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Resolution WHA47.10: Maternal and child health and family planning: traditional practices harmful to the health of women and children
Dear Reader,

Please find enclosed the World Health Organization’s (WHO) Information kit on female genital mutilation (FGM). As you are aware, FGM is an issue of concern with recognized implications for the health and human rights of women and girls. In communities where FGM is a traditional practice, it is paradoxically performed as an indication of love and care for a daughter, and, unlike other public health problems, FGM may not be seen as a health issue. Great effort will therefore be required, in terms of developing a dialogue and negotiating with the communities concerned, to eliminate the practice.

Current WHO activities include:

1. Advocacy and Policy

A joint WHO/UNICEF/UNFPA policy statement on FGM and a Regional Plan to Accelerate the Elimination of FGM were published to facilitate policy development and action at the global, regional and at national level. These have been distributed in countries where FGM continues as a traditional practice. The two documents have become a reference point for decision making in countries. Several countries, where FGM is a traditional practice, are now developing national plans of action based on the FGM prevention strategy proposed by WHO. For example, with the technical support from WHO, Nigeria has adopted a national policy and a plan of action on FGM.

2. Research and Development

A major objective of WHO’s work on FGM is to generate knowledge, test interventions to promote the elimination of FGM and improve management of its health consequences. WHO has reviewed programming approaches for the prevention of FGM in countries and is organizing training for community workers to sharpen their approaches to the prevention of FGM at the grassroots level. Research priorities on FGM have been identified with regional researchers, health and nongovernmental groups in countries where FGM is a traditional practice. Research protocols have also been developed with a network of collaborating research institutions, biomedical and social science researchers with linkages to communities. Currently, WHO is developing a regional research and development programme in six sub-Saharan countries (Kenya, Nigeria, Cameroon, Burkina Faso,
Ghana and the Gambia) to assist countries to identify best practices for the prevention of FGM.

3. Development of training materials and training for health care providers

WHO has developed training materials for integrating the prevention of FGM into nursing, midwifery and medical curricula as well as for in-service training of health workers. Evidence based training workshops, to raise the awareness of health workers and to solicit their active involvement as advocates against FGM, have also been developed for nurses and midwives in the African and Eastern Mediterranean region.

You will find in the information kit a list of local, national and international organizations which might be of further interest to you in terms of furthering action to accelerate the elimination of FGM. If access to the Internet is possible, visit us for updates at [www.who.int/fgm](http://www.who.int/fgm)

We thank you for your interest in this subject.

Best regards,

[Signature]

Dr Olive Shisana
Executive Director
Health Systems and Community Health
The World Health Organization
Geneva
Female Genital Mutilation:

STATEMENT OF THE WHO DIRECTOR-GENERAL


"...I shall take the example of excision. Just denouncing the practice can make some of us feel better and self-righteous but it certainly does not solve the problem. Our purpose should not be to criticize and condemn. Nor can we remain passive, in the name of some bland version of multiculturalism. We know that the practice of genital mutilation is painful and can have dire consequences on the health of the baby girl and, later on, of the woman. But we must always work from the assumption that human behaviours and cultural values, however senseless or destructive they may look to us from our particular personal and cultural standpoints, have meaning and fulfil a function for those who practise them. People will change their behaviour only when they themselves perceive the new practices proposed as meaningful and functional as the old ones. Therefore, what we must aim for is to convince people, including women, that they can give up a specific practice without giving up meaningful aspects of their own cultures.

Experience shows for example that many people in the societies concerned do not naturally see the link between genital mutilation suffered by a woman in her childhood and the pain, infections and health problems she may suffer in her later years. Our first task must be to document this link, and then to inform people very simply and clearly about it. It is for us to explain how and why the ritual practice does not prevent but, in its most severe forms, may in fact increase the risk of infertility. Parents are much the same everywhere: given the chance, they want the best for their children. They will accept the changes proposed once they realize that these are in the best interests of their children and that, together with better health, their daughters are more likely to enjoy a successful social and economic future.

The same approach could apply whenever we want to induce sustainable changes in harmful dietary habits and lifestyles, or to promote safe sex and condoms, family planning, children’s treatment with oral rehydration salts, hygiene, immunization, rational drug use, etc. It must be our responsibility to present the changes proposed in such a way that they can make sense to the people themselves and fit in with their own social, cultural and economic environments..."
In order to facilitate information collection and monitoring of progress, WHO convened a group of experts to reach consensus on a standardized definition of female genital mutilation (FGM) and a classification of types. The definition and classification are given below.

**Definition**

Female genital mutilation constitutes all procedures which involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

**Classification of FGM**

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

**Type II** Excision of the prepuce and clitoris together with partial or total excision of the labia minora.

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

**Type IV** Unclassified: includes pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the definition of FGM given above.

**What is involved in FGM?**

Types I and II (excision of the clitoris and labia minora) are the commonest types of female genital mutilation. They constitute up to 80% of all female genital mutilation practised.

Type III (infibulation) is the most extreme form of FGM and constitutes approximately 15% of all procedures. Infibulation involves the complete removal of the clitoris and the labia minora, as well as the inner surface of the labia majora. The two sides of the vulva are then stitched together with thorns or by silk or catgut sutures so that when the remaining skin of the labia majora heals, it forms a bridge of scar tissue over the vagina. A small opening is preserved by the insertion of a foreign body to allow for the passage of urine and menstrual blood. The girl's legs are sometimes bound together from thigh to ankle and she may be immobilized for several weeks to allow scar tissue to form over the wound.

When the wound has healed the reconstructed opening is surrounded by skin and tough scar tissue. If the vulva does not heal successfully or the opening is considered too big, the girl is operated on again.

Since a physical barrier to intercourse has been created, the infibulated woman has to undergo gradual dilation by the husband after marriage. This is very painful and may take several days. Sometimes it is not possible for the husband to penetrate at all, and the opening has to be re-cut.

At childbirth, the trauma of mutilation is repeated. The woman has to be
defibulated to allow the passage of the baby. The passage can cause obstructed labour due to tough scar tissue surrounding the birth canal. After birth, the raw edges are sutured in the same way again, referred to as re-infibulation.

Infibulation is the most extreme form of female genital mutilation and causes the most damage to girls' and women's health in the immediate and long term.

**How is FGM carried out?**

The procedure is carried out with special knives, scissors, scalpels, pieces of glass or razor blades. There is often additional unintended damage due to crude tools, poor light and septic conditions. The procedures are usually carried out by an elderly woman of the village who has been specially designated for this task, or by traditional birth attendants. In urban areas, more affluent families may prefer to use the services of health personnel such as midwives and doctors although the medicalization of the procedure has been consistently condemned by WHO.

Anaesthetics and antiseptics are not generally used. Assistants and/or family members hold down the girl to prevent her struggling. The procedure lasts 15 to 20 minutes, depending on the ability of the person carrying it out, and the amount of resistance put up by the child. Men are rarely present at such operations. Paste mixtures made of herbs, local porridge, ashes, or other mixtures are rubbed on to the wound to stop bleeding.

