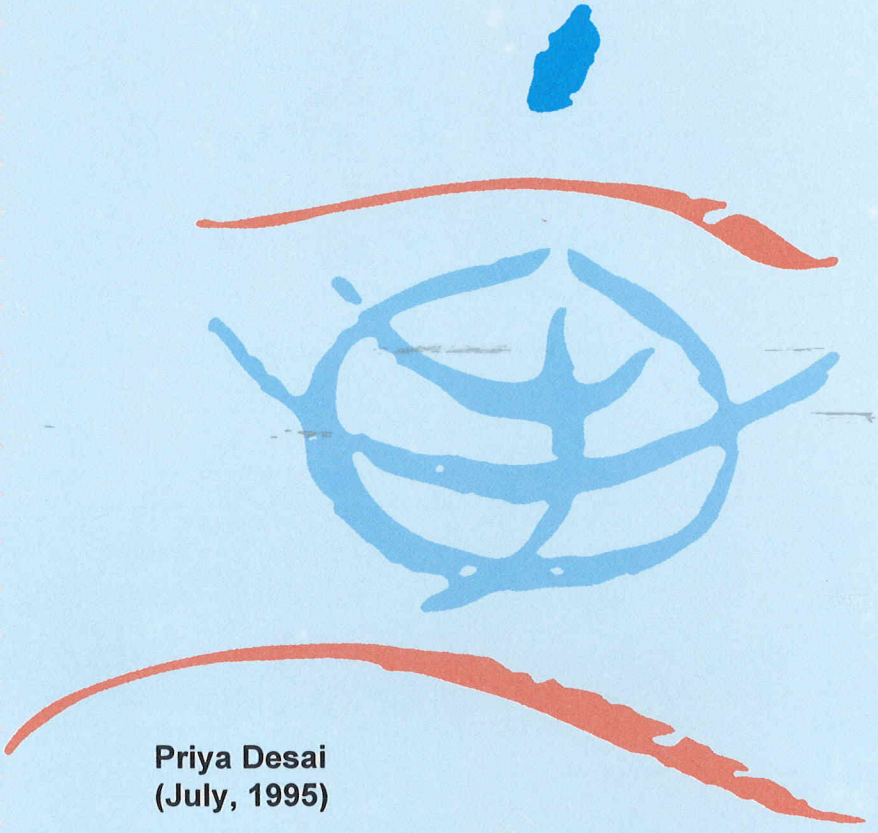
TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN



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Traditional Practices Affecting the Health of Women and Children - Female Genital Mutilation.

I)Female Genital Mutilation (FGM) is a practice that damages the health and lives of an estimated 85 to 114 million girls and women. It is estimated that each year about 2 million or more girls undergo this practice, (WHO: Division of Family Health, Female genital mutilation, 1994) and that each day approximately 6000 girls are at risk.
More painful still is the fact that with a rapid population growth, especially in Sub-Saharan Africa, the total number of mutilated women is constantly on the increase and many more very young girls are excised each day.

I1)Descriptions of the practice of FGM

Here is a description of the ceremonies which accompany the practice of female genital mutilation. (FGM).

"A little girl about six or seven years old is prepared for circumcision. She gets some fine, bright new clothes and shoes. A day or two before circumcision day her friends paint henna on her hands and feet. They have a little party in preparation for the event. On the circumcision day itself she is adorned with jirtig, a ritual widely practiced on wedding occasions. An older women puts jewellery on the feet and winds red silk threads around her wrist. This custom is connected with an old belief that jirtig is necessary to drive away evil and keep angels by the side of the betrothed or the circumcised.
The child is then taken to a midwife's house, where most operations take place. In smaller towns a midwife may come to the family's home, especially when a group circumcision is to take place. The family may circumcise several girls from the same family on the same day. The scene on circumcision day, whether in the villages or in the city, is more like a funeral than a party. Despite the new clothes and the bridal appearance, complete with firka, a bright silk cloth covering the bride, little girls are not impressed or persuaded. Apparently they all know that some type of amputation will take place.
Afterwards, a feast is given. It includes men if boys are circumcised on the same day. The size of the feast depends on the financial ability of the family. Amid the tears of the pain ridden child, festivities go on, and children's tunes are played. The child is told that she will soon be better and should join the festivities. Women relatives and neighbours come to say congratulations, implying that what happened to that little girl calls for celebration; it is a happy event! Those offering felicitations usually give the girl a sum of money, which she is free to spend as she wishes."[1]

However, a description of the actual procedure carried out during FGM reveals the dreadful injustices of the practice:

"The little girl, entirely nude, is immobilized in the sitting position on a low stool by at least three women. One of them with her arms tightly around the little girl's chest: two others tightly around the child's thighs apart by force, in order to open wide the vulva. The child's arms are tied behind her back, or immobilized by two other women guests. The traditional operator says a short prayer: "Allah is great and Mahomet is his prophet. May Allah keep away all evils." Then she spreads on the floors some offerings to Allah: split maize or, in urban areas, eggs,. Then the old woman takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip. This nymphectomy and scraping are repeated on the other side of the vulva. The little girl howls and writhes in pain, although strongly held down. The operator wipes the blood from the wound and the mother, as well as the guests, "verify" her work, sometimes putting their fingers in. The amount of scraping of the large lips depends upon the "technical" ability of the operator. The opening left for urine and menstrual blood is minuscule. Then the operator applies a paste and ensures the adhesion of the large lips by means of an acacia thorn, which pierces one lip and passes through into the other. She sticks in three or four in this manner down the vulva. These thorns are then held in place either by means of sewing thread, or with horse hair. Paste is again put on the wound. But all this is not sufficient to ensure the coalescence of the large lips; so the little girl is then tied up from her pelvis to her feet: strips of material rolled up into a rope immobilize her legs entirely. Exhausted the little girl is then dressed and put on a bed. The operation lasts from 15 to 20 minutes according to the ability of the old woman and the resistance put up by the child."[2]

2)Female circumcision or Female Genital Mutilation?

In 1990 in Addis Ababa, during an Inter-African Committee (IAC) Regional Conference co-sponsored by the World Health Organisation (WHO), delegates implored that the procedure regularly classified as "female circumcision" should instead be labelled "Female Genital Mutilation". They insisted that by using the latter term the true nature of the practice; the removal of healthy tissues which cannot be replaced, was disclosed. Furthermore, because FGM frequently involves the definitive and irremediable removal of a healthy organ, the clitoris, the practice falls within Webster's definition of a mutilation.

a)What is Female Genital Mutilation?

Female Genital Mutilation (FGM), is a practice which consists of the cutting away of parts of or all of the external genitalia of a female. The female genital organ normally is constituted by the vulva, which comprises the labia majora, the labia minora and the clitoris which is covered by it's prepuce.

