

WHAT IS FEMALE GENITAL MUTILATION?

The different types of mutilation

Female genital mutilation (FGM) is the term used to refer to the removal of part, or all, of the female genitalia. The most severe form is infibulation, also known as pharaonic circumcision. An estimated 15% of all mutilations in Africa are infibulations. The procedure consists of clitoridectomy (where all, or part of, the clitoris is removed), excision (removal of all, or part of, the labia minora), and cutting of the labia majora to create raw surfaces, which are then stitched or held together in order to form a cover over the vagina when they heal. A small hole is left to allow urine and menstrual blood to escape. In some less conventional forms of infibulation, less tissue is removed and a larger opening is left.

The vast majority (85%) of genital mutilations performed in Africa consist of clitoridectomy or excision.

The least radical procedure consists of the removal of the clitoral hood.

In some traditions a ceremony is held, but no mutilation of the genitals occurs. The ritual may include holding a knife next to the genitals, pricking the clitoris, cutting some pubic hair, or light scarification in the genital or upper thigh area.

The procedures followed

The type of mutilation practised, the age at which it is carried out, and the way in which it is done varies according to a variety of factors, including the woman or girl's ethnic group, what country they are living in, whether in a rural or urban area and their socio-economic provenance.

The procedure is carried out at a variety of ages, ranging from shortly after birth to some time during the first pregnancy, but most commonly occurs between the ages of four and eight. According to the World Health Organization, the average age is falling. This indicates that the practice is decreasingly associated with initiation into adulthood, and this is believed to be particularly the case in urban areas.

Some girls undergo genital mutilation alone, but mutilation is more often undergone as a group of, for example, sisters, other close female relatives or neighbours. Where FGM is carried out as part of an initiation ceremony, as is the case in societies in eastern, central and western Africa, it is more likely to be carried out on all the girls in the community who belong to a particular age group.

The procedure may be carried out in the girl's home, or the

home of a relative or neighbour, in a health centre, or, especially if associated with initiation, at a specially designated site, such as a particular tree or river. The person performing the mutilation may be an older woman, a traditional midwife or healer, a barber, or a qualified midwife or doctor.

Girls undergoing the procedure have varying degrees of knowledge about what will happen to them. Sometimes the event is associated with festivities and gifts. Girls are exhorted to be brave. Where the mutilation is part of an initiation rite, the festivities may be major events for the community. Usually only women are allowed to be present.

Sometimes a trained midwife will be available to give a local anaesthetic. In some cultures, girls will be told to sit beforehand in cold water, to numb the area and reduce the likelihood of bleeding. More commonly, however, no steps are taken to reduce the pain.

The girl is immobilized, held, usually by older women, with her legs open. Mutilation may be carried out using broken glass, a tin lid, scissors, a razor blade or some other cutting instrument. When infibulation takes place, thorns or stitches may be used to hold the two sides of the labia majora together, and the legs may be bound together for up to 40 days. Antiseptic powder may be applied, or, more usually, pastes — containing herbs, milk, eggs, ashes or dung — which are believed to facilitate healing. The girl may be taken to a specially designated place to recover where, if the mutilation has been carried out as part of an initiation ceremony, traditional teaching is imparted. For the very rich, the mutilation procedure may be performed by a qualified doctor in hospital under local or general anaesthetic.

Geographical distribution of female genital mutilation

An estimated 135 million of the world's girls and women have undergone genital mutilation, and two million girls a year are at risk of mutilation — approximately 6,000 per day. It is practised extensively in Africa and is common in some countries in the Middle East. It also occurs, mainly among immigrant communities, in parts of Asia and the Pacific, North and Latin America and Europe.

FGM is reportedly practised in more than 28 African countries (see *FGM in Africa: Information by Country* (ACT 77/07/97)). There are no figures to indicate how common FGM is in Asia. It has been reported among Muslim populations in Indonesia, Sri Lanka and Malaysia, although very little is known about

the practice in these countries. In India, a small Muslim sect, the *Daudi Bohra*, practise clitoridectomy.

In the Middle East, FGM is practised in Egypt, Oman, Yemen and the United Arab Emirates.

There have been reports of FGM among certain indigenous groups in central and south America, but little information is available.

In industrialized countries, genital mutilation occurs predominantly among immigrants from countries where mutilation is practised. It has been reported in Australia, Canada, Denmark, France, Italy, the Netherlands, Sweden, the UK and USA. Girls or girl infants living in industrialized countries are sometimes operated on illegally by doctors from their own community who are resident there. More frequently, traditional practitioners are brought into the country or girls are sent abroad to be mutilated. No figures are available on how common the practise is among the populations of industrialized countries.

The physical and psychological effects of female genital mutilation

Physical effects

The effects of genital mutilation can lead to death. At the time the mutilation is carried out, pain, shock, haemorrhage and damage to the organs surrounding the clitoris and labia can occur. Afterwards urine may be retained and serious infection develop. Use of the same instrument on several girls without sterilization can cause the spread of HIV.

More commonly, the chronic infections, intermittent bleeding, abscesses and small benign tumours of the nerve which can result from clitoridectomy and excision cause discomfort and extreme pain.

Infibulation can have even more serious long-term effects: chronic urinary tract infections, stones in the bladder and urethra, kidney damage, reproductive tract infections resulting from obstructed menstrual flow, pelvic infections, infertility, excessive scar tissue, keloids (raised, irregularly shaped, progressively enlarging scars) and dermoid cysts.

First sexual intercourse can only take place after gradual and painful dilation of the opening left after mutilation. In some cases, cutting is necessary before intercourse can take place. In one study carried out in Sudan, 15% of women interviewed reported that cutting was necessary before penetration could be achieved.¹ Some new wives are seriously damaged by unskilful cutting carried out by their husbands. A possible additional problem resulting from all types of female genital mutilation is that lasting damage to the genital area can increase the risk of HIV transmission during intercourse.

During childbirth, existing scar tissue on excised women may tear. Infibulated women, whose genitals have been tightly closed, have to be cut to allow the baby to emerge. If no

attendant is present to do this, perineal tears or obstructed labour can occur. After giving birth, women are often reinfibulated to make them "tight" for their husbands. The constant cutting and restitching of a women's genitals with each birth can result in tough scar tissue in the genital area.

The secrecy surrounding FGM, and the protection of those who carry it out, make collecting data about complications resulting from mutilation difficult. When problems do occur these are rarely attributed to the person who performed the mutilation. They are more likely to be blamed on the girl's alleged "promiscuity" or the fact that sacrifices or rituals were not carried out properly by the parents. Most information is collected retrospectively, often a long time after the event. This means that one has to rely on the accuracy of the woman's memory, her own assessment of the severity of any resulting complications, and her perception of whether any health problems were associated with mutilation.

Some data on the short and long-term medical effects of FGM, including those associated with pregnancy, have been collected in hospital or clinic-based studies, and this has been useful in acquiring a knowledge of the range of health problems that can result. However, the incidence of these problems, and of deaths as a result of mutilation, cannot be reliably estimated. Supporters of the practice claim that major complications and problems are rare, while opponents of the practice claim that they are frequent.

Effects on sexuality

Genital mutilation can make first intercourse an ordeal for women. It can be extremely painful, and even dangerous, if the woman has to be cut open; for some women, intercourse remains painful. Even where this is not the case, the importance of the clitoris in experiencing sexual pleasure and orgasm suggests that mutilation involving partial or complete clitoridectomy would adversely affect sexual fulfilment. Clinical considerations and the majority of studies on women's enjoyment of sex suggest that genital mutilation does impair a women's enjoyment. However, one study found that 90% of the infibulated women interviewed reported experiencing orgasm.² The mechanisms involved in sexual enjoyment and orgasm are still not fully understood, but it is thought that compensatory processes, some of them psychological, may mitigate some of the effects of removal of the clitoris and other sensitive parts of the genitals.

Psychological effects

The psychological effects of FGM are more difficult to investigate scientifically than the physical ones. A small number of clinical cases of psychological illness related to genital

¹ Lightfoot-Klein, H., "The Sexual Experience and Marital Adjustment of Genitally Circumcised and Infibulated Females in the Sudan", *The Journal of Sex Research*, 26 (3), pp. 375-392, 1989.

² Lightfoot-Klein, H., *Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa*, Haworth Press, New York, 1989.

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mutilation have been reported.³ Despite the lack of scientific evidence, personal accounts of mutilation reveal feelings of anxiety, terror, humiliation and betrayal, all of which would be likely to have long-term negative effects. Some experts suggest that the shock and trauma of the operation may contribute to the behaviour described as “calmer” and “docile”, considered positive in societies that practise female genital mutilation.

Festivities, presents and special attention at the time of mutilation may mitigate some of the trauma experienced, but the most important psychological effect on a woman who has survived is the feeling that she is acceptable to her society, having upheld the traditions of her culture and made herself eligible for marriage, often the only role available to her. It is possible that a woman who did not undergo genital mutilation could suffer psychological problems as a result of rejection by the society. Where the FGM-practising community is in a minority, women are thought to be particularly vulnerable to psychological problems, caught as they are between the social norms of their own community and those of the majority culture.

Why FGM is practised

Cultural identity

“Of course I shall have them circumcised exactly as their parents, grandparents and sisters were circumcised. This is our custom.”

An Egyptian woman, talking about her young daughters ⁴

Custom and tradition are by far the most frequently cited reasons for FGM. Along with other physical or behavioural characteristics, FGM defines who is in the group. This is most obvious where mutilation is carried out as part of the initiation into adulthood.

Jomo Kenyatta, the late President of Kenya, argued that FGM was inherent in the initiation which is in itself an essential part of being Kikuyu, to such an extent that “abolition... will destroy the tribal system”.⁵ A study in Sierra Leone reported a similar feeling about the social and political cohesion promoted by the *Bundo* and *Sande* secret societies, who carry out initiation mutilations and teaching.

Many people in FGM-practising societies, especially traditional rural communities, regard FGM as so normal that they cannot imagine a woman who has not undergone mutilation. Others are quoted as saying that only outsiders or foreigners are not genitally mutilated. A girl cannot be considered an adult in a FGM-practising society unless she has undergone FGM.

Gender identity

FGM is often deemed necessary in order for a girl to be considered a complete woman, and the practice marks the divergence of the sexes in terms of their future roles in life and

marriage. The removal of the clitoris and labia — viewed by some as the “male parts” of a woman’s body — is thought to enhance the girl’s femininity, often synonymous with docility and obedience. It is possible that the trauma of mutilation may have this effect on a girl’s personality. If mutilation is part of an initiation rite, then it is accompanied by explicit teaching about the woman’s role in her society.

“We are circumcised and insist on circumcising our daughters so that there is no mixing between male and female... An uncircumcised woman is put to shame by her husband, who calls her ‘you with the clitoris’. People say she is like a man. Her organ would prick the man...”

An Egyptian woman ⁶

Control of women’s sexuality and reproductive functions

“Circumcision makes women clean, promotes virginity and chastity and guards young girls from sexual frustration by deadening their sexual appetite.”