**When is FGM carried out?**

The age at which the mutilation is carried out varies. The practice may be carried out during infancy, childhood, at the time of marriage or during a first pregnancy. The most common age seems to be between four and ten, although it appears to be falling, indicating a weakening of the link to initiation into adulthood.

**Why is FGM practised?**

It has not been possible to determine when or where the tradition of FGM originated.

The reasons given to justify FGM are numerous and reflect the ideological and historical situation of the societies in which it has developed. Reasons cited generally relate to tradition, power inequalities and the ensuing compliance of women to the dictates of their communities. In sociological studies, the following reasons have been given for the practice of FGM: custom and tradition; religious demand; purification; family honour; hygiene (cleanliness); aesthetic reasons; protection of virginity and prevention of promiscuity; increasing sexual pleasure for the husband; giving a sense of belonging to a group; enhancing fertility; and increasing matrimonial opportunities. It is important to note that FGM is not required by any religion.

Many women believe that FGM is necessary to ensure acceptance by their community and they are unaware that FGM is not practised in most of the world. Female genital mutilation continues to be a sensitive subject and those who practise it may often believe in it without perceiving all its repercussions. However, attitudes are gradually changing among some urban educated men and women.
Due to the sensitivity of the subject, and neglect by the scientific community, systematic surveys have not been undertaken and there are no comprehensive, country-by-country data available on female genital mutilation (FGM). The only nationwide survey data available are from the Sudan, Ivory Coast and Central African Republic. As part of the National Demographic and Health Surveys, a module has been developed to investigate FGM and is available for use by countries. On the basis of the information available from a few small scale studies, it is estimated that around the world there are between 100 and 132 million girls and women who have been subjected to FGM. Each year, a further 2 million girls are estimated to be at risk of the practice. Most of them live in 28 African countries, a few in the Middle East and Asian countries, and increasingly in Europe, Canada, Australia, New Zealand and the United States of America.
<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated prevalence</th>
<th>Number of women (000s)**</th>
<th>Source of the prevalence rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin*</td>
<td>50%</td>
<td>1,370</td>
<td>Report of the National Committee (1995).</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>70%</td>
<td>3,650</td>
<td>Estimated prevalence based on a study (1994) in southwest and far north provinces by the Inter-African Committee, Cameroon section.</td>
</tr>
<tr>
<td>Cameroon</td>
<td>20%</td>
<td>1,330</td>
<td>National Demographic and Health Survey (1994). A reduced rate of FGM amongst younger age groups. Secondary or higher education can be associated with reduced rates of FGM. No significant variations between rural and urban rates. The prevalence of FGM is highest amongst the Banda and Mandjia groups where 84% and 71% of women respectively have undergone FGM.</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>43%</td>
<td>740</td>
<td>National Demographic and Health Survey (1994). A reduced rate of FGM amongst younger women. No significant variations occurred between urban and rural rates. Secondary and higher education can be associated with reduced rates of FGM. The highest prevalence of FGM appears amongst the Muslim population 80%, compared with 15% amongst Protestants and 17% of Catholics.</td>
</tr>
<tr>
<td>Chad</td>
<td>60%</td>
<td>1,930</td>
<td>1990 and 1991 UNICEF sponsored studies in three regions.</td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>43%</td>
<td>3,020</td>
<td>National Demographic and Health Survey (1994). A reduced rate of FGM amongst younger women. No significant variations occurred between urban and rural rates. Secondary and higher education can be associated with reduced rates of FGM. The highest prevalence of FGM appears amongst the Muslim population 80%, compared with 15% amongst Protestants and 17% of Catholics.</td>
</tr>
<tr>
<td>Egypt*</td>
<td>80%</td>
<td>24,710</td>
<td>Type I and Type II practised by both Muslims and Christians. Type III-infibulation, reported in areas of south Egypt closer to Sudan.</td>
</tr>
<tr>
<td>Eritrea*</td>
<td>90%</td>
<td>1,600</td>
<td>A 1995 UNICEF sponsored survey in five regions and an Inter-African Committee survey in twenty administrative regions. Type I and Type II commonly practised by Muslims and Coptic Christians as well as by the Ethiopian Jewish population, most of whom now live in Israel. Type III is common in areas bordering Sudan and Somalia.</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>85%</td>
<td>23,240</td>
<td>A limited study by the Women's Bureau (1985). Type II commonly practised.</td>
</tr>
<tr>
<td>Ghana</td>
<td>30%</td>
<td>2,640</td>
<td></td>
</tr>
<tr>
<td>Guinea*</td>
<td>50%</td>
<td>1,670</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Estimated prevalence</td>
<td>Number of women (000s)*</td>
<td>Source of the prevalence rate</td>
</tr>
<tr>
<td>-------------------------</td>
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<td>----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>50%</td>
<td>270</td>
<td>Limited 1990 survey by the Union démocratique des Femmes de la Guinée-Bissau.</td>
</tr>
<tr>
<td>Kenya</td>
<td>50%</td>
<td>7,050</td>
<td>A 1992 Maendelen Ya Wanawake survey in four regions. Type I and II commonly practised. Type III by a few groups. Decreasing in urban areas, but remains strong in rural areas.</td>
</tr>
<tr>
<td>Liberia*</td>
<td>60%</td>
<td>900</td>
<td></td>
</tr>
<tr>
<td>Mali*</td>
<td>75%</td>
<td>4,110</td>
<td></td>
</tr>
<tr>
<td>Mauritania*</td>
<td>25%</td>
<td>290</td>
<td></td>
</tr>
<tr>
<td>Niger*</td>
<td>20%</td>
<td>930</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>50%</td>
<td>28,170</td>
<td>A study by the Nigerian Association of Nurses and Nurse-midwives conducted in 1985-1986 showed that 13 out of the 21 States had populations practising FGM, prevalence ranging 35% to 90%. Type I and Type II commonly practised.</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>90%</td>
<td>2,070</td>
<td>All ethnic groups practise FGM except for Christian Krios in the western region and in the capital, Freetown. Type II commonly practised.</td>
</tr>
<tr>
<td>Somalia</td>
<td>98%</td>
<td>4,580</td>
<td>FGM is generally practised; approximately 80% of the operations are infibulation.</td>
</tr>
<tr>
<td>Sudan</td>
<td>89%</td>
<td>12,450</td>
<td>National Demographic and Health Survey (1989/1990). A very high prevalence, predominantly infibulation, throughout most of the northern, north-eastern and north-western regions. Along with a small overall decline in the 1980s, there is a shift from infibulation to clitoridectomy.</td>
</tr>
<tr>
<td>Togo*</td>
<td>50%</td>
<td>1,050</td>
<td></td>
</tr>
<tr>
<td>Uganda*</td>
<td>5%</td>
<td>540</td>
<td></td>
</tr>
<tr>
<td>United Republic of Tanzania*</td>
<td>10%</td>
<td>1,500</td>
<td></td>
</tr>
<tr>
<td>Zaire*</td>
<td>5%</td>
<td>1,110</td>
<td></td>
</tr>
</tbody>
</table>

** Anecdotal information only; no published studies.

* Number of women calculated by applying the prevalence rate to the 1995 total female population reported in the United Nations Population Division population projections (1994 revision). Totals may not add due to rounding.
Sources

Estimated prevalence rates have been developed from national surveys, small studies and from the following:

National Demographic and Health Surveys, Macro International, Inc., 11785 Beltville Drive, Calverton, MD 20705, USA.
Female genital mutilation (FGM) is a deliberate procedure which causes grave damage to children and women, and which in many cases results in serious health consequences. Some documentation and studies are available on the short-term and long-term physical complications of the different types of FGM, but little has been documented on the psychological and psycho-sexual effects. The mortality of girls and women undergoing these practices is probably high, but few records are kept and deaths due to FGM are rarely reported.

