REPORT ON THE
Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa
6-10 APRIL 1987, ADDIS ABABA, ETHIOPIA

ORGANIZED BY THE
Inter-African Committee on Traditional Practices Affecting the Health of Women and Children

CO-SPONSORED BY THE
Ministry of Health of Socialist Ethiopia
United Nations Economic Commission for Africa
Organization of African Unity
United Nations Children's Fund (UNICEF)

IN COLLABORATION WITH THE
World Health Organization
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<tr>
<td>AFRO</td>
<td>WHO Regional Office for Africa</td>
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<td>ATRCW</td>
<td>African Training and Research Centre for Women</td>
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<td>ECA</td>
<td>Economic Commission for Africa</td>
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<td>f.c.</td>
<td>Female Circumcision</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>IAC</td>
<td>Inter-African Committee</td>
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<td>MCH</td>
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<td>Non-governmental organization</td>
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<td>Organization of African Unity</td>
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<td>PH</td>
<td>Primary Health</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>UN</td>
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<td>UNDP</td>
<td>UN Development Programme</td>
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<td>UN Fund for Population Activities</td>
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CHAPTER I
PREFACE
by
Mary Racelis, Regional Director, UNICEF, Nairobi

Tradition represents that part of a people's culture that gives continuity and meaning to people's lives. This body of beliefs and practices that holds the members of a society together can, however, develop over time a validity in people's minds that resists questioning and takes on an aura of morality and correctness even in the face of contrary indications. While persistence of tradition has its positive elements, it also engenders a rigidity that becomes its own excuse for being. And so, beliefs and practices like female circumcision, early childhood marriage, nutritional taboos and the like persist.

History shows us, however, that societies do change as new realities impinge on them. Accordingly, when certain beliefs and practices no longer appear functional or credible to their proponents, once these customs are observed more in the breach than in practice, the stage is set for a transformation to a new set of opinions and activities.

It is in this fluid context of changing Africa that the IAC, a group of courageous African women and men, has seized opportunities to help their brothers and sisters re-examine certain cultural propositions, question some, and eventually discard those that can be proven clearly to undermine the well-being of children and women. Effective education, information and communication programmes have helped make this possible.

UNICEF's active support of the efforts of Governments, NGO groups and individuals to bring about a revised set of positive traditions, even as other salutary ones remain, has been most rewarding. It has brought substance to UNICEF's advocacy in favour of "working together for children". This collaborative endeavour is also working successfully because of the willingness of ordinary people in rural and poor urban communities to explore, accept and take often difficult decisions to incorporate new ideas into their cultural outlooks. The resulting reformulation becomes the basis of a new tradition.

Special compliments and thanks are due the Seminar organizers for their long-standing commitment to this challenging work. It has been a privilege for UNICEF to share the process of mutual enlightenment in which people are hearing from development workers about new developments in health and nutrition, on the one hand, and development workers are learning to respect many elements of African traditions, on the other. We hope to continue this productive partnership, especially as the arena for action
shifts onto the national, district and community scenes. The accelerated formation of National Committees and their carrying out the Plan of Action agreed upon in Addis Ababa will admirably serve African transformation for the benefit of children and women.

* * * * *
CHAPTER II

PLAN OF ACTION
FOR THE ERADICATION OF HARMFUL TRADITIONAL PRACTICES
AFFECTING THE HEALTH OF WOMEN AND CHILDREN IN AFRICA

Proposed and Approved at the Inter-African Committee (IAC)
Regional Seminar in Addis Ababa, Ethiopia, 6-10 April 1987

IAC AND ITS MEMBER COMMITTEES

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* * * * *
SECTION I: INTRODUCTION

1. A general examination of the situation of women and children in Africa with regard to hazardous traditional practices, such as early marriage and pregnancy, female circumcision, nutritional taboos, inadequate child spacing and unprotected delivery, has revealed that these practices are current realities in many African countries.

2. Women are the main victims of harmful traditional practices, often to the point of permanent physical, psychological and emotional damages, even death, and yet little progress has been achieved in the abolition of these practices.

3. The harmful effects of these traditional practices on the health of women and children have rarely been officially surveyed. They have not been fully acknowledged by policy makers and opinion leaders, nor have effective steps to stop them been given precedence in health development planning.

4. The victimization of women by harmful practices has a serious effect on population factors and health, to the detriment of development. High rates of consecutive births, coupled with high rates of maternal and child mortality, are common patterns in Africa. Low fertility resulting from the poverty and poor health of women also occurs, causing unnecessary family tension and divorce.

5. At the Regional Seminar of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in Africa, held in Addis Ababa, Ethiopia, from 6 to 10 April 1987, guidelines were drawn up, by which national governments and local bodies as well as international and regional organizations might take action to protect women more fully from unnecessary hazardous traditional practices.

6. These guidelines constitute the "Plan of Action for the Eradication of Harmful Traditional Practices Affecting the Health of Women and Children in Africa". The participants at the Seminar recommended that each country should identify its own priorities within the Plan as appropriate for the national development strategy. It was recognized and welcomed that the Plan of Action could reinforce national health and development plans.

7. The Plan should be implemented within ten years, with a mid-term progress review along with annual evaluations by the national IAC committees.

8. Since many of the changes are achievable only on a long-term basis, the guidelines include both short-term and long-term strategies. As the vast majority of African people still live in rural areas where poverty is often acute, actions related to the rural woman, her health, well-being and life, are given greater attention than those directed to urban areas.

9. The situation as to the extent and effect of harmful practices on women and children varies across the African continent. Thus, the implementation of the Plan, and the urgency of particular measures to be taken, may also be expected to vary from country to country.

10. Acknowledging the sustained support provided by serious humanitarian NGOs, the participants of the Seminar laid special emphasis on the importance of ensuring the availability of resources, both human and financial, for the implementation of the Plan. With regard to financial resources it was stressed:

   a) that all available sources of support should be explored, including community resources and those of the various private funding agencies;
b) that programmes for implementing the proposals should be given priority in national health and development plans; this could improve their chances to attract international and bilateral assistance;

c) that special efforts should be made to inform both the donors and the recipients of such assistance about the importance of regarding the protection of women from the hazards of certain traditional practices as an integral part of and contribution to the country's process of development.

SECTION II: ORGANIZATIONAL MACHINERY

Efforts to widen opportunities for women and men to combat harmful traditional practices affecting women and children will require action by society at large through governmental machinery, non-governmental organizations and other groups and individuals, all of which may be supported by individual and regional organizations. Appropriate machinery and administrative procedures are essential.

Action to be taken
1. At the national level

Where such machinery does not already exist at the national policy and planning level, the following should be established:

(i) National Committees to combat harmful traditional practices consisting of leading men and women who would make recommendations and action proposals and establish their priorities for action adopted from this Plan;

(ii) Permanent Sub-Committees to undertake research, to formulate projects and programmes, and in general to seek the integration of measures against harmful traditional practices in all sectors of health, education, economic and social development programmes and policies;

(iii) An Inter-Departmental Body of Experts to work within or closely with the national committee, consisting of men and women from various fields—such as health, education, nutrition, vocational training, employment, social affairs, communication and information, population, law, religious affairs—to ensure coordination of programmes and adequate representation within international policy and planning bodies, as well as to serve as advisers to the Permanent Sub-Committee;

(iv) A Non-Governmental Organization (NGO) Coordinating Committee to assist in organizing women to seek representation in decision-making bodies, to work towards changing attitudes, to supplement public resources and facilities, and to promote international collaboration and exchange of information and experience. The NGOs should also take action to implement recommendations made at national, regional and international conferences relevant to women's and children's health and well-being.

2. At the regional level

The IAC is unique in that it is the only inter-African organization concerned directly with combating the harmful traditional practices affecting women and children with a constitution, a mandate and an established programme to achieve this purpose.

In order for IAC to stimulate national implementation of the Plan of Action, the following additional machinery should be ensured:

(i) Support in general

Adequate funding as well as material and technical assistance should be sought to permit the IAC
- to coordinate more closely the work of the National Committees;
- to interchange educational materials and relevant experiences between the committees;
- to monitor and support effective evaluation of the programmes of the committees;
- to work in close collaboration with international and regional organizations, especially ECA, OAU, WHO, UNICEF and UNFPA.

(ii) Special support

ECA

a) Recognizing the effective collaboration and support provided by the ECA and the existing memorandum of agreement between the ECA and the IAC, additional regional machinery and support should be provided.

b) The African Training and Research Centre for Women (ATRCW) should establish a plan to assist governments and voluntary agencies in order to strengthen their efforts to eliminate harmful traditional practices. The functions of ATRCW should include
- national training in successful methods and techniques to combat harmful practices;
- research and collection of information - harmonizing data and developing indicators of women's campaigns against harmful practices and of the results of these campaigns - and diffusion of such information;
- a revolving fund to assist cooperative and/or individual activities (entrepreneurship) among women, as lack of this economic factor tends to cause the maintenance of many of the harmful practices;
- support of national bodies in their efforts to create their own revolving funds;
- an African Resource Task Force, composed of experienced persons who have successfully worked against harmful traditional practices; this would allow members of the Task Force in one part of the region to serve in another area where so requested.

WHO

All efforts should be made to incorporate the work against harmful traditional practices in the WHO Regional Health Programmes aiming at Health for All by the Year 2000.

UNICEF

UNICEF should integrate the IAC Plan of Action in its drive for child survival in Africa.

3. The use of mass media

Special measures should be taken to ensure that the mass media give wide publicity to the Plan of Action and to IAC publications.

The mass media - press, radio, television, film - should be involved in disseminating information regarding the hazards of certain traditional practices at local, national and regional levels.

SECTION III: CHILDHOOD MARRIAGE AND EARLY PREGNANCY

In view of the fact that childhood marriage and early childbirth have very negative effects on the psychological, physical and social well-being of young girls, it is a matter of grave concern for all governmental and non-
governmental organizations and agencies to establish and embark on programmes and projects aimed at

1) education (both formal and non-formal),
2) measures to improve socio-economic status,
3) measures to improve health,
4) enacting laws against childhood marriage which might entail early pregnancy.

1. Education
Education is the right of every citizen and is particularly important for women. It is well known in Africa that if you educate a man, you educate an individual, but if you educate a woman, you educate a whole nation. A woman's education is an asset not only to her family but to the nation as a whole. If an inexperienced young girl is pushed into marriage without the necessary maturity, she cannot assume her proper role in society. The woman should also be given the right education to act as an agent of change.

Action to be taken
a) Family life education should be taught to both boys and girls in primary, secondary and higher institutions of learning.
b) Primary education should be regarded as a priority everywhere and compulsory free primary education should, if at all possible, be established in all countries.
c) Adolescents (rural and urban) should be taught responsible parenthood, using formal or non-formal type of education to prevent young lovers from eloping to get married.
d) Functional literacy campaigns should be aimed at disseminating information about the harmful effects of childhood marriage and early pregnancy.
e) Governments and NGOs should establish vocational institutions for young girls who are unemployed and drop out from school because of early pregnancies, so as to improve their standard of living.
f) Mass media - press, radio, television, plays, cultural songs and film shows - should be used to educate youths and parents concerning the disadvantages and risks of childhood marriage and early pregnancy.
g) Governments and NGOs should provide counselling services in all rural and urban areas.
h) Sex education should be introduced in the educational curriculum of colleges and universities.
i) TBAs, MCH aids and traditional healers should through the use of audio-visual materials be motivated to work against childhood marriage and early pregnancy.
j) Trained and concerned citizens should try to identify problems in the rural and urban areas and to solve them.
k) Education and information about family planning should be made available and acceptable to all in both rural and urban areas.

2. Measures to improve socio-economic status
There is an established correlation between childhood marriage and the socio-economic status of parents who encourage it. To discourage childhood marriages and early pregnancies will demand an improvement of the socio-economic status of parents because of the influence of poverty, prestige and other social factors.
Action to be taken
a) Income-generating activities should be provided to low-income parents.
b) Non-school-attending girls should be provided with income-generating activities to occupy them.
c) Vocational institutions should be established to train young girls for income-generating activities that would make them self-sustaining.
d) Governments should improve housing and social conditions, because overcrowding breeds promiscuity and incest.
e) Governments should censor pornographic films, videos and books.

3. Measures to improve health

WHO considers health as a state of physical and mental well-being, not merely the absence of disease. Total health is the aspiration of every community but is not easy to achieve. Nonetheless, a step towards proper health care should not be denied young people who are victims of early marriage, which can have grave complications such as anaemia, hypertension leading to eclampsia, acute kidney failure and death of the young mother, foetal retardation, premature births, low birthweight and malnutrition of the infant.

Action to be taken
a) Governments and NGOs should support community-based health programmes, i.e. Primary Health Care (PHC), especially in areas where this is identified as a definite need.
b) Agencies involved in women's activities should be motivated to mobilize more women's groups for education.
c) Family Planning Services should be made available and acceptable to all, in both rural and urban areas.
d) International agencies, including NGOs, should make every effort to support African governments endeavouring to strengthen their health units and institutions in terms of medical equipment and training programmes, particularly for midwives, MCH aids and TBAs.

4. Enacting laws against childhood marriage

Every citizen should have the right to decide on when to get married and to whom, and when to have children. Since some parents think that they have the God-given right to decide whom their daughters should be married to, there is a need to enact laws to eradicate this mal-practice, while at the same time protecting the freedom and dignity of young girls.

Action to be taken
a) Governments should raise the legal age for marriage to 18 years.
b) All forms of marriages should be registered and legalized so that children can benefit from their parents' properties.

SECTION IV: FEMALE CIRCUMCISION

Female circumcision (f.c.) is the partial or complete removal of the female external genitalia.

F.c. is widely practised throughout Africa. The nature of the operation, deeply rooted in African cultures and traditions, varies from one country to another, and from one ethnic group to another. It is performed at any stage, from the neo-natal period, infancy and puberty, to pregnant and post-partum women.
The adverse consequences of this practice are numerous. They contribute to high mortality and morbidity in Africa. They include shock from severe pain and haemorrhage, urinary retention, infection (especially tetanus), and secondary complications such as infertility. Obstetric complications comprise obstructed and prolonged labour resulting in vesico-vaginal and recto-vaginal fistulas (VVF and RVF). A victim of female circumcision who has experienced such adverse consequences may be socially alienated and this may cause serious emotional and psychological disturbance, which could result in suicide. Another important implication of f.c. is the waste of family income on an unnecessary and life-threatening practice, because the circumcisers often have to be remunerated, a costly ceremony arranged and gifts offered to the young girls just circumcised.

In view of the above, it is an utmost necessity to eradicate f.c. in all its forms.

**Action to be taken**

a) **Aims**

**Short term goal:**

to create awareness of the adverse medical, psychological, social and economic implications of f.c.

**Long term goal:**

1) to eradicate f.c. by the year 2000;
2) to restore the dignity and respect for womanhood, and thus
3) to raise the status of women in society.

b) **Strategies**

**Research**

Research to collect baseline data should be carried out by countries which have not already done so.

**Implementing Agents:** universities, medical or nursing associations, national women's organizations.

**Collaborating Agents:** Government health related institutions, international NGOs.

**Coordinating Agents:** The National IAC Committees.

**Resources:** Human (personnel who will carry out surveys and analyse the data).

**Financial.**

**Educational materials**

For public enlightenment the following actions should be taken:

- Training materials - including video films, posters, pamphlets - should be produced.
- Information and communication personnel should be trained.

**Implementing Agents:** Government Ministries of Education, Information and Health.

**Collaborating Agents:** International and National NGOs and UN agencies should provide funds for production of video films, posters, etc., as well as supply educational materials and technical assistance.

**Coordinating Agents:** the National IAC Committees.

**Target groups:**

- health professionals
- mass media personnel
- TBAs, village health workers, community development workers.
Sensitization of the general public, i.e. creation of awareness of f.c., should take place through
- seminars, workshops, symposia and village meetings;
- effective utilization of national newspapers and popular magazines; use of video films and mobile cinema, radio and television, posters and leaflets.

Implementing Agents: The National IAC Committees and various women's organizations, universities.

Collaborating Agents: International and national NGOs for provision of funds and materials; relevant Government Ministries and Departments such as the Ministry of Health (PHC, MCH and FP units), the Ministry of Youth and Social Development, the Ministry of Rural Development, etc. Others - voluntary organizations and concerned citizens - could also be involved.

Coordinating Agents: The National IAC Committees.

Resources: Human resources that could be mobilized for execution of the strategy, such as doctors, nurses, voluntary workers, extension workers, etc.

Target groups to be sensitized
- Religious leaders and religious associations,
- traditional leaders,
- opinion leaders in communities,
- political leaders, policy decision makers,
- TBAs and traditional practitioners including circumcisers,
- village health workers and community development workers,
- youth organizations,
- women's and men's clubs and associations, such as Zonta, Soroptimists, Rotary and Lion's Clubs,
- town and village development committees,
- market women,
- other NGO structures.

Educational programme

Education is a key to eradicating harmful traditional practices which affect the health of women and children. Thus, there should be inclusion of information on f.c.
- as a component of family life education in functional as well as formal educational programmes;
- in school curricula from primary to university level;
- in medical and nursing curricula;
- in the training programmes of TBAs and village health workers.

Implementing Agents: Government Ministries of Education and Adult Literacy, directors of private schools, Ministries of Health and private practitioners, Ministries of Social Welfare, Ministries of Youth and Social Development; international and national NGOs, agencies engaged in women's health related activities.

Collaborating Agents: Women's organizations, associations and councils of health professionals, other relevant and interested associations and individuals.

Coordinating Agents: The National IAC Committees.
Target Groups: - adult women and men,  
- adolescents,  
- school children,  
- all health professionals,  
- TBAs, village health workers, community development workers, etc.

Integrated approach

A component concerning the eradication of f.c. should be integrated into the following existing programmes:

(i) Primary Health Care Programmes,
(ii) Public Health Programmes,
(iii) Maternal and Child Health and Family Planning Programmes,
(iv) Rural/Community Development Programmes,
(v) TBAs and Traditional Health Training Programmes,
(vi) Nutritional Programmes,
(vii) Income-generating programmes such as agricultural extension and home economic activities.

SECTION V: NUTRITIONAL TABOOS

The existence of food prohibitions in Africa is universally acknowledged. Women and children are the most affected groups.

Paradoxically, in some of the African countries forced feeding of women is being practised.

The essence of these practices is generally linked with some mythical and sociological elements to which one must constantly refer in order to understand them.

It must be pointed out, however, that these practices, instead of stimulating the development of women and children, lead rather to disastrous consequences, such as childhood malnutrition, lack of essential elements in the diet of pregnant and breast-feeding women, increase in the number of women undergoing forced feeding, and decrease in life expectancy. Nobody is unaware of the need for a varied and balanced diet for the harmonious development of human beings in general and women and children in particular.

This is why the IAC has undertaken to fight against nutritional taboos and forced feeding of women.

Action to be taken

a) At the national level

1) Mass mobilization campaigns by means of information and training through the mass media (radio, television, posters, films, etc.), through workshops, seminars, conferences and debates, as well as through health and social educational structures together with women's organizations;

2) Action coordination campaigns mounted by the National IAC Committees;

3) Survey of the food practices and the nutritive value of local products in order to demystify the reasons and beliefs attached to the taboos, combined with promotion of diversified consumption as the basis for good health;

4) Incorporation of additional programmes of good food practices into the general Economic and Social Development Planning of each country;
5) Health education programmes with emphasis on the urgent need to abolish forced feeding of women in countries where it is being practised;

6) Intensification of education and functional literacy programmes in order to fight against the ignorance which is responsible for the maintenance of these harmful practices;

7) Research to promote the storage of foodstuffs in Africa, so as to make all the elements essential for a varied and balanced diet available throughout the year.

b) At the regional level

8) Periodic meetings at the regional and sub-regional levels as well as follow-up meetings to exchange experiences gained from the activities undertaken in the fight against the harmful nutritional practices;

9) Setting up a committee of resource people to speak on specific topics in local committees.

c) At the international level

10) Material, technical and financial assistance from international bodies for carrying out specific actions, such as
- cooperation with WHO and UNICEF in their programmes,
- cooperation with NGOs to incorporate education on taboos into their nutrition syllabus.

SECTION VI: CHILD SPACING AND DELIVERY PRACTICES

Social, economic and demographic factors are closely inter-related. Change in one or more invariably involves all. Alterations in the pattern in which women have been denied full participation in the development process involve, among other things, changes in certain crucial demographic variables such as age at marriage, age at birth of first child, spacing of children, and total number of children. A decisive factor in such changes is to enable women to determine, in relation to work and family life, when and how often to bear children.

In order to avoid the negative effects of high fertility on the health of the mother and the foetus, and to ensure a decrease of the rate of mortality caused by consecutive births, it is necessary to consider the value of child spacing with intervals of at least 4 years between each delivery.*)

In most rural areas of Africa traditional birth attendants play a major role in the delivery of children, often performing 90-100% of all rural deliveries. Nevertheless, TBAs are often untrained, unregistered, and unmonitored. In general they receive little if any cooperation from official government bodies.

Action to be taken

1. Raise the minimum age of marriage to 18 for women (see also Section III).

2. Make available to individuals and couples through an institutionalized system, such as a national family planning programme, information and means to enable them to determine the number and spacing of their children, and to overcome sterility.

3. Involve men as well as women in the effort to ensure responsible parenthood.

*) WHO position: By spacing births at least two to three years apart, death of newborn babies and infants will be reduced and the health and well-being of infants improved ("In Point of Fact" No. 33/1986).
4. Ensure balanced demographic, economic and social development by closely relating population policies and programmes to measures for improving the situation of women.

5. Utilize all humanitarian means (including adequate social security for the aged) to encourage a family size that is appropriate to national objectives.

6. Promote awareness of the harmful effect on the health of the mother, and the decreased chances of survival of the child, caused by pregnancy during early adolescence and after the age of 35 years.

7. Provide education on maternal and child health, and on the means for improving the conditions of infants and young children.

8. Provide services to improve the conditions of family life, particularly in the rural areas, to eliminate the need for a large family with many children.

9. Those governments that have not already done so, should adopt a policy by 1990 to support the positive traditional practice of breast-feeding, encouraging all steps to increase duration to ensure maximum security against conception, such as feeding hours incorporated in the work schedule of lactating mothers, and the creation of day-care centres.

10. Any introduction and use of modern contraceptive methods whether by governments or NGOs should be delivered with a well planned counselling component to ensure that users know both the proper use and the potential complications of each method, as well as the value of utilizing many of them for child spacing.

11. Ensure a well-planned and well-organized out-reach programme to extend the family planning services to remote areas and to young girls in particular. In this context, optimum utilization of nurses and other paramedical personnel should be considered.

12. Improve the management of the delivery system as a whole.

13. National PHC programmes should have a strong component of family planning services.

14. Where high fertility is caused by the economic need to increase the family income through additional family labour hands, and also by high infant mortality rates, all efforts should be made
   - to lower the death rates, with specific attention to appropriate child spacing as an effective means to achieve this,
   - to find other economic alternatives to child labour for rural family budgets.

15. Enlisting the cooperation of TBAs rather than attempting to eliminate them, especially in rural Africa, is of great importance: they should be incorporated in the national plan to space childbirths.

6. TBAs are to be trained and re-trained on safer delivery methods and should receive appropriate counselling and information on the use of modern contraceptives.

7. To substitute the income gained by TBAs from performing f.c. and also to promote their status, appropriate ways to improve their financial situation must be investigated and implemented, for instance through the direct sale of modern contraceptives or by incentives and monetary prizes offered by official bodies.
SECTION VII: LEGISLATIVE AND ADMINISTRATIVE MEASURES

Legislative and administrative measures can be instruments for accomplishing the full eradication of harmful practices affecting women and children. Through these, governments can guide and institutionalize changes in attitudes towards harmful traditional practices and enable women to achieve freedom from such harmful afflictions. This is envisaged in the Universal Declaration of Human Rights, in the Convention on the Elimination of All Forms of Discrimination Against Women, in the proposal for the UN Convention on the Rights of the Child, and in other international instruments.

Where such legislation does not exist, women's organizations should support its introduction, and where the legislation does exist, they should investigate the extent of its implementation. Public information campaigns should also ensure that women as well as men have full understanding of their rights to a hazard-free life, and that they are aware of the measures they can take to enforce these rights.

Action to be taken

1. Accord women the legal rights enumerated in sections III, IV, V and VI of this Plan of Action.
2. Accord women equal status with men in matters related to the formation and dissolution of marriage.
3. Remove legal and other restrictions regarding the dissemination of information concerning family planning and the sale and distribution of contraceptive devices.
4. Provide legal aid for family counselling, where possible free of charge, in both rural and urban areas.
5. Promote the adoption by national governments of the policies of WHO and UNICEF concerning the provision of protection of women and children against harmful traditional practices.

SECTION VIII: SUMMARY

Every effort was made in this Plan of Action to indicate the rightful place that the fight against harmful traditional practices should have within the overall development of any African country.

Women in the African region have a crucial role to play both in the development of their countries and in the solution of problems arising from the practice of harmful traditions. Health is a sine qua non for development. In recognition of this, the recommendations of the Inter-African Committee Regional Seminar on Harmful Traditional Practices Affecting the Health of Women and Children, contained in this Plan of Action, aim at drawing greater attention to the needs and the possibilities for action promoting the health, well-being and protection of women and children, and thereby their contribution to the development process.

The guidelines include both short-term and long-term strategies for change. They give special attention to basic improvements at the local level. Although specific information about the condition of women and children and the current activities of governments vary throughout the region, general agreement has been possible in several areas describing priority attention.

It is therefore hoped that improving the conditions of women and children and expanding their opportunities in such fields as education and training, employment, health, public life and overall protection against harmful traditional practices, will be seen not only as a matter of social justice, but also as a significant means of achieving development purposes and overall health goals.

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Comments on the Plan of Action by Dr. M.A. Silva, Chairman, Health Committee, National Council of Women's Societies, Nigeria have been received at the Inter-African Committee, Geneva. They are included here for your information and consideration.

SECTION I INTRODUCTION

Paragraph 3: You may wish to add:

Harmful effects of these traditional practices have been surveyed by researchers in many countries. There is need for more surveys and collaboration on information from these surveys.

SECTION II ORGANIZATIONAL MACHINERY: NATIONAL COMMITTEES

These committees should consist of Representatives from Ministries of Health, Social Development, Education, Agriculture and Economic Development besides NGOs. Membership may be spelt out.

SECTION III CHILDHOOD MARRIAGE AND EARLY PREGNANCY

Education

Avoid the word sex education which is misunderstood by many. It should be implied in Family Life Education. Nutrition Education should be included. School Health Education should include the above, if properly organized.

Measures to improve socio-economic status

More low cost and subsidized Day Care Centres should be established for children to enable the mothers to go out to work. These may be near the homes or in the places of work.

Measures to improve health

Free health services should be made available to young mothers and children. High protein foods should also be made available through international agencies and local NGOs. Women should be encouraged to grow nutritious foods and keep poultry. Many are engaged in farming but must be enlightened on how to use the food produced to advantage. Some give away eggs, fruits and vegetables.

Enacting laws against child marriage

Laws against child marriage should be enforced when enacted. Young Persons' Acts exist in many countries but are not enforced. Young persons should be informed about where to get legal aid when required. Some do not know what to do when they are being forced into marriage against their wishes.
SECTION IV FEMALE CIRCUMCISION

Educational materials
Target groups should include Traditional Medical Practitioners who perform f.c. and parents as well as grandmothers. The activities of women going round the world advocating f.c. should be stopped as a matter of urgency.

Integrated approach
Add Adult Literacy Classes to the list.

SECTION V NUTRITIONAL TABOOS

Action to be taken
a) At the national level
   Add the following:
   - Governments should be urged to intensify efforts to improve transportation of local foods from area to area, particularly perishable foods like fish and fruits. This will ensure better distribution of food in each country.
   - Women should be encouraged to keep market gardens, particularly in the urban areas.
   - Rich protein foods which are expensive should be subsidized so that the low income groups can afford them. At present, these foods are beyond the reach of the poor.

SECTION VI CHILD SPACING AND DELIVERY PRACTICES

All countries should be urged to formulate National Population Policies which will promote child spacing and F.P. practices among families.

SECTION VII LEGISLATIVE AND ADMINISTRATIVE MEASURES

Action to be taken
Provision of machinery for the enforcement of existing laws which will enhance the health of women and children. These laws exist in many countries, e.g. Young Persons' Acts.

To be added: Other Harmful Practices
Countries should report to the Inter-African Committee other traditional harmful practices when identified.
(An example is routine uvulectomy brought to the attention of the participants at a workshop in Kano, Nigeria.)

* * * * *
The opening ceremony as well as the seminar itself took place at Africa Hall in the building of the Economic Commission for Africa, Addis Ababa, Ethiopia.

Seven addresses were made at the opening session:

1. Mrs Berhane Ras-Work, President of the Inter-African Committee
2. Comrade Dr Gizaw Tsehai, Minister of Health of Socialist Ethiopia
3. Professor Adebayo Adedeji, Executive Secretary of the Economic Commission for Africa
4. Mr Venant Wege Nzomvita, Head of Labour and Social Affairs Division, Secretariat of the Organization of African Unity, Addis Ababa
5. Dr Leila Mehra, Senior Medical Officer MCH, World Health Organization, Geneva
6. Mrs Jane Cole, Programme Officer, UNICEF, Addis Ababa
7. Dr M. Nizamuddin, Deputy Representative UNFPA, Addis Ababa.

For the texts of these addresses see the following pages.
The President of the Inter-African Committee,
Mrs Berhane Ras-Work, made the following introductory speech:

"Comrade Dr. Gizaw Tsehai, Minister of Health, Comrades Ministers, Professor Adebayo Adedeji, Executive Secretary of the Economic Commission for Africa, Distinguished Representative of the Organization of African Unity, Excellencies, Ladies and Gentlemen,

It is a great privilege and an immense pleasure for me to welcome you to this very important regional seminar on Traditional Practices Affecting the Health of Women and Children in Africa, organized by the Inter-African Committee in collaboration with the Ministry of Health of Socialist Ethiopia, the Economic Commission for Africa, the Organization of African Unity, the World Health Organization and UNICEF.

Three years ago in 1984 when we set up the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children to follow up the implementation of the Dakar Seminar, we made a giant step forward in africanizing the solutions for sensitive problems related to culture and tradition. Since then, the IAC has endeavoured to live up to the expectations of its members, following the mandate given to it and working in collaboration with national and international organizations.

As most of you know, the overall objective of the IAC is fighting harmful traditional practices like female circumcision, early childhood marriage, nutritional taboos, while at the same time identifying and promoting positive customary practices such as breast-feeding, baby massage, care for widows and the aged.

In order to achieve these objectives, IAC proceeded with the task of setting up effective national mechanisms. It mobilized national and international resources to support local activities. The committee was fortunate to have dedicated persons as working partners in most of the countries to which it reached out. Thanks to their commitment and hard work the programmes of IAC have advanced at a satisfactory speed. More and more people in many countries are informed about the dangers of female circumcision, early marriage, nutritional taboos. The religious misconception and the taboos concerning female circumcision have been broken. I witness a change of attitude on the part of many during my travels in the various countries lately. It gives me satisfaction to note that many people have been informed about traditional practices affecting the health of women and children, unlike four years ago when my colleagues and I had to go through the
difficult task of explaining what the issue implied. Now that more and more people are sensitized, it has become easier to find collaboration for the campaign.

