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Report on the

# INTERCOUNTRY WORKSHOP TO STRENGTHEN NATIONAL CAPACITY TOWARDS EVENTUAL ELIMINATION OF PRACTICES HARMFUL TO WOMEN IN THE WHO EASTERN MEDITERRANEAN REGION

Sharm El Sheikh, Egypt, 6–9 March 2000

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## 1. INTRODUCTION

The intercountry workshop to strengthen national capacity towards eventual elimination of practices harmful to women in the WHO Eastern Mediterranean Region was held in Sharm El Sheikh, Egypt, from 6 to 9 March 2000. The objectives of the workshop were to:

- Assess the extent of activities undertaken toward the elimination of female genital mutilation in the affected countries of the Eastern Mediterranean Region;

- Gain a better understanding of the perceptions and beliefs of communities with regard to FGM and how these affect the activities of health professionals in striving for the elimination of female genital mutilation;

- Identify the feasibility of integrating activities towards the elimination of female genital mutilation with reproductive health/family health programmmes.

Fourteen participants from 5 countries of the Region attended the workshop. In addition, 6 resource persons were invited along with representatives from the United Nations Population Fund (UNFPA), the United Nations Relief and Works Agency for Palestine refugees in the Near East (UNRWA), the Arab World Regional Office of the International Planned Parenthood Federation (IPPF/AWRO), the United States Agency for International Development (USAID), John Snow Incorporation, CARITAS, Coptic Evangelical Organization for Social Services (CEOSS) and WHO/EMRO. The workshop was organized with the financial support of the Department of Women's Health, WHO/HQ.

The workshop was inaugurated by Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean, who welcomed the participants and expressed his gratitude to the Ministry of Health and Population of Egypt for hosting the workshop. Dr Gezairy stated that the traditional practices of a society were closely linked with the living conditions of the people and with their beliefs and priorities. While some traditional practices were beneficial to women, others were harmful in nature. In almost every society of the world the reproductive role of women was associated with traditional taboos and myths, many of which had harmful effects on the lives and health of women.

One traditional practice that had attracted much attention in recent years was female circumcision. Wherever it had come to the attention of people who did not practise it, female circumcision had elicited reactions of horror and condemnation. While this had helped break the silence surrounding the subject, experience showed that their reaction generally blinded outsiders to the complexities of the issue, and might even exacerbate the problem.

Female circumcision, which was rightly called female genital mutilation, was a common practice in some countries of the Region. It entailed the excision of the external genital organs, usually by a midwife or birth attendant at the girl's home or, in some cases, in a special house where a group of girls were sequestered during the initiation period. The immediate problems arising from the procedure were pain, bleeding and infections such as

tetanus, all of which could lead to shock and death. In societies where AIDS was prevalent, the procedure might also spread this dangerous disease.

Long-term complications from female genital mutilation were also common, particularly for women who had undergone one of the worst forms of this practice, infibulation. The blocking up of the urethra or the vaginal opening by scar tissues could lead to discomfort and build-up of urine and menstrual blood. This in turn could cause chronic pelvic and urinary tract infections, which could lead to kidney damage and infertility. Childbirth posed many special dangers for infibulated women as the pressure of the head of the fetus could result in fistulae. Not surprisingly, depression and anxiety were also frequent consequences of this practice.

The practice of female circumcision was not endorsed by any religion. The Qu'ran made it clear that any change in God's creation was an atrocity inspired by the devil, while the Prophet Muhammad ﷺ said "take good care of women". In 1995, the Regional Office confirmed the non-religious nature of the practice through its publication *Islamic ruling on male and female circumcision*, a document prepared by distinguished scholars and scientists. It was agreed that the initiative for abolition of female circumcision must be taken by women themselves from within the societies where it was practised. Such national and local initiatives would receive complete support from the various agencies concerned.

In recent years, Dr Gezairy said, the Regional Office for the Eastern Mediterranean had made efforts to gather information and to generate awareness of the adverse effects of the practice. Earlier, in 1979, the Regional Office organized a seminar in Khartoum, Sudan, on traditional practices affecting the health of women and children. The Khartoum seminar was one of the first interregional and international attempts to exchange information on traditional practices in countries of the Region, and above all female circumcision, and to make specific recommendations on measures to be taken by the health services to prevent and control this harmful practice. Since then numerous seminars, workshops and consultations organized by the Regional Office had drawn the attention of countries to this issue. A joint statement by WHO/UNICEF/UNFPA in 1997 clearly established the collective condemnation of this practice by the three organizations, as well as their unequivocal opposition to any performing of the operation, under any circumstances, by physicians or other health professionals.

Though the pace of change was slow and adherence to the practice remained strong in some societies, it was hoped that the phenomenon would soon disappear from the countries where it was still practised, especially given the increasing commitment of decision-makers, and the increase in health and religious awareness and education among the public in general, and among women in particular.

Dr Gezairy concluded by praising the stand taken by the Ministry of Health and Population of Egypt in fighting against this social disease and working on establishing appropriate legislation to confront it. Dr Gezairy also expressed the hope that the workshop would succeed in determining appropriate strategies for eventual elimination of these practices, in agreeing on measures needed to convey the correct religious teaching to every

father, mother and daughter, and in convincing all of the need for joint efforts to eliminate harmful customs.

