

Sexual Mutilations

Case studies presented at the workshop:

African women speak on female circumcision

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Babiker Badri - Scientific Association for Women Studies

Female circumcision in Sudan

Introduction

Female circumcision (the partial or complete removal of the external female genitalia) is widely practised in the Sudan. It has persisted for centuries because of lack of awareness and knowledge about its adverse physical and psycho-social consequences and because of a firm belief in its supposed benefits of ensuring female chastity and securing marriage and subsequent harmonious family life. In the Sudan, female circumcision has for long remained in secrecy but it is now being brought to the surface by health and medical practitioners, sociologists, psychiatrists, psychologists and others who are all interested in the various physical, psychological and socio-cultural aspects of the practice.

This paper is primarily presented as a summary of contributions especially prepared for the present Workshop. Additional material to complete the presentation is drawn from other written sources dealing with issues and problems relating to female circumcision in the Sudan. The purpose of this paper is to summarize available information and findings on female circumcision as presently practiced in the Sudan and to examine and assess efforts made to abolish it. It is hoped that the paper will be useful in stimulating constructive discussion that lays the foundation for fuller understanding, action, and commitment to eradicate the practice of female circumcision.

Background information on Sudan

Some background material on the Sudan is relevant. The Sudan is the largest state in Africa with an area of about 2.5 million square kilometers. Its terrain consists primarily of an extensive plain rising gradually to highlands in the north-east near the Red Sea coast, and plateau and low mountains near the southern and western borders of the country. In the Sudan the climate is mainly tropical, being equatorial in the extreme south and arid in the north.

The Sudan is sparsely populated with an enumerated population of about 14 million in 1973 and an estimated population of about 14 million in 1973 and an estimated population of over 19 million in 1981. The population in the Sudan is very young, with nearly 46 per cent of the population aged 15 and only 3 per cent aged 65 and over. The current rate of natural growth is estimated to be around 3.2 per cent annually. The Sudan is predominantly rural with less than 20 per cent of its population living in the urban areas.

The educational level of the adult population in the Sudan is low. In 1973 among persons 10 years of age and older, about 32 per cent of males and 12 per cent of females were literate. Recently,

there has been rapid expansion in education. About one-half of the boys and more than one-third of the girls aged 7-12 are currently enrolled in primary schools.

The economy of the Sudan is largely based on agriculture; in 1973 about 66 per cent of the economically active people were engaged in agricultural pursuits.

The population of the Sudan falls into several ethno-cultural and tribal groups. In the South there are Christians and Muslims although the majority of people still follow their own traditional religious beliefs and practices. In the rest of the country Islamic religion predominates. Besides Arabic, the lingua franca of the Sudan, different languages and dialects are spoken by various ethnic groups. Politically, from 1899 to 1955 the Sudan was a British colony and it became an independent country on 1st January 1956. From 1958 to 1964, the Sudan came under military rule; from 1964 to 1969 it was ruled by civilian governments, and with the May Revolution of 1969, a single party Presidential system has been instituted, with the Sudanese Socialist Union as a mass political party.

Forms of circumcision and its consequences

While some variations exist, there are three major forms of female circumcision practised in the Sudan. These fall into (a) infibulation; known in the Sudan as Pharaonic Circumcision, which entails the removal of the whole clitoris, labia minora and either the entire or most of the anterior parts of the labia majora. The two edges are then brought together by stitching or other means and are left to heal. Infibulation is often described as the oldest and most prevalent in the Sudan. (b) Circumcision proper, known in the Sudan as Sunna circumcision, which involves the excision of the tip of the prepuce of the clitoris. The Sunna circumcision is regarded as the mildest form. (c) Intermediate Female circumcision in the Sudan (between Pharaonic and Sunna) which entails the removal of the clitoris, anterior parts or the whole of the labia minora and parts of the labia majora. The two sides are then stitched together leaving a variable opening to allow passage of urine and menstrual blood. The Intermediate form of circumcision is identified as having various degrees of severity.