A generic classification of FGM distinguishes three different forms of mutilation. A fourth type of mutilation also exists which is an intermediate form between the two

most severe of the procedures. The form of mutilation which is performed depends largely upon the country, the ethnic group or the community in question.
The different types of FGM are known as clitoridectomy, excision, and infibulation. The last of the three involves the most acute cutting and is known to cause the most severe damage to girls' and women's health in the immediate and long run. The fourth type of procedure which exists is appropriately termed intermediate as the amount of tissue removed here is somewhere between excision and infibulation. This fourth type of mutilation is increasingly practiced in countries such as the Sudan where infibulation is outlawed.

i))Clitoridectomy or circumcision consists of the circumferential removal of the prepuce or hood of the clitoris (partial clitoridectomy or Sunna which means "tradition in Arabic) or includes the removal of the clitoris (total clitoridectomy). Here the labia minora and labia majora are left intact. This is the mildest form of mutilation and it affects only a small proportion out of the millions of women concerned.
Because a partial clitoridectomy is a very delicate operation, it is rarely performed in Africa or in the Middle East where, in general, operators possess no anatomical knowledge and work on the ground, in dark huts or under trees with crude tools.

ii))Excision is the removal of the clitoral hood, the clitoris and all or part of the labia minora. With excision the labia majora are left intact and the vagina is not closed. The amount of tissue removed varies widely between different communities and according to the custom of the person carrying out the mutilation. This is the most widespread form of FGM and concerns 80% of mutilated women

iii))Infibulation (Pharaonic Circumcision as it always has been practiced in upper Egypt and was known to the ancient Egyptians) involves a total clitoridectomy, removal of the labia minora and at least two-thirds of the inner surface, but often the whole, of the labia majora. Following this is the pinning together of the two sides of the vulva with silk, by thorns or by catgut sutures. Infibulation may also occur spontaneously by adherence of the wounded sides of the labia, especially where extensive operations are performed, for instance in Senegal, Burkina Faso and Mali.
When the remaining part of the labia majora heals it forms a bridge of scar tissue over the vagina. A small opening is preserved by the insertion of a foreign body such as a tiny piece of wood or reed to permit the flow of urine and menstrual blood. The girl's legs are then bound together from thigh to ankle and she may be immobile for several weeks or up to one month to allow scar tissue to form over the wound or until the wound of her vulva has closed.
When the wound has healed the reconstructed opening is surrounded by skin and tough scar tissue. Because of the intense mutilation and alteration of the female genitalia after infibulation, prior to intercourse the infibulated woman has to undergo gradual dilation by her husband. This is very painful and usually it takes at least several days before penetration is possible. If the opening is too small and the husband is not able to

penetrate at all, then the opening has to be re-cut (often performed by the husband using a knife) and the healing process repeated.

iv)Intermediate consists of the removal of the clitoris and some parts of the labia minora or the whole of it. Sometimes slices of the labia majora are removed and stitched. There are various degrees of intermediate, done according to the demands of the girl's relatives. This form of mutilation is normally closer to infibulation than to excision however it differs from the former only because the opening left is slightly larger.

3)The origins of female genital mutilation

The origin(s) of FGM, a practice which has existed for more than two thousand years steeped in myths and shrouded by silency, has caused endless speculation but has yet to be established. There is no consensus about whether the practice originated in one region and spread by virtue of relocation diffusion and phases of military conquests of cultures who do not mutilate by cultures which do, or whether it evolved independently among different ethnic groups in different areas. The term "Pharaonic Circumcision" indicates that the practice already existed amongst the ancient Egyptians and some sources claim that it originated here. A second explanation is that the operations originated in the Middle East on the Arab Peninsula and were spread by Arab traders. Some put forth a third argument which is that these operations are so widespread that it is unlikely that they have a common origin. Finally, a fourth view is that FGM could be an old African rite that came to Egypt by diffusion.[3]
It is interesting that infibulation is widespread in Northern and Central Sudan, in Somalia and in Djibouti where Arab and black African cultures meet. In these African countries, where the dominating culture is Arabic as opposed to black African, it is probable that infibulation was enforced on black African women during the Ancient Arab slave trade. Still today African women from the non-Muslim southern part of Sudan who marry Sudanese Arabs in Northern Sudan are forced to undergo infibulation.
It is also interesting that when Islam entered Asian countries through Arabia or Iran, it did not bring FGM with it, but when it was imported to Asia through Nile Valley cultures, FGM was a part of it (Daudi Bohra of India practices FGM and is an Egyptian based sect of Islam).[4]

Nevertheless, despite the absence of a consensus about where female genital operations originated, one has literary references indicating that the practice has existed for many thousands of years.
The earliest description of infibulation in historic literature is given by a Venetian historian called Pietro Bembo. In one of his works belonging to the 16th century, Bembo transmits reports of travellers to the Red Sea. Bembo describes that in this part of Africa, virginity is held in such high esteem that "the private parts of girls are sewn together immediately after birth... when adult, the girls are given away in marriage...The husband's first measure is to cut open with a knife the solidly consolidated private parts of the virgin." [5]

In the medical literature, the idea that the clitoris must be amputated can be traced as far back as the 2nd century A.D. Soramus, a Greek physician who practiced about 138 A.D in Alexandria and Rome, referred to the practice of FGM when he claimed that "In some cases, the clitoris (the seat of pleasure- according to Aristotle) is so large that it presents a shameful deformity". Soramus, fearing that this could be a cause of overexcitement and excessive sexual intercourse cut away with a scalpel "what seems to be too much". [6]
Aetius, again a physician (502-575 A.D), also refers to the practice when he approved of the Egyptian custom of amputating the clitoris of a girl "before it grows too large".
Finally, Sir Richard Francis Burton (1821-1890), voyager and linguist who travelled the world over, described in a book written in the mid 19th century that excision is performed because otherwise women would be insatiable and indulge in excessive sexual intercourse.
Burton also reported that right after the wedding, during the space of a week, the spouse remains with his espoused, scarcely ever venturing out of the hut." Although Burton did not explain the reason why the bride could not leave the house, Hosken explains "after her infibulation has been cut open, she had to remain secluded with her legs spread apart, until the wound was healed. She was subjected to frequent sexual intercourse, as custom required, until the newly cut opening to her vagina assumed the size needed by her husband for penetration for his pleasure".[7]
Hosken reports that she witnessed the continuation of this ancient tradition in Somalia in 1979. "The bridegroom is honour bound to penetrate the wife he has acquired for a steep price - after opening her with a knife or other sharp instrument - as his natural weapon is usually unable to overcome the artificially created obstruction. Intercourse then is frequently repeated through the open wound to keep it from closing again - without any regard for the terrible pain inflicted. The helpless bride, who often has barely reached her teens, must remain on her back with her legs wide open for days to keep the wound and vagina from closing". [8]

The fear that unmutilated women would become lesbians can also be traced way back to the 7th century A.D. Paulus of Aegina, a Greek physician, stated that an enlarged clitoris is a shameful thing that could "erect like a penis and could be used for lesbian coitus". [9]

It is interesting that the idea of FGM as a hygienic practice goes back again to the 2nd century A.D. Mr. Niebuhr, German traveller and sole survivor of the first European scientific expedition to Arabia, Egypt and Syria, reported on the practice of excision in 176 A.D. He stated that: "In Oman, on the shores of the Persian Gulf among the Christians of Abyssinia, and in Egypt among the Arabs and Copts, this latter custom was prevalent". He also claims that "Out of cleanliness, and to render ablution easier, the practice of circumcising women has been first adopted. No law has appointed it... it is usage, not a religious duty".[10]

Like Mr.Niebuhr, all those who have subsequently attempted to trace the history of FGM agree that the practice pre-dated Islam, Christianity and other major religions. What is more no religious text, be it the Koran, the Bible or the Torah (only the

Ethiopian Falashas practice FGM), make specific mention of this practice. It is interesting to note here that FGM is not practiced in predominantly Islamic countries such as Saudi Arabia, Kuwait, Algeria, Pakistan and the Gulf States.