Dr Mohamed Kamel, IPPF Regional Director for the Arab World, thanked the Regional Office for the invitation to attend the workshop and stated that IPPF policies towards all practices harmful to women, with particular reference to female genital mutilation (FGM), left no room for misinterpretation. IPPF and its member family planning associations were committed to fighting this extremely harmful practice and were striving for its total eradication. FGM contravened the most basic human rights, namely the rights of women and girls to security, physical and psychological well-being, as well as to the integrity of their bodies. Dr Kamel cited specialists in Islamic jurisprudence whose opinions were that, according to Islamic ruling, FGM was a criminal offence and an act of aggression that deserved punishment. They also emphasized that FGM was equivalent in cruelty to *wa'id* (the act of burying baby girls alive), a practice that used to be performed during pre-Islamic times.

Dr Kamel stated that the IPPF Regional Office for the Arab World had been urging family planning associations in affected countries to incorporate anti-FGM activities into their awareness-raising programmes. He also stressed the importance of directing further focus on adolescents as agents of change in the community.

H.E. Dr Ismail A. Sallam, Minister of Health and Population, Egypt, welcomed the participants to the workshop and expressed his pleasure at the wide representation of concerned decision-makers, programme managers, agencies and organizations in the Region. Dr Sallam indicated that the participation of women in both planning and implementation of women's health related programmes and activities, especially in the local community, was one of the main strategies used by the Ministry of Health and Population for bridging gaps between urban and rural areas, men and women and well-developed and underprivileged communities. Based on this strategy, the Ministry of Health and Population had given special attention to a holistic approach to women's health care and the provision of its related services through all health care facilities, with special emphasis on health education through women's health clubs in local communities. Community participation through nongovernmental organizations was another equally important strategy considered by the Ministry of Health and Population for bridging gaps between the served and the underserved populations.

Women's health clubs throughout the country had been proven to provide unique opportunities for the conduct of information, communication and education activities as well as for discussing classically sensitive issues such as practices harmful to women and hence raise the mass awareness of women and family-related issues among women themselves. Dr Sallam emphasized the participation of community leaders, particularly religious scholars and scientists, as active and experienced advocates for human welfare in the community. Islamic teachings were well known for their principles of advocacy and counselling. He stated that these principles should be studied and then used to enhance measures for advocating women's well-being. Harmful practices were an important and sensitive issue which were dealt with by the Ministry of Health and Population through activities aimed at promoting awareness and improving practices, along with strict legislation against those who performed such practices. Another supportive strategy that had been adopted was to include women's health and

development as an essential element in the socioeconomic development process. Dr Sallam concluded his address by expressing the hope that the participants would be able to suggest practical and effective guidelines that could further enhance national strategies and programmes aimed at promoting women's health in countries of the Region.

Dr Ghada Hafez, Special Adviser, Gender Mainstreaming and Women's Development, described the objectives and mechanics of the workshop. Dr Hafez stated that there was often debate over the basic question of whether a practice was harmful or necessary. Usually, debates relied on simplistic divisions between scientific "Western" and local "traditional" medical values. But this approach did not completely clarify the complicated reasons for defending harmful practices in certain communities. In April 1997, WHO, UNICEF and UNFPA had issued a joint statement that summarized the importance of and the challenges inherent in addressing harmful health practices. One of the most harmful traditional practices known was female genital mutilation (FGM). This practice was the focus of the workshop, which had been organized by the Regional Office in recognition of the urgent need to intervene against practices harmful to women.

Dr Hafez explained that the technical presentations at the first plenary session and the topics for group discussion had been selected to further orient the participants to the scope and prevalence of practices harmful to women, with particular reference to female genital mutilation, and to review measures to overcome this problem while taking into account unique situations in the countries of the Region. The recommendations of the workshop were expected to serve as guidelines to further develop national capacity towards eventual elimination these practices in the Eastern Mediterranean Region.

Dr Moushira El Shafie (Egypt) and Dr Hamid Rushwan (Sudan) were elected as Chairperson and Rapporteur, respectively. The agenda, programme, list of participants and group discussion questions are given in Annexes 1, 2, 3 and 4, respectively.

## 2. TECHNICAL PRESENTATIONS

### 2.1 Overview of practices harmful to women in the Eastern Mediterranean Region

*Dr Ramez Mahaini, Regional Adviser, Women's and Reproductive Health,* WHO/EMRO

Traditional practices in the Region have a long history and wide variation in terms of their implications for health. Some of these practices have proven benefits and should therefore be promoted. Others are either useless or harmful and should obviously be eliminated. Unfortunately, harmful practices in many cases are focused on women and have negative impact on women's physical, mental and social well-being throughout their entire life span. These practices violate the human rights of women and girls to physical and mental integrity, to freedom from discrimination and to the highest attainable standard of health. Examples of harmful practices include restricting food intake among pregnant women because of morning sickness and fear of large fetus; massaging the abdomen during labour to hasten delivery; avoiding bathing and keeping women indoors during the postpartum period; blaming mothers for congenital abnormalities; and smoking, alcohol consumption and drug

abuse. Such practices not only negatively impact the well-being of women themselves, they affect their children and families as well.

One of the most serious harmful practices is female genital mutilation, which involves partial or total removal of the external female genitalia and causes grave damage to girls and women. WHO estimated in 1996 that there were still between 100–132 million girls and women subjected to FGM worldwide, with a further 2 million at risk for this dreadful practice every year. Unfortunately, this evil custom is still practised in some countries in the Eastern Mediterranean Region, with wide variations in terms of its prevalence and severity.