Information and education are carried out through various ways which are considered to be appropriate to each cultural context. Some of these measures consist of organizing local seminars and workshops, surveys, distributing leaflets and reading materials, using the media to reach a wider public and organizing income generating projects. These commendable activities were not carried out without difficulties and constraints.

The last three years were characterized by hard work on the part of many of our members, followed by gratifying results, increased partnership from governmental and non-governmental organizations and recognition of the IAC as a viable African non-governmental body.

Needless to say that a great deal remains to be accomplished and that there have been difficult and challenging moments in some cases. But what has already been achieved gives us added energy and encouragement to continue and we know that where there is determination and commitment there is always a way.

At the creation of the Inter-African Committee, when I was invited to assume the presidency, I felt highly honoured but at the same time hesitant due to the heavy responsibilities I was given. A determination to do my best and my faith in the ability of us Africans to find lasting solutions to social problems gave me the strength to accept the challenge. Now when I look back and analyse the work so far accomplished, my conclusion is that I am happy to be a part of this important process thanks to your support.

Even more exciting are the open declarations and public pronouncements on the subject matter under discussion by some of the highest African political leaders such as President arap Moi of Kenya, President Diouf of Senegal, President Kerekou of Benin and President Sankara of Burkina Faso which have immensely encouraged us.

It gives us pleasure to put on record the recognition given to our work by the UN Human Rights Commission in setting up a special Working Group on Traditional Practices Affecting the Health of Women and Children. The conclusions of the Working Group have been widely distributed by us. The UN Draft Convention on the Rights of the Child also contains an article pertaining to the issue of traditional practices. This is another such major development at the UN level.

The objectives of this seminar, as explained in the seminar documentation, are to assess progress and shortcomings in the work of the IAC and to plan for the future based on experiences gained.

Through such meetings we expect to strengthen those national committees which have been created to proceed with their noble tasks and provide them with the necessary funding. We also hope to encourage other countries to set up national committees. We plan to establish mechanisms for sub-regional coordination and
generally provide information and education at the grassroots level. We should not forget that our activities are aimed at the poorly informed rural woman.

Such seminars and meetings are appropriate for exchanging experiences and new ideas. They help in reaffirming our position to achieve the common objectives. It is in such gatherings that we can make collective appeals and statements concerning the issues we are dealing with in order to make a strong national and international impact.

In conclusion, I would like to take this opportunity to thank the Ministry of Health of Socialist Ethiopia for co-sponsoring the meeting and for collaborating in the organization. I would also like to thank the Economic Commission for Africa not only for co-sponsoring this seminar but also for providing office space and secretarial services for the IAC regional office. The IAC regional presence was made possible thanks to the agreement signed with ECA. We look forward to wider collaborative programmes at the field level. We also appreciate greatly the contribution received from the Organization of African Unity, and we thank UNICEF for its sustained help and excellent collaboration and the World Health Organization and UNFPA for the support they have provided.

Comrade Minister, Ladies and Gentlemen,

The activities of the IAC, including the realization of this seminar, would not have been possible without the invaluable assistance of many organizations. Their names will appear in the final report. On behalf of the IAC I would like to express great appreciation to them all.

In conclusion, I would like to thank the members of the Inter-African Committee and my colleagues of the offices in Addis Ababa and Geneva for a task well done."

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Speech delivered by Comrade Dr Gizaw Tsehai, Minister of Health, Ethiopia

"Madam President, Distinguished Participants and Invited Guests, Comrades,

On behalf of the Party, Government and on my own I would like to take this opportunity to welcome all our distinguished foreign guests to Ethiopia and all of you to this important conference. Revolutionary Ethiopia is greatly honoured to host this Inter-African Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa.

When we talk about traditional practices, Africa has plenty of good traditional and beneficial practices to offer to the world, such as extended family norms, prolonged breast-feeding and some useful traditional medicine. On the other hand, there are traditional practices in almost all African countries which adversely affect the health of the people in general and the health of women and children in particular. These traditional malpractices, combined with the low socio-economic status of women, impose a great threat to the well-being of the population of our continent.

Traditional practices affecting women and children in Ethiopia are many. In addition to the four subjects of discussion of this seminar, childhood marriage and early pregnancy, female circumcision, practices related to delivery and nutritional taboos, which are so far identified and have equal importance and need our particular attention, I would also mention milk teeth extraction, uvulectomy, vein puncture, burning of the skin, face scarification and tonsilectomy of children, which are done under the most unhygienic and shocking torture, causing mental and physical disabilities and sometimes even death.

These malpractices cause health problems, such as bleeding, infections etc., and social problems because of the mental and physical handicaps these victims suffer as the consequence of the malpractices. The complete eradication of harmful traditional practices takes a long time and fully depends on vigorous and concerted efforts of both governmental and non-governmental organizations including the public in general and the women in particular. It requires initiatives, creativity, innovative ideas and continuous research and, most of all, ability to understand and communicate with the community.

The Government of Socialist Ethiopia has adopted the strategy of primary health care in its endeavour to provide health services to the population. Maternal and child health service, as
one of the main components of primary health care, has been given top priority, as a result of which the prevention of traditional malpractices and the promotion of health are implemented by all categories of health workers at all levels. Traditional birth attendants, community health agents at the village level, training institutions and all health service providers and community development workers are being involved in the dissemination of information about the harmful consequences of these practices. Mass organizations, especially women's, youth, peasants' and urban dwellers' associations and other non-governmental organizations, share the responsibility in educating the public. It is our utmost belief that such problems cannot be dealt with by the efforts of the Ministry of Health alone but require intersectoral collaborative efforts of all governmental and non-governmental organizations as well as organized and institutionalized community participations.

The national committee, organized by the Ministry of Health and composed of all the above mentioned organizations, is created with major functions to identify such problems, to design strategies, to compile and disseminate information and to coordinate and implement programmes for the prevention of traditional malpractices.

This seminar is very important and has special interest for all of us because, with the vast experience exchanges and with genuine and frank deliberations, programmatic policies and strategies and a plan of action can be formulated and implemented to abolish these devastating and harmful practices.

Before I conclude, I would like to thank all sponsor agencies and organizers of this conference and would also like to assure you that the Ministry of Health will carefully follow your deliberations and will spare no efforts to implement your recommendations.

I wish you very fruitful deliberations and it is my pleasure to declare open the conference on 'Traditional Practices Affecting the Health of Women and Children in Africa'.

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Statement by Professor Adebayo Adedeji,
United Nations Under-Secretary General and Executive Secretary
of the Economic Commission for Africa

"Comrade Dr. Gizaw Tsehai, Minister of Health of Socialist
Ethiopia, Madam Chairperson, Excellencies, Distinguished
Delegates, Ladies and Gentlemen,

On behalf of the Secretariat of the United Nations Economic
Commission for Africa and on my own behalf, it gives me great
pleasure to welcome you all to the Inter-African Committee's 1st
Regional Seminar on "Traditional Practices Affecting the Health
of Women and Children in Africa". I also wish to take this
opportunity to express our sincere appreciation to Comrade Dr.
Gizaw Tsehai, Minister of Health of Socialist Ethiopia, for
having graciously agreed to open this meeting. Through you,
Comrade Minister, I would like to thank the Government and people
of Socialist Ethiopia for the hospitality extended to delegates
since their arrival here in Addis Ababa. Cognisant of the
important work carried out by the Inter-African Committee on
Traditional Practices Affecting the Health of Women and Children,
the ECA has been happy to enter into a co-operative arrangement
with the Committee in order to promote the health and welfare of
African women and children.

Non-governmental organizations such as yours have played a
significant role in the transfer of resources and technical know-
how to the developing world; in creating opportunities for the
involvement of women at the national, regional and international
levels; in raising global consciousness about such issues as
equality of women, development and peace. In this capacity, NGOs
have earned respect and recognition from governments and United
Nations bodies alike. As a young regional African NGO, the Inter-
African Committee has a tremendous responsibility. You have set
yourself a dual task: first, the promotion of our African
heritage, those traditions and customs that strengthen African
community life, and second, the eradication of those that are
harmful to the health of women and children.

NGOs have also been very instrumental in strengthening ECA's
activities directed at the advancement of African women. If at
present most African countries have established focal points or
organizations for the advancement of women in our region, it is
due to the pioneering work done by non-governmental
organizations. Most of the national machineries for the
advancement of women have developed from the pioneering work of
voluntary women's groups.

ECA believes that the health of the population has a major
bearing on development possibilities and prospects. This is
particularly so for our women, since women affect directly not only the quantity but also the quality of the labour force. Women shape the attitudes, creativeness and ingenuity of the young, qualities crucial for development. The health status of women is of paramount importance. The ECA has been alarmed, for instance, by the high maternal mortality rates in Africa. It has been estimated that this is 200-600 per 100,000 live birth, whilst that of Denmark, for instance, is 10 per 100,000 live birth. It is our view that socio-economic factors have a direct bearing on this situation and that poverty constitutes a high risk factor in the survival of women. What is tragic is the fact that if only basic and elementary health care could be provided, over 80 per cent of these maternal deaths would be avoided. Furthermore, the poorer women are, the more vulnerable they are to the harmful traditional practices with which this meeting is concerned. Thus, it seems to me that health and economics are inextricably linked together.

Cultural factors constitute another dimension to be considered. As you all know, Africa is a continent rich in traditions: traditions that have survived the so-called modernizing forces of the 20th century, traditions that have helped sustain our people during the harshest oppressive experiences of the colonial era and the subsequent dislocations of family and social systems, traditions that have continued to shape our unique identity and personality.

We must admit, though, that some of these traditions and customs, which may once have appeared to serve the needs of our societies, are no longer relevant. We must recognize that some cultural beliefs and traditional norms number among the major factors that hinder women from fully enjoying their educational, political and social rights. The situation warrants a willingness to examine our value structures closely and critically and a readiness to disregard those practices which we find to be harmful to the health and well-being of individuals in our society, and at the same time to treasure the richer aspects of our culture which enhance and strengthen our communities.

Not only economic constraints, inadequate infrastructures, lack of awareness but also socio-cultural and religious factors continue to hamper women's access to health services. Where there is poverty and illiteracy, where the differences in the socio-economic status of men and women are wide, where the contributions of women in production is unrecognized, women suffer the worst effects from traditional practices from infancy through adulthood. In Africa, the female child usually gets a lesser portion than the male child in the allocation of family food resources, with consequences that are determinant to her physical and psycho-social development. She is often denied educational opportunities. She marries too young and starts having children too early and too frequently for her physical and emotional maturity. Furthermore, the lack of adequate nutrition for the African woman is compounded by nutritional taboos. Her frail body is subjected to the severest types of traditional practices such as excision and infibulation. All these contribute to the high rate of infant and maternal morbidity and mortality in Africa, which represent a high social and economic cost to society. It is clear that the health and well-being of women and the health and well-being of a nation are closely intertwined: the problem of women therefore cannot be divorced from the
Attitudes passed on from one generation to the next have been powerful obstacles to the active participation of women in mainstream development. And for too long women's own beliefs have often surfaced as important barriers and their role in the transmission of cultural and traditional values has contributed to the perpetuation of various harmful practices. Thus, overcoming such traditional practices depends as much on women's integration into development as it does on changing societal value structures and attitudes.

The Nairobi Forward Looking Strategies for the Advancement of Women adopted in 1985 unequivocally states that "health education should be geared towards changing those attitudes and values and actions that are discriminatory and detrimental to women's and girls' health". The Strategies further elaborate the importance of creating and strengthening the necessary infrastructures to facilitate access to promotive, preventive and curative health measures.

Finally, let me inform you that, soon after your meeting, representatives of African governments will be meeting in ECA to consider the future of the ECA Women's Programme. The participants of the African Regional Co-ordinating Committee for the Integration of Women in Development will be considering your recommendations and I can assure you that that body will lend its fullest support to your endeavours.

I wish you a very successful meeting and await your report and recommendations with great interest."

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"Your Excellency, Minister of Health of Socialist Ethiopia, Your Excellency, Executive Secretary of ECA, Madam President, Honourable Delegates, Distinguished Guests,

It is an honour and a pleasure for me to speak, in the name of the Organization of African Unity, at this opening session of the Inter-African Committee Seminar on Traditional Practices Affecting the Health of Women and Children. Allow me, Excellencies, Ladies and Gentlemen, to welcome you to Addis Ababa and to convey to you the good wishes of OAU for the complete success of your work.

The importance of the seminars and other meetings that the Inter-African Committee organizes in Africa, on such a delicate and complex subject, escapes the attention of no one. Although OAU is participating for the first time in such a seminar, its support of the Committee has never been lacking and its contribution to the organization of this meeting is just one evidence of this.

For the Organization of African Unity, that I have the privilege to represent, this seminar takes place at a propitious moment. We are indeed glad that it is held at a time when, within the framework of the Lagos Plan of Action and Africa's Priority Programme for Economic Recovery, our continent is mobilizing enormous efforts to revalue its human resources to use them fully in favour of economic development, promotion of social welfare and cultural fulfilment of the peoples of Africa.

It is interesting and comforting to note that in these commendable efforts the countries of Africa, while duly taking into account the African identity and cultural characteristics, are nevertheless forced to recognize that certain practices, inherent in African tradition, still weigh heavily on the health of women and children. Today, it is urgent to change these practices and it is our duty to identify them and clearly explain the harm they cause to the health of those subjected to them. This extremely delicate and complex task falls to the Inter-African Committee and it calls for the support of each and every one of us.

This is perhaps the moment to acclaim and congratulate the Inter-African Committee on the multiple actions it has undertaken in the campaign for the eradication of these in all senses outmoded and harmful practices. These actions are all the
more praiseworthy as everybody knows how difficult it is to upset traditions and to seek to modify or abolish practices which have been considered as socio-cultural necessities for thousands of years and which no one has questioned until recently.

I therefore seize this occasion to pay tribute, in the name of OAU, to Mrs. Berhane Ras-Work, President of the Committee, and to all her collaborators for their truly dynamic action which, in our eyes, constitutes a major contribution to the promotion of the health of women and children and, in consequence, the whole of society.

No one can deny that the task of the Inter-African Committee is arduous. It is not, however, impossible, on condition that each of us makes his contribution to the dissemination of the knowledge that has been accumulated on all these preoccupying questions, for we believe that the persistence of these practices is, to a large extent, the fault of ignorance, illiteracy and widespread traditional observances.

It is because this task is arduous, but also noble and elating, that OAU cannot but associate itself with such work. OAU is, in effect, essentially concerned with the well-being of African women and children who are the most sure guarantees for the solidarity and the future of African society.

It is both with pleasure and interest that at OAU we follow, through your publications, the activities of the Inter-African Committee and their results and also the hopes they create in many places in Africa. We share your hopes and we think, like you, that it is at present right to believe that the eradication of traditional practices harmful to the health of women and children is becoming a reality, that is to say an urgent aim to be achieved. Today, this objective is no longer a utopian scheme or a naive dream, for Africans have more and more access to information and knowledge. They constantly question their past in order better to explain the present and guarantee a better future for generations to come. Thanks to this information, they understand better and better the ins and outs of certain interventions and the harmful character of these outmoded practices. Finally, it is a very good thing that, more and more, serious and credible voices are raised everywhere in Africa to denounce these practices and to demand changes.

By way of one example alone, I have chosen the Kilimanjaro Action Programme on population, which recommends to African governments, in addition to other concerns, to carry out special studies in order to eliminate from African societies traditional practices causing prejudice to the economic, social and cultural emancipation of women. This same programme also urges governments to adopt legislation safeguarding the rights of children.

We therefore hope that the present seminar, combined with other activities of the same kind undertaken by the Inter-African Committee, will not fail to make people more and more conscious of the necessity to bring about changes.

This is, in any case, the hope of the Organization of African Unity which, by my modest voice, repeats its wishes for your complete success."

* * * * *
"It is indeed an honour and a privilege for me and my colleagues to be representing WHO at this very important regional seminar on "Traditional Practices Affecting the Health of Women and Children in Africa". The seminar is indeed well timed as most of the world is expressing concern over the health of women and children especially in the developing countries.

Traditional practices and social attitudes that directly or indirectly affect the health of women and children exist in one form or another in most countries. The traditional practices of a society are closely linked with the living condition of the people and with their beliefs and priorities. In societies where women's needs have been subordinated to those of men, traditional practices often serve to reinforce their disadvantage, with direct and indirect effects on their health. We are glad that the African women who have gathered here today have decided to do something about those traditional practices that are harmful and that are found predominantly in their regions, through a frank and fruitful exchange of information and ideas.

In the last few years, the topics of traditional practices related to delivery, nutritional taboos, early childhood marriage and particularly female circumcision have been moved from a cloud of secrecy to the centre of a strategy to bring about changes. The key to the elimination of harmful customs is discretion and understanding, accompanied by ways and means to demystify the taboos which surround them. The approach is to encourage activities, consider measures to strengthen integrated strategies aimed at the eradication of harmful practices, while at the same time identifying useful ones which should be preserved and promoted.

The lives and status of women must be elevated - by improving their health, reducing the maternal mortality and morbidity and providing them with education or, where necessary, simply the ability to read and write. For it is education that is the springboard for rescuing women in the Third World from poverty, illness, endless childbearing and lowly social status. As stated in one of the WHO's documents: "Education is the key to the fulfilment of women's aspirations and has a positive impact on the health of the entire family". This is not only a moral imperative to benefit half of humanity and an end in itself - but a means to a far greater end. Because progress for all depends on progress of women. Indeed WHO's Member States have selected an adult literacy rate for both men and women that exceeds 70% as one of the indicators for monitoring progress towards attaining
health for all by the year 2000.

It must become self-evident to everybody, especially after the UN Decade for Women, that the health and survival of all - women, children and indeed men themselves - is served through the advancement of women. Women are referred to as "front line child health workers" and natural resources where health is concerned.

Dr. Halfdan Mahler, Director-General of WHO, in his opening address at one of the international conferences last year made a keynote statement: "Investment in the health of women and children is a direct entry point to improved socio-economic development, productivity and better quality of life, and as such, is a developmental priority at all times and for all countries." He went on to say that maternal and child health is also the "logical entry point for primary health care and in turn offers... the best opening for community participation and contact with families".

A report in response to a resolution by the World Health Assembly has been prepared on the progress of activities undertaken and proposed by the Organization to implement the Nairobi Forward-Looking Strategies for the Advancement of Women within the framework of national, regional and global strategies for Health for All by the Year 2000. The report also briefly reviews the mechanisms for implementation and monitoring of women, health and development as part of the organization's programme of work in support of national efforts in this field, as well as collaboration within the United Nations system and with non-governmental organizations.

As far back as in 1976, at the World Health Assembly, Dr. Halfdan Mahler stated that there was a need to combat superstition and practices detrimental to the health of women and children, and he drew particular attention to female circumcision. Since then, concerted efforts have been made by Member States and by WHO - particularly its Regional Office for the Eastern Mediterranean - to gather information and to generate awareness of the adverse health effects of the practice.

In 1979, a seminar on Traditional Practices that affect the Health of Women and Children, organized mainly by the Regional Office for the Eastern Mediterranean, was held in Khartoum, Sudan. The Khartoum seminar was one of the first interregional and international attempts to exchange information on female circumcision and other traditional practices, to study their implications, and to make specific recommendations on the approach to be taken by the health services. National and local initiatives have since been initiated by women themselves through their organizations, greatly helped by outside support including WHO.

For the past eight years WHO has played a role that has included technical and financial support for national surveys, for the relevant training of health workers, and for grassroots initiatives. For example, WHO has supported the Working Group on Female Circumcision, formed in 1977, and now comprising 20 members of non-governmental organizations under the name of "Working Group on Traditional Practices Affecting the Health of Women and Children".

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In August 1982, WHO made a formal statement of its position with regard to female circumcision to the United Nations Commission on Human Rights. This statement endorsed the recommendations of the Khartoum seminar, namely:

- that governments should adopt clear national policies to abolish the practice, and to inform and educate the public about its harmfulness;

- that programmes to combat it should recognize its association with extremely adverse social and economic conditions, and should respond sensitively to women's needs and problems;

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

In the same statement, the Organization expressed its unequivocal opposition to any medicalization of the operation, advising that under no circumstances should it ever be performed by health professionals or in health establishments.

Together with UNICEF, WHO also stated its readiness to support national efforts against female circumcision and to continue collaborating on research and dissemination of information.

In 1983, during the Thirty-sixth World Health Assembly, WHO together with the NGO Working Group convened an informal meeting on the subject with African delegates to the Health Assembly.

In 1984, WHO headquarters, together with its Regional Offices for Africa and for the Eastern Mediterranean, joined UNICEF and the United Nations Fund for Population Activities (UNFPA) in helping to finance a seminar in Dakar organized by the NGO Working Group and sponsored by the Government of Senegal. The Dakar seminar gave impetus to the establishment of national committees in all the countries where female circumcision is practised. It set up an Inter-African Committee to act as a bridge between the groups working among the people and the outside supporters of their work. Today's seminar is the result of the efforts of this Committee.

The subject of female circumcision, along with other harmful practices, was also subsequently discussed during the Regional Workshop on Women, Health and Development, jointly sponsored by WHO, UNFPA and UNICEF in November 1984 in Damascus, Syrian Arab Republic.

In view of WHO's interest as stated above, we are happy to be collaborating with IAC in this seminar. Its deliberations and recommendations will be of great interest to us. WHO headquarters and its regional offices for Africa and Eastern Mediterranean will be most willing to extend their technical support to countries for any research projects which may emerge as a result of these five days' discussions. Operational research directed to prevalence and to epidemiological, health education, psycho-social and training issues related to the traditional practices will receive priority.

In line with WHO's policy for further strengthening its collaboration with non-governmental organizations, we would be happy to join hands with IAC in responding to the challenge of
eradicating the harmful traditional practices and at the same
time promoting the beneficial practices.

In the end, I would like to thank the organizers for inviting
WHO to participate in this seminar and to extend the best wishes
of our Director-General, Dr Halfdan Mahler, Dr Monekosso,
Regional Director for Africa, Dr Gezairy, Regional Director
Eastern Mediterranean Region and Dr Angèle Petros-Barvazian,
Director, Family Health Division, for a very fruitful and
successful meeting."

* * * * *
Statement made by Mrs Jane Cole, Programme Officer, UNICEF Addis Ababa

"Madam Chairperson, Your Excellency Comrade Gizaw Tsehai, Minister of Health, Prof. Adebayo Adedeji, ECA Executive Secretary, Representative of OAU, Distinguished Guests, Participants to the Seminar, Ladies and Gentlemen,

It gives me great pleasure to make a statement on behalf of UNICEF at this important Regional Seminar. Let me begin by saying that the health hazards and psychological risks, long-term as well as immediate, to young girls as a result of female circumcision in its various forms have been a serious source of concern to UNICEF. UNICEF's approach to female circumcision is that it is basically a socio-cultural and human-rights problem with health consequences, and UNICEF is convinced that the issue is most effectively addressed by promoting awareness through education of the public, of health professionals and traditional health workers and through the involvement of local communities and their leaders.

A number of socio-cultural aspects need serious consideration in the designs of action and information programmes. Religious consideration is one. Even though no religion prescribes female circumcision, many people in fact believe that the operation derives from religious presumptions. Furthermore, the practice is embedded in a total cultural system. Also of importance are the concepts of femininity, male-female social and sexual relations, the status of practitioners or operators and the great variations in aspects of the practice that require flexibility in the development of supportive approaches.

UNICEF's programme objectives to halt the practice of female circumcision have been:
- to increase awareness and understanding of the health and socio-cultural aspects,
- to enhance the capacities of governments and NGO personnel to develop and implement concrete programmes, and
- to encourage epidemiological and socio-cultural research.

These programmes have been conducted on two fronts: global and national.

Globally, UNICEF has joined cooperative efforts with WHO. UNICEF participated in a WHO sponsored seminar on traditional practices affecting the health of women and children in 1979 in the Sudan. Government officials of several countries where female circumcision is widely practised or confined to certain groups -
Democratic Yemen, Djibouti, Egypt, Ethiopia, Kenya, Nigeria, Oman, Somalia, Sudan and Upper Volta - along with high level experts who took part in the meeting, agreed by consensus on recommendations calling for national policies, establishment of national commissions, educational efforts directed towards the general public and educational programmes for community level practitioners.

In March 1980, a two-day high level inter-agency consultation was sponsored by UNICEF and WHO in Alexandria, Egypt, to explore areas of collaboration and elaborate future cooperation in joint initiatives to combat the practice of female circumcision. The meeting, which was also attended by representatives of a number of other agencies and in which nationals of some affected countries served as consultants, culminated in the formulation of a joint WHO/UNICEF action programme. It emphasized that great caution should be urged on the part of outsiders lest their well-intentioned efforts to help eradicate the operation be construed as interference, leading to counterproductive reaction. Rather work should be undertaken by and through nationals whenever possible, with programmes tailored to each country according to the level of awareness and activity regarding female circumcision. As a public health problem, female circumcision can be successfully approached through primary health care with emphasis on multi-sectoral coordination and community participation.

A number of recommendations were adopted in Alexandria for WHO/UNICEF initiatives in programmes of cooperation with countries on female circumcision. These involved advocacy, identifying and supporting individuals and organizations with national stature, influence and credibility in this field, integrating the discussion on female circumcision into educational and training programmes; fostering action-oriented research on female circumcision and disseminating the results of successful action and of research programmes. A further breakthrough occurred later when representatives of African governments attending a regional preparatory meeting of the World Conference of the United Nations Decade for Women in Lusaka, Zambia, put forward and agreed on a resolution condemning the practice of infibulation.

Nationally, UNICEF has been supporting action-oriented research programmes. The research study on "Harmful Traditional Practices Affecting the Health of Women and Children in Ethiopia", sponsored by the Ministry of Health in Ethiopia and funded by UNICEF Addis Ababa Office, is a typical example of national programmes being implemented by UNICEF. This study highlights the harmful effects of traditional practices such as female circumcision. It makes several recommendations to speed up the process of change. These include the dissemination of information to raise the consciousness of the general public with a view to eventually eradicating the practice.

UNICEF is happy to be associated with this Seminar. UNICEF already participated as a member of the core group which prepared its programme. I wish the participants to this Seminar fruitful deliberations."

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Opening remarks by Dr M. Nizamuddin, UNFPA Deputy Representative

"Honourable Minister of Health, Members of the Inter-African Committee, Distinguished Participants, Ladies and Gentlemen,

It is indeed a great pleasure for me to have this honour and the opportunity to welcome you all to this important Seminar on Traditional Practices Affecting the Health of Women and Children in Africa. On behalf of the United Nations Fund for Population Activities and on my behalf, I would like to congratulate the Inter-African Committee for promoting the health of women and children in Africa by organizing such seminars at the national, regional and international levels. UNFPA is gratified to note that this African network is expanding and several national level IAC committees have been established in Africa. These committees can provide an excellent base of power from which to undertake actions and to introduce policies benefiting women and their families.

We express our sincere hope that this expanding network will be channelled to create a consensus among the women, the legislators, the religious leaders and the government officials about the harmful effects of traditional practices such as female circumcision, early childhood marriages, teenage pregnancies and certain practices related to delivery and child spacing.

We further hope that these national IAC committees go beyond organizing seminars. They should plan and carry out effective public education and information campaigns to change traditional attitudes towards the health and welfare of women and children.

It is regretful to note that despite official pronouncements about the improvement in the status of women, a great majority of women are still subjected to additional risks because of traditional discriminatory health related practices and the physical demands of frequent pregnancies and lactation. A large number of women in the rural areas as well as those in the poorer urban areas of Africa go through the process of childbirth without proper medical care. There is a growing evidence confirming a higher rate of death among infants born to teenage mothers than among those born to women in older age groups. Death related to childbirth still claims hundreds of women's lives per 100,000 births. There is a strong correlation between maternal mortality and infant mortality rates, which are high in many countries of Africa.

There is an urgent need to plan and implement effective
public education programmes that can combat the harmful traditional practices and create an environment responsive to women's needs and problems. We trust that this Seminar will produce a better understanding of the situation of women in Africa, and of their health and welfare in particular, as well as identify priority areas for follow-up actions.

We at the UNFPA are proud to have been associated with the Inter-African Committee since its very inception in 1984 by supporting and partially funding its activities in several countries.

Finally, I would like to thank the Inter-African Committee, the Ministry of Health of the Government of Ethiopia and the Economic Commission for Africa for organizing this valuable Seminar.

I wish you all success in your deliberations."

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CHAPTER IV
ELECTION OF OFFICERS; AGENDA; PROCEEDINGS
STATEMENTS BY THE CHAIRPERSON OF THE SEMINAR AND
THE PRESIDENT OF THE IAC; ACKNOWLEDGEMENTS

The office bearers of the seminar were elected as follows:
- Chairperson: Dr. Irene Thomas, Nigeria
- Vice Chairperson: Mrs. Cathy Sall, Senegal
- Rapporteur in English: Mrs. Gloria Aryee, Ghana
- Rapporteur in French: Mrs. Kankou Diallo, Mali

The agenda was adopted with the following items:
1. Childhood Marriage and Early Pregnancy
2. Female Circumcision
3. Practices Related to Delivery and Child Spacing
4. Nutritional Taboos

The Chairperson of the seminar, Dr. Irene Thomas, then addressed
the participants. Her speech was followed by a report on the IAC
activities, with acknowledgements, by Mrs. Berhane Ras-Work,
President of the Inter-African Committee. For the text of these
speeches see the following pages.

The proceedings consisted of:
- introductory speeches followed by discussions;
- special meetings on educational materials, presentation of
  project proposals etc.;
- showing of films;
- group work in English speaking and French speaking working
  groups;
- reports on the group work to the plenary meetings.

On the basis of these reports, a Plan of Action was drawn up,
containing guidelines for action to protect women and children
from hazardous traditional practices; the Plan should be
implemented within ten years. It was unanimously agreed upon and
adopted. It is presented as Chapter II of this report.
Dr Thomas, Chairperson of the Seminar, gave the following welcome address:

"I bid you welcome to this first triennial Seminar since our Committee, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in Africa, was inaugurated in Dakar, Senegal, on February 10th, 1984.

It is a singular coincidence that the Addis Ababa seminar should be held exactly 38 months to the day after the Dakar seminar (6th to 10th February, 1984). When we met in Dakar, I was sceptical of the outcome of that meeting. From my experience of meetings revolving around traditions and cultures, there was always a tendency for some women to say: 'Why don't we leave these issues alone? They are sensitive areas with political bias and we shall never succeed in our attempt to bring about a change. We shall be told that as a result of our Western type of education we have ceased to appreciate our African culture.'

The Dakar meeting, however, proved to be one with a big difference, as the women there, gathered from twenty African countries, declared with one voice that the time was ripe for ACTION to be taken by them, and pledged never to relent their efforts to bring about AWARENESS, especially to the unperceived, of the dangers and harmful effects of such practices as female circumcision, early childhood marriage, methods related to child delivery and child spacing, and nutritional taboos. As a result of this decision, there now exist 13 national committees of the IAC, all of which are working at their own pace towards achieving the goals of our Organization.