Mrs Njeri, a defender of female genital mutilation in Kenya⁷

In many societies, an important reason given for FGM is the belief that it reduces a woman’s desire for sex, therefore reducing the chance of sex outside marriage. The ability of uncut women to be faithful through their own choice is doubted. In many FGM-practising societies, it is extremely difficult, if not impossible, for a woman to marry if she has not undergone mutilation. In the case of infibulation, a woman is “sewn up” and “opened” only for her husband. Societies that practise infibulation are strongly patriarchal. Preventing women from indulging in “illegitimate” sex, and protecting them from unwilling sexual relations, are vital because the honour of the whole family is seen to be dependent on it. Infibulation does not, however, provide a guarantee against “illegitimate” sex, as a woman can be “opened” and “closed” again.

In some cultures, enhancement of the man’s sexual pleasure is a reason cited for mutilation. Anecdotal accounts, however, suggest that men prefer uncut women as sexual partners.

³ Baasher, T.A., “Psychological Aspects of Female Circumcision”, *Traditional Practices Affecting the Health of Women and Children, Report of a seminar, 10-15 February, 1979*, WHO-EMRO Technical Publication 2, WHO, Alexandria, Egypt, 1979, pp. 71-105.

⁴ Assaad, M.B., “Female Circumcision in Egypt: Social Implications, Current Research and Prospects for Change”, *Studies in Family Planning*, 11:1, 1980, pp. 3-16.

⁵ Kenyatta, J., *Facing Mount Kenya: The Tribal Life of the Kikuyu*, Secker and Warburg, London, 1938.

⁶ Assaad, M.B., *ibid.*

⁷ Katumba, R., “Kenyan Elders Defend Circumcision”, *Development Forum*, September, 1990, p. 17.

Beliefs about hygiene, aesthetics and health

Cleanliness and hygiene feature consistently as justifications for FGM. Popular terms for mutilation are synonymous with purification (*tahara* in Egypt, *tahur* in Sudan), or cleansing (*sili-ji* among the Bambarra, an ethnic group in Mali). In some FGM-practising societies, uncut women are regarded as unclean and are not allowed to handle food and water.

Connected with this is the perception in FGM-practising communities that women's uncut genitals are ugly and bulky. In some cultures, there is a belief that a woman's genitals can grow and become unwieldy, hanging down between her legs, unless the clitoris is excised. Some groups believe that a woman's clitoris is dangerous and that if it touches a man's penis he will die. Others believe that if the baby's head touches the clitoris during childbirth, the baby will die.

Ideas about the health benefits of FGM are not unique to Africa. In 19th Century England, there were debates as to whether clitoridectomy could cure women of "illnesses" such as hysteria and "excessive" masturbation. Clitoridectomy continued to be practised for these reasons until well into this century in the USA. However, health benefits are not the most frequently cited reason for mutilation in societies where it is still practised; where they are, it is more likely to be because mutilation is part of an initiation where women are taught to be strong and uncomplaining about illness. Some societies where FGM is practised believe that it enhances fertility, the more extreme believing that an uncut woman cannot conceive. In some cultures it is believed that clitoridectomy makes childbirth safer.

Religion

FGM predates Islam and is not practised by the majority of Muslims, but has acquired a religious dimension. Where it is practised by Muslims, religion is frequently cited as a reason. Many of those who oppose mutilation deny that there is any link between the practice and religion, but Islamic leaders are not unanimous on the subject. The *Qur'an* does not contain any call for FGM, but a few *hadith* (sayings attributed to the Prophet Muhammad) refer to it. In one case, in answer to a question put to him by 'Um 'Attiyah (a practitioner of FGM), the Prophet is quoted as saying "reduce but do not destroy".

Mutilation has persisted among some converts to Christianity. Christian missionaries have tried to discourage the practice, but found it to be too deep rooted. In some cases, in order to keep converts, they have ignored and even condoned the practice.

FGM was practised by the *Falasha* (Ethiopian Jews), but it is not known if the practice has persisted following their emigration to Israel. The remainder of the FGM-practising community follow traditional Animist religions.

Testimony

"I was genitally mutilated at the age of ten. I was told by my late grandmother that they were taking me down to the river to perform a certain ceremony, and afterwards I would be given a lot of food to eat. As an innocent child, I was led like a sheep to be slaughtered.

Once I entered the secret bush, I was taken to a very dark room and undressed. I was blindfolded and stripped naked. I was then carried by two strong women to the site for the operation. I was forced to lie flat on my back by four strong women, two holding tight to each leg. Another woman sat on my chest to prevent my upper body from moving. A piece of cloth was forced in my mouth to stop me screaming. I was then shaved.

When the operation began, I put up a big fight. The pain was terrible and unbearable. During this fight, I was badly cut and lost blood. All those who took part in the operation were half-drunk with alcohol. Others were dancing and singing, and worst of all, had stripped naked.

I was genitally mutilated with a blunt penknife.

After the operation, no one was allowed to aid me to walk. The stuff they put on my wound stank and was painful. These were terrible times for me. Each time I wanted to urinate, I was forced to stand upright. The urine would spread over the wound and would cause fresh pain all over again. Sometimes I had to force myself not to urinate for fear of the terrible pain. I was not given any anaesthetic in the operation to reduce my pain, nor any antibiotics to fight against infection. Afterwards, I haemorrhaged and became anaemic. This was attributed to witchcraft. I suffered for a long time from acute vaginal infections."

Hannah Koroma, Sierra Leone

FEMALE GENITAL MUTILATION IN AFRICA: Information by Country

<i>Country</i>	<i>Estimate % of women and girls who undergo FGM</i>	<i>Type of FGM practised</i>
Benin	50%	Excision FGM is mainly practised in the north of the country. There is no law specifically prohibiting FGM. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) has been campaigning against FGM since 1982, collaborating with the Ministry of Social Affairs and Health. Educational materials are distributed in government-run clinics.
Burkina Faso	70%	Excision All but a few of the country's 50 ethnic groups practice FGM. Recent legislation outlaws FGM and the government campaigns widely against the practice. The National Committee for the Fight against Excision (CNLPE), affiliated to the IAC, was set up in 1990 and carries out extensive educational work.
Cameroon	20%	Clitoridectomy and excision FGM is practised in some areas of the far north and south-west. There is no law specifically prohibiting FGM. The IAC's Cameroon chapter was created in 1992. The government supports their activities. IAC Cameroon is invited to all meetings organized by the Ministry of Social Welfare and Women's Affairs, and the Ministry of Public Health.
Central African Republic	50%	Clitoridectomy and excision FGM is prevalent in approximately 10 of the country's 48 ethnic groups. There has been a law against FGM since 1966 and the government has taken a number of measures against the practice.
Chad	60%	Excision and infibulation FGM is practised in all areas of the country, infibulation being performed in the eastern part bordering Sudan. There is no law specifically prohibiting FGM. The IAC is active in outreach programmes. The government plays a minimal role in trying to eradicate the practice.
Côte d'Ivoire	60%	Excision FGM is deeply rooted in animist initiation rites. It is also prevalent among Muslim women. It is practised particularly among the rural populations in the north, north-east and west. A new law prohibiting FGM is being drafted. Non-governmental organizations (NGOs) campaigning against FGM include the International Movement of Democratic Women (MIFED), the IAC, the Ivorian Association for the Defence of Women's Human Rights (AID-F), and the Ivorian Association for Safe Motherhood (AMS). They receive some government support.
Democratic Republic of Congo	5%	Excision FGM is practised on girls living in the northern equatorial part of the country. No law specifically prohibits FGM.

Female genital mutilation in Africa:
information by country

Country	Estimated % of women and girls who undergo FGM	Type of FGM practised
Djibouti	90-98%	<p>Excision and infibulation</p> <p>An estimated 95% of women from all ethnic groups are infibulated. A Penal Code provision outlawing FGM has been in force since 1994. Among the several organizations working on the issue are the Association for the Equilibrium and Promotion of the Family (ADEPF) and the <i>Union Nationale des Femmes de Djibouti</i> (UNFD), National Union of Women of Djibouti, which organize workshops to raise awareness about the health risks of FGM. Both groups receive occasional media coverage. The Ministry of Health allows clinics and health training centres to distribute information about FGM and other harmful traditional practices.</p>
Egypt	97%	<p>Clitoridectomy, excision, and infibulation</p> <p>FGM is practised by both Muslims and Coptic Christians, infibulation being particularly prevalent in the southern part of the country. A presidential decree in 1958 prohibited FGM, making it punishable by a fine and imprisonment. In July 1996, Health Minister, Ismail Sallam, banned all licensed health professionals from performing FGM. In June 1997 an Egyptian court overturned this ban. In his decision, Judge Abdul Aziz Hammad stated that FGM was a form of surgery which doctors have the legal "right" to perform, without interference from ministerial bodies. The health minister and the head of Egypt's medical syndicate have appealed against the court's decision, and the Sheikh of al-Azhar, the highest religious authority in the country, has declared his support for the ban. The health minister has announced that his July 1996 ban will remain in place until the appeal process is completed. Various NGOs are active in the campaign against FGM, including the Egyptian Organization for Human Rights.</p>
Eritrea	90%	<p>Clitoridectomy, excision and infibulation</p> <p>FGM is carried out by almost all ethnic groups. No law specifically prohibits FGM. Prior to winning independence from Ethiopia in 1991, the Eritrean People's Liberation Front (EPLF) undertook abolition campaigns in areas under its control with the stated aim of discontinuing the practice. Based on the EPLF experience, FGM is included in the Eritrean government's health and general education programmes. The National Union of Eritrean Youth and Students and the official women's organization have embarked on a campaign to discourage FGM.</p>
Ethiopia	90%	<p>Clitoridectomy and excision, except in areas bordering Sudan and Somalia, where infibulation is practised</p> <p>FGM is practised among most of Ethiopia's 70 or more ethnic groups, including Christians, Muslims and the minority Ethiopian Jewish community (the Falasha), most of whom now live in Israel. Ethiopia has an extremely high maternal mortality rate, due in part to birth complications related to FGM. There is no law specifically prohibiting FGM although the Constitution prohibits harmful traditional practices. A wide range of educational outreach activities are carried out by NGOs. The Revolutionary Ethiopian Women's Association (REWA) had a mandate under the former Mengistu regime to eradicate customs and practices that deny women their rights. REWA supported eradication of FGM, as did the Ministry of Health. The National Committee of the IAC was set up in 1985 and given permission to establish its regional headquarters permanently in Addis Ababa. Similar anti-FGM educational programmes have been conducted since the overthrow of the Mengistu regime in 1991, with active governmental and NGO support. Ethiopia has a strong national anti-FGM NGO affiliated to the IAC.</p>