There is a need for a systematic evidence-based approach for eliminating practices harmful to women in the Region. The Regional Office has made concrete efforts to collect information on and stimulate interest in eliminating female genital mutilation since the early 1970s. A seminar was convened in 1979 in Khartoum, Sudan, on traditional practices affecting the health of women and children. The seminar was an unprecedented step in formulating recommendations for governments to eliminate female genital mutilation. Since then, the Regional Office has maintained its close collaboration with countries in support of national measures aimed at protecting girls and women from this and other harmful practices. This has included passing resolution EM/RC35/R.9 in 1988, which urged countries to "improve the condition of women with a view to ensuring the elimination of harmful traditional practices, including female circumcision". Tremendous efforts have been made by the affected countries in collaboration with WHO as well as other United Nations agencies and international and nongovernmental organizations towards eventual eradication of female genital mutilation in the Eastern Mediterranean Region. At the country level, the recent efforts made by the Egyptian Ministry of Health and Population set an excellent example to other countries not only in the Region but also in other areas in the world.

The participants were reminded that over the four days of the workshop, around 24 000 girls in the world would be subjected to female genital mutilation, and that a considerable proportion of these girls lived in countries of the Region. Hence, there was an urgent need to invest in opportunities at the national, regional and global level to put into action country strategies, programmes and activities aimed at eliminating female genital mutilation.

Practical points to be taken into account in the group work session included the following principles:

- While countries have an obligation under the international standards to take legal action against FGM, legislation needs to be accompanied by a broad and inclusive strategy for community based awareness-raising.
- The involvement of health professionals in performing FGM undermines the message that FGM denies women their right to highest attainable standard of health.
- Any action against FGM must take into account the multiplicity of factors that give rise to this practice.
- While the role of international solidarity is to complement and support the work carried out locally, those best placed to set directions are grass roots and community workers.

## 2.2 Health consequences of female genital mutilation: a health provider's perspective

*Dr Hamid Rushwan, Free Lance Counsellor, Khartoum, Sudan*

Female genital mutilation is defined as all procedures that involve partial or total removal of female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

Female genital mutilation is clinically classified as follows:

- **Type I**: involves excision of the prepuce with or without excision of part or all of the clitoris
- **Type II**: involves excision of the clitoris together with partial or total excision of the labia minora
- **Type III**: involves excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
- **Type IV**: an unclassified form which involves other practices such as pricking, piercing or incision of the clitoris and/or labia, stretching of the clitoris and/or labia, or cauterization by burning the clitoris and surrounding tissues.

The immediate complications of female genital mutilation include bleeding, shock, swelling, fever, wound infection/failure to heal, injury to other body parts, difficulty in passing urine, urine retention, bowel dysfunction, nervous troubles and tetanus. The long-term complications include keloid formation, dermoid or inclusion cysts, vulval abscesses, menstrual problems, difficult micturition, urinary tract infection, calculus formation, fistulae and incontinence, chronic pelvic infection, infertility, problems at pregnancy and delivery, surgical complications related to decircumcision and recircumcision and sexual and psychosexual problems.

Previous initiatives aimed at eliminating FGM were usually focused on three areas; raising people's awareness about FGM, appropriate training for reproductive health care providers and advocacy against practices harmful to women.

## 2.3 The role of the family and community in eliminating female genital mutilation: what works

*Dr Tayseer Mandoor, Faculty of Medicine for Girls, Al Azhar University*

The health rights of women are frequently violated in some communities due to certain customs, traditions and misconceptions of religious teachings. These are manifested by practices harmful to women, including female genital mutilation.

Findings of studies and research have indicated that in communities where FGM is prevalent it is often justified on traditional, religious and marital grounds. In these communities it is commonly believed that FGM is a religious obligation and a good tradition and that it protects virginity, avails cleanliness, increases chances of marriage, increases sexual pleasure for the husband, improves fertility and prevents immorality. For instance, 60% of women in Egypt wrongly believe that FGM is a religious practice, compared to only 19%

who know that this practice is against religion. These findings point to the need to focus more attention on the role of the decision-makers in the family and community.

## 2.4 Sociocultural aspects of female genital mutilation with reference to lessons learned

*Dr Magdy Helmy, Member of Female Genital Mutilation Task Force, CARITAS, Egypt*

The experiences of nongovernmental organizations concerned with the elimination of female genital mutilation provide important lessons for future plans and strategies; defining priorities and constant monitoring at different phases. The conclusions and recommendations that emerged from the different experiences had a great deal in common and were complementary.

Significant lessons were learned from these experiences. Coordination between governmental and nongovernmental initiatives working in similar geographical areas is greatly needed in order to avoid conflicts and duplications. NGOs should be allowed a more positive role in raising awareness on general reproductive health issues, with specific focus on FGM, and exchange of experience and information in order to maximize the impact of the implemented activities.

Previous consciousness-raising messages focused on the health hazards of FGM. This had negative repercussions, one of which was pushing the practice into the realm of the medical profession, as it was assumed that having a medical doctor perform the procedure would eliminate complications. For such reasons, FGM has to be approached from a wider perspective than as simply a harmful practice. The integration of consciousness-raising FGM must be considered as a component of women's and reproductive health and in comprehensive socioeconomic developmental strategies. Since all members of society are responsible for the perpetuation of the practice of FGM, all of them are target groups for consciousness-raising against FGM. The existing educational material needs to be revised and updated.