It is obligatory therefore that we should come together again
- to take stock of and evaluate the programmes and activities undertaken at national and international levels during the past 38 months;
- to provide new impetus to the setting up of National Committees;
- to discuss programmes on education, sensitization, research, training, workshops etc.;
- to recognize areas of collaboration with other agencies dealing with health and education;
- to seek government support for the activities of national committees;
- to renew our appeal to international humanitarian organizations for financial, material and technical support to the IAC and its national committees;
- to reiterate a collective appeal to African governments to adopt and pursue a strong policy against harmful practices hitherto identified and other such practices, for example son preference, uvulectomy, zur-zur.

I think it is fitting that this seminar should be held in Ethiopia, the country of Berhane Ras-Work, President and Coordinator of IAC. Through her efforts, complemented by the cooperation of her assistants, she has succeeded in strengthening the growth of the first national committees, while at the same time encouraging the birth of new ones.

We are happy to be in your beautiful and ancient city of Addis Ababa. The opportunity to have here representatives of 29 different nationalities from the vast continent of Africa is truly great and exciting and offers us the means of not only appreciating one another but also of understanding the vastness of the continent as judged by the number of stop-overs and flight connections some of us had to make, even in these modern days.

I welcome our friends and collaborators from Europe, Asia and the Americas, the representatives of the OAU, ECA, WHO, UNICEF, UNFPA and other agencies, governmental and inter-governmental, who have taken an interest in our work. I welcome members of the NGO Working Group on Traditional Practices Affecting the Health of Women and Children and all international humanitarian organizations which have supported the activities of IAC, financially and otherwise.

It is my hope that our inter-reactions during the next four days will yield fruitful discussions and valuable solutions to the problems to be highlighted by us, bearing in mind the encouraging and supportive statements made by Professor Adebayo Adedeji of the ECA, the representative of the OAU and the representatives of the WHO, UNICEF and UNFPA.

We, African women, have travelled a long way to come to this point. The journey has only just begun, but our path is clear: we shall continue our march forward towards improving the Health and Status of African Women and Children and with the help and support of all our collaborators, governmental and non-governmental agencies, we know we shall succeed."
I. INTRODUCTION

1. The three years of existence of the Inter-African Committee (IAC) have witnessed interesting but challenging moments. The first challenge was making the Committee an effective and recognized body with a strong regional network. Several steps were taken in order to achieve this objective. To start with, letters of introduction announcing the creation of IAC were widely disseminated. These were sent out to governmental and non-governmental organizations and to agencies of the United Nations system. This was followed by a summary report which highlighted the recommendations made at the seminar held in Dakar.

2. The letters explained the decision of the participants of the Seminar to take the matter of traditional practices into their hands by setting up an African body to deal with the issues of traditional practices affecting the health of women and children in Africa. An appeal was also made for cooperation and solidarity in support of this initiative. The responses received from several organizations were most encouraging and supportive.

3. In order to make IAC a legal body, the first draft constitution was drawn up by a consultant and the document was first presented to members of the IAC Bureau. After their consent it was presented to the Government of Senegal for recognition and registration as a non-governmental organization. This was done with the idea of opening an office in Dakar. Unfortunately, the process took more than a year. In the meantime, the programme of the Committee was being carried out from the President's office in Geneva.

4. In January 1986, IAC signed an agreement with the Economic Commission for Africa whereby the Inter-African Committee was provided with office space and thus was able to have an African base. This was a major step forward in mobilizing activities from Africa. Thanks to the Economic Commission for Africa, IAC has now a coordinating office in Addis Ababa. The agreement signed allows also collaborative programmes with ECA at the field level.
II. ACTIVITIES CARRIED OUT FROM IAC OFFICES IN GENEVA AND ADDIS ABABA

A. Field level

5. The main task of the IAC is to set up effective national committees and groups for carrying out programmes of education, research, training etc, related to the issue of traditional practices affecting the health of women and children in Africa. For this purpose, representatives of IAC carried out extensive missions, meetings and consultations in at least 20 African countries. Through continued dialogue and correspondence, IAC was able to initiate the setting up of national committees in the following 13 countries:

Benin, Djibouti, Egypt, Ethiopia, Gambia, Ghana, Liberia, Mali, Nigeria, Senegal, Sierra Leone, Sudan and Togo.

6. Details of the activities of these committees will be presented by representatives present at this seminar. IAC was able to offer financial contribution to support the activities of the committees in the following countries:

Djibouti, Egypt, Gambia, Ghana, Liberia, Nigeria, Sierra Leone, Sudan and Togo.

7. In Senegal, the Committee collaborated with an organization called Bok Diom and supported its campaign against female circumcision; a representative of this organization is present at the seminar and could give the details of its activities. The Committee also made financial contributions for the realization of workshops run by the Somali Women's Democratic Organization (SWDO). It is hoped that collaboration with SWDO will continue.

The IAC groups/sections FORWARD and "Groupe Femmes pour l'abolition des mutilations sexuelles" (G.A.M.S.) work actively in England and France, respectively, to abolish female circumcision among the immigrant population in these countries.

The Committee was able to give financial support to carry out activities in the various countries thanks to grants it received from UNICEF, UNFPA, governmental and non-governmental organizations.

B. Educational materials

8. Many IAC counterparts expressed the need for educational materials. Ideas received from Africa and grants received from the Anglican Church of Canada made it possible for IAC to respond to this request and produce and distribute a great number of anatomical models, flannelgraphs and viewers with slides. The demand is still high but unfortunately the funds received for this purpose are at present completely exhausted.

C. Distribution of reports and relevant documents

9. The following relevant documents were widely distributed:

- Report on the Dakar Seminar, in English and French;
- Reports on missions;
- Report on the Nairobi IAC workshops;
- Reports on national workshops (to donors and interested organizations);
- World Health Organization policy on female circumcision.

D. Newsletter

10. Although sending out documents entails financial strains, it is felt that national committees and other interested bodies should be kept informed about progress made at the national and international levels concerning the issue of female circumcision and other such practices. The IAC publishes and distributes its newsletter twice a year, in English and French. This document provides information on the policies and programmes of the IAC. It also helps to exchange ideas and to introduce major developments.

E. IAC workshops in Nairobi during the UN Decade for Women Conference/Forum

11. For the UN Decade for Women World Conference/NGO Forum in Nairobi in July 1985, the IAC had ensured the participation of 55 African delegates and to hold two workshops on the subject of female circumcision. The workshops proved to be an appropriate forum for discussing the progress made by African countries in the campaign against female circumcision. The collective appeals made by the participants for Governments to take action on female circumcision and the clarification of a very high Islamic religious leader concerning the position of the Koran regarding female circumcision had a strong international impact. As mentioned earlier, the report on these workshops was widely distributed.

F. Participation in Conferences and in Seminars

12. IAC is represented in relevant international meetings and conferences and it endeavours to present the issue of traditional practices in a manner acceptable to Africans. It provides necessary documents and background information. It took an active part in the sessions of the Working Group on Traditional Practices of the UN Commission on Human Rights. It also participated in the NGO Forum during UNICEF Board meetings. It also takes part in the meetings of the NGO Sub-Committee on the Status of Women which is under the Special Committee on Human Rights. It carried out information campaigns and lobbying at various international meetings.

III. FINANCING, ACKNOWLEDGEMENTS

13. IAC would not have been able to function and carry out any of its activities without financial support. Fund raising has therefore been a substantial and necessary part of its work. The Committee has received financial assistance from the following sources:
Canadian International Development Agency (CIDA)
The Government of the Netherlands
UNFPA
UNICEF
WHO
Algemeen Diakonaal Bureau (Reformed Churches of the Netherlands)
The Anglican Church of Canada
Christian Aid, United Kingdom
Church of Sweden Aid
Commonwealth Foundation, United Kingdom
Danchurchaid, Denmark
Danish Red Cross
Development and Peace, Canada
Development Services International, Canada
Diakonia, Sweden
League of Red Cross and Red Crescent Societies, Switzerland
Misereor, Federal Republic of Germany
Nederlands Comité voor Kinderpostzegels
Norwegian Red Cross
Overseas Development Administration, United Kingdom
Oxfam, United Kingdom
Population Crisis Committee, USA
Rädda Barnen, Sweden
Redd Barna, Norway
Save the Children, United Kingdom
Save the Children, USA
The L.J. Skaggs and Mary C. Skaggs Foundation, USA
Society for the Protection of Human Rights, United Kingdom
Swedish Red Cross
The United Church of Canada
Voluntary and Christian Service, United Kingdom
Private persons

Note: This list covers the period up till the end of 1987, i.e. also grants received after the Seminar but before the printing of this report.

The grants received have been highly appreciated and it is hoped that this support will continue in order to make it possible for the IAC to accomplish its tasks.

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CHAPTER V

ITEM 1: CHILDHOOD MARRIAGE AND EARLY PREGNANCY

Introduction by Dr. Leila Mehra, WHO Geneva, and Dr. Wedson Mwambasi, AFRO Brazzaville.

Reports were submitted from the following countries:

Burkina Faso
Central African Republic
Chad
Ethiopia
Tanzania

The issue of childhood marriage and early pregnancy is also dealt with in country papers comprising more than one subject of the seminar (see Chapter IX).
CHILDHOOD MARRIAGE AND EARLY PREGNANCY

by

Dr Leila Mehra, WHO, Geneva

and

Dr Wedson Mwambazi, AFRO Brazzaville

Dr. Mehra said that early childhood marriage has been practised since time immemorial in Asia, Africa and Latin America. Customs relating to the practice differ widely. Reports from Islamic Northern Nigeria and Uganda state that early marriage is common and that childbearing starts soon after puberty, when most girls have not reached their greatest reproductive potential. Harrison reported a mortality rate of 34/1000 in this group (1978).

Customs in Ethiopia show early marriage in several ethnic groups, where girls are given away as early as at seven years of age, and even though childbearing may not commence until 13-15 years, vesico-vaginal fistulas are a common occurrence after prolonged and obstructed labour.

The major consequences of early marriage, enumerated by Dr Mehra, are unwanted pregnancies and uncontrolled adolescent fertility, lowering of socio-economic progress, undermining of cultural and moral life, increase of illegal abortions, impairing of the health and careers of those involved, especially young women, increasing infant mortality rates which make young mothers vulnerable to additional pregnancies, and undermining of self-confidence and self-identity. Dr Mehra stated that the adolescent period starts from about 10 years and ends at 20 years (WHO 1965).

In most African traditional societies, a child grows straight to adulthood, the landmark being puberty, instead of the child changing gradually to become an adult. It is observed that puberty occurs at an earlier age now than was the case several decades ago, and this implies that adolescence and fertility also occur at an earlier age. The number of girls at fertility risk will therefore continue to grow.

Several studies in African countries have shown that there are certain sub-culturally instituted practices which encourage early marriage when the adolescents are not physically, psychologically or socially prepared for it. Even where laws prohibiting marriage for females under 15 exist, they are neither seriously observed nor enforced. The victims are usually illiterate and economically underprivileged, and have no say in the choice of their spouse. The scarceness of trained TBAs and midwives and lack of transport and other facilities, especially in the rural areas, aggravate the serious consequences associated with early sexual life, teenage pregnancy and resultant
childbearing complications, such as obstetric fistulas and incontinence - the latter leading to psycho-social problems, such as feelings of shame and shunning friends. Added to these is the increased risk to the life of both mother and baby.

In view of these disastrous consequences, the World Health Assembly passed a resolution in May 1985 which, among other things, urges all member states to act immediately to promote healthy families through the provision of adequate information and guidance for responsible parenthood to adolescents, and to promote the delay of childbearing until both prospective parents, but especially the mother, have reached maturity in adulthood.

Dr. Mwambazi started by presenting a WHO working definition of adolescence. He said that the topic under consideration should be viewed in the wider context of adolescent health as a whole, and also within the context of socio-economic potential.

He then highlighted some of the special features of adolescence in Africa which influence the status of adolescent health:

1. The proportion of adolescents in Africa is increasing faster than in other regions.

2. Traditionally, African children are exposed to sexual activity early in life, either through early marriage or through the risk-taking behaviour inherent in the age group. Early marriage is practised for many reasons which may differ from one country to the other.

3. The increase of the number of adolescents has meant that social services, e.g. school and employment opportunities, are increasingly becoming over-pressurized; therefore the majority of children of school age remain at home after primary school, i.e. between 13 and 17 years of age; employment opportunities are non-existent. Inevitably, the majority of young girls simply get exposed to unprotected sexual activities.

4. The percentage of African adolescents experiencing sexual intercourse between 10 and 19 years is rapidly increasing.

5. As a result of the above, a tremendous rise in adolescent fertility rate has been observed during the last two decades.

6. The lack of access to family planning facilities and programmes exposes this age group to a high risk of unwanted pregnancies and the potential complications.

7. It is also well established that a relatively large proportion of youngsters live with people other than their parents. In most low-income situations this may contribute to a lack of necessary care and guidance because of overcrowding and large numbers of household members.

8. The impact of current hardship is felt even by adolescents to the extent that their desire and need to cope with the cash economy gets easily exploited by anyone who can offer monetary rewards. This has led to increasing child abuse of every kind.
9. Because of inadequate law enforcement infrastructures, African youths can easily get away with offences against regulations, such as those pertaining to access to and misuse of tobacco, alcoholic beverages, etc.

10. Sexually transmitted diseases have tremendous implications for the adolescent girl. There is a high preponderance of females over males in morbidity caused by sexually transmitted diseases in adolescents, while the reverse is the case in adults.

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CHILDHOOD MARRIAGE AND EARLY PREGNANCY IN BURKINA FASO

by

Mrs Henriette Bary, Head of the Cabinet of the
Minister of Higher Education and Scientific Research,
Burkina Faso

Several ethnic groups in Burkina Faso practise childhood marriage for various reasons (fear and shame of girls getting pregnant before marriage, gratitude towards a benefactor, respect for tradition...). Having defined its harmful consequences on the health of young women, organizations working for the promotion of women have carried out campaigns of sensitization at different levels to awaken consciousness of the problem.

A family code law has been adopted, making 18 the marriageable age for girls; the Committee of Reflection on Pediatry has asked that this age be raised to 20. In order that this law be effectively implemented, it is henceforth compulsory in Burkina Faso that all marriages take place before the civil authorities; religious or traditional marriages alone are no longer valid. A vast operation to provide identity papers has been organized.

At the same time, numerous information campaigns in the national languages have been undertaken with the use of the media, and debates have been organized to sensitize those who still need this information. It is only later that the real impact of these measures can be evaluated.

It should be stressed that to support these decisions, numerous projects have been set up in order to create profitable occupations for girls, in urban as well as in rural areas. Unfortunately, such projects have not yet been set up in the whole country.

Concerning early pregnancies of girls who were married too young or who were not informed of the risks incurred at the time of sexual relations, numerous activities have been undertaken to sensitize and inform young people and their parents, of both sexes, of the drawbacks of such practices: training seminars, information and sexual education courses, conferences with debates on family planning in all its aspects and meetings in the towns and villages at the end of which the participation of everybody is required and also ensured.

It is along these lines that sexual education is introduced in secondary education, professional training and social centres. Together with family planning it is introduced in informal talks in Mother and Child Health Centres and alphabetization groups. These subjects are developed in the training of medical and paramedical personnel (doctors, nurses, midwives, group
educators, social assistants, village midwives, health workers in primary health care centres...).

Studies have not yet been undertaken to evaluate the changes that have taken place in this field since this vast campaign of sensitization was started.

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Current practices in Central African Republic concerning childhood marriage and early pregnancy oblige us to explain the concept of early marriage. In effect "marriage" means either traditional or civil ceremonies. In Central African Republic free sexual relations and early pregnancies are more predominant. These practices are essentially due to socio-economic reasons, for our young girls are influenced by phenomena like fashion which necessitate the availability of appropriate means.

It should be noted that these young girls are under-informed or badly informed, as sexual problems are still taboo for both parents and educators. They are equally under-informed on the use of contraceptive methods and family planning. These young girls are generally victims of unscrupulous men, although often in a responsible position, who to relieve their sexual needs do not care about the consequences which their acts lead to for the girls.

Once they are pregnant, these young girls have only two possibilities:
- to try to abort with the complicity of friends rather than parents and by methods that are often archaic and dangerous, or
- to keep the baby.

In the last case, the girl must leave school and stay at home. Other obligations are forced upon the authors of the pregnancies by the parents. A man who receives a girl like this considers her either as a nuisance in his home, if he is married, or as irksome and to be easily abandoned on the least occasion for lack of motivation and free choice at the beginning. Because of this, there is a high divorce rate for such couples and an increase in the number of unmarried mothers who are at the charge of their parents or guardians or abandoned to themselves with all the risks which that entails.

Currently, several projects of sensitization and training of young girls are being carried out in our country. For some years, these projects have been regrouped on the initiative of the Government and placed under the guidance of an Inter-Ministerial Committee for Health Education. In the plan of action of this Committee there are two essential phases:

1) at Primary School level, introduction of activities aiming at cleanliness, bodily and environmental hygiene,
2) at Secondary School level, introduction of activities oriented towards sexual education and family planning.

The realization of these programmes is preceded by vast sensitization campaigns in all the classes concerned.

We hope that the activities of sensitization, information and training organized by the Inter-African Committee will permit an efficient fight against traditional practices which have negative effects on the health of our women and children.

* * * * *
CHILDHOOD MARRIAGE

by

Mrs Fatimé Adoum Moussa Seif,

Member of the Executive Committee of the National Council of the Women's Organization of UNIR (OFUNIR), Chad

Definition of marriage in Africa

Marriage is a world-wide social phenomenon. It is a procedure according to which two persons of opposite sex and from different families agree to live together, after the consent of their respective families, in keeping with the legitimate ties according to custom or law.

However, marriage is quite a complex problem in Africa for several reasons, which are at the origin of many difficulties for young couples. One can distinguish between marriage by mutual consent of the two parties and early childhood marriage, still commonly called forced marriage, which is the subject of this paper.

Marriage in Traditional Society

In traditional Africa in general, and in Chad in particular, marriage is an affair between men. Even today in rural areas, marriage is still considered to be a taboo subject where only men have the power of decision. Marriage is among the most important problems discussed by men under their palaver tree in family councils presided over by either the father or the oldest member of the family.

In the Sara land, once a general agreement has been reached, the payment of the dowry is made in traditional currency by the offer of either a horse or traditional items, such as knives, and completed by periods of work in the fields that the young husband must carry out for his parents-in-law. There is neither a time limit nor a term for the payment of the dowry. Thus, a Sara proverb says: "The payment of the dowry ends only at the tomb."

Owing to the importance of the question, women are excluded; their opinion is not required and even less that of the future wife, who is simply informed by her mother at a suitable moment. Propriety is of no importance. Everything is subordinated to the consent of the male relatives. The two young persons who often do not know each other, learn to live together from the day the decision is officially announced. Considering the education of the girl who has been taught total submission, it is rare to note cases of disagreement leading to separation. The young wife suffers in silence, without hope of help from her parents.
Nevertheless, in the Sara society, particularly in rural areas, where the age for marriage is fixed at 18/20, the problems linked to childbirth indicated in the second part of this exposé, childhood marriage, are rarely found in traditional marriages.

Childhood or Forced Marriage

Childhood marriage is a premature union. It is a marriage that takes place earlier than it should, for various reasons. The problem manifests itself in several different ways.

The first example is forced marriage for religious reasons, particularly among Moslems, according to which the young girl is considered as a ripe fruit which should be consumed before it is overripe. At the age of 13-14 the girl is already prepared for marriage. She should then not stay any longer at home.

During this time she is subject to strict supervision while waiting for an ideal marriage candidate. Even if she is a schoolgirl or a student, her will does not count, since the only aim of the parents is marriage. There is no possible means of dissuasion. As long as the future husband is a capable man, who will be a good father, the essential thing is that he fulfils the conditions and there will be no problem for him. As for the young girl, she must submit to the wish of her family and she must marry to safeguard the honour of her parents. This kind of marriage is often found even today, with grave repercussions on the health of the young girls and their future babies.

It is in this category that numerous cases of sterility are found among young wives not having reached the normal age for marriage. This category is responsible for 90% of marriage failures especially in the case of sterility which is the most common cause for husbands to repudiate their wives.

The second example concerns the dowry, a very different situation from the first which is explained by the Moslem religion and its deep conception of honour.

The dowry today has no longer a symbolic value. It has become a plague, a means of male pressure in contempt of the will and the future of the young girl. The age of the man in relation to that of the young girl is no longer taken into account. It is sufficient for a rich man to pay an important sum for marriage arrangements to be made in defiance of all objectivity. This practice constitutes an obstacle above all for young people who do not have the possibility to marry according to their choice and it provokes the rebellion of young girls, leading to prostitution and suicide.

In conclusion we can say that early marriage entails many harmful consequences for women, among other things gynaecological problems leading to frigidity and sterility for some, and difficult delivery for others. Socially, exhorbitant dowries are the cause of numerous cases of divorce and prostitution and even of suicide of young girls not having the possibility to marry as they wish. It is therefore befitting that appropriate measures be taken at different levels to sensitize parents in general and young girls in particular, in such a manner that this harmful practice will be definitively eradicated.

* * * * *
Sexual activity can be considered as an expression of a normal bodily function if
- women have attained the necessary biological maturity not only to engage in the coital act but also to carry pregnancy to a successful end; in other words, pregnancy and childbirth should pose no additional risk to the mother, and the risk of death or damage to the unborn infant should be minimal;
- potential mothers and fathers are aware that unprotected coitus can lead to pregnancy and are prepared to assume full social responsibility; in order to assume such responsibility with minimum emotional and social cost, it is necessary that the potential parents have attained the necessary maturity, and that the union is sanctioned by the family and the community.

Reproduction among couples who do not have the above attributes often results in death and excessive damage to mother and child, the extent of which varies with the circumstances of pregnancy and childbearing.

Marriage in traditional societies

In developing countries, where the dominant life style is that of the traditional rural society, most women have their first pregnancy as adolescents, usually within the first 2 years of puberty. Almost all these mothers have not yet completed their own growth, so that the foetus and the mother compete nutritionally. Many of these teenagers develop nutritional anaemia (iron deficiency) during pregnancy.

Newborns of teenage mothers who continue to grow during pregnancy show various grades of intrauterine growth retardation, probably due to protein and energy undernutrition. Likewise the teenage mother may show overt signs of undernutrition.

Teenage housewives are expected to attend to household chores in addition to participation in agricultural work. Many such mothers appear thin, frail and exhausted, a phenomenon referred to as the "maternal depletion syndrome". Maternal anaemia increases the risk of foetal asphyxia and maternal death from such obstetric complications as post-partum haemorrhage.

Protein energy undernutrition compromises the foetus as evidenced by the higher mortality rates in undernourished newborns. Undernourished newborns have also greater difficulty in
making neonatal transition and such babies are more likely to die before they reach their first birthday. Those with neonatal difficulty who survive beyond the first year have a greater risk of developing mental and neurological handicaps. Adolescent child bearers in early teens are also prone to develop pregnancy induced hypertension. If severe, such hypertension can lead to maternal and foetal death or damage.

One of the most important causes of foetal and maternal death and damage is obstructed labour. This occurs most often when the baby is too large for the birth passages. Obstructed labour leads to maternal damage, the most crippling of which is vesico-vaginal fistulas leading to urinary incontinence. In Ethiopia, and also in other African countries, the disorder is most common in women who have early marriages and early pregnancies. Disorders cited above can be prevented by intensive and individualized application of modern obstetric care. Such care is not generally available to pregnant women in developing countries and, therefore, adolescent pregnancy carries increased risk.

Table 1. Maternal complications of early marriage, pregnancy and childbirth

<table>
<thead>
<tr>
<th>Nutritional</th>
<th>Obstetric</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaemia - iron deficiency</td>
<td>Pregnancy induced hypertension</td>
<td>Illegal abortion</td>
</tr>
<tr>
<td>Higher risk of death in case of haemorrhage</td>
<td>Eclampsia: acute renal failure, coma and death</td>
<td>Death from haemorrhage and septic shock</td>
</tr>
<tr>
<td>&quot;Maternal depletion syndrome&quot; - foetal parasitism</td>
<td>Vesico-vaginal fistula: urinary incontinence</td>
<td>The adolescent failure syndrome</td>
</tr>
<tr>
<td>Higher risk of intercurrent infection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Complications in the foetus, neonate and infant of the adolescent mother

<table>
<thead>
<tr>
<th>Foetal growth retardation</th>
<th>Protein-energy undernutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foetal hypoxia</td>
<td>Maternal anaemia</td>
</tr>
<tr>
<td></td>
<td>Maternal hypertension</td>
</tr>
<tr>
<td>Perinatal asphyxia</td>
<td>The compromised foetus</td>
</tr>
<tr>
<td></td>
<td>Maternal anaemia</td>
</tr>
<tr>
<td></td>
<td>Obstructed labour</td>
</tr>
<tr>
<td>Disorders in mothering --- less infant-mother bonds</td>
<td>Failure to breastfeed + --- severe malnutrition</td>
</tr>
<tr>
<td></td>
<td>Recurrent diarrhoea</td>
</tr>
<tr>
<td></td>
<td>Neglect</td>
</tr>
<tr>
<td></td>
<td>Battering???</td>
</tr>
</tbody>
</table>
Adolescent pregnancy in modern industrialized societies

Adolescent pregnancy is also common in developed and industrialized societies. There, it is a multi-faceted sociologic problem somewhat different from similar problems in developing communities. The pregnant adolescent in developed countries is more likely to be a child with behaviour problems, often in rebellion ending in flight from home to a life of excessive sex, alcohol and drugs. Pregnancy often occurs in a context of high morbidity from sexually transmitted diseases, addictions, and intense unhappiness with overt suicidal tendencies.

The media of the developed countries present sex as glamorous, exciting. The very young teenager sees that premarital sex and free cohabitation are a way of life. At the same time the young receive the message that "good" girls should not engage in sex, which precipitates a radically negative reaction. Once the teenager conceives out of wedlock, she is condemned to a life of multiple inadequacies: failure to complete school and to experience the adolescent transition to adult life, with consequent personality disorders. The literature refers to the above as the "adolescent failure syndrome".

Secular trends in developing countries and adolescent pregnancy

Developing countries are undergoing rapid social and economic transformations. This is more vivid in urban areas where we have a growing influx of people from the rural areas. Many such persons constitute the urban poor, often with large families. Children from these families are exposed to a wide variety of life styles, including sexual behaviours. While traditional norms dictate that girls should be married as soon as puberty occurs, modern city life encourages the full development of the person through adolescence prior to marriage. Although parents in developing countries may see the dangers of exposure of their children to city life, they are unable to exert the necessary moral pressure to influence the behaviour of their children. The casual observer in any urban centre in a developing country can easily see that the young people emulate their counterparts in the developed countries. Thus in many urban centres in developing countries, increasing numbers of adolescents in their early teens experience pregnancy.

The consequences of unintended pregnancy in an adolescent in a society undergoing economic and social development are more devastating than in a more affluent society. Any adolescent who conceives out of wedlock is viewed as a source of humiliation of her parents. Thus the first reaction of the adolescent is to deny that pregnancy has occurred. Many weeks may pass and the opportunity for proper care is often lost. Even if the reality of pregnancy is accepted, it is kept secret until further arrangements can be made.

The pregnant adolescent has one of four options: to marry, to have an abortion, to put the baby up for adoption, or to raise the baby herself. Few adolescent mothers will opt for the last alternative. Initially they will seek ways and means of terminating pregnancy. In nearly all developing countries, there is no non-medical regulation concerning abortion. Abortions are induced under illegal conditions, often by unskilled operators. According to the WHO, illegally-induced abortions account for 7 to 50% (median 15%) of maternal deaths in developing countries.
Those who do not succeed in aborting continue with the pregnancy, often with no antenatal care. In traditional communities, the grandmother or a relative often "adopts" the child. If family resources are limited, as they often are, the baby is at an increased risk of death from repeated episodes of diarrhoea and severe undernutrition during the first 24 months of life. Opportunities for adoption outside the family are rare and surviving babies may end up in crowded orphanages with resultant excessive morbidity and mortality.

Occasionally the unmarried adolescent may continue to care for her newborn. Such newborns often die in early infancy from severe undernutrition and repeated infections because of failure to establish normal child-mother-bonds. Infant and child battering occur under these circumstances, although this pattern has not been systematically documented in developing countries.

Conclusion

If we take a moment and reflect on the subject of adolescent pregnancy, we can readily appreciate that the phenomenon is brought about by the actions of adults. In traditional societies, girls are given in marriage between the ages of 12 and 16. This action has largely prevented conception by the adolescent out of wedlock, although the pregnancy may not be wanted in the strict sense. In modern societies, the adolescent girl is encouraged to pursue schooling without the convenience of close parental guidance in matters of sex and pregnancy. It is not surprising that many young adolescents in developing countries become pregnant and suffer premature death or permanent damage. No event affects the life of a young, unsupported woman so profoundly and so permanently as an unintended pregnancy.

* * * * *
This practice still occurs in Tanzania but of course it has got reasons behind it. Most of the parents believe that teenage girls are almost like rotten goods, just like ripe tomatoes: when they are ripe and red, they should be used, otherwise they will be rotten, i.e. they will lose their virginity and become pregnant. People believe that you cannot turn down a marriage proposal - if you do, nobody is going to propose again. Prestige: they want their girls to be virgin when they get married.

The habit of performing a very big wedding ceremony is a fashion, especially in Zanzibar Islands. A marriage takes 3-7 days. People marry their young daughters to foreigners, like Oman Arabs, who tend to pay a big dowry which ranges from 100,000 to 150,000 shillings. This is partly due to the changing rate on the black market of the Oman reale. As a result there is a big drop-out rate of our schoolgirls from lower to upper classes. When these young girls get married and finally pregnant, of course problems arise.

The women who are in high positions in Tanzania, i.e. in Parliament and in the Party National Executive Council, have raised these problems and as a result the Government has imposed, in 1982, an Education Act which says:

"No pupil compulsorily enrolled shall marry or get married before completion of basic primary and junior secondary education (it takes 11 years). In case marriage is contracted while at school, such a pupil shall be expelled." (Sub-section 3).

"A female pupil who is found to be pregnant or a male pupil who is found to be responsible for the pregnancy of a female pupil while at school before completion of the period under sub-section 3 above shall be liable to be expelled from school. A male teacher who is responsible for the pregnancy of a female pupil covered under sub-section 3 above or a female teacher who is made pregnant by a pupil in similar category shall be liable to termination of service."

The girls are nevertheless still getting married at an early age, especially in rural areas. The parents here make a common trick of putting together a boy and a girl in a hut. They surround the hut and pretend that they have caught them redhanded - so they marry them.

The Party and the Government are at present mobilizing the masses through education. Family Life Education is included in our school curriculum.
Discussion on Item 1: Childhood Marriage and Early Pregnancy

The discussion on this item took place both in plenary and in discussion groups. These are some of the comments made:

Mali
- Early childbearing often necessitates caesarean delivery.
- Vesico-vaginal fistulas are common in young girls.
- Financial complications arise as the young woman cannot do any remunerated work.
- Cultural identity: young girls are made to understand that they must marry in order not to be ridiculed; everyone wants to do what is being done by others, and so the problem persists.