Female genital mutilation in Africa:
information by country

Country	Estimate % of women and girls who undergo FGM	Type of FGM practised
Gambia	60-90% average; almost 100% of Fula and Sarahuli women	<p>Excision, infibulation in a very small population percentage</p> <p>The Foundation for Research on Women's Health, Productivity and the Environment (BAFROW), a Gambian women's organization, reports that seven of the Gambia's nine ethnic groups practice FGM. There is no legislation specifically prohibiting FGM. In 1981, the Gambia National Committee on Traditional Practices Affecting the Health of Women and Children was set up. One of its focuses is the eradication of FGM. BAFROW was founded in 1991 and also aims to abolish FGM. In May 1997, the Gambia Telecommunications (GAMTEL) Director of Broadcasting Services issued a directive prohibiting the broadcast by Radio Gambia or Gambia Television of any programmes opposing FGM. GAMTEL, a state-owned company which controls Radio Gambia and Gambia Television, is responsible for radio and television stations with the largest national audience, and the only ones that reach the entire country. NGOs campaigning for the elimination of FGM issued a protest to the President against this media policy.</p>
Ghana	15-30%	<p>Excision</p> <p>FGM is most prevalent in the regions of the Upper East, Upper West and North where more than 75% of girls have reportedly undergone excision. It is also practised by migrants in the south. The practice persists despite the passing of legislation in 1994 that explicitly prohibits it. The government issued a formal declaration in 1989 against FGM and other harmful traditional practices. Section 69A of the Criminal Code makes FGM a second degree felony punishable by a fine and imprisonment. Since its enactment in 1994 two practitioners have been convicted. All levels of government have come out strongly against FGM. NGOs working against FGM include the Association of Church Development Projects (ACDEP), the Ghana Association for Women's Welfare (GAWW) and the Muslim Family and Counselling Services (MFCS). GAWW, established in 1984, is a charter member of the IAC.</p>
Guinea	70-90%	<p>Clitoridectomy, excision and infibulation</p> <p>FGM is widely practised in Guinea without distinction as to ethnicity, religion, or region. The practice is illegal under Article 265 of the Penal Code. The Supreme Court is working with the local Coordinating Body on Traditional Practices Affecting the Health of Women and Children (CPTAFE) to propose an amendment to the Guinean Constitution which would specifically prohibit FGM. The head of state, the president's wife, and other high-level government officials have publicly spoken out against the practice. CPTAFE, the Guinean branch of the IAC set up in 1988, is recognized by the government.</p>
Guinea-Bissau	50% average; 70-80% in areas inhabited by the Fula and Mandinka; 20-30% in urban areas	<p>Clitoridectomy and excision</p> <p>FGM is widespread among the Fula and Mandinka. There is no legislation specifically prohibiting the practice. In 1992, the Guinea-Bissau chapter of the IAC organized a government-supported public awareness seminar on FGM. In 1995, a proposal to outlaw FGM was defeated. The Assembly, however, approved a proposal to hold practitioners criminally responsible if a woman dies as a result of FGM. Some government support is given to outreach groups conducting educational seminars and publicity.</p>

Female genital mutilation in Africa:
information by country

Country	Estimated % of women and girls who undergo FGM	Type of FGM practised
Kenya	50%	Clitoridectomy and excision, some infibulation in far eastern areas bordering Somalia and in some refugee camps housing Somalis. FGM is prevalent among various ethnic groups. There is no law specifically prohibiting the practice. Government hospitals are instructed by the Ministry of Health to cease the practice of FGM. A motion brought before Parliament, seeking legislative authority to ban FGM, was defeated by an overwhelming majority in November 1996. NGOs active in combatting FGM include the National Council on Women in Kenya, the Kenyan National Committee on Traditional Practices and <i>Maendeleo Ya Wanawake</i> (MYWO).
Liberia	50-60%	Excision Thirteen ethnic groups reportedly practice FGM. Some experts estimate that the incidence of FGM may have dropped to 10% as a result of the civil war; exact statistics are not available. No law specifically prohibits FGM. In 1985, the Liberian National Committee, also called the National Association on Traditional Practices Affecting the Health, was set up. It conducted research into attitudes towards and the prevention of FGM.
Mali	90-94%	Clitoridectomy, excision and, in the south of the country, infibulation. FGM is common throughout Mali. No law specifically prohibits FGM. A number of NGOs campaign against the practice, including AMSOPT, which has educated youth and religious leaders and held sensitization programmes for excisors and their assistants. Other active organizations are the Association for Promoting the Rights of Women (APSD), the Action Committee for the Rights of Women and Children (CADEF), the National Women's Organization (NOW) and the National Chapter of the IAC. The government supports their activities. Radio Mali disseminates information on FGM and other harmful traditional practices in its Women and Development Programme.
Mauritania	25% average; 95% among the Soninke and Halpulaar, 30% among Moor women	Clitoridectomy and excision No law specifically prohibits FGM. NGOs and public health workers educate about the harmful effects of FGM.
Niger	20%	Excision There is no legislation specifically prohibiting FGM. In 1990 a government decree established the Niger Committee Against Harmful Traditional Practices (CONIPRAT), which has studied the prevalence of FGM and organized sensitization seminars and workshops. The government participates in educational seminars.
Nigeria	50%	Clitoridectomy, excision and, in the northwest, some infibulation. FGM is practised throughout the country and among all ethnic and religious groups. No law specifically prohibits FGM. The National Association of Nigerian Nurses and Midwives (NANNM) has been active in the fight against FGM. Nurses and paediatricians have campaigned throughout the country, conducting educational activities at the state and community level. In 1984, a Nigerian National Committee, the National Chapter of the IAC, was set up. The Committee has had support from the Ministries of Health, Education and Information.

Female genital mutilation in Africa:
information by country

Country	Estimate % of women and girls who undergo FGM	Type of FGM practised
Senegal	20%	<p>Excision</p> <p>In 1988 a survey on FGM was carried out by ENDA (Environmental Development Action in the Third World) with support from the IAC. This study revealed that FGM is prevalent among the Muslim population and is practised most widely in the eastern region of the country, where it also affects the non-Muslim population. No law specifically prohibits FGM. The President of Senegal, Abdou Diouf, spoke out against the practice in the mid 1980s. In 1981, <i>Campagne Pour L'Abolition des Mutilations Sexuelles</i> (CAMS), Campaign for Abolition of Sexual Mutilation, was formed in Paris, with Awa Thiam as the President and a branch organization <i>Femmes Et Société</i> (Women and Society) in Senegal. CAMS-International was later based in Senegal. The organization takes a gender perspective in addressing FGM — organizing seminars on violence against women and FGM and setting up a gender research unit on women at the University of Dakar. The Senegalese Committee on Traditional Practices (COSEPRAT), the IAC national chapter in Senegal, conducts medical research into FGM, and their activities include radio broadcasts which reach a large percentage of the population. COSEPRAT collaborates with the government.</p>
Sierra Leone	80-90%	<p>Excision</p> <p>All ethnic groups practice FGM except the Creoles, who are mainly based in the capital, Freetown. No law specifically prohibits FGM. It is practised within a strong ritualistic context, within traditional power bases for women known as <i>Bundo</i> (secret societies). These societies are shrouded in secrecy and taboo. Membership is conferred on a girl when she is subjected to FGM, and non-members are considered to be outcasts. Fear surrounds the practice of FGM and those who criticize the secret societies have been known to receive death threats.</p> <p>In August 1996 supporters of FGM launched an offensive, drawing support from members of the influential elite, who are members of the <i>Bundo</i> themselves, or have relatives as members. In January 1997, 600 girls were reportedly subjected to FGM in a displaced people's camp near Freetown. In July 1997, Sierra Leone's military ruler, Major Johnny Paul Koroma, who came to power following a military coup in May 1997, assured supporters of FGM that he supports this and other traditional practices.</p> <p>A National Chapter of the IAC, called the Sierra Leone Association on Women's Welfare, was set up in 1984. It advocates education against FGM and legislation to eradicate the practice. Other NGOs that have been active in the campaign against FGM include the Movement for the Eradication of FGM, the Canaan Christian Fellowship Fund, and Plan International.</p>
Somalia	98%	<p>Infibulation</p> <p>Virtually all Somali women are genitally mutilated. There is no law specifically prohibiting FGM. In 1977 the Somali Women's Democratic Organization (SWDO), a governmental women's organization, was formed to eradicate FGM. This was followed by a series of initiatives, most notably by the Somali Academy of Arts and Sciences and the Institute of Women's Education. In 1987, SWDO and the Italian Association for Women and Development (AIDOS) founded an anti-FGM project designed to eradicate infibulation. AIDOS provided technical and methodological support and SWDO was responsible for the content and direction of the campaign. In 1991, when the Siad Barre regime was overthrown and the state disintegrated into warring factions, the projects collapsed.</p>

Female genital mutilation in Africa:
information by country

Country	Estimated % of women and girls who undergo FGM	Type of FGM practised
Sudan	89% of northern Sudanese women	Infibulation predominates, some excision reported FGM is widely practised in northern Sudan, and to a much lesser extent in the south. Attempts have been made to eradicate FGM for the past 50 years. Despite this, women are still being infibulated. Sudan was the first African country to outlaw FGM. The 1946 Penal Code prohibited infibulation, but permitted <i>sunna</i> , the less radical form of FGM. The law was ratified again in 1957, when Sudan became independent. In 1991 the government affirmed its commitment to the eradication of the traditional form of FGM. The 1993 Penal Code, however, does not mention FGM, leaving its status unclear. NGOs most active in the campaign against FGM are the Organization for the Eradication of Traditional Harmful Practices Affecting the Health of Women and Children (ETHP), and the Babiker Badri Organization. The Ministry of Social Planning recognizes both groups.
Tanzania	10%	Excision, infibulation FGM is practised in five regions of Tanzania. There is no legislation specifically prohibiting FGM. The government has made sporadic efforts to eradicate the practice, including a campaign in two regions in 1971. The Tanzanian chapter of the IAC was formed in 1992.
Togo	12%	Excision FGM is practised in the north of Togo. No law specifically prohibits FGM. Human rights and women's rights groups educate rural populations about the dangers of the practice. An IAC chapter was formed in 1984 with the support of the Ministry of Social Affairs.
Uganda	5%	Clitoridectomy and excision FGM is practised in Kapchorwa district. No law specifically prohibits FGM; the government publicly condemns FGM. The IAC campaigns against the practice, collaborating with the Ugandan Women Lawyers' Association, the Safe Motherhood Initiative, the National Association of Womens' Organizations in Uganda, the Media Women's Association, and the Association of Uganda Doctors. Government ministries have given them some material help.

Sources

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United States Department of State Reports, February 1997.

World Health Organization Papers, *Female Genital Mutilation*.