Adverse medical and health consequences of female circumcision

In the Sudan a variety of complications of female circumcision have been reported in the medical literature. Usually immediate and late complications such as immediate shock, bleeding, infection, tetanus, difficulty in passing urine and urinary retention, where as late complications include, among others, vulval swelling, difficulties during labour and delivery, and coital difficulties such as severe pain at penetration and lack of orgasm or sexual gratification. In a nation-wide and cross-sectional survey, Asma El Dareer traced the incidence of both immediate and late complications of female circumcision and their frequency for each of the major types of circumcision among circumcised Sudanese women. The following is a summary of the main findings. The immediate complications of all three forms of circumcision numbered 790 cases (25 %) of all circumcised females. The frequency for each type of circumcision alone was: Pharaonic 26 %, Intermediate 24 %, and Sunna 8 %. Of all the immediate complications, difficulty in passing urine, wound infection, and bleeding were the most common. On the other hand, the delayed complications amounted to 1023 (32 %) of all circumcised cases. The frequency of each type of circumcision alone was: Pharaonic (33 %), Intermediate (31 %), and Sunna (15 %). The most common delayed complications were recurrent urinary tract infections, chronic pelvic infection and results of tight circumcision, namely difficulty in penetration, pain during sexual intercourse, and difficulty in menstruation. An interesting result of Asma El Dareer's study is that the pattern of complications of Pharaonic and Intermediate forms of circumcision was found to be the same.

Adverse psychological consequences of female circumcision

Serious psychological consequences of female circumcision are numerous and most have been reported by students of Mental Health. Material concerning the adverse psychological effects of female circumcision in the Sudan...

Circumcision is not based on extensive surveys but rather it is based on observation and clinical cases. The available information indicates that the immediate physical complications of female circumcision, especially the pain associated with the operation form an instant source of psychological hazards to circumcised female children. It is true that much is done by Sudanese families to lessen the painful effects of female circumcision, but nonetheless, the circumcised female child undergoes an unforgettable experience. The clandestine nature of the operation together with the fear-provoking situation associated with it combine to disturb the mental state of circumcised girls to the extent where they cause worry, anxiety, sleeplessness, nightmares or even panic. As the girls grow up and the adverse and late physical complications set in, mental injuries in the form of distorted images about menstruation, sex, marriage and childbirth tend to increase. Moreover, many circumcised females are most likely to be caught in the web of conflicting expectations and roles. This relates to the fact that in the Sudan circumcised girl is regarded as an adult female and quite often treated as such even though she is just a child trying to play the roles appropriate to early or middle childhood. In such circumstances young girls may experience personality changes; a lively, innocent and friendly child becoming timid and introspective. Again, delayed complications of female circumcision, especially deformity in the female genitalia, swelling and the development of fistulae may cause serious patho-psychological changes and precipitate a series of abnormal psychological disturbances ranging from chronic irritability to reactive depression and psychosis.

Other adverse consequences of female circumcision

Equally important is that female circumcision has serious negative psycho-sexual effects on women and men alike. Women are most likely, for instance, to meet with lack of orgasm or sexual gratification in intercourse as a result of amputation of the clitoris. This is so because, unlike what is commonly believed in the Sudan, the excision of the clitoris does not reduce desire for sex, but rather it spoils sexual gratification. Among men injury to male sexuality is likely to occur if a man failed to accomplish successful coitus with an infibulated wife. The statistics given by the Sudan Fertility Survey were 79.4 per cent Pharaonic, 16.5 per cent Sunna and 4.1 per cent uncircumcised. The information yielded by Asma El Dareer's survey showed that of 3,171 circumcised females, 2,636 (83 per cent) were Pharaonically circumcised, 386 (19 per cent) had had Intermediate circumcision, 80 (2.5 per cent) had had Sunna circumcision and 69 (2 per cent) could not be classified because they were unable to identify which form they had had.

Surveys undertaken among specific populations indicated that in more recent years there have been significant changes in female circumcision practices. In particular, surveys carried out among college and high school female students reported a rise in the incidence of Sunna and Intermediate forms of circumcision. The statistics given by Gasim Badri, for instance, were 28 per cent Pharaonic, 11 per cent Sunna, 55 per cent Intermediate, and 6 per cent incircumcised. These figures provided evidence suggesting that there has been a shift away from Pharaonic circumcision among certain categories of females, especially young and urban-oriented ones.

The practice of female circumcision in the Sudan is closely correlated with increasing illiteracy whether this illiteracy

concerns those who were circumcised or their parents. Eightyone and 6 tenth per cent (81.6%) of the respondents were illiterate. Again, of all the women interviewed in Asma El Dareer's research, 43 per cent were illiterate, 84 per cent of their mothers and 42 per cent of their fathers were also illiterate.

Regional and ethno-cultural differences relating to female circumcision are of some interest, but lack of numerical data precludes detailed statistical analysis. However, different observers noted disparity even within the same region. Thus while in Eastern Sudan the Beja tribes, especially the Hadandowa and Beni 'Amir practice the severest type of infibulation, their neighbors, the Rashaida Arabs, hardly carry out any form of circumcision among their women.

In the Sudan such failure is regarded as a slur on a man's virility and it is likely to breed psychological complications ranging from anxiety to impotence. Moreover, these complications may interfere with marital relationships as when a husband accuses his tightly circumcised wife of his impotence or when a wife is adamant about her husband's failure and ready to declare it. In such situations impotence is likely to result in suicide or homicide - the husband taking revenge on himself or on his wife to defend his honor.