Gambia
- Early childbearing is on the increase in urban areas, due to tourism, which is being officially encouraged to improve the country's economy.
- Sex education right from primary school level at 10 years to college level is provided, but young people cannot get contraceptives without the consent of their parents.

Nigeria
- A high increase in adolescent pregnancy could be attributed to the withdrawal of government subsidies for primary and secondary school education, which resulted in most poor parents withdrawing their daughters from school in preference to their sons. Girls have therefore taken to petty trading and fallen prey to men. They are unprotected and have had no family planning education. Abortions and early pregnancies and deliveries are prevalent. The issue of early pregnancy and delivery cannot therefore be separated from political and economic issues.
- Girls should be encouraged to complete their education and job opportunities should be provided to prevent unwanted or early pregnancies.

Ghana
- Reasons why early childhood marriage is practised:
  a) to avoid an unwanted illegitimate child in the family;
  b) the dowry system of giving cattle, sheep, etc., which help to pay for debts of parents and the family;
  c) people are disdainful of premarital sex which may carry with it sexually transmitted diseases; such children are usually ostracized in the community;
  d) in appreciation for services rendered by the other family.

Participants from both Kenya and Nigeria mentioned that studies made indicate that some 50% of all deliveries are by young girls.

Dr. Mehra, WHO Geneva, said that the WHO would take note of all the views expressed. Something must be done about the problem now. There should be sensitization to show that such problems do exist. Research will be encouraged and assisted. Young people will be used to run programmes for youth. They are the victims; therefore the programmes must be implemented through youth movements. Unless both parents are mature, especially the girls, they should not be allowed to marry. Girls have died through
these pregnancies. Dropouts must be helped. Women must be made more independent economically.

Dr. Mwambazi, WHO AFRO Brazzaville, said that WHO was in Addis Ababa to learn and has learnt through the issues discussed that all is not well; therefore there is need for collaboration between WHO member states to work towards improving the quality of life in the community and to promote programmes to help states solve the problems, especially of women.

The Chairperson said that action is the key word. Action should be taken by the IAC, national governments, health ministries, religious groups, NGOs, and by market women. She deplored the giving away of young girls into marriage and cited the case of a 12-year-old girl who refused to have the marriage consummated and was therefore dismembered. Women, she said, must help eliminate the sufferings.

The recommendations made on Item 1: Childhood Marriage and Early Pregnancy are included in the Plan of Action, see Chapter II.

* * * * *
CHAPTER VI

ITEM 2: FEMALE CIRCUMCISION

Introduction by Dr Olayinka Koso-Thomas, Sierra Leone.

Address by the first Vice-President of the IAC, Mrs Edna Adan Ismail, Somalia.

Reports were submitted from the following countries:

- Benin
- Burkina Faso
- Djibouti
- Egypt
- Ghana
- Kenya
- Mali
- Mauritania
- Senegal
- Sierra Leone
- Somalia
- Sudan
- Togo
- G.A.M.S., France

The issue of female circumcision is also dealt with in country papers comprising more than one subject of the seminar (see Chapter IX).

Note: The expression "female circumcision"(f.c.) is used to indicate all forms of female genital mutilation.
FEMALE CIRCUMCISION AND RELATED HAZARDS
by
Dr Olayinka Koso-Thomas, President, Sierra Leone IAC
National Committee on Traditional Practices Affecting
the Health of Women and Children

Female circumcision (f.c.) is a term used to describe the
traditional practice of removing parts of or whole organs of the
female genitalia. There are three types of f.c.:

Type I   Clitoridectomy - this is the removal of the
clitoris leaving the labia minora and majora intact.*

Type II  Excision - this is the removal of the clitoris and
the labia minora leaving the labia majora intact.

Type III Infibulation - this is the removal of the clitoris,
the labia minora and majora, and the suturing
together of the vulva skin, leaving a pin-hole
opening for the passage of urine and menstrual
blood.

As a result of this mutilation many health hazards occur.

Immediate problems:
1. shock due to pain, as no local anesthesia is used;
2. infection due to the use of unsterilized equipment and
unsanitary surroundings where the operation takes place;
3. tetanus due to infection by tetanus bacteria from the
instrument used and to the surrounding areas as well as to the
application of infected herbal local dressings applied on the
wound;
4. sepsis from bacteria in the wound getting into the general
blood stream;
5. injury to surrounding structures due to circumcisers not
conversant with the genital areas, or to the use of blunt
instruments or to the girl's fighting and struggling because of
pain; her urethral opening or vagina or upper thigh may be cut;
on occasion a girl ends up with a fractured clavicle or upper arm
where she is held rigidly;
6. haemorrhage, excessive bleeding from the clitoral artery and
vessels surrounding the labia minora;

*) Note: This type is often called "sunna" in Moslem countries.
7. urine retention as the girl is afraid to urinate due to reflex action of the damaged urethral opening and the fear of passing urine which is usually acidic on the raw wound of the vulva.

**Late health effects:**

a. Keloid formation due to infection and failure of the wound to heal, thus producing excess inelastic scar tissue.

b. Vulva cysts and abscesses due to part of the vulva skin being embedded during the suturing together of the vulva.

c. Acute and chronic pelvic infection from infection at time of circumcision which has gone untreated and undiagnosed.

d. Infertility due to the above, which blocks the Fallopian tubes, so that the egg released by the ovary cannot be fertilized by spermatozoa deposited in the vagina during sexual intercourse.

e. Dysmenorrhoea - painful menstruation, a result of pelvic inflammation and pin-hole vaginal opening, where menstrual blood is retained and cannot easily flow out.

f. Haemotocolpos - accumulation of menstrual blood of many months, bulging as a bluish mass on the external vulva. Incision relieves this condition and also the pain at menstruation.

g. Dyspareunia - painful sexual intercourse due to tight vaginal opening. This can lead to anal intercourse, as the frustrated husband has no anatomical knowledge of the female genitalia. This anal intercourse eventually leads to faecal incontinence, as the anal sphincter has been damaged by sexual intercourse.

h. Recurrent urinary tract infection due to the urethral meatus being damaged at circumcision or covered by a flap of skin after the wound has healed. Urinary products accumulate in this area, which becomes infected and the infection spreads upwards into the bladder, ureters and kidneys.

i. Difficulty with urination due to inelastic scar tissue covering the urinary meatus, thus preventing free flow of urine. This can cause retention of urine in the bladder and backflow into the kidneys leading to chronic kidney infection with stone formation.

**Problems experienced at time of marriage:**

Difficulty in consummation due to tight vaginal opening. The girl becomes anxious, afraid or depressed. If she has an understanding husband, consummation may take many weeks before it is effected, but most times, the husband cannot wait and wants to prove his masculinity (macho reflex) so he damages his wife's genitalia by either cutting her open with a sharp instrument or blade or resorting to anal intercourse.

**Problems experienced during first childbirth:**

1. Perineal tear if there is no health professional to perform proper episiotomy to release the foetal head.

2. Prolonged labour due to small vaginal opening with the possibility of the baby dying in the vagina due to lack of oxygen. This is known as fresh "still birth". In some cases the uterus ruptures and both mother and baby die. Prolonged labour also produces necrosis of the vaginal wall and the bladder or the rectum, producing an opening between these
organs. This opening is called a "fistula". Here urine or faeces drips out of the vagina uncontrollably. This condition is very distressing to these women, as they smell of urine or faeces wherever they go. They therefore become outcasts, miserable, unhappy, depressed. In some cases such women have committed suicide rather than face being ostracized.

3. Prolapse is due to prolonged labour where the posterior wall of the bladder and the anterior wall of the uterus are pushed out, because of the inelastic scar tissues caused by circumcision. This condition is also very depressing, as women have to urinate frequently and have a feeling of heaviness around their genitalia. The only solution is surgical repair which most of them cannot afford. Therefore they have to live with this ailment for the rest of their lives and this affects their physical and mental well-being.

Conclusion
It is imperative that all African women work towards the eradication of f.c. following the recommendations of this seminar.

* * * * *
"In the name of God, the Compassionate, the Merciful,

Madam Chairperson, Dear Sisters,

It is ten years to the day since I first stood on a podium and delivered a public address which described pharaonic female circumcision as the paganistic, useless, medically dangerous and mutilating practice that it is.

It is ten years to the day since we formed the first committees and drafted resolutions that called for an end to female circumcision.

It is ten years to the day since we heard Islamic religious leaders condemn the practice, categorically stating that infibulation was a traditional mutilation and not a religious obligation.

Since that time, the details of infibulation have been shown in films, illustrated in the international press, and debated in the media. You are all aware of the horrified response that these disclosures aroused throughout the world.

In the intervening period, medical scientists have written volumes about female circumcision, and countless students of medicine, of anthropology and of social sciences have chosen it as the subject of their dissertations. In fact, there are hardly any universities which have not had someone doing research on this topic at one time or another. During this period, international, inter-governmental and non-governmental organizations have raised funds for further research and for activities designed to end the practice of infibulation.

Yet, in spite of this, millions of our daughters continue to be mutilated, and thousands continue to die.

It is nine years since the first international seminar, sponsored by the World Health Organization, was held in Khartoum on Traditional Practices Affecting the Health of Women and Children.

It is eight years since we met in Lusaka, during the African preparatory meeting for the United Nations Decade for Women World Conference in 1980, and seven years since we met in Copenhagen at the Conference itself. It is three years since we were last
together in Dakar, where this Inter-African Committee was established.

During all that time, Madam Chairperson, we advocated "progress by education", advocated raising public awareness to the dangers of infibulation and its pointlessness, all in the belief that these in themselves would lead to abolition.

We opposed legal intervention because we thought that enlightenment would bring change. I, myself, was in the forefront of those who opposed legislation.

Yet, none of the effort, the research, the campaigns, have had a real impact. I am convinced, now, that our activities must indeed be supported by legislation.

As we sit here today, in the comfort of this Conference Hall, a symbol of African Unity, more lives are being wasted - with impunity, because no law exists that actually protects our children.

We all know, and statistics show, that in developing countries on an average one-fifth of our children die during their first five years. We lose thousands more to droughts, famine, floods, wars and epidemics. With urbanization, we are losing an increasing number to road and other accidents, to chemical poisoning and to criminal offences against children. But still, Madam Chairperson, after all these tragedies have taken their toll of the lives of our youngsters, we ourselves continue to catch and kill, with our own hands, those who have miraculously survived all these catastrophes. How many more must die before we take action?

I say: "Enough is enough! The killing must stop!"

Madam Chairperson,

I CALL FOR more aggressive tactics to end infibulation.

I APPEAL FOR more active support, especially from Islamic religious leaders, since it has been confirmed, time and again, that this practice is contrary to the teachings of Islam.

Above all, Madam Chairperson,

I CALL FOR

NATIONAL LEGISLATION TO STOP FEMALE CIRCUMCISION."

* * * * *
From the creation of the world, God demanded respect for the human soul. Tortures, mutilations and murders were severely punished: "Cursed be the one who purposely causes the blood of his neighbour to flow." Let us remind ourselves of the fate reserved for the criminal fratricide Cain.

The prophet Abraham was the first to use a knife to shave, to cut nails, hair and other forms of body hair - with the injunction to make use of it with precaution so as to avoid wounding.

In general, Islam forbids all cutting, tattooing and depigmentation of the human body.

As to women they have been well treated since the pre-Islamic period. Islam accords them special care and it is to be noted that several passages of the Holy Koran have prescriptions on the subject of the women
- as human beings,
- as female beings,
- as wives.

Thus, nearly all Sura IV entitled "Women" is devoted to this subject, as well as S. II V. 187 and S. III V. 35-36.

God, forbidding the ill-treatment of girls, women and wives, and their defamation by obscene talk which insults chastity, reminds us of the punishment cited in the above-mentioned Sura.

Excision is nowhere alluded to in the Hadith. Only circumcision is considered to be SUNNA.

If we examine all the solicitude with which the Holy Koran surrounds the woman, because of her physically delicate constitution and all she endures at the time of pregnancy and childbearing, we can understand the reason why Islam energetically condemns excision and considers this sordid and barbarous practice as HARAM.
In Burkina Faso, because of religious or traditional beliefs, numerous ethnic groups practise female circumcision. The age of the intervention depends on the group. Numerous voices have been raised decrying this practice, including that of the President of Faso, who has already made several appeals to the communities.

Today, female circumcision is forbidden in Burkina Faso and all national structures are called upon to demask and combat it. The practice is already rare in urban areas, but it still remains anchored in rural areas. An intensive campaign for its eradication has started. Didactic materials prepared by the CI-AF will have an impact when used at the time of functional alphabetization and discussions on family planning and education in family life.
ACTIVITIES AGAINST INFIBULATION IN DJIBOUTI

by

Mrs Saida Hassan Bogoreh, Secretary General of the National Union of Women of Djibouti

I am going to limit myself to giving you a brief exposé of the activities already realized and those to be undertaken to fight against the very widespread practice of infibulation by the National Union of Women of Djibouti (UNFD), which I have the honour to represent at this conference.

The national committee in charge of fighting against the practice of infibulation has unmasked the problem by speaking openly to women. Conscious of the delicacy of the subject, our organization has fixed as an objective to lower the percentage of infibulation, which is now 99%, in favour of "Sunna", which is considered to have less harmful effects.

In the first instance, we proceeded by sensitization activities in the different urban annexes of our organization.

As the first reason evoked for the perennity of this practice is the Moslem religion, we approached the problem by making women listen to a cassette recorded by a religious leader. He speaks of the absence of religious foundation for the practice of infibulation and encourages the practice of the "Sunna" form of female circumcision.*) Thereafter we showed the complications caused by this practice with the help of a cassette which explains the gynaecological problems. The exposé was prepared by a national gynaecologist. Mothers were able to see slides made in Djibouti, as well as those sent by the Inter-African Committee, showing the complications at delivery suffered by our women (obligatory episiotomy). Finally, we have informed the public of our sensitization activities by the publication of an article in the country's weekly newspaper. This article stirred up an open debate on the subject which is still continuing.

As a second step we plan to carry out sensitization of women in rural areas. Nevertheless, in order to achieve concrete results it is indispensable that the UNFD fulfils its role in sensitizing the authorities to the problem.

*) Note: This is contrary to the position of WHO and CI-AF which call for the abolition of all forms of female circumcision, without intermediate stages.

* * * * *
Research and reports on female circumcision in Egypt have made it clear that there are ambiguous motives behind female circumcision, as follows:

1. Familial and social values, that impose themselves even when there may be lack of conviction about the benefits of circumcision;
2. Protection of the girl's chastity on the assumption that circumcision decreases libido;
3. Belief that circumcision helps the girl reach puberty and achieve full womanhood;
4. Belief that circumcision is recommended by religion (this may be the reason behind naming it "tahara": purification);
5. Fear that the girl will be refused by men for marriage if not circumcised.

Because this subject was never open for public discussion, it did not receive the proper attention by leaders or professionals. That is the reason why the Cairo Family Planning Association (CFPA) discussed this subject at a seminar held in 1979. The CFPA adopted, in 1981, the recommendations made at this seminar and formulated its plan according to them.

In accordance with this plan, the CFPA decided, in 1987, to publish a series of articles on the hazards of female circumcision with the aim of sensitizing the target public regarding such hazards. The following (i-vi) are extracts of some of these articles.

i. Family Planning Association Cairo, Mother and Child Welfare Programme (Female Circumcision)

The CFPA has sought to study the issue of female circumcision which involves physical violation of young girls. This subject is of paramount importance as it adversely affects the health and psychology of women from their early childhood and up to their womanhood and motherhood. Female circumcision is the outcome of old traditions and erroneous beliefs that have spread due to ignorance on the one hand and to the fact that dealing with such an issue was tabooed on the other.

Unfortunately all data collected through field studies at either the local or the international level indicate that this harmful custom is still widely practised in many countries,
ii. A Study of the Problem of Female Circumcision

The project research team conducted a study on female circumcision covering 490 Egyptian girls, in two groups: the first consisted of students in the faculties of Social Service and Physical Education Teachers' Training Institutes, and the second comprised students of different specializations in the nursing schools.

The study indicated that f.c. was practised on many of these girls, particularly those above the age of 25, and those whose parents were not educated. The study further proved that 32% of the families practising f.c. do it in respect of tradition and practice.

The research team also prepared a questionnaire to identify trends and attitudes vis-à-vis this harmful practice. The result was quite surprising; it showed a great deficiency in information on this issue even among nurses, of whom 33% expressed their intention to have their daughters undergo this operation.

iii. A Whisper in your Ear

We can maintain the morals of our daughters only by implanting virtue and good principles in their hearts, not by committing excision against them.

iv. The Stand of Islam vis-à-vis Female Circumcision

Islam honours girls, for the girls of today are the wives and mothers of tomorrow. The Prophet, God's prayers be on him, states: "Heaven is under the feet of mothers" meaning that if one seeks to go to paradise one should first gain the approval of one's mother.

Girls have their own status in the family. The Prophet called upon Moslems to take care of their daughters, as contrary to the way they were treated in the pre-Islamic era, for He says: "He who begets daughters and treats them nicely will go to heaven, as these girls would protect him from hell."

If Islam observes this status for girls, why do their parents hurt them and mutilate their bodies for no real health reason?

No girl could possibly suffer any harm as a result of her reproduction organs. It must be mentioned here that, although pregnancy, child birth, menstruation and lactation are mentioned in the Holy Koran, there is no mention whatsoever of female circumcision, as it can never be considered a confirmed practice of the Prophet. This is why many Islamic countries which abide by Sharia (or Moslem law), such as Saudi Arabia, Iraq, Iran, Syria, Libya and Morocco, do not perform excision on their girls. And if it has been proved that female circumcision is harmful, it could never have been an ordinance of God.

Had the young girls against whom excision is committed been allowed to express their opinion they would have shouted: "Please do not torture me and let me be!" For Islam is absolutely against torture.
v. Did you know?

Not one verse of the Holy Koran refers to female circumcision.

There is no mention in the books of the Sunna (the practice of the Prophet of Islam) referring to female circumcision.

As a result of female circumcision, a young girl loses trust and confidence in those closest to her, namely her mother and father.

Female circumcision is a distortion of what God has created, and God is satisfied with his creation. For the Holy Koran states: "Surely He created man of the best stature".

vi. The Stand of Christianity vis-à-vis Female Circumcision

No mention has been made in either the Old or the New Testament of female circumcision. Scholars and historians report that f.c. was not known to the Jews, for there is a big difference between the boys' circumcision mentioned in the Old Testament (Genesis 17:9-11) and f.c. For boys' circumcision does not amputate any part of the boy's body or his reproduction organs. Only an outer skin is removed without harming the organ itself. F.c. involves the amputation of part of her reproduction organs. Thus there is no religious ground in Christianity for f.c.
At the Dakar seminar in 1984, a subject which generated a lot of discussion and much concern was female circumcision. The practice was found to be not only injurious to the health of women and children but most unnecessary. It was condemned as being sheer mutilation of the sex organ. All the participants agreed that National Governments should do everything possible to stop the practice. Each participating country was to form a national committee to implement the decisions made at the seminar. In line herewith the "Ghanaian Association for Women's Welfare" (G.A.W.W.) was formed.

Very little was known of the practice in Ghana. There were no empirically based evidence and statistics to show the type of operation and the extent of f.c. It was for this reason that G.A.W.W. embarked upon a survey which would provide the necessary data for the educational programme and the strategy to use for the abolition of f.c.

The survey was carried out by Dr John Kadri in the northern regions of Ghana where the practice was known to exist, with funds from FORWARD, a group/section of IAC working in England.

Facts established from the survey

1. It has been established that f.c. is regrettably still a very important traditional practice in the rural areas of the Upper Regions of Ghana.

2. It can be said that
   - the practice does not have any religious basis;
   - it is an inherited traditional practice related to the belief of ancestral ascendancy after death;
   - the chastity of the girl is believed to be kept untarnished until marriage;
   - in the days of nudity in the North, however, the practice served a purpose.

3. It was found that very few hospitals presented records that proved an awareness that this traditional practice is largely to blame for the high rate of maternal and neonatal deaths. The Presbyterian Mission Hospital and the Islam Maternity Home in Bawku, however, provided some records on the matter.

4. It has been established that excision or clitoridectomy is the type practised in Ghana.
The reasons given for the practice on the whole are not convincing in any way for the encouragement of its continuation. G.A.W.W. is convinced that steps should be taken to stop it. The areas where the practice is prevalent are now established. G.A.W.W. now knows exactly where to start with programmes for the abolition of f.c.

Programme of activities/action
a) Workshops to create an awareness of f.c. and the gravity of the problem. Two such workshops have already been organized in Northern Ghana.

b) Educational talks: It is important for the victims and others involved in the practice to understand the problem and its implications, so as to give up the practice rather than force this by legislation.

Personnel to be involved:
Community Health Nurses, Sociologists, Teachers, Midwives and those in charge of maternity homes, Doctors, Nurses, TBAs, Red Cross.

Follow-up
The survey by Dr Kadri recommended a survey to be carried out at migrant quarters in selected parts of the Southern region. A proposed "Education oriented survey to eradicate the practice of f.c." will be directed by Professor P.A. Twumasi, a medical sociologist of the Dept. of Sociology, University of Ghana. A full report on the practice could then be submitted to the Government recommending legislation against the practice.*)

Miscellaneous
- A branch of the Association has been formed in the Northern Region.

- The Association is in contact with some hospitals and maternity homes which are noting those cases of f.c. with labour complications.

- It is of interest to note that only recently a young girl, 18 years old, who had been circumcised, died as a result of prolonged labour. She was brought to hospital too late to be saved.

- There is a need for an intensive education programme. At least those who are already victims of the practice should be made aware of the dangers involved at delivery and advised to go to the hospital at the onset of labour.

- Lack of transportation and funds are barriers to progressive action. We must find a way to reach the victims and save their lives, particularly the innocent children who are forced or coaxed to have the "cut".

*) A survey was carried out in the summer of 1987, funded by Population Crisis Committee, USA.
REPORT ON ACTIVITIES AGAINST FEMALE CIRCUMCISION,
WEST POKOT DISTRICT, KENYA *)

by
Dinah Katina, Project Leader, and
Margaret Limakori, Project Coordinator

We wish to thank both the sponsors and the organizers of the Seminar which was held in Dakar, Senegal, in February 1984. This well-organized and successful seminar gave us a lot of courage which enabled us to face our own community in campaigning against female circumcision. Since then we have organized eight seminars at local, divisional and district levels. *)

The most interesting forum was at a Christian Youth Camp, where we gave lectures to girls and boys, including men attending the camp. They passed a resolution promising to campaign against the practice of female circumcision in their areas.

Women who attended six other forum seminars showed much resentment at the beginning, but after a lot of teaching using the modern and very useful teaching aids provided by IAC in Geneva, the women agreed that female circumcision was not good. They promised to campaign against it.

Resolutions

The following resolutions were passed during the forum seminars:
1. that Chiefs should not give permits for circumcision ceremonies;
2. that more seminars for boys and girls, also including women and men, be organized from time to time;
3. that seminars be organized to prepare Chiefs, Councillors and other local leaders to campaign against f.c.;
4. that circumcisers should not circumcise girls without proper authorization.

*) This programme is financed by Rädda Barnen, Sweden.
REPORT ON THE EXECUTION OF A PROJECT, IN 1986, OF INFORMATION AND SENSITIZATION FOR RECYCLED TRADITIONAL MIDWIVES (ATRs) ON THE HARMFUL EFFECTS OF FEMALE CIRCUMCISION

by

Mrs Halimatou Traoré, Director, Ouélessébougou Training Centre for Rural Animators (C.F.A.R.), National Union of Malian Women (U.N.F.M.)

We reached all the ATRs of the 74 villages in the sphere of influence of the C.F.A.R. in 74 days.

It is necessary to recall that for the social and economic training of peasant women the C.F.A.R. has trained eight women animators (aids) in each village as follows:
- 2 in Health/Nutrition, Hygiene, Sanitation from 18 to 25 years
- 2 in Agriculture from 24 to 40 years
- 2 in Literacy from 30 to 50 years
- 2 in Mother and Child Health from 50 to 70 years and over

The latter were trained by the ATRs (Recycled Traditional Midwives).

These women aids were chosen by their respective villages and the differences in age according to category are to be noted.

The four persons who participated in putting the project into effect were the Director of C.F.A.R., the Head of Training, and the training specialists in Hygiene and Sanitation, and in Animal Breeding.

During the 74 days we talked to 307 old women, including 148 ATRs. The presence of other women was required by the ATRs because of the delicacy of the subject. In fact, because f.c. is a taboo subject, it cannot be talked about without the presence of the old woman "Moussocoro contigi". This post of responsibility is held, by right, by the oldest woman.

To pierce the myths and the mysteries that surround the practice of f.c. we gave the ATRs a questionnaire consisting of seven questions.

1. According to you, when did the practice of f.c. begin?
   None of the old women were able to reply to this question, since they know only that it is an ancestral tradition which they must continue to respect.

2. What are the reasons for f.c. in our communities?
   The explanations were as follows: it is a traditional practice (psychological reason), and a non-excised woman will not be respected either by her own family or by others. A child born to such a woman will be relegated to the lowest place in the
hierarchy of the village. Such children could never be village chiefs (social reason). Another explanation was that it is a practice advocated by the Moslem religion.

3. Are all the old women entitled to carry out female circumcision? If yes, why?

The response was negative, for only the old women of the blacksmith caste hold the secret of f.c. In fact the blacksmiths are a caste with a reputation for sorcery and mastery of the occult. They are at the head of the secret societies and lead all ritual acts.

4. Do you know communities which do not practise f.c.? If yes, which?

The women questioned cited white women (that is, Europeans) and Ouolof women (Senegal). They had not heard of such communities in their own country; we cited the Bobo, Maure and Sonrai as peoples who do not practise it in Mali.

5. Does female circumcision have some advantages?

They are numerous, according to these women. F.c. facilitates childbearing and makes sexual relations easy. It permits the woman to stay faithful to her husband. It marks the passage from a girl's life to the life of a woman, that is to say to honour, respect and confidence.

6. Does it also have harmful effects on the life of the woman?

In this connection, they were able to cite only haemorrhage and adhesion of the labia minora.

7. Taking account of communities which do not practise f.c., what do you think of an eventual suppression of this practice in our part of the world?

This question came generally at the end of our discussions and, after the information that we had given to them on the harmful effects of f.c., optimistic replies were given.

On the basis of these replies we started our work of sensitization, dwelling essentially on the negative effects of f.c., notably pain at the time of the operation, haemorrhage, adhesion of the labia minora and risk of tetanus. We also talked about the decrease in sensuality, which according to them produces self-control and fidelity, but which often leads to frigidity, making sexual intercourse with the husband a real cross to bear.

Point by point we tried to demonstrate that the arguments they advanced had no solid foundation. For example, so far as the religious reason is concerned, it has been demonstrated by the great marabouts that nowhere does the Moslem religion advocate f.c. Besides this, women are not excised in the country which is a place of pilgrimage because it is the source of the Moslem religion.

Concerning the psychological reason of attachment to traditions, we told them that cultural identification does not mean that we should accept all the customs of our ancestors. The world is changing and values are no longer the same. We made them notice that the comparisons we made, followed by critical analysis, constitute the privileged means of permanent adaptation to this change.
On the subject of the advantages evoked by the old women, we tried to combat them with flexibility. For example, they told us that f.c. facilitates childbirth and sexual relations. Nevertheless, in the course of our conversations, some of them affirmed that in the past the woman could become a mother one or two times before being circumcised. Apparently these deliveries took place without problems and the children grew up normally. We also used as an argument that peoples who do not practise female circumcision continue to grow in a prosperous way.

They also told us that excision was the occasion to bring together young girls to train them in preparation for conjugal life and the life of a woman. Accepting this reality, we invited them to assemble young girls of 10-15 years of age, annually or biennially, for at least one month, so as to give them the same traditional training. This will also be enriched by modern knowledge given unhampered by village animators.

At the end of our conversations the audiences seemed very satisfied, for they confided to us that they had made real discoveries. They promised to be our faithful interpreters to other women and above all to the old ones, who are in fact the decision makers.

The impact of this project will make itself felt little by little, for it is concerned with a reconversion of mentalities. Nevertheless, with perseverance, we hope to end up with positive results. This is the reason why we think that it will be necessary to extend both information and sensitization to all the animators trained by C.F.A.R., whatever their specialisations may be.

We are convinced that this project will, in the long run, have positive results, above all if we continue this sensitization, extending it to the other animators already trained by C.F.A.R.- U.N.F.M.

* * * * *
REPORT ON THE ACTIVITIES FOR 1983-1987 OF THE CENTRE DJOLIBA IN MALI ON TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN, ESPECIALLY FEMALE CIRCUMCISION

presented by

Mrs Renée Sidibé, Djoliba Centre, Mali *)

For the implementation of this programme of activities, the Djoliba Centre aimed:

a) to start from existing information centres which are the Centres for the Promotion of Women of Badalabougou, Bamako,

b) to proceed by successive phases,

c) to extend the action to the whole city of Bamako and to all the regions of Mali,

d) to reach the intelligentsia and the medical world.

a) **Poles of Dissemination**

The Centres for the Promotion of Women of Badalabougou have existed since 1980. They aim to respond to the needs of women and young girls there to find the possibility of continued training for progressive integration into the urban environment. From the beginning they have enjoyed the sympathy of the population because of the seriousness of their activities.

b) **Activity Phases**

1. **Sensitization**

   * Make the population conscious of female circumcision and its consequences.
   * Environmental studies:
     - regional study on health education, analysis of the socio-cultural factors which tend to support the practice of f.c.
     - study on f.c. in some Bamako and rural maternity hospitals.
   * Meetings to make the problem known to those in positions of responsibility and to instructors.
   * Spreading of information by the press.

2. **Implementation of an Action Programme**

   * Research for educational material, including visual aids, adapted to the problem.

*) The work against f.c. of the Djoliba Centre is supported by Rädda Barnen, Sweden, with the educational material of IAC.
Pedagogical training of those responsible and of instructors to give them the capacity to deal with the issue with women and young girls in the local centres.

Organization of meetings in the twelve local Centres to sensitize as many women as possible. Approach to the question in schools.

c) Extension

1. Sensitization

* by making contacts
  - in Mali: in both rural and urban areas;
  - in Burkina: with development agents in the Bobo Dioulasso region and with the West Africa Centres of Social Studies (C.E.S.A.O., Centres d'Etudes Sociales d'Afrique de l'Ouest).
  * by requesting participation in survey work;
  * by sending newspapers, the Dakar recommendations, articles dealing with the subject in the local press and by the spreading of the thesis of Agnès Dembélé: "Some customs which do harm to the health of the woman: excision and infibulation."

2. Action Programme

* Training meetings in some Centres for the Promotion of Women
* Participation in health workers' meetings
* Use of pedagogical material.

d) The intelligentsia and the medical world

In March 1987, the Djoliba Centre organized a round table with the theme "Custom, Society and the Woman: the Special Case of Female Circumcision". The debates were very open. The medical world was well represented and the debates were shown on the Malian television.