Women subjected to the more severe forms of FGM are particularly likely to suffer from health complications requiring medical attention throughout their lives. Some complications such as severe bleeding and infections may occur immediately or shortly after the practice is performed; other complications may occur years after the event. It is difficult to assess the frequency with which the various complications of FGM occur, as too few surveys have been undertaken to establish the incidence of health consequences. It is however apparent that the physical, psycho-sexual and psychological complications of FGM are sizeable and constitute in some countries a serious public health problem which endangers the life and health of women and children.

IMMEDIATE COMPLICATIONS

Haemorrhage is a common and almost unavoidable immediate result. Amputation of the clitoris involves cutting across the high pressure clitoral artery. Haemorrhage may also occur after the first week as a result of sloughing of the crust over the artery, usually because of infection. Cutting of the inner and/or outer labia further damages arteries and veins. As a result of the severe bleeding, serious collapse or sudden death may occur in the case of massive haemorrhage. Major blood loss can result in long-term anaemia.

Shock is due not only to the bleeding, but also to the severe pain and anguish. Most procedures are performed without anaesthesia. Traumatic or neurogenic shock has sometimes been reported to cause death. Infection, due to unhygienic conditions, and the use of unsterilized instruments or crude tools, is a likely outcome of the operation. Infection can also be contracted due to the traditional medicines used for healing the wound. The practice of binding the patient's legs after an infibulation may aggravate an infection by preventing drainage of the wound. The infection may spread internally to the uterus, fallopian tubes and ovaries, causing chronic pelvic infection and infertility. Infection may include tetanus, which is usually fatal, as well as potentially fatal septicaemia. Gangrene occurs when spores are introduced from unsterile instruments or faecal contamination.

Urine retention for hours or days is a common immediate complication of FGM and is due to pain, fear of passing urine on the raw wound, tissue swelling, inflammation, or injury to the urethra. Incidence varies according to the type of procedure. This condition often leads to urinary tract infection.

Injury to adjacent tissue such as the urethra, vagina, perineum or rectum results from the use of crude tools, poor light, careless techniques, or from the struggles of the girl. Such damage may result in incontinence.
LONG-TERM COMPLICATIONS

Bleeding can arise sometime after the procedure is carried out if the wound becomes infected. Repeated defilation and re-infibulation during childbirth may also cause major blood loss, which may lead to the development of long-term anaemia.

Difficult micturition is due to obstruction of the urinary opening or damage to the urinary canal. Urinating may be painful and result in urinary retention, frequent urination, incontinence and consequent urinary tract infection.

Recurrent urinary tract infections are often a result of the damage caused to the lower urinary tract during the mutilation or because of subsequent complications, leading to painful and difficult urination. Recurrent urinary tract infections are particularly common in infibulated women, where the normal flow of urine is deflected and the perineum remains constantly wet and susceptible to bacterial growth. Retrograde urinary infections may result and affect the bladder, ureters and the kidneys.

Incontinence may be a result of a damaged urethra at the time of the procedure, with severe social implications.

Chronic pelvic infections are common in infibulated women. FGM and partial occlusion of the vagina and urethra increase the likelihood of infection. These infections are painful and may be accompanied by a noxious discharge. Infections may spread to the uterus, fallopian tubes and ovaries, and may become chronic.

Infertility is a risk due to infections causing irreparable damage to the reproductive organs.

Vulval abscesses can develop due to infected cysts, stitch (or thorn) abscesses, as well as other infections.

Keloid formations (vicious scars) result from wound healing with hard scar tissue. These considerably shrink the genital orifice with attendant consequences.

Dermoid cysts, as a result of the inclusion of epithelium during healing, may lead to swelling or pockets producing secretion. Such cysts often form on the scar line. The cysts may grow to the size of an orange or bigger.

Neurinoma can develop where the dorsal nerve of the clitoris is cut. The whole genital area becomes permanently and unbearably painful.

Calcus formation may develop due to menstrual debris or urinary deposits in the vagina or in the space behind the bridge of skin created when infibulation is performed. Fistulæ, vesico-vaginal or recto-vaginal, may form as the result of an injury during FGM, or due to defilation or re-infibulation, intercourse or obstructed labour. Continuous leakage of urine and faeces can plague the woman all her life and turn her into a social outcast.

Sexual dysfunction in both partners may be the result of painful intercourse and reduced sexual sensitivity following clitoridectomy, and even more so following infibulation. Penetration may be difficult or even impossible, and at times, re-cutting has to take place.

Difficulties in menstruation often occur because of partial or total occlusion of the vaginal opening. This may result in dysmenorrhoa. Haematocolpos may result from the retention of menstrual blood due to the almost complete coalescence of the labia. Distension of the abdomen induced by the accumulation of menstrual blood, together with the lack of any outward evidence of menstruation, may give rise to suspicion of pregnancy, potentially causing severe social implications for the girl.
Problems in pregnancy and childbirth are common in women who have undergone FGM. In the event of a miscarriage the foetus may be retained in the uterus or the birth canal. Tough scar tissue may prevent dilatation of the birth canal, and result in obstructed labour. Exhaustion due to prolonged labour may result in uterine inertia. Obstructed labour is hazardous and health consequences may be fatal for both mother and baby. The mother may suffer lacerations and the formation of fistulas, as well as severe blood losses. The baby may suffer neonatal brain damage or death as the result of birth asphyxia. Defibilation is necessary in order to allow the passage of the baby. If a trained attendant is not available to cut the skin hood, the labour will be obstructed. This may cause additional loss of blood, injury to surrounding parts, fistulae and infection. Re-infibulation is often demanded by the husband and the woman concerned. Repetition of defibulation and re-infibulation will weaken scar tissue, and re-infibulation carries the same long-term risks as the original infibulation. In some instances where psychosexual counselling on the health implications of defibulation and re-infibulation has been offered to both women and their partners during pregnancy, there has been a noticeable decrease in the requests for re-infibulation.