Female genital operations were also believed to have been practiced in pre-Islamic Arabia, ancient Rome (slave girls in ancient Rome were infibulated to prevent conception, as childbearing would hinder their work) and in Tsarist Russia.
In England, they were practiced in the 19th and 20th centuries as treatment for psychological disorders and to prevent masturbation.

a)The Geographical Distribution of FGM at present

On the African continent there are more than 26 countries which still practice some form of FGM.
Excision is practiced in a broad area all across the continent parallel to the Equator: from Egypt, Ethiopia, Somalia, Kenya and Tanzania in East Africa to the West African coast, from Sierra Leone to Mauritania and in all countries in between, including Nigeria. It is also practiced in the southern part of the Arab Peninsula and around the Persian Gulf, including Yemen, Oman, the United Arab Emirates and Bahrain.[11] A less damaging form of the procedure, such as a partial clitoridectomy, is practiced by Muslim populations in Indonesia, Malaysia and among the Bohras in India.
It is however significant that within a country different ethnic groups are not necessarily affected in the same way. In Kenya for example the second largest ethnic group, the Luo, do not practice any female genital operation despite the fact that they are surrounded by ethnic groups which do: the Kikuyu practice excision as a puberty rite and the Masai, on the night of their wedding.
In Nigeria, the Yoruba, the Ibo and the Hausa practice mainly excision or clitoridectomy, however the Nupes and the Fulanis do not practice any form of genital operation on their girls. Given as a last example one can cite the Wollofs in Senegal for the absence of FGM whereas the other ethnic groups, the Sarakolé, the Bambara and the Toucouleurs, all practice excision/infibulation.

The countries with the highest incidence of FGM are Somalia, Sudan and Ethiopia, where eighty to ninety percent of women are said to be infibulated.

Infibulation is practiced on all females, almost without exception, in all of Somalia. It is also performed throughout the upper Nile Valley, including southern Egypt, in Eritrea, in parts of Ethiopia and all along the Red Sea Coast.
In Sudan, almost all Muslims are infibulated and at present, with Islamic influence spreading in the South of Sudan, infibulation is also touching the non-Muslim population of Sudan.

In West Africa, Infibulation is practiced in Mali and in northern Nigeria among some Muslim population groups

There are a number of African countries in addition to those shown in the table below where a small percentage of the population practices FGM. These include Cameroon Congo, Zaire, Mauritania, Tanzania and Uganda. The total number of mutilated girls and women in these countries is estimated to be between 2-3 million. This number should hence be added to the total given in the table.[12]

Also the mutilations on girls and women which occur outside the African continent are not included in the table.

Increasingly, in Western countries - Europe (France, Sweden, UK, Italy, Germany), Australia, Canada and North America, immigrant families are bringing the practice along with them. Many continue to have their daughters mutilated, either secretively in the immigrant country or during visits to their country of origin.

4)Reasons given for practicing FGM?

"The cause of the practice of excision and infibulation is long in the distant past; typically, no one in Africa can give a plausible explanation for genital mutilation of girls that is not tied to myths, magic, misconceptions and ignorance of the biological facts."[13]

The justifications for FGM vary across ethnic groups; tradition, culture and religion are some of the frequently cited reasons which are given for continuing this practice. However there is no religious basis for FGM.
The operation is traditionally performed, as in sub Saharan Africa, as a puberty rite and symbolises a girls entry into adulthood.
Tradition is the reason most often cited in Africa and the Middle East for practicing excision and infibulation on children. Most Africans believe that these customs are decreed by their ancestors, and hence, must be continued. The truth however is that women must be excised if they are to find husbands. The firm belief that a woman will run wild and become promiscuous if she is not excised is also a justification for this practice. In the Sudan and the Middle East and in Muslim societies, women are excised and infibulated in order to ensure that they are "untouched" before marriage and also so that they will remain faithful to their husbands.

In Ethiopia and in parts of Nigeria, the fear that the clitoris represents the male sex organ and, if not cut, will grow to the size of a penis leads to excision.
Excision is also practiced throughout Africa so as to ensure fertility. The clitoris is viewed as a dangerous organ that can prevent female fertility. In Kenya for example, it is believed that a woman who is not excised is unable to have children.
In Burkina Faso and elsewhere in West Africa, the belief prevails that a new-born will die if it's head touches the clitoris.

Aesthetic reasons are sometimes cited, as in Egypt, for the practice of FGM.

Nowadays, and especially in urban areas, health and hygienic justifications for FGM are frequently mentioned. In the Sudan however the operation, known as "tahur" which in Arabic means purity, is traditionally connected with cleanliness. Here it is believed that a woman is polluted and can only be cleansed and prepared for marriage and childbirth through excision.[14]

A woman who has not undergone genital mutilation runs the risk of being called a social outcast or of "destroying her family's honour.[15]
Furthermore, in many African countries, carrying out the mutilation is important if the girls family is to receive a "bride price".[16]

a)The objective of infibulation

Infibulation, the most severe form of FGM, is carried out in order to make sexual intercourse impossible for a woman prior to marriage, and hence to ensure that a bride is intact for her husband. It is practiced chiefly by Muslims who attach great importance to chastity. Another motive for performing this procedure is that the smaller the opening, the higher the bride-price. Brides are often examined by their female in-laws before the bride-price is paid.
In The Hosken Report there is the account of an incident in Burkina Faso in 1977 where a woman in labour with her first child was brought to a maternity clinic, "she could not deliver as she was almost completely closed. There was nothing at all left of her external genitalia. She had evidently conceived through a tiny opening..."[17]

Women who are infibulated often have to be cut open prior to intercourse and again, with a larger opening, before child delivery. In the Sudan and Somalia wives are traditionally reinfibulated after the baby is born, and when the child is weaned, they are opened up again for intercourse.
In the Sudan, women have been reported to demand re-infibulation after delivery to make intercourse more pleasurable for the husband. It also was the custom for men to have their wives re-infibulated before leaving home for extended periods of time.[18]

5)When is FGM carried out?

The age at which the mutilations are carried out varies from area to area and depends very much on the ethnic group to which the girl belongs. In general, groups which practice infibulation tend to carry out the procedure on their girls' when they are infants or very young, and groups which practice excision/clitoridectomy perform the mutilations on girls' when they are slightly older and around the time of puberty.[19]

Traditionally FGM is performed for the first time between the ages of one week (in Ethiopia, Mauritania and among the Yoruba in Nigeria) and fourteen years, and as a puberty or coming of age rite on girls before the onset of menstruation (sub-Saharan Africa, Ibo of Nigeria).
In Kenya and Tanzania however, whereas the Kikuyu women are excised before puberty, Masai women have an excision (or a clitoridectomy) on their wedding night or after marriage.
Among certain tribes in Burkina Faso re-infibulation may even be performed on women after death or on women who have escaped the practice when alive. Here the burial rites cannot be performed unless the woman is mutilated.

In some countries where infibulation is practiced, women are re-infibulated after childbirth, after divorce or with the death of their husband.[20] A tightly infibulated woman must be de-infibulated before childbirth to allow the passage of the baby. After giving birth she is then reinfibulated.
It has already been underlined in the previous section that husbands may choose to

have their wives re-infibulated if they are to be absent over a certain period of time and especially as they may have several wives, this is done with the intent of keeping the wives faithful.

More recently, and in particular in urban areas, the age at which excision and infibulation are performed has been reduced and many of the traditional initiation ceremonies surrounding the operations have been simplified or even abandoned. It appears that parents believe that by performing the mutilations on ever younger girls they are less likely to suffer and to remember the pain they underwent. Also they fear that if they wait too long, their girls might refuse to undergo the procedure and run away. A third reason why families are mutilating their girls at younger ages is to avoid conflict with the law. Families seeking to live abroad have been known to mutilate girls at a younger age in order to overcome legislative measures against FGM in the foreign country. Thus, in most cases the mutilation now takes place when the girl is about three to eight years of age.

6)Who performs female genital mutilation and where is it performed?

FGM is performed almost entirely by women, generally village traditional birth attendants or by elderly women of the village who have been designated for the task. In the village environment women who perform the operation are greatly respected and they hold a position of authority within their community. They are paid for their services and they sometimes go from village to village to perform the mutilation.
Male operators are much less likely to be called upon however, in urban areas in Nigeria, Ghana and Egypt, barbers have been known to carry out the mutilations.