Contacts were made with doctors in hospitals to exchange views on the subject and documents at their level were provided.

Results

* A certain liberation among women to talk openly about f.c. A discovery of themselves.
* Seriousness in approaching the subject, a relevant pedagogy including the acquisition of the necessary vocabulary to discuss it.
* A new mentality has been created: a will to fight for the health of women and young girls so as to obtain fundamental women's rights.
* A firm decision in certain families to abolish the custom.
ANALYSIS OF THE PRE-INQUIRY ON FEMALE CIRCUMCISION
carried out in 1984 in 3 maternity hospitals in Nouakchott, Mauritania

by

Mrs Aminata N'Dao, Director of Studies
National School of Public Health, Mauritania

Objective no. 1: To take account of the number of women examined and to calculate the percentage subjected to excision.

In the course of seven days, 153 women were examined; 104 of them (68%) were found to be excised. The other 49 (32%) were not excised.

It may therefore be concluded that this practice is still carried out in Mauritania. This sampling is not representative of all the Mauritanian ethnic groups. A study on excision as well as on all other harmful practices is necessary in the whole regions of Kaïdi, Rosso and Sélibaby.

Objective no. 2: To specify, by ethnic group, the number and percentage of excised women.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number</th>
<th>Excision</th>
<th>Non-excision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Maure</td>
<td>97</td>
<td>66</td>
<td>31</td>
</tr>
<tr>
<td>Ouolof</td>
<td>18</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Toucouleur</td>
<td>29</td>
<td>27</td>
<td>2</td>
</tr>
<tr>
<td>Soninké</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

This table makes clear to us that three ethnic groups are particularly affected by this mutilation. In order of importance they are the Toucouleurs, 93%, the Soninkés, 78% and the Maures, 68%. In the Ouolof ethnic group excision is tending to disappear since it is shown by only 12%. The Ouolof, Soninké and Toucouleur ethnic groups are not, however, representative of the Nouakchott area.
Objective no. 3: To take account of the methods of excision and the number practised in Mauritania.

Table B

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Total Excision</th>
<th>Partial Excision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Maure</td>
<td>14</td>
<td>21%</td>
</tr>
<tr>
<td>Ouolof</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toucouleur</td>
<td>16</td>
<td>60%</td>
</tr>
<tr>
<td>Soninké</td>
<td>2</td>
<td>30%</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>31%</td>
</tr>
</tbody>
</table>

Total excision = clitoris + labia minora  
Partial excision = clitoris only

Here again, this table shows us that first the ethnic group Toucouleur, then the Soninké and the Maure, are most affected by this practice. As to the Ouolof, 2 women out of 18 were excised but the study did not reveal the method.

For the other ethnic groups the data have not always been usable, since the numbers of total and partial excision do not correspond to the total figure of excisions.

This table also indicates that total excision (clitoris + labia minora) is more frequent among the Toucouleurs than among the Soninkés.

Objective no. 4: To take account of the sequels of the cicatrization of the excision.

The information obtained is of little use. Of the 104 women examined, 93 showed nothing of note; 6 had an adhesion, 1 a cyst, 1 a narrowing of the vulva, 1 a urinary meatus very exposed to germs. It should be noted here that sequels are more important in women who have been totally excised (clitoris + labia minora).

Objective no. 5: To calculate the percentage of excised women by ethnic and age groups:
- very often after baptism
- certain ethnic group (Soninké) do it at an advanced age.

The majority of women questioned on this practice affirmed that they have it done because of
1. tradition,
2. religious obligation in order to pray,
3. ignorance

* * * * *
Since the Dakar seminar in February 1984 on Traditional Practices Affecting the Health of Women and Children, the "Bok Diom" Women's Association at Diourbel has undertaken various activities to eradicate female circumcision in the region. This work has sometimes met with success; at other times the difficulties have proved to be enormous.

It must be said that the subject is not easily broached. In the Diourbel region, the practice of female circumcision remains the prerogative of women of certain ethnic groups (Toucouleur, Sarakolé, Peul, Bambara). It is very rare among the dominant ethnic groups (Ouolof, Sérère) but for all that it remains a big problem. For certain circumcisers it is a flourishing business.

Through our group meetings, attended by more than 200 women, we set in motion a small committee which soon took the initiative to draw up a programme to combat this harmful traditional practice by insisting on three points: approach, information, education. This committee, it should be noted, includes circumcised and non-circumcised women.

The committee's first task was to make contacts with persons known to perform f.c. While some accepted to discuss the issue with us, others refused outright.

Our committee organized several meetings for information and sensitization in the different parts of Diourbel and in the rural areas. During these meetings we questioned several victims as to what advantages they could possibly see in being circumcised. It would seem that the answer is "to obtain better genital hygiene". According to those who militate in favour of the practice, the circumcised woman is less exposed to infections by loss of blood etc. The circumcised woman, they believe, is "clean". It would also appear that certain men belonging to the above mentioned ethnic groups that practise f.c. prefer to marry circumcised women. Cases have even been noted of repudiation of non-circumcised women.

A workshop on traditional practices was held in the Diourbel region from 8 to 12 December 1936. More than 60 women from the three administrative sub-divisions of the region took part in the meeting, the first of its kind. The participants showed keen interest in the lecturers' statements. Educational materials - an anatomical model, slides and flannelgraphs - were greatly appreciated. The workshop was attended by religious leaders and
other notabilities; their presence was warmly welcomed. We sought
the opinion of the religious leaders: Islam, dominant religion of
Senegal, does not recommend female circumcision.

Women are becoming increasingly aware of the pernicious
results of such a practice. The accidents involved are not rare,
deaths are sometimes caused by haemorrhage, infections such as
tetanos occur, nasty scars make childbirth less safe, not to
mention the aftermath of frigidity or phobia of sexual relations
and so on.

If the practice concerns us so much at this time, it is
because our respective societies are undergoing profound changes.
It is through a programme of education and the fundamental
sensitization concerning the harmful aspects of f.c. that we
shall finally win, and thus render unto woman her full bloom.

The workshop in December 1986 gave birth to an organization
called "Woman's Association for Strengthening the Struggle
against Traditional Practices".*) Administrative follow-up
committees were created in the region with an action programme
centred in the first instance on information, sensitization,
education and an approach directed towards men.

We congratulate and encourage the Inter-African Committee for
the integrity of its work and the production of its Newsletter
which proves to be the ideal means for exchanging information
between the national committees and persons who fight for this
just cause. We thank the donor countries for financing this
Newsletter.

*) Association Féminine pour le Renforcement de la Lutte contre
les Pratiques Traditionnelles (AFRLPT)
"GIVE ME A CHOICE"
by
Mrs Aminata Kargbo, Public Health Tutor,
National School of Nursing,
Vice President IAC National Committee, Sierra Leone *)

The population of Sierra Leone is 3.09 million, 75% being rural habitants. Women aged 15-44 years who have been victims of female circumcision make up 22% of the population. The infant mortality rate is 130-200 per 1000 live births. This high death rate is supported by a correspondingly high fertility rate. The maternal mortality rate is 4.5 per 1000 deliveries, caused mostly by eclampsia, haemorrhage before and after delivery, and rupture of the uterus due to disproportion which can be the complication of female circumcision.

Only 30% of our population uses medical services. The rest, mostly outside the capital, depend on traditional practitioners and prefer traditional medicine. The women traditional practitioners are the TBAs (traditional birth attendants). There are over 16,000 of them in the country, all living within a three mile radius of each other.

The TBA is the head of the traditional secret society, the "Bundo", where many things which are positive in our culture are practised. The TBA looks after women in her area from birth to grave. Statistical data gathered from 300 TBAs - out of the 600 trained by the Ministry of Health and recognized by the medical profession - showed the following:

- 85 of these TBAs have no formal education;
- over 70% are 50 years old and of these 18% are 70 years old or more;
- all are married with children;
- 51% have practised for 18-25 years, 21% for over 25 years;
- nearly all are members of the Bundo society and some hold significant posts as Digbas, Sowies or Majos: these are the consultants in the tribal hierarchy;
- 1/3 of them have additional trades or alternative occupations, as farmers, gardeners, herbalists and petty traders.

*) This article contains proposals which do not correspond to the position of WHO and IAC, which consider the practice of f.c. as medically unethical; it should thus not be carried out by medical staff and health workers. These organizations also condemn modern improvement of this practice, regarding it as inconsistent with medical ethics.
All the 18 rural tribes in Sierra Leone practise excision during initiation. Only one group of the population, the Krios, who live in the Freetown area, do not all practise it. Fortunately, initiation is no longer compulsory, as a result of inter-marriage. In urban areas, educated parents doubt the relevance of this aspect of our culture. In rural areas, in contrast, it is the graduation stage for any woman. It is after initiation that a woman is termed adult or sayma - a prestige stage in maturation and development.

TBAs command considerable influence and prestige in the society or community they serve. They deliver more babies than midwives and the obstetric services of the community. They wield power over 308,000 women, from initiation at puberty, i.e. 12 years on average, until menopause.

The society the TBA heads is a powerful traditional, political-social organization that is supported by a corresponding male indigenous secret society. The Bundo society is the only authentic organization where women exert power in their own right without male interference. The members are called saymas, non-members bowas. Women in the highest hierarchy of law, education, medicine, nursing, modern media and research claim membership.

Why have I described these TBAs at such length? The reason is that they will contribute to the lowering of our high maternal mortality rate through the reduction of complications of female circumcision, of infant mortality and tetanus rates. It is these women we have challenged to modify the excision that is practised, and to have it eradicated by the year 2000. They also hold membership in our organization *). Our honoured secretary is the only medical demographer and researcher in MCH (Mother and Child Health) and she and our CMO (Chief Medical Officer), a woman concerned about the complications of female circumcision, conducted research in 1982 concerning TBAs. The result gave her the coveted Akinsyo prize for medical research. These Sowies were participants in our first seminar. A Majo who attended our seminar is educated and a Christian.

This seminar, held in February 1986, received radio, TV and newspaper coverage. There were open discussions on initiation and female circumcision. It afforded us the opportunity to establish dialogue and channels of communication with the leaders of the secret societies and TBAs at all hierarchical levels. It was previously unheard of to mention this term in public or ordinary conversations. Non-members are not allowed to talk about it.

After the seminar we identified all the top level health personnel in our country who collaborate in our campaign. Sensitization of our male youth, not to demand female circumcision from marriage partners is ongoing under the banner of "Give us a Choice". Female circumcision should be postponed until school-leaving age, when the young women can choose or withhold consent to initiation. Our organization has been invited twice this year at national women's conferences to read papers or chair sessions. This recognition has given us publicity in some girls' secondary schools.

*) = the IAC national committee
**Action Plan**

In the action plan we have the support of our Directors, MCH Services and Senior Specialist Surgeons and Gynaecologists. The objectives are

1. to prevent complications from haemorrhage, tetanus and other infections and to minimize keloid formation;
2. to ensure quick healing without a lot of scarring;
3. to improve the standard of hygiene of the initiates;
4. to introduce modern safe methods and medical instruments;
5. to educate young women about modern concepts of nutrition, immunization, family planning, antenatal care and infant welfare.

We, nurses and midwives, will make ourselves available during initiation to give:

1. free emergency or continuing care when called upon;
2. advice that the ceremony take place in a disinfected area on a clean mackintosh;
3. advice that all initiates should have had two injections of tetanus toxoid a month before the ceremony.

We will introduce a kit containing sterile blades, a scalpel, dressing lotions and disinfectants, as well as suturing materials. Analgesics, antibiotics and local anti-haemorrhage applications can be added at small cost. This will be a standard kit like the UNICEF kit. The support of income-generating activities that can ensure a moderate living standard is to be pursued by NGOs, our Ministries of Development, Health, Social Welfare and Youth and Women's Bureau.

What is required in Sierra Leone is not legislation, as the TBAs come under traditional laws that protect them from prosecution. But dialogue, education, modernization and a change of heart by the community itself are necessary to abolish female circumcision. We believe that when

- the young men are made aware,
- the marriage age has been raised,
- the initiation has been deferred until school-leaving age,
- female education and urbanization have become widespread,
- the 18% of the TBAs who are now 70 years old or more have died,
- the 51% of them who have now practised 18-25 years will be too old to be effective in the face of health education and may be given other incentives,

then we may report to the IAC about the final eradication of female circumcision in Sierra Leone.

* * * * *
SUMMARY REPORT ON FEMALE CIRCUMCISION IN SOMALIA
by
Somali Women's Democratic Organization (SWDO)

The Somalis are a homogeneous Moslem ethnic group of about six million people.

In Somalia, the practice of genital mutilation has persisted for centuries and is still prevalent among all classes of women in both rural and urban areas. Practically every girl is circumcised, and the majority are infibulated. No girl can expect to grow to the age of puberty without undergoing this operation. Infibulation or pharaonic circumcision is the type generally practised.

The secrecy surrounding the continuation of this brutal practice, the unwillingness of those involved in it to face reality, and the excuse that cultural practices are sacrosanct, are no longer convincing to many Somali women. They realize that action must be taken now against this mutilation which humiliates and degrades them. Their former silence was not because they did not experience pain and suffering, but because they were unaware that any alternative to silent acceptance existed. Only women themselves can create awareness in their society, influence change in the attitudes of society, fight against the humiliation of the practice and urge its total abolition.

Even though the constitution lays down equal rights for women and men in all fields and many legal efforts have been made to realize these rights, there is still need for an adequate mechanism or legal apparatus for the meaningful implementation of the existing laws. Also, patriarchal customs of centuries cannot be easily changed by law.

Reasons for the continuation of the practice of infibulation in Somalia

In the Somali Democratic Republic numerous reasons are given for the performance and continuation of the practice of female circumcision.

1. The operation of female circumcision appears to have been performed with a view to attenuate sexual desire, preventing women from indulging in premarital sex and from losing their virginity. However, female circumcision, even in its extreme form of infibulation, cannot serve to secure women's virginity or to ensure their chastity, as it is possible for a female to get recircumcision shortly before marriage through a simple surgical operation.
2. A common belief is that a circumcised woman is clean and a proper woman, and that an uncircumcised woman is unclean and not a proper woman. Again, in the light of current medical and health knowledge, this reason or rather assertion has no substantial support.

3. Another reason is that a man will not marry a girl unless she is infibulated. The argument for this view is that men derive more sexual gratification from a tightly circumcised woman with a narrow orifice. But the various forms of circumcision can only add to women's agony and misery, and contribute to men's lack of sexual satisfaction and eventual impotence.

4. The operation has often been performed under the pretext that it is endorsed by Islamic religion. This claim has been repeatedly refuted by religious leaders. The Somali Minister of Justice and Religious Affairs has stated that the practice of female circumcision has no religious basis. He referred to an unconfirmed saying of the Prophet (Hadith): "When you perform excision do not exhaust (it should be the slightest touching or just smelling of the knife against the clitoris)". The Minister explained that this saying had been misinterpreted, as the cutting or removing of the clitoris is forbidden.

5. Many Somali families continue to perform the operation as a tradition or custom dictated by and in line with group norms, values and identity.

The Somali Women's Democratic Organization (SWDO) is a broadly-based organization that unifies Somali women, motivating them to participate actively in the political, social, economic and cultural life of Somali society. The organization's mandate is to propose, promote and initiate progressive policies and programmes to the advancement of Somali women.

SWDO is totally opposed to the unholy, ugly and hideous malpractice of pharaonic circumcision (as it is widely known). To end circumcision is a major goal of our organization, written into our constitution. The problem of circumcision and how to combat the practice has been discussed for several years within the organization and also publicly. The most important thing is education. SWDO is undertaking a project concerning "The Eradication of Female Circumcision and Infibulation", which goes a long way towards fighting the social and health problems of female circumcision and infibulation.

**Orientation campaign**

We selected 30 to 50 women from each of the 13 districts of the Banaadir region. They were SWDO members and housewives, their ages ranging from 19 to 35 years. They were selected because

1. they had high awareness of social problems and a high level of political consciousness;
2. they were the most active elements in their respective districts and could play an active role in subsequent campaigns;
3. they had experienced the pain, suffering and problems of female genital mutilation;
4. they were mothers with one or more girls who would be involved in future campaigns;

5. the operation of female circumcision and infibulation has usually been and was still performed by these middle-aged mothers;

6. they have close contact with the rest of the people, and could be good communicators and messengers.

The campaign activities were mainly in the form of meetings and discussion groups with prepared lectures on the health hazards of f.c.

National Seminar on Health Hazards of Female Circumcision

From August 30 to September 3, 1986, SWDO held a historical seminar on the health hazards of female circumcision and its eradication in Somalia, at Hamar Weyne community centre in Banaadir Region/Mogadishu. Most of the expenses (if not all) and all the educational and training materials of this seminar were provided by the Inter-African Committee (IAC) and Rädda Barnen (Swedish Save the Children): it was also supported technically by Somali Family Health Care Association.

The seminar was attended by ministers, deputy ministers and other officials of the Somali Government, senior party members, leaders of social organizations, gynaecologists, medical staff and health workers, prominent religious leaders and well-known Islamic speakers. The following participants also attended the seminar: the Somali Revolutionary Socialist Party committees of Banaadir Region, the Mayor of Mogadishu, Representatives of international agencies including USAID, UNDP, UNFPA, the UNICEF representative, the University Research Corporation, the USAID contractor who is implementing the Somali Family Health Service Project, the Somali National Academy of Science and Arts, and all the executive committees of SWDO, as well as 35 persons from five different regions. It was the first time that representatives from such a large number of ministries, party members, organizations and agencies, had gathered together to discuss openly and frankly female circumcision and its health complications in Somalia.

It was decided that the resolutions of the seminar should be released continuously through the mass media to the Somali people, with the objective of arousing consciousness about the health, psychological and social damage resulting from female circumcision and informing the public about the religious stand towards it. The resolutions passed at the seminar concerned, among other things:

- the organization of a series of meetings, seminars, workshops and conferences throughout the country;
- education and information campaigns through many relevant channels and bodies;
- scientific research in several regions of Somalia;
- the creation of a national commission composed of various ministries and agencies;
- legislation and a national policy;

all aimed at combating female circumcision.
Family Health Outreach Campaign

SWDO is embarking on its first major IEC (Information Education and Communication) campaign of its health programme in the Hodan District of the Banaadir region (Mogadishu). One hundred-twenty-five tabella leaders (tabella equals approximately one hundred families) and one hundred-twenty-five community members will be trained to deliver a house-to-house, person-to-person communication campaign based on these three areas:

1. the health hazards of female circumcision;
2. the advantages of child spacing;
3. the advantages of oral rehydration solution.

Teaching methods employed in the Hodan campaign draw on Somali culture. A drama was written, with actors, actresses and musicians. Both the drama and the songs will be video- and audio-taped, to be used for training sessions on a closed-circuit basis.

Additionally the TV station will make a thirty-minute documentary of the entire training and service delivery components of the campaign. The documentary will be telecast, broadcast and recorded on video cassette, to be used as a basis for discussion in group viewing sessions, and will also be part of the general public awareness of family health.

This campaign is actually a field test for a considerable amount of SWDO-IEC activities that have been in the development process for one year. The Hodan campaign will be further field tested in three rural areas and the 1988 and 1989 communications campaign will be based upon the results of the 1987 activities.

* * * * *
I. Activities by the National Committee and the NGOs

The Sudan National Committee for the Eradication of Traditional Practices Affecting the Health of Women and Children was established in 1984 by a resolution signed by the Minister of the Ministry of the Interior and Social Welfare. The committee consists of members representing governmental and non-governmental bodies (NGOs) working for the eradication of female circumcision. All activities suggested by Sudanese NGOs pass through the committee for final approval. The Committee is recognized and supervised by the Ministry of Health and Social Welfare.

Activities carried out by the national committee in cooperation with NGOs during the period April 1984 - April 1987 included:

1) A series of group discussions in various institutions, schools and some rural areas.

2) Production of a one-hour video film with discussion of f.c. and some drawings.

3) A seminar on f.c. held at the Faculty of Medicine, University of Khartoum, under the patronage of the President of the Council of Ministers. This seminar was held with the aim of giving the regional associations and students' unions enough information on the hazards of f.c. for them to take the message back to their regions and village people.

4) A training workshop in Tayba El Hassanab village in June 1986, funded by the IAC, under the guidance of the Ministry of Health and Social Welfare. The participants were from the health and social work sectors; some teachers and office directors also participated; the recommendations of this workshop were recognized and generally followed.

5) Production of educational materials, mainly posters of three different designs. These posters were distributed during the group discussions and during all seminars and training workshops.

6) A seminar on traditional practices affecting the health of women and children, held in El Fashir in 1987, under the guidance of the Governor of Darfur Region. The seminar was funded by IAC. The participants came from 12 rural councils. It was a good representation of trained midwives, traditional midwives, health visitors, medical officers, teachers of all levels, social workers and housewives, in addition to representatives from the
political parties. Twelve working papers were discussed and educational material was presented. The final recommendations included the following:

a) Immediate establishment of a regional committee unit as a branch of the national committee; thus, before the end of the seminar the participants suggested the formation of the committee and sent this to the Governor for his immediate decision and action.

b) Detailed statistical research on traditional practices in the Darfur region is necessary.

c) Provision of educational materials to reach all people in the Darfur region is urgently required.

d) A strong law to eradicate f.c. in the Sudan.

e) Sex education and the eradication of harmful traditional practices to be taught in schools, in all women's training centres as well as in literacy classes.

f) TV and broadcasting should put much emphasis on these subjects.

g) All political parties should be involved in the eradication campaign.

h) Religious leaders need to be trained in order to discuss these issues and feel confidence to convince people of various levels of education.

i) People need to be convinced through scientific methods: films and slides are necessary during group discussions and seminar sessions.

j) Much work and supervision on the issue of f.c. should be carried out in schools for midwives.

k) Policemen should be involved in the campaigns.

l) Information on experiences concerning the eradication of f.c. in other countries should be translated into the native languages and distributed in the rural areas.

m) Transportation should be provided to those employed in the social work and health sectors to travel to rural areas to inform people about these matters.

7) The issue of eradication of female circumcision has been integrated in population education programmes and in income-generating programmes, and is going to be integrated in adult education programmes.

II. Complication of Female Circumcision in Sexual Life

In order to understand sexual life, we must know the functions of both the male and the female sexual organs. At the same time, we must also understand the whole process of sexual arousal and pleasure that leads up to orgasm. Most Sudanese people are ignorant of the functions of the sexual organs and the whole process of sexual intercourse.

The process of sexuality (sexual intercourse) starts when a person, male or female, feels there is an inner need or drive, like hunger. This drive emerges from the human brain (libido). For a man, when he sees a woman passing by, this can cause sexual
arousal. Just seeing, listening to a woman's voice or smelling a nice perfume, touching or even remembering someone can cause sexual arousal. Even during sleep a man can dream and become aroused, causing penis erection leading to ejaculation. These points are important when we talk about female circumcision.

It is a false belief that female circumcision can prevent sexual hunger (need) and feelings of sexual desire. It is true that f.c. can deteriorate the sexual life of a woman. However, the belief that f.c. prevents sexual desire and arousal is completely wrong. As mentioned earlier, sexual drive comes from the brain, not from the genital organs. The female genital organs, especially the outside ones (the clitoris and two labia) are very sensitive and important, because they contain many nerves. These nerves transfer messages directly to the brain, just like electric wires, going from the genital organs to the brain. The genital organs allow us to taste the sweetness of sexual intercourse by enhancing the arousal and pleasure which leads to fulfillment and relaxation. The female organs, especially the outside parts, are very important for obtaining satisfaction during sexual intercourse.

When we circumcise a girl by tearing (cutting) off the most sensitive parts - the clitoris and the two labia - it will never take away the sexual drive (desire) and prevent her from thinking about sexual activity. In fact, the f.c. process leaves the woman with feelings of sexual desire and a yearning for sexual satisfaction like all other women, but she will not be fully fulfilled and may never experience the real sweetness and satisfaction of sexual orgasm.

With circumcised women, in order to overcome sexual problems, men need to spend a greater amount of time stimulating them, as their most sensitive genital organs have been removed. We recommend to men not to neglect this point. Men should spend more time in foreplay in order to satisfy their wives at least partially, so as not to leave them hanging between the sky and the ground. Most circumcised women, when they go to bed with their husbands, just lie on the bed silently and expect the man to perform. Men will describe them as "just lying like a pillow". Most women think that married life is only for having children and doing domestic chores; they do not give any thought to their sexual life. This is, as mentioned earlier, a result of ignorance.

Female circumcision, in fact, merely complicates our lives. The complication starts with our daughters from the moment they are circumcised, with all the pain that accompanies it. Marriage scares them physically and psychologically, and they develop fear of sexual intercourse.

There is a belief that circumcision has something to do with cleanliness. Women who feel that f.c. is a practice of cleanliness will not enjoy any part of their life, including their sexual life.

Mothers traditionally tell their daughters that when they are circumcised there will be a big ceremony with many people invited and gifts. Because they are young, they think this is something good. Those girls who are not circumcised and see this special ceremony and the gifts demand it for themselves.
What happens to women who have been circumcised?

- The woman will probably respond coldly to sexual intercourse, become like a "pillow".

- Some women will develop a phobia whenever they are with a man, particularly on the wedding night. During sexual activity the muscles will become rigid and the man will be unable to penetrate. Sometimes the woman has to be taken to the hospital to be treated with medicine to relax the muscles in her body.

- The man and the woman will struggle and eventually the man will penetrate and ejaculate, but in a very tough and aggressive way, causing much bleeding and pain for both partners. Hatred towards sexual intercourse may develop.

- In some cases this traumatic experience will leave men feeling hesitant about themselves and they will come to doubt their ability to perform.

- Because of this anxiety, they may become impotent, and in time eventually separate from their wives.

All these problems confront young couples in the early days of marriage. Most men describe their women as cold and become intolerant of them. The man may leave the woman or send her back to her family. Thus, the women in her area will insinuate that the girl was not a virgin; on the other hand, the men will say that the man was not capable and had a sexual problem. In fact, the real problem is generally female circumcision.
REPORT ON THE ACTIVITIES OF THE TOGOLESE COMMITTEE OF IAC (CNSFE) 

by 

Mrs Akim Banabessé, President, National Committee for the Health of Women and Children, Togo 

Female circumcision is a plague the harmful effects of which have been denounced over and over again in Africa at international conferences.

In Togo, the authorities are conscious of the gravity of the problem. A national policy was established by the creation, in 1984, of the National Committee for the Health of Women and Children (CNSFE), affiliated to the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (CI-AF).

The activities of this committee have been varied since its creation; after three years of existence it can announce a positive result, reflecting the preoccupation of the authorities with the problem.

The national seminar on traditional practices affecting the health of women and children, which was held in Sokodé in the centre of the country from 30 September to 1st October 1986, is good proof of this. Placed under the patronage of the Ministry of Public Health, Social Affairs and Women's Affairs, this seminar attracted more than 120 participants, representing all political, social and religious groups of the region.

At the close of this seminar, the importance of which was deeply felt by the participants, a recommendation was adopted. This recommendation asked the National Union of Togolese Women (UNFT) and all organizations concerned with women to profit from their different meetings by recalling the harmful consequences of female circumcision and understanding that f.c. should no longer be considered as an initiation rite but should be abolished.

Radiodiffusion Radio-Lomé broadcast, in March 1986, a special programme with the title "F comme Femme" (W as in Woman), presenting to the public a recording on the damages caused by f.c. This broadcast, which pleased a good number of listeners, has been repeated on several occasions.

The half-yearly review "Happy Association for Family Well-Being (ATBEF), published in its December 1986 number an important article on the distressing consequences of f.c.

In addition, at the study days for secondary and higher education students in Sokodé, in March 1987, the National
Committee for the Health of Women and Children held an informal talk on "Female circumcision and its harmful consequences on the health of women".

It is to be noted that visits have been paid to certain circumcisers and that the national seminar of October 1986 has already borne fruit. We are happy to announce that several village chiefs in the prefectures have taken decisions in favour of the fight against f.c., and a significant decrease of the practice has been noted.

The National Committee has also been solicited by the Ministry of National Education and Scientific Research to develop themes on female circumcision and childhood marriage specifically for primary and secondary teachers. It is also to be noted that teaching aids, including visual materials (with slides) have been an effective means of sensitization. We are using them well.

Counting on the infrastructures of communication and broadcasting in our country, we wish to have at our disposal a permanent fund to enable us to intervene at every opportunity to advance our objectives in all regions. To allow us to bring circumcisers together and provide them with even more information, the creation of fund-raising projects is imperative.

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G.A.M.S.
Women's Group for the Abolition of Sexual Mutilations
Summary of the report presented by Mrs Coumba Touré,
Paris, France

G.A.M.S. is a French association which brings together African, Afro-American and European women. G.A.M.S. defends the rights of women and children and aims at contributing to the disappearance of customs which are dangerous to their health. Ever since its creation, G.A.M.S. has been collecting information on this issue through the study of scientific works and through international contacts.

Many immigrants in France come from African countries where mutilation practices are prevalent. It is a question in particular of people from Mali, Senegal and Ivory Coast belonging to the Bambara, Sarakolé and Toucouleur ethnic groups but also of families coming from Burkina Faso, Benin, Egypt, Ethiopia, Gambia, Kenya, Mauritania, Nigeria, Somalia. They live mainly in and around Paris.

G.A.M.S. estimates that in France 12,500 women and 10,500 girls are either mutilated or threatened with mutilation. The most frequent intervention is "excision" comprising clitoridectomy and ablation of part of the small labia.

Sexual mutilation of women is prohibited in France by the Medical Code (Deontological Code of Doctors) (article 22) and by the Penal Code (article 312).

In France, G.A.M.S.
- organized instruction at the University of Paris VIII on the subject of sexual mutilation of females;
- participated in the working group set up by the Ministry of the Rights of Women (1982-84) and has drawn up a large part of the report made on the situation in France;
- sensitizes professional health workers (doctors, midwives, paediatric nurses, social workers...) by participating in their initial or continued training;
- informs the immigrant population by interceding in African meetings and festivals;
- proposes, in particular to Mother and Child Health Care teams, a health programme adapted to immigrant families;
- takes part in numerous informative meetings organized by associations, communes, women's groups and so forth.
At the international level, G.A.M.S. has taken part in many meetings of health officers as well as of women's groups. G.A.M.S. is the French section of the Inter-African Committee.

The work done by G.A.M.S. since its creation favours action on the spot. The educational materials used are:
- those of the Inter-African Committee, notably the anatomical model;
- the "Universal Childbirth Book" published by Women's Inter-national Network News, Lexington, USA.

We use these different materials at the African women's meetings organized by the MCH services or other bodies. Men are sometimes present.

We can bear witness to the development registered in the MCH Centres where new excisions progressively disappear as families understand better the risks incurred by their daughters.
Discussion on Item 2: Female Circumcision

The introductory speech by Dr. Koso-Thomas and the very moving appeal by Mrs. Ismail, calling for national legislation to stop f.c., were followed by statements from all the participating countries regarding

- occurrence of f.c. in their respective countries,
- action undertaken,
- plans for the future.

The participants unanimously condemned this harmful practice which causes much unnecessary physical and mental suffering and pledged to work for its total eradication.