The risk of HIV transmission may be increased for women with FGM, due to scar tissue, and the small vaginal opening prone to laceration during sexual intercourse or as a result of anal intercourse due to inability to penetrate the vagina. HIV may also potentially be transmitted when groups of children are simultaneously mutilated with the same unsterile instruments.

PSYCHOSEXUAL, PSYCHOLOGICAL AND SOCIAL CONSEQUENCES

Almost all the types of female genital mutilation involve the removal of part or the whole of the clitoris, which is the main female sexual organ, equivalent in its anatomy and physiology to the male organ, the penis. Sexual dysfunction in both partners may be the result of painful intercourse and reduced sexual sensitivity following clitoridectomy and narrowing of the vaginal opening. The more severe types of FGM, like infibulation, remove larger parts of the genitals, and close off the vagina, leaving areas of tough scar tissue in place of sensitive genitals, thus creating permanent damage and dysfunction.

FGM may leave a lasting mark on the life and mind of the woman who has undergone it. The psychological complications of FGM may be submerged deeply in the child's subconscious mind, and they may trigger the onset of behavioural disturbances. The possible loss of trust and confidence in those that are the care-givers has been reported as another serious effect. In the longer term, women may suffer feelings of incompleteness, anxiety, depression, chronic irritability, frigidity, marital conflicts, conversion reactions, or even psychosis. Many women traumatized by their FGM may have no acceptable means of expressing their feelings and fears, and suffer in silence. Unfortunately, inadequate research exists to establish scientifically the precise magnitude of psychological and social consequences of FGM, and its effect on child development.
In most rural communities where female genital mutilation (FGM) is the accepted norm, operations are usually performed by traditional birth attendants or traditional practitioners. However, with increasing awareness of the adverse health consequences, health workers have become involved in performing FGM which has led to the "medicalization" of the procedure in a number of countries. Some individuals and local organizations have promoted the performance of the procedure in clinical conditions in order to reduce the health risks.

A major effort is needed to prevent the "medicalization" of all forms of FGM. The case for doing so has to rest on the basic ethics of health care where body mutilation cannot be condoned by health services personnel. The health complications from FGM are also a serious problem and they serve as a good basis for dissuading people from continuing to perform the practice.

WHO, together with other UN agencies, has assured governments of its readiness to support national efforts towards the elimination of FGM, to continue collaboration in research related to prevalence, types and consequences of FGM and to disseminate information about the findings.

WHO has recognized the need for special attention to be given to the training of health workers at all levels, including obstetricians/gynaecologists (OB/GYNs), paediatricians, midwives and nurses on how to deal with the complications of FGM and how to advise and prevent families from seeking FGM for their daughters.

Given WHO's commitment to advance the health, and protect the lives of women and children, including their reproductive and psychological health, the Organization continues to advise unequivocally that FGM must not be institutionalized, nor should any form of FGM be performed by any health professionals in any setting, including hospitals or other health establishments.

Over the years, both nationally and internationally, within nongovernmental and intergovernmental organizations, and among professional, religious and community leaders, the seriousness of the scope and consequences of FGM has become more apparent. Progressively, it is becoming less sensitive as a policy and programme concern. These changes in the perception of the problem are a reflection of the understanding that the inequitable position of women is not only a threat to their own health and development, but a major impediment to social and economic development in general. It is also a reflection of the recognition that FGM is a violation of the basic human and health rights of the girl child. Such rights are protected by several international and regional instruments and it is accepted that all governments must strive to make these rights a reality for all women and children.
While we still await the accounts of successful interventions for the elimination of female genital mutilation (FGM) in countries, we have learned from the achievements already realised, particularly by women's organizations, of the importance of abiding by several key principles:

Reconciling strategies to the distinctive features of each culture

Listening to and respecting the community's own perceptions on FGM before embarking on sensitization and information campaigns can be the foundation of collaboration and change.

Integrating strategies with other health and development efforts

Women are frequently faced with issues of their own and their families' survival and may not see FGM as an immediate priority. The incorporation of FGM into broader efforts to improve women's status and health such as reproductive and family health, family planning, adolescent health, safe motherhood and child health may have wider appeal. The role of education in changing attitudes and loosening the hold of tradition is worth remembering.

Forming alliances between modern and traditional healers

Reasons for the continuation of FGM are related to tradition, power inequities and the ensuing compliance of women to the dictates of their communities. Dialogue and collaborative activities between modern and traditional healers can create the basis for understanding of healthy values and practices to promote in unison.

Exercising discretion and tact in referring to deeply held beliefs

FGM is a sensitive subject and those who practise it may very often believe in it without understanding all its consequences.

Seeking solutions from within countries complemented by international solidarity

Although it is generally accepted that the process of eliminating FGM must be undertaken by governments concerned and women themselves, their activities benefit enormously from international technical support, advocacy and finance.

Framework for action

- Adopt a clear national policy for the abolition of FGM including, where appropriate, the enactment of legislation prohibiting it.

- Establish inter-agency teams incorporating members from relevant government ministries, professionals and nongovernmental organizations to coordinate and follow up action for the elimination of FGM.

- Support research into all aspects of FGM, including the incidence, prevalence, main reasons why FGM continues to be practised, and health consequences as well as operations research in order to support the design of appropriate interventions for eliminating it.
- Organize strong community outreach and family life information and education programmes involving village and religious leaders which addresses the main reasons sustaining the continuation of the practice. Experience shows that where leadership is enlightened and committed, information and education activities are more successful.

- Emphasize the importance of sustainability and integrate action to eliminate FGM into existing health education, child protection and community development efforts.

- Use consistent messages and all available channels to communicate information to all sectors of the public. Mass media, popular music, drama and crafts, group sessions, as well as one-to-one counselling, have been successfully used to target women and men, old and young, community elders and family members.

- Prohibit the practice of FGM by health professionals in any setting, including hospitals or other health establishments; and provide professional guidance and training for health professionals for its elimination.

- Ensure that there is appropriate rehabilitation and treatment for women and girls who have suffered problems with FGM. Include counselling so that women and adolescent girls have the opportunity to express their fears and concerns about their sexuality.

- Support and encourage nongovernmental organizations, particularly women's groups, education and advocacy groups. An initial group can serve as an important catalyst to start open discussion of FGM where formerly it was considered as taboo.

- Target traditional healers and birth attendants who practise FGM for information and retraining, otherwise efforts for the elimination of FGM will be undermined by indifference or opposition.

- Avoid intervention strategies which lead to the creation of a cultural vacuum. Where appropriate, encourage alternative rites of passage for young girls, which involve gift-giving and celebration and help promote positive female traditional values, without causing physical and psychological damage to girls.

- Target young people and couples, in particular, and provide information holding unmutilated girls and women in high esteem, providing the necessary support to enable them to resist pressures to expose their daughters to FGM. Generally, young people are in the vanguard in creating new social norms but, at the same time, there is a need for sensitivity when working with young women who have already undergone FGM.