Among more affluent urban societies the operation is usually carried out by health personnel and only on health service premises. (Many are now pushing that this become the rule for all women who undergo the procedure.)
A clitoridectomy is usually performed on the ground or sitting on a low stool or a rock with the girls' legs spread apart.
Excision and infibulation are usually performed on the ground under a special tree, in designated woods, inside huts or in the backyards of houses. Sometimes the mutilation is furtively performed at dawn.

A survey[21] conducted in Cairo in 1985 indicated that:

- 79.3% of cases of FGM procedures took place in the girl's home,
  13.5% of operations were performed in a clinic,
  4.1% of cases of FGM took place in street booths (where a public
- declaration of the daughter's circumcision is desired by the family)
  3% of operations were in hospitals.

Persons performing the operation were in:

- 60.9% of cases midwives,
- 22.9% of cases physicians,
- and in 16.2% of cases barbers.

a)The instruments used to perform FGM

In the African villages, the instruments traditionally used to perform FGM include kitchen knives, razor blades, glass and sharp stones. Instruments are not usually sterilised and wounds are dabbed with a range of treatments including alcohol, lemon juice, ash, herb mixtures or cow dung.
Effective anaesthetics are rarely, if ever, available in these conditions.
When FGM is performed in a health clinic or a public hospital, scalpels are normally used and an anaesthetic is more likely to be used.

The procedure lasts between 15-20 minutes, depending on the ability of the person performing the operation and the degree of resistance put up by the child.

7)The effects of FGM (physical, psychological and sexual)

The highest maternal and infant mortality rates in the world are documented in the regions of Africa where FGMs are widely practiced. However deaths in childbirth of both the mother and the child are never related to the operation.

Because of the harsh conditions in which the mutilation usually takes place and the use of unsterilised tools to perform the operation, most women who have undergone FGM experience some form of FGM-related health complication.
Infibulated women are especially vulnerable and they are most likely to suffer health complications requiring medical attention at some stage during their lives.
A comprehensive list of the most common health problems was issued by Dr. Olayinka Koso-Thomas, the President of the Inter-African Committee's (IAC) National Committee for Sierra Leone. The dangers of these mutilations to a woman's health are made very clear by reading this list.[22]
Other sources have been used to identify additional FGM-related health problems.

Immediate problems:
Shock due to severe pain and blood loss, fever, haemorrhage, acute urinary retention, urinary infection, infections of the wound and tetanus which is fatal, septicaemia (blood poisoning), fractured clavicle, femur or humerus, trauma to adjacent tissues- the rectum and the urethra, and death. HIV and hepatitis B can be transmitted through the use of unsterile instruments, especially when FGM is carried out simultaneously on groups of girls.
Death due to FGM is one of the many factors contributing to the high infant mortality

rates in these countries. For example, Somalia which has one of the highest rates of circumcised women in the world, has the world's forth highest infant mortality rate. Many young girls bleed to death because of careless or clumsy errors by operators who cut into the pudendal artery or the dorsal artery of the clitoris. Other girls die of post-operative shock because of ignorance about how to revive the girls or the distance to the local hospital or clinic. The majority of mutilations still happen in rural areas where deaths due to FGM are rarely reported. Nevertheless, hospital staff in all the areas concerned are very familiar with urgent and often hopeless attempts to stop the bleeding of little girls'. Rosemary Mburu, a Kenyan gynaecologist has estimated that 15% of all circumcised females die of bleeding of infections.[23]
Other reports estimate that for every 1000 mutilated females, 70 loose their lives from it.[24]

Intermediate problems:
Pelvic infection, delay in wound healing, cysts and abscesses at the site where the clitoris is removed, keloid scar formation on the vulval wound can become enlarged and obstruct walking, dyspareunia (painful intercourse) and dysmenorrhoea(painful menstruation).
Severe infections can lead to incontinence. Sometimes the hole left after infibulation is too small and prevents the flow of menstrual blood which collects in the abdomen. There have been instances where girls have been killed to preserve their family's honour when the swelling of their bellies and the absence of menstruation have been wrongly interpreted as pregnancy.[25]

In a study in the Sudan in 1983 it was found that nearly all infibulated women reported agonising periods, in which the menstrual flow was all but totally blocked. This resulted in the build up of clotted tissue requiring surgical intervention.

Late complications:
Haematocolpos (accumulation of menstrual blood of many months),
A doctor in Djibouti describes how a 16 year old girl was brought to hospital with unbearable abdominal pains. She had not menstruated for several months, and had not had intercourse, but her abdomen was swollen. She was infibulated, with a minuscule opening. The doctor performed a de-infibulation and released 3.4 litres of blackish foul smelling blood.[26]
Infertility, recurrent urinary tract infection caused by difficulty in urinating (the average time it takes an infibulated women to urinate is 10-15 minutes), kidney stone formation, clitoral neuroma (development of a tumour on the clitoral nerve), anal incontinence and fissure.

Consummation problems:
Difficulty in penile penetration, and false vagina (failure of the circumcision scar to dilate).

Delivery problems:
Prolonged and obstructed labour as the vulva has lost it's elasticity, haemorrage,

perineal laceration, unnecessary caesarian sections and still birth.
Difficulties in childbirth for infibulated women occur quite frequently and can be serious due to scarring and hardened tissue blocking the passage at birth. Due to the hardened scars from the mutilations, women often cannot dilate and give birth normally. Without trained help they die or the vagina ruptures resulting in incontinence. Delayed births are also common and there can be brain damage and death of the baby because of a lack of oxygen. Often the lives of the baby and of the mother are threatened because the opening is too small.

Postnatal complications:
Fistulas (urinary and rectal), prolapse, rectocele and cystocele (displacement of the anterior wall of the rectum and the posterior wall of the urinary bladder into the vagina).

The problems of FGM which can affect fertility are readily identified in the above list. They may in some cases give rise to infertility. These problems are grouped under the following types of infertility:

Female circumcision problems causing primary infertility (the inability to become pregnant for the first time).
Keloid scar and haematocolpos: These cause obstruction of the vaginal orifice and prevent penile penetration. As a result conception cannot take place.
Dyspareunia and clitoral neuroma: These cause severe pain and hypersensitivity to the extent that the adolescent sufferer puts up stiff resistance to any sexual intercourse. Often none can take place and therefore pregnancy is impossible.

Chronic pelvis infection/frozen pelvis: This arises from the use, under some conditions, of unsterilized equipment and wound dressings. As a result multiple adhesions are formed around the internal reproductive organs (uterus, ovaries and fallopian tubes), blocking the fallopian tubes. Under such conditions, spermatozoa deposited in the vagina cannot enter the fallopian tubes to fertilize the eggs released from the ovary.

Female circumcision causing secondary infertility (inability to have a second or subsequent pregnancy).

Cysts and abscesses: These are brought about by damage to the Bartholin's duct, which secrets mucus to lubricate the vulva area. The secretion from the damaged duct accumulates in the vulva and forms cysts, which when infected become abscesses. These are very painful and uncomfortable and can, if left untreated, develop into chronic vulva infection and prevent sexual intercourse from taking place.

Fistulas: This is a hole which develops between the bladder and the vagina or between the rectum and the vagina. This occurs when the circumcision scar fails to yield during delivery. Constantly there is a constant pressure of the baby's head on the posterior wall of the bladder and this causes necrosis of the vagina and bladder walls, leaving

a hole between them. Sufferers from this condition smell of urine all the time, and the stench of it often keeps away prospective male partners. In the unlikely event of conception ever taking place, urine usually sips through the cervical os and poisons the growing foetus. Repeated miscarriages always result.