Dr. Leila Mehra, WHO Geneva, recalled that the WHO position is that there should be no midway in the dealing with f.c. All states which are members of the World Health Organization have agreed that f.c. should be abolished and that there should be no medicalization of the practice.

Mrs. Mary Tadesse, Chief Executive of the ECA African Training and Research Centre for Women (ATRCW) spoke of the collaboration between ATRCW and the NGOs. There should be concerted efforts by governments and NGOs; ECA can bring the necessary information into the governmental machinery. She felt that women were shy about the issue of f.c. and had not been as strong as the situation demands. They should be aggressive and not underestimate their power and strength. F.c. should be totally abolished in Africa before the year 2000.

Written reports on f.c. were received from most of the participating countries (see this chapter and chapter IX). Further statements were made as follows:

Benin
- F.c. is practised in two northern provinces and there is a team working against the practice in these regions.
- A programme has been drawn up for sensitization of the public through seminars.

Cameroon
- F.c. exists in certain areas, but there is no infibulation.
- Information on the practice is very difficult to come by and no data are available.

Central African Republic
- Around 8 - 10 of the 48 ethnic groups in the country practise f.c.
- The Government does not support the practice and those who adhere to the custom are often ridiculed and therefore keep information on the issue secret.

Chad
- About half the population of the country practises f.c.
- International support is needed to combat the practice.
Côte d'Ivoire
- F.c. is practised by about half the population (mainly by two ethnic groups), but there is no infibulation.
- Enlightened people have taken action against the practice and a national committee will be formed to coordinate activities.

Niger
- F.c. is practised by a minority ethnic group; the majority of the population does not perform f.c.

Tanzania
- Of the country's 25 regions, there are 5 where f.c. is widespread.
- Women have drawn the attention to the hazards of this practice and there has been legislation on the local level against it.

The following African countries have legislation against f.c.:
- Central African Republic, since 1966,
- Egypt, since 1956,
- Guinea, since around 20 years,
- Sudan, since 1945.

Tanzania has such legislation at local level and in Burkina Faso a draft law will shortly be enacted. In Benin, Burkina Faso, Kenya and Senegal, the Head of State has pronounced himself against the practice of female circumcision.

The President of IAC appealed for more support from WHO. It was decided to address a letter to the organization on that very day, 7 April, - the World Health Day - requesting WHO to take up the matter of eradication of f.c. in a constructive way.

The OAU representative said that any OAU member state could request that a matter be put on the OAU agenda. Therefore, a firm stand concerning f.c. is needed.

Referring to the interventions made, the Chairperson, Dr Irene Thomas, stressed the importance for the participants to make themselves heard at all levels and ensure that their requests for action and support get to the appropriate decision making quarters.

The President of IAC called attention to the question of the possible connection between f.c. and AIDS (Acquired Immune Deficiency Syndrome).

Dr Mehra, WHO Geneva, stated that there is no immediate link between f.c. and AIDS. Most people agree that areas in Africa where female circumcision is practised do not coincide with areas where AIDS is most prevalent. However, the potential danger of contamination through bleeding and the use of unsterilized instruments when f.c. is performed must be borne in mind. Bleeding during intercourse also poses a possible danger for the spread of AIDS.

On a specific question by a representative from Kenya, Dr Mehra said that midwives should not perform deliveries with their bare hands, especially if they have open wounds on their hands. They
would then risk contamination from an AIDS infected women and to contract other diseases as well.

The recommendations made on Item 2: Female Circumcision are included in the Plan of Action, see Chapter II.

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CHAPTER VII

ITEM 3: PRACTICES RELATED TO DELIVERY AND CHILD SPACING

Introduction by Dr. Nadia I. Atif, Egypt.

Reports were submitted from the following countries:

- Burkina Faso
- Mali
- Niger

The issue of practices related to delivery and child spacing is also dealt with in country papers comprising more than one subject of the seminar (see Chapter IX).
1. Population setting

SIZE: The population of Egypt was estimated to be 50 million in 1986, with an increase of one million every eight months, as compared to every 9 months in 1985 and every 10 months in 1984.

This increase is a result of a gradual decline in death rates since the 1940's, reaching approximately 10 per 1,000 by the early 1980's, with birth rates not experiencing the same decline. Actually, birth rates started an annual decline between 1967 and 1973 which was reversed to an upward trend until the end of the decade, increasing natural growth rates from 2.4% in 1966 to almost 2.9% in 1979. The current estimated growth rate is around 2.7% (Gadalla, Saad, 1968, and Loza, Sarah et al, 1986).

The initial decline in birth rates has been mainly attributed to the 1967 war and the continuous mobilization of armed forces until 1973. The reversed upward trend was attributed to post-war baby boom and the age-sex structure of the population, with a larger proportion of females in the child-bearing age.

Currently, around 40% of the population is below 15 years of age. The population is expected to reach at least 70 million by the year 2000, regardless of all efforts to reduce fertility levels (Loza and El-Safry, 1986).

DISTRIBUTION: The population growth in Egypt has been accompanied by a steady increase in the proportion of the population living in urban areas. The urban percentage, which increased from 37% in 1960 to 44% in 1976, is estimated to have reached 50% by 1985.

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS: Several studies have shown significant differences in demographic and socio-economic characteristics between urban and rural areas in Egypt. In general they suggest that the rural population is characterized by a somewhat younger age structure than the urban population. The proportion in current marital unions is somewhat higher in rural than in urban areas, and urban residents are much more likely than their rural counterparts to have had at least primary education.

Egypt is also characterized by differences in the demography and socio-economic conditions of populations living in Lower Egypt and Upper Egypt. At the time of the 1976 census, 43% of the total population lived in Lower Egypt, while 35% were from Upper
Egypt. The population density in Upper Egypt (1,047 persons per sq. km) was considerably greater than that in Lower Egypt (714 persons per sq. km/CAPMAS 1984). Both fertility and mortality levels were higher in Upper than in Lower Egypt (National Academy of Science, 1982). In 1976, the crude birth rate was estimated to be 44.1 per 1,000 in Upper Egypt, compared to 38.6 in Lower Egypt, while the infant mortality rate was estimated to be around 50% higher in Upper Egypt (145 deaths per 1,000 births) than in Lower Egypt (99 deaths per 1,000 births/National Population Council Survey, 1984).

2. Population control

Warnings about the perils of population were brought forth in 1930 by Al-Ruwad, a group of social work professors that discussed Egypt's social and economic needs. They asked the Mufti of Cairo for an edict (fatwa) to interpret the Islamic stand on contraception. This was issued in 1937. A 1936 book on the Population Problem in Egypt by Wendell Clelland was also catalytic in promoting discussions among the Egyptian Medical Association members and the Ministry of Social Affairs. But until the overthrow of the old order in 1952, there was simply no impetus for action on population growth (Warwick, 1982).

After the revolution of 1952, various government actions in the field of family planning were taken. The following is a brief chronology:

1952 The Revolution
1953 The Institution of the National Committee of Population Problems
1954 The Foundation of the first clinics for family planning by the National Committee
1962 The Proclamation of the Charter of President Nasser that eliminated many obstacles for family planning
1964 The Joint Committee for Family Planning was founded to coordinate the work of volunteer groups operating in most of Egypt's Governates, with several hundred family planning clinics under their auspices. The Joint Committee was later replaced by the General Family Planning Association
1965 The Institution of the Supreme Council of Family Planning, which in 1973 was changed to the Supreme Council for Population and Family Planning, and in 1985 renamed the Population Council.

To sum up, the government has had an official National Family Planning Programme since 1965. Family Planning services are provided at highly-subsidized rates at Ministry of Health units and urban centres of the Egyptian Family Planning Association, a federation of private voluntary organizations (Loza et al, 1986).

It is worth noting that voluntary agencies in Egypt pioneered family planning services and clinics long before the government adopted an official family planning policy and programme.

The Women's Health Improvement Association (Tahseen El Seha), the Cairo Women's Club and similar organizations, were instrumental in implementing clinics in the urban and rural centres and in supporting mobile family planning teams. An innovative and active social marketing programme has been established; it continues to be run by a voluntary organization,
the Family of the Future, which began distributing to physicians and pharmacists an oral contraceptive under the brand name "Norminist".

3. Child spacing practices

By child spacing is meant controlling the time span between delivery of one child and the conception of the next. Any form of family planning practised in Egypt comes under this title.

Traditional barrier methods (sponges, leaves, etc), folk herbs and breast-feeding were the most popular until voluntary organizations began pushing the pill, followed by IUD, both of which were later adopted by official government programmes launched in 1966. Although other methods have since been introduced, they were not widespread. The pill and the IUD remain the most popular modern contraceptive methods utilized, and breast-feeding the most popular traditional method practised (see figures 1 and 2). Whereas breast-feeding is utilized basically for spacing, the modern method of the pill is mainly used to terminate pregnancies after the desired family size is reached; IUD is utilized to limit the number of children after the third child is born, as shown in table 1.

| TABLE 1 |
|--------------------------|-------------------|-------------------|
| Percent of women (excludes those relying on sterilization) currently using family planning to cease childbearing or to space births, by age and number of surviving children, Egypt, 1984. | |
| Demographic characteristic | Cease childbirth | Space birth |
| TOTAL | 84.4 | 14.7 |
| Age | | |
| Under 20 years | 17.5 | 82.5 |
| 20-24 years | 51.6 | 48.4 |
| 25-29 years | 74.1 | 25.1 |
| 30-34 years | 89.1 | 10.3 |
| 35-39 years | 95.9 | 3.4 |
| 40-44 years | 98.7 | 1.3 |
| 45-49 years | 98.3 | 1.2 |
| Surviving children | | |
| None | 10.0 | 90.0 |
| 1-2 children | 57.6 | 42.0 |
| 3-4 children | 92.4 | 7.3 |
| 5-6 children | 97.2 | 2.1 |
| 7 or more children | 96.0 | 3.2 |

The practice of having a first born soon after marriage remains unchanged. The desire as well as practice of having a second child within 1-2 years after the first is widespread. A substantial minority begins sterilizing contraceptions after the third or fourth child is born and the majority of contraceptors in Egypt use contraceptives to terminate childbearing rather than for child spacing, when they have "sufficient" numbers of living children.
Fig. 1
Percent Distribution of Current Child Spacing Users by Method Used, Egypt, 1984

Fig. 2
Percent Distribution of Current Child Spacing Users by Age and Method Used, Egypt, 1984

From the Egyptian National Population Council Survey 1984 (pp 153 and 157)
FACTORS GOVERNING INADEQUATE PRACTICE OF CHILD SPACING: Despite the encouraging findings of the Egyptian Population Council Survey of 1984, contraceptive use is still quite low among the urban poor and rural families. The popular motivation to regulate fertility is disregarded when compared to benefits and advantages of having large families. The perceived costs of contraceptives, in terms of fear of their debilitating effects on the physical strength of the wife and mother, act as another factor lowering demand for family regulation (Loza et al, 1986, El-Hamansy, 1972).

These large family norms are supported by religious norms and values. While family planning for spacing children is encouraged in Islam, family size limitation is not. There is still no clear consensus among religious leaders on the standing of family planning vis-à-vis religious principles. This ambiguous religious stand encourages some religious leaders to advocate that family planning is against Islamic teaching, putting political leaders in a position to stay away from such probable volatile issues, and to provide limited public support for family planning (Loza et al, 1986).

Also, the Egyptian intelligentsia does not provide sufficient support for direct political leadership involvement. Several scholars view population growth-rate arguments as being used as scapegoats by the government. For them, population conditions reflect developmental conditions and not the reverse. To blame the micro level for inefficiencies at the macro level is in their opinion an unacceptable shift of responsibilities and an oversimplification of the facts (Loza et al, 1986).

To sum up, the large family norms, the ambiguous religious stand, and the low government profile in support of family planning, all act in combination to reduce overall demand for contraceptives, especially among the rural and low-income urban families. Thus, the decline in overall fertility rates is quite modest.

4. Recommendations

Many recommendations have been put forth to remedy the situation of the burgeoning population of Egypt. The following summarizes the majority of them:

"The present wide network of about 4,000 basic health units providing or designed to provide family planning as part of their programme of activities needs to be upgraded so that family planning be considered an integral and essential component of services rendered in any health delivery unit, project, programme and plan" (Hassan, 1985, p. 85).

To this end Dr Faseg Rizk Hassan recommends:

1. Firm commitment of the authorities regarding the gravity of the health implications of the population problem, the necessity of maintaining an effective intervention programme, and the provision of necessary legislative and motivation support - this being an important prerequisite of utmost priority.

2. Strengthening family planning services of these units, as an integral part of their programme of activities. This includes:
a) adequate training of physicians and nurses and other personnel, with clearly defined terms of reference and job descriptions;
b) a manual guide of instructions regarding the use of contraceptive methods, choice of the proper contraceptive, counselling, possible side effects and methods to remedy the situation;
c) an adequate and continuous supply of contraceptive methods and correct logistics;
d) adequate counselling services;
e) an adequate and simple statistical system of recording and registration;
f) adequate and effective technical supervision and guidance;
3. A well-planned and well-organized outreach programme to extend family planning services to remote areas. In this context, optimum utilization of nurses and other paramedical personnel should be considered.

Hassouna (1980, pp 165-166) adds that the primarily clinic only, oral contraceptive, physician-dominated programme needs modifying, and this through:

a) An active outreach programme with communication activities at all units for expansion, motivation enhancement and follow-up purposes;
b) provision of a broader range of contraceptive methods to eliminate loss of clients due to lack of choice;
c) increasing family planning personnel and specifically training teams in IUD insertion and follow-up, and in a client oriented barrier method service provision;
d) improving the management of the delivery system, including the establishment of unit level acceptor targets and evaluation procedures and facilitating regular dispatch of contraceptive supplies from regional centres to individual units.

With regard to child spacing, greater attention to the popular traditional practice of breast-feeding should be promoted. Breast-feeding influences positively fertility levels as well as the health of mothers and their children.

To this effect Dr Mahmoud Karim of Ain Shams University Medical College strongly urges that working mothers continue to evacuate their breasts in sterilized bottles to be refrigerated for later feeding to their infants. This maintains lactation volume and continuity, while assuring improved child spacing.
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This matter is very advanced in Burkina Faso because all bodies have made it their war horse. Burkina Faso, inhabited today by 7,975,000 people, has a young population (45.4% are younger than 15) and a female majority (51.8% women). Its rate of growth is high (2.68%) and the population will be doubled in 26 years if the present demographic tendencies continue. In order to permit better conditions of life for its people, Burkina Faso has therefore opted for family planning and child spacing, thereby guaranteeing better health for mother and child and the whole family.

Numerous actions have been initiated directed toward different social strata of the population, to sensitize, inform and train them in the field of sexual and population education and education concerning family life and family planning.

A study was carried out in January 1986, by the Direction for the Health of Mother and Child, in the context of the project "Consolidation of Medical Benefits for the Family in Burkina Faso" with the aim of improving the family planning services, integrated in the mother and child health care. Through this study the obstacles to the use of these services were identified.

The following conclusions have been drawn from the study which comprised 1,007 women 15-49 years of age and 603 men between 18 and 60 years old:

- a marked interest by both sexes in family planning (one woman in three, and one man in four with children wish to stop having children);

- child spacing is accepted by everybody, a good interval being judged to be 2-4 years and the number of children per family to be 4;

- the knowledge of traditional methods of family planning is current among women 25 to 49 years old who apply them, while the younger women (15-25) have better knowledge of modern methods. Abstinence was much criticized by those questioned as disturbing conjugal harmony;

- a very strong desire among women to control births with a predisposition towards the use of modern contraceptive methods;

- unsatisfied demands for family planning due to the insufficiency of health services and the lack of availability of contraceptive methods in sufficient quantity in the existing structures, or lack of means among couples who cannot always pay
for the examination required before the prescription of oral contraceptives (for example, of 3,266 examinations requested in 1985, only 1,599 were carried out) or who cannot always buy the prescribed contraceptives.

- a general lack of in depth information on methods of family planning; in fact, men and women are aware of the existence of modern methods but do not know enough about them, leading to possible errors of interpretation which are responsible for certain fears (for example, some confuse planning with stopping pregnancy altogether or see the pill as a sterilizer).

This inquiry also revealed the persistence of certain socio-cultural, if not psychological, barriers in regard to the adoption of family planning, even if its existence is known and one is attracted to it intellectually; there is often fear of going against the will of God (who gives children to some and not to others, who gives many or few...), of seeing wives become unfaithful because of the protection, of not becoming pregnant at the desired time, etc. The lack of dialogue between partners concerning everything that concerns sexual relations does not favour a positive attitude towards the use of family planning.

These conclusions have permitted us to reconsider the problem of information and training in family planning. From now on it is necessary:

- to redefine the institutional context of family planning to allow for better coordination of different activities, the means in use and the division of the different areas to be reached;
- to equip the provinces with technical laboratory equipment and reagents;
- to emphasize, in educational population programmes given in secondary, technical and professional schools, the different kinds of family planning;
- to introduce the techniques of family planning in the training of medical and para-medical personnel and, if need be, to recycle all the personnel already practising, so that this problem will become their daily preoccupation too.

* * * * *
FAMILY PLANNING IN MALI

by

Mrs Bintou Fofana, National Executive Office of
the National Union of Malian Women (U.N.F.M.)

Mali was one of the first African countries to accept a family planning policy. This policy is child spacing.

In Mali there exists an association called the "Association Malienne pour la Promotion et la Protection de la Famille" (A.M.P.P.F.). This Malian Association for the Promotion and Protection of the Family is supported by the I.P.P.F. (International Planned Parenthood Federation) and concerns itself with problems of family planning.

The A.M.P.P.F. has sections in the seven regions of Mali and in the District of Bamako. These sections work in close collaboration with U.N.F.M. (National Union of Malian Women). A representative of U.N.F.M. and a consultant sociologist carried out an inquiry, in October 1986, into the relations which exist between family planning and women’s organizations in Mali.

The facts established were as follows:

- The women have understood the importance of family planning.
- They visit family planning centres where they receive information and appropriate care.
- The regional sections of A.M.P.P.F. function well but have difficulties, because of lack of means of transport, to supervise the activities of distant areas.

The Training Centre for Rural Animators, C.F.A.R./U.N.F.M., of Ouelessebougou, which groups 72 villages, also teaches its animators family planning; once trained and back in their respective villages, they inform the rest of the population on the importance of the principles and practices of family planning.

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DELIVERY AND CHILD SPACING IN NIGER

by

Mrs Gaptia Ramatou Kanfideni,
Women's Association of Niger (AFN)

In Niger, delivery is still the privileged domain of traditional midwives, who deliver 80% of the women in the urban as well as in the rural areas. It is to be noted that in the context of the policy of primary health care (the Governmental option) these traditional midwives receive a brief medical training. However, their number remains insufficient; of the 9,000 Nigerien villages, 3,000 only have birth attendants who have received training.

Delivery

Delivery usually takes place in a crouching position. The umbilical cord is cut before the descent of the placenta, to save the woman from having to stay for a long time on her knees. The woman who has given birth receives for 7 days an intimate toilet with warm water, traditional soap and fruits of the tannin tree prepared beforehand. This procedure makes it possible to avoid infections associated with childbirth. The baby is washed in tepid water with traditional soap. The navel is coated with karité butter and a special salt which comes from the far North of Niger (Guichiri'n Balma). After the umbilical cord has dropped off, the wound is treated with a little antimony. Healing occurs at the end of 2 weeks. After 40 days the woman gives up warm intimate bathing.

Child Spacing

Traditional practices associated with child spacing are disappearing. It is however fitting to call them to mind again. For example, so as not to be condemned by the village community, women avoid close pregnancies, which are considered shameful. For this reason the woman sometimes goes to stay with her parents for a year after giving birth. Other methods also exist, notably breast-feeding.

Our Government has opted for a policy of child spacing. In this context a centre of family health has been created with the objective, among others, of sensitizing and educating women in modern practices of contraception. This family health centre envisages undertaking studies with the aim of getting to know the different traditional practices of child spacing which are better adapted and less costly. Current modern practices are not only very complex for a population of whom the majority are illiterate but also very costly for people whose annual revenue is low. The Women's Association has undertaken an extensive information campaign throughout the country to sensitize women to the problems of child spacing.

* * * * *
Discussion on Item 3: Practices Related to Delivery and Child Spacing

At the debates on this item, in plenary session and in discussion groups, comments were made by participants from many African countries. Some are given below.

Benin
- There is a national committee for family welfare under the Ministry of Public Health.
- A child spacing policy exists and people are informed about fertility and sterility.

Ethiopia
- Training of TBAs is included in the Primary Health Care programme.
- TBAs have gained recognition, especially in the rural areas and their services are much used.
- Thanks to them, infant mortality has been reduced by 20%.
- There is often a kind of referral system between the TBAs and expert midwives.

Ghana
- In the Upper Regions of Ghana, 70% of all deliveries are performed by TBAs.
- The Ministry of Health, the Red Cross and Zonta International have embarked on programmes of TBA training.

Mauritania
- Training of TBAs has been going on for the last 10 years.
- A census of TBAs has been taken and a survey of their work has been carried out with assistance from WHO.
- The TBAs have to study their own methods for a period of one month and classify them into good, harmful and neutral ones. The ideas are shared between the TBAs who are, after this study period, given basic equipment and identity cards so that they can be recognized by health personnel.
- Continuous training and exchange of ideas has a good impact on the rural population.
- The TBAs are supervised locally by midwives and by the central headquarters twice a year.

Nigeria: Zur-zur
A very harmful, dangerous practice is zur-zur which is performed on women who are expecting their first child, in the 34th-35th week of pregnancy. The purpose is to prepare them for delivery without difficulty. A deep wound is made in the anterior wall of the vagina, sometimes on the posterior wall as well, by a traditional healer with his/her knife. The pregnant woman is made to bleed into a pan, then laid down for a while and thereafter sent home to nurse her cuts.

Complications:
- death through bleeding and shock,
- infection of the birth canal,
- vesico-vaginal or recto-vaginal fistula, due to deep cuts.
Some women go to hospital after bleeding. The midwife or doctor thinks it is ante-partum haemorrhage and does a Caesarean section, but the bleeding does not stop. Midwives are fighting the practice which should be eradicated.*)

Sudan
- Elderly people in rural areas put oil on the umbilical cord and apply a piece of hot metal to burn the cord, thereby sometimes causing infection.
- Week-old babies are cut on the tummy to let out bad blood and a traditional medicine is put on the cut.
- When babies have a high fever, they are tossed into the air and fire is flashed in their faces.

Togo
- The government and the Association for Family Welfare work together in a national family planning programme.
- The number of TBAs is decreasing and there are schools for auxiliary midwives.
- Home delivery is practised but women are encouraged, through health education, to go to maternity homes for delivery.

The recommendations made on Item 3: Practices Related to Delivery and Child Spacing are included in the Plan of Action, see Chapter II.

*) A similar practice is the so-called gishiri cut, usually carried out by old women using a razor blade, as treatment for obstructed or prolonged labour and also against infertility, dyspareunia, amenorrhoea, backache, headache, dysuria and goitre. According to WHO, zur-zur is mostly practised in Ethiopia and gishiri cut only in northern Nigeria.
CHAPTER VIII

ITEM 4: NUTRITIONAL TABOOS

Introduction by Comrade Bogalech Alemu, Ethiopia.

Reports were submitted from the following countries:

Burkina Faso

Central African Republic

Ghana

Niger

The issue of nutritional taboos is also dealt with in country papers comprising more than one subject of the seminar (see Chapter IX).
SOME COMMONLY PRACTISED NUTRITIONAL TABOOS IN ETHIOPIA
AND THEIR IMPACT ON WOMEN AND YOUNG CHILDREN
by
Comrade Bogalech Alemu, Ethiopian Nutritional Institute,
Addis Ababa

The improvement of nutrition offers one of the principal answers to the most serious problems concerning both health and life in the world at large and in Africa in particular. Food patterns are moulded by the agricultural resources, technical progress and economic status of a region and are also based on the edible materials considered as food. Many food items may not be considered as food by some cultures, but others eat them. Thus, most people shy away from insects, but fat crickets are sold at the market in Bangkok, sun-dried termites are a delicacy in Zimbabwe, etc.

Experience has shown that food habits are hard to change. Strong resistance is often found as a result of important early feeding experiences. Those concerned with changing the nutritional habits of a community need to know how such nutritional habits are established in each generation: how the child learns what to eat and what to avoid and how much of a certain food should be eaten, and how the learning of food habits is sustained by other aspects of a community's life. And how a new pattern of feeding could be developed that will be nutritionally sound and which is strong enough to replace the food pattern that is less nutritional.

As soon as primitive people become part of a large political system their culture is no longer self contained but is subject to decisions and events originating far away. Their dietary patterns are often externally controlled by systems like land tenure, trade pattern, labour market and discriminatory customs, whereby a dominant tribe imposes or influences the food habits of subordinate groups.

Today the majority of the people in African societies are in a state of rapid change and old patterns have been disturbed and are being replaced by new ones.

Ethiopia has a wide variety of ecological areas with various geographical and cultural differences. Consequently, the food habits are also numerous and varied.

Some of the commonly practised nutrition practices and taboos in Ethiopia are listed below.

1. Abrupt or rapid weaning of an infant without gradually introducing the infant to solid or semi-solid foods other than breast-feeding is common practice. In most cases the
1. The child is sent away to a relative or to grandparents where the child is confronted with emotional deprivation due to the mother's absence and the lack of breast milk.

2. So-called fenugreek water is usually given to an infant after boiling the seeds 2 or 3 times and throwing away the first and second water to get rid of the bitter taste, then the third water is given after discarding the seeds, and the child will not gain any of the nutrients as such.

3. Some parents believe that a child will get worms and will have bulky and smelling stools if introduced to weaning foods before he is able to walk.

4. Some parents refrain from giving honey to their children as they assume that honey will retard their speech development.

5. It is often a taboo for the young child to eat before his parents and elder siblings. In fact the young ones are normally fed on leftovers from the elder ones, whereas the young child should eat better, nutritious food to enhance his healthy growth and development.

6. Some mothers assume that feeding eggs to children will give them tapeworm.

7. In the northern part of Ethiopia the consumption of turkey, ducks, vulture and hippopotamus is forbidden and people of a particular ethnic group that consumes such foods are usually considered as social outcasts.

8. Most of the highlanders in Ethiopia do not eat meat from camels, horses, donkeys, pigs, dogs, monkeys or cats, although camel meat is normally consumed by the lowlanders.

9. Milk from sheep, camel, horse and donkey is a forbidden food for the majority of Ethiopians, except for the lowland nomads who consume camel and goat milk.

10. In most regions of Ethiopia the infant is usually wrapped with clothes or kept indoors, mostly to protect him from evil eyes. Such a practice results in depriving the child from getting vitamin D from sunshine which is vital for developing his bones.

11. For unknown reasons, some people think that items like milk and "kolo" which are very nutritious should not be consumed by pregnant women.

12. Some very nutritious foods, such as brown teff, brown whole wheat bread, "kolo" and pea flour stew, are normally branded as a diet for the poor and such foods are often avoided by the rich.

13. In traditional societies of the highlanders, young girls and women are not allowed to eat raw green pepper, as it is believed that they would mature early or their interest in the opposite sex would increase.

14. Another taboo is that eating heart would make one forgetful and the consumption of heart as food is therefore avoided.

15. If a person eats the tip of a tongue, it is normally believed that he would become quarrelsome; therefore most people cut off and throw away the tip before preparing a meal with tongue.
Some of the food taboos for Moslems are as follows:

1. All pork and pork products are prohibited.
2. All meat slaughtered by a Christian is forbidden, except for the one slaughtered according to the Islamic ritual, i.e. letting the blood while mentioning the name of Allah or God.
3. During fasting certain foods are highly recommended, such as milk, dates, meat, seafood, honey and oil.
   Note: Fasting is practiced every year for one month which varies with the Islamic lunar calendar.
4. Menstruating, pregnant and lactating women are not required to fast but must make up the fasting at other times.
5. Moslems are advised not to eat to full capacity but always to share food.

Concerning fasting as a nutritional taboo among the Orthodox Christians of Ethiopia, the following should be noted:

1. The Orthodox church prohibits the consumption of such nutritious foods as meat, eggs, milk and butter during fasting.
2. Most Orthodox Christians regard fish as permitted food during fasting periods, but some clergy and conservative members of the church still refrain from eating fish.
3. During pregnancy women in general follow the fasting rule, but the above mentioned study indicates that pregnant women suffer from various nutritional problems due to lack of certain nutrients.

A study conducted among the Rift Valley Arsi Galla ethnic group indicated the nutritional taboos as follows:

1. Eggs are never included in their diet for unknown reasons.
2. It is usually believed that if a pregnant woman breast-feeds her child, the milk will endanger the child's life, as it is considered poisonous.

Among the Sidamo people of Southern Ethiopia, food items like fish, heart and liver are forbidden and people who consume such forbidden foods have very low status in the community.

In the above mentioned community men are receiving the food first and are therefore privileged to get the largest share and often the most valuable part. Women and children are receiving leftovers.

It is a pity that some of the good traditional practices are being replaced by new ones, such as the use of polished and refined cereals, sweet dishes and beverages from the West. For instance whole wheat bread, boiled whole cereal, legumes (Nefro) and roasted whole cereals and pulse are being replaced by cakes, cookies, tea, white bread and carbonated drinks such as Fanta and Coca Cola, which are not as nutritionally sound as the former food items.

In most African countries women play crucial roles in the maintenance of family life and health, in their reproduction and mothering roles as well as in their roles as wives, home makers, income earners, and food producers. They have been and continue
to be responsible for the daily activities basic to the health of the family. Women's role in the production of food, directly for the family diet or for the family income, is particularly important and for them to be able to play such a role effectively they ought to be fed a healthy diet.

Malnutrition is one of the prevalent problems in Ethiopia today. In order to study in detail this serious problem in the country and to suggest ways and means of improving the situation of the most vulnerable groups, that is women and children, the Children's Nutrition Unit which is now the Ethiopian Nutrition Institute was established in 1962. It was believed that an organized and systematic approach through such a body should be taken to solve this crucial national problem.

In addition to the research activities which are indicators of the nutritional problems in the country, the Ethiopian Nutrition Institute has embarked on many applied nutrition programmes through the use of media, women's organizations, farmers' associations, nutrition field workers, agricultural and home economics agents, etc.

The present day approach to the problem of food practices focuses on the change of food habits, and such change in the diet could be achieved by reinforcing common food stuffs or by the introduction of an additional nutrient in a familiar form or by the provision of supplements to be blended with familiar family food. Unfamiliar foods and methods of preparation need to be studied and possible values recognized before changes are suggested. A family may be encouraged to continue its own methods of preparation and then gradually helped to institute necessary changes to correct any poor practices.

If malnutrition exists among the inhabitants of a community, therapeutic diets should be interpreted for the patient or the person in charge of food preparation for the family, usually the home maker, in terms of the regional cultural or religious food patterns. The marked improvement in homes where the mother has had the opportunity to learn to adjust to local foods and customs, shows that instruction as well as understanding form an important phase of nutrition work.

Rapid change is taking place in all countries of the world in regard to food habits and practices and it should be kept in mind that most developing nations are recipients of the UN Nutrition Educational programmes. And thus what is a typical nutritional taboo today, may not be it in a few years to come.