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

World Health Organization

August 1996
In the last decade, a wide range of organizations and individuals have attempted systematic community-based activities for the prevention and the elimination of female genital mutilation (FGM). These efforts are being matched by an increasing effort to bring the problem to the attention of international and national political, religious and community leaders to create an atmosphere of political support for the elimination of the practice. The momentum and commitment that have been generated at the global and national levels for eliminating FGM presents an excellent opportunity for international associations of health professionals and their national counterparts to become involved in the formulation and implementation of advocacy, action, training and research initiatives directed at their members.

The case for supporting this global initiative rests on the basic ethics of health care, where body mutilation cannot be condoned by health professionals. Furthermore, as international migration has brought the practice to countries previously unfamiliar with FGM, health workers throughout the world have had to respond to the health needs of women who have undergone FGM and consequently they have had to deal with the difficult health as well as ethical problems raised by the practice.

International and national associations of health professionals may have to strengthen their collaboration with national authorities, such as ministries of health, social welfare, education, information and culture, as well as with training and research institutions, and with non-governmental organizations such as women’s groups and family planning associations.

Some approaches they might employ to be effective in their efforts include:

- Sensitizing policy makers, health authorities and other influential groups to the potential physical, mental and social consequences of FGM and its impact on safe motherhood and child survival.

- Formally declaring a position against FGM and its medicalization and establishing mechanisms to facilitate the association’s involvement in elimination efforts, as well as censoring members who perform such operations in all its forms.

- Encouraging national authorities and other influential groups to develop mechanisms, including legislation, to ban the practice of FGM, specifically targeting those who profit most from the practice.

- Providing training to professional colleagues and specialists on how to deal with the complications of FGM.

- Developing simple educational materials that can be used to promote the prevention of the practice, as well as for counselling of those who have undergone it.

- Encouraging, facilitating and participating in research related to the practice and its complications, and bringing the results to the attention of other colleagues and health authorities.

World Health Organization

August 1996
Female genital mutilation (FGM) is a traditional practice which can have serious health consequences, and is of concern to the World Health Organization (WHO). Activities are carried out to combat this practice as part of its broader programmes on women and children’s health.

WHO supports the recommendations of the Khartoum Seminar of 1979, the Dakar Seminar of 1984, the Safe Motherhood conference, Naimey, 1989, the UN Seminar on Human Rights, Burkina Faso, 1991, the UN International Conference on Population and Development (ICPD), Cairo, 1994, the Fourth World Conference on Women, Beijing, 1995 and the Inter-African Committee’s Regional Conferences of 1987, 1990 and 1994, related to Traditional Practices Affecting The Health of Women. These recommendations stated that governments should adopt clear national policies to abolish FGM, and to intensify educational programmes to inform the public (women and men) about the harmfulness of FGM. In particular, women’s organizations at local levels are encouraged to be involved, since without women themselves being aware and committed, no changes are likely. In areas where FGM is still being practised, women also face many other critical problems of ill health and malnutrition, lack of clean water, death in childbirth and overburden of work. These occur in extremely adverse social and economic circumstances. Surveys carried out with WHO support also point to the continuing cultural and traditional pressures which perpetuate the practice. Programmes to combat harmful traditional practices, including FGM, should be seen within this context, and should respond sensitively to women’s needs and problems.

WHO, together with other UN agencies, has assured governments of its readiness to support national efforts against FGM, and to continue collaboration in research and dissemination of information. Special attention is given to the training of health workers at all levels, especially for traditional birth attendants, midwives, nurses, and other practitioners of traditional medicine.

WHO has consistently and unequivocally advised that FGM, in any of its forms, should not be practised by any health professionals in any setting - including hospitals or other health establishments.

Over the last fifteen years the activities of WHO in respect to FGM have included: preparation of informational material by staff members and consultants, particularly on the health consequences and the epidemiology of FGM; support to incorporate this material into appropriate training courses for various categories of health workers; technical and financial support to national surveys; convening and collaborating in conferences and seminars referred to above; holding consultations to clarify and unify approaches; and disseminating information on FGM.

WHO has cooperated with the NGO Group (NGO Sub-Committee on the Status of Women, Working Group on Traditional Practices Affecting the Health of Mothers and Children) established under the auspices of the UN Commission on Human Rights to coordinate the action of NGOs on this subject. A seminar was held in Dakar in February 1984 on Traditional Practices Affecting the Health of Women and children in Africa organized by the NGO Group and the Government of Senegal to which WHO, assisted by UNFPA and UNICEF, gave substantial financial, technical and administrative support. As a result of the seminar, the Inter-African Committee on Traditional Practices was created and WHO has been working closely with this group and other groups to facilitate follow-up activities.

All these efforts have culminated in the adoption, by the World Health Assembly 1994,

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of Resolution WHA 47.10 urging governments to take measures to eliminate traditional practices harmful to the health of women and children, particularly female genital mutilation. The Resolution reiterates WHO's position on FGM and further reaffirms its support for the United Nations Convention on the Rights of the Child and the United Nations Economic and Social Council Resolution 1992/251 on traditional practices affecting the health of women and children. The Resolution urges Member States to assess the extent to which these practices constitute a social and public health problem, establish national policies and programmes that will help abolish FGM and collaborate with national NGO groups active in this field.

In the light of this Resolution, WHO is strengthening its technical support to, and cooperation with, countries in implementing all measures stated in the Resolution. The Organization will continue global and regional collaboration with NGOs, and UN and other agencies in establishing strategies for the abolition of FGM and mobilizing additional extra-budgetary resources to sustain the action at national, regional and global levels.
The issue of female genital mutilation (FGM) has been of concern to the UN and its agencies since the early 1950s.

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

1958  The Economic and Social Council (ECOSOC) in resolution 680 BII (XXVI) invites WHO to undertake study "of persistence of customs which subject girls to ritual operations" and of measures adopted or planned to end these practices.

1960  UN Seminar on the Participation of Women in Public Life discusses the question in Addis Ababa.

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

1962  WHO Executive Board widens the scope of the study to include cultural and socioeconomic background of countries involved.

1976  WHO Regional Office for Eastern Mediterranean undertook a review of the medical literature and embarked on a programme of activities.

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


1981  The Association of African Women for Research and Development, under the aegis of the Economic Commission for Africa discuss FGM.

The Working Group on Slavery of the Sub-Commission on Prevention of Discrimination and Protection of Minorities recommends study into all aspects of FGM.

WHO's Mother and Child Health Programme, in collaboration with UNICEF, offers support to governments to combat female circumcision, and collaborates in research and dissemination of information with other United Nations agencies.

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

1984  Seminar on Traditional Practices Affecting the Health of Women and Children in Dakar condemns female circumcision as a health hazard and as unnecessary human suffering. The seminar also creates an Inter-African Committee (IAC) on Traditional Practices to follow up the implementation of its recommendations. The Inter-African Committee has national committees in 24 countries to date.

The Commission on Human Rights recommends formation of an inter-agency working group to conduct a comprehensive study of traditional practices affecting the health of women and children.