FEMALE GENITAL MUTILATION: Contact Organizations & Advocacy Groups

INTER-AFRICAN COMMITTEE (IAC) ON TRADITIONAL PRACTICES COMITE INTER-AFRICAIN (CI-AF) SUR LES PRATIQUES TRADITIONNELLES

BENIN

Mme. Victorine Odounlami
CI-AF Bénin
BP 538
Porto-Novo

BURKINA FASO

Mme. Mariam Lamizana
CNLPE (Comité national de lutte contre la pratique de l'excision)
B.P. 515/01
Ouagadougou 01
Tel: (226) 307915

CHAD

Mme. Mariam Alladoumngue
Comité national du CI-AF
c/o CIRAD-CA/TCHAD
B.P. 764
N'Djamena

DJIBOUTI

Mme. Safia Youssouf Eguch
CNLCPT (Comité national de lutte contre les pratiques traditionnelles néfastes à la santé de la mère et de l'enfant)
c/o UNFD
B.P. 10217
Tel: (253) 351981/350421

EGYPT

Mrs. Aziza Kaamel/ Dr. Mohamed El Tobgui
The Egyptian Society for the Care of Children
25 Kadri Street, Sayeda Zeinab
Cairo

ETHIOPIA

IAC Headquarters
c/o ECA/ICA
P.O. Box 3001
Addis Ababa
Tel: (251) 1 51 5793/517 200 ext.33-127
Fax: (251) 1 514 682

Ms. Bogalech Alemu
NCTPE (National Committee on Traditional Practices)
P.O. Box 12629
Addis Ababa

GAMBIA

Mrs. Amie Joof-Cole
GAMCOTRAP
P.O. Box 2990
Serrekunda

GHANA

Mrs. Gloria Aryee
GAWW (Ghanaian Association for Women's Welfare)
P.O. Box 9582, Airport
Accra
Tel: (233) 21 773068

GUINEA

Dr. Mariama Djélo Barry
CPTAFE (Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Santé des Femmes et des Enfants)
BP 585
Conakry
Tel: (224) 462805
Fax: (224) 441682

GUINEA BISSAU

Mme. Antonia Mendes Teixeira
Comité national de lutte contre les pratiques néfastes
CP 560
Bissau

KENYA

Mrs. Jane Kirui
Kenya National Council on Traditional Practices
P.O. Box 7850
Nairobi

LIBERIA

Mrs. Patricia Marbey
IAC-IL
P.O. Box 6006
Monrovia

MALI

Mme. Sidibé Kadidia Maïga Aoudou
AMSOPT (Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles)
B.P. 1543
Bamako

Mme. Fatoumata Siré Diakite
APDF (Association pour le Progrès et la Défense des Droits des Femmes Maliennes)
B.P. 1740
Bamako

MAURITANIA

Mme. Mariame Baba Sy
CI-AF Mauritanie (AMPTSFE)
B.P. 3772
Nouakchott

Female genital mutilation:
Contact organizations & advocacy groups

NIGER

Mme. Salamatou Traoré
CONIPRAT (Comité nigérien sur les pratiques traditionnelles)
B.P. 11 613
Niamey

NIGERIA

Dr. Irene M. Thomas
Nigeria National IAC Committee
P.O. Box 71607, Victoria Island
Lagos
Tel: (234) 1 614909/614912
Fax: (234) 1 635072, 637547

SÉNÉGAL

Mme. Marianne Sidibé N'Diaye
COSEPRAT (Comité National Sénégalais contre les Pratiques
Traditionnelles Néfastes)
Hôpital Le Dantec
B.P. 3001
Dakar

SIERRA LEONE

Dr. Olayinka Koso-Thomas
SLAWW (Sierra Leone Association on Women's Welfare)
P.O. Box 1069
Freetown
Tel: (232) 33 24456
Fax: (232) 33 226031

SUDAN

Mrs. Amna Abdel Rahman Hassan
SNCTP (Sudan National Committee on Traditional Practices)
P.O. Box 10418
Khartoum

SWITZERLAND

IAC (Inter-African Committee on Traditional Practices
Affecting the Health of Women and Children)
147, rue de Lausanne
1202 Genève
Tel: (41) 22 731 2420/732 0821
Fax: (41) 22 738 1823

TANZANIA

Mrs. Jennifer Chiwute
IAC Dodoma Project Coordinator
c/o Ministry of Labour and Youth Development
P.O. Box 2862
Dodoma

TOGO

Mme. Assibi Napoe
CI-AF Togo
B.P. 3907
Lomé

UGANDA

Dr. Elizabeth Madraa
NCTPU (National Committee on Traditional Practices Uganda)
P.O. Box 7296
Kampala

Other Contact Organizations and Advocacy Groups

AFRICA

BENIN

Thony Topanou
Amnesty International Bénin
BP 01 3536
Cotonou
Tel/Fax: (229) 32 36 90

BURKINA FASO

Dr. Penda N'Diaye
The Population Council
258, rue 13.21- Zone du Bois
01 B.P. 6250-Ouagadougou 01
Ouagadougou

CÔTE D'IVOIRE

Blanche Pango-Tati
Amnesty International Côte D'Ivoire
04 B.P. 895
Abidjan 04

EGYPT

Cairo Institute for Human Rights Studies
9 Rustom Street
Garden City
P.O. Box 117 Maglis Al Shaab
Cairo
Tel: (20) 2 354 3715
Fax: (20) 2 355 4200

Egyptian Organization of Human Rights
10th floor Mathaf El-Manyal Street
Manyal Er-Roda
Cairo
Tel: (20) 2 363 6811
Fax: (20) 2 362 1613

Mrs. Hedy Banoub
The Coptic Church
Care for Girls Organization
2 El-Mas Street
Salah El-Din
Heliopolis
Cairo 11351
Tel: (20) 2 591 3466

Mrs. Marie Assad
Egyptian Task Force on FGM
c/o Ministry of Population and Family Planning
Corniche El Nile
Maadi
Cairo

ETHIOPIA

Africa Training and Research Centre for Women
Economic Commission for Africa
P.O. Box 3001
Addis Ababa
Tel: (251) 1 51 7200

Female genital mutilation:
Contact organizations & advocacy groups

THE GAMBIA

ACDHRS (African Centre for Democracy and Human Rights Studies)
Kairaba Avenue
K.S.M.D.
Tel: (220) 394 961/394 525
Fax: (220) 394 962

BAFROW (Foundation for Research on Women's Health, Productivity and Development)
214 Tafsir Demba Mbye Road
Tobacco Road Estate, Banjul
P.O. Box 2854
Serrekunda
Tel: (220) 225 270
Fax: (220) 223 266

GHANA

Samuel Zan
Education Department
Tamale Archdiocese
P.O. Box 42
Tamale
Tel/Fax: (233) 71 23068

Dr. K. Odoi-Agyarko
Rural Help Integrated
P.O. Box 166
Bolgatanga
Tel/Fax: (233) 72 3040

GUINEA

Mme. Bamiedele Adu
Women's International Network Project
Kissidougou-Gueckedou Prefectures
B.P. Kissidougou

Salimatu Bah-Barrie Foundation
Bangura Village (Pita)
Province of Fouta Djallon

KENYA

Mrs. Dinah Katina
FGM Project
P.O. Box 3
Kapenguria

Kenya Red Cross Society
Attention: Information Officer
P.O. Box 40712
Nairobi
Tel: (254) 2 503 781/ 503 789
Fax: (254) 2 503 845

MYWO (Maendeleo Ya Wanawake Organization)
Maendeleo House, 4th Floor
P.O. Box 44412
Monrovia Street
Nairobi
Fax: (254) 2 225390

PATH Kenya
30 Ole Odume Road
P.O. Box 76634
Nairobi
Tel: (254) 2 569 331
Fax: (254) 2 566 714

MALI

Mme. Bah
Amnesty International Mali
BP 2804
Bamako
Tel/Fax: (223) 22 52 68 (All communications c/o Mr. Lagdaf)

NIGERIA

FGM Coordinator
AI Nigeria
PMB 3061
Suru-Lere
Lagos
Tel/Fax: (234) 1 833 873

FENAM (The Federation of Female Nurses and Midwives of Nigeria)
22 Bajulaiye Road
Shomolu
Lagos
Tel/Fax: (234) 1 820 483

Theo O. Obasiani
Executive Director
Village Life Panorama Projects
Grassroot Mobilization for Rural People
P.O. Box 15, AWGU
Enugu State
Tel/Fax: (234) 1 833873

SENEGAL

Amnesty International Sénégal
Cabinet Mbaye Jacques Diop
13 rue de Thiong
Dakar
Tel: (221) 22 1684 (Ask for Isma Daddis Sagna)

CAMS (Commission Internationale pour l'Abolition des Mutilations Sexuelles)
B.P. 11.345
Dakar

Ms. Marie Hélène Mottin-Sylla
ENDA (Environment and Development in the Third World)
B.P. 33370
Dakar
Tel: (221) 224229/216027
Fax: (221) 222695

SIERRA LEONE

AI Sierra Leone
PMB 1021
Freetown
Tel: (232) 22 227 354
Fax: (232) 22 224 439 or 22 222 053 (Attention AI)

MEFEGM (Movement for the Eradication of Female Genital Mutilation)
Attention: Mr. Abu-Bakar Kamara
90 Sanders Street
Freetown
Tel: (232) 22 242264
Fax: (232) 22 241620

Canaan Christian Fellowship Fund
Attention: Mr. Bernard A. James
P.O. Box 1071
Freetown
Tel: (232) 22 226488

Female genital mutilation:
Contact organizations & advocacy groups

SIERRA LEONE continued

Light of Light Ministry
Attention: Mr. Peter D. Musa
P.M.B. 427
Freetown

SOMALIA

Mrs. Batulo Sheik Ahmed
SWDO P.O. Box 1099
Mogadishu

SUDAN

Babiker Bedri Association Scientific Association
For Women's Studies
Ahfad University for Women
P.O. Box 167
Omdurman

Mutawinat Benevolent Co.
P.O. Box 2348
Khartoum
Tel: (249) 11 784300

TANZANIA

Hon. Jitto Ram
NCTP
PO Box 12542
Dar es Salaam
Fax: (255) 51 38282

TOGO

Yidu Kosi
Amnesty International Togo
BP 20013
Lomé
Tel: (228) 225820
Fax: (228) 268955 (c/o Gaglo Allotey
"Prière de remettre à AI Togo")

Mme. Banabessé Akim
Comité National pour la Santé des
Femmes et des Sockodé
(Tchaoudjo)
Tel: (228) 500 071

UGANDA

Mr. Francois Farah
REACH Programme
c/o UNFPA
15B Clement Hill Road
P.O. Box 7184
Kampala
Fax: (228) 268955

EUROPE

FRANCE

CAMS (Commission pour l'abolition des Mutilations
Sexuelles)
6 Place Saint-Germain-des-Prés
75006 Paris
Tel: (33) 1 4549 0400
Fax: (33) 1 4549 1671

GAMS (Group Femmes pour l'Abolition des Mutilations
Sexuelles)
66 rue de Grand Champs
75020 Paris
Tel: (33) 1 4348 1087
Fax: (33) 1 4348 0073

ITALY

AIDoS
Via dei Giubbonari, 30
00186 Rome
Tel: (39) 6 687 3214
Fax: (39) 6 687 2549

NETHERLANDS

Defence for Children International
Dutch Section
P.O. Box 75297
NL-1070 AG Amsterdam
Tel: (31) 20 420 3771
Fax: (31) 20 420 3832

NORWAY

Redd Barna
Hammersborg Street Torg 3
Post Box 6903
Olavs Plass
0130 Oslo
Tel: (47) 22 990 900

SWEDEN

Rädda Barnen (Swedish Save the Children)
S-107 88 Stockholm
Tel: (46) 8 698 9000
Fax: (46) 8 698 9012

UNITED KINGDOM

AI International Secretariat
Angela Robson and Ignacio Saiz
1 Easton Street
London WC1X 8DJ
Tel: (44) 171 413 5500
Fax: (44) 171 956 1157