Sexual problems:

Some women who have undergone genital mutilation refuse to admit that their sexuality has been affected whereas others claim that it has. Factors such as the degree of mutilation, cultural and social expectations, affection and bonding in relationships all affect the extent to which a woman's sexuality is affected. In Egypt in 1985, Badawi examined the effects of FGM upon sexual stimulation by comparing a subset of genitally mutilated women with non-mutilated women. He compared 133 genitally mutilated women with 26 non-mutilated women. These women were compared with respect to sexual excitement in response to stimulation of the clitoris/clitoral area. Badawi found that eight times as many non-mutilated experience sexual excitement from stimulation of the clitoris/clitoral area than did the mutilated women. Manual stimulation of the clitoris/clitoral area resulted in the experience of orgasm in 50% of the non-mutilated women and in 25% of the genitally mutilated women.[27]
According to a Dr. Bakr "excision and infibulation results in destruction of the nerve supply of the vulva" and touch organs are removed by the operation, because of this it is impossible for a mutilated woman to feel sexual arousal during intercourse.[28]

8)Link between FGM and AIDS

FGM contributes to the spread of AIDS which is rampant in some African countries. In no other continent are so many women infected. According to the WHO, in 1990 there were 6.5 million people infected throughout the world. Of these, 2 million were women whereof 1.5 million in Africa.[29]
The fact that FGM contributes to the transfer of the HIV virus is hardly surprising when one considers the bloodiness of the operation and the fact that young girls are mutilated simultaneously with the use of a single instrument and in the absence of facilities for sterilization of these instruments.
The story of a 14 year old virgin who was diagnosed as HIV positive describes the fate of many mutilated women. This young girl of the Yao tribe in the Southern end of Malawi had contracted the HIV virus during the mutilation. Blame was laid on the fact that during tribal circumcision the same razor would be used on any number of children at the same time. The solution the chief offered to take up- that in future each child was to bring their own razor.[30]

Furthermore, if the operator is AIDS infected or is an AIDS carrier and she happens to injure her hands or fingers while performing the operation, she is likely to transmit the virus to an uninfected initiate while applying herbal dressing to the initiate's raw wounds.

The dangerous connection between FGM/HIV persists after the actual procedure has been carried out. In situations where a mutilated female has sexual contact for the first time, there are usually tears in the vulva area. Blood flows naturally from this tear, and this constitutes an added risk for either person to contract the AIDS virus.[31]

Similarly, Infibulation and subsequently de-infibulation both cause terrible damage to the female sexual organs and both procedures may lead to contraction of the HIV virus. Also, in many cases where infibulation prevents vaginal intercourse, partners are more likely to resort to anal intercourse as an alternative. Here the resulting damage to tissue is also a quick route to infection by HIV.

II9)Strategies for the eradication of FGM.

In April 1994 the Director-General to the World Health Organisation (WHO) declared at the Global Commission on Women's Health, "It must be our responsibility to present the changes proposed in such a way that they can make sense to the people themselves and fit in with their own social, cultural and economic environments..."(Statement of the Director-General to the World Health Organisation's Global Commission on Women's Health, 12th April 1994)

He also claimed that "what we must aim for is to convince people, including women, that they can give up a specific practice without giving up meaningful aspects of their own cultures". He emphasised that many people in the societies concerned fail to see the link between genital mutilation suffered by a woman in her childhood and the pain, infections and health accidents she may suffer in her later years. For this reason the Director-General of the WHO urged that this link be clearly explained and that information be provided in simple terms to the different societies which subscribe to the practice of female genital mutilation. An explanation of how and why the ritual practice does not prevent but, in it's most severe forms, may in fact increase the risk of infertility was an example used by the speaker to the commission on women's health.

Others have also warned that treating the eradication of FGM as an isolated activity is futile and that it is necessary to integrate the prevention of FGM into other programs such as those dealing with family planning, health and safe motherhood. Hosken is keen to make this clear and her idea which is to "replace a damaging tradition such as FGM with a progressive activity such as family planning (since both are concerned with reproduction)" is particularly interesting, especially in the African continent where population growth is, in general, too high.

a)Instruments to eradicate FGM

ai)The Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children .

In 1984 in Dakar, the foundation of the *Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children*, was a crucial moment for women in Africa to speak against traditions that violate their integrity. The IAC now has affiliates in most African countries where FGM is practiced as well as in Egypt. It is an essential structure for the battle against FGM and a structure which recognises that working towards the eradication of the mutilations must begin on the grass-roots level

In April 1987, an IAC regional seminar held in Addis Ababa in collaboration with the WHO, the Organisation of African Unity (OAU), the Economic Commission for Africa (ECA) and UNICEF, adopted a Plan of Action calling for the eradication of female circumcision and other harmful traditional practices (HTPs) by the year 2000.[32] The main proposals issued during the 1987 IAC regional seminar were to set up:

- special training and information campaigns,
- training or orientation of traditional birth attendants and other practitioners,
- national IAC committees and support zonal meetings,
- (preparation and distribution of reports on seminars and workshops, as well as of educational and information materials,
- support of research activities, advocacy, evaluation of programmes, fundraising.)

Training and information campaigns (TIC):

The programme provides training courses for opinion leaders who generally come from different regions of a given country. They receive training on information, education and communication methods in relation to traditional practices and they are subsequently expected to disperse the knowledge they have acquired to their community and to raise awareness of the dangers surrounding the practices. In this way the participants become trainers for their communities.

IAC has initiated and implemented these courses in a number of African countries: Benin, Burkina Faso, Djibouti, Egypt, Ethiopia, Gambia, Ghana, Guinea, Liberia, Mali, Nigeria, Sudan and Togo.

Training and orientation of Traditional Birth Attendants (TBA) and other practitioners

Because of the position of influence and respect which they hold within their communities, as well as their active role in preserving and performing the mutilations, Traditional Birth Attendants (TBAs) are often selected as participants and opinion leaders in the training and information campaigns mentioned above. Not only is it essential to sensitize TBAs about the dangers of FGM but it is equally important to train them in order to update their skills, knowledge and practices.

The IAC is also concerned with providing former operators with training courses for other ways to earn their living. This is essential in order to persuade them to stop doing the mutilations which otherwise provide them with a good income.

National committees in Djibouti, Ethiopia, Gambia, Ghana, Liberia, Mali, Nigeria, Senegal and Togo have implemented the training programme for TBAs.

Setting up national IAC committees and Zonal meetings

The role of the different national committees is to ensure that programmes are well

implemented and that they reach all levels of the community.
National committees are expected to plan activities for at least one year and to have their constitution recognized by their respective governments. By 1990 national committes could be found in Burkina Faso, Chad, Guinea, Niger, Tanzania and Uganda.

At the time of the adoption of the IAC Plan of Action in 1987, countries were regrouped into five zones with one country in each zone acting as coordinator. This zonal structure was set up so as to ensure coordination/exchange of information and experiences among countries of similar cultural settings. According to the plan, zonal meetings should take place twice a year.