The Ministry of Health must monitor the implementation of its decrees regarding the banning of FGM at the hands of medical practitioners in hospitals, health units and private clinics and must penalize those who do not comply. It must also open channels of communication with different media agencies, address influential community leaders in society, train them and provide them with information so that they may participate in anti-FGM programmes.

It is important to document and record the different activities undertaken in order to benefit from their experiences in the long term. This is possible by making NGOs aware of the importance of good documentation as a constant process and by providing them with training on ways and methods of documentation. Community leaders can also be allies in monitoring and recording activities in detail.

Sociocultural studies and research related to reproductive issues need to be encouraged with particular focus on FGM. Studying different aspects and dimensions of this practice may facilitate the process of eliciting behavioural change.

Although the lessons learned lead us away from framing FGM as a religious issue, people's questions about religion's position on FGM should not be ignored. It should be clearly emphasized that FGM is a tradition that was practised prior to the appearance of monotheistic religions. Muslims in Saudi Arabia, Islamic Republic of Iran and Iraq, for example, do not practise FGM, just as Christians all over the world do not. Al Azhar's clear position on FGM is represented in the opinion of Sheikh Mohamed Sayed Tantawi, who said that FGM is a tradition and not a religious rite. He also said that doctors are the reference points for this matter.

### 2.5 The role of health care providers in eliminating practices harmful to women with particular emphasis on female genital mutilation

*Dr Siham Ragheb, UNFPA Country Support Team for Arab States and Europe*

The role of health care providers in eliminating practices harmful to women is determined by a variety of influences. Health care providers work within a health care system and their roles are usually predetermined by the policies of the system and its goals, targets priorities and standards. They are products of educational systems that shape their knowledge, attitudes and skills and qualify them to carry out certain jobs. They are also affiliates of professional organizations that set frameworks for their practice. Moreover, every now and then the health care providers need to fine-tune their performance based on the findings of evidence-based research. Therefore, the stakeholders who determine the role of health care providers are the policy-makers, the managers, the basic professional education systems, the professional organizations and the researchers.

Policy-makers are required to adopt clear national policies for elimination of FGM set time bound goals and targets, develop plans of action, allocate necessary budgets, develop national and district level indicators for monitoring and evaluating progress, enact legislation and build partnerships with national and international interested parties.

Programme managers are required to establish baseline data about FGM in their localities, design, implement, monitor and evaluate elimination strategies, establish research agendas, integrate FGM elimination and counselling into major health programmes for women and children, or specially women's health and reproductive health programmes and integrate training in FGM elimination matters into staff development plans.

Education and training programmes can help through revising the basic professional and continuing education curricula and integrating into them concepts related to human rights, children's and women's rights and gender issues as well as factual information about FGM. There is also a need for strengthening health education and counselling components and for training teachers and trainers in FGM elimination measures. The role of service providers could be clearly determined and become effective and sustainable when policies are well established, management permits, education and training prepares, professional organizations support and research directs.

The categories most qualified to be involved in FGM elimination activities are primary health care workers, reproductive health care workers, social workers and clinical

psychologists. Through information and education programmes they can raise community awareness and create public opinion against such harmful practices. The closeness of the primary and reproductive health care workers to the grass roots enables them to teach and counsel the stakeholders in their local communities. These include community elders who are usually the decision-makers in the families, local religious leaders whose role in shaping the attitude and practice of the community members cannot be underestimated, community leaders and school teachers. Male involvement is another equally important strategy that should be taken into account by the health care providers. As women's attitudes begin to change they need to find support among their brothers, fathers and husbands.

There is also a need to teach traditional practitioners about the health complications of FGM. They should be trained to manage the care of women with female genital mutilation before and after childbirth, and they also need to be assisted in finding alternative income sources instead of earning their living through performing FGM.

## 2.6 Research as an approach to monitoring of progress towards eliminating female genital mutilation: case study

*Dr Ezzeldin Osman Hassan, Executive Director, Egyptian Fertility Care Society*

International research has repeatedly documented the adverse effects of FGM on the lives and health status of women. A bulk of this research has been directed toward estimation of the prevalence of FGM and learning the reasons behind the practice as well as the factors helping to maintain its high prevalence rate. In an effort to document the prevalence of this practice, self-reporting is the most widely used methodology. However, marked variations have been observed in prevalence rates reported by different studies and are probably due to the following reasons:

- differences in study populations: field-based, clinic-based, population-based, studying different sociodemographic and economic strata;
- differences in sampling techniques: particularly when data are derived from wider health surveys not intended for study of the problem, with possible selection bias such as oversampling of rural or urban areas or certain age categories;
- problems with the reliability of the self reporting methodology e.g. cultural factors resulting in providing false positive or false negative information, or errors with questionnaire design or even with the wordings used;
- problems with the selection and training of data collectors, whether interviewers or physicians;
- differences in research methodologies utilized for data collection and analysis that can be affected by the attitude of the researcher towards FGM.

On the other hand, clinic-based investigations of the topology of FGM are also needed not only to investigate the accuracy of self-reporting in estimation of prevalence, but also to obtain descriptive information about the range of FGM practices.

In the case of Egypt, a number of studies were carried out before 1995. These small studies were field-based and covered limited populations. Marked variations can be observed

in the prevalence rates reported by these studies, but in sum, they pointed to a prevalence between 80%–84%, and their impression was that the rate was on the decline. In 1995, an FGM module was included in Egypt Demographic Health Survey (EDHS). This is a population-based study intended to assess maternal and child health and the use of family planning methods, and utilized self-reporting as a method to determine the prevalence of FGM. The sample was representative for urban and rural population with probably an over-sampling of the rural community. The major findings were striking: 97% of married Egyptian women were circumcised; there was a trend towards medicalization of the practice (a higher percentage of daughters were circumcised by physicians); support of the practice continued among mothers; age at circumcision was higher in daughters than mothers.

In the same year, 1995, a larger population-based study of a sample representative of Menoufiya Governorate was conducted by the Egyptian Fertility Care Society (EFCS) to document maternal morbidity and found that 92.8% of clinically examined women were circumcised. In 68% of these cases the clitoris and labiae minorae were excised.

In 1996, EFCS again conducted a cross-sectional study in 11 clinics providing gynaecological and family planning services in 7 governorates. The participating sites included 5 university hospitals, 4 Ministry of Health and Population rural hospitals and 2 clinics. The study had two main objectives: to investigate the accuracy of self-reporting of FGM and to obtain descriptive information about the range of FGM practices in Egypt from a clinic-based population.

Women participating in the study were first interviewed in private by specially trained female interviewers who participated in the 1995 EDHS. They used a standardized questionnaire composed of the same 1995 EDHS questions on FGM. Next, women were examined by specially trained female obstetric gynaecologists. Physicians and interviewers were both unaware of the results of the interview or clinical examination. A total of 1339 women were included in the analysis.

Self-reporting studies and clinic-based investigations on the topology of FGM are still required to monitor progress towards eradication and to modify information, education and communication strategies. Special focus should be placed on a combination of qualitative and quantitative research methods for conducting in-depth interviews with key informants (women, husbands, in-laws and service providers), provided they agree beforehand to discuss the subject of FGM openly. A multidisciplinary approach should be used for developing:

- different questionnaires for each group to cover the social, medical and psychosexual effects of the practice (other than those complications that can be prevented by medicalization of the procedure)
- case studies to answer questions on how and why FGM continues to be practised
- structured observation using anthropological research methods to build an ethnology for the practice.

## 3. COUNTRY PRESENTATIONS ON THE MAGNITUDE OF THE PROBLEM, ACHIEVEMENTS AND CONSTRAINTS

### 3.1 Djibouti

More than 98% of women have undergone female genital mutilation in Djibouti. A 1997 knowledge, attitudes and practices survey indicated that only 30% of adolescents had appropriate knowledge about the health hazards of female genital mutilation, and 51% of men were still in favour of this practice.

A national committee against harmful practices was established in 1988, and in 1994 a penal code (Article 333) was issued prohibiting female genital mutilation. In 1998, elimination of female genital mutilation was integrated as a component of the national safe motherhood programme. Advocacy, sensitization of target populations, research, training and legislation are among the main national strategies directed towards eliminating practices harmful to women in the country.

### 3.2 Egypt

The 1995 demographic and health survey conducted in Egypt indicated that female genital mutilation was practised on 97% of females in the country. Physical examination of women with female genital mutilation showed that only 91.8% of women who self reported to be genitally mutilated were actually circumcised. Meanwhile, 4.6% of the studied women provided false positive answers and 1.5% provided false negative answers. Type I, type II and type III female genital mutilation were distributed as follows: 17%, 67% and 9%, respectively. In the vast majority of the cases, the practice was performed at home, while some cases took place at private health institutions or at the homes of relatives. The survey indicated that the decision to perform this practice was influenced by the girls' mothers in 15.4% of the cases, grandmothers in 10%, and other relatives of the mothers in 10.5%. Fathers and their relatives were responsible for 10% and 5.9% of the cases, respectively. Meanwhile, traditional beliefs, religious misconceptions and cleanliness were mentioned as main reasons for supporting the conduct of female genital mutilation.

In 1996, the Minister of Health and Population issued a decree banning the practice of female genital mutilation in public and private hospitals and clinics and making physicians who performed this practice liable to legal penalty in accordance with medical codes of practice.

A holistic approach for eliminating female genital mutilation has been adopted by the Ministry of Health and Population. A national information, education and communication (IEC) strategy has been implemented for raising public awareness about practices harmful to women with particular focus on female genital mutilation. An information kit on female genital mutilation was produced and disseminated to decision-makers in medical, social, legislative, religious and media fields. Training manuals for all categories of health care providers were prepared to improve their knowledge, attitudes and practices regarding female genital mutilation.

In order to monitor progress of relevant programmes and activities aimed at reducing the prevalence of harmful practices including female genital mutilation, a specific section for these practices has been included in the national reproductive health monitoring indicators.

The importance of research as a tool for eliminating female genital mutilation is acknowledged by the Ministry of Health and Population. Sociocultural studies have been given special attention in order to determine traditional norms contributing to practices harmful to women in the country. In addition, close collaboration is maintained with governmental, nongovernmental and international organizations, including the National Council for Population and Development and CEOSS.

### 3.3 Somalia

Female genital mutilation is almost a universal practice in Somalia. Usually, girls between 6 and 10 years are subjected to this practice as a matter of common tradition in the country.

The local authorities have made concrete efforts to fight this practice in the north-west region in collaboration with UNICEF, UNFPA, WHO, local religious leaders, women's groups and other local nongovernmental organizations. These efforts have been aimed at raising community awareness about the short, intermediate and long-term medical complications of female genital mutilation as well as the Islamic ruling on this practice. All available channels for health education activities are being utilized, especially mosques, schools and the mass media.

It is believed that considerable effort is still required to create pressure, especially among women themselves, to protect girls and women from female genital mutilation and other harmful practices. This is particularly due to the fact that mothers and grandmothers are believed to be the main decision-makers concerning female genital mutilation in the family.

### 3.4 Sudan

The practice of female genital mutilation is predominant in the northern states and nearly absent in the southern states. The vast majority (82%) of women subjected to female genital mutilation are infibulated, and most of these women undergo the procedure while they are between 5 and 9 years of age.

A national programme for eliminating female genital mutilation was established in 1992. The programme is aimed at raising awareness of community leaders about harmful practices and sensitizing health providers to promote the elimination of these practices. The programme is aimed at achieving 10% reduction in this practice by the year 2000. Extensive efforts have been made by the Federal Ministry of Health to clarify the position of Islam regarding this practice as well as to raise awareness of the medical complications which may result from this harmful custom. Close collaboration is maintained with concerned groups and nongovernmental organizations including religious leaders, youth associations, the women's union, the Red Crescent Association and the mass media. Nevertheless, it is believed that the

programme strategies still need to be further strengthened through an evidence-based approach with particular reference to quantitative and qualitative research.

### 3.5 Republic of Yemen

A demographic and health survey conducted in the Republic of Yemen in 1990 showed that female genital mutilation was practised in the country with an overall prevalence rate of 22.6%. Girls were usually subjected to female genital mutilation a week after birth. The survey also indicated that in 49% of cases this practice was performed by ear-piercers. Traditional birth attendants (31%), nurse-midwives (11%), relatives (8%) and physicians (1%) were responsible for the other cases.

In the vast majority of cases the practice is performed at home, mostly because of religious misconceptions and traditional beliefs. As in Somalia, the decision about female genital mutilation is made by the women themselves. The survey indicated that around 74% and 22% of the cases were decided upon by the mothers and grandmothers of the girls, respectively.

## 4. GROUP WORK

There was one session for group work. Participants were pre-assigned into 3 working groups according to affiliation and area of expertise. These included the following topics for discussion:

**Group A**: effective use of media in raising community awareness for the prevention of FGM
**Group B**: community mobilization for abolishing harmful practices
**Group C**: integration of anti-FGM activities with reproductive and family health programmes.

A set of suggested questions for each group was provided (Annex 4). Groups were advised that the questions had been given only as means to stimulate discussion and were encouraged to discuss any relevant additional questions. Each group nominated a chairperson and a rapporteur who presented the group work report in a plenary session on the third day of the workshop.

## 5. MAJOR CONCLUSIONS

- Traditional practices harmful to women, especially female genital mutilation, constitute major health and social problems in some countries of the Eastern Mediterranean Region and have considerable negative consequences on the health of women and children.

- Country reports presented in the workshop and available information revealed wide variations in the prevalence and severity of the practice.

- It is evident that there is an urgent need for further concerted efforts to eliminate female genital mutilation where the practice is prevalent.

- Available findings of studies and research show variations in the age at which the practice is performed, in the performers of the procedure as well as in the geographical distribution within a country.

- The reasons for perpetuation of the practice also vary from country to country, but traditional beliefs and religious misconceptions were the major reported reasons.

- The majority of FGM procedures in the different countries are performed by traditional practitioners such as traditional birth attendants, healers and ear piercers. However, a small proportion is still being performed by health providers within the health care system.

- Emphasizing the immediate and long-term medical complications of FGM in information, education and communication programmes has unintentionally encouraged the medicalization of the practice, in that parents are resorting to physicians to avoid these preventable complications.

- In the majority of countries where the practice is prevalent, FGM was previously performed in health institutions. Nevertheless, some of these countries have recently taken active steps towards the prohibition of the practice in health institutions (e.g. Egypt).

- It was noted that decision-making regarding FGM is frequently in the hands of the family elders, mothers and grandmothers.

- Although the physical health consequences of FGM have been clearly documented, there are still many gaps in knowledge with regard to the psychosocial and psychosexual consequences of the practice.

- Findings of relevant research reveal that community awareness about the health and psychosocial consequences of FGM is remarkably inadequate.

- The existing pre-service and in-service training curricula of health care providers do not include adequate information on FGM and its consequences.

- Previous experiences have shown that addressing FGM in a vertical manner does not allow the related activities to achieve desired objectives. This is possibly because local communities feel threatened in their traditions and customs.

## 6. RECOMMENDATIONS

### 6.1 To Member States

*Policy formulation*

1. A well-defined clear policy should be set up. The policy should indicate that any activities aiming at abolishing FGM need to be an integral component of community development and women's and reproductive health programmes.

2. The draft policy should be discussed and agreed upon among leaders and the community and should be developed for all stakeholders.

3. Partnership with nongovernmental organizations should be clearly reflected in the policy.

4. The policy should be supported by appropriate legislation, ministerial decrees and professional codes of ethics issued by relevant professional societies.

5. The policy should also address resource mobilization strategies in order to implement anti-FGM programmes within the context of women's and reproductive health.

6. The policy should emphasize that practices harmful to women, particularly female genital mutilation, should be dealt with in an integrated fashion within the context of women's and reproductive health programmes rather than in a vertical approach.

*Advocacy strategies and activities*

7. Advocacy is an essential component of anti-FGM programmes, and the support of policy-makers, religious and community leaders, women's groups, schoolteachers, youth and family should be enlisted.

8. Appropriate research activities should be conducted in order to assist in the development of sound advocacy strategies.

9. FGM advocacy strategies should address the following measures:

   - integration of elimination of FGM within the context of reproductive and primary health care

   - advocacy against other harmful practices affecting the health of women

   - focusing on complete elimination of FGM rather than a step-by-step approach.

*Information, education and communication activities*

10. All channels available for information, education and communication activities should be utilized as appropriate to disseminate culturally sensitive messages related to elimination of harmful practices.

11. IEC messages should be consistent and carefully selected due to the sensitivity of the issue.

12. IEC messages should be based on scientific data, including focus group discussions.

13. Basic professional education of health care providers should include FGM prevention and management issues.

14. The family, women's groups and youth groups should be specially targeted by IEC activities.

15. Male and community involvement in the development of the elimination strategies should be emphasized.

16. IEC programmes should highlight the health complications that cannot be prevented by medicalization of the procedure, such as psychosomatic and psychosexual complications.

*Service provision*

17. While implementing long-term strategies for the elimination of FGM, clinical management of women with FGM should be strengthened to reduce the mortalities and morbidities associated with this practice, for example considering prenatal de-circumcision in certain situations.

18. Health care providers should be trained in order to enable them to clinically manage women with FGM, and hence minimize complications related to this practice.

19. Anti-FGM counselling should be part of every contact between health care providers and primary recipients of reproductive health services, including women, parents, family elders and adolescents, as well as secondary recipients including teachers, community and religious leaders and decision-makers at the local level. Counselling should not be looked upon as an added job and should be reflected as part of reproductive health training.

*Monitoring and evaluation*

20. There is a need for developing indicators for monitoring and evaluation of anti-FGM programmes at all levels of the health care system and for all programme activities. This should also be accompanied by the establishment of feedback mechanisms.

21. Internal and external evaluation should be conducted on a regular basis to allow for adjustment and revision of the programme strategies and activities based on evidence.

*Research*

22. Research is an important tool for the development of evidence-based strategies for the elimination of female genital mutilation. Several research issues are evident at present especially in the area of psychosocial and psychosexual research. Present scattered information should be reviewed in each country, and areas of research to be conducted can be determined accordingly, utilizing different research tools and methodologies.

23. Available population surveys, such as censuses and demographic and health surveys, should be utilized for the determination of the magnitude of the problem of FGM.

### 6.2 To WHO, UN agencies and international organizations

24. It is recommended that WHO provide support to Member States in their efforts to eliminate FGM, particularly in the areas of policy development, service protocols, IEC material, research and other activities as appropriate.

25. Exchange of lessons learned and success stories among countries inside and outside the Region should be promoted by the Regional Office and other concerned agencies.

26. Funding agencies such as UNFPA, UNICEF, USAID and others should provide resources to support countries in their efforts to eliminate FGM.

## Annex 1

## AGENDA

1. Inaugural session
2. Election of Chairperson and Rapporteur
3. Adoption of the agenda
4. Introductory session including mechanics and objectives of the workshop
5. Regional overview of activities for eliminating practices harmful to women with particular reference to FGM in the Eastern Mediterranean Region
6. Health consequences of female genital mutilation: a health provider's perspective
7. The role of the family and the community in eliminating female genital mutilation: what works
8. Sociocultural aspects of female genital mutilation with reference to lessons learned
9. The role of health care providers in eliminating practices harmful to women with particular emphasis on female genital mutilation
10. Research as an approach to monitoring of progress towards eliminating female genital mutilation–case study
11. Country presentations on the magnitude of the problem and achievements and constraints
12. Group session in three groups
13. Presentation of group reports and discussion
14. Major conclusions and recommendations
15. General discussion
16. Closing session

## Annex 2

## PROGRAMME

**Monday 6 March 2000**

| | |
|---|---|
| 08:30–09:00 | Registration |
| 09:00–10:30 | Inaugural session |
| 10:30–10:45 | Introduction of participants<br>Election of Chairperson and Rapporteur<br>Adoption of the agenda |
| 10:45–11:00 | Objectives and mechanics of the workshop<br>*Dr G. Hafez, Special Advisor, Gender Mainstreaming and Women's Development, WHO/EMRO* |
| 11:00–11:30 | A regional overview of activities for eliminating practices harmful to women with particular reference to FGM in the Eastern Mediterranean Region<br>*Dr R. Mahaini, Regional Advisor, Women's and Reproductive Health, WHO/EMRO* |
| 11:30–12:00 | Health consequences of female genital mutilation: a health provider's perspective<br>*Dr Hamid Rushwan* |
| 12:00–14:00 | The role of the family and the community in eliminating female genital mutilation: what works<br>*Dr Tayseer Mandoor* |
| 14:00–14:30 | Sociocultural aspects of female genital mutilation with reference to lessons learned<br>*Dr Magdy Helmy* |
| 14:30–15:30 | The role of health care providers in eliminating practices harmful to women with particular emphasis on female genital mutilation<br>*Dr Siham Ragheb and Dr Kamilia Abu Shabana* |
| 15:30–16:00 | Research as an approach to monitoring of progress towards eliminating female genital mutilation–case study<br>*Dr Ezzeldin Osman* |