It can be seen that female circumcision has serious complex and far-reaching psychological, physical and social results.

Nature and extent of female circumcision practice in Sudan

For a long time female circumcision has been practised in the Sudan despite the harmful physical, psychological and social effects. Among the different groups in the country it is generally associated with much ceremonial and ritual activities. Moreover, female circumcision is characteristically a women's affair and as a deeply-rooted custom it is embedded in a complex set of beliefs and values. On the other hand, the operation of female circumcision is often carried out by non-skilled practitioners under very adverse hygienic conditions. For example, the instrument commonly used is a razor blade and in most instance little or no attempt is made at sterilizing it.

Female circumcision in the Sudan is reported to be performed at ages after 6, between 5 and 8 years, or between 4 and 8 years. According to Asma El Dareer's survey 81.4 per cent of the women interviewed were circumcised by the time they were 9 years, with 63.3 per cent having been circumcised between 5 to 9 years of age.

The Sudan Fertility Survey and Asma El Dareer's study provide a broad picture of the prevalence and distribution of female circumcision in the Sudan. These two nationwide surveys indicate that the practice is quite prevalent in the country. Thus, according to the Sudan Fertility Survey, 95.9 per cent of the respondents (ever married females) have been circumcised. In addition, these two surveys provide a useful indication of the incidence of each of the major forms of circumcision currently.

Baggara Arabs continued to practice Sunna circumcision for quite a long time before turning to more drastic forms of infibulation whereas many of the Muslim tribes of Darfur (extreme West) do not perform circumcision on their females. A milder form of circumcision is common throughout the groups inhabiting Northern and Central Sudan as well as among the Kababish Arabs of Western Sudan. In Southern Sudan female circumcision or any form is not in practice except perhaps where the local peoples come into contact with some Northern groups. In a vast country like the Sudan, these regional and ethno-cultural differences in the practice of female circumcision are scarcely surprising though further research is needed to substantiate them.

Reasons for the continuation of the practice

In the Sudan numerous reasons are given for the performance and continuation of the practice of female circumcision. First, the operation of female circumcision appears to have been performed

with a view to attenuate sexual desire. According to this popular belief, lessening sexual appetite prevents women from indulging in pre-marital sex and from losing their virginity. Loss of virginity and pre-marital sex are deplored and regarded as improper or even immoral in Sudanese Society. However, it has been repeatedly argued that female circumcision even in its extreme form of infibulation (fastening or stitching together the edges of the *libia majora*) cannot serve to secure women's virginity or to ensure their chastity. This is because it is possible for a female to engage in pre-marital sex and lose her virginity, but through a simple surgical operation get recircumcised shortly before marriage. All this implies that in the light of medical knowledge the view that infibulation protects virginity and ensures continence is certainly invalid.

Secondly, in Sudan female circumcision is performed because of a common belief that a circumcised woman is "clean" and an uncircumcised woman is "unclean". Again, in the light of current medical and health knowledge this reason or rather assertion has no substantial support.

Thirdly, a reason for circumcision most frequently given is that men will not marry a girl unless she is infibulated. The argument for this view is that men derive more sexual gratification from a tightly circumcised woman with a narrow orifice rather than from an uncircumcised one. Incidentally, it is this kind of reasoning which explains why many Sudanese women get involved in the vicious series of decircumcision and recircumcision after each successive childbirth. But as mentioned earlier, the various forms of circumcision can only add to women's agony and misery and contribute to men's lack of sexual satisfaction and impotence.

Fourthly, in the Sudan the operation of female circumcision has quite often been performed in the pretext that it is endorsed by the Islamic religion. However, this popular belief has still a strong hold. It has been repeatedly refuted by religious leaders. As Sheikh Hassan Ahmed Abu Sabib has indicated there is no evidence of the Islamic religion favouring female circumcision. The Sheikh also pointed out that Muslim countries associating the practice with religion should revise their stand and that female circumcision should not be practised by any Muslim on the basis of Islam.

Fifthly, in the Sudan, traditionally the operation of female circumcision used to be performed on girls who were approaching puberty. Consequently, female circumcision could be interpreted as an initiation ceremony which functions through certain rites to reinforce and give meaning to the process of psycho-social development from puberty to adulthood. But, now as the age at which the operation is carried out on Sudanese girls varies from one week to about 10 years, the practice of female circumcision may simply create a sense of awareness in the child regarding her future sexual role, but it can hardly prepare her to enact that role. Indeed, with much of its ceremonial and ritual acts being minimized female circumcision can no longer influence the process of socialization or maturation.