1985  World Health Assembly resolution WHA 38.27 recognises problem of harmful traditional practices and calls for concrete action to eliminate FGM.
First session of Inter-Agency Working Group calls on governments to adopt policies and legislative measures for the elimination of FGM.


1987 WHO co-sponsors IAC Regional seminar on FGM and other traditional practices in Addis Ababa.

1988 WHO Regional Committee for Eastern Mediterranean adopts a resolution EM/RC35/R.9 stating that women's health must be safeguarded by ensuring the elimination of harmful practices.

1989 Safe Motherhood Conference in Niamey calls for the elimination of harmful traditional practices including FGM. WHO Regional Committee for Africa adopts resolution AFR/RC39/R.9 recommending that concerned members adopt appropriate policies and strategies to eliminate female circumcision.

1990 WHO co-sponsored IAC Regional Conference in Addis Ababa proposes change in terminology from "Female Circumcision" to "Female Genital Mutilation".


1992 WHO Technical Discussions on Women, Health and Development propose more courageous steps be taken by national and international communities to eliminate FGM. WHO position opposing medicalization of any form of female genital mutilation was reaffirmed during the Netherlands Consultancy for Maternal Health and Family Planning Congress on Female Circumcision.

1993 46th World Health Assembly passes Resolution WHA46.18 and issues a press release on female genital mutilation. The Vienna Declaration and the Programme of Action of the United Nations Conference on Human Rights addresses gender-based violations which include female genital mutilation. The UN adopts the Declaration on Violence Against Women which also encompasses female genital mutilation and other traditional practices harmful to women.

1994 93rd session of WHO Executive Board adopts resolution on traditional practices harmful to the health of women and children. The Programme of Action of the International Conference on Population and Development (ICPD) includes recommendations which commit governments and communities to take urgent steps to stop the practice female genital mutilation.

1995 The Declaration and Programme of Action of the World Summit for Social Development in Copenhagen refers to female genital mutilation, reinforcing the ICPD recommendations. The Platform for Action of the World Conference on Women in Beijing, includes a section on the girl child and urges governments, international organizations and nongovernmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child including female genital mutilation.

World Health Organization

August 1996
Female genital mutilation and the rights of women and the rights of the child

Female genital mutilation (FGM) is an issue of concern with recognized implications for the human rights of women and children. It is considered as a form of violence against the girl child, which affects her life as an adult woman.


FGM and health rights

The documented complications of FGM on women and their sexual and reproductive health violate health rights. Even if operations are done under hygienic conditions the potential loss of sexual function constitutes a violation of the right to physical and mental health. Health rights are guaranteed by the Universal Declaration of Human Rights (Art. 25), the International Covenant on Economic, Social and Cultural Rights (Art. 12), the Convention on the Rights of the Child (Art. 24) the African Charter on Human and Peoples' Rights (Art. 16 and Art. 21). Further, the equal right to health care is guaranteed by the Convention on the Elimination of All Forms of Discrimination against Women (Art. 12).

FGM and gender discrimination

FGM is linked to gender inequalities entrenched in the political, social, cultural and economic structures of societies in which it is practised. It is a reflection of the discrimination against women in both public and private life.

The most comprehensive instrument on women's rights was adopted by the United Nations General Assembly in 1979 as the Convention on the Elimination of All Forms of Discrimination against Women. This Convention constitutes an international "bill of rights" for women. And it also sets up an agenda for national action to end discrimination.

Several provisions of the Convention can be interpreted to require States parties to take action against FGM, namely:

- "to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women" (Art. 2.f);

- "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women" (Art. 5.a);

- "States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services including those related to family planning" (Art. 12).

FGM and the rights of the child

When performed on infants and children, FGM can be interpreted as a violation of the rights of the child guaranteed in treaties adopted by the United Nations and the Organization of African Unity (OAU). The Convention on the Rights of the Child protects the rights to gender equality (Art.2), to be free from all forms of mental and physical violence and maltreatment (Art. 19.1), to the highest attainable standard of health (Art. 24.1), and to be free from torture or
cruel, inhuman and degrading treatment (Art. 37.a). Article 24.3 of the Convention explicitly requires States to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children.

Progress on the implementation of the Convention is monitored by a Committee on the Rights of the Child consisting of 10 elected experts with recognised competence in the field covered by the convention. The Committee considers reports that States Parties to the Convention submit 2 years after ratification and every 5 years thereafter. Specialized agencies of the UN are able to attend meetings of the Committee. Other competent bodies including NGOs in consultative status with the UN and UN organs can submit pertinent information to the Committee and be asked to advise on the optimal implementation of the Convention.

FGM and the 1993 World Conference on Human Rights

A milestone was achieved in efforts to eliminate FGM when the World Conference on Human Rights urged Governments to intensify their efforts for the protection and promotion of human rights of women and the girl child, stressing that gender-based violence including that resulting from cultural prejudice is incompatible with the dignity and worth of the human person and must be eliminated.

FGM and the work of the UN Committee on the Elimination of Discrimination Against Women (CEDAW)

The implementation of the Convention is monitored by the Committee on the Elimination of Discrimination against Women (CEDAW), established in 1982. The Committee convenes once a year to evaluate the progress made in the countries that have ratified or acceded to the Convention. For that purpose, these countries compile national reports on the measures they have taken to comply with the treaty's obligations.

On the basis of these reports, the Committee members might suggest areas for further action by specific countries. The Committee's mandate also allows for making general recommendations to the States parties for eliminating discrimination against women.

This group of independent experts, has called on governments to eliminate FGM as a threat to women's health and well being. The Committee urges States to:

- collect and distribute information on FGM through universities, medical associations and women's groups;
- support national and local women's groups working to eliminate FGM;
- encourage politicians, professionals, and religious and community leaders, the media and artists to cooperate in influencing attitudes supporting elimination of the practice; and
- introduce educational and training programmes about the problems arising from FGM.

CEDAW has also recommended that strategies for eliminating the practice be included in national health policies.

In 1992, CEDAW called on governments to modify practices which constitute discrimination against women, involve violence or coercion and which are perpetuated by traditional attitudes through which women are regarded as subordinate to men or as having stereotyped roles.
A WHO Technical Working Group on Female Genital Mutilation met in Geneva 17-19 July 1995. The Technical Working Group was convened to draw attention to female genital mutilation and its health consequences, to begin the process of developing standards and norms and to make recommendations for further activities. Its specific objectives were:

- to review existing knowledge about female genital mutilation;

- to recommend for adoption standard definitions and a classification for the different types of female genital mutilation;

- to consider appropriate research methodologies and formulate guidelines for data collection and analysis;

- to discuss the effectiveness of different types of interventions for the prevention and elimination of female genital mutilation;

- to identify needs and intervention strategies for future action.

The Technical Working Group adopted a definition and classification that encompasses the physical, psychological and human rights aspects of the practice. This is outlined in the fact sheet entitled "The Practice". The definition has been submitted for inclusion in the next revision of the International Classification of Diseases.