After the Ethiopian revolution a lot of efforts have been made to combat backward beliefs and practices which are militating against the rapid progress of the nation. Very encouraging results have been achieved even though cultural and attitudinal changes will require many years of effort.

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There are some alimentary prohibitions linked to totem customs or to religion and taboos in connection with a certain number of our agricultural and farm animal products in Burkina Faso.

Knowing the impact of a varied and balanced diet on the development of the child and on the health of each individual, and realizing that malnutrition is rife in our country, we can, thanks to a study that has been carried out, measure the negative effects of these taboos on our population. The problem is all the more serious because it concerns mainly women (51.8% of the population) and children (45% under 15 years of age), 40% of those visiting Mother and Child Health Centres, that is to say women of child-bearing age and children under 5. It is this population which, in fact, has the greatest need to have enough to eat and to have, in sufficient quantity, all the nutritive substances that are indispensable for the body to function well, viz. animal and plant proteins, lipids, carbohydrates, vitamins and mineral salts (children need them because they are growing and women because they procreate, breast-feed and carry out innumerable tasks which consume their energy).

In Burkina Faso taboos concern, above all, foods rich in proteins (such as eggs, leguminous plants: beans and peanuts, and certain kinds of meat) and in vitamins and mineral salts (certain green leaves, certain fruits and raw vegetables).

The study of the nutritional situation has also revealed the existence of important nutritional problems due to abrupt weaning, the inadequacy of alimentary products and nutritional taboos. These problems are the cause of retarded growth in children, of their lowered resistance to infectious and parasitic diseases and of the high level of mortality. They also favour fatigue and the threat of miscarriage in pregnant women and asthenia in those who are breast-feeding.

The study reveals the following figures which show the extent of the problem which the country has to face:

- level of severe malnutrition of energizing protein: infants from 6 months to 3 years: 0.2 - 2% according to regions; children from 6 months to 5 years: 1.04 - 3.5%; children from 6 to 10 years: 3.5 - 5.8%; women from 16 to 45: 0.2 - 0.7%;
- level of global malnutrition: infants from 6 months to 3 years: 39 - 53%; children from 6 months to 5 years: 41 - 55%; children from 6 to 10: 48 - 66%; women from 16 to 45: 31 - 37.5%.

As a consequence of these established facts, studies have been undertaken to determine the nutritive value of our local products and the daily protein requirements of children from 0 to 5 years of age, in order to determine the composition of food allocations. Enquiries on alimentary habits have allowed us to collect recipes from the different ethnic groups, in order to improve them and make them available for general distribution.

These studies have led to various activities being undertaken to fight against alimentary taboos in particular, and malnutrition in general. Medical and para-medical personnel have therefore been retrained to qualify them to be able to lead campaigns of sensitization, information and training for expectant and breast-feeding mothers in MCH centres, social centres, maternity hospitals, village groups and training centres for young agricultural workers. The accent has been put on the domain of nutrition in the training of village midwives and health workers. A retraining of primary school teachers and secondary school bursars has been undertaken in order that good nutritional habits will be established from childhood. Demonstrations have also been carried out in all the sensitization centres. It is to be expected that women will commit themselves to introduce new food products and new cooking techniques into their homes. Unexpected visits to families allow us to ascertain if mothers effectively follow the instruction given to improve the meals of their children and their entire households.

The National Revolutionary Council has nutritional self-sufficiency as its war-horse. All practices that thwart the fulfilment of women and children have been discredited and are being fought against. Alimentary taboos have been condemned in this connection, and a campaign has been launched to ensure that every person in Burkina will not only have enough to eat, but also eat what is really necessary. Several activities have been initiated in order to attain this goal.

The slogan for the year 1987, "Let's Produce and Consume in Burkina" aims at re-energizing our production in all domains and incites us to eat our own products, which are therefore no longer from the outset intended for exportation, but must contribute to assure the complete fulfilment of the people of Burkina. Numerous demonstrations showing the use of our products have convinced the majority of the population. Already, the adoption of a number of agricultural products and their integration into the daily diet can be seen in many families in towns and their peripheries. Without doubt this will reach all the rural areas and in this way the battle against nutritional taboos will be won. It is, however, necessary to wait for a year before evaluating the achievements, in order to confirm or modify the changes in mentality that are taking place in this respect.

* * * * *
NUTRITIONAL TABOOS IN THE CENTRAL AFRICAN REPUBLIC

Intervention of the Central African Party

In the traditional Central African social context, nutrition is considered not only as a means of survival but also, and above all, as an act of respect and fidelity to ancestral, mythical values. In addition to permanent reference to ancestral values, at each level of the social hierarchy there is a corresponding type of nutrition.

Alimentary prohibitions are the same for all children whatever their sex. These prohibitions are lifted in proportion as boys grow up and reach the higher levels of the social hierarchy, until they become elders when in general everything is permitted.

Alas, as far as girls are concerned, most of the prohibitions are imposed upon them for life.

The prohibitions to which women are subject are very numerous and vary considerably from one ethnic group to another. These prohibitions are profoundly steeped in superstitious implications, which complicate enormously the choice of food possible for our women.

Nutritional prohibitions hit pregnant women even harder, since they must be content with green vegetables alone, above all from their sixth month of pregnancy. The most widespread prohibitions that are found almost everywhere in the country concerning pregnant women are for example

- monkey: the child will inherit its looks;
- antelope or gazelle: the child will be weak or the birth will be in a breech position;
- reptiles, tortoise, eel, etc: there will be a risk of their method of locomotion having repercussions on the future baby.

In general, pregnant women must not eat just anywhere and above all, they must not eat in front of just anybody, for malevolent spirits can, through consumption, poison the foetus inside the mother.

Many domestic animals are forbidden to women in general, and to pregnant and breast-feeding women in particular: chickens, pigs and sheep. On the other hand, glutinous, green vegetables are strongly encouraged. All animals and fish are considered as totem by one ethnic group and are not consumed by the members of this group (particularly young people).
It goes without saying, that all these prohibitions diminish enormously the quantity of animal protein essential to the harmonious development of the woman and the child, especially since the woman has a multitude of tasks to accomplish each day in which she invests almost all her physical energy. The fight against these prohibitions is carried out indirectly through the governmental socio-educational structures.

We wish precise recommendations to be made to the different national committees, so that concrete action will be taken to help the classic governmental structures to fight against this persistent evil.

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It has been established through research and studies that certain traditional practices, such as nutritional taboos, affect the health of women and children. The question of nutritional taboos was discussed extensively in a seminar organized in the upper region of Ghana.

Generally, children and women are deprived of foods that are considered to be very nutritious. Traditional reasons are usually given for preventing them from eating these foods. Some of these taboos are:

1. Pregnant women are not allowed to eat pork, the reason being that the baby would snore like a pig when it is born.

2. A pregnant woman is not allowed to eat millet flour mixed with water; if she does, she would have too much blood, which would cause hypertension.

3. A pregnant woman must not eat the meat of a horse: it is believed that the child would cry like a horse.

4. A pregnant woman is prohibited from eating beef (especially bush cow) as it is believed that the child may be born with red and white patches.

5. If a pregnant woman eats antelope meat, the child when born would have a hunchback.

6. Pregnant women in some ethnic groups are not allowed to eat much protein foods because it is believed this would make the baby grow too big and create labour problems for the mother.

7. Pregnant women are not to eat okra or snail, especially in fresh form, although these foods provide good sources of proteins, as it is believed that the sticky nature of these foods would cause the child to have excessive salivation.

As a matter of fact, one should view the causes of these taboos that affect the health of women and children as stemming from

a) ignorance
b) poverty
c) illiteracy
d) male chauvinism.

The solution to these problems cannot be tackled single-handedly due to lack of resources. In other words, there is a need to plan integrated programmes for target areas where all
governmental bodies as well as NGOs, equipped with necessary resource materials and personnel, would cooperate and vigorous action taken.

Solutions

The solution to the problem of nutritional taboos should be directed towards rural communities where the problem is prevalent, as well as slum areas in urban communities. Since ignorance, poverty and illiteracy are the causes of such taboos, the following steps for action are suggested:

1. Vigorous nutritional education campaigns, supported by demonstrations, should be given to the target areas with emphasis on the benefit to the body of certain forbidden foods.

2. Women, young girls and men should be encouraged to form social groups in the target areas. These groups should be involved in educational programmes with emphasis on nutrition, etc.

3. Encouragement should be given to rural communities to produce foods rich in protein, energy and vitamins through demonstration farms, with expert supervision by agricultural extension officers.

4. In order to improve the communities' standard of living, the Association should encourage income generating ventures, i.e. poultry keeping, dry season gardening etc.

The G.A.W.W. has undertaken to organize educational campaigns with emphasis on nutrition, income generating programmes and literacy campaigns through the National Council on Women and Development, the Department of Community Development, the Red Cross, Mothers' Clubs, YWCA, Catholic Christian Mothers, and other religious and women's groups.

* * * * *
In Niger nutritional taboos are particularly tenacious in rural areas. Considering that the diet of our population is very badly balanced, it is easy to understand the disastrous consequences that may ensue from nutritional taboos.

Let us examine the nutritional taboos associated with pregnancy. Pregnant women are forbidden to eat certain foods, particularly eggs and camel meat. The reason given for not eating eggs is that the woman who disregards this, risks giving birth to a dumb child or to a thief. As to camel meat, it is necessary to abstain from this to avoid a pregnancy that would last at least a year.

Prohibitions also exist for children. Thus the mother is advised not to give marrow from sheep to her child in order that he will not lose his memory.

Two kinds of prohibitions can be distinguished: permanent and temporary.

1. **Permanent Prohibitions**

These can be applied to:
- a large segment of the population: for instance Moslems who are forbidden to drink alcohol and to eat pork.
- an ethnic group, a family: totem prohibitions. The members of the group or the family think that their destiny is linked to such and such an animal or plant and eating them would lead to illness or death: for example certain ethnic groups in Niger do not eat the meat of goats or drink their milk to avoid catching leprosy.

Permanent nutritional prohibitions concern generally a very limited number of products, and consequently do not have a harmful effect on nutrition; in fact substitution products remain possible; for example if goat meat is not eaten, mutton can be eaten instead.

2. **Temporary Prohibitions**

These are applicable only to certain times in the life of an individual and lead to diets that are believed to be good under particular circumstances: for example, pregnant Hausa women do not eat iguana so that their children will not have rough skin.

The government of Niger has created MCH centres throughout
the country. Their aim is to sensitize and educate women in family health care. In this setting accent has been put on the list of prohibited foods in order to lead women to take no notice of this. For this reason cooking sessions are organized for both rural and urban women, in the course of which different prohibited products are used.

In conclusion, the initiative undertaken by these centres has considerably contributed to limiting the importance and the extent of these prohibitions. Their total abandonment requires much long-term work of persuasion, but the essential thing remains our will to work for the well-being of our population.

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Discussion on Item 4: Nutritional Taboos

The discussion on how to cope with nutritional taboos underlined the importance of a) research and surveys to establish the reasons why many available products of high nutritive value are forbidden; b) health education programmes with promotion of diversified food intake; c) promotion of vegetable gardening as well as poultry and other small scale animal farming.

It was pointed out that in some parts of Africa forced feeding of girls is being practised making them consume enormous quantities of milk and cereals in order to fatten them and make them look older so they can get husbands.

Some comments from different African countries:

Benin
- Some people eat reptiles, others do not.
- It is believed that children who are ill with measles should not eat eggs and meat as this would worsen the disease.
- Due to ignorance and poverty, people will rather sell their livestock than kill them for their children to eat.

Djibouti
- Girls should not drink tea, as this would make them fat.
- Kidney is not given to twins as one of them would then die.
- Eating cat meat is believed to be dangerous for the health.

Gambia
- Some vegetables should not be eaten, because they would cause worms.
- Bad food preservation causes great wastage.
- Over-cooking of food is common.
- In polygamous communities, wives tend to compete among themselves and give all the good food to the husband, depriving mothers and children.

Guinea
- There is need to be tactful in dealing with taboos: we do not calculate in calories, but in traditional values. We should not generalise, but conduct research and surveys and not just immediately condemn.

Guinea-Bissau
- There is need to classify good and bad taboos. Even in modern medicine, pregnant women are not allowed to eat certain things.
- Some people sell their crop to buy expensive clothes rather than feed their family with it.

Mauritania
- It should be forbidden for pregnant and lactating mothers to fast during Ramadan.
- Forced feeding of girls is an aspect of early childhood marriage.
- Fish is available but the population does not eat much fish; people are now encouraged to add fish to their diet.
- Eating of fresh dates is also being encouraged.
Nigeria
- Food may be available at low price, but taboos create a problem.
- Milk, vegetables and fruits are believed to cause diarrhoea and dysentry.
- In many Nigerian states pregnant women must not eat groundnuts, as they would then develop rashes and night blindness.
- In some states where edible snails are available, pregnant women do not eat them for fear of salivating profusely.
- Certain foods are forbidden for boys as it is believed they would not become manly and would be killed if they became soldiers.

Sierra Leone
- Some food taboos exist as it is believed they will ensure the birth of small babies which is preferred due to complications from female circumcision.
- Some foods have high fat and cholesterol contents and must be discouraged.
- We export monkeys, snails and frogs, only to import pork and sweets; this should be discouraged.
- When looking at nutritional taboo problems, we must also consider the importance of preparation, preservation and wastage.

Sudan
- WHO, UNESCO, UNICEF and other organizations have established special departments all over the country promoting home gardening, giving lessons on malnutrition and involving schools in nutrition education.
- As for home gardening, water has posed a problem, but well digging has been promoted.
- The previously existing nutritional taboos have been overcome to around 90%.

Tanzania
- Poverty is only partly the reason for the continuation of nutritional taboos: for how can men eat chicken, other meat and eggs and tell women that these foods are taboos for them? This is tradition combined with selfishness and men should be ashamed of themselves to continue promoting such habits.

Togo
- Pregnant women are not allowed to eat certain foods, as it is believed they would then bleed.
- Pregnant Moslem women do not fast during Ramadan but often "pay the debt" (i.e. fast) after delivery when lactating, which is not good for the health of mother and child.
- We should not disregard ancestral values but try to highlight good foods during the many ceremonies and celebrations which occur throughout the year.

Summing up part of the discussion, one of the WHO representatives underlined the fact that girls are at a disadvantage in the allocation of foods. This situation must be corrected; it is not just a question of poverty and ignorance.

The recommendations made on Item 4, Nutritional Taboos are included in the Plan of Action, see Chapter II.
CHAPTER IX

ADDITIONAL STATEMENTS AND PAPERS

Statements and papers comprising more than one subject of the seminar were submitted as follows:

UNICEF: Mr James Grant, Executive Director, New York, USA;
CAMEROON: Mrs Comfort Effiom, Ministry of Women's Affairs, Yaoundé;
COTE D'IVOIRE: Mrs Juliette Coulibaly, School of Midwifery, Abidjan;
DJIBOUTI: Mr Ismael Saïd, Djibouti Red Crescent Society;
ETHIOPIA:
  i) - Ministry of Health, MCH Coordinating office, Addis Ababa;
  ii) - Revolutionary Ethiopia Women's Association, Addis Ababa;
GAMBIA: Mrs Alaba M'Boge, President, Gambia IAC National Committee, Banjul;
GHANA:
  i) - Report on two seminars;
  ii) - The place of the TBAs and VHWs in the Ghanaian Health Care Delivery System;
GUINEA: Mrs Fatoumata Tounkara, Conakry;
GUINEA-BISSAU: Mrs Maria Lima da Costa, UDERU - Democratic Women's Union, Bissau;
LIBERIA: Reports from the National IAC Committee by Mrs Rachel Marshall, President, Monrovia;
NIGERIA: Report from the National IAC Committee by Dr Irene Thomas, President, and Mrs O.A. Adewole, Secretary, Lagos;
TANZANIA: Report by Hon. Lucy Lameck, M.P., Moshi.
Mr Grant addressed the seminar, stressing the importance of the role of women's knowledge. Their attitudes make a lot of difference to the health of the child.

Women and children are a priority for UNICEF. Curiously enough, UNICEF has only men at the top, but attempts are being made to redress this imbalance.

Three quarters of the problems of children's health will be solved if mothers are given more knowledge.

Mr Grant mentioned rural and village water supply as the largest single UNICEF project. He also indicated the important improvement in children's health due to immunization programmes. The women's decade has made progress, but the road is still long. UNICEF looks forward to the results of the deliberations of the Addis Ababa seminar.

The Chairperson, thanking Mr Grant, said she was comforted to hear that UNICEF was sensitive to women's issues. Africa, she stated, can progress only if the women march side by side with the men. We want to be partners, she said. She then presented to Mr Grant the Letter of Appeal decided upon by the seminar, in which the participants urge UNICEF to include eradication of female circumcision in its programme for child survival and asked Mr Grant to do everything possible to comply with the request in this appeal.

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"There is very little information and no data at all relating to the traditional practices that affect the health of women and children in Cameroon. Traditional practices such as female sexual mutilation, nutritional taboos and early childhood marriage do exist, although a lot of people are ignorant about them except for the tribes who actually carry them out.

About a month before coming here for this seminar, a colleague and I carried out a preliminary study just to find out if female circumcision, nutritional taboos and early childhood marriage and early pregnancy really exist and, if so, if they are a big problem. The reason we did carry out this little study was because almost everyone we spoke to was ignorant about the existence of harmful traditional practices. We made up a questionnaire with simple straight-forward questions that the women could understand. In some areas we needed translators.

Female sexual mutilation does exist in some areas of Cameroon, but the age at which it is carried out and the type of mutilation differ from tribe to tribe. Only two types of sexual mutilation seem to exist in Cameroon:
- circumcision - clitoridectomy, in the Manyu Division, South West Province,
- excision - removal of the clitoris and the labia minora, among the Choa Arabs of the Extreme North Province.

When asked why female circumcision is carried out among them, 10% replied that it is a tradition that has existed for a long time. Some women have it done because they do not want to be laughed at by their friends, who would think they are unclean because they have not been circumcised. In the South West Province, Manyu Division, the practice of female circumcision seems to be dying off because the younger mothers and their husbands do not want it done on any of their daughters. - Who carry out this practice? Mostly old women who have been locally trained.

Nutritional taboos seem to be disappearing in all the areas we visited. This has been due to the influence of the missionaries in the areas - as one woman said, "The missionaries say whatever is good for a man to eat is also good for a woman".

The most common taboo that exists is that women are not allowed to eat snakes. This is because they are very tasty and delicious, and once a woman tastes snake's meat she will always
want more, and snake meat is not that easy to come by. Pregnant women are not allowed to eat eggs either for fear of having a baby born with no hair.

Early childhood marriage does exist in some areas but these days the girl is not forced to marry a man she does not love. All the women we spoke to were married at the age of 15 years, except for one who was married at the age of 10. From what she said she was given to her husband as a gift by her parents because he was kind and helped them on their farm. In the case of the Choa Arabs, the girl never knew her husband until the day of her marriage. They usually marry between the ages of 13-15 years. Complications arising from early pregnancy affect both mother and baby.

For the young mother:
- due to her inexperience she is usually malnourished;
- caesarean section usually has to be made during delivery, as the pelvic girdle is not fully developed to expand to allow the baby to pass through.

For the young baby:
- low birth weight;
- malnutrition due to lack of education about proper feeding.

In some areas there is a socio-cultural factor that leads to early marriage. In some tribes, for example, it is unlucky for a young girl to start menstruating while still in her parents' home. Some parents are forced to send their daughters off to early marriage due to a bitter and disappointing experience with an elder daughter who was pregnant when sent to school to receive better education.

Following our preliminary study, we made the following recommendations:
- That a more detailed study should be carried out on the extent of female genital mutilation in Cameroon; lack of finance might hinder this.
- That a multisectorial committee be set up in Cameroon with members from the different ministries, such as Women's Affairs, Social Affairs, Public Health and other non-governmental organizations, religious bodies and also parents/teachers associations.

This committee will have to look into the problem of harmful traditional practices, especially female genital mutilation, and come up with ideas of how the practice could be stopped. Education must play an important role in helping to eradicate this practice. Governments should pass laws forbidding the removal of any female organ. Anyone who violates the law should be severely punished.

Since this is the first time ever that such a study has been carried out in Cameroon, I am happy to be here so that I can learn from the experiences of the other countries present."

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"In Côte d'Ivoire the non-governmental organization "The Association for Family Well-Being" (AIBEF) that my colleague and I are representing here, fights actively for the spacing of births, in spite of the pro-natal policy of our government. We are supported by and receive a subvention from the IPPF (International Planned Parenthood Federation).

By means of training, information and sensitization seminars for our rural as well as urban populations, we draw the attention of our authorities to the galloping demographic development in Cote d'Ivoire, which has the following characteristics:

- an annual growth rate of 4.3%,
- an overall index of 7.5 children per family,
- a reproductive interval of 1 1/2 years instead of 2 years,
- early and frequent pregnancies,
- early marriages.

To attract mothers, we organize vaccination campaigns in rural areas, at the same time sensitizing them on child spacing. We insist on the impact that the spacing of births has on the good health of the mother and the child. We also visit schools when requested by the board to do so.

We train the para-medical personnel of the MCH centres and maternity hospitals to sensitize the patients there. We have opened our first family planning clinic in Abidjan called the 'Family Life Information and Education Centre'.

We are glad to participate in this seminar in which we are sensitizing ourselves on 'Traditional Practices Affecting the Health of Mothers and Children'. We will study how to include this struggle in the context of our activities on behalf of family well-being."

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REPORT ON PRIMARY HEALTH CARE ACTIVITIES OF THE
DJIBOUTI RED CRESCENT AND SOME TRADITIONAL PRACTICES
IN THE REPUBLIC OF DJIBOUTI
by
Mr Ismael Said, Djibouti Red Crescent Society

The Red Crescent Society of the Republic of Djibouti, founded on August 1st 1977, is a member of the International Red Cross, the great, universal, humanitarian organization based in Geneva. Its role consists essentially of assisting all victims of natural disasters such as earthquakes, floods, drought, cyclones.

Apart from these specific activities, the society is engaged in the process of the application of primary health care in close collaboration with the Government and non-governmental, national and international bodies. Concrete results of this policy are:

- practical courses for traditional midwives on delivery and demonstrations of infibulation and its complications with the help of a model with several parts of the female genital system,
- sanitary education,
- environmental hygiene,
- participation in the extended programme of vaccination,
- protection of the mother and the child,
- youth training for relief work.

In the Republic of Djibouti 35% of the population are nomads or semi-nomads. Certain men and women possess knowledge and practical methods to relieve pain or to care for the sick. These are called healers.

The Red Crescent has created a health committee for the most disadvantaged districts. The committee advises against bad, harmful and useless practices, for example pharaonic infibulation which is still currently practised in Djibouti. This evil practice will end in some years' time thanks to sensitization campaigns undertaken by the UNFD (National Union of Djibouti Women) and the Djibouti Red Crescent.

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Note: A report was also presented by the Djibouti Red Crescent on "Some Traditional and Nutritional Practices Affecting the Health of Djibouti Children", which deals principally with: the ablation of the uvula, the curettage of the adenoids (Sanbor"), the extraction of the embryonic canine teeth ("Ilga Dawo" or "Moudimi"), ignipuncture, massage of the anus and rectum (Xoq").

This document is included in the report on the seminar in Dakar in February 1984 on "Traditional Practices Affecting the Health of Women and Children in Africa".
Ethiopia is a highland country situated in the Horn of Africa, covering approximately 1.2 million sq. kms. with nearly 5% of the land surface at more than 500 m. above sea level. The population of Ethiopia is estimated as 42.1 millions, according to the national population census of 1984, thus ranking third in Africa after Nigeria and Egypt. It embraces a great variety of nationalities speaking some 70 languages and over 200 dialects. There are two major religions: Orthodox Christianity and Islam.

The young population below 15 years of age represents about 45% of the total population. It is estimated that approximately 86% of the population live in rural areas and about 95% of these are engaged in agriculture and animal husbandry. Gross National Product per capita is estimated at US$ 120 (World Bank). Administratively, the country is divided into 16 regions including the capital city of Addis Ababa and Assab Administrative Region. There are 102 provinces (Awarja) and 577 districts (Warda).

Health problems of mothers and children are:
- communicable diseases,
- diseases due to malnutrition,
- harmful traditional practices.

Infant mortality is estimated to be 144 per 1000 live births and maternal mortality, also high, is estimated to be 20 per 1000 live births (A.A. maternal mortality survey 1980). The health care delivery system is directed towards the expansion of services in rural areas with emphasis on prevention, promotion, curative and rehabilitation services, and strengthening of the existing health infrastructure, and manpower development.

There are many traditional practices and taboos widely used which have drastic effects on the health and social welfare of women and young girls in our country, particularly female circumcision. In 1980, after the WHO conference held in March in Alexandria, Egypt, a resolution was passed that a country survey should be conducted to determine the magnitude of this problem. This became the basis for conducting an exploratory survey on female circumcision and other traditional practices in five administration regions.

In 1979/80 an MCH/FP (mother and child health/family planning) programme was established as one of the major components in the primary health care strategy within the infra-
structure of the Ministry of Health. At present, MCH/FP services are being provided by 88% of the hospitals, by 50% of the health stations and by all health centres. Breast-feeding as one of the beneficial traditional practices has been integrated into the routine MCH/FP activities in both the rural and the urban areas.

The exploratory survey mentioned above was funded by UNICEF. The prevalence of female circumcision in the areas covered by the survey was found to be high: over 85% of all women involved in the survey had undergone one of the three types of female circumcision (sunna, excision, infibulation). The type of f.c. practised seems to be influenced by ethnic group, status of women within the group, religion and way of life.

After the completion of the survey, a National Core Group or advisory committee to review the first draft of the survey was formed, consisting of the relevant ministries and mass organizations. The advisory group recommended certain actions to be taken by the concerned agencies for prevention and final eradication of harmful practices such as female circumcision. The recommendations made by the Core Group were discussed by Ministry of Health officials, who decided to establish a National Committee composed of all relevant ministries and mass organizations, UNICEF and the IAC Coordinator.

The major functions of the National Committee are:

1. to use the findings of the survey to identify strategies for health education of the public and of traditional practitioners;
2. to develop methods of supervision and follow up for eradication of the practice of f.c.;
3. to suggest ways to support traditional healers who are economically dependent on performing these harmful practices;
4. to compile information on harmful traditional practices from various government and mass organizations' documentation that is currently available, and to suggest ways and means of how these malpractices should be controlled;
5. to identify means of obtaining additional information on harmful traditional practices for possible eradication;
6. to use the findings and recommendations of the survey on f.c. and other findings available from various organizations, to define the role of the relevant governmental, mass and international organizations for the prevention and control of harmful practices.

Note: Many suggestions have been made in the National Committee for activities against harmful traditional practices to be implemented by various agencies. They are largely included in the Plan of Action adopted at the seminar (see Chapter II).
References:


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SUMMARY REPORT OF THE REVOLUTIONARY ETHIOPIA WOMEN'S ASSOCIATION (REWA)

by

Comrade Fantaye Awash, Chairperson, REWA Addis Ababa

The problem of backward traditional practices not only affects the health of women and children but also hinders the integration of women in development. This is especially true in developing countries. To attain equality, women have to be economically independent and participate fully in the development process of their country. On the other hand, women's true equality can only be obtained if the whole society is free from exploitation and has obtained a high level of political, economic, social and cultural development.

Ethiopia is a country of many nationalities with their own diverse cultural and traditional practices, of positive and negative nature. The positive ones are worth preserving since they help us maintain our cultural heritage and national identity.

The 1985 study on Harmful Traditional Practices Affecting the Health of Women and Children in Ethiopia undertaken by the Ethiopian Government and UNICEF/Ethiopia, through an exploratory survey, tries to identify the major backward practices with recommendations for their eventual elimination. These include female circumcision, cutting of the uvula, extraction of babies' teeth, incision of the eyelid, excision of nails, incision of the face, lack of nutrition, early marriage, etc.

Revolutionary Ethiopia Women's Association, REWA, is the sole women's national machinery existing in the country. It has two objectives:

- To make every effort to ensure that the necessary conditions are created for women to exercise their rights and discharge their responsibilities as mothers, workers and citizens.

- To prepare women to participate in socialist construction alongside their fellow men and thereby liberate themselves from economic dependence and backward cultural practices.

To tackle the problem of backward cultural practices, REWA uses various methods and programmes. One such method is to teach our members and the general public in collaboration with government bodies and mass organizations about the backwardness and harmfulness of practices that affect the health of women and children and how they hinder the equality of women. Because of the sensitive nature of some of the practices, due attention is given to the ways and means by which this is done.
Provision of adequate health services for women and children is another way by which we are tackling the problem. Through the Ministry of Health the Government of Ethiopia has adopted a policy of the development of primary health services, as a result of which establishment of health centres and health stations are given paramount importance. In order to broaden the bases of the health service system, training of community health agents and traditional birth attendants are undertaken to reach the rural population where the majority of our women and children live. The establishment of the MCH section in the Ministry of Health has proved to be of great help in looking after the health of women and children. REWA collaborates very closely with the ministry in these activities.

The national literacy campaign has also been used as a means where careful agitation has been carried out against harmful traditional practices.

About five years ago when the Head of State, Comrade Mengistu Haile Mariam, paid a visit to the northern regions, he gave directives to the region of Gojjam that the harmful practice of giving girls of early age in marriage should be stopped. As a result a committee was set up which has ruled that the age of marriage for girls should be 15 and that its approval is needed for the acceptability of a marriage. All those who violate this are brought to account before the judicial tribunal of the peasants' association. The experience of Gojjam has proved to be useful to other regions in their effort to combat early marriage. Subsequently, the occurrence of early marriage in the regions has decreased significantly.

Through such concerted actions of government and mass organizations the struggle to eliminate harmful traditional practices has brought about commendable success. As a result of continuous agitation and teaching, the practice of infibulation, which was prevalent in some parts of Ethiopia, has in most cases been replaced by a less harmful practice of circumcision. Incision of the face in quest of beauty practised in some districts has been almost eliminated. The practice of cutting the uvula of children, extraction of babies' teeth, massaging of pregnant women during labour, have been much reduced in urban areas. As indicated earlier, in some regions the marriage age of girls has been raised from as early as 7-10 years to about 15 years.

However, it has to be admitted that much more remains to be done before we see the last of the harmful traditional practices in Ethiopia.

REWA is very much encouraged by this seminar. We feel that the publicity attached to it and the outcome would help us in our work. Using this opportunity, I would like to assure you that we in REWA would do our best to implement the decisions and recommendations that come out of the seminar.

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This Committee was established in 1985. It consists of 23 members including the Executive members. Since its creation, the committee has held a number of meetings even though this number falls short of its scheduled programme. This is due mainly to the unavailability of funds to enable it to be functional. However, the coordinating institution for traditional practices affecting the health of women and children, the National Women's Bureau, has been assisting in the implementation of the committee's activities.

After the Dakar Conference a meeting was convened by the Bureau and the need to establish a National Committee was put forward. Several meetings were held thereafter, followed by the creation of two sub-committees namely:

1. Sub-Committee on Female Circumcision
2. Sub-Committee on Traditional Practices Related to Child Delivery, Nutritional Taboos, Early Childhood Marriages and Health Hazardous Activities.

At subsequent meetings the National Committee came up with several proposals for a plan of action. The coordinating institution assisted the committee in the drafting of its constitution, in the preparation and designing of project proposals, the general administration and the implementation of funded proposals, for instance a workshop at Jenoi.

In effect, the members of the committee are highly experienced in their various disciplines and proposals from the committee are generally meaningful and worth implementing.

Activities carried out so far on behalf of the committee

a) Radio programmes in which several committee members participated. Issues discussed included female circumcision, the reasons for such practices and the implications, early childhood marriages and child delivery, nutritional taboos etc.

b) Sensitization group meetings on f.c., through the Women's Bureau's field officers.

c) Introduction of the health effects of f.c. to women attending family planning clinics, by family planning field officers.
d) Health implications of f.c. have been components in 2 workshops organized by the Family Planning Association during the period under review.

e) A National Workshop organized by the Women's Bureau on behalf of the National Committee and funded by the IAC was also one of the major activities during this period (for details see workshop report).

f) Attempts are being made to link the Bureau's income generating activities closely with programmes related to f.c. in order to provide alternative income to those associated with this practice.

g) Attempts are being made to introduce an act to protect the child from any form of bodily mutilation.

Plans for the future

The Committee has noted with great concern the need to become functional. Being aware of its financial constraint, it was proposed during the last meeting to launch wide-scale fund-raising activities. The proceeds will be invested to sustain the committee, which can no longer afford to depend on its coordinating body to administer and execute all its proposed activities.

The National Committee also proposes to involve other NGOs in its anti-f.c. campaigns. It is desirable for the committee to have its own accounts and to appoint an administrative officer, to be temporarily housed at the Women's Bureau.

It is hoped that a second National Workshop will be organized soon. And for the future, the Committee proposes to conduct more decentralised workshops (regional and locally based) to be conducted in selected parts of the country. More radio talks and invitation of additional significant professionals, including a gynaecologist and a parliamentarian, are envisaged.

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SUMMARY REPORT ON TWO SEMINARS HELD IN THE UPPER REGIONS OF GHANA IN 1986

Both seminars were organized by the Ghanaian Association for Women's Welfare (G.A.W.W.) with financial support from the Inter-African Committee. The first seminar was held in February, in Bolgatanga in the Upper East Region, with participants also from the Northern Region and the second in August in Wa, Upper West Region.

A. Seminar in Bolgatanga, Upper East Region

In his opening address, the government Regional Secretary stressed the importance of the action of the G.A.W.W. in mobilizing the population against harmful traditional practices. He also expressed the concern of the government to ensure that health services reach the entire population and he also mentioned the efforts made to safeguard the interests of women by promulgating a law on inheritance, marriage and divorce. He stressed the need for the eradication of female circumcision and exhorted participants to find solutions to nutritional taboos that cause malnutrition.

In his keynote address, the Director of Health Services explained that the Primary Health Care programme in Upper East Region included training of Traditional Birth Attendants (TBAs) to bring health services for the eradication of all ancient practices that militate against the health of women.

In a lecture on Early Childhood Marriages, the Regional Director of Education explained about the two types of marriage existing in Ghana at the moment, that is, Ordinance and Customary marriages. He also touched on the conditions for early marriages and categorically explained some of the adverse effects of this practice on young girls.

A second lecture was given on Child Birth Problems and Management, and the lecturer elaborated on the various problems encountered during child birth which, she lamented, are common in circumcised women. She also touched on the management of child birth by untrained traditionalists and the grave consequences that they carry. She regretted that the morbidity and mortality rates in women were high in the rural areas because of inaccessibility to medical facilities and called for special care for women adding that "the woman is the axis of family life".

Dr John Kadri of the Ministry of Health gave a lecture on Female Circumcision, emphasizing its hazardous effects and calling for the total eradication of this practice.
A Regional Nutrition Officer delivered a lecture on Nutritional Taboos, indicating their source as owing to economic, religious and superstitious reasons. She stressed the ill-effects of nutritional taboos on women and children and condemned the practice as unreasonable, calling for significant concerted efforts from all quarters to eliminate these practices once and for all.

The following resolutions were adopted at the end of the seminar:

1. All organizations involved in education should take this message seriously and help eradicate female circumcision from our society.
2. The government should enact an appropriate law to stop child­hood marriages.
3. The government should sponsor research into f.c. and help in supporting programmes to stop this practice. If possible, the government should enact a law against it.

B. Seminar in Wa, Upper West Region

In his opening address, the government Regional Secretary, Upper West Region, congratulated the G.A.W.W., organizer of the seminar, on its efforts towards eradication of harmful traditional practices as a follow-up to the Regional Seminar held in Dakar in 1984. He stressed the importance of such seminars since society is subject to change, and the good health of the people is one of the main concerns of the government. The children of to-day are the leaders of to-morrow and the education of a woman implies the education of a nation. It is therefore of outmost importance to fight against anything that will affect the health of these national assets.

The keynote address was delivered by the Regional Medical Officer of Health, Upper West Region, during which he opened the minds of the participants to the dangers inherent in the practice of female circumcision. He also touched on the nutritional taboos for the pregnant woman which expose her and her child to dangerous nutritional deficiencies. The lack of hygiene in the care of newly delivered mothers and newborn children is a source of high mortality and should be improved by teaching traditional birth attendants (TBAs) modern methods complementary to useful traditional practices.

Dr. John Kadri of the Ministry of Health presented a report on his recent survey on Female Circumcision in the Upper East Region which showed that more than 90% of the women were still circumcised. He explained the different health hazards resulting from f.c. and stressed the urgent need for total eradication of this practice.

Another lecture was given on Child Birth and Management with a comparison between delivery by a trained person in a hospital or even at home, and delivery by an untrained person under bad hygienic conditions.

A talk was given by a lawyer on Laws Affecting Women and Children, with a general outline of the relevant laws. The subject is vast and it is hoped that future seminars will offer
more opportunity for treating this topic. A great number of laws protect women and children but the woman continues to be the subject of abuse and discrimination because of the lack of information, especially in the rural areas. This calls for campaigns to educate women about laws affecting them.

Several workshops were held on these subjects and the recommendations were the following:

1. Considering the concern shown by the government for the welfare of women and children, manifested through recent laws promulgated for their benefit, attention should be focused on certain traditional practices which have hitherto not engaged governmental attention.

2. Traditional practices like female circumcision which adversely affect the health of women and children should be banned by law.

3. The government should initiate a comprehensive programme reviewing the prevailing high level of bride prices in the Northern, Upper East and Upper West Regions.

4. The Primary Health Care Programme should create mobile antenatal health services to supplement the community health delivery system.

5. The various District Councils charged with the registration of customary marriages and divorce should as a matter of urgency step up education on the need to have such marriages registered.

6. The Radio Station at Bolgatanga should take an increasing interest in the education and information of the people on traditional practices that militate against the health and welfare of women, in the various local languages of the Upper regions.

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THE PLACE OF THE TBAs AND VHWs (TRADITIONAL BIRTH ATTENDANTS AND VILLAGE HEALTH WORKERS) IN THE GHANAIAN HEALTH CARE AND DELIVERY SYSTEM

by

Mr Azu-Billa Anabah, Regional Secretary Red Cross,
Upper East Region, Ghana

Records in Ghana show that only 30% of the population living in the urban and suburban areas enjoy modern health facilities. 70% of the population, mostly the rural dwellers, are still exposed to traditional medical methods. This trend will probably continue for some time.

The government of Ghana is, however, making great efforts to improve the situation within its limited resources. It has realized that to achieve health for all by the year 2000, the concept of putting up prestigious medical hospitals in urban areas for political reasons must give way to community oriented health programmes. PHC (Primary Health Care) programmes are the order of the day.

These programmes seek to utilise health care potentials existing in the rural communities to develop acceptable medical care, using local resources.

The fact must be accepted that the 70% of Ghanaians who live in the rural areas are cared for by traditional healers. Furthermore, 90% of the deliveries that occur in the rural areas are performed by TBAs. Even though various agencies in Ghana, like the Red Cross, Zonta and church organizations, are involved in programmes to provide preventive and curative care to rural communities, their efforts would get nowhere if they refuse to recognize the potentials of traditional healers and TBAs.

Since the TBAs are accepted by their communities and will continue to live with them, I am of the opinion that they should be encouraged, trained and motivated to help to eradicate certain practices that affect the health of the woman and the child.

Note: The Ghana Red Cross Society has elaborated a two year programme aimed at eradicating practices that affect the health of women and children in the Upper East Region of Ghana. The harmful practices prevalent in the area are identified as:
- female circumcision,
- bodily tattoos with knife on sick and on healthy children,
- early childhood marriage,
- nutritional taboos.

* * * * *
The practice of female circumcision has affected all ethnic groups of all religions in our country, for years. It was only in 1969 that the idea was born in the mind of one of our sisters to attempt to abolish this practice. This fight, a very hard one as you know, started and was conducted discreetly, even in secret, until November 1985.

At that time of social and political changes taking place in our country, Sentinelles, an NGO, organized the first seminar to discuss, with the participation of eight other African countries, the following subjects:
- female circumcision,
- childhood marriage,
- problems of the menopause.

Encouraged by the convincing results and the support of the two great religions in our country (Islam and Catholicism), conferences followed at school and village levels. An audience of more than 2,400 persons was reached in the course of 1986. Six more conferences were held since January 1987.

The IAC has given us invaluable help toward the success of the conferences by putting at our disposal appropriate teaching materials. We are most grateful for this assistance.

* * * * *
Female circumcision

The practice of female circumcision (f.c.) is common in West Africa especially among Moslem populations. The most common age at which f.c. is performed in Guinea-Bissau is around 8 years, and it is accompanied by teaching on behaviour in marriage, in the family and in society, for a period of 3 months.

Circumcision is preceded by a ceremony indicating its social importance: an uncircumcised girl cannot even participate in prayers, she is socially not accepted. The actual operation can be of various kinds: removal of the clitoris and labia minora only, or removal of the vulva and stitching. Infibulation is generally practised on adolescents or adults.

Female circumcision was carried out at one particular time of the year and it was so widespread that some age groups at schools were absent in large numbers. The Government changed the timing, which is now during the holiday period.

Somatic consequences: Life is often endangered and haemorrhage as well as severe anaemia are frequent. Damage of the urethra, abscess of the vulva, urinary infections, gangrene, septicaemia, tetanus, etc. are common. The long term consequences are numerous. Statistically, complications at childbirth are most frequent among Moslem women, because circumcised.

Psycho-social consequences: Not much is said about these because of the taboos surrounding the issue. There are two situations: f.c. practised before sexual intercourse has begun, in which case orgasm is unknown, and performed after sexual intercourse has begun. Little is known about frigidity on account of the secrecy surrounding the subject.

Mentalities are beginning to change and some women now refuse to have the practice performed. No drastic actions are undertaken by the Party of the Government, but changes are brought about through education and awareness. We are convinced of the negative effects of f.c. on the health of women and children and on the family as a whole.

Strategies and solutions are envisaged through health education, including sex education; through informing religious leaders on the dangers of f.c.; through awareness programmes for the elimination of the practice and through mass information.
campaigns about social and health aspects of circumcision.

Since the Dakar seminar in 1984, at which the Democratic Women's Union of Guinea-Bissau participated, the fight against f.c. has been intensified also through changes in the curriculum of the health professions. Thus, in June 1985, the National Council was able to discuss f.c. and early marriage; fortunately both practices seem already on the wane.

**Early and forced marriage**

Some progress has been made through the liberation movement which transformed the role of young women. Yet, there is still a great difference between women who are better educated and progressive and the rural population where marrying off a daughter is of financial benefit to the bride's family. The husband is often very much older because the contract is made at the time of the birth of the girl. The Women's Union is actively fighting these negative practices and giving support to young girls.

Nutritional taboos still exist in Guinea-Bissau, especially in the case of pregnant women but nutrition is gradually improving as a result of health education.

* * * * *
REPORTS FROM THE NATIONAL IAC COMMITTEE IN LIBERIA
by
Mrs Rachel Marshall, President

The President of the Committee, Mrs Rachel Marshall, submitted two reports highlighting the preparation, launching and subsequent activities of this committee, NATPAH (National Association on Traditional Practices Affecting the Health).

The Association was officially launched in March, 1985. NATPAH has 4 standing committees: 1) Planning, 2) Research, 3) Education and Training, 4) Fund Raising and Publicity Committee.

Two annual forums have been held: in March 1986 and in March 1987. The issues presented at these meetings comprised:
- female circumcision
- nutrition
- delivery practices
- breastfeeding
- early marriage
- family planning
- dental health.

Approximately 75 persons attended each forum. At the opening programme of the 1987 forum statements were made by:
- Ministry of Internal Affairs
- UNICEF Representative
- Family Planning Association of Liberia
- West African College of Nurses
- Family Life Promotion
- Liberian Rural Communication Network
- Liberian Board of Nursing and Midwifery.

In addition to these one workshop, one seminar and one symposium have been held, with an average of 30 participants each.

The Association has made contacts and established working relationship with the Ministry of Health and Social Welfare, WHO, Ministry of Internal Affairs, Ministry of Planning and Economic Affairs, UNICEF and the Liberian Red Cross Society. NATPAH hopes to strengthen the relationship and establish linkage with the Liberian Nursing Association, Liberian Medical and Dental Association and other non-governmental organizations. There are also plans to establish working relationship with other government agencies such as Ministries of Education, Information, etc.
As for female circumcision, it should be noted that all efforts to collect preliminary information on knowledge, attitude and practices of female circumcision among health workers in Montserrado County have proved fruitless. Questionnaires were distributed to many persons but returns were negligible. A second attempt will be made in 1987/88.

A second research on the epidemiology of female circumcision in Liberia is in progress. A third research is designed to study the effect of female circumcision on all stages of labour.

The health educator/NATPAH makes regular weekly visits to five clinics in Montserrado County. The purpose of these visits is to inform and educate the clinic staff and patients about the harmful effects which some traditional practices have on the health of women and children; and about the aim and objectives of NATPAH.

Other areas visited are the Division of Family Health, Bureau of Preventive Services, Ministry of Health and Social Welfare; ELWA Hospital (private) in Paynesville, near Monrovia; Red Cross clinic (private), Monrovia, and the National Bureau of Culture and Tourism.

Articles on female circumcision have been published in local newspapers. A radio script is now being prepared as a supplement to the lessons already prepared.

As for traditional family planning, people have used many methods, such as plants and other substances to control fertility. Certain behaviour patterns, such as cultural background and religious affiliation, influence the type of traditional practices used over the years. Post partum abstinence associated with lactation is the most important practice in Africa. Coitus interruptus (the so-called withdrawal), which has come down through the ages, is still being used by many couples. Cord is also worn around the hip mainly by the women of the Kru, Vai and Lorma tribes. How this prevents pregnancy is not known.

It is believed that traditional family planning practices are still widely being used in Africa today, more than on any other continent, because of its very large rural and village life.

It is quite encouragingly found that most illiterate Liberian women practise the act of breastfeeding their children whenever the child needs it. An unlettered woman is never shy to breastfeed her child.

* * * * *
REPORT FROM THE NATIONAL IAC COMMITTEE IN NIGERIA

by

Dr Irene Thomas, President, and Mrs O.A. Adewole, Secretary

The Nigerian National Committee of the IAC was inaugurated in May 1985. At the inauguration a firm resolution was taken that steps be intensified to eradicate harmful practices affecting the health of women and children in Nigeria. We pledged to seek support at local, state and federal levels.

Three sub-committees were established:

a) Research sub-committee
b) Education and publicity sub-committee
c) Finance and legal sub-committee

The members of the committee were drawn from Government agencies, Medical Women's Association, National Council of Women's Societies (NCWS), Red Cross, Federation of Women Lawyers, Board of Traditional Medicine and interested individuals from governmental and non-governmental organizations.

Members of the National Committee participated in a two day workshop organized by the Women & Development Committee to prepare country statements which were presented in July 1985 in Nairobi at the Forum of the UN Decade for Women Conference. These members of the Nigerian committee attended the IAC workshops in Nairobi and contributed to decisions related to the establishment of an IAC Newsletter and a Draft Constitution in the making.

The IAC collaborated with the NCWS and UNICEF to organize a workshop on the Health of Women and Children in Nigeria. The workshop was held in Kano in the Northern part of Nigeria, in June 1986. It was a successful workshop. A Task Force is now working on the recommendations.

One main project of the NCWS was the building of a surgical theatre annex and ward for the victims of recto/vesico vaginal fistulas which number about one thousand (1000). The building was formally handed over to the Government in June 1987.

In 1986, the committee participated in the drafting of a National Government Policy on the Child, which will soon be ratified.

The committee cooperates in the implementation of Primary Health Care policies of the Federal Ministry of Health. The committee is encouraged to work with other NGOs and the Federal Ministry of Health on a good strategy towards the success of Health for All by the Year 2000.
The national committee is involved in activities of the Health Committees of the NCWS and Women & Development working in rural areas, in order to emphasize the health hazards caused by bad traditional practices.

A seminar/workshop was held by the Nigerian committee in March 1987 at the United States Information Service (USIS), Lagos. The topics at the workshop were as follows:

1) Practices related to delivery and child spacing
2) Female circumcision
3) Nutritional taboos
4) Early childhood marriage and teenage pregnancies.
Other bad practices, such as uvulectomy, son preference, tribal marks and forced feeding, were also discussed.

Participants came as representatives from many NGOs and United Nations' agencies, from the Federal and States' Ministries of Health, Social Development, Youths & Sports, from the Local Government Authority, Lagos State, Red Cross, Planned Parenthood Federation, Nigeria, Specialist Hospitals and the National Board of Traditional Medicine. The seminar/workshop was also attended by Traditional Birth Attendants, Market Women, Christian and Moslem leaders, Girl Guides, National Association of Top Senior Army Officers' Wives (NAOWA) and the National Committee of the IAC.

Special messages were received from the Federal Minister of Health, UNICEF, WHO, Nigerian Red Cross Society, Ford Foundation and the National Assembly of Army Officers' Wives.

The workshop was a success and valuable recommendations to be followed up were made concerning each of the issues discussed.

* * * * *
TRADITIONAL PRACTICES AFFECTING THE HEALTH OF MOTHERS AND CHILDREN IN TANZANIA

by

Hon. Lucy Lameck, M.P.

Man as a social animal has always been identified from other animal species by the intellect he has and his ability to understand and control the environment to suit his development. This development to the level seen today has gone through some transitional stages, which can be clearly identified. Thus, people today can be classified by their culture and practices which form the basis of their way of life. From the African point of view, some of the traditional practices have of late been seen as having had a negative impact on the health of mothers and children.

In most African countries, mothers and children form the majority of any population total, and they are often the persons most at risk. Some statistics:

- the women of child-bearing age form 22%
- the 0-14 years old constitute 47%
- maternal mortality 2%/oo
- infant mortality 135%/oo
- total female population 52%
- official age at marriage 16 years

From the above it is obvious that the majority of the Tanzanians are persons at risk, i.e. women and children. Despite that, the fact is that there have been (and possibly still are) traditional practices that have been followed even when it has been known that they do affect the health of our population at risk - which we have apparently been fighting to help. These traditional practices were in family formation, food and nutrition, chances to self advancement etc.

a) Family Formation

Most people adhering to traditional practices have married off their young at the age of 15-16 (on the pride of wanting virginity). But evidences show that both infant and maternal mortality rates are higher for young mothers less than 20 years of age.

It is also evident that some of the traditional practitioners would like to see mothers keep on bearing children up to their very old age. But this has also been seen to affect the health of mothers and children in the sense that chances of mothers surviving during childbirth have been very low, and so were their children's chances. Where both survive, mothers are bound to suffer many complications associated with childbirth and children born are often of very low birth weight - with little chance of surviving.
Some traditions adhere to very old men marrying young girls (equal to their own grandchildren). This has the effect that most young mothers become widows at a very young age and with no one to take responsibility for them and the children left. This obviously affects the future health of the mothers and their children.

b) Traditional Nutrition Practices

In some cultures the very best nutritious foods are not given to women and children due to certain beliefs and taboos that something bad would befall the mothers and the children to be born. These included not eating eggs, some type of fish, chicken. Meat is left for the men.

All the above (and many other beliefs) leave the women and children on an unbalanced diet which affects the future growth of the children and the health of the mothers.

c) Equal Opportunities to Educational Development

Some practices have regarded women as people of the kitchen who need no formal education. As a result, women had little chance of education, employment, etc.

In some societies women have been taken to be "house workers for men" rather than partners with equal responsibility in the house. They are the ones that do all the work from tilling the land and caring for the animals to being the people in the house. Such is the order of the day, the year round and for all of the women's lifetime. On top of that they are expected to be pregnant every two years or even more often. There is no need for substantiation of the effect this has on the health of mothers and children.

The eating habits of some societies allowed for the men to be brought the whole pot of food. The man could eat to his fill and whatever was left was for the women and children.

Problem solving

Education of the people about the rights of women and children form the crucial objectives to be carried out through programmes by

a) Government

b) NGOs: Family Planning organizations, church bodies, etc.

c) Other agencies: UN agencies (UNFPA, UNDP, UNESCO, UNICEF, etc.), SIDA, CIDA, etc.

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CHAPTER X

DECISIONS

A. Plan of Action
B. Letters of Appeal
C. Board Elections
D. Headquarters
E. Zonal Arrangements
F. Next Regional Meeting
A. Plan of Action

The recommendations made on each of the traditional practices under debate at the seminar were assembled as guidelines in a Plan of Action. This plan comprises also proposals for organizational machinery as well as legislative and administrative measures to be taken for its realization.

The plan was unanimously endorsed by the participants who pledged to ensure its implementation, to as high a degree as possible, within the next decade. This will constitute a very important factor in the overall endeavour to bring about 'Health for All by the Year 2000' in Africa.

The Plan of Action is included in this report as Chapter II.

B. Letters of Appeal

It was proposed that the seminar participants send letters to the Heads of State of the African countries concerned appealing to their Governments to adopt the Plan of Action of the seminar and prioritize the strategies for its implementation, also appealing to them to receive the presidents of the national IAC committees so that they could present the Plan and the strategies for the eradication of harmful traditional practices.

It was also proposed that letters of appeal be sent to the Ministers of Health of these African countries as well as to the Heads of OAU, of ECA, of WHO - and also to the WHO Regional Directors in Brazzaville and Alexandria -, of UNICEF New York and of the newly created Afro-Arab section of UNICEF, asking that the Plan of Action of the seminar be included in future development programmes for Africa.

These proposals were unanimously accepted and the letters of appeal sent as proposed.

C. Board Elections

The President of IAC, Mrs Berhane Ras-Work, was reelected President.

The Vice President of IAC, Mrs Edna Ismail, Somalia, had asked to be relieved of her duties, as she was now employed by WHO and was no longer in a position to hold that office. Dr Irene Thomas, Nigeria, was therefore elected Vice President.

The Secretary General and the Treasurer of IAC had not replied to convocations to the seminar. Letters were to be sent to them giving them 3 months in which to react. Mrs Kankou Diallo, Mali, was elected Acting Secretary General and Mrs Safiatu Singhateh, Gambia, was elected Acting Treasurer.

D. Headquarters

It was decided that the Headquarters of IAC should be in Addis Ababa, Ethiopia. This will promote the close cooperation between the IAC and the Economic Commission for Africa,
particularly the African Training and Research Centre for Women. A memorandum of agreement with ECA exists since January 1986.

E. Zonal Arrangements

In order to group the African countries concerned into regional zones for coordination of activities and information, the following five IAC zones were created:

**Zone 1:** Djibouti, 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  
Coordinating country: Togo

Note: Due to linguistic difficulties Djibouti was later transferred from zone 1 to zone 4.

F. Next IAC Regional Seminar

An invitation was extended to the IAC delegates to hold the next regional seminar in Egypt in three years' time. This invitation was accepted with thanks and it was decided that this seminar would evaluate the activities undertaken so far in the various countries concerned for the implementation of the Plan of Action.

* * * * *
Address by the Chairperson of the Seminar.

Address by the President of IAC.
"Distinguished Participants,

During the last four days, we have devoted our time to discussing various traditional practices which have negative effects on the general physical, mental and social well-being of women and children in Africa, namely:

1. Early childhood marriage and teenage pregnancies
2. Female circumcision and related hazards
3. Practices related to delivery and child spacing
4. Nutritional taboos.

In our discussions, we shared with each other vital informations pertaining to these practices and as a result a general "Plan of Action" has evolved.

As you return to your respective countries, we would expect you to use the "Plan of Action" as guidelines in the preparation of your own programmes to suit your individual situation and needs. For example, some nationals have yet to establish a national committee, whilst others are operating under the umbrella of an already established Women's Bureau or Organization. If you have been stimulated sufficiently by what you have heard (and we believe you have) then we would expect you to decide for yourselves how best you can be effective in order to make the necessary impact on public opinion and attitude.

Furthermore, we urge you to pledge yourselves here and now that, come March 1988, i.e. within the space of twelve months, all of you here present will have established a national committee as an arm of the Inter-African Committee on Traditional Practices.

We urge you to seek interviews with your countries' Ministries of Health, Social Welfare, Culture, Economic Planning and Development, Youth, or their equivalent, and inform them on your programmes.

We urge you to introduce your national committees and programmes to such agencies of the United Nations Organizations as WHO, UNICEF, UNDP/UNFPA and to other humanitarian organizations, and collaborate with professional associations, non-governmental organizations and any religious bodies which are concerned about the health and welfare of women and children.
We expect you to hold seminars/workshops at national level at least annually and collaborate with any other organizations in the running of seminar/workshops on topics similar to ours.

As you have been told, we have divided ourselves into zones. At zonal level, therefore, we would urge that the coordinators so appointed do see to it that zonal seminars/workshops be held at least twice before the general Assembly of IAC is convened in Cairo, Egypt, in 1990.

You will also be taking home with you a copy of our Letter of Appeal to your respective governments. We expect you to follow this letter up and ensure that audience is granted your delegations.

As we make our way home, I want to say how wonderful it has been for us to be here in Addis Ababa, to enjoy the warm hospitality of the Government and people of Socialist Ethiopia, the Ministry of Health, the Economic Commission for Africa, the Women's Revolutionary Council of Ethiopia, and, by no means the least, the unpredictable weather. We are appreciative of the immense contribution to our discussions from the representatives of WHO, UNICEF, UNESCO, UNFPA, FAO, IPPF, CIDA and the Population Crisis Committee of the USA. The experience has been tremendous and one which will long remain with us.

I thank you all, members of the IAC, for electing me Chairperson of this Seminar, for your great contribution from the floor and above all for the great interest and patience shown throughout. On your behalf, I wish to express our thanks to the President and officers of the IAC, to the Chairperson of the ATRCW, to the Vice Chairperson and Rapporteurs of this seminar and to all the "behind the scene" personnel whose great efforts have helped to make this seminar a huge success. For me, it has been a delightful experience interacting with you all and one I shall long cherish. I thank you all also for appointing me Vice-President of the IAC. I wish you all a safe journey home and a happy reunion with your families.

This Assembly stands adjourned until 1990 when we meet in Cairo, Egypt. Thank you."
"Dear Participants,

We have spent five days discussing the subject of Traditional Practices Affecting the Health of Women and Children. We have shared the knowledge of experts and we have reflected on resolutions to take. We have discussed threats to health and life and the need to stamp out all harmful practices.

The IAC Committees have created awareness but more efforts are needed to reach the population at large. We also need strong support from international organizations in order to integrate the campaign against these harmful practices into every relevant programme aiming at Health for All by the Year 2000.

The Plan of Action is a challenge for all of us. Where there is determination, there is always a way. We have set ourselves a target of three years from now, when we shall be in Cairo for an evaluation of the extent of implementation of the Plan of Action that we have achieved by then. In Cairo we shall see what has been done and what is still left to be done.

Many partners are working with the IAC and this partnership should be strengthened. We welcome and encourage the formation of more national committees. We have created friendly relationships which should keep us together.

I congratulate the participants on their hard work and endeavour. We thank all the co-sponsors for helping to organize this seminar, especially the Ministry of Health of Socialist Ethiopia for welcoming us, for being with us and for providing valuable assistance. We also thank Revolutionary Ethiopia Women's Association for the reception at their headquarters. We thank you all for being here and for making the Seminar successful."

* * * * *
LIST OF ATTENDANCE

A. List of Participants

BENIN

Mrs Veronique Ahoyo
Ministry of Labour and Social Affairs, Cotonou

Mrs Modukpe Aisha Bio Tchané
Cotonou

BURKINA FASO

Mrs Henriette Bary
Cabinet of the Minister of Higher Education and Scientific Research, Ouagadougou

BURUNDI

Mr Ernest Basita
Ministry of External Relations, Bujumbura

CAMEROON

Mrs Comfort Effiom
Ministry of Women’s Affairs, Yaoundé

Mrs Madeleine Sao
Embassy of Cameroon, Addis Ababa, ETHIOPIA

CENTRAL AFRICAN REPUBLIC

Mr Marc Ningatoloum
Ministry of Public Health and Social Affairs, Bangui

Mrs Antoinette Teguedere-Kette
Ministry of Education, Bangui

CHAD

Mrs Adoum Moussa Seif
Women's Organization of UNIR (OFUNIR), N'Djamena

Mrs L.N. Koutou
Chad Red Cross Society, N'Djamena

Mrs Taha Salim
Embassy of Chad, Addis Ababa, ETHIOPIA

Mrs Fatime Kosso
Embassy of Chad, Addis Ababa, ETHIOPIA
COTE D'IVOIRE

Mrs Juliette Coulibaly
School of Midwifery, Abidjan

Mrs. T. Yvette Koue-Lou
Association for Family Well-Being (AIBEF), Abidjan

Mrs Koussna N'Da
Embassy of Côte d'Ivoire, Addis Ababa, ETHIOPIA

DJIBOUTI

Mrs Saida Hassan Bogoreh
National Union of Djibouti Women (UNFD), Djibouti

Mrs Kadra A. Osman
National Union of Djibouti Women (UNFD), Djibouti

Mr N. Ismael Said
Djibouti Red Crescent Society, Djibouti

EGYPT

Mrs Aziza Kaamel
Cairo Family Planning Association (National IAC Committee), Cairo

Dr M. El Tobgui
Cairo Family Planning Association (National IAC Committee), Cairo

Dr Nadia Atif
Women in Development, Bulkeley, Alexandria

ETHIOPIA

Ministry of Health

Comrade Asresu Misikir
MCH Coordinating Office, Addis Ababa

Comrade Debessay Haile
Addis Ababa

Comrade Sister Alemitu Kassa
School of Midwifery, Addis Ababa

Comrade Andulaem Gelaye
School of Health Assistants, Addis Ababa

Comrade Mehret G. Amlak
Eritrea Region Health Department, Asmara

Comrade Abeba Tzegai
Eritrea Region Health Department, Asmara

Comrade Frewoyen Samuel
Eritrea Region Health Department, Keren

Comrade Manamnosh Wolde Mariam
Gojjam region

Comrade Abebetch Asratye
Gojjam region

Comrade Wala Abebe
Community Health, Gojjam region

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