

How To Guide

REPRODUCTIVE HEALTH IN REFUGEE SITUATIONS



**From Awareness
To Action**

**Pilot Project
To Eradicate
Female Genital
Mutilation**

Hartisheikh, Ethiopia
May 1998
UNHCR



The How To Guide



This is the second in a planned series to document field experiences on **how** various actors undertook the implementation of Reproductive Health activities. The document was compiled from field reports, discussions with key actors and selected telephone interviews.

The audience of the guide is field-based refugee workers including UN system, NGOs and governments staff in the health, community services, protection and other related sectors.

Each **How To Guide** documents one field experience which demonstrates an innovative approach to a particular area of RH. It documents how one refugee situation undertook an activity. There are many more such examples. The **How To Guide** is not meant as a definitive recommendation on how to do something, but should be used and adapted as appropriate for each refugee setting.

It is hoped that the **How To Guide** series will stimulate a sharing of other similar examples of how various refugee situations are undertaking activities to strengthen responses to the reproductive health needs of refugees.

If you have any questions, please contact the specific actors directly involved in the example given. In this case, please direct your queries to the UNHCR, Addis Ababa, Ethiopia, e:mail ethab@unhcr.ch, or the other actors mentioned in the document.

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1 What Is the Purpose of This How To Guide?

This HOW TO GUIDE describes activities to eradicate Female Genital Mutilation (FGM) with Somali refugees living in Hartisheikh Camp and the surrounding national population in Eastern Ethiopia during 1996-97. It specifically describes an, initially, six month pilot project which actually ran for more than one year, that was undertaken by the National Committee on Traditional Practices in Ethiopia (NCTPE) with support and guidance from UNHCR and in coordination with Ethiopian authorities. The GUIDE also provides useful information on how other countries are working to eradicate FGM, provides UNHCR's policy on FGM as well as references and resources for further reading.

2 Who Is This Guide For?

This guide is for anyone working with refugees among whom female genital mutilation (FGM) is the custom. In virtually every country where FGM is practised there are people working for its eradication, in a host of different ways. All have valuable things to say about how to address this most sensitive subject, but this guide is an attempt to share the thinking behind, and lessons learned from just one such project in a refugee situation in Eastern Ethiopia. After reading the guide, users should be able to:

- ▶ assess the situation regarding FGM in a given setting
- ▶ identify key players to address the issue
- ▶ develop a plan of action and identify the steps needed to carry it out
- ▶ set the criteria for recruiting staff
- ▶ organise training
- ▶ evaluate activities

3 What Is UNHCR's Policy on FGM?

In December 1997, UNHCR issued an internal policy statement, known as an Inter-Office Memorandum (IOM 83/97)/ Field Office Memorandum (FOM 90/97) which set out UNHCR's policy on harmful traditional practices including FGM.

UNHCR's position is:

UNHCR's concern with harmful traditional practices is an integral part of its protection responsibility for persons under its mandate. UNHCR staff have an obligation to uphold those rights and freedoms enshrined in international human rights instruments. A harmful traditional practice which violates the individual rights of refugees will normally require the intervention of UNHCR. Inaction in these cases can result in unnecessary injury and even death.

UNHCR's policy on harmful traditional practices is in line with the recently issued Policy Paper on UNHCR and Human Rights and the guiding principles outlined in UNHCR's Policy on Refugee Children, namely: "In all action taken concerning refugee children, the human rights of the child, in particular his or her best interests, are to be given primary consideration."

UNHCR fully endorses the Joint Statement of WHO, UNICEF and UNFPA on Female Genital Mutilation which expresses a common purpose in supporting the efforts of governments and communities to promote and protect the health and development of women and children. The joint statement also provides useful strategies for national and community action and international approaches and actions to eradicate FGM. (See Annexe 1 for the IOM/FOM)

BOX 1: Definition of Female Genital Mutilation

The term Female Genital Mutilation has replaced "female circumcision" as a more accurate description of the operation, which is not the same as male circumcision. FGM involves partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.

There are four types of FGM:

- the removal of the prepuce, or hood, of the clitoris is sometimes known as "Sunna";
- clitoridectomy—the removal of the whole of the clitoris, not just the prepuce;
- excision of the clitoris and the labia minora;
- excision and infibulation involves the removal of the clitoris, labia minora and labia majora, and the stitching up of the two sides of the vulva, often using thorns, to leave a tiny opening for the passage of urine and menstrual blood. This is sometimes known as "pharaonic circumcision".

4 What Is the Refugee Setting for This Project?

Hartisheikh is the largest of eight camps housing Somali refugees in Eastern Ethiopia. The influx of refugees to this arid corner of the country began in 1988 with the collapse of Somalia into civil war. Since then there have been waves of refugees in both directions fleeing civil strife in both countries. At its peak, the refugee and returnee population in the area numbered about 600,000, and Hartisheikh housed around 200,000 people. As of May 1997 the population of Hartisheikh was 58,000. The people on both sides of the national border are Somali-speaking and share the same customs. The camps are not "closed"; refugees are free to interact with the local population at all

levels. There are no restrictions on economic activity, though there are extremely limited opportunities for formal employment in the area. The camps have an air of impermanence as people intend and expect to go home as soon as it is safe to do so. A pilot phase of voluntary repatriation from two of the camps took place in February 1997, and repatriation from other camps is expected to take place soon. Some refugees have suffered repeated loss of possessions and livelihood, having fled their homes more than once.



A typical Somali refugee camp in Eastern Ethiopia.

Hartisheikh refugee camp has two primary schools, catering for grades 1 to 6 and are attended predominantly by boys. In addition there are 7 private schools, where young refugees teach for a small payment from the students, and 23 Koran schools. There are no other organised activities for the youth. The camp has 7 mosques, two health centres, two food distribution centres and three markets.

5 What Is the Administrative Set-up in Hartisheikh?

The refugee camps are managed by a government organisation, the Administration for Refugee and Returnee Affairs (ARRA), funded by UNHCR. ARRA has a regional office in Jijiga, the capital of the Somali region (region 5) and an office in each camp. Anyone providing specialist services or wanting to run programmes in the camps must have a formal agreement with ARRA. At present there are very few NGO activities in the camps. Handicap International is implementing rehabilitation services and a mine awareness programme, and Save the Children UK began implementing a joint UNHCR/UNFPA reproductive health project in November 1997. The primary health care programme is run by ARRA, as are the primary schools. UNHCR administers the eastern programme from Sub-Office Jijiga (SOJ).

In each camp UNHCR is represented by a field assistant who has an office and residence near or in the camp. The main task of the field assistant is to monitor assistance and protection to the refugees provided by ARRA. One of the field

BOX 2: Refugees Points of View on FGM

"We have heard from the religious people that this harmful tradition is not good. We have had meetings, and have learned the health consequences of infibulation. After I learned this, I stopped performing infibulations. For a while I performed only Sunna, but now I started doing it again because I don't have money." *FGM Practitioner*

"When I used to do infibulations I was the mother of all mothers. All the women would stand when I walked into their houses, they respected me, shook my hand. I was even more respected than a religious leader. But now that I started performing this Sunna, they only give me a little money and maybe something to drink and eat. They don't respect me as they did before. When I try to tell them that Sunna is better, that Sunna is right, they just give me a little money but they don't respect me anymore in the same way." *FGM Practitioner, 55.*

"All the women remember the dreadful act of cutting and recutting of the genitals for marriage and delivery purposes, but they will only leave their daughters uncircumcised when they are assured that their daughters will not face problems." *Baseline Survey, 1993.*

"(The men) said that women are not responsive to their sexual needs because their (women's) sexual desire is affected by the circumcision. Men sympathize with women and also share the problem caused by the repeated cuts women have to undergo during marriage and delivery. A bride goes to her marriage bed with a fresh wound from the genital opening she undergoes as part of the preparatory ceremony for marriage...Men blame cultural norms that demands them to inflict additional pain on their brides on their wedding nights. They blame the culture because it also has a mechanism of enforcing the practice as old ladies check the bride on the morrow to confirm that the groom has done his duty. Failure to conform to cultural values expose the groom to slanders and defamation." *Baseline Survey, 1993.*

assistants is also focal point for women, children and vulnerable groups and covers all camps in that capacity. The field assistants are supervised by Sub-Office Jijiga Programme Officer. Sub-Office Jijiga also has international staff for management, protection and repatriation. UNHCR has a regional liaison office in Addis Ababa (RLO) and ARRA head office is also based Addis Ababa.

6 What Are the Customs Regarding FGM Among the Refugees and the Local People?

It is estimated that at least 99% of the adult women in Hartisheikh and surrounding areas have undergone FGM as children, typically around the age of 7 years. The vast majority have been infibulated, since this is the custom of the region. Practitioners are older women for whom the practice is a source of income and status. At the beginning of 1996 there were estimated to be more than 20 such practitioners among the refugees in Hartisheikh. Many people, especially among educated Somalis, now recognise FGM is harmful and wrong and they are against it in principle. But deciding to protect their daughters from the practice is another matter: the pressures to conform to ancient tradition are many and strong.

They include:

- ▶ fear that their daughters will be stigmatised as “unclean” or “sexually forward” and not accepted by society (to be called “uncircumcised” is still a terrible insult);
- ▶ fear that their daughters will not be able to find a husband—and most will have few options for survival or social status outside of marriage;
- ▶ the belief that the Koran mandates the practice of FGM;
- ▶ the influence of older women, especially grandmothers and traditional practitioners, who may still believe implicitly in the practice and whose opinions and wishes are traditionally respected;
- ▶ the fact that virginity in an unmarried woman is highly prized, and a matter of honour to her male relatives and prospective husband. Also, if a husband finds out that his bride is not or not sufficiently infibulated, he may divorce her and claim back the bride price.



A vast majority of Somali women have undergone FGM, typically around the age of seven.

7 What Is the Legal Status of FGM in Ethiopia?

Though FGM is not mentioned explicitly, the law and the Constitution in Ethiopia provide protection to women and girls against the practice. According to the Ethiopian Constitution “the state shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited.” However, the law is rarely invoked, and the experience here and in many other countries shows that it has to be used with extreme sensitivity, or it can do more harm than good (see Box 3). At the first workshop in Hartisheikh, an Ethiopian official informed her audience that FGM was illegal in the country and anyone practising it could be prosecuted. Her words caused fear and anxiety in the camp, and were unhelpful to the project whose staff had to win back the refugees’ trust before they could approach the issue effectively.

BOX 3: FGM and the Law: Lessons From Elsewhere

- As this Guide is being prepared, the Organisation of African Unity is drafting a legislative framework against FGM for all its member states, with violence against women as the focus. Laws have great value in underpinning education efforts and giving credibility and authority to those working to eradicate the custom. However, criminalizing those who practise FGM and threatening them with punishment can drastically inhibit discussion about this extremely complex phenomenon, deter people from coming forward with their personal concerns, and force the whole issue underground. (See Annexe 2)
- In Kenya, Somali refugees, who were told just before they were to leave for asylum in Canada that circumcising their daughters was a criminal offence in that country, subjected all the young girls *en masse* to the operation before leaving Kenya. This is not an isolated incident, and the community’s response is one reason why so many countries fail to invoke existing laws in their anti FGM campaigns.
- Efua Dorkenoo, director of FORWARD (The Foundation for Women’s Health Research and Development) says that once a law is in place, those who have to confront the practice in the course of their work—such as health personnel, social workers, police officers, and teachers—should be given special training in all the issues involved, as well as directives and protocols to guide their professional response. This is the approach taken in the United Kingdom where large numbers of refugees from FGM-practising countries have settled.
- In Burkina Faso, grassroots activists frustrated at the slow progress towards eradication of FGM despite years of public awareness education and widespread condemnation of the practice, recently turned to the law. They have set up an SOS, a child protection helpline to which anyone fearing that a child is about to be subjected to FGM can telephone the police to protect the child. The great strength of this community support system is that it was a response initiated by the community itself, rather than being action taken from above.

8 How Did the Idea for the Pilot Project Against FGM Originate?

Already in the 1980s, before civil war broke out, certain women in Somalia had begun to campaign for the eradication of FGM. Their activities stopped with the upheaval of war, but some who arrived in Ethiopia as refugees had already been exposed to information about the harmfulness of FGM, even if they were not all convinced it should be abolished. In 1993 UNHCR invited the National Committee on Traditional Practices in

BOX 4: The IAC and National Committees on Traditional Practices

The Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children in Africa, is established in 1984, with its headquarters in Addis Abeba. The IAC is an umbrella organisation whose aim is to co-ordinate efforts towards the eradication of harmful traditional practices, including FGM. It is one of the most prominent actors in the world-wide struggle against FGM. In some 26 African countries National IAC Committees have been established with the objective to carry out IAC's work at national level. The NCTPE, the National Committee on Traditional Practices in Ethiopia, is one of these Committees and was the most obvious national partner to implement the pilot project in Hartisheikh.

Ethiopia (NCTPE), to conduct a survey of attitudes and practices in the Somali camps. As a result of the survey a project agreement was signed between UNHCR, ARRA and NCTPE to set up an IEC (Information, Education and Communication) campaign on FGM. The NCTPE employed one male field co-ordinator for the campaign, whose job was to raise awareness among the population in all eight refugee camps and surrounding communities in Eastern Ethiopia. The campaign started with a series of training programmes for TBAs (traditional birth attendants), some of whom also perform the FGM operations. Seminars for NGOs and government officials working with the local

people followed, as well as workshops for influential groups in the communities. The idea was that all these key people would spread the word in the normal course of their activities. The population and geographical area covered were very large. Moreover the IEC materials that were used by the NCTPE were developed in Amharic (Ethiopian official language) and were not culturally appropriate for the Somali refugee and local population. The IEC campaign was developed by NCTPE, without involvement of the refugees or local Somali population. Furthermore UNHCR was not involved in the design of the programme. During visits to the camps of the RLO Officer for Women and Children and the Sub-Office Jijiga Field Focal Point for Women, Children and Vulnerable Groups, it was felt that the campaign, which was not formally evaluated, had had limited impact.

The idea of having a pilot project focusing solely on FGM was discussed with and welcomed by the refugees. The idea for the pilot was to try to find ways, together with the refugees and culturally appropriate, of moving beyond IEC—concentrating activities in a more limited area to improve their impact—with the aim of establishing an FGM eradication programme for the whole area based on the lessons learned. The pilot programme was a joint effort of the NCTPE, UNHCR, and the refugees of Hartisheikh.

9 What Were the Aims of the Pilot Project?

The aims of the pilot project were:

- ◆ to develop, *together with the community*, a range of information materials and approaches that would be appropriate for a variety of audiences—e.g. teachers and schoolchildren, health personnel, including TBA's, young women, young men, adult women, and men, religious leaders, FGM practitioners etc. Besides written and pictorial materials (leaflets, posters etc.), the plan was to develop such things as drama, music, poetry, stories, a video, and audio cassettes for playing to people waiting for health care, water, food etc.;

- ▶ to develop strategies for taking the campaign beyond IEC. The pilot project was specifically set up, with the notion that awareness raising is not enough to change an age old tradition. People may well be aware of the harmfulness of FGM, but will still maintain the practice when the deeply rooted reasons and beliefs behind the practice are not being addressed. Hence the title of this guide: *From Awareness to Action*.

Ideas included:

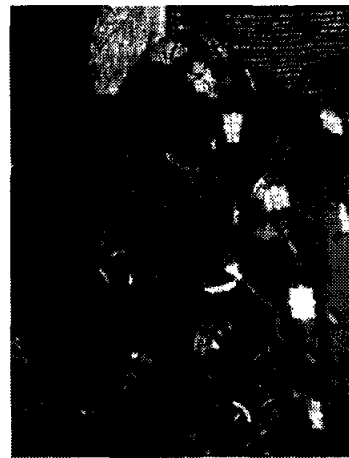
- developing alternative ceremonies to FGM for marking the “rite of passage” from childhood (see BOX 5);
- developing income generating activities for FGM practitioners that would give them alternative ways of making a living equal to the living they earn with the FGM practice, and retaining social status;
- setting up mechanisms within the community to support anyone wishing to challenge the status quo and refuse FGM for their daughters. Such a mechanism might be a “support group” of mothers or families undertaking to help each other resist pressure, or even force, to have their daughters undergo FGM.

BOX 5: Alternative Ceremonies in Celebration of Womanhood

In a number of countries where FGM is the tradition, some people have taken the initiative of replacing this harmful practice with alternative ceremonies for celebrating the transition to womanhood.

Examples include:

- In Kenya mothers in one community have started holding a ceremony at which girls are taken into seclusion at a certain age and taught about their culture, as is the tradition, but are given a small white, specially bound sacred book to treasure for life, rather than being subjected to FGM. The idea was developed with the community and supported by a Kenyan women’s organisation, Maendeleo Ya Wanawake.
- In Uganda a number of families of the Sabine people started to honour the transition to womanhood in a ceremony that replaces the girl’s childish clothes with the head-dress of an adult, and celebrates the occasion with feasting, singing and dancing, but without the FGM they used to perform.
- In Ethiopia one mother had described a ceremony she and some of her friends gave their daughters in which FGM was replaced with the symbolic “pinching” of the clitoris only. No cutting or bleeding occurred, and the occasion was marked with social celebrations. Inspired by the words of this mother, during the pilot project an alternative ceremony was developed whereby even the ‘pinching’ of the clitoris is not performed. Instead the traditional practitioner has a symbolic role and gets paid for her presence, in order to ensure her social status and income. The ceremony involves change of clothes, hairdressing, singing, a feast meal. Two video’s, in Somali and in English, have been produced on the pilot project, showing the alternative ceremony. Also on the Sabine example, a video has been produced (see Annexe 6).



Mother and daughter happy after alternative ceremony.

There is little information as to whether these alternative ceremonies have been sufficient to ensure social acceptance and marriageability of the girls, which will be the crucial test. It is therefore important that an alternative ceremony be carefully introduced and accompanied by a well designed campaign involving all levels of the community and focusing on the acceptance of girls who have not undergone FGM.

10 What Were the Project's Guiding Principles?

The guiding principles were:

- ▶ to address the issue in a non-judgmental way at all times;
- ▶ to treat all personal discussions with community members as confidential;
- ▶ to make it clear that all forms of FGM are unjustified and unacceptable threat to the health and integrity of girls and women, and that the objective is to eradicate the practice altogether, not simply modify it.

11 How Was the Project Organized?

The pilot project was launched in January 1996. The NCTPE was responsible for implementation in consultation with UNHCR which provided the funding. In addition, the NCTPE and UNHCR worked closely with ARRA which was responsible for the day to day running of the camp. Establishing a good relationship with the ARRA camp co-ordinator was vital to the project: all activities and movements required official sanction, and often written permits with official stamps. The goodwill of the local authorities—including the police and the military—was essential too in extending the project to the local communities outside Hartisheikh. Besides these official figures, there were other key people, such as religious leaders and the community elders, whose support for the project was essential.

The NCTPE project team operated out of the UNHCR compound in Jijiga, where they had a very moderate office. They had limited funds for office equipment and supplies, but were able to use UNHCR's facilities, such as the fax machine, if necessary. The NCTPE was required to submit monthly progress reports to NCTPE Addis Ababa, UNHCR SOJ and RLO and ARRA.

12 What Staff Did the Project Have?

The NCTPE employed three full-time staff exclusively for the project. They were a female project co-ordinator, a male assistant co-ordinator, and a vehicle driver. An NCTPE programme officer, based in Addis Ababa, was appointed to monitor the pilot project and keep its accounts. When they conducted workshops or seminars, the co-ordinators brought in outside experts such as a gynaecologist from the government health services in Jijiga, and other health department personnel who discussed the health implications of FGM. These extra facilitators received a honorary fee for their services.

13 How Were the Staff Recruited and Trained?

The NCTPE and UNHCR interviewed prospective candidates for the posts of co-ordinator and assistant together.

The most important criteria for selection were:

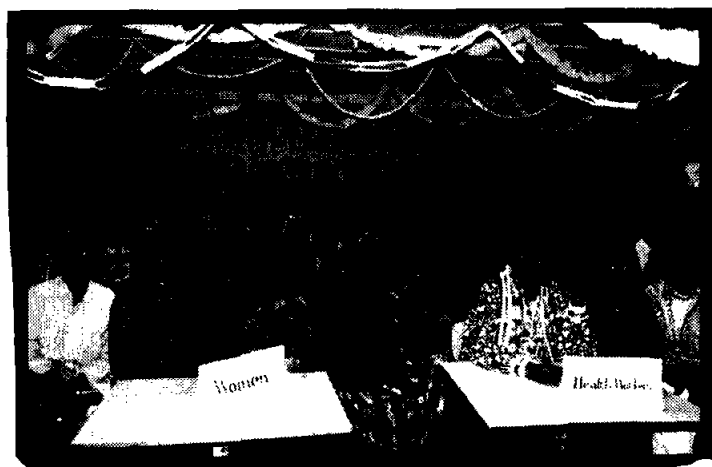
- ▶ deep commitment to combating FGM;
- ▶ knowledge of the language and culture of the people (both were of Somali culture and Somali-speakers, so were considered "insiders", acceptable to the people. Also the driver was selected on these criteria);
- ▶ the co-ordinator of the project should be female, taking into account the sensitive subject and the major target groups; women, girls, FGM practitioners;
- ▶ imagination, independence, and the strength of character to challenge the status quo;
- ▶ self-motivation;
- ▶ good communication skills.

The project co-ordinator was a trained nurse and midwife. The assistant co-ordinator had a degree in social work. Their salaries were based on the going rate for local staff working for NGOs in the area. Before starting work in the field, the two co-ordinators were given 10-12 days training in Addis Ababa by the NCTPE, which put them through their standard "Training of Trainers" (TOT) course. This covered the basic practices of FGM, the health implications, and the main groups to be targeted with IEC activities. Training materials for the course had been prepared by an Italian NGO, AIDOS, who had been working with NCTPE on the development of training material. Besides these materials, the NCTPE had a plastic model of the lower body with genitalia that were detachable so that the course instructor could show trainees what a healthy vagina looked like, compared to a mutilated one. Unfortunately this model was not available in the camps.

14 How Did They Operate?

The organisers of the project decided not to draw up a detailed workplan at the start, believing that defining the tasks too closely and specifying target groups would be a constraint rather than a help. The idea was that the project staff should have maximum freedom to seek out the relevant people to address and follow any leads that looked promising in working with the community. Moreover the project should be genuinely a project of the people, designed and planned with the refugees and not for the refugees. It was felt that a pre-structured workplan would hamper a sense of ownership of the project for the people.

The staff started with a series of workshops lasting 3-4 days and involving people from key target groups—women's committees, health workers and TBAs, religious leaders, FGM practitioners, school teachers, elders, and youth. Several workshops were necessary because of the numbers involved, but each workshop had a mixed audience, which, amongst other things, helped guard against groups passing blame for FGM on to others. Key elements of the workshops were the showing of the video 'Infibulation', and in-depth discussion of the health implications as described by the experts. Light refresh-



Community members participate in training workshop.

ments were provided and each participant received a small per diem allowance. They also received a "certificate of participation" at the end, bearing their own name and an official NCTPE stamp: this was a source of great pride, and a talking point in families when displayed on tukul (hut) walls. In all, 146 influential members of the refugee community participated in these workshops. A workshop was also held with local UNHCR, ARRA, government and NGO staff, at which the video was shown before wider discussion of the issues started.

In addition to organising workshops, the co-ordinators visited the camp and sought out people and groups with whom to discuss FGM. The project co-ordinator worked with the women, spending much of her time going from tukul to tukul to talk personally with people. She set herself the task of collecting personal stories from infibulated women. During home visits she would ask the women why they practised infibulation and if they said they believed it was a religious obligation, she would then accompany the women to a sheikh to discuss the issue with the religious leader. Sensitized religious leaders were very important allies in the pilot project. The co-ordinator met the younger girls (below 15 years) not in their homes but informally in the streets while they were fetching water. She visited newly married women and those delivering their first babies separately to discuss the personal problems caused by infibulation.

A very important and influential group that was not identified as a target group before the project started was 'female religious leaders', with whom the project co-ordinator worked closely. The female 'leaders' are mostly young educated women who have learned how to read and interpret the Koran. They can reach women much easier than male religious leaders do, since women usually do not go to the mosque to pray, but pray at home instead. The religious women gather weekly and made FGM an integral part of their discussions with other women of the community.

The assistant-co-ordinator would meet men and youths at social gathering places and discuss FGM informally while drinking tea together or chewing "khat" (a locally-grown herb that intoxicates). Both co-ordinators had to keep the community elders informed about their activities.

Besides discussion, they worked with the community on preparing information and education materials, including drama, songs, poetry, and stories. Some leaflets already produced by the NCTPE in Amharic and English were translated into Somali, and these and a poster were modified to make them culturally acceptable. In particular, the pictures showing full-frontal views of FGM gave offence, and were altered to present a side view of the child.

The co-ordinators also set up support groups within the community: young men, young women, and newly married women were organised to raise awareness of the issues among their peers.

15 What Materials Did They Have to Work With?

A video showing FGM

In April 1994 the video 'Infibulation' was made by the NCTPE, funded by UNHCR, that shows the FGM operation, without anaesthetics, of a 7-year old girl. The child's legs are spread open and strapped to the legs of another woman on whose lap she is sitting, so that she can be held firmly while the FGM practitioner operates. It is an extremely harrowing film that leaves its audience in no doubt of the fear, agony and disbelief of the little girl at what is happening to her. This is not sophisticated film-making since it was made on a shoestring, and the quality of the video is not very good; nor does it take the issue beyond a description of the practice to suggest ways of combating it.

Nevertheless, everywhere it was shown it had an extremely powerful effect on the men, especially, since they are not around when FGM is performed on their womenfolk and generally have little idea of the anguish it entails. On several occasions people were unable to watch the film, and walked out of the hall; some hid their faces; and a number of men stood up in the workshops and denounced the practice, vowing to protect their own daughters from it.



Anti-FGM drama performance.

designed to stimulate discussion among the audience. For each performance a selection of the two-hour material was made. The drama was performed during workshops and at the closing ceremony of the pilot project.

Community Drama

Another powerful medium was a drama on the subject. This drama was developed by a team of Somali professionals—playwright, actors, and musicians—based in Jijiga, who were invited by the project staff. The artists were paid for their services. The playwright spent time with the community, gathering personal stories and views on infibulation from a variety of different people, which he used for the storyline of the drama. The result was a two-hour show with a play, songs and dances. The show was

Educational Materials

When visiting people in the community, the co-ordinators had a limited range of leaflets and posters to assist their discussions. Some cultural appropriate material has been developed during the pilot project. But most of the material that the pilot would have liked to develop (school-educational material, good quality comprehensive posters, life story booklet) did not materialize, mainly because of lack of funds. Fortunately, towards the end of the pilot project, funds could be ensured (through UNHCR's Refugee Women Initiative Fund) to produce two video's on the project, 'From Awareness to Action', in English and in Somali (see Annexe 6).

16 What Support and Supervision Did the Project Staff Receive?

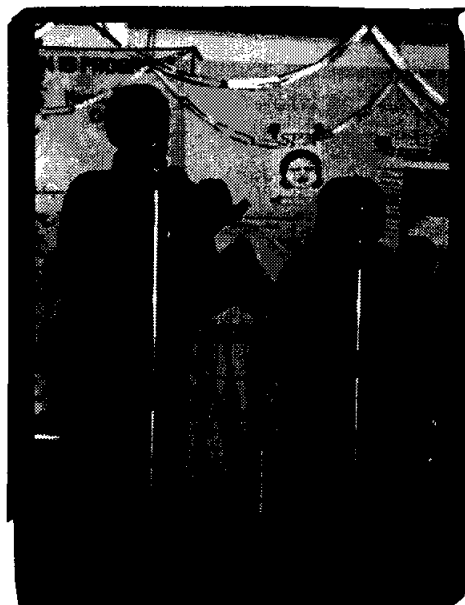
The Addis-based NCTPE programme officer visited the project area occasionally. However, responsibility for supervision fell mainly on UNHCR Addis-based women and children officer and SOJ's Field Officer focal point for women, children and vulnerable groups. They were strongly committed to the ideals of the project and offered constant support to the project staff. The UNHCR field assistant in Hartisheikh was also very committed and worked closely with the project staff. The UNHCR-RLO officer for women and children visited Jijiga monthly for about a week at a time, during which she monitored the project and discussed problems and ideas at length with the project staff and SOJ staff involved.

17 How Did the Community Participate in the Project?

As already stated, religious leaders (men and women) were especially active in the project, speaking out regularly about FGM in the mosques, at Koran schools and at social gatherings. Health staff in the camps were also closely involved, reminding people at any opportunity of the health implications. Community members helped with the translation of existing leaflets and posters into Somali and produced songs and stories of their own. And, as described, a local professional drama group was engaged in developing a play from the personal stories of the refugees, which proved extremely popular. Support groups undertook to raise the issue of FGM with their peers.

18 How Did the Pilot Project End?

The official ending of the pilot project was marked with a closing ceremony. Some 300 persons were invited, including representatives of all refugee groups (religious men, women, elders, women committees, TBA's, teachers, youths, parents, refugees from a neighbouring camp), local authorities, ARRA, NCTPE, WFP and UNHCR.



A religious leader and project co-ordinator at the closing ceremony.

The drama on FGM was performed and included music and dance. Speeches were given by ARRA, UNHCR, NCTPE and local authorities. From the refugees the following persons were given speeches and testimonies: a representative of the refugee committee, women committee, religious leader, mothers, youth and former FGM practitioner.

Testimonials From Refugees

The religious leader promised to select the parts from the Koran which would clarify that FGM is not a religious obligation and he would translate them into Somali.



Young man testifying that he will not marry an infibulated girl.

A young man testified that he would continue discussing with his peers as he has been doing ever since he learned about the harmfulness of FGM. Moreover he testified that he would never marry an infibulated girl and he would try to convince his friends to do the same.

All others testified that they would continue the struggle against FGM. Many aired their concern that the struggle would weaken and finally stop, if the community would not get the support through a project like this one. Both refugees and ARRA pleaded that the project would continue.

The closing ceremony was an important landmark for all parties involved. It showed that the issue of FGM was now being shared between all members of the community, both refugees and locals; population and authorities. It was a clear message to ARRA, NCTPE AND UNHCR that the community appreciated the efforts of tackling FGM and that these efforts should continue. During the ceremony the hope was expressed that now the community would be able to continue their campaign on their own. But, although the commitment was there, it was felt, as mentioned before, that the community would continue to need external support.

19 What Were the Costs Involved?

The project was funded by UNHCR's general programme funds under the Community Services special programmes for women (line item H). The total expenditures for the pilot project which ran for 15 months was 180,000 Birr or \$ US 28,000 (1US\$ = 6.3 birr). The regular costs of the programme included: co-ordinators' salaries ranging from 1,500-1,800 birr per month (\$230-\$280), office supplies, vehicle operation and maintenance and educational activities and training workshops. Facilitators who assisted in the educational activities received incentives between 60-200 birr (\$10-30). Costs involved in running training workshops included per diem payments of 30-40 birr per participant; refreshments, stationery and other miscellaneous running costs.

20 What Were the Results and Achievements of the Project?

For obvious reasons, measuring the success of the project in quantitative terms is extremely difficult, and most of the evidence of achievement is qualitative and anecdotal.

- ▶ When the project co-ordinator started her work in the camp the women would ask her: "You want to discuss our genitals? Are you mad?" and "Don't you have work to do? We could give you some!" She was offered nothing to drink when she visited their homes. Slowly she won their confidence. It is a measure of her success and that of her colleague that today the subject of

FGM is no longer taboo, and is widely and frequently discussed. Children sing songs about it; women have written personal stories and poems about it; and some young men have taken a stand against the custom by vowing publicly not to marry infibulated girls.

- ◆ Religious leaders, both male and female, have expressed thankfulness that the subject is in the open. They regularly address it during religious instructions, stressing that FGM is not a religious obligation but is in fact against the teachings of the Koran. As mentioned before, one influential leader has testified that he would mark out the texts in the Koran which condemn any practices that physically harm or mutilate women.
- ◆ Apparently, the debate has continued even though the pilot project has officially ended. This gives weight to the impression formed by some observers that the community had a strong sense of ownership of the anti-FGM activities; a sense that it was their own ideas that were being given expression, not outsiders' views being imposed on them, and that they were dictating their own pace.



- ◆ Songs composed by the community have been taped and are broadcast occasionally on Ethiopian radio. A shop owner in the area has asked for taped songs to sell. The drama has been particularly effective at raising awareness.
- ◆ A feasibility study into alternative income generating activities was carried out with FGM practitioners. Many practitioners have since approached the project staff to ask for help in finding a new livelihood.
- ◆ According to interviews among the women, no infibulations have been carried out since the project started, though some children have been subjected to "Sunna" instead. While the project staff neither support nor condone what practitioners believe to be a less harmful modification of tradition, they do understand the rationale behind it, and believe it is important to challenge this practice too in a non-judgmental manner.

BOX 6: FGM and Religion

It is commonly believed that FGM is a religious tradition. In reality, the origins of the practice are not known, but it is sure that the tradition, specifically infibulation, can be traced back more than 2000 years to the ancient Egyptians, thus being a pre-Islamic and pre-Christian tradition. Infibulation is also called 'Pharaonic circumcision' which shows its relation with the ancient Egyptian Pharaoh's.

FGM is performed by both Moslems and Christians. However, neither Koran nor Bible refer to FGM as a religious obligation. According to Islamic religious leaders, it is clear that infibulation is against Islamic ruling, with regard to milder forms of FGM, specifically Sunna. A debate is still going on. For more information on the debate on whether the *hadiths* (a *hadith* is a saying or action ascribed to the Prophet Mohammed or an act approved by the Prophet Mohammed) that refer to *Sunna*, are authentic, see: 'Islamic Ruling on Male and Female Circumcision' (see Annexe 6). In this WHO publication prominent Moslems conclude that FGM in any form is against Islamic ruling.

The strong advocacy role of religious leaders, both male and female, explaining that FGM is not a religious tradition, has proven of vital importance in the pilot project.

21 What Weakness and Problems Did the Project Encounter?

The main weakness of the project was that an efficient system for disbursing funds was not set up at the start, and this created major difficulties for the staff in the field. They did not have access to a vehicle until well into the project, and had to rely on chance lifts to make their visits. Frequently they were late for meetings that had been set up, which undermined the community's trust in them. The fact that the co-ordinators' salaries were not paid on time was a source of hardship and frustration; but it is a tribute to their commitment that their motivation remained strong despite their personal difficulties.

Another weakness was the fact that they did not have a fully-equipped office with computer etc. When writing their reports, the co-ordinators had to rely on the goodwill of UNHCR office staff to have them typed.

The conscious decision not to prepare a detailed workplan and to allow the project to develop spontaneously had weaknesses as well as strengths. As hoped, the flexibility did mean that groups and individuals were drawn into the project who might not otherwise have been identified—most notably the women religious leaders, who are an influential but largely hidden force in the community. However, it takes considerable skills in community development to make such an unstructured project work effectively. Although the subject was touched upon in their training, the co-ordinators were insufficiently prepared for this task. The project made slower progress than anticipated. Moreover, there was no mechanism, such as follow-up training for the project staff, for dealing with their gaps in skills as they became apparent.

As far as administering the project was concerned, the roles and responsibilities of UNHCR and the NCTPE were not clearly defined. There was, for example, confusion regarding keeping the accounts and monitoring the project. The problem stemmed partly from the fact that the NCTPE had set up a regional branch office based in Jijiga in November 1995, but it had encountered many obstacles, including high staff turnover, and never really became fully functional.

Despite the success of the project in overcoming taboos and challenging FGM, some refugees mounted a counter-campaign to try to prevent change. Among them were some practitioners, who were motivated to an extent by anxiety over the threat to their livelihood and social status. *Their opposition could perhaps have been overcome if more progress had been made in setting up alternative income-generating activities.*

In general, the co-ordinators felt handicapped by the lack of appropriate information materials for use with the community. They were hampered, too, in their activities by long delays in receiving documents or letters of authority confirming their official status. At one point the co-ordinators were unable to hand out certificates to workshop participants because the NCTPE were slow to provide an official stamp and signature. Besides disappointed participants, it meant that valuable opportunities for stimulating discussion about FGM were probably lost, since certificates on tukul walls seemed to be good talking points.

The project did make an attempt to go beyond simply awareness building to action. It, however, turned out to be necessary for many members of the community to continue raising awareness. It would need much more time than hoped for, before sufficient ground were laid for widespread action to eradicate FGM. Some members of the community, though, were ready for action, as is shown in the video 'From Awareness to Action', where, amongst others, a mother shows great pride in holding an alternative ceremony for her daughter (see Annexe 6).

22 What Would Be Done Differently Next Time?

If they were starting the project again, the organizers would:

- ◆ Draw up a detailed workplan, but allowing as much flexibility as possible.
- ◆ Ensure that roles and responsibilities of the different agencies and of all staff members involved are clearly defined.
- ◆ Push for a budget based on a project proposal, rather than trying to plan the project to fit in with an existing budget.
- ◆ Ensure that all logistics—especially disbursement of funds, transport, office accommodation and communications—are properly organised before the project was launched.
- ◆ Give clear guidelines for monitoring the project.
- ◆ Make provision for supplementary training for the staff as needs arise.
- ◆ More emphasis on identifying skills and resources available locally that could be tapped when necessary, e.g. people with expertise who could be called upon to help with training.
- ◆ Give much greater priority to exploring and implementing alternative income generating activities with FGM practitioners, which would secure the same economical and social status.
- ◆ Ensure that field staff have the documents and authority they need for their work from the beginning.
- ◆ Identify convinced opponents of FGM within the community and work closely with them on action, on moving beyond awareness raising.

23 What Is the Future of the Activities to Eradicate FGM?

The plan is for an initiative to be launched that covers all refugee affected areas of Eastern Ethiopia. It will have the same objectives and guiding principles as the pilot project and take full account of the lessons learned. Moreover it will look at other countries for ideas and lessons. The new campaign will be part of a comprehensive UNHCR/UNFPA supported Reproductive Health programme to be undertaken by SCF-UK in co-ordination with ARRA. This will help ensure it is well funded, receives vital technical support and is given due priority. It is clear from the pilot project that any initiative to overcome FGM needs deep and constant commitment from team members and strong budgetary and technical support in order to make progress.

The video 'From Awareness to Action' which shows the activities and achievements of the pilot project, will be used to encourage community based action to eradicate FGM.

It has been recognised that **there is an urgent need for similar activities to be conducted in Somalia and Somaliland (north-west Somalia)**, especially in the areas from which the refugees have come. The concern is that when they return home, the refugees will come under strong pressure from relatives they left behind, to follow tradition and have the young girls mutilated. Moreover, older women often take the initiative themselves in having granddaughters infibulated without any reference to mothers and fathers. They could seriously undermine eradication prospects unless they too are involved in a community based awareness and action campaign.

24 What Innovative Ideas Have Been Used Elsewhere to Combat FGM?

Refer to the References and Resources for More Information—See Annexe 6

- ◆ One activist has developed a fable which she uses to stimulate discussion in an audience about various issues of FGM. The story describes a society in which the tradition is to amputate one leg of young girls as an initiation ritual. All the same reasons are given for this practice as for FGM—for example, religious obligation, to curb sexual appetite, fear that the leg will grow to the size of a tree if it is not “excised”, to preserve cleanliness, virginity, chastity etc.—and the same people are responsible for carrying it out and perpetuating it. The story always raises laughter and recognition. Not only is use of the symbolic leg an effective way of addressing a taboo subject without mentioning genitalia, it is also a way of highlighting the crippling effects of a custom that many people practice without questioning. There are many entry points for discussion in the telling of the tale, which touches in particular on the powerlessness of women. (*Tradition Tradition*, by *Efua Dorkenoo*)
- ◆ In Australia campaigners are focusing on children’s human rights and child protection in challenging FGM among refugees. This is proving an effective entry point for discussion, though it has caused great anxiety among some who see it as divisive and threatening to family unity. (Ref.: *Efua Dorkenoo*)
- ◆ In Gambia, an economic development expert has been engaged in a research project for one year in which she has been exploring with the local FGM practitioners what the practice of FGM means to them in terms of income and status, and what ideas they have for replacing these. The researcher is Gambian and has the trust of the practitioners who are now ready to embark on alternative income generating activities.
- ◆ In Tanzania, three FGM practitioners in Dodoma region who have recognised the harm of their profession are now running a campaign themselves against FGM. They have bicycles for visiting the villages, where they have developed a programme of alternative income generating activities with other traditional FGM practitioners. The programme offers literacy training to all as a first step, and the aim is to develop activities that bring in substantially higher incomes than performing FGM. (Ref.: *FORWARD*)
- ◆ The lesson from all programmes engaged in finding alternative employment for practitioners is that they must be underpinned by painstaking research with the FGM practitioners themselves to ensure the new activities are feasible, sustainable, and really meet their needs for income and status. Top-down solutions do not work.



Annexes

ANNEXE 1

UNHCR IOM/FOM on Harmful Traditional Practices—December 1997



UNHCR/IOM/83/97
UNHCR/FOM/90/97

OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES

GENEVA

Inter-Office Memorandum No. 83/97

Field Office Memorandum No. 90/97

To: All Directors, Representatives, Chiefs of Mission and Heads of Sub-Offices and Field Offices in the Field
All Directors, Chiefs of Sections, Heads of Desk and Regional Legal Advisers at Headquarters

From: Dennis McNamara, Director, Division of International Protection

Ref: ADM 1.1, PRL 9.5, OPS 5.41 **Date:** 19 December 1997

Subject: UNHCR Policy on Harmful Traditional Practices

1. The purpose of this memorandum is to set out UNHCR's policy on harmful traditional practices and provide suggestions for their eradication (see Annexe 1). It should be read in conjunction with UNHCR's existing policies and guidelines in respect of refugee children and refugee women.

2 Refugees, coming from a diverse array of countries, cultures and backgrounds, bring with them norms and traditions which govern their societal behaviour. Customary or traditional practices are usually derived from social, cultural or religious values and relate to age, gender or social class. When these traditional practices are beneficial, or harmless, refugee communities should be encouraged to continue them as a way of maintaining their identity and preserving their culture. However, some traditional practices are harmful to health, well-being and development; most often, girls and women are the ones affected by harmful traditional practices.

3. Female genital mutilation (FGM) and early childhood marriages are examples of harmful traditional practices that are most prevalent among some populations of concern to UNHCR. These practices are internationally condemned due to the grave health risks they may entail as well as the human rights principles they violate. Other prevalent harmful traditional practices include son preference and dowry (see Annexe 2).

4. Whether a traditional practice is harmful should not be determined subjectively, but by reference to the physical and mental harm caused to the individual and in light of international human rights instruments. Harmful traditional practices violate a number of human rights enshrined in international instruments, including, for example, the right to security of person, the right to the highest attainable standard of physical and mental health, the right to freedom from all forms of physical and mental violence and maltreatment, the right to freedom from torture or cruel, inhuman, or degrading treatment and the right to life.

5. A number of international instruments specifically address the issue of harmful traditional practices. The Convention on the Rights of the Child (1989) requires states to take all effective and appropriate measures to abolish traditional practices that endanger the health of children. It also stipulates that in all actions concerning children, "the best interests of the child shall be a primary consideration". The Declaration on the Elimination of Violence against Women (1993)¹ states that violence against women includes: "physical, sexual and psychological violence occurring in the family, including... dowry-related violence,... female genital mutilation and other traditional practices harmful to women...". It stipulates that states should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination.² The Declaration urges states, as well as UN specialised agencies, to take specific action.³

UNHCR's Position

6. UNHCR's concern with harmful traditional practices is an integral part of its protection responsibility for persons under its mandate. UNHCR staff have an obligation to uphold rights and freedoms enshrined in international human rights instruments. A harmful traditional practice which violates the individual rights of refugees will normally require the intervention of UNHCR. Inaction in these cases may result in unnecessary injury and even death.

7. UNHCR's policy on harmful traditional practices is in line with the recently-issued Policy Paper on UNHCR and Human Rights⁴ and the guiding principles outlined in UNHCR's Policy on Refugee Children, namely: "In all action taken concerning refugee children, the human rights of the child, in particular his or her best interests, are to be given primary consideration".⁵

8. UNHCR fully endorses the Joint Statement of WHO, UNICEF and UNFPA on Female Genital Mutilation which expresses a common purpose in supporting the efforts of governments and communities to promote and protect the health and development of women and children. The joint statement also provides useful strategies for national and community action and international approaches and actions to eradicate FGM. (Please see the attached booklet.)

9. Actions to eradicate harmful traditional practices unavoidably conflict with strong cultural norms. While there are no hard and fast rules for dealing with these highly sensitive issues, the guidance contained in Annexe 1 entitled "Strategies to Eradicate Harmful Traditional Practices" may provide help for field workers. Moreover, UNHCR should promote and implement, where possible, the "Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children", adopted by the Sub-Commission on Prevention of Discrimination and Protection of Minorities in 1994 (see Annexe 3).

¹ The Declaration on the Elimination against Women (1993) is contained as Annexe 3 in the Guidelines on Preventing and Responding to Sexual Violence against Refugees.

² Article 2.

³ Articles 4 and 5.

⁴ See Memorandum by AHC, 7 August 1997.

⁵ UNHCR Policy on Refugee Children (1994), para. 26 (a).

10. Field staff are advised to plan their strategy to address the occurrence of these practices carefully, in conjunction with the refugee community, implementing partners and any other relevant UN organisations. Working with the refugee community is important to ensure measures taken are as effective as possible. In addition, local NGOs and the government, who may already have active campaigns in the country, and host communities could be involved. In particular, UNHCR staff could benefit from the expertise and experience of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children which has national committees (local NGOs) in 26 African countries and groups/sections in some European countries. Field staff should also become familiar with the national laws, if any, of the countries of origin and asylum which address these issues; in some countries where FGM takes place, laws prohibit the practice. Staff should consult Headquarters for advice where necessary.

11. In accordance with this policy, I am counting on UNHCR staff to ensure that measures are taken as far as possible to reduce or eradicate harmful traditional practices which affect persons of our concern. I draw your attention to the reporting requirements under the Annual Protection Reporting exercise, whereby field offices are obliged to report on problems relating to harmful traditional practices and concrete action taken by the Office to address them. Should you have any queries on the issue of harmful traditional practices, please contact the Legal Adviser (Refugee Women and Children), Standards and Legal Advice Section of the Division of International Protection at Headquarters.

Thank you for your cooperation on this important issue.

ANNEXE 1 of IOM/FOM**Strategies to Eradicate Harmful Traditional Practices**

The highly sensitive nature of dealing with harmful traditional practices is appreciated. While there are no hard and fast rules for eradicating these practices, the following may provide some guidance for field workers:

- ◆ Experience has shown that the initial step in addressing harmful traditional practices is providing education and information on such practices, with a particular focus on the negative consequences. However, action-oriented activities must follow on after initial awareness building.
- ◆ Campaigns to eliminate these practices are more likely to succeed and be accepted by the target population where they emphasise harmful health consequences rather than the legal or human rights aspects.
- ◆ It is necessary to have a thorough understanding of the nature and extent of the particular practice, including its roots and the social consequences it entails. This will obviously involve discussions with the refugees themselves. This underlies the importance of understanding the culture and habits of the refugees, as advocated under the People Oriented Planning (POP) approach.
- ◆ Focus on educating target populations (both men and women), namely religious leaders, traditional leaders such as chiefs, tribal elders and political leaders, traditional birth attendants, other health workers and the refugee women, men and children themselves on the harmful health consequences of these practices. In particular, it is very important to educate young girls on these issues.
- ◆ Promote, provide technical support, and mobilise resources for national and local groups that will initiate community-based activities aimed at eliminating harmful traditional practices. National Committees to eradicate harmful traditional practices exist in many countries and their expertise should be mobilised.
- ◆ In Kenya, local NGOs running campaigns aimed at eliminating FGM found it more acceptable by the refugees when the issue was dealt with in workshops covering other reproductive health issues as well, such as STDs, HIV/AIDS, and safe motherhood, rather than as a stand-alone topic. On the other hand, the campaign in Ethiopia began as a stand-alone model and was quite successful, being incorporated into a larger reproductive health programme only later. This illustrates the importance of tailoring each programme to the community involved.
- ◆ The "medicalization" of harmful practices such as FGM (i.e. supporting health care professionals to perform practices in health facilities under more hygienic conditions) should not be supported. Health workers in refugee situations must be aware that their involvement in such practices will not be tolerated and will lead to immediate termination of employment. In countries where FGM is practised, this should be stipulated in the employment contracts of health personnel.
- ◆ It is important that alternative income generating activities are found for those carrying out harmful practices such as FGM. Additionally, the community's respect for traditional practitioners must be maintained.

- ▶ Videos have proved an excellent way of demonstrating the harmful effects of some traditional practices. Videos depicting FGM actually being performed or a woman who has not undergone FGM giving birth have proved effective.
- ▶ The use of drama and other cultural activities, such as plays or songs, can also be an effective method of disseminating information on the negative effects of harmful traditional practices. The radio and local papers may also be used to help disseminate information on harmful traditional practices.
- ▶ In the Sudan, some health workers focus mostly on men in their campaign to save girls from FGM because their decisions may have the most influence. Men are often unaware of the exact nature and severity of the procedure.
- ▶ In Uganda, support for conducting the "rites of passage" ceremony is emphasised while stopping the harmful practices of FGM. Programmes encourage the continuation of the ceremonial aspects of the "coming of age" for young women, but eradicate the "cutting". In Sierra Leone, FGM is part of an initiation process for women's secret societies. These societies can be very important for women's self empowerment because they provide a support network and contacts for income generating activities. While it is important to encourage groups that empower women, it is equally important to encourage initiations which do not require FGM.
- ▶ The importance of educating girls and women cannot be underestimated. The incidence of harmful traditional practices, such as FGM and early childhood marriage, decreases with gains in female literacy. Therefore, promoting and supporting female education, both for adults and by the enrollment of girls in schools, should be a priority.
- ▶ Growing immigrant populations in industrialised countries have brought FGM with them to states where it was not usually practised. Canada, the US, Australia and many European countries now have laws prohibiting the practice. France has prosecuted a number of parents for subjecting their daughters to the procedure in France. UNHCR discourages informing refugees about the criminalisation of the practice in resettlement countries prior to departure, as this may result in mass FGM operations before resettlement occurs. Instead, the authorities of the resettlement country should be encouraged to inform refugees of these laws upon their arrival.

Field staff are advised to plan their strategy for eradication carefully, in conjunction with the refugee community, implementing partners and any other relevant UN organisations. Working with the refugee community is important to ensure measures taken are as effective as possible. In addition, local NGOs and the government, who may already have active campaigns in the country, and host communities could be involved. In particular, UNHCR staff could benefit from the expertise and experience of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children which has national committees (local NGOs) in 26 African countries and groups/sections in some European countries. Staff should consult Headquarters for advice where necessary. A document entitled "HOW TO GUIDE—From Awareness to Action: Eradicating FGM in Somali Refugee Camps in Eastern Ethiopia" (December 1997) detailing concrete methodology for conducting anti-FGM campaigns is available from Programme and Technical Support Section (PTSS) in Headquarters.

ANNEXE 2 of IOM/FOM

This Annexe provides information on the following harmful traditional practices:

- I. Female Genital Mutilation
- II. Early Childhood Marriage
- III. Son Preference
- V. Dowry

I. Female Genital Mutilation

Female genital mutilation (FGM), sometimes referred to as female circumcision, is a practice which involves the cutting away of all or part of the external female genitalia or all other procedures involving other injury to the female genital organs.

This procedure is performed on approximately 2 million girls each year. Most of the girls and women that have undergone FGM live in 28 African countries, although some live in Asia.¹ (See the attached map and statistics).

Definition

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

Classification

The different types of female genital mutilation known to be practised are as follows:

- | | |
|-----------------|---|
| Type I | Excision of the prepuce, with or without excision of part or all of the clitoris (also known as clitoridectomy). |
| Type II | Excision of the clitoris with partial or total excision of the labia minora (also known as excision). |
| Type III | Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation, also known as Pharonic circumcision). |
| Type IV | Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above. |

The procedures described above are irreversible and their effects last a lifetime.

¹ Female Genital Mutilation," Joint WHO/UNICEF/UNFPA statement, Geneva 1997, p.5. See also, Preliminary report submitted by the Special Rapporteur on violence against women, its causes and consequences, Mrs. Radhika Coomaraswamy, E/CN.4/1995/42, para. 146, which lists the countries where FGM is traditionally practised: Somalia, Djibouti, Sudan, Ethiopia, Egypt, Mali, the Gambia, Ghana, Nigeria, Liberia, Senegal, Sierra Leone, Guinea, Guinea-Bissau, Burkina Faso, Benin, Cote d'Ivoire, Tanzania, Togo, Uganda, Kenya, Chad, Central African Republic, Cameroon, Mauritania, Indonesia, Malaysia, Yemen.

Approximately 15% of women and girls subjected to FGM are infibulated, while the majority receive a clitoridectomy or excision. The incidence of infibulation is much higher in Djibouti, Somalia and northern Sudan, with a higher rate of complications. Infibulation is also reported in southern Egypt, Eritrea, Ethiopia, northern Kenya, Mali and Nigeria.²

There may be both immediate and long term health consequences to the practice of FGM. Immediate complications include severe pain, shock, haemorrhage, urine retention, ulcerations of the genital region and injury to adjacent tissue. Haemorrhage and infection can cause death. More recently, there have been concerns regarding the transmission of HIV/AIDS when a circumcisor uses the same unsterilized, sharp object to perform the FGM procedure on a group of girls or women one after the other.

Long term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction. Infibulation carries additional complications, including recurring infections and infertility. Complications during delivery are common. Closing of the vagina after birth is also practised, further causing pain and suffering. Some reports also indicate that the risk of maternal death and stillbirths greatly increase as a result of FGM. Additionally, the psychological health of the girl or woman may also be adversely affected.

The medicalization of FGM (i.e. supporting health care professionals to perform FGM in health facilities under more hygienic conditions) cannot be tolerated as an attempt to make this procedure "safer". Medicalization inappropriately legitimises FGM and does not eliminate the harm caused by the practice. Health workers employed in refugee situations must be informed that their involvement in "medicalizing" FGM will result in immediate termination of their contract.

The reasons for FGM tend to be culture-specific, but they include ensuring virginity at the time of marriage, suppressing a woman's sexual desire, enhancing social integration, religious reasons and numerous myths. However, there are no proven religious justifications founded in the Christian or Muslim faith; quite the contrary, as the practice of FGM runs against the teachings of the Bible and the Koran.

There is widespread condemnation of FGM by the international community. The World Health Organisation (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the Special Rapporteur on violence against women condemn all forms of FGM and reject its justification on any grounds. UNHCR also opposes this practice as a violation of fundamental human rights.

Additional information regarding FGM can be found in WHO's Information Kit on FGM, available in English and French, and the Joint WHO/UNICEF/UNFPA Statement on FGM.

Other References:

- Inter-Agency Field Manual on Reproductive Health in Refugee Situations (UNHCR)
- HOW TO GUIDE—From Awareness to Action: Eradicating FGM in Somali Refugee Camps in Eastern Ethiopia (PTSS 1997)
- A variety of videos on FGM in several African countries can also be obtained from PTSS.

² See note 1, Joint WHO/UNICEF/UNFPA statement.

II. Early Childhood Marriage

The World Health Organisation recommends that the minimum age of marriage for girls should be 18 years. In parts of Asia, forty percent of women are married by the age of 18, with many married before reaching puberty.³ Men, on the other hand, tend to marry at a later age. Harmful traditional marriage practices also exist in Africa. In East Africa and Nigeria, the number of girls married at an early age is increasing because young virgins are thought to be less likely to be infected with HIV/AIDS.⁴

Early childhood marriage often involves girls being withdrawn from school and early pregnancy. Early maternity lessens the life expectancy of girls and adversely affects their health, nutrition, education and employment opportunities. Their lowered economic participation rate in turn may lower their worth to families as income earners.

Early childhood marriage has been linked to extremely high maternal and child mortality rates in parts of Asia. A factor that contributes to the high mortality rates is women under 18 years having unspaced and recurrent pregnancies, often in search of a son. Since many young mothers are still physically developing themselves, there may be competition for nutrition between the foetus and the young mother, leading to nutritional deficiencies for mother and baby. According to UNICEF, no girl should become pregnant before the age of 18 because she is not yet physically ready to bear children.

Discriminatory feeding can start as soon as girls are born because boys are considered the future breadwinners for a family. When those girls become wives and start to bear children, they will generally eat the residual food at meals and will not be aware of the need to take nutritious food during pregnancy. Malnutrition is common among poor lactating mothers. Malnutrition, including anaemia, is especially prevalent among women who have many, closely-spaced pregnancies, rendering them vulnerable to diseases adversely affecting their health and the health of their family.

Female education appears to push up the female mean age at marriage, bring down infant mortality rates and depress fertility. Marriage patterns are directly related to the education levels of women. In societies where female literacy is high the proportion of married women between 15 and 19 years is very small and virtually disappears with universal female literacy. Consequently, infant mortality and total fertility (number of children) decrease as women's education level rises.

III. Son Preference

The practice of son preference is the preferential treatment by parents of male children. This often manifests itself in the neglect, deprivation or discriminatory treatment of girls to the detriment of their physical and mental health. Son preference is primarily found in Asia, but also commonly occurs in Africa. Its intensity varies from one country to another. Some of the areas that have been identified as being the most affected by this practice are South Asia (Bangladesh, India, Nepal, Pakistan), Western Asia (Jordan, Syrian Arab Republic, China and some parts of Africa (Algeria, Cameroon, Egypt, Liberia, Libyan Arab Jamahiriya, Senegal, Tunisia, Morocco)).⁵

³ Report of the second United Nations Regional Seminar on Traditional Practices Affecting the Health of Women and Children, E/CN.4/Sub.2/1994/10, par. 47.

⁴ Preliminary Report of the Special Rapporteur on traditional practices affecting the health of women and children, Mrs. Halima Embarek Warzazi, R/CN.4/Sub.2/1995/6, par. 29

⁵ Preliminary Report of the Special Rapporteur on traditional practices affecting the health of women and children, R/CN.4/Sub.2/1995/6, par. 25..

While the historical roots of son preference are attributed to the existence of patriarchal societies, it is perpetuated by the traditional role of men in agriculture and as property owners. Additionally, in Africa the preference for sons may be based on erroneous religious interpretations. In situations of extreme poverty, the parents may feel it is more important to ensure the survival of sons rather than daughters.

Son preference manifests itself in a number of ways, all of which have negative repercussions for girls and women. Discriminatory treatment of girls and women can arise in the following areas:

Family Nutrition

Girls will be breastfed for a shorter period than boys in order to hasten conception to try to produce a boy. In families where food is scarce, the most nutritious food is reserved for boys and men, who may also be fed first, with the leftovers feeding women and girls resulting in higher incidences and degrees of malnourishment and mortality among female children.

Health Care

Boys are likely to receive medical attention before girls. Additionally, girls may be taken to traditional healers, while boys are more likely to be taken to qualified physicians. Expenditures for treatment of girls may be half of that spent on boys. One country found that when measles immunisation was provided free of cost the proportion of boys and girls being immunised was almost equal, but when a small fee was charged the proportion of girls fell to 25%.

Education

Families with higher incomes may send both boys and girls to school, but poorer families choose to send the boy rather than the girl. Girls may also be kept out of school to work in the home or fields. In some parts of Asia, women form two thirds of the illiterate population. In addition to extending educational opportunities to women, the curricula, textbooks and teaching material must not reflect gender stereotypes.

Age of Marriage

Some parents prefer to marry their daughters at an early age because girls are an economic liability; an Asian proverb which reflects this sentiment states "bringing up girls is like watering the neighbour's garden." WHO recommends that the minimum age of marriage be 18 years old. (See Early Childhood Marriage)

Inheritance

In some societies, property and other possessions are only passed down to the son or revert back to the father's family. Wives and daughters will not only be deprived from sharing in the family's wealth, but may find themselves economically destitute upon the death of a husband or father.

Recreation

Girls from poor families are expected to help with house and fieldwork, while boys may be exempted from this type of responsibility. As a result, girls may be allowed less time for recreation which is essential to their growth and development.

Employment

Compared with men in certain areas, women have fewer opportunities for remunerative wage employment and less access to skills training which makes employment possible. Women may also be denied access to better paid positions.

Female foeticide or infanticide:

In certain South Asian communities, amniocentesis tests and sonograms for sex determination are followed by abortion of female foetuses.

IV. Dowry

Dowry is a socially-legitimised payment normally given by the bride's family to the groom. Historically in many societies dowry was socially beneficial for the woman, so that in times of emergency the woman had assets of her own to rely on. It is the violent reactions by the groom and/or his family when the bride's family fails to pay dowry that can make this a harmful traditional practice.

In parts of South Asia, dowry crimes are on the rise.⁶ Failure to provide the appropriate amount of dowry can mark the beginning of family violence against the woman. She may be verbally abused, mentally and physically tortured, starved and, in certain communities, even burnt alive by the husband and/or his family members. The practice of dowry is condemned by the international community in situations where brides are harmed due to unmet dowry payments. In such cases, the state is obliged to intervene, although in some countries or areas it may not. An additional concern is that younger brides may fetch lower dowries, encouraging parents to marry off daughters at a young age. Moreover, girls may intentionally be fed less by families because some believe that a high caloric diet makes girls reach puberty faster and hastens the need to arrange for dowries.

⁶ Report of the second United Nations Regional Seminar on Traditional Practices Affecting the Health of Women and Children, E/CN.4/Sub.2/1994/10, par. 55.

ANNEXE 2

Addis Abeba Declaration to the Organization of African Unity



INTER-AFRICAN COMMITTEE (IAC) ON TRADITIONAL PRACTICES
Affecting the Health of Women and Children

COMITE INTER-AFRICAIN (CI-AF) SUR LES PRATIQUES TRADITIONNELLES
ayant effet sur la santé des femmes et des enfants

ACTION POINTS

as a follow-up to the Symposium for Legislators
held at the Headquarters of
The Organization of African Unity, Addis Ababa, Ethiopia
September 10 - 12, 1997

1. **Target Date**

By the year 2000 concrete mechanisms for the implementation of a national policy shall be established and legislation for the elimination of all forms of violence against women and girl children especially FGM will have been enacted.

2. **Legal Literacy**

Lawyers' groups, para-legal groups and National Committees of IAC shall organize strong community outreach programmes that involve individuals, the communities, fathers, emirs, chiefs and traditional practitioners.

3. **Establishment of a Co-ordinating Body**

All States and Governments shall establish a co-ordinating body at the highest level of government to implement and monitor national policy and legislation for the elimination of all forms of violence against women and girls children, particularly female genital mutilation.

4. **Review of Legislation**

All countries shall immediately review existing policies and legislation and report to IAC. The status of such policies and legislation relating to women and girl children particularly female genital mutilation, early marriage and widowhood rites.

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5. **Support of Eradication of FGM and Harmful Traditional Practices**

IAC, supported by other non-governmental organizations, interested groups and other agencies e.g. WHO, UNICEF, the United Nations, shall bring the issue of FGM to the Heads of State and Government through the OAU and request that such States/Government shall desist from hindering, in any form, efforts to eradicate the practice of female genital mutilation and other harmful traditional practices.

6. **Network**

IAC shall develop a network programme as a follow-up of the September 1997 Symposium with a yearly meeting where progress in respect of the Addis Ababa Declaration shall be assessed and new strategies developed for the eradication of harmful traditional practices particularly FGM.

7. **The Role of the OAU**

The OAU shall present the Addis Ababa Declaration to the Heads of State and Government for endorsement and action at its next meeting in 1998. IAC shall be in constant touch with the OAU to monitor the progress of the Addis Ababa Declaration.

ACTPOINT

ANNEXE 3

Distribution and Prevalence of FGM



Female Genital Mutilation: PREVALENCE AND DISTRIBUTION

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.



The distribution reported and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the distribution of its frontiers or boundaries. Information on this map is based entirely on printed and unprinted data.

ESTIMATED PREVALENCE OF FEMALE GENITAL MUTILATION IN AFRICA

Country	Estimated prevalence women (000s)	Number of	Source of the prevalence rate
Benin*	50%	1,370	
Burkina Faso	70%	3,650	Report of the National Committee (1993)
Cameroon	20%	1,330	Estimated prevalence based on a study (1994) in southwest and far north provinces by the Inter-African Committee, Campaign section
Central African Republic	43%	740	National Demographic and Health Survey (1994/1995). Signs of decline amongst younger age groups. Secondary or higher education can be associated with reduced rates of FGM. No significant variations between rural and urban areas. The prevalence of FGM is highest amongst the Herds and Mandja groups where 84% and 71% of women respectively have undergone FGM.
Chad	60%	1,930	1990 and 1991 UNICER sponsored studies in three regions.
Cote d'Ivoire	43%	3,020	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 Mandja population 80% compared with 15% amongst Protestants and 17% of Catholics.
Dahomey*	98%	290	Type III widely practised. UN ESCOROC Report (1991)
Egypt*	80%	24,710	Type I and Type II practised by both Muslims and Christians. Type III-inhabitation reported in areas of south Egypt closer to Sudan.
Eritrea*	90%	1,600	
Ethiopia	43%	23,240	A 1995 UNICER 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.
Gambia	80%	450	A limited study by the Women's Bureau (1985). Type II commonly practised.
Ghana	30%	2,640	Pilot studies in the Upper East region (1986) and amongst migrant settlement in Accra (1987) by the Ghana Association of Women's Welfare.
Guinea*	50%	1,670	

Country	Estimated prevalence	Number of women (000s)**	Source of the prevalence rate
Guinea-Bissau	50%	270	Limited 1990 survey by the Union démocratique des Femmes de la Guinée-Bissau.
Kenya	50%	7,050	A 1992 Maendeleo 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.
Liberia*	60%	900	
Mali*	75%	4,110	
Mauritania*	25%	290	
Niger*	20%	930	
Nigeria	50%	28,170	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.
Senegal	20%	830	Report of a national study by ENDA (1991).
Sierra Leone	90%	2,070	All ethnic groups practise FGM except for Christian Krios in the western region and in the capital, Freetown. Type II commonly practised.
Somalia	98%	4,580	FGM is generally practised; approximately 80% of the operations are infibulation.
Sudan	89%	12,450	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.
Togo*	50%	1,050	
Uganda*	5%	540	
United Republic of Tanzania*	10%	1,500	
Zaire*	5%	1,110	
Total		132,490	

* 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:

Hosken, Fran. *The Hosken Report: Genital and Sexual Mutilation of Females*. Fourth Revised Edition. Lexington, MA. WIN NEWS, 1993

National Demographic and Health Surveys, Macro International, Inc., 11785 Belville Drive, Calverton, MD 20705, USA.

Toubia, Nahid. *Female Genital Mutilation: A call for global action*, New York: Women, Ink., 1993



World Health Organization

August 1996

ANNEXE 4

Health Consequences of FGM



Female Genital Mutilation: HEALTH CONSEQUENCES

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 defibulation 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.

Calculus 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.

Fistulae, vesico-vaginal or recto-vaginal, may form as the result of an injury during FGM, or due to defibulation 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 **dysmenorrhoea**. **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. Defibulation 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.



ANNEXE 5

International Agreements Relevant to FGM

Most governments in countries where female genital mutilation is practised have ratified several United Nations Conventions and Declarations that make provision for the promotion and protection of the health of girls and women, including the elimination of female genital mutilation, as follows:

- 1984** **The Universal Declaration of Human Rights** proclaims the right of all human beings to live in conditions that enable them to enjoy good health and health care.
- 1966** **The International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights** condemns discrimination on the grounds of sex, and recognises the universal right to the highest attainable standard of physical and mental health.
- 1979** **The Convention on the Elimination of All Forms of Discrimination against Women** can be interpreted to require States to take action against female genital mutilation, 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 of either of the sexes or on stereotyped roles for men and women" (Art. 5.a)
- 1990** **The Convention on the Rights of the Child** protects the right to equality irrespective of sex (Art.2), to freedom 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 freedom from torture or cruel, inhuman or 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.
- 1993** **The Vienna Declaration and the Programme of Action of the World Conference on Human Rights** expands the international human rights agenda to include gender-based violations which include female genital mutilation.
- 1993** **The Declaration on Violence Against Women** expressly states in its article 2: "violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including...dowry-related violence...female genital mutilation and other traditional practices harmful to women..."

1994 The Programme of Action of the International Conference on Population and Development (ICPD) includes recommendations which commit governments and communities to “urgently take steps to stop the practice of female genital mutilation and to protect women and girls from all such similar unnecessary and dangerous practices”.

1995 The Platform of Action of the Fourth World Conference on Women includes a section on the girl child and urges governments, international organisations and non-governmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including female genital mutilation.

ANNEXE 6

References and Resources

Others Working to Eradicate FGM

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

FORWARD (The Foundation for Women's Health Research and Development)
40 Eastbourne Terrace,
London W2 3QR.
Tel: +44 171 725 2606
Supports projects internationally.

The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children

Headquarters: Attention—Mrs. B. Ras Work, President
147 rue de Lausanne
Geneva 1202 Switzerland
Tel: 41 22 731 2420, Fax: 738 1823

Or contact national committees found in most countries where FGM is practised

UN Working Group on Traditional Practices

147 rue de Lausanne
Geneva 1202 Switzerland

UNFPA

Contact local country offices or
220 East 42nd Street
New York, NY 10017 USA
Fax: 212 297 4915

UNHCR

Case postale 2500
1211 Geneva 2 Switzerland
Fax: 41 22 739 73 67

UNICEF

Contact local country offices or
3 United Nations Plaza
New York, NY 10017 USA
Fax: 212 326 73 36

World Health Organization

Distribution and Sales
1211 Geneva 27 Switzerland
E-mail: publications@who.ch

World Health Organization

Family and Reproductive Health
1211 Geneva 27 Switzerland
Fax: 41 22 791 41 89
E-mail: lamberts@who.ch

Reference Materials

Inter-Agency Field Manual on Reproductive Health in Refugee Situations, UNHCR/UNFPA—1998. Provides guidelines for eradication of FGM in refugee situations.

UNICEF, UNFPA, WHO Joint Statement on Female Genital Mutilation—1997

WHO-Information Packet on Female Genital Mutilation—1996.

"The Circumcision of Women: A Strategy for Eradication", by Olayinka Koso-Thomas, Zed Books Ltd., ISBN 0-86232-701-6

"Sisters in Affliction: Circumcision and Infibulation of Women in Africa", by Raqiya Abdalla, Zed Books Ltd.

"Cutting the Rose," by Efua Dorkenoo, Minority Rights Group, London 1994.

"Tradition Tradition," by Efua Dorkenoo, Forward Ltd, 38 King Street, London, WC2E 8JT, ISBN: 0 9519246 13. Pictorial story of a fictional community that cuts off a leg of young girls—used as an analogy for FGM.

Guidelines on the Prevention of Female Genital Mutilation, Ministry of Foreign Affairs, Danida, 2 Asiatisk Plads, 1448 Copenhagen K, Denmark.

Islamic Ruling on Male and Female Circumcision, Muhammed Lutfi al-Sabbagh, World Health Organization; Regional Office for the Eastern Mediterranean, Alexandria, Egypt, 1996

Videos produced by Maendeleo Ya Wanawake (P.O.Box 44412, Monrovia St. 4th Floor, Nairobi, Kenya) show the custom of FGM in "Secret and Sacred," and suggest ways of eradicating it in "Rites of Passage."

Videos produced by National Committee on Traditional Practices of Ethiopia portrays young girls undergoing FGM.

"From Awareness to Action"—Video in English and Somali describing the Pilot Project to Eradicate FGM in Somali Refugee Camps in Ethiopia.

Contact the Television Trust for the Environment (TVE) for more videos on FGM eradication.