The Group also made several recommendations for further research, advocacy and information, education and communication, national policies and legislation, and training, in order to accelerate the elimination of female genital mutilation.

The Technical Working Group identified the following areas as needing research:

- the magnitude (prevalence, incidence and recurrence rates) of the different types of female genital mutilation in communities where it is practised and its physical, mental and sexual complications;

- approaches for the management of the physical and psychological consequences, including counselling, for those who have undergone female genital mutilation;

- customs, traditions and beliefs surrounding the practice of female genital mutilation, including studies of those who have stopped practising it and are opposed to it, reasons for continuing the practice and factors precipitating change within groups;

- evaluation of the effectiveness of ongoing approaches for the prevention and elimination of the practice;

- the development and pilot-testing of information, education and communication (IEC), advocacy and training materials;
the identification and evaluation of existing mechanisms and organizations that might be helpful in campaigns for the prevention and elimination of female genital mutilation;

evaluation of the effectiveness of existing legislation covering female genital mutilation and ways of integrating legal and human rights aspects into activities against female genital mutilation.

On advocacy and information, education and communication, the Technical Working Group made several recommendations which include the need to:

- develop coalitions of advocates;
- develop advocacy and IEC messages which are research-based, use the WHO definition, and are accurate, clear, consistent and simple and are formulated in consultation at local level to take account of sociocultural conditions and community concerns.

On national policies and legislation, the key recommendations which emerged from the WHO Technical Working Group are as follows:

- female genital mutilation should be addressed as a public health issue, and activities for its prevention and elimination should be incorporated into existing institutional budgets and health education curricula, including reproductive health, safe motherhood, national HIV/AIDS control programmes and school health programmes;
- policies should set clear goals, targets and objectives, and a schedule for their attainment;
- policies should focus on prevention and rehabilitation, with emphasis on advocacy and IEC, and should not legitimize, institutionalize or medicalize any type of female genital mutilation;
- legislation should be developed and introduced in consultation with the various groups concerned. However, legislation alone is insufficient. It should be accompanied by appropriate information, education, training and other activities.

As regards training, the Technical Working Group recommended that training on FGM should:

- be based on a needs assessment and should be integrated with existing programmes;
- equip the various categories of service providers concerned, particularly nurses, midwives and traditional birth attendants and healers, with appropriate knowledge, attitudes and skills to enable them to work for the prevention and elimination of female genital mutilation and to provide clinical and psychological care and support for girls and women who have undergone the procedure, taking due account of cultural and personal sensitivities.

The Technical Working Group on Female Genital Mutilation concluded the meeting by making several recommendations to WHO. The salient points are as follows:

- WHO should continue to develop standards and norms in the area of female genital mutilation. It should submit the new definition and classification of female genital mutilation for consideration for inclusion in the next revision of the International Classification of Diseases.
WHO should develop and disseminate research guidelines and protocols.

WHO should promote and coordinate relevant research on female genital mutilation in collaboration with governments, international agencies, scientific institutions, nongovernmental organizations and other interested parties.

WHO should develop and test training materials suitable for use at regional and country level and promote their incorporation in training curricula.

WHO should seek to strengthen collaboration between French-speaking and English-speaking countries in their work against female genital mutilation. It should support the provision of research, information and training materials in several languages.

WHO should collaborate more effectively with other United Nations agencies concerned with female genital mutilation, such as UNICEF and UNFPA.

WHO should promote the establishment of effective partnerships with and between relevant nongovernmental organizations.


World Health Organization

August 1996
Female Genital Mutilation:

INTERNATIONAL NGOS AND ADVOCACY GROUPS ACTIVE IN THE FIELD OF FGM

This is a selected list of NGOs and advocacy groups. An attempt has been made to identify groups with interest and activities that reach beyond their national boundaries. As new organizations are rapidly being formed to address female genital mutilation and increasing numbers of health and human rights organizations are devoting attention to it, this list cannot be comprehensive.

AIDoS (The Italian Association for Women in Development)
Via dei Giubbonari, 30
00186 Rome
Italy

Anti-slavery International
Unit 4
Stableyard
Broomgrove Road
London SW9 9TL
United Kingdom

Amnesty International*
International Secretariat
1 Easton St
London WC1X 8UJ
United Kingdom

CAMS (Commission Internationale pour l'Abolition des Mutilations Sexuelles)*
BP 11.345
Dakar
Senegal

CEDPA (The Centre for Development and Population Activities)
1717 Massachusetts Avenue, NW
Suite 200
Washington D.C. 20036
USA

Defence for Children
International Section
PO Box 75297
NL - 1070 AG Amsterdam
The Netherlands

Equality Now
226 West 58th Street
New York
NY 10019
USA

FORWARD International (Foundation for Women's Health, Research and Development)*
Africa Centre
38 King Street
London WC2E 8JT
United Kingdom

IAC (Inter-African Committee on Traditional Practices Affecting the Health of Women and Children)*
PO Box 3001
Addis Ababa
Ethiopia

IPPF (International Planned Parenthood Federation)*
P.O. Box 759
Inner Circle, Regent's Park
London NW1 4LQ
United Kingdom

Minority Rights Group International
379 Brixton Road
London SW9 7DE
United Kingdom

(* = and national affiliates)
NGO Working Group on Traditional Practices Affecting the Health of Women and Children
147 rue de Lausanne
1202 Geneva
Switzerland

PATH (Program for Appropriate Technology in Health)
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1990 M Street, NW
Washington, D.C. 20036
USA

Redd Barna (Norwegian Save the Children)
Grensesvingen 7
Box 6200
Etterstad 0602
Oslo 6
Norway

Rädda Barnen (Swedish Save the Children)
Torsgatan 4
S-107 88 Stockholm
Sweden

RAINBÒ (Research Action Information Network for Bodily Integrity of Women)
915 Broadway
Suite 1603
New York
NY 10010-7108
USA

Terre des Hommes
31 Chemin Frank Thomas
1208 Geneva
Switzerland

Wallace Global Fund
1120 19th Street, NW
Suite 550
Washington, D.C. 20036
USA

WIN News (Women's International Network)
187 Grant Street
Lexington, MA 02173
USA

Women Living Under Muslim Laws
International Solidarity Network
Boite Postale 23
34790 Grubes
France

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INTER-AFRICAN COMMITTEES/
NATIONAL COMMITTEES/
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CONGO
Mme Germaine Onanga
Comité National des Droits de la Femme
B.P. 686
Brazzaville

COTE D’IVOIRE
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Comité national de lutte contre
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The Egyptian Society for the Care of
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OTHER ACTIVE GROUPS AND CONTACT PERSONS IN AFRICA

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*World Health Organization*

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Fatima is 30 years old and married to a university graduate. She was infibulated at the age of 9 and had to be hospitalised for 7 days for care and blood transfusions. She was unable to urinate and, when her wound was reopened in hospital, a large blood clot was found to be causing the blockage.

Amina was married at 14. Penetration took 15 days with much pain and bleeding and intercourse continued to be painful for another 3 months. She has 5 children, two of them girls. After each birth she has had herself re-infibulated to a 2 cm opening. Her husband wanted her very small, she explains, but she did not agree to a pinhole size infibulation. "Enough is enough," she says, "I don't want any more pain."

The first of Hudeya's two daughters has been infibulated and nearly died of blood loss. She has decided not to treat the second one this way, explaining that, in her family, there have been too many such complications, among her sisters and their daughters as well. Her husband agrees with her and they plan to send their daughter away to school when the time comes, to remove her from members of the family who do not agree with their decision.

Mariam is a 24 year old nurse. At the age of 4 she was infibulated but she remembers little of the experience except that she cried a great deal. Her marriage was arranged for her at the age of 16. In the village where she lived, custom demanded that the husband should penetrate his bride in a single night. The experience was so brutal for Mariam that she was terrified of her husband for half a year afterwards. She adapted to living with him to a degree but was never able to enjoy sexual relation with this husband. She begged her family to arrange a divorce for her and this was done after the birth of a son when she was 17. Mariam was resutured to make her ready for her second marriage, but this time a 2 cm opening was left. She married a man she had loved since childhood and she experienced only a day of pain with penetration. He is patient and gentle, she says, and she feels secure and loved with him.

Asha has one daughter whom she intends to have infibulated but in a less severe way than herself, leaving a larger opening. She says she does not want her daughter to suffer as she did with her first husband, but this decision is a source of disagreement with her mother-in-law. Asha is afraid for her daughter because she
worries that her mother-in-law may have the procedure done to her daughter when she is away.

Zuraya has had little education. She was infibulated at the age of 7 by a traditional birth attendant, without any anaesthetic, and says that the pain was so great that she bit the block of wood that was placed in her mouth in two. She could not pass urine for two days. Her labia majora and part of the labia minora were left after the operation but she was infibulated to 2 cm. This was the technique used by the traditional birth attendant practising in her village. Later, another TBA came to the village who performed total excision, and many people returned to this older custom, feeling it was more "proper".

When Nafisa was 9, a grapefruit sized, painful, infected dermoid cyst developed at the operation site. She could not walk or sit until the cyst was removed surgically.

Huda has six daughters and three sons. She describes how, at the birth of her first child, she was hung from the roof of the hut by her wrists, "in the old way", while the TBA squatted in front of her and cut her open. She was resutured after each child to a 1 cm opening. Repenetration takes up to 2 months and is very painful. Four of her daughters have been infibulated as she was, and she intends to do the same with the others. She feels that her own mutilation has created much havoc in her life, but sadly states that she must do the same to her children because "it is the custom".

Zainab is a 22 year old woman whose parents emigrated to live in a European country. She tells her story in her own words:

"I was born and brought up here, so I've been here all my life. I went to school and college here. I was 8 years old when I was infibulated. My two sisters and myself and my mum went to visit our family back home. I assumed we were going for a holiday.
Anyway, they didn’t tell us straight away that we were going to be infibulated, but a bit later we were told. The day before our operations were due to take place, another girl was infibulated and she died because of the operation. We were so scared and didn’t want to suffer the same fate. But our parents told us it was an obligation which they had to fulfil, so we went.

We fought back. It was terrible, we really thought we were going to die because of the pain having no anaesthetic. We each had ladies holding us down. You have one lady holding your mouth so you wouldn’t scream, two holding your chest and the other two holding your legs. It’s the only way they can operate.

After we were infibulated, we had rope tied across our legs so it was like we had to learn to walk again. We had to try to go to the toilet, if you couldn’t pass water in the next 10 days that was a sign that something was wrong and that there was a risk of death. We were lucky I suppose, we gradually recovered and didn’t die like the other girl.

But the memory and the pain never really goes. I was really young, you know, what could I do? One of my friends was infibulated at a very late age, in her teen years, so she has a very strong memory of what happened to her and she suffers from nightmares constantly. I don’t see myself as getting married. I always feel, "Oh, I’m going to have to be reopened and to have that operation again. So I won’t even think of getting married."

_Sofia_ is 35 years old, a civil servant, who had decided with her husband that their three daughters should not be subjected to the mutilation that she herself had undergone:

"They were born in Europe, while my husband and I were finishing our studies. When we returned to home, my mother was the first to ask me if I had had my children excised and infibulated. I replied "no", and stated explicitly that I had no intention of having it done. It was during the holidays. Having found work, I often left my children at my parents and came to fetch them at the weekend.

One day, on the way back from work, I went to say hello to them. I was astonished not to see my daughters. Normally they would rush out to greet me. Then I asked my mother where they were. "They’re in that room," she replied, indicating the place where they usually slept. I wondered if they were sleeping or just didn’t know that I was there. I went into the room. There they were on the floor, on mats covered with cloths.

At the sight of their swollen faces and eyes full of tears, I gasped and cried out: "What is it? What’s happened to you my children? But even before the little
occupants of the room could reply, the voice of my mother reached me: "Don't you go disturbing my grandchildren. They have been excised and infibulated this morning."

Om Gad is from a rural village and the wife of a garage-keeper.

"There are some occasions in life which are unforgettable. One of these was my circumcision.

I was nine years old when I was circumcised. One day, cousin Zahra came running up to me and said, "Come on, come on, we are going to be circumcised." She was happy. We are told it's a big event. Our parents prepare us by saying, "We'll slaughter a chicken for the occasion. We'll feed you sweets," and so we children rejoiced at all these possibilities.

Although I'd heard a child scream being circumcised, I wasn't afraid. Some of our cousins had already been circumcised when we arrived at the house. They were sitting there laughing. It only hurts the moment the razor hits, then the stinging goes away.

My cousin Zahra sat first. I heard her cry out. I was a little frightened then. I said, "I don't want to be circumcised." So they got hold of me, and my maternal uncle's wife sat behind me and held my legs apart. I was sitting on the floor on a piece of rug. The barber stood in front of me and did the operation. I cried out once, then they made a bandage of cotton and gauze and placed it between the "sisters" (labia) and said, "Don't bring your legs together or the wound will heal over. If this happens, when a woman gives birth, she is torn."

We did as we were told. Every day we washed the wound with water and disinfectant and then sprinkled a powder made from the little insects, soos, which nest in the dried twigs of the cotton plant when it is stored on the roof of the houses in the village. We didn't use mercurochrome or sulphur powder as they do now.

Circumcision is absolutely necessary. I don't know why but it is a tradition. These parts in a woman grow bigger the older she gets. We found this custom handed down to us from our grandfathers, and theirs, and from those of whom we are not even aware, and those we no longer know. We emerged into this world and found this habit already existed. It's just so. My people do this, and so I must do like they do."

Sources

The Forty-seventh World Health Assembly,

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

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


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

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

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

2. URGES all Member States:

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

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

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

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

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

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

Twelfth plenary meeting, 10 May 1994
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