Lastly, many Sudanese families continue to perform the operation of female circumcision on their girls as a tradition or custom dictated by and in line with group norms, values and identity.

Efforts to combat female circumcision in Sudan

In Sudan the interest in the practice of female circumcision and concern about its adverse effects were not new. As early as the three decades preceding the Second World War, Sudanese and British Administrators, religious leaders, politicians and other enlightened Sudanese had all been concerned with finding ways and means to abolish the practice. Medical practitioners expended much effort to disclose the extent and nature of the damage inflicted by female circumcision upon its victims; Religious leaders directed their energies towards dissociating the practise of female circumcision from Islamic religions and making it clear to the public that true Muslims should give up repulsive practices such as excessive excision and infibulation which have no support

in the basic principles of Islam. Political leaders and notables gave their blessings and support and the fight against female circumcision went on and eventually culminated in the promulgation of the law of 1946. This legislation prohibited the practise of Pharaonic circumcision and made it illegal and punishable by fine and imprisonment.

From the start many serious misgivings were pronounced against these early efforts to deal with female circumcision and against the law that was intended to impose a strict ban on Pharaonic circumcision. The efforts were seen by some Sudanese as a direct interference on the part of the colonial government with intimate practices and values of the Sudanese society and culture and extreme nationalists viewed the whole campaign against female circumcision as a threat to national solidarity as it tended to divide Sudanese people into those for and against anti-circumcision laws. Moreover, one of the immediate effects of the legislation of 1946 was that many girls were hurriedly taken by their mothers to be circumcised at earlier ages thereby giving those who were trying hard to convince the people to abandon the practice gradually, a serious setback. Indeed, over the years Pharaonic circumcision continued, though less openly, in spite of the fact that the prohibition of 1946 has never been formally revoked. In short, the anti-circumcision legislation has never been fully accepted either in theory or in practice. Nevertheless, the pre-war efforts to deal with female circumcision were not without useful results. Beside focusing the attention of a relatively large audience of the issue of female circumcision in the Sudan, a number of essential lessons can be extracted from these earlier experiences. First, it is extremely difficult if not impossible, for legislation to wipe out such a deeply-rooted tradition as female circumcision. Second, and most important, is that in introducing laws and similar measures, due consideration should be given to such factors as the political climate and the socio-psychological setting or rather the socio-cultural way of life of the people or communities concerned. Finally, if it is deemed necessary to introduce laws to combat a sensitive custom such as female circumcision, a genuine attempt should be made to grasp the full implications of these laws in order to avoid their undesirable results or unintended consequences.

The campaign against female circumcision in Sudan apparently has waned in the two decades or so following the Second World War. However, with the country's rapid change and development over recent decades, interest in female circumcision has been renewed and fresh attempts have been made with a view to eradicating it. Evaluating existing and on-going concerns and action dealing with female circumcision in the Sudan is an onerous task. However, the main features of recent attempts are easy to summarize. On the one hand, considerable and valuable efforts to combat female circumcision have been, and are being made in the country. On the other hand, much of what has been done so far is rather diverse and disparate. Unevenness and diversity are no doubt the inevitable results of the nature and complexity of female circumcision or the problem itself, the multiplicity of bodies and groups involved in it, and the variety of measures and actions made or suggested for the eventual eradication. These statements are not intended to belittle efforts, past or present, made toward combating female circumcision in the Sudan. They are intended solely to draw attention to the uneven and diverse nature of these efforts and to suggest that there is a need for a more co-ordinated work and a new strategy to do away with female circumcision in Sudan.

Much has been said or implied in this paper about the complexity of various aspects of female circumcision in Sudan. Here it is important to point out that in the last decade or so the number of organizations focusing their attention and interest on female circumcision has increased and that this reflects in a wide range of activities and measures intended to abolish the practice. Indeed, recently many more voluntary organisations, national and international bodies have been actively engaged in work and action-oriented activities with the objective of gaining more

knowledge about circumcision-related issues and suggesting appropriate measures to eradicate the practice. The organisations include medical associations (Obstetrics and Gynaecological Society), Sudan Family Planning Association, Ahfad University College for Women, Babiker Badri Scientific Association for Women's Studies ; High Nursing College, Department of Social Welfare, Maternal and Child Health Service of the Ministry of Health, the Sudan Women's Union, University of Khartoum, the National Committee for the Eradiction of Female Circumcision of the Ministry of Internal Affairs and WHO, UNICEF, the Swedish Radda Barnen, Swedish Housewives Association, and the Norwegian Action Group. These organizations articulated their activities and measures through a variety of channels, embracing conferences, seminars, symposia, workshops, discussion groups, