FEMALE CIRCUMCISION, EXCISION AND INFIBULATION:
the facts and proposals for change
FEMALE CIRCUMCISION, EXCISION AND INFIBULATION: the facts and proposals for change
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INTRODUCTION

In Africa today, women's voices are being raised for the first time against genital mutilations still practised on babies, little girls, and women. These voices belong to a few women, who, from Egypt to Mali, from the Sudan and Somalia to Senegal, remain closely attached to their identity and heritage, but are prepared to call it in question when traditional practices endanger their lives and their health. They are beginning the delicate task of helping women free themselves from customs which have no advantage and many risks for their physical and psychological well-being, without at the same time destroying the supportive and beneficial threads of their cultural fabric.

Sexuality remains for many of us an obscure area, mined with cultural taboos, loaded with anxiety and fear. This is one of the reasons why the subject of genital mutilations provokes violent and emotional reactions, both from those in the West who are shocked and indignant, and from those in Africa and the Middle East who are wounded when these facts are mentioned, and prefer to minimise the quantitative importance of the practice. The total number of women affected is in any case unknown, but without any doubt involves several tens of millions of women. Medically unnecessary, painful, and extremely dangerous operations are being carried out every day, at the present time.

Our endeavour in this report is firstly to communicate the facts, drawn from as many different countries as possible where information is available, and then to discuss practical programmes to eradicate the custom. These will be limited to proposals which can be put into operation immediately, given goodwill in the countries concerned, and given practical and financial assistance from international organisations.

PART I

THE FACTS ABOUT FEMALE GENITAL MUTILATION

'Any definitive and irremediable removal of a healthy organ is a mutilation.

The female external genital organ normally is constituted by the vulva, which comprises the labia majora, the labia minora or nymphys, and the clitoris covered by its prepuce, in front of the vestibule to the urinary meatus and the vaginal orifice. Their constitution on female humans is genetically programmed and is identically reproduced in all the embryos and in all races. The vulva is an integral part of the natural inheritance of humanity.

When normal, there is absolutely no reason, medical, moral, or aesthetic, to suppress all or any part of these exterior genital organs.'

- Gérard Zwang

Mutilations sexuelles féminines. Techniques et Résultats.

Types of mutilations

i) Circumcision, or cutting of the prepuce or hood of the clitoris, known in Muslim countries as 'Sunna' (tradition). This, the mildest type, affects only a small proportion of the millions of women concerned. It is the only type of mutilation which can correctly be called circumcision, whereas there has been a tendency to group all kinds of mutilations under the misleading term, 'female circumcision'.

ii) Excision, meaning the cutting of the clitoris and of all or part of the labia minora.

iii) Infibulation, the cutting of the clitoris, labia minora and at least the anterior two-thirds and often the whole of the medial part of the labia majora. The two sides of the vulva are then pinned together by silk or catgut sutures, or with thorns, thus obliterating the vaginal introitus except for a very small opening, preserved by the insertion of a tiny piece of wood or a reed for the passage of urine or menstrual blood. These operations are done with special knives (in Mali, a saw-toothed knife), with razor blades (in Sudan, a special razor known as Moss el Shurfa), or with pieces of glass. The girl's legs are then bound together from hip to ankle and she is kept immobile for up to forty days, permitting the formation of scar tissue.

iv) Intermediate, meaning the removal of the clitoris and some parts of the labia minora or the whole of it. Sometimes slices of the labia majora are removed and stitched. It has various degrees, done according to the demands of the girl's relatives.

Operators: Most frequently, the operations are performed by an old woman of the village (known as 'Gedda' in Somalia), or traditional birth attendant (known as 'Daya' in Egypt and the Sudan). In Northern Nigeria and in Egypt village barbers also carry out the task, but usually it is done by a woman: rarely, it seems, by the mother. In Mali and Senegal it is traditionally carried out by a woman of the blacksmith's caste gifted with knowledge of the craft. The operation is done preferably on little girls, but is becoming more frequent in adolescents. Excisions and infibulations are being done by qualified nurses and doctors, but in small numbers. More recently, in some countries, mutilations are also being carried out in hospitals in urban areas; for example, female children one month old are excised in Bamako Hospital in Mali. Any accompanying ceremonies obviously disappear in a hospital setting, but they are disappearing equally in rural areas where traditional birth attendants do the operations. Every year, in two or three African countries, women are operated on shortly before marriage, but only before the first child among the Aboli (in midwestern Nigeria). Most experts agree, however, that the age of mutilation is becoming younger, and has less and less to do with initiation into adulthood.

Description of an Infibulation

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

This description, by M.A.S. Mustafa, is recounted in the thesis of Dr. Alan David working in his home territory of Djibouti3, and is similar to the description by anthropologist Annie de Villeneuve4, and by Jacques Lantier in La Cité Magique5. Lantier goes on to describe the wedding night in Somalia when the husband, having beaten his wife with a leather whip, uses a dagger to open her: "According to tradition, the husband should have prolonged and repeated intercourse with her during eight days. This work is in order to "make" an operator. The woman remains lying down and moves as little as possible in order to keep the wound open. The morning after the wedding night, the husband puts his bloody dagger on his shoulder and makes the rounds in order to obtain general admiration."

Physical consequences

Health risks and complications depend upon the gravity of the mutilation, hygienic conditions, the skill and eagerness of the operator, and the struggles of the child. Whether immediate or long-term, they are grave.
Immediate complications: Haemorrhage from section of the internal pudendal artery or of the dorsal artery of the clitoris; post-operative shock (death can only be prevented if blood transfusion and emergency resuscitation are possible). Bad eyesight of the operator or the resistance of the child causes cuts in other organs: the urethra, the bladder (resulting in urine retention and bladder infection), the anal sphincter, vaginal walls or Bartholin glands. As the instruments used have rarely been sterilized, tetanus (often fatal), and septicemia often result.

It is impossible to estimate the number of deaths, since the nature of the operation requires that unsuccessful attempts be concealed from strangers and health authorities, and a very small proportion of dead babies is admitted to hospital. Nevertheless, hospital staff in all the areas concerned are very familiar with last minute and often hopeless attempts to save bleeding, terrified little girls. Operators are not held responsible by parents if death or infection result from the operation.

Long-term complications: Chronic infections of the uterus and vagina are frequent, the vagina having become, in the case of infibulation, a semi-sealed organ. Sometimes a large foreign body forms in the interior of the vagina as a result of the accumulation of mucous secretions. Keloid scar formation on the vulval wound can become so enlarged as to obstruct walking. The growth of implantation dermoid cysts as large as a grapefruit is not rare. Fistula formation (due to obstructed labour — rupture of the vagina and/or uterus) causes incontinence later in life, so that many mutilated women are continually dribbling urine. Other grave complications include dysmenorrhoea (extremely painful menstruation) since menstrual blood cannot escape freely, and young infibulated girls try to dislodge the accumulated clots with their little fingernails, if the opening is big enough. Dr. Ollivier (a military doctor in Dakhla) observed cases of dysmenorrhoea up to the age of forty, in a hospital at one a.m. with unbearable abdominal pains. She had not menstruated for several months, and had not had intercourse, but her abdomen was swollen and sensitive, with the signs of a uterus in labour. She was infibulated, with a minuscule opening. Penetration would appear to have been impossible and there was no sign of beating of a foetal heart. Dr. Ollivier performed a disinfibulation (opening of the scarred vulva), and released 3.4 litres of blackish foul-smelling menstrual blood. There are other accounts of similar complications, with more tragic results: the increased size of the abdomen together with the absence of menstruation leads the family to think a girl is pregnant. She is therefore killed for the prestige of the family. (Dr. Asma A. El-Dareer, Female circumcision and its consequences for mother and child. Yaoundé 12-15 December 1979.)

The most excruciating result of excision, rendering the whole genital area permanently and unbearably sensitive to touch, is the development of neuroma at the point of section of the dorsal nerve of the clitoris. Vulval abscesses can also develop. Mutilated women, it goes without saying, feel severe pain during intercourse (known as dyspareunia), and they sometimes become sterile due to improper handling of which the reputation of the organ suffers.

Further complications during childbirth are unavoidable for infibulated women. Splitting of the scar is always needed to let the baby out. The tough obliterated vulva has lost its elasticity, and if it is not re-opened in time, may fatally hold up the second stage of labour. The head of the baby may be pushed through the perineum which tears more easily than the infibulation scar, so causing a high incidence of perineal tears. There is unnecessary blood loss, and the pain produced may result in uterine inertia. The long and obstructed labour can lead to intrauterine foetal death, or brain damage to the baby. If a cut is made (bilateral or anterior episiotomy), other structures may be injured: the vagina or the cervix of the mother, or the scalp or any other part of the baby, especially if the operator is working in a hurry. Again, there is the danger of infection. Custom demands that a woman be re-infibulated, or sewn up again, after each delivery, and this may be done twelve times or more.

Sexual problems

In all types of mutilation, even the most 'mild' clitoridectomy (excision of the clitoris), a part of a woman's body containing nerves of vital importance to sexual enjoyment is amputated. The glans clitoridis with its specific sensory apparatus is a primary erogenic zone. When it has been reduced to an area of scar tissue, no orgasm can be released by its manipulation. The well-known work of William Masters and Virginia Johnson, and many others, has conclusively proved that all orgasms in women originate in the clitoris, although they may be felt elsewhere. There remains confusion, however, over the terms 'clitoral orgasm' and 'vaginal orgasm'; for clarification of the issue, a more complete understanding of our anatomy is necessary. The Hite Report (Dell Books, New York, 1976), is helpful here, from which this brief quotation is taken:

'The vestibular bulbs and circumvaginal plexus (a network of nerves, veins and arteries) constitute the major erectile bodies in women. These underlying structures are homologous to, and about the same size as, the penis of a man. They become engorged (swollen) in the same way that a penis does. When fully engorged, the clitoral system as a whole is roughly thirty times as large as the external clitoral glans and shaft — what we commonly know as the "clitoris". Women's sex organs, though internal and not as easily visible as men's, expand during arousal to approximately the same volume as an erect penis. ...In short, the only real difference between men's and women's erections is that men's are on the outside of their bodies, while women's are on the inside.

Female orgasms are triggered by the stimulation of the clitoris, whereas men are triggered by vaginal contractions:

'Cli toral stimulation evokes female orgasm, which takes place deeper in the body, around the vagina and other structures, just as stimulation of the tip of the male penis evokes male orgasm, which takes place inside the lower body of the male.'

The earlier a woman is mutilated, the greater is the damage, since infantile and adolescent masturbation teaches the organism and the consciousness the proper function of the sexual reaction. There is no surgical technique capable of repairing a clitoridectomy, nor of restoring erogenous sensitivity of the amputated apparatus.

Very little research has been done on the sexual experiences of mutilated women. Dr. A.A. Shandall found that some of the women he interviewed in the Sudan had no idea at all of the existence of orgasm. He reports on cases of tight infibulation where the husbands, unable to penetrate into the vagina, resorted to anal intercourse, or even used the urethral meatus as an opening.

The consummation of a marriage may take several weeks, the opening of the scar of an infibulated woman being done by the husband either with his fingers, a razor, or a knife. It is questionable whether men get any satisfaction from these practices, or from intercourse with infibulated women whose tight openings are thought to be desirable. Of 300 Sudanese husbands interviewed by Dr. Shandall (each of whom had more than one wife, of whom only one was infibulated), 266 stated categorically that they preferred non-excised or sunna-circumcised wives sexually. They enjoy intercourse with them more because they seem to share with them the desire, the act and the pleasure, he reports.

There is great difficulty in obtaining accurate research data on the sexual experiences of mutilated women, because the majority of them are reluctant to speak on the subject at all until the third or fourth visit to a clinic, and are generally ambivalent on questions of sex enjoyment. A great deal more research is needed (and not only in countries where female genitals are mutilated) on subjects such as the relationship between male excitation and the presence of pain in the female, male concepts of female sexual pleasure, and the psychodynamics of these traditions. As a result of his work with Egyptian and Sudanese female patients, Dr. T.A. Ba'asher, World Health Organization Regional Adviser for the Eastern Mediterranean on Mental Health, reports:

'It is quite obvious that the mere notion of surgical interference in the highly sensitive genital organs constitutes a serious threat to the child and that the painful operation is a source of major physical as well as psychological trauma.'

Many personal accounts and research findings contain repeated references to anxiety prior to the operation, terror at the moment of being seized by an aunt or village matron, unbearable pain; a sense
i) **Psychosexual.** There is frequent mention (Mali, Kenya, Sudan, Nigeria) of the clitoris being believed to be an aggressive organ, threatening the male organ and even endangering the baby during delivery. In some areas, notably Ethiopia, people believe that if the female genitals are not excised they will dangle between the legs like a man’s.

More deeply rooted in mythology is the belief that both the female and the male sex exist within each person at birth. The clitoris representing the masculine element in a young girl, and the foreskin representing femininity in a boy, both must be excised to demarcate clearly the sex of the person.22

Very frequently, the reason offered by both women and men is ‘the attenuation of sexual desire’. Since the focus of this desire is clearly recognised to be the clitoris, excision is believed to protect a woman against her own sexual nature, saving her from temptation, suspicion and disgrace, whilst preserving her chastity. These beliefs must be understood in context of societies where virginity (for a woman) is recognised to be the clitoris, excision is believed to protect a woman where a man has several wives, it is said that since it is physically impossible for him to satisfy them all, it helps if they are not too demanding.

Although the intention of the operation may be to diminish a woman’s desire, the facts, from a medical point of view, are that excision of the clitoris reduces sensitivity, but it cannot reduce desire, which is a psychological attribute. Offering as a reason for infibulation ‘the preservation of virginity and the prevention of immorality’ is odd on a strictly practical level, since refibulation is easily done to look like the original one, whereas a ruptured hymen is more difficult to repair. Thus infibulation can be construed as giving a girl more chances to ‘misbehave’.23 Cases are reported in Somalia, where most husbands and fathers want their young daughter’s first sexual experience to be with a devout woman, according to the satisfied husband, married, divorced, re-infibulated, paid for and married again five times or more. In the course of his research in the Sudan, Dr. A.A. Shandall examined 200 prostitutes, of whom 170 had been infibulated, a rate actually higher than that among hospital patients. He concludes, ‘Infibulation does not confer any protection or deterrent action on females. Moreover, the vulval skin diaphragm, being an artificially constructed device, can always be reconstructed without any suspicion that this is not the original ... in the writer’s opinion, infibulation would encourage immorality rather than protect against it’.24

If you can stand the pain.

The Tagouana of the Ivory Coast believe that a non-excised woman cannot conceive25, whereas the Yoruba used excision as a form of contraceptive: since they believed that sperm found its way into a nursing mother’s milk with adverse effects for the child, she went without sex for eighteen months of breastfeeding, and the fact of having been circumcised made it easier to bear a sexless life.26

ii) **Religious.** Excision and infibulation are practised by Moslems, Catholics, Protestants, Copts, Animos, and non-believers in the various countries concerned. The custom has, however, frequently been carried out in the genuine but erroneous belief that it was dictated by the Islamic faith, or perpetuated as a required Islamic custom. Dr. Taha Ba’asher, Regional Adviser on Mental Health for the World Health Organization for the Western Mediterranean, clarifies the position:

‘Among Moslem communities in Egypt and the Sudan, for example, it is not uncommon to find that female circumcision has been traditionally practised under the pretext of adherence to religious principles. It is remarkable that this custom is no longer observed in leading Arab countries such as Saudi Arabia, the cradle of Islam and the centre of the Holy Lands. With such a wide diversity between Moslem communities, it is not surprising to come across conflicting views regarding the place of female circumcision in relation to her oppressed nature, saving her from temptation, suspicion and disgrace, whilst preserving her chastity. These beliefs must be understood in context of societies where virginity (for a woman) is clearly the sex of the person 22.

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iii) **Sociological.** Some authors explain the practice in terms of initiation rites, of development into adulthood. In many areas (Northern Sudan, Kikuyu in Kenya, Tagouana in the Ivory Coast, Bambara in Mali) an elaborate ceremony surrounded, and in some cases still surrounds, the event - with special songs, dances and chants intended to teach the young girl her duties and desirable characteristics as a wife and mother; with ritual rich in symbolism; with special convalescent huts for the girls attended only by the instructress and cut off from the rest of society until their emergence, healed, as marriageable women; or simply with special clothes and food. However, it seems that today in many of these societies the ceremonial has fallen away; both excision and infibulation are performed at a much younger age that cannot be construed as having anything to do with entry into adulthood or marriage, and the child’s role in society does not change at all after the mutilation. Assitan Diallo devoted her thesis, entitled ‘L’Excision en Milieu Bambara’, to discovering whether in Mali today excision possesses the same functional value as in traditional society, whether it still has its initiation significance. She goes deeply into the details of ritual ceremonies, and finds from her respondents (who are women, excised some time ago, and men, considering the excision of their children today) that these ceremonies have in most cases disappeared. The traditional songs are no longer taught to the girls, and not one of her respondents had received instruction to do with initiation into adulthood. 32% of her respondents, male and female, said that hygiene was the main justification for excision, whereas 23% said it was custom, and 23% had no explanation at all. She concludes from her research that 98% of excisions are carried out before puberty, and 53% before one year old.

In the absence of symbolism, with no feeling of ‘stepping into a new life’, and stripped of the rejoicing of the community, the psychological effect caused by this mutilation is likely to be more grave, and the physical pain harder to bear.

On a strictly practical level, a bride price cannot be obtained if a girl is not ‘pure’. In Nigeria, the operation serves the purpose of enabling the potential mother-in-law to discover whether or not the girl is a virgin:

‘If she is found not to be a virgin, the husband-to-be has the right to reject her and refuse to go along with the marriage. A row ensues and a refund of the dowry has to be made. The disgraced family is stigmatized, and the girl may have to leave home to find a husband outside of her community.28

iv) **Hygiene and aesthetics.** In countries toward the Eastern part of the belt on the map, the external female genitals are considered dirty. In Egypt, for instance, the uncircumcised girl is called ‘Nigsa’ (unclean) and bodily hairs are removed in efforts to attain a smooth, and therefore clean, body. The same sentiment appears in Somalia and the Sudan where the aim of infibulation is to produce a smooth skin surface, and women questioned insist that it makes them
cultural fabric, had at last begun on an international level. The following actions were recommended by the seminar and addressed primarily to the governments concerned: 
Adoption of clear national policies for the abolition of female circumcision. 
Establishment of national commissions to coordinate and follow up the activities of the bodies involved, including, where appropriate, the enactment of legislation prohibiting female circumcision. 
Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and undesirability of female circumcision. 

Intensification of education programmes for traditional birth attendants, midwives, healers and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision, with a view to enlisting their support along with general efforts to abolish this practice. 

These recommendations have not, to date, been implemented. The WHO should be encouraged by member states to take an active part in doing so. 

UNICEF, the United Nations Children's Fund, with children's programmes all over Africa, only became active on the subject in March 1980. Given UNICEF's considerable experience in educational work with traditional midwives, and their grassroots work with mothers and children in rural areas, their official professed ignorance of the customs until 1980 is transparent. Non-interference with traditional customs has been immaculately respected by international organizations in this case concerning women and children's bodies, but is entirely ignored in others (for example, the heavy insistence by many sources of international aid on family planning, in recipient countries). In March 1980 a joint meeting of WHO and UNICEF came up with a joint 'plan of action' endorsing a 'through primary health care' approach, and laying down as an essential principle that all activity should be undertaken throughout nations. The plan recommended: 

strong advocacy efforts towards WHO/UNICEF staff, national policy and decision-makers, all health and health-related personnel, and the general public; 
the identification and support of organizations with national structures and credibility in the field; 
the integration of discussion of the subject into educational and training programmes; 

fostering action-oriented research on epidemiology, and socio-cultural studies encompassing behaviour, values and attitudes; 
the dissemination of the results of successful action and research in practising countries. 

As far as UNICEF is concerned, responsibility for the implementation of these recommendations 'lies jointly with the individual UNICEF country or area representative and the appropriate government authorities'. From the lengthy background papers, it seems that UNICEF have difficulty even persuading their own personnel of the need to eradicate genital mutilation; their inactive approach, apparent in the wording of the above recommendations, is borne out by the fact that no specific funds have been set aside for their implementation. Those who normally support UNICEF, perhaps by buying their Christmas cards, may wish to comment, either to their national UNICEF committee, or by writing to the Senior Adviser on Family and Child Welfare, Programme Division, United Nations Children's Fund, United Nations, New York, N.Y. 10017, U.S.A. 

UNESCO, the UN Educational, Scientific and Cultural Organization, maintains total silence on the subject. The question of mutilations has not yet been discussed at any of the many conferences, debates, or research studies on cultural patterns in Africa, on social change, education or human rights; nor during the International Year of the Child, in 1979. No UNESCO personnel in the field collect information, stimulate research, nor assist with education campaigns. 

(We understand, however, that from November 1980 it may be possible for the Human Rights Division of UNESCO to sponsor research programmes.)

Recent international conferences

- In December 1979, the African Symposium on the World of Work and the Protection of the Child, organized by the International Institute for Labour Studies in Yaoundé, strongly recommended the organization of campaigns and of teaching by all educational means, on the dangers of excision. The symposium also urged the International Institute of Social Sciences to constitute a data bank on excision, the evaluation of prevailing attitudes, and the best ways toward elimination. 
- The Second Regional Conference (Lusaka 3-7 December 1979) on The Integration of Women in Development, unanimously adopted a resolution condemning infibulation, and called upon African governments to assist national women's organizations in their research for a solution to this problem. 
- The United Nations: 

In July 1980 the World Conference of the United Nations Decade for Women was held in Copenhagen, concentrating on the sub-themes: health, education, and employment. In the 'Review and Evaluation of Progress Achieved in the Implementation of the (1975) World Plan of Action: Health' (document A/CONF.94/9) the subject of female circumcision is mentioned once, as follows: 

'Paragraph 45. Female circumcision and infibulation can lead to complications during pregnancy. The Second Regional Conference on the Integration of Women in Development, held at Lusaka from 3 to 7 December 1979, condemned sexual mutilation practices, but was also critical of uniformed international campaigns against these practices, and called upon African Governments and women's organizations to seek solutions to the problem.' 

This mention forms one of 152 paragraphs, and comes under the sub-heading 'Cultural practices affecting women's health'. 

In the main policy document of the Conference, the Programme of Action For The Second Half of the United Nations Decade for Women: Equality, Development and Peace, the subject is not referred to at all by name. Under the section 'Objectives and priority areas for action taken in connexion with the subtheme of the World Conference, "Employment, health and education"', para graph 129, refers to the promotion of 

'extensive health education programmes, including special efforts to encourage positive traditional practices, especially breast-feeding, and to combat negative practices detrimental to women's health.' 

No African country took up the question in the official conference. Due to pressure from the Swedish public, the Swedish delegation mentioned the subject, indicating that the Swedish authorities were prepared to support activities undertaken by the countries concerned but would take no action of their own in this respect. 

- The Copenhagen Non-Governmental Organizations Forum:

Parallel to the official United Nations Conference, the more informal Forum brought together 8,000 women from 120 countries to discuss and plan action on issues of importance to women. This time the subject was 'through the back door', and round table discussions on specific subjects, panel debates on more general themes, through films, slide-shows, lectures and press conferences. 

It became evident from the very beginning the extent to which 'female circumcision', as it was largely referred to, is a sensitive and sensation-prone subject. The three pre-planned workshops on the topic expanded to at least seven more, some ad hoc. Several groups of participants could be distinguished: 

those from Eastern Africa; 
those from West Africa; 
those from Europe and the U.S. 

African immigrants in Europe 
Africans studying in Europe. 

The 'sensation-value' of the subject for the media was felt to be regrettable in many ways, since it can make it more difficult for those in the countries concerned to accept and understand the interest shown by the Western world, and might slow down the progress of activities aimed towards abolition. On the other hand, it was frequently stressed that some years ago it would have been impossible in most countries even to mention the subject in public. 

The emphasis given to the issue at the Forum might hopefully have influenced those participants, largely from western Europe, who were at first shocked and unable to understand the interest shown. They stressed that the abolition of these practices is not a priority for them — sufficient food and clean water having a far greater importance. 

They perhaps overlooked the fact that those in the 'developed' world who wish to help in the struggle against mutilation are not likely to divert their interest and the funds available to such overall...
NOTES


6 The consequences of sexual mutilations on the health of women have been studied by Dr. Ahmed Abu-el-Futuh Shandall, Lecturer, Dept. of Obstetrics and Gynaecology, Fac. of Medicine, University of Khartoum, in a paper entitled, ‘Circumcision and Infibulation of Females’ published in the Sudanese Medical Journal 1967 Vol 5 No.4; and by Dr. J.A Verzin, in an article entitled ‘The Sequelae of Female Circumcision’, published in Tropical Doctor, October 1975. A bibliography on the subject has been prepared by Dr. R. Cook for the World Health Organization.

7 From an account by Dr. R. Ollivier who worked as a military doctor in Djibouti, reproduced by Renee Saurel in her article, ‘L’Enteree Vive’ VIII in Les Temps Modernes Feb 1980.


9 Dr. Shandall cit p.188.

10 From 2 to 12 weeks, in a survey of some 340 Sudanese women studied by Dr. Asma A. El Darree, Dept of Community Medicine, University of Khartoum, Box 102, Khartoum, in a paper entitled, ‘The Changing Status of Sudanese Women’ 23 Feb-1st Mar 1979.

11 Dr. Taha Ba’asher, ‘Psychosocial Aspects of Female Circumcision’ paper presented to the Symposium on the Changing Status of Sudanese Women.

12 These feelings of rejection are clearly articulated by Kenyan girls in ‘The Silence over Female Circumcision in Kenya’ in Viva Magazine, August 1978. (Box 46319, Nairobi).


14 See Fran Hosken cit, for details and estimates of ethnic groups involved.


16 Marie Assaad, ‘Female Circumcision in Egypt — Current Research and Social Implications’ American University in Cairo 1979, p.12.

17 The Sudanese law forbidding infibulation was enacted in 1946. In Dr. Shandall’s study of 4000 women in Khartoum in 1967, 80% were infibulated. In Dr. El Darree’s report of her current research in the Sudan, 84% of respondents were infibulated.

18 Marie Assaad cit.

19 Dr. Asma El Darree, cit.


21 For a description of this belief, see Assitan Diallo, cit, p.18.

22 Interesting to compare this belief with the conclusions of Dr. C.G. Jung. Parallel to embryological development (which does in fact consist of a possibility of both sexes), Jung discovered a psychological complementarity — feminine in the man and masculine in the woman. Described by the name ‘anima’ for a man, and ‘animus’ for a woman, this force can by turns be friend or foe, but is the sole guide towards the self and the ultimate integration of opposites.


24 Shandall cit, p.195.

25 Aminata D. Traoré, Ministere de la Condition Feminine, B.P.V. 200, Abidjan, Ivory Coast, ‘Elements pour une autre methode d’approche au probleme de l’excision’ presented to the above symposium in Yaoundé.

26 Esther Oggunmodede in a background paper prepared for this report, entitled ‘Female Circumcision in Nigeria’ available from Companion Features, 48 Winnock Road, Yiewsley, West Drayton, Middx, U.K.

27 Ba’asher, cit, p.5.

28 Esther Oggunmodede, cit.

29 Aminata D. Traoré, cit.

30 Esther Oggunmodede, cit.


33 Seminar report is available from W.H.O. Eastern Mediterranean Office, P.O. Box 1517, Alexandria, Egypt.

34 At the 21st General Conference (Belgrade, Nov 1980) the Secretariat of UNESCO will submit to the member states a project on genital mutilations. For details contact the Division of Human Rights and Peace, UNESCO, 7 Place Fontenoy, 75700 Paris.


The cover map is a compilation of the latest information available from the International Planned Parenthood Federation, from WIN News, and from individual researchers.
PART II: PROGRAMMES AND PRACTICAL PROPOSALS FOR CHANGE

The African and Arab women who are now beginning to speak out against traditions of genital mutilation, sometimes at great personal cost, appreciate the resolutions and recommendations resulting from conferences on the subject. They await the implementation of those recommendations. In the hope of contributing to the discussion of and the establishment of practical programmes towards eradication of these customs, the second part of this report is devoted to the views of a number of women experts from Senegal, Somalia, Upper Volta, Egypt, Kenya, Nigeria, Benin and the Sudan.

Let African Women speak out

In 1978 a Senegalese woman, Awa Thiam, wrote a book (La Parole aux Negresses, Ed. Dencöl-Gonthier, Paris 1978) on the condition of women in Africa. The two major themes of the book are polygamy and genital mutilations, and its strength lies in the authenticity of the evidence, much of it in the form of personal accounts gathered by the author from a number of countries.

She presents, for instance, the case of a mother aged 35, a civil servant with secondary education, who had decided with her husband that their three daughters would not be subjected to the mutilations which she herself had undergone.

"They were born in France, while my husband and I were finishing our studies. When we returned to Mali, a mother was the first to ask me if I had had my children excised and infibulated. I replied "no", and stated explicitly that I had no intention of having it done. It was during the holidays. Having found work, I often left my children at my parents and came to fetch them at the weekend. One day, one the way back from work, I wanted to speak to the other children. One day, we went to the hospital. Normally they would rush out to greet me. Then I asked my mother where they were. "They're in that room", she replied, indicating the place where they usually slept. I wondered if they were sleeping, or just didn't know that I was there. I went into the room. There they were on the floor, on mats covered with cloths. At the sight of their swollen faces and eyes full of tears, I gasped and cried out: "What is it? What's happened to you, my children?"

But even before the little occupants of the room could reply, the voice of my mother reached me: "Don't you go disturbing MY grandchildren. They have been excised and infibulated this morning."

This young mother, asked her views on putting an end to the practice, replied: "I don't know exactly how, but it doesn't seem to be impossible. At what price I don't know. But nothing can be done towards abolition of these customs if the women concerned do not get together to impose their point of view."

Another account is given by a young woman from Mali, now married and with a degree, who tells how she tried in vain to escape "opening by the knife" on the eve of her wedding. The attitude of the medical personnel to whom she turned sticks in the mind:

"I don't remember anything of my excision or infibulation which were done to me when I was very young. It was only when I was twenty, just before my marriage, that I became aware of my condition. I grew up in a closed society, where sex and sexuality were taboo subjects. When I became conscious of my excision and infibulation, I was overcome with a feeling of revulsion. What should I do, I asked myself. For me, there was no question of letting myself be "opened" with a knife on the day of my marriage as is the custom for all women who are both excised and infibulated. Then the idea came to me of getting myself operated on in a hospital. I went to see doctors and then to midwives, but each time I met with a blank refusal. I thought it must be a sort of social consensus. Every single one was against my being operated upon. Every man and woman whom I asked for a hospital operation treated me like a strange animal. One doctor didn't hesitate to say to me: "You want to live a life of debauchery, and for that you are asking my complicity?" I nearly got thrown out of his consulting room. From day to day I lived with my anger and my revolt. I saw to what extent social pressure can be powerful. The day of my marriage approached. The chances of escaping this "opening by the knife" were diminishing. At last, on the eve of my wedding, I had to face my ill fortune and submit to it."

A Toucouleur woman from Senegal recounts how she tried, with the aid of her husband and children, to prevent the mutilation of little Aissata whom they had taken in. But in vain, since Aissata's father took her back by force to her village. "Several days later, we were informed that Aissata had been excised and infibulated. To our great despair."

Awa Thiam includes, however, the discordant voice of a young Mali woman with a degree in economics who is pleased to feel no sexual desire at all: "This demonstrates, she says, to a certain degree the function of excision: it permits a woman to be mistress of her body. This is why I don't see it as a mutilation at all."

What should be done? Awa Thiam feels that there are only two groups of people who want these mutilations to continue: certain Moslem fanatics, and some women who hold absolutely to the continuation of these customs in the name of ancestral values. But she thinks that the majority of young girls and children wish for abolition. "Little girl who is excised, even if she wants it because all the little girls of her age are done and because she has been persuaded, doesn't feel any less the terrifying pain. Moreover, she feels deeply the hurt done to her body. She is conscious of being wounded, diminished specifically. Whatever else may be suggested, she experiences a mutilation..."

In the opinion of Awa Thiam, action should be based on precise and objective information, and on the getting together of women, in other words, an organized female action. She emphasizes that clitoridectomy and infibulation are not subjects for discussion for most African men and women. Nor is the condition of women in general. 'In the context of negro-african mass organizations, whether of the left or of the right, these questions are avoided.' Thus it is for women to pose the problems which specifically concern them and to work towards their solution. "There is room to inform women objectively; explain to them the consequences of excision and infibulation. The care of their bodies should be left to them, and women will often be a question of a struggle which the isolated woman may too often lose, as is illustrated by the example of the young woman who didn't want to be 'opened by the knife' mentioned above. Sometimes individual initiative can nevertheless serve at least as a breaking point, and Awa Thiam suggests that already-excised and infibulated women could from now on usefully give an example by campaigning in their own locality. But their struggle will only be effective if they are united. 'Against' men? Awa Thiam's reply is nuanced, and fair; every struggle for the liberation of women will be carried out against certain men, and with others.

Two other points come out strongly from Awa Thiam's perspective: on the one hand, the wish for a vast reciprocal solidarity among oppressed women, whatever their specific struggle; on the other, the realization that the road is a very long one. And it is on this theme that her book concludes:

"Essential, right now, are groupings of women quite free of the practices of party politics dominated by the fascism inherent in their structures and phallocratic ideology. At the same time accepting the idea that the liberation of oppressed masses, to be effective, requires a struggle fought with and against women, with and against men. In fact, the solution of the problem of women will be collective and international. Change in their status will also be at this price or not at all. If one just casts an eye over the history of the condition of women — marked by struggles, it has continued to evolve, but at such a pace that it seems that women who struggle for their liberation and at the same time for that of their societies, are undertaking a long drawn-out campaign. In other words, it's a question not of a sprint but of a marathon. So women should prepare with this in mind, in order to succeed."

Comments from Somalia

In 1977, when Somali Women's Democratic Organization was formed, Edna Adan Ismail, an experienced health worker, spoke out with government permission about infibulation. She was afraid that the great bulk of women might throw their shoes at me. Instead they stood up and applauded. So many individuals then wanted to speak that the assembly broke into smaller meetings: at the end each group in turn called for abolition. Now the Somali Women's Democratic Organization are the implementing agents for the Commission concerned with the Abolition of the Operations, appointed by the Government.

In Khartoum in 1979 at the WHO Seminar, two women representing the same organization, Raqiya Haji Dualeh and Mariam Faraf Warsame, enumerated the measures necessary to combat mutila-
To demonstrate our privileged new status, all the circumcised girls formed a chain, and walking with our legs apart (sign of circumcision), toured the alley, singing and frolicking.

Again and again, like the women interviewed in a poor suburb of Cairo, the daya emphasized the importance for people in the village to conform to tradition and customary practices, by making statements such as the following:

'We can't afford being different. We found our mothers circumcised, we learned that our great mothers and great-grandmothers were circumcised, and we have to carry the tradition to our children and grandchildren. We can't think of anyone who is not circumcised. Once a man divorced his wife as soon as he discovered that, out of negligence, one of her two leaves was not cut off. This man told his wife: 'What have I married? A man or a woman?'. News of the incident was propagated, and the woman did not know where to hide because of the scandal.'

When asked whether she thought that circumcision affected libido, the daya retorted:

'Of course not. All the women I know, including myself, enjoy our sex life, just as much as our husbands do. We experience orgasm as our men, and every woman is capable of achieving it.

Men's views on the custom are very important, and we have no means of determining whether those who do not have its roots in religion run a high risk of creating a religious issue. If we actively encourage some religious leaders to take a stand against the practice, others will inevitably take a stand in support of it, developing a religious opposition to any change. This has been the experience with family planning. When much stress was laid on religious views and family planning, the rejectors have used religion as a camouflage for other objections, and the religious proponents have been accused of adjusting religious beliefs to suit political expediency.'

1. Action research

a. Epidemiological and psychological research to ascertain the distribution of the different forms and the physical and psychological damages caused by the milder (sunna) more common form of circumcision practised in Egypt. We need to discover how to communicate our knowledge of the damages to the ardent promoters, and help them correlate the operation with the harmful effects. We need to ascertain that the milder form causes frigidity, that it is so traumatic that circumcised girls tend to have more psychological problems than those who are spared, that circumcised women suffer from sexual intercourse and childbirth. We then need to ensure that the different leadership groups are trained to interpret those findings and work through the points thus identified as vulnerable to attack.

b. Socio-anthropological studies to identify the meaning of the practice in relation to socio-cultural patterns and values concerning women and girls.

Men's views on the custom are very important, and we have no studies describing these. We need to ascertain whether men would truly refuse to marry uncircumcised girls, as is often claimed by Cairo, the daya emphasized the importance for people in the village to conform to tradition and customary practices, by making statements such as the following:

'We can't afford being different. We found our mothers circumcised, we learned that our great mothers and great-grandmothers were circumcised, and we have to carry the tradition to our children and grandchildren. We can't think of anyone who is not circumcised. Once a man divorced his wife as soon as he discovered that, out of negligence, one of her two leaves was not cut off. This man told his wife: 'What have I married? A man or a woman?'. News of the incident was propagated, and the woman did not know where to hide because of the scandal.'

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2. Action

a. Groups for delaying action: Regarding the mistaken views linking female circumcision with Islamic beliefs and practices, all studies have indicated the fact that both Christians and Muslims in Egypt practise female circumcision, and the practice is perpetuated on the basis of custom and tradition rather than on the basis of religious beliefs. Hence, any undue stress on religious arguments to counteract it may create counter arguments. Religious leaders are the product of their own culture. Like anyone else they have internalized the values of their own culture that may unconsciously affect their religious views, however much they endeavour to separate one from the other. Calling their attention to a topic which they ostensibly does not have its roots in religion runs a high risk of creating a religious issue. If we actively encourage some religious leaders to take a stand against the practice, others will inevitably take a stand in support of it, developing a religious opposition to any change. This has been the experience with family planning. When much stress was laid on religious views and family planning, the rejectors have used religion as a camouflage for other objections, and the religious proponents have been accused of adjusting religious beliefs to suit political expediency.'

Seminar on 'Bodily mutilation of young females'

Ms Assaad's proposals are underlined in concrete form by the recommendations resulting from a Seminar held by the Cairo Family Planning Association in October 1979. This seminar brought together representatives of the Arab League, UNICEF, WHO, the Sudanese Embassy, the Egyptian Ministry of Social Affairs, the General Organization of Information, Medical Depart-
Budget

A budget has been prepared as follows: (in Egyptian £'s)

Preparation and printing 7 booklets (5,000 copies) 18,900
Preparation and printing 5 plays 11,000
Preparation and production of audio-visual materials 5,000
14 Training Sessions, each to include approx. 50 people 21,000
+ honoraria for training leaders 4,200
Salaries: Director (half-time) 5,400
Secretary (full-time) 5,400
Stationary and office expenses 3,600

Total for three years: 74,500

This project needs funding. Here is a very specific opportunity for individuals or organizations who wish to take action in a practical way towards the elimination of mutilation. For further information and a detailed budget, please contact:
The Assistant General Secretary to the Middle East Council of Churches, c/o the Women's Programme, the Coptic Orthodox Church, P.O. Box 35, Nasr City, Cairo.

Advice from Kenya

The Hon. Mrs Eddah Gachukia (her address is: P.O. Box 21389, Nairobi, Kenya), one of five women members of the Kenyan Parliament, has been actively engaged through the National Council of Women of Kenya in efforts to counteract mutilation in Kenya. She contributed these views:

‘Little or no concrete work or research has been carried out on female circumcision in Kenya so far. The National Council of Women of Kenya has appealed to various agencies including the International Council of Women, UNICEF, World Health Organization, and Fran Hosken, for a grant that will enable Kenyan women scholars and gynaecologists from the areas that practise female circumcision to carry out reliable studies that would result in badly needed facts which the Council could then use to lobby for government support on the discouragement (if not banning) of the practice.
The National Christian Council of Kenya leadership also recently called for research into the practice in Kenya.
As you are no doubt aware, female circumcision is carried out with a lot of variation in the countries under question. In most parts of Kenya today, girls will voluntarily go for it rather than be coerced into it. Our problem then has to do more with education (based on full information and knowledge) and specifically with the expansion of girls’ education as an alternative means of achieving self-identity rather than with legislation. Our concern is also with the education of women (mothers and girls themselves) as to the medical complications and their consequences. The basis for this education has to emanate from research and data gathered here in Kenya. I have personally discussed this whole issue with the Head of the department concerned in the University of Nairobi medical school and his staff have already embarked upon this work in a small way. They could, however, do with a research grant that would enable them to send research students out to the field for comprehensive studies. I do not believe that international propaganda can be helpful at the country level, especially when this is highly coloured by prejudice, alarmist, and based on erroneous information. International Organizations and genuinely interested individuals should support local effort and expertise which we lay at their disposal.’

Proposals for eradication in Nigeria

by Esther Ogunmodede, a Nigerian journalist. Several years ago the thought occurred to her that there must be other African girls circumcised like herself, who questioned the practice. Her enquiries showed that several hundred thousand excisions take place in Nigeria every year, and she began to write and speak out against the custom.

It has to be appreciated that in Nigeria, the practice of circumcising females cuts right across ethnic, religious, cultural and language barriers and considerations. Although the detrimental effect of female genital operations is very serious, it would be counter-productive to ‘over-kill’ by urging religious leaders to get in on the campaign to eradicate it, simply because:

(a) It is not a religious problem — at least not in Nigeria — it simply is a cultural custom that has become traditional.
(b) Religious leaders would find it too embarrassing to talk on the subject and may consider it quite outside their province.
That is not to say that their support, if it could be enlisted, would not be useful, especially in the rural areas where they are often the leaders of society in their communities.

Without doubt, the campaign to eradicate the practice has to be from the medical point of view. That is the only valid reason that can be advanced for wanting to eradicate such a deeply entrenched and widely practised tradition.

Research

The starting point towards a sustained programme of eradicating female genital operations in Nigeria has to be a well-ordered research. There is an urgent need for a research to be launched to compile information and data as to:

(a) Which ethnic groups in Nigeria practise female circumcision.
(b) Their reasons for doing so, in order to allay their fears for discontinuing the practice.
(c) The numbers of girls and women who have been or are likely to be circumcised.
(d) The ages at which the circumcision takes place in the different areas.
(e) The operators or circumcisers and the types of instruments they use.
(f) How many cases end up in hospitals requiring emergency treatment and other ‘repair jobs’.
(g) The medical as well as the psychological effects on the girls of circumcision.

The World Health Organization, UNICEF and other World Bodies

These international bodies should initiate the research, provide the resources, and an adequate back-up eradication programme to combat a major factor detrimental to the health of women in Africa. We have had too many conferences and resolutions but precious little action. Now is as good a time as any for action to get started. The programme should co-operate fully with the important Ministries of Health, Education and Information, to exploit fully the findings of the research.

Special units should be incorporated within the existing framework of the Ministry of Health, drawing on the facilities and resources of the other two ministries to launch a massive educational programme, the targets to be aimed at being as follows:

1. Maternity Clinics

These clinics in Nigeria usually comprise both the ante-natal as well as the ‘baby’ clinics. Here is where the candidates for future circumcision begin their lives, and here is the effective place to begin to educate mothers about the needlessness of the operation as well as the detrimental effects of it on girls.

Normally, there are talks by nurses and midwives at these clinics to educate the would-be mothers and new mothers about child care. This is the opportunity to include the education regarding circumcision and so save thousands of girls from the circumcisers’ razors. The fact that the two clinics are often in the same building in most areas, make them ideal places to show films, put up posters and give out leaflets. Husbands, too, can be invited along to see such films.

2. Womens’ Societies

Contrary to popular opinion held in Western countries, the women in Africa rather than the men, are the champions of female circumcision. Since mothers are the guardians of their daughters’ morals, they have a special interest in preserving their daughters’ morality and purity. Therefore, any campaign to abolish the
Our Working Group was formed here in Geneva in 1977 by members of non-governmental organizations having consultative status with the Economic and Social Council of the United Nations. These non-governmental organizations form part of the Special Committee on Human Rights, and its Sub-Committee on the Condition of Women. Our Working Group concerns itself exclusively with excision and its grave consequences for women's health. We have reflected on the most effective way of combating these practices. It has become clear to us that we should interest ourselves in the training of medical and social workers who are in contact with rural populations, and also in the information of these same populations.

In order that these two initiatives — training and information — have a chance of success, it is indispensable to obtain the agreement and co-operation of the official bodies and of the women directly concerned.

Our discussions with women's associations in several countries in Africa gave us to understand that, by means of modest development projects at village level, it would be possible gradually to bring to the attention of women the dangers of excision.

The first projects have just started in Kenya and in the Sudan. The conception and implementation of them are entirely the responsibility of the African village women themselves. Under cover of activities which will allow women to provide for their needs, talks on health education will be organized two or three times a month. They will talk about family planning, nutrition, care of pregnant women and children, and above all of excision and its grave consequences. These health education talks will be carried out by trained African doctors, midwives, nurses and birth-attendants.

We think that women will listen willingly, and will follow the advice of those who live and work with them, in their villages. It is still too early for results. However, we sincerely hope that, by means of these small projects, women will gradually be convinced of the grave dangers of excision.

**Sudan — the longest experience**

(Genital operations are customarily referred to as female circumcision in the Sudan, and we respect this preference.)

The Sudan has the longest history of efforts to combat female circumcision over a period of forty years; however, even in 1979, more than 80% of Sudanese women continue to be infibulated. Lessons may be learned from their experience. A brief account follows, drawn from articles and opinions cited in the Hosken Report, Second Edition, 1979.

Midwifery training in the Sudan was instituted by the British in 1921, and by 1948 the midwifery school of the Wolff sisters had trained more than 900 midwives in different areas all over the country. In 1943 a Medical Committee was set up by the then Governor-General to study the problem of female circumcision, resulting in a booklet in Arabic and English, supported by religious leaders, and stating that pharaonic circumcision was cruel and harmful and should be abolished. This was supported by a press and radio campaign. None of this had any discernible effect, so in 1946 the government resorted to legislation. People raced to have their children infibulated before the law came into effect, with a high incidence of catastrophe. Under the law, midwives who performed infibulations were subject to a fine and imprisonment for up to 7 years. Such violent riots greeted the first arrests that the law was enforced, and few further prosecutions were made. In the words of a Sudanese judge in the 1950s, these events 'brought to mind the risks involved in the rigid application of the new law without first preparing the people ... no social reform could be properly and righteously effected by legislation, particularly when that legislation was imposed by a foreign ruler ... the ordinary, modest, bashful Sudanese man, for whose supposed satisfaction women are performing this operation in secret, would not tolerate his womenfolk being dragged into jail or punished for doing what their ancestors had been doing without hindrance for over two centuries ... the only effective way for eradication of that bad and cruel custom is by education of both male and female Sudanese alike.'

Education for both sexes has since advanced significantly in the Sudan, but surveys and statistics presented to the WHO Seminar in Khartoum in 1979 show that the situation as far as pharaonic circumcision is concerned has changed very little indeed. In fact, in provincial towns, practically all schoolgirls are infibulated long before they are ten years old.

The current situation in the Sudan

is summed up by Awatif Osman, Director of the College of Nursing, Ministry of Education, Khartoum. At the WHO Seminar in 1979, Ms Osman was one of the rapporteurs, representing the International Confederation of Midwives. She has long years of experience on the subject of female circumcision.

At one time, the Sunna type of circumcision which is legal, was taught in midwifery schools on the premise that if it was to be done, it should be done in an aseptic manner and with the least amount of mutilation. Today the schools no longer teach any technique, and midwifery trainees are urged to discontinue the practice. In the College of Nursing in Khartoum, the Dean teaches a course in social ethics in which she discusses female circumcision as a mutilation, and the student nurses are made aware of the psychological as well as the medical consequences of the operation.

In spite of these efforts in the clinical field, circumcision persists; it persists for socio-cultural reasons, largely because it has a ritualistic importance, and it persists for economic reasons because it is a source of income for the midwife. Men continue to demand it of their prospective wives, and women continue to have it done for the same reason. Influential people in various places have defied tradition, and there are clusters of women who have not been infibulated, but there are few.

Time and education are the essence of the eventual solution of the problem. Attitude surveys being done now, on some on university students, may identify the approach that must be taken in the education of the public. Knowing why large segments of the population still believe in the practice is essential to developing the strategy to eliminate it. This research is being conducted by teams through the Faculty of Medicine, Khartoum University, through the Ministry of Health, and through Ahfad College for Women. Stress is placed on clinical and social aspects.

It would be counterproductive to focus on this problem in isolation when there are so many problems of maternal and child health to be addressed. Ultimately, it is a Sudanese problem — a problem which we are aware of and which must be solved by us. In every discussion with Sudanese, the importance of greater literacy is emphasized, especially educational opportunities for women.

Symposium on 'the Changing Status of Sudanese Women'

This symposium was held in February 1979 by the Ahfad University College for Women in co-operation with interested community leaders, in Khartoum. The recommendations of the symposium on health aspects included the following:

1. The Symposium strongly recommended the stopping of female circumcision in all its forms, pharaonic or sunna.

2. A campaign including the use of mass media and curriculum programmes should be carried out to inform the public of the harmful effects of circumcision.

3. Medical experts should convince religious leaders and policy makers of the dangers of circumcision.

4. Traditional midwives who practise circumcision should be trained in other medical or health fields so as to enable them to procure a compensatory source of income.

Among the specific recommendations of the Ahfad Symposium was the forming of a voluntary association. It has now been registered under the name of 'Babiker Badri Scientific Association for Women Studies', as a tribute to the founder of women's education in the Sudan. This Association undertakes the implementation of the Symposium recommendations, and, further to group discussions held during the Symposium with women leaders from many villages and different provinces of the Sudan, it gives priority to:

Caring for children through women's education.
Raising future prospects for families through training of mothers in income-generating activities.
Abolishing female circumcision.

A project already underway in the Sudan

A specialised committee, formed by the Association, has started a specific plan of action: 'Child Health Through Mother Education'. The White Nile Province was selected for a pilot project to be implemented in five villages. This project is funded by the Swedish
Scilla McLean trained as a social scientist at Trinity College, Dublin, and has worked for many years in health education in Southern Africa. She has been the research director and organizer of the Minority Rights Group in France, and a consultant to the Human Rights Division of UNESCO on Women's issues.

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Diagrams by Denise Berry, 3 rue Lecomte, Paris 75017.

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The Reports already published by the Minority Rights Group are:

- No. 1 Religious minorities in the Soviet Union (Revised 1977 edition)
- No. 2 The two Irelands: the double minority — a study of inter-group tensions (Revised 1979 edition)
- No. 3 Japan's minorities: Burakumin, Koreans and Ainu (New 1974 edition)
- No. 4 The Asian minorities of East and Central Africa (up to 1971)
- No. 5 Eritrea and the Southern Sudan: aspects of wider African problems (New 1976 edition)
- No. 6 The Crimean Tatars, Volga Germans and Meskhetians: Soviet treatment of some national minorities (Revised 1980 edition)
- No. 7 The position of Blacks in Brazilian and Cuban Society (New 1979 edition)
- No. 8 Inequalities in Zimbabwe (Revised 1981 edition)
- No. 9 The Basques and Catalans (New 1977 edition) (también en catalán) (The Basques' most en français, much auf deutsch)
- No. 10 The Chinese in Indonesia, the Philippines and Malaysia
- No. 11 The Biharis in Bangladesh (Revised 1977 edition)
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- No. 14 Rome Europe's Gypsies (Revised 1980 edition) (aussi en français, also in Romanò)
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