**Tuesday 7 March 2000**

| | |
|---|---|
| 09:00–10:30 | Country presentations on the magnitude of the problem and achievements and constraints<br>Djibouti<br>Egypt<br>Sudan<br>Somalia<br>Republic of Yemen |

| | |
|---|---|
| 10:30–11:30 | Discussion |
| 11:30–11: 45 | Briefing for group discussion |
| 11:45–16:30 | Group session in three groups:<br>Group A: Effective use of the media in raising community awareness for the prevention of FGM<br>Group B: Community mobilization for abolishing harmful practices<br>Group C: Integration of anti-FGM activities with reproductive and family health programmes |

**Wednesday 8 March 2000**

| | |
|---|---|
| 09:00–14:00 | Group discussions (continued) |
| 14:00–15:00 | Presentation of group reports |
| 15:00–16:00 | Discussion |

**Thursday 9 March 2000**

| | |
|---|---|
| 09:00–11:30 | Major conclusions and recommendations<br>Discussion |
| 11:30–12:00 | Closing session |

**Annex 3**

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**Annex 4**

## GROUP DISCUSSION QUESTIONS

### Group A

Effective use of the media in raising community awareness for the prevention of female genital mutilation (FGM).

*The following questions have been provided to stimulate discussion on the topic. Participants are encouraged to raise additional questions of relevance and importance. After concluding discussions on the issues raised here and additional ones, the group is expected to prepare a report to be presented in the sessions of group reports:*

1. How can you effectively use mass media (radio, television, newspapers, cinema and video industry, etc.) in raising community awareness for the prevention and eventual elimination of FMG? What is your assessment of the role of mass media in your country in approaching this harmful practice?

2. Who are the most appropriate "key change agents" who can be attracted to participate effectively in the mass media campaigns to raise the community awareness of FGM? How can you approach and mobilize them?

3. What kind of advocacy strategies against FGM and information, should be adopted and disseminated through mass media? Who should participate in their development and presentation to the public?

4. Is it good in your opinion to address FGM as an isolated topic in mass media campaigns, or it is better to introduce it within several broader health topics concerning the traditional harmful and good health practices in your society?

5. What are the most negative health consequences of FGM, that should be highlighted in awareness-raising campaigns to mobilize policy makers, community leaders and the women themselves against this harmful practice?

6. How can the mass media be utilized to inform parents, teachers, community leaders about replacing FGM with an alternative symbolic ritual like feasting and gift giving to promote healthy traditions instead of harmful practices?

**Group B**

Community mobilization for abolishing harmful practices

*The following questions have been provided to stimulate discussion on the topic. Participants are encouraged to raise additional questions of relevance and importance. After concluding discussions on the issues raised here and additional ones, the group is expected to prepare a report to be presented in the sessions of group reports:*

1. The primary objective of any project aiming at eliminating FGM is to identify and educate key change agents who can advocate against FGM. If you agree with this statement who are the key change agents in your country? What are the main items of the project you intend to develop to eliminate FGM?

2. Some other key change agents such as teachers, religious leaders, artists, law workers, etc. may play very important role in awareness-raising campaigns for the eventual elimination of FGM. How you can target them? What are the main components of your plan to mobilize them?

3. How can you approach the male community leaders, who generally approve this harmful practice? What are the main components of your plan to mobilize them against FGM?

4. It is widely believed that women, who have been circumcised themselves, when they have knowledge about the health consequences of FGM they will be the best advocates against this harmful practice, refraining their girls from undergoing this procedure. Do you agree with this statement?

5. How can the interventions you suggest for raising community awareness and involvement against FGM be evaluated?

6. In several countries, governments have introduced legislation against practices harmful to women, including FGM. To what extent have these legislations been effective in controlling or eliminating FGM? Can you suggest an alternative to legislation and criminalizing this practice?

**Group C**

Integration of anti-FGM activities with reproductive and family health programmes

*The following questions have been provided to stimulate discussion on the topic. Participants are encouraged to raise additional questions of relevance and importance. After concluding discussions on the issues raised here and additional ones, the group is expected to prepare a report to be presented in the sessions of group reports:*

1. It is widely believed that health care providers including reproductive and family health workers are the "first line change agents and advocates against FGM".

   • If you agree with this statement how can you target this group?

   • What are the main components of your plan to mobilize them?

   • How can they integrate FGM activities into their specific programmes?

2. Efforts to eliminate FGM should be strengthened, when specific target groups such as midwifes and traditional birth attendants can be educated about the risks of FGM. How can the training peogrammes of these groups be developed to integrate the topic of the harmful health practices including FGM?

3. Addressing FGM within a broader reproductive health focus is a key element in raising awareness of the potential clients and the staff providing these services. If you agree with this statement what are the main components of your plan to develop such services?