The zones were designed as follows:

Zone 1: Egypt, Ethiopia, Somalia, Sudan,
coordinating country: Sudan

Zone 2: Kenya, Lesotho, Rwanda, Tanzania, Uganda, Zambia, Zimbabwe
coordinating country: Kenya

Zone 3: Gambia, Ghana, Liberia, Nigeria, Sierra Leone,
coordinating country: Ghana

Zone 4: Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Senegal
coordinating country: Senegal

Zone 5: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Togo, Djibouti (transferred from zone 1)
coordinating country: Togo

aii)Foundation for Women's Health Research and Development (FORWARD)

FORWARD was founded following the enactment of the *Prohibition of Female Circumcision Law* in 1985 (see Legislation in Immigrant Countries). The organisation, headed by a Ghanian woman by the name of Stella Efua Graham-Dorkenoo, works exclusively with African immigrants living in the United Kingdom.
The organisation's objectives are to provide "advisory services to African women, conduct workshops and provide speakers, conduct research and inform the caring professions about the special needs of African women and their families and pioneer health-care strategies".[33]
Since it's creation, FORWARD has developed several activities and initiatives involving African immigrants living in the UK. Among these activities are health education and training programs, both for African immigrant families as well as British government social service and health workers teaching and serving the African

community in the UK. A manual for educators and group facilitators was published by FORWARD to introduce new ways to discuss FGM by social workers and other community professionals. Community meetings, discussions, plays, and celebrations have also been organised over the years to attract Africans to the center. A particularly interesting way of demonstrating to the African community in the UK about FGM-related concerns is to stage plays with the participation of community members themselves.

aiii)Groupe Femmes Pour L'abolition des Mutilations Sexuelles (G.A.M.S)

G.A.M.S. is a private French women's Group for Abolishment of Sexual Mutilations which was organised in 1982, after the reported deaths of daughters of African immigrants due to excision. Headed by Dr. Marie Hélène Franjou, G.A.M.S. affiliated in 1990 with the IAC and has set up several clinics in the Paris region where many immigrants from the Former African colonies have settled. French health services require every mother who gives birth in Africa or who has small children to come regularly for checkups.
G.A.M.S. works with immigrant women by providing education about the damage done by FGM. It is interesting that G.A.M.S. initiates contact with, and then proceeds to educate, African immigrants in France about FGM-related health problems Health professionals teach about reproduction, about the human body, about sexuality, pregnancy and other related matters.[34]

aiv)WHO Activities

Dr. Mark A. Belsey, WHO Programme manager for the *Maternal/Child Health and Family Planning Division of Family Health*, reported in 1993 that by the next 20 years the practice of FGM could not be totally eradicated but that, by this time, it should no longer be on the increase.

The WHO has issued a number of principles for the eradication of FGM.[35]

- **Reconciling strategies to the distinctive features of each culture**: listening to and respecting the community's own perceptions on FGM before introducing sensitization and information campaigns can form the basis for collaboration and change.

- **Integrating strategies with other health and development efforts**: the linking of FGM with broader efforts to improve women's status and health such as reproductive and family health, family planning, adolescent health, safe motherhood and child health may have wider appeal. The role of education and the replacement of negative practices with progressive ones is also important.

- **Forming alliances between modern and traditional leaders**: dialogue and collaborative activities between modern and tradional healers will create the basis for understanding of healthy values and practices to promote in unison.

- **Exercising discretion and tact in referring to deeply held beliefs**:

- **Seeking solutions from within countries complemented by international solidarity**: although it is generally accepted that the process of eliminating FGM must be undertaken by women themselves, their activities benefit greatly from international technical support, advocacy and finance.

The World Health Organisation's framework for action:[36]

i)Adopt clear national policies for the abolition of FGM, as a real risk to the reproductive and psychosocial health and well-being of girls and women.

ii)Establish national coalitions involving government representatives, professionals and NGOs to coordinate and follow up the activities of bodies concerned with discouraging FGM including, where appropriate, the enactment of legislation prohibiting it.

iii)Support and encourage NGOs, women's groups, education and pressure groups. An initial group can act as a catalyst to start open discussion of FGM where formerly it was a taboo subject. Advocacy on the part of such organisations can generate support from national policy makers.

iv)Organize information and education programmes to inform people of the harmful affects of FGM. Mass media, popular music and crafts, as well as teaching groups, have been successfully used to target young women and men, health workers, teachers and community elders. Include health workers, traditional healers and birth attendants who practice FGM, otherwise efforts to reduce it will be undermined by indifference or even opposition.

v)Emphasize the importance of sustainability of programmes and focus on integrated campaigns using consistent messages.

vi)Target young people, using information and education campaigns holding unmutilated women in high esteem and resisting pressures to surrender their children to FGM. Young people are often in the vanguard in creating new social norms but, at the same time, sensitivity is needed to the confusion and ambiguity of young women who have already undergone FGM.

vii)Identify alternative income sources for practitioners of FGM for whom it provides a livelihood.

viii)Involve local and religious leaders. Experience shows that where the local leadership is enlightened and committed, information and education activities are more successful. The involvement of religious leaders is vital for dispelling misconceptions about the religious origin of FGM.

ix)Enlist the participation of men so that as women's attitudes begin to change they find support among brothers, fathers, friends and partners.

x)Prohibit the practice of FGM by health professionals in any setting, including hospitals or other health establishments.

xi)Increase research into all aspects of FGM, including the incidence, prevalence, main reasons why FGM continues to be practiced in particular groups, health consequences and successful interventions for eliminating it.

xii)Inform traditional and professional health workers of the health complications caused by FGM, including how to treat women before and after childbirth. Include counselling so that those who have experienced FGM have the opportunity to express fears and concerns about their health and sexuality.

xiii)Incorporate FGM treatment and counselling into major health programmes for women and children such as family planning, immunization and control of diarrhoeal diseases.

xiv)Recognise and encourage alternative puberty rites, which involve gift-giving and celebration and promote positive traditional values, without causing physical damage to the child.

av)Chronology of United Nations action against FGM.[37]

- 1952 UN Commission on Human Rights raises issue for first time.

- 1961 The Economic and Social Council requests World Health Organisation to examine the medical aspects of operations based on customs to which many women were still being subjected.

- 1979 WHO Regional Office for Eastern Mediterranean holds seminar on the subject of Traditional Practices affecting the health of women and children, in Khartoum, in collaboration with WHO regional Office for Africa. The Khartoum seminar takes a major and unprecedented step in formulating recommendations for Governments to eradicate female circumcision, including setting up national commissions for co-ordination of activities and intensification of education.

1980 The World Conference on the UN Decade for Women in Copenhagen appeals to African Governments and Women's Organisations to seek solutions to the problem of female circumcision and infibulation.

1982 WHO makes a formal statement of its position regarding FGM to the UN Human Rights Commission. It expresses unequivocal opposition to medicalization of the practice in any setting, and strongly advises health workers not to perform female circumcision under any conditions.

- 1984 Creation in Dakar of an Inter-African Committee (IAC) on Traditional Practices.
- **1990 WHO co-sponsored IAC Regional Conference in Addis Ababa proposes change in terminology from "female Circumcision" to "Female Genital Mutilation".**

1992 WHO position opposing medicalization of any form of FGM was reaffirmed during the Netherlands Consultancy for Maternal Health and Family Planning Congress on female Circumcision.

- 1994 93rd session of WHO Executive Board adopts resolution on traditional practices harmful to the health of women and children.

b)International Condemnation of FGM

Various United Nations bodies have submitted recommendations about the best way to fight FGM.

In the final *Declaration on the Elimination of Violence Against Women,* adopted by the UN General Assembly Resolution 48/104 in December 1993, FGM is regarded as a form of violence against women and is recognised as a human rights violation.
Article 2 of this declaration explicitly states "Violence against women shall be understood to encompass...(a) Physical, sexual and psychological violence occurring in the family, including... female genital mutilation and other traditional practices harmful to women..."[38]

The United Nations *Committee on the Elimination of All Forms of Discrimination Against Women* (CEDAW), has "adopted" General Recommendation No.14, Female Circumcision. In this 1990 recommendation, the Committee is: [n]oting with grave concern that there are continuing cultural, traditional and economic pressures which help to perpetuate harmful practices, such as female circumcision....[39]

The *United Nations High Commissioner for Refugees* (UNHCR) Executive Committee Conclusion 73 (1993) on Refugee Protection and Sexual Violence, [s]upports the recognition as refugees those whose claim to refugee status is based on a well-founded fear of persecution, through sexual violence, for reasons of race, religion, nationality, membership of a particular social group or political opinion.[40]

In a series of recommendations issued by the *United Nations Population Fund* (UNFPA), and included in the 1994 *Report of the Round Table on Women's Perspectives on Family Planning, Reproductive Health and Reproductive Rights,* reproductive rights are defined as human rights: 1) Governments, the international community and non-governmental organizations should work towards implementing fully the Convention on the Elimination of All Forms of Discrimination Against Women and other human rights conventions that guarantee women their rights, particularly those that relate to sexual and reproductive health....

