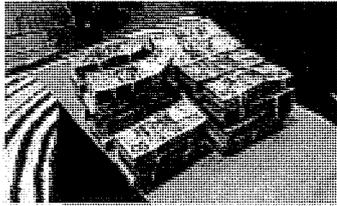


People with narcolepsy may be more creative because of how they sleep



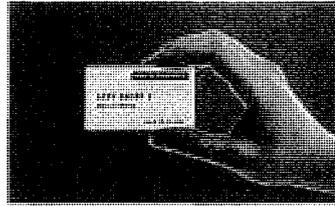
High-tech vertical farming is on the rise – but is it any greener?

PROMOTED STORIES



How Australian Citizens Are Making A Second Income In 2019? financialmentor.co

#2AussiesInCali Los Angeles Tourism



Aussies Saving Big on Health Cover This EOFY, and You Can Too Health Insurance Comparison

[Gallery] 20 Unbelievable Photos That Are Totally Real Editor Choice

Recommended by

Contact us | Help | About us | Privacy & cookies | Terms & conditions

Advertise | Write for us | Events | Science jobs | Syndication | RSS feeds

Gift subscriptions | Student subscriptions | Educational subscriptions | Corporate subscriptions

GET THE APP



FOLLOW US



© Copyright New Scientist Ltd.

Back to top