Akina Mama Wa Africa
4 Wild Court
Kingsway
London WC2B 4AU
Tel: (44) 171 405 0678
Fax: (44) 171 831 3947

Anti-Slavery International
Thomas Clarkson House
The Stableyard
Broomgrove Road
London SW9 9TL
Tel: (44) 171 924 9555
Fax: (44) 171 738 4110

FORWARD (Foundation for Women's Health, Research and
Development)
40 Eastbourne Terrace
London W2 3QR
Tel: (44) 171 725 2606
Fax: (44) 171 725 2796

Female genital mutilation:
Contact organizations & advocacy groups

UNITED KINGDOM continued

IPPF (International Planned Parenthood Federation)
Regent's College
Inner Circle
Regent's Park
London NW1 4NS
Tel: (44) 171 487 7900
Fax: (44) 171 487 7950

LBWHAP (London Black Women's Health Action Project)
Cornwall Avenue Community Centre
1 Cornwall Avenue
London E2 OHW
Tel: (44) 181 980 3503
Fax: (44) 181 980 6314

Minority Rights Group International
379 Brixton Road
London SW9 7DE
Tel: 44 171 978 9498
Fax: 44 171 738 6265

Royal College of Nursing
Attention: Mrs. Vicki Allanach
20 Cavendish Square
London W1M 0AB
Tel: (44) 171 409 3333
Fax: (44) 171 647 3431

NORTH AMERICA

CANADA

Women's Health in Women's Hands
2 Carlton Street
Suite 500
Toronto, Ontario M5B 1J3
Tel: (1) 416 593 7655
Fax: (1) 416 593 5867

UNITED STATES

Equality Now
P.O. Box 20646
Columbus Circle Station
New York, NY 10023
Tel: (1) 212 586 0906
Fax: (1) 212 586 1611

FORWARD USA
Mimi Ramsey
1046 West Taylor Street, Suite 204
San Jose, California 95126
Tel: (1) 408 298 3798
Fax: (1) 408 298 3893

The Hesperian Foundation
1919 Addison, Suite 304
Berkeley, CA 94704-1144
Tel: (1) 510 845 1447
Fax: (1) 510 845 9141

NOCIRC (National Organization of Circumcision Information
Resource Centers FGM Awareness and Education Project)
PO Box 2512 San Anselmo
CA 94979-2512
Tel: (1) 415 488 9883
Fax: (1) 415 488 9660

PAI (Population Action International)
1120 19th Street, NW
Suite 550
Washington, D.C. 20036
Tel: (1) 202 659 1833
Fax: (1) 202 293 1795

Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Tel: (1) 212 339 0500
Fax: (1) 212 755 6052

PPFA/FPIA
810 Seventh Avenue
New York, NY 10019
Tel: (1) 212 541 7800
Fax: (1) 212 247 6274

RAINBO (Research, Action and Information Network for
Bodily Integrity of Women)
915 Broadway
Suite 1603
New York 10010-7108
Tel: (1) 212 477 3318
Fax: (1) 212 477 4154

Salimatu Bah-Barrie Foundation
Mariama Lamharana Barrie
88 Quail Run Drive
Deer Park, NY 11701
Tel/Fax: (1) 516 242 9769

SAFRAD (Somali Association for Relief and Development)
Attention: Professor Asha A. Samad
95 West 95th Street
Suite 25E
New York, NY 10025
Tel: (1) 212 650 8269
Fax: (1) 212 650 7530

USAID
Office of Women in Development
Room 3.08-042U RRB
Washington, DC 20523-3801
Tel: (1) 202 712 1254
Fax: (1) 202 216 3173

WIN News (Women's International News Network)
Fran Hosken
187 Grant Street
Lexington, MA 02173
Tel: (1) 617 862 9431

UNITED NATIONS ORGANIZATIONS

UN Centre for Human Rights
Palais des Nations
8/40 Avenue de la Paix
1211 Genève 10, SWITZERLAND
Tel: (41) 22 917 4326
Fax: (41) 22 917 3456

UN Division for the Advancement of Women
United Nations
Room DC2-1220
New York, NY 10017, USA
Tel: (1) 212 963 3104
Fax: (1) 212 963 3463

UNICEF (UN Children's Fund)
3 United Nations Plaza
New York, NY 10017, USA
Tel: (1) 212 326 7000
Fax: (1) 212 888 7465

UNFPA (UN Fund for Population Activities)
220 East 42nd Street
New York, NY 10017, USA
Tel: (1) 212 297 5011
Fax: (1) 212 297 4901

UNHCR (UN High Commissioner for Refugees)
P.O. Box 2500
1211 Genève 2, SWITZERLAND
Tel: (41) 22 739 8111
Fax: (41) 22 739 7377

US Committee for UNICEF
Attention: Public Information Officer
333 East 38th Street, 6th floor
New York, NY 10016, USA
Tel: (1) 212 686 5522
Fax: (1) 212 779 1679

UNIFEM (UN Development Fund for Women)
304 East 45th Street, 6th floor
New York, NY 10017, USA
Tel: (1) 212 906 6400
Fax: (1) 212 906 6705

WHO (World Health Organization)
Division of Family Health
220 Avenue Appia
1211 Genève 27, SWITZERLAND
Tel: (41) 22 791 2111
Fax: (41) 22 791 0746

WHO (World Health Organization)
Regional Office for the Eastern Mediterranean
P.O. Box 1517
Alexandria, EGYPT
Tel: (20) 3 482 0224

FEMALE GENITAL MUTILATION

Strategies for change

In the campaign to eradicate female genital mutilation (FGM), developments at the intergovernmental level have been encouraging. However, they have only been possible due to the sustained activism of international and national non-governmental organizations (NGOs). The achievements of these organizations are considerable. They have succeeded in breaking the silence on FGM, and in placing the subject firmly on the international human rights agenda.

Clearly, future strategies against FGM must draw on the wealth of experience the various bodies have accumulated, and should be founded on a systematic assessment of the impact of previous campaigns. Greater collaboration and coordination of international initiatives efforts in recent years offer the real possibility of developing a global strategy for eradication.

In the forefront of today's activists are women and men from African countries. Of the 29 countries in Africa identified as having communities which practise FGM, 22 have branches of the **Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC)**. The IAC was formed in Dakar in 1984 to coordinate the activities of national NGOs. The main focus of its efforts are: training and information campaigns aimed at local activists, traditional birth attendants and other community members; advocacy at the national, regional and international levels; and supporting the IAC's own national committees and partners.

In September 1997 the IAC held a Symposium for Legislators at the headquarters of the Organization of African Unity (OAU) in Addis Ababa, Ethiopia. The Symposium issued the Addis Ababa Declaration, which called on African governments to adopt clear policies and concrete measures aimed at eradicating or drastically reducing FGM by the year 2005.

Other international NGOs with a long history of working on FGM include **Forward International**, **Minority Rights Group**, **Commission pour l'Abolition des Mutilations Sexuelles (CAMS)**, **Research Action Information Network for Bodily Integrity of Women (RAINBO)** and **Equality Now**. These and other organizations have together made enormous contributions in the areas of research; awareness-raising; financial and logistical support for grassroots initiatives; lobbying of decision makers at the governmental and intergovernmental level; developing protection mechanisms in Western countries; and mobilizing international concern. All have situated the issue of FGM in the context of discrimination and violence against women and the denial of basic social, economic, civil and political rights of women and children.

The pioneering efforts of NGOs and individuals at the national level are too numerous and varied to list. Those involved include women's organizations, health workers, educationalists and other community workers from a range of disciplines and backgrounds. A global survey and assessment of campaigning efforts to date is beyond the scope of this document. Nevertheless, it is possible to identify some key strategic considerations which emerge from a review of past experience.

The role of legislation

States have an obligation under international standards to take legal action against FGM, as part of the measures they must take to prevent violence against women and to protect children from abuse (see *Female Genital Mutilation and International Human Rights Standards* (ACT 77/14/97)). Legislation making FGM a criminal offence is important in that it represents an unambiguous statement that the practice will not be officially tolerated. However, careful thought needs to be given to the kind of legislation enacted; the context into which it is introduced; how it is enforced; and how it is integrated into other aspects of a comprehensive eradication strategy.

In Kenya and Sudan, legislative efforts have been undermined where they have been identified with earlier interventions under the former colonial administration. Early attempts to enforce legislation in Sudan caused such popular outcry that enforcement was subsequently abandoned. In several African countries where FGM legislation exists, it is not enforced for fear of alienating certain power bases or exacerbating tensions between practising and non-practising communities. In Burkina Faso, where excisers have been prosecuted in connection with the deaths of young girls during FGM ceremonies, some Burkinabe activists have subsequently argued that criminalizing practitioners and families can drive the practice underground and be an obstacle to outreach and education.

These experiences and others elsewhere have shown that, in order for legislation to be effective, it must be accompanied by a broad and inclusive strategy for community-based education and awareness-raising. This is consistent with the provisions of relevant international instruments, such as the UN Declaration on the Elimination of Violence against Women, which set out a range of preventive measures which states must take in addition to prosecuting and punishing perpetrators.

Laws explicitly prohibiting FGM exist in several countries outside Africa, including Sweden, Switzerland, the UK and USA. In many Western countries child protection laws exist which can also be applied to protect girls from being genitally mutilated. This has been the case in the UK and Australia. In France at least 19 people have been convicted under French assault laws for performing FGM or causing FGM to be carried out.

The importance of legislation was stressed at the 1997 IAC Symposium. The Symposium called for legislation to eliminate all forms of violence against women and girls, in particular FGM, to be enacted by the year 2000 in all countries represented.

The danger of medicalization

Some countries have sought to encourage performance of less severe forms of FGM by qualified medical professionals. Sudan, Djibouti and Egypt have all tried this strategy, rather than imposing a complete ban. Experience has shown, however, that such policies are unsuccessful, and only serve to legitimize and perpetuate genital mutilation. In some cases older female relatives have merely performed another, more severe operation if they feel the procedure has not been carried out adequately.

The involvement of medical professionals in FGM undermines the message that FGM denies women and girls their right to the highest attainable standard of health. Most activists are strongly opposed to medical involvement in FGM and argue that official policy should always be complete eradication. The World Health Organization (WHO) takes a very strong stand against the medicalization of FGM in any form.

The need for a holistic and sensitive approach

Any action against FGM must take into account the multiplicity of factors that give rise to the practice. It is an issue that demands a collaborative approach involving human rights activists, educationalists, health professionals, religious leaders, development workers and many others.

From a human rights perspective, FGM cannot be viewed in isolation from other forms of violence and discrimination against women, from the vulnerability of children to abuse, and from issues of access to education and economic development.

The issue requires an understanding of the complexity of perceptions and beliefs surrounding FGM. Involving religious leaders in raising awareness that FGM is not a religious requirement has been crucial to the success of some initiatives. The cultural significance of FGM cannot be ignored. Eradicating the practice must be presented as a question not of eliminating rites of passage, but of redefining or replacing

those rites in a way that promotes positive traditional values while removing the danger of physical and psychological harm.

In view of these sensitivities, particular consideration must be given to the respective roles of all those committed to taking action against FGM. Global action is necessary if the practice is to be eradicated promptly. While internationally agreed human rights standards provide a basis and justification for international intervention, those best placed to set the direction of the campaign are the grassroots activists and community workers with a presence in the areas where FGM is practised. The role of international solidarity is to complement and support the work carried out locally by providing technical, methodological and financial support, and undertaking international advocacy and lobbying.

"A global action against FGM cannot undertake to abolish this one violation of women's rights without placing it firmly within the context of efforts to address the social and economic injustice women face the world over. If women are to be considered as equal and responsible members of society, no aspect of their physical, psychological, or sexual integrity can be compromised."

Nahid Toubia, *A Call for Global Action*

A 10-point program of action

Governmental action alone will not end FGM. But while many actors have a role to play in eradicating FGM, governments have it within their power to determine whether eradication will be achieved within a generation, or whether millions more girls will pay the price of their inaction. Moreover, for governments, taking action is not a choice but an obligation under international law. Lack of resources cannot be invoked by governments as an excuse to flout these obligations. However, the international community has a responsibility to ensure that resources are available to assist developing countries in waging effective campaigns against FGM. Implementation can then clearly be seen as a question of will.

Amnesty International proposes the following program of action for governments. The program draws on the provisions of international human rights standards and the recommendations of UN human rights bodies and specialized agencies, and plans of action proposed by NGOs.

Governments should:

1. Affirm that FGM is an abuse of human rights, and recognize their obligation to end it. They should make a clear and unequivocal commitment to eradicate or drastically reduce the prevalence of the practice within a defined time frame.
2. Set up mechanisms for consultation and collaboration with relevant non-governmental sectors (religious, health, women, human rights, development) as well as international organizations and UN agencies working on human rights, health and development.

3. Undertake research into the practice of FGM in their countries. Information is particularly needed on its prevalence, physical and psychological effects, social attitudes and religious requirements. Research should also review the impact of efforts to date. In particular, work needs to be done to study the prevalence of FGM outside Africa, especially in the Middle East, Latin America and in many countries where it is practised among immigrant communities.

4. Review all relevant domestic legislation to see how effectively law and practice protect against FGM and comply with international standards, particularly the UN Convention on the Elimination of Discrimination against Women (Women's Convention), the Convention on the Rights of the Child (CRC) and the Declaration on the Elimination of Violence against Women. Ensure that legislation complies with the recommendations of the UN Special Rapporteurs on violence against women and on traditional practices affecting the health of women and children.

5. Ratify the International Covenant on Civil and Political Rights, International Covenant on Economic, Social and Cultural Rights, the Women's Convention, the CRC and all other relevant standards without limiting reservations or interpretive statements. Comply with their commitment to report to relevant treaty bodies, and to include specific mention of steps to prevent FGM in reports to all relevant treaty bodies and international human rights mechanisms.

6. Ensure that FGM programs are integrated into all relevant areas of state policy. Departments of health should clearly prohibit medicalization of FGM, and move to incorporate this

prohibition into professional codes of ethics for health workers. Departments of education, women's affairs, immigration and development should all include FGM programs, as well as addressing the underlying factors which give rise to FGM, such as access to education. Countries providing development assistance should identify ways of supporting FGM projects.

7. Recognize FGM as a form of gender-based persecution falling within the scope of the UN Convention relating to the Status of Refugees. States should adopt and implement the recommendations set out in the Guidelines on the Protection of Refugee Women of the UN High Commissioner for Refugees.

8. Carry out widespread public information programs using relevant media. These should be tailored to specific groups, such as men, women, young people, children, the elderly, influential community figures, religious scholars, and those who carry out FGM.

9. Support the work of NGOs and individuals working against FGM. Provide them with protection against threats and other attempts to undermine their work.

10. Take an active role in supporting regional and international initiatives to combat FGM, such as the WHO, UN Children's Fund (UNICEF), UN Population Fund (UNFPA) program. Encourage adoption by the OAU of the IAC's Addis Ababa Declaration. Endorse and support the work of the UN Special Rapporteurs on violence against women and on traditional practices affecting the health of women and children.

THE CAMPAIGN TO ERADICATE FEMALE GENITAL MUTILATION

A role for Amnesty International

Female genital mutilation (FGM) is arguably one of the most widespread and systematic violations of the human rights of women and girls, of whom approximately 135 million worldwide are genitally mutilated. The World Health Organization estimates that two million girls a year — some 6,000 a day — undergo genital mutilation.

Since the 1970s, many non-governmental organizations (NGOs) and a number of intergovernmental and governmental organizations have been active in raising awareness about FGM and developing strategies for its eradication.

Amnesty International (AI) recognizes that in order to identify its own role, it must first take stock of the efforts of those who are already working at a national and international level. Strategies for campaigning on FGM in each country can only be devised when the results of past efforts have been examined and assessed, and obstacles and opportunities for progress identified, both at governmental level and among civil society. AI Sections will be in a better position to identify their role when they have analysed existing governmental and non-governmental initiatives in their country and assessed the position of key sectors of society — such as educators, health workers and religious leaders — with regard to FGM.

FGM was first included in AI's promotional work on human rights at its International Council Meeting in August 1995. The aim of this promotional work is to raise public awareness of FGM as a human rights issue and urge governments to ratify and implement international human rights treaties that are of relevance in eradicating the practice. In doing so, AI aims to work in partnership with other NGOs at a local, national and international level.

AI recognizes that FGM is a practice which is deeply rooted in the traditions of a number of societies. As such, it requires a careful and sensitive approach that situates FGM within the broader context of violence and discrimination against women across cultures, and that respects the primacy of the role of grassroots actors in its eradication. AI is thus proceeding with great care in developing the political will to support the elimination of FGM, mobilizing public opinion through education and using international advocacy and networking. By following this approach, AI feels that it can play a significant role in protecting millions of women and girls from mutilation.

AI does not seek to displace the role of other key actors in this field, but rather to support and complement the activities of

other organizations and individuals who are working towards the eventual eradication of FGM. Its central goal is to contribute its expertise and experience in human rights campaigning, advocacy and education, as well as its strength as an international and independent mass-membership organization with an increasingly strong presence in Africa, to the efforts of other organizations working towards eradication.

At an international level, AI lobbies appropriate intergovernmental organizations (IGOs) to ensure the development, monitoring and implementation of the international instruments most relevant in combating FGM. Developing partnership links with relevant international NGOs has helped advance this agenda and created opportunities for jointly supporting local FGM-related projects.

At the national level, AI is, in many situations, particularly well-placed to act as a catalyst for coalition building. Joining forces with other key national actors can serve as a stimulus to devise a national plan of action on which to lobby the relevant authorities, and with which to empower local organizations and influence other crucial sectors of society. Any national plan of action should take into account the government's obligations under international human rights treaties, including its commitments arising from the UN Beijing Declaration and Platform for Action of 1995.

Ensuring that such international and national developments have an impact at the grassroots level is a task which AI recognizes it can only accomplish in close collaboration with domestic organizations and other local actors. AI both respects and supports the primacy of their expertise and their role as educators and agents of change among target communities. AI's intention is to ensure that its own lobbying and outreach activities complement and enhance local awareness-raising efforts.

The overall objective of AI's work on FGM is to contribute to the eradication of FGM by:

- **stressing the relevance of a human rights approach to the work against FGM**
- **using AI's strength as an international, independent mass-membership human rights organization to lobby governments and mobilize key actors and organizations into taking action against FGM**
- **supporting international, regional and local organizations and individuals working to eradicate FGM.**

WHY AND HOW AMNESTY INTERNATIONAL TOOK UP THE ISSUE OF FEMALE GENITAL MUTILATION

Amnesty International (AI) has been concerned with the human rights implications of female genital mutilation (FGM) for over 15 years. The issue was first tabled at the 1981 International Council Meeting, in the wake of the interest aroused worldwide by an international conference organized by the World Health Organization in Khartoum, Sudan, in 1979.

For a decade following AI's first discussions on FGM, the organization's work remained focused on a closely defined range of repressive acts carried out directly by state forces, acts which were in breach of states' legal obligations under international human rights standards. AI campaigned solely against violations by governments because it was they who were considered to be bound by international human rights treaties, treaties that provided a framework and justification for AI to intervene and hold governments accountable.

The early 1990s saw a broadening of AI's focus to include armed political groups as perpetrators of abuses. The laws of armed conflict (international humanitarian law) provided a source of legal obligations to which AI could refer in holding such entities to account. To date, though, AI's mandate has been limited to protecting certain basic rights in the face of grave abuses of political power by governments and armed political groups.

FGM, domestic violence, slavery, and a whole range of other practices, represent equally grave attacks on the rights AI seeks actively to protect (such as the right to physical integrity and to non-discrimination). However, they have only been addressed in AI's campaigning where committed by agents of the state or with their direct complicity.

More recently, AI has explored possibilities for addressing governments' failure to prevent or punish abuses by private individuals as a breach of their international legal obligations. This reflects a significant evolution in the conceptualization of human rights within the international human rights movement in recent decades.

Numerous critiques have sought to demonstrate that traditional interpretations of international standards have created an artificial, hierarchical distinction between violations by state forces in the realm of public political activity and similar abuses in the "private" sphere. One of the results has been that the international legal regime has offered scant protection to women from systematic, grave and gender-based abuses inflicted on them by non-state actors. The public/private distinction overlooks the fact that systematic abuse in the "private" sphere has a public dimension, in so far as it arises from more or less officially sanctioned prejudices,

discrimination or intolerance. It precludes these abuses from being considered as a human rights issue.

In 1995 AI decided to include the issue of FGM in its promotional work on human rights, pending further discussion and decision-making on the broader issue of other abuses by non-state actors. In doing so, AI recognized the urgency of taking a position against this widespread form of violence against women prior to the Fourth UN World Conference on Women held in Beijing in September 1995. This decision was one of a range of steps taken by AI that year to strengthen its commitment to address violations against women and girls more effectively than in the past.

AI's promotional work has included raising awareness among international public opinion and at governmental level about the human rights implications of FGM; urging governments to ratify and implement international human rights treaties and to uphold other international human rights standards relevant to the practice; supporting global, national and community-level efforts by other non-governmental organizations (NGOs) and individuals, as well as cooperating with them in performing the above tasks.

First steps

AI's first initiative to establish a strategy for awareness-raising on FGM was a meeting, held in Ghana in April 1996, of AI members from western Africa and Ghanaian NGO representatives. The seminar, entitled "Working together for change — stop female genital mutilation", took place in Bolgatanga, the capital of Ghana's Upper East Region, a region where FGM is prevalent. It was co-organized with the Ghanaian Association of Church Development Projects. The meeting addressed means of increasing public understanding of FGM in order to promote a mass campaign against the practice, focusing on a grassroots approach to eliminating FGM. Participants included 50 representatives from a diverse range of NGOs, local traditional leaders, government representatives and AI delegates from western Africa.

The seminar considered the practice of FGM from various perspectives, including gender, human rights, health, religion and the law. Discussions also covered the factors which give rise to FGM and approaches to its prevention. One of the outcomes of the meeting was a commitment to devise a national plan of action to eradicate FGM in Ghana.

The Bolgatanga seminar also discussed the contribution that AI could make to stopping FGM. AI delegates and others identified some key strategic considerations:

Why and how Amnesty International took up the issue of female genital mutilation

- AI's initiatives should be led by AI branches in countries where FGM is prevalent. They should act in close collaboration with national and local NGOs, and with the community representatives best placed to act as grassroots educators.
- AI's techniques should be appropriate to the context and should take into account the complex and sensitive nature of the issue. AI's strength lies in its potential for forum-building. Its awareness-raising workshops should serve as catalysts for outreach to key sectors, media work and lobbying of authorities at the local and national level.
- AI should contribute to the work against FGM primarily from a human rights perspective, while at the same time recognizing the need for multidimensional approaches to the issue and ensuring complementarity of its work and that of other organizations at a local and international level.

An AI Working Group on FGM was formed at the meeting to act as a consultation point for the organization's work on FGM, to coordinate FGM activities within the region with other relevant NGOs and to review AI initiatives. The Working Group has representatives in Benin, Côte d'Ivoire, Ghana, Mali, Nigeria, Sierra Leone and Togo.

The seminar attracted widespread media coverage. It was featured as the main news item on Ghanaian television as well as in several newspapers, provoking intense public debate about the practice. The seminar also inspired FGM programs in other countries with AI sections.

AI's first East African seminar on FGM took place in Dodoma, Tanzania, in May 1997. Its theme was "Human rights are women's rights: Eradicate female genital mutilation". There were 52 participants — members of NGOs, women's groups

and religious organizations, government and opposition party representatives, legal and medical professionals, and representatives from the press. From the seminar it emerged that FGM is practised in Tanzania in the regions of Dodoma, Singida, Arusha, Kilimanjaro and Mara. There is currently no legislation against the practice in Tanzania. The seminar concluded that eradication of FGM would only be achieved by governments, religious institutions, international organizations, NGOs and funding agencies joining forces in a vigorous and multidimensional approach to tackling the problem.

At the time of writing, AI's Côte d'Ivoire Section was due to host a human rights awareness workshop on FGM in Korhogo, in the north of the country. Such regional initiatives have been supported by outreach, advocacy and fundraising efforts by the International Secretariat and AI sections in other countries.

Conclusions

AI's first steps on the way to eradication of FGM have been modest but encouraging. Working against FGM is a major challenge for AI. It requires a creative and thoughtful approach to a multifaceted human rights problem which is rooted in cultural traditions and systemic discrimination against women and girls. It demands a rethinking of AI's traditional techniques and a reorientation of its lobbying and awareness-raising efforts towards key sectors of society in addition to its focus on governments. It requires AI to work alongside its partners in the human rights movement to devise joint or complementary strategies.

The steps taken so far by AI's membership in Africa and elsewhere suggest that AI has a valuable role to play in helping to protect millions of women and girls from the risk of mutilation.

FEMALE GENITAL MUTILATION

A human rights issue

"FGM is an issue that concerns women and men who believe in equality, dignity and fairness to all human beings, regardless of gender, race, religion or ethnic identity. It must not be seen as the problem of any one group or culture, whether African, Muslim or Christian. FGM is practiced by many cultures. It represents a human tragedy and must not be used to set Africans against non-Africans, one religious group against the other, or even women against men."

Nahid Toubia, *A Call for Global Action*

At a seminar organized by Amnesty International Ghana in early 1996, Hannah Koroma, Women's Officer for Amnesty International's members in Sierra Leone, recounted her traumatic experience at the age of 10:

"I was taken to a very dark room and undressed. I was blindfolded and stripped naked... I was forced to lie flat on my back by four strong women, two holding tight to each leg. Another woman sat on my chest to prevent my upper body from moving. A piece of cloth was forced in my mouth to stop me screaming. I was then shaved. When [it] began, I put up a big fight. The pain was terrible and unbearable. During this fight I was badly cut and lost blood. All those who took part... were half drunk with alcohol."

This is not a testimony about torture in custody. Hannah's assailants were not members of the country's warring factions. They were friends of her family. She is describing how she was taken by her grandmother to be genitally mutilated with a blunt penknife.

Every day, thousands of girls are targeted for mutilation. Like torture, female genital mutilation (FGM) involves the deliberate infliction of severe pain and suffering. Its effects can be life-threatening. Most survivors have to cope with the physical and mental scars for the rest of their lives.

This violence has been inflicted systematically on millions of women and girls for centuries. Governments in the countries concerned have done little or nothing effective to prevent the practice.

But while the prohibition of torture has been enshrined in international law since shortly after the Second World War, FGM has only recently found a place on the international human rights agenda.

Several factors prevented it from being seen as a human rights issue for many years. FGM is encouraged by parents and family members, who believe it will have beneficial consequences for the child in later life. Violence against women and girls in the home or in the community was seen as a "private" issue; the fact that perpetrators were private actors

rather than state officials precluded FGM from being seen as a legitimate human rights concern. An additional barrier was the fact that FGM is rooted in cultural tradition. Outside intervention in the name of universal human rights risked being perceived as cultural imperialism.

Today, however, the human rights implications of FGM are clearly and unequivocally recognized at an international level. The 1993 UN World Conference on Human Rights in Vienna was a milestone in this respect. The Vienna Declaration and Programme of Action sounded a historic call for the elimination of all forms of violence against women to be seen as a human rights obligation:

"In particular, the World Conference stresses the importance of working towards the elimination of violence against women in public and private life... and the eradication of any conflicts which may arise between the rights of women and the harmful effects of certain traditional or customary practices."

The Universal Declaration of Human Rights and a host of international standards that flow from it, underscore the obligation of states to respect and ensure respect for basic human rights, such as the right to physical and mental security, freedom from discrimination on the basis of gender, and the right to health. Governmental failure to take appropriate action to ensure the eradication of FGM violates these obligations.

Moreover, a number of more recent international standards, including widely ratified treaties, contain explicit prohibitions of FGM. The issue has been on the agenda of the UN Sub-Commission on Prevention of Discrimination and Protection of Minorities since the early 1980s. FGM was recognized as a form of violence against women in the UN Declaration on the Elimination of Violence against Women and in the UN Beijing Declaration and Platform for Action. A range of UN specialized agencies have more recently developed policies and programs on FGM (see *FGM and International Standards* and *FGM: UN initiatives*).

Many non-government actors have also adopted a human rights framework for their approach to eradication.

The implications of framing FGM as a human rights issue

A human rights perspective sets FGM in a broader continuum of violence against women which occurs in all societies in different forms. FGM is just one manifestation of gender-based human rights violations which aim to control women's

sexuality and autonomy, and which are common to all cultures. Though striking because of its severity and scale, FGM cannot be viewed in isolation. Recognizing that FGM is one of many forms of social injustice which women suffer worldwide is key to overcoming the perception that international interventions on FGM are neo-imperialist attacks on particular cultures.

A human rights perspective also sets FGM in the context of women's social and economic powerlessness. Recognizing that civil, political, social, economic and cultural rights are indivisible and interdependent is a crucial starting point for addressing the whole range of underlying factors behind the perpetuation of FGM.

A human rights perspective affirms that the rights of women and girls to physical and mental integrity, to freedom from discrimination and to the highest standard of health are universal. Cultural claims cannot be invoked to justify their violation.

A human rights perspective requires governments, local authorities and others in positions of power and influence to honour their obligations — established under international

law — to prevent, investigate and punish violence against women.

A human rights perspective also obliges the international community to assume its share of responsibility for the protection of the human rights of women and girls. The fact that FGM is a cultural tradition should not deter the international community from asserting that it violates universally recognized rights.

"It is unacceptable that the international community remain passive in the name of a distorted vision of multiculturalism. Human behaviours and cultural values, however senseless or destructive they may appear from the personal and cultural standpoint of others, have meaning and fulfil a function for those who practise them. However, culture is not static but it is in constant flux, adapting and reforming. People will change their behaviour when they understand the hazards and indignity of harmful practices and when they realize that it is possible to give up harmful practices without giving up meaningful aspects of their culture."

Joint statement by the World Health Organization,
UN Children's Fund (UNICEF) and
UN Population Fund, February 1996

FEMALE GENITAL MUTILATION AND ASYLUM

In several jurisdictions, women have been recognized as refugees under the 1951 UN Convention relating to the Status of Refugees (UN Refugee Convention) on the grounds that they would be at risk of FGM if returned to their country. It is important to note, however, that there are still only a tiny number of such cases.

In 1993 Canada granted refugee status to a Somali woman, Khadra Hassan Farah, who had fled her country with her 10-year-old daughter, Hodan, because she feared that Hodan would be forced to undergo genital mutilation. In making the ruling, immigration officials said that Hodan's "right to personal security would be grossly infringed" if she was returned to Somalia.

In 1996 Fauziya Kasinga, who had sought sanctuary in order to escape FGM in Togo, was finally granted asylum by the US authorities. She had been held in harsh conditions in detention camps for more than a year. An immigration judge initially rejected her asylum claim, saying "this alien is not credible". His decision was overturned and Fauziya's claim for refugee status was granted.

In 1997 two families were granted asylum in Sweden on the grounds that the female members of these families would be in danger of genital mutilation if returned to their country of origin, Togo. Though the authorities did not recognize the families as refugees under the UN Refugee Convention, they did grant them residence permits on humanitarian grounds.

The Australian Government's *Guidelines on Gender Issues for Decision Makers*, issued in 1996, recognize that FGM "may

constitute persecution in particular circumstances". In addition, the French Refugee Appeal Commission has accepted that FGM may be classified as persecution and give rise to a claim for refugee status.

In a letter to the British Refugee Legal Centre dated 8 July 1994, the United Nations High Commissioner for Refugees (UNHCR) outlined its position on FGM. The letter states that: "FGM, which causes severe pain as well as permanent physical harm, amounts to a violation of human rights, including the rights of the child, and can be regarded as persecution. The toleration of these acts by the authorities, or the unwillingness of the authorities to provide protection against them, amounts to official acquiescence. Therefore a woman can be considered a refugee if she or her daughter/daughters fear being compelled to undergo FGM against their will; or, she fears persecution for refusing to undergo or allow her daughters to undergo the practice."¹

The UN Refugee Convention defines a refugee as someone who "...owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country..." (Article 1(A)(2)). Under this definition, women from a particular country or ethnic group who are at risk of female genital mutilation (FGM) can be properly construed as a "particular social group". The fact that the "particular social group" may consist of large numbers of women is irrelevant; other Convention grounds, such as nationality and political opinion, are also characteristics shared by large numbers of people.

¹ Crawley, Heaven, *Women as Asylum Seekers — A Legal Handbook*, p. 71, Immigration Law Practitioners' Association and Refugee Action, London, 1997.

FEMALE GENITAL MUTILATION AND INTERNATIONAL HUMAN RIGHTS STANDARDS

“To succeed in abolishing the practice of FGM will demand fundamental attitudinal shifts in the way that society perceives the human rights of women.”

Efua Dorkenoo, *Cutting the Rose*

The subordinate position historically occupied by women and girls within the family, community and society has meant that abuses such as female genital mutilation (FGM) have to date been mostly ignored, a marginalization which has too often been reflected in the preoccupations of the international human rights movement. Nevertheless, a whole range of standards exist which present governments with a clear obligation to take appropriate and effective action.

The **Universal Declaration of Human Rights (UDHR)**, the cornerstone of the human rights system, asserts that all human beings are born free and equal in dignity and rights. It protects the right to security of person and the right not to be subjected to cruel inhuman or degrading treatment — rights which are of direct relevance to the practice of FGM. The traditional interpretation of these rights has generally failed to encompass forms of violence against women such as domestic violence or FGM. This arises from a common misconception that states are not responsible for human rights abuses committed within the home or the community.

More recent instruments give greater specificity to the range of rights enshrined in the UDHR. They also affirm that FGM, along with other forms of violence against women and other harmful traditional practices, is an assault on the dignity, equality and integrity of women and an affront to human rights.

FGM and discrimination against women

“[Excision] shows an attempt to confer an inferior status on women by branding them with this mark which diminishes them and is a constant reminder to them that they are only women, inferior to men, that they do not even have any rights over their own bodies or fulfilment either bodily or personal... As we can view male circumcision as being a measure of hygiene, in the same way we can only see excision as a measure of inferiorization.”

Thomas Sankara, former President of Burkina Faso

FGM is rooted in discrimination against women. It is an instrument for socializing girls into prescribed roles within the family and community. It is therefore intimately linked to the unequal position of women in the political, social, and economic structures of societies where it is practised.

The **UN Convention on the Elimination of All Forms of Discrimination against Women**, which came into force in 1981, sets out in detail the measures that have to be taken to eliminate discrimination. Article 5 of the Convention requires states to work towards “the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes”. Gender-based violence is recognized as a form of discrimination which seriously inhibits a woman’s ability to enjoy the full range of rights and freedoms on a basis of equality with men.

The Committee on the Elimination of Discrimination against Women, the monitoring body of the Convention, has issued several general recommendations relating to FGM. General Recommendation 14 (1990) calls on states parties to take appropriate and effective measures with a view to eradicating the practice, including introducing appropriate health care and education strategies and including information about measures taken to eliminate FGM in their reports to the Committee.

General Recommendation 19 draws a connection between traditional attitudes which subordinate women, and violent practices such as FGM, domestic violence, dowry deaths and acid attacks, stating that: “Such prejudices and practices may justify gender-based violence as a form of protection or control of women”. The Recommendation also recognizes that violence against women not only deprives them of their civil and political rights (such as the right to physical integrity); it denies them their social and economic rights: “While this comment addresses mainly actual or threatened violence, the underlying (structural) consequences of these forms of gender-based violence help to maintain women in their subordinate roles, contribute to their low level of participation and to their lower level of education, skills and work opportunities.”

The provisions of the Convention are strengthened and complemented by the **UN Declaration on the Elimination of Violence against Women**, adopted by the General Assembly in 1993. It addresses gender-based violence “both in public or private life”, and includes within its scope FGM and other traditional practices harmful to women. Article 4 provides that states should not invoke any custom, tradition or religious consideration to avoid their obligation to eliminate violence against women. The Declaration sets out an internationally recognized framework for action by governments. It details the measures states should adopt to prevent, punish and eradicate such violence. These duties include due diligence in investigating and imposing penalties for violence and establishing effective protective measures.

The **UN Beijing Declaration and Platform for Action**, resulting from the Fourth World Conference on Women in 1995, contains a clear condemnation of FGM as a form of violence against women and reaffirms the responsibility of states to take action to curb such violence.

FGM and the rights of the child

The **UN Convention on the Rights of the Child** was the first binding instrument explicitly addressing harmful traditional practices as a human rights violation. It obliges governments to “take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child” (Article 19(1)). Article 24 (3) of the Convention specifically requires governments to “take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.”

At a regional level, the **African Charter on the Rights and Welfare of the Child**, adopted by the Organization of African Unity in 1990, but yet to enter into force, contains many similar provisions to those in the UN Convention. However a number of unique provisions relate to FGM, including the provision that “any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations contained in the present Charter shall... be null and void”. The Charter requires governments to take all appropriate measures to eliminate social and cultural practices “harmful to the welfare, normal growth and development of the child, in particular those prejudicial to the health or life of the child and those customs and practices discriminatory to the child on grounds of sex or other status.”

The **UN Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief** protects the rights of the child against abuse carried out in the name of a particular belief or cultural tradition, stating that: “Practices of a religion or belief in which a child is

brought up must not be injurious to his physical or mental health or to his full development...” (Article 5(5)).

FGM and the right to health

The severe consequences of FGM for the psychological and physical health of women and girls bring it within the scope of the human rights instruments mentioned above. The right to enjoy the highest attainable standard of physical and mental health is enshrined in the **International Covenant on Economic, Social and Cultural Rights**. This Covenant refers to specific steps governments are obliged to take to achieve full realization of this right, including measures for reducing the infant mortality and still-birth rates and for the healthy development of the child.

Misconceptions about FGM (such as the belief that the clitoris can damage a baby during childbirth) are perpetuated in many areas because of women’s lack of access to information about their sexual and reproductive health. The 1994 **UN International Conference for Population and Development** in Cairo emphasized the interconnections between reproductive health and human rights. Its Programme of Action urges governments to put a stop to the practice of FGM and put in place programmes for education and rehabilitation. The World Health Organization has a long history of addressing FGM from the perspective of the right of women and girl-children to the highest attainable standard of health (see *FGM: UN Initiatives*).

FGM is a graphic illustration of the indivisibility and interdependence of all human rights. This violation of the right to physical and mental integrity of women and girls cannot be addressed in isolation from the context of systematic deprivation of women’s civil, political, social and economic rights. Governments have clear obligations under international law to take appropriate and effective measures to eradicate and prevent FGM. To do so, they must address the human rights implications of the practice in a holistic manner, recognizing that violence against women is indivisible from and interdependent with gender-based discrimination in all its forms.

FEMALE GENITAL MUTILATION

United Nations Initiatives

International efforts to eradicate female genital mutilation (FGM) have a long history. As early as the 17th century, there were attempts by Christian missionaries and colonial administrations in Africa to prevent the practice. These efforts, perceived as a colonialist attempt to destroy the local culture, were strongly resisted.

The years following the end of the Second World War saw the beginning of a process of decolonization and the creation of a universal framework for the protection of human rights in the form of the Universal Declaration of Human Rights. It is in this context that FGM first appeared on the agenda of the **United Nations** (UN) in 1958. The chequered history of previous efforts at outside intervention on the issue was a factor which prevented FGM from being taken up in earnest by the UN for another twenty years.

A seminar organized in 1979 in Khartoum, Sudan, by the **World Health Organization**, set the direction for renewed international initiatives. Its recommendations, aimed mainly at the 10 governments from eastern and western Africa represented at the meeting, called for the adoption of clear national policies, the establishment of national commissions to coordinate the activities of various official bodies; the enactment of legislation where appropriate; and the organization of public education and outreach involving health workers and traditional healers.

Interest resurfaced among international non-governmental organizations (NGOs) during the **UN Decade for Women** (from 1975 to 1985) which highlighted the status of women in developing countries. The Programme of Action of the UN World Conference on Women held in Copenhagen in 1980 called for urgent steps to combat negative traditional practices detrimental to women's health.

This call echoed increasing demands from African women's organizations and others for greater attention to be paid to these practices. These demands led to the creation in 1984 of a **UN Working Group on Traditional Practices Affecting the Health of Women and Children** and the appointment of one of its members as a **Special Rapporteur** to the Sub-Commission on Prevention of Discrimination and Protection of Minorities. The Rapporteur, Halima Warzazi, undertook field missions to Djibouti and Sudan and produced two reports in 1989 and 1991 which contributed to a better understanding of the phenomenon.

Two regional seminars were organized by the UN in Burkina Faso (1991) and Sri Lanka (1994) to assess the human rights aspects of FGM and other traditional practices affecting women and children. The seminars — a forum for discussion

between national officials, UN specialized agencies and NGOs — led to the 1994 **Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children**.

The Plan of Action states that FGM "is a human rights violation and not only a moral issue...[It] is an expression of the societal gender subordination of women". It contains 62 measures for governments to take at a national level. Key among these are: giving a clear undertaking to end traditional practices, and in particular FGM; ratifying and implementing relevant international instruments; drafting legislation prohibiting such practices; and creating bodies and mechanisms to ensure adopted policies are implemented.

At an international level, the Plan of Action recommends the inclusion and integration of FGM in the work of various UN specialized agencies and other UN bodies, including the Commission on the Status of Women and relevant treaty bodies such as the Committee on the Rights of the Child. It also urges NGOs to integrate and reinforce their activities.

In order to follow up the Plan of Action, and to allow more in-depth analysis of the issue to take place, the mandate of the Special Rapporteur was extended. Her July 1997 report examines the status of implementation of the Plan of Action in a number of countries and surveys more recent international efforts to combat the practice.

Her work has been complemented by that of the **Special Rapporteur on Violence against Women**, Radhika Coomaraswamy, whose reports to the Commission on Human Rights have included analysis of FGM as a form of violence against women and concrete recommendations for prevention.

Two recent world conferences have also marked a critical development in the UN's role on FGM. In 1994 the **International Conference on Population and Development** was held in Cairo. One of the achievements of the Conference was to highlight the intimate interconnections between women's health and women's human rights. The Conference declaration urged governments to prohibit FGM, and to give support to community organizations and religious institutions working to eliminate the practice.

The **Fourth UN World Conference on Women**, held in Beijing in 1995, represented a historic attempt to overcome the traditional neglect and indifference surrounding women's human rights. The Beijing Declaration and Platform for Action underscored the obligations of governments to combat violence against women — including FGM — as a priority.

In April 1997, three UN agencies — the **World Health Organization, United Nations Children's Fund** and **United Nations Population Fund**, unveiled a Joint Plan to bring about a major decline in FGM within ten years and to completely eradicate the practice within three generations.

The plan emphasizes the need for a multi-disciplinary approach, and the importance of teamwork at a national, regional and global level. This teamwork would bring together governments, political and religious institutions, international organizations and funding agencies. The basis for this cooperation at a country level would be national "inter-agency teams" supported by international organizations. The plan takes a three-pronged approach: educating the public and law makers on the need to eliminate FGM; "de-medicalizing"

FGM — tackling it as a violation of human rights as well as a danger to women's health; and working with the entire UN system to encourage every African country to develop a national, culturally specific plan to eradicate FGM.

The Joint Plan represents a welcome step towards greater integration and coordination of the activities of UN agencies on FGM. Now that recognition of FGM as a human rights issue has been reflected in international instruments, the challenge is to ensure that those instruments are translated into effective action at the national level. This goal can only be achieved in collaboration with the national and international NGOs who for years have been at the forefront of awareness-raising, lobbying and other eradication efforts. It is thanks to their efforts that progress at the international level has been made.

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IAC Newsletter, Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, 147 rue de Lausanne, CH-1202 Geneva, Switzerland.

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