The issue of "Genital mutilation" is directly addressed in this recommendation:

8) Genital Mutilation is a major lifelong risk to women's reproductive health and a violation of the rights of girls and women. Governments should vigorously act to stop that practice and to protect the right of women and girls to be free from such unnecessary and dangerous procedures.[41]

The imposition of FGM may infringe on human rights protected under the following international legal instruments:

CEDAW 1979 is the most comprehensive piece of international human rights legislation for women. It addresses "...the right of half of humanity to protection from oppressive practices embedded in laws and customs..." and article 5 of CEDAW officially acknowledges that "culture" cannot continue to be used as a justification for human rights violations against women.

The 1990 *United Nations Convention on the Rights of the Child recognises that FGM* violates the rights of the child as well as those of adult women. Article 24 (3) of this convention states that: State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.[42]

In May 1993, the WHO adopted a resolution on *Maternal Child Health and Family Planning for Health*, drafted by Guinea, Kenya, Nigeria, Togo and Zambia, which urged all Member States to: 1) Continue to moniter the effectiveness of their efforts to achieve the goals and targets of the Strategy for Health for All, the World Summit for Children and the International Conference on Nutrition, with particular reference to eliminating harmful traditional practices which "...restrict the attainment of the goals of health, development and human rights for all members of society".[43]

The *African Charter on the Rights and Welfare of the Child* provides protection against harmful social and cultural practices. Article 21 declares 1) States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:
a)those customs and practices prejudicial to the health or life of the child; and
b) those customs and practices discriminatory to the child on the grounds of sex or other status.[44]

c)Country Laws to prevent FGM.

Until the present, only a few African countries have officially condemned FGM and still fewer have enacted formal legislation against the practice. Official declarations against the practice have been made by the Presidents of Benin, Gambia, Burkina Faso, and Senegal. A form of legislation against the mutilation exists in the Sudan, Egypt, Somalia and Kenya. However in these countries which traditionally subscribe to the practice of FGM, tradition still triumphs over legislation. The latter has hence not yet been effective in eliminating or reducing FGM.

In Kenya in 1982, President Moi condemned FGM and called for the prosecution of those who practiced it. Legislation providing for the arrest of a traditional practitioner who performs the mutilation was finally passed in 1990. In the Sudan, the Ministry of Health launched a campaign against FGM in 1946 and succeeded in getting a law passed which prohibits infibulation but allows for sunna. Burkina Faso has incorporated into it's draft constitution a prohibition on FGM. In 1991 the Cote D'Ivoire informed the United Nations that existing provisions of the nation's criminal code could be used to prohibit the practice. The position of Egypt is not entirely clear; by permitting a partial clitoridectomy there is overall confusion as to what can and cannot be performed. Finally, in Somalia legislation remains in the form of a proposed bill to eradicate FGM.[45]

ci)Legislation in Immigrant Countries

When enacting legislation against FGM in immigrant countries, one is dealing with an especially difficult issue. FGM "abroad" is practiced by a minority group and marginalized community, consisting of largely immigrants and refugees who view it as a cultural norm and firmly hang on the practice. Alas, in addition to all the FGM-related dangers and disadvantages which have been reviewed here, mutilated girls living abroad are also subject to other pressures. They are likely to feel vulnerable, excluded and different from their peers and they may in fact be socially ostracized at school. There is again a bigger problem which surfaces as family planning clinics in the West are not always well prepared to deal with the specific needs of mutilated women.

Legislation prohibiting the practice has been passed in a number of countries with an immigrant population who subscribe to the tradition. In several of these countries, it has been designated as child abuse.

In Sweden, a law was passed in 1982 prohibiting FGM, whether consent has been given or not. Up to ten years may be served in prison if the law is violated.

In The United Kingdom the *Prohibition of Female Circumcision Act* was passed in 1985. This Act made the operations illegal in all cases except for where there were physical or mental reasons for them that could not be linked to custom. Anyone guilty of performing the operation is liable to five years in prison. Anyone who is known to aid, abet or counsel a person towards the operation is also considered guilty of breaking the law. The 1985 Act is supplemented by the *Children Act* of 1989 which provides for the investigation of suspected violations of the female genital mutilation prohibition and enables the removal of the child from her home

where this is deemed the only way her protection can be guaranteed. The children Act also empowers the courts to prohibit parents from removing their children from the country to have the operation done elsewhere.

France does not have specific legislation on FGM, but is actionable as a mutilation under Article 312 of the Penal Code which punishes violence against children. Under this article, a penalty of 10-20 years imprisonment is imposed if the act of violence "results in a mutilation, amputation of a limb...or other parts of the body or has unintentionally caused the death of the child". If the mutilation is carried out by a parent or guardian, life imprisonment is imposed.

The Medical Ethics Code 1979 forbids the practice of FGM except where medically required.

France was the first country in the western world to bring criminal charges for FGM and to give jail sentences, to both parents and excisors Here in 1993, a Gambian women was convicted for having her two baby girls excised in Paris. Of the five years' sentence, four were suspended but she has had to serve one year. In a letter addressed to the French Ministry of Health, Social Affairs and Integration, expressing alarm and concern about the conviction, the IAC launched an appeal to handle the case with compassion so that it will be of benefit to the immigrants who come from countries where genital mutilation is practiced. Their children need protection and arresting the mother of eight children risks being more harmful for the family. The letter stated that "this kind of situation will come up again and again unless a policy is adopted to inform all immigrants that this practice is intolerable and illegal, and also why"[46].

Canada Here the *Criminal Code and the Young Offenders Act* outlaw the practice of FGM. In 1993 Canada amended the Criminal Code and Young Offenders Act. The new Bill C-126, contains a clause designed to extend domestic protection to children who are normally resident in Canada, from their removal from Canada with the intention of committing assault causing bodily harm, aggravated assault or any sexual offense.

The College of Physicians and Surgeons of Ontario has declared that any doctor performing FGM would be guilty of professional misconduct.

In March 1993, the Chairperson of the *Canadian Immigration and Refugee Board* issued ground-breaking guidelines for Women Refugee Claimants Fearing Gender-Related Persecution. The Canadian board proclaimed that women's demands for asylum or refugee status in Canada were well founded if they feared "persecution as the consequence for failing to conform to, or for transgressing, certain gender-discriminating religious or customary laws and practices in their country of origin".[47]
In July 1994, legislation was passed guaranteeing asylum to women and their daughters if the mother feared that if they returned home, their daughters would be forced to undergo excision.

Europe. The Council of Europe has not specifically addressed the question of FGM. However, a London based organisation known as FORWARD (Foundation for Women's Health, Research and Development), which is involved with a variety of activities including programs, education and training activities for African immigrants to the UK, has also urged the

European Community to examine the problem. In 1992 FORWARD organised the first European Study Conference with participants from France, the Netherlands and Italy as well as from the US and Canada. A declaration was formulated that firmly rejects all forms of FGM or injury of female genital organs and outlines a "unified approach for the abolition of the practice in Europe and other Western countries".[48]
European nations, including Belgium, the Netherlands, Norway, Sweden (one of the first countries to specifically condemn FGM), Switzerland and the United Kingdom, have already passed legislation against FGM.(see Legislation in immigrant countries) As with the countries whose legislation was reviewed above, in most of these countries it has also been designated as child abuse.[49]

The Australian Government recently issued a discussion paper on the issue of FGM which was subsequently passed on to the Family Law Council for review in 1994. In collaboration with the Australian Education Union (AEU), the Family Law Council submitted a series of recommendations on how to combat the practice of FGM and how to protect girls from the practice being performed within the country and whilst the child is abroad. The recommendations urge that legislation outlawing the practice should be passed as quickly as possible. The Australian Family Law Council has recommended legislation similar to that which exists in the UK or in Canada as a means to protecting children from being taken abroad for the purpose of mutilation.

In Australia laws dealing with offenses against the person falls within the competence of the States and Territory Governments. The different States Governments claim that FGM is adequately covered in their criminal codes.

There are two conceivable channels for enacting formal legislation against FGM in Australia. The first one of these consists of amending the different State and territory laws. This option would involve amendments to the eight criminal codes and the various State/Territory child protection statutes. The second channel would require that the Commonwealth pass legislation under it's external affairs power to meet Australia's international obligations especially under Article 24(3) of the Convention on the Rights of the Child but also under the CEDAW instrument. [50]

cii)FGM in the Netherlands

Sponsored by the Consultancy for Maternal Health and Family Planning, a Symposium on Female Genital Mutilation was organised in Leiden in October 1992. Here health workers expressed their concern that FGM was on the uprise among the immigrant groups in the country and that gynaecologists, nurses and midwives were not well prepared to treat infibulated women.
A survey sponsored by the Refugee Health Care Centre (CGV) did indeed reveal that physicians were receiving Somali immigrants with requests for infibulation, defibulation or reinfibulation. This marked the beginning of a conflict between those who authorised the medicalization of FGM, and those who remained firmly against the operations being carried out under any circumstances. Those who insisted on a total eradication of the practice

organised protests and campaigns to express their disapproval of the view promoting the medicalization of FGM. At the opening of the Symposium, 60,000 signatures opposing the medicalization of the practice were presented to the Minister of Health.

The IAC also expressed its opposition by sending letters to the relevant authorities in the Netherlands. and the IAC's President, Mrs. Berhane Ras-work, spoke about the progess made in the anti-FGM campaign and stated that a policy of medicalization in the Netherlands would seriously hamper all the efforts which had been made so far .
A representative from the WHO, stating the position of the organisation towards the subject of FGM, underlined the prohibition of the practice and that medical personnel were forbidden to perform FGM. She therefore urged the Government of the Netherlands to refrain from legalizing the practice. The Ministry for Development Cooperation subsequently published a position stating that "The Minister for Development Cooperation subscribes to the view that the circumcision of women and young girls is unacceptable in any country and should be eradicated". [51]

Traditional Practices Affecting the Health of Women and Children - Female Genital Mutilation.

I1)Descriptions of the practice of Female Genital Mutilation

2)Female circumcision or Female Genital Mutilation?

a)What is Female Genital Mutilation?

3)The Origins of Female Genital Mutilation

a)The Geographical Distribution of FGM at present

4)Reasons given for practicing FGM

a)The objective of infibulation

5)When is FGM carried out?

6)Who performs FGM and where is it performed?

a)Instruments used to perform FGM

7)The effects of FGM (physical, psychological and sexual)

8)Link between FGM and AIDS

II9)Strategies for the eradication of FGM.

a)Instruments to eradicate FGM

ai)The Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children .

aii)Foundation for Women's Health Research and Development (FORWARD)

aiii)Groupe Femmes Pour L'abolition des Mutilations Sexuelles (G.A.M.S)

aiv)WHO Activities

The World Health Organisation's framework for action:

av)Chronology of United Nations action against FGM.

b)International Condemnation of FGM

c)Country Laws to prevent FGM.

ci)Legislation in Immigrant Countries

cii)FGM in the Netherlands

In Senegal, an IAC programme was realized in collaboration with the National Red Cross in a modified version. The trainees were midwives and heads of the Red Cross's medico-social centres all over the country.

a) Activity report from the Senegalese Red Cross

During the sensitization and information campaign organised jointly by the Senegalese Red Cross and the IAC, national television, radio and newspapers became important sources of information and disseminators of information. The Senegalese Red Cross estimates that within the first five months of the campaign, 5.200 persons had already been sensitized in the regions where FGM is most prevalent. However because of insufficent means of transport and the distances between the different places to be supervised, coordination between the programmes was said to be difficult. Field operations were for this reason also useful and they included the:

-creation of committees at regional and departmental levels as well as the creation of mothers' committees on the district level,
-organisation of discussions on issues such as female circumcision and childhood marriage in all medico-social centres of the Senegalese Red Cross,
-introduction into the curricula of training schools of a strategy to combat practices harmful to the health of the mother and the child.

In a study which begun in 1985 on 6000 Senegalese women, the Senegalese association for family welfare (ASBEF) calculated the percentages of excised /non excised women belonging to different ethnic groups. The study revealed that the ethnic groups which practiced excision on the largest scale were the Sarakolé(77.58% of the women were excised), the Bambara (74.78%), the Toucouleurs (68.54%), the Socé (57.14), and the Peulh (50.33%).
The percentages of excised women belonging to other ethnic groups and who were examined were significantly smaller. Of wolof women only a very small percentage of women were excised (1.11%), and Serere women (4.73%).
These figures are still more meaningful when compared with an ethnic breakdown of the Senegalese population which shows that the largest ethnic groups are the ones where excision is the least practiced. The wolofs represent 43.7% of the Senegalese population, the Sereres 14.8% and the Peulhs and Toucouleurs 23.2%.

In 1988 the IAC and ENDA (Environment and Development of the Third World) undertook a study on nearly 4500 women whose geographical distribution reflected the demographical distribution of the Senegalese population. This study stated that the global rate of FGM in Senegal does not exceed 20%. This figure is however much smaller than what is indicated in other sources of reference.
Three factors appeared to strongly determine the prevalence of FGM. Firstly the ethnic group to which the women belonged influenced whether they were likely to have been circumcised. According to this report the Halpulaar, Mandé, Diolas mandinguisés and Tenda are the ethnic groups most likely to practice FGM.
Religion was cited as the second factor with Muslim women being the most likely to be circumcised and the number of circumcised Catholic women being very low.
Thirdly the women's place of residence was important. Whereas the rates of FGM are low or none in the most densely populated zone of Senegal (west of a line going approximatively from Saint-Louis to Louga, east of Touba, east of Kaolack) and in the zone south and west of Ziguinchor, in three thirds of the surface of the country which is sparsely populated and which covers the whole eastern region, from north to south, the practice of FGM is practically general.

The survey undertaken by the IAC and ENDA found that the mean age at which the practice is carried out is six years, but that there was a great disparity from one ethnic group to another with some groups performing FGM on girls aged less than two years (Toucouleurs, Soninkés) and other groups performing FGM when the girls were eight years old and above (Diolas, Mandés).
Although the team carrying out the study did not find any cases of infibulation the practice of taf (suture through cicatrization) is known to be current. The types of circumcision are generally clitoridectomy (Diolas) or clitoridectomy plus partial nymphectomy (Toucouleurs). Almost all of the procedures were performed by women in a traditional style and setting. Only one operation out of five is carried out in towns. Among some ethnic groups FGM is linked to initiation practices (Diolas, Sokés).

Case histories

Kenya: A 16 year-old bled to death after she was circumcised at Kapsigirio village in Kericho. She was seven months pregnant, and died in hospital while undergoing treatment. [1]

FGM in KENYA

FGM in Canada (JUNE 1992 P.13)

Statement by First Lady of Burkina Faso (p.7 Dec.1991)

**BENIN Some trad. practices in Bariba Country (p.8, Dec.1991)

FGM in Egypt(p.12, Dec.1991)

Mali: A look at the activities of the national IACcommittee (p.9 Oct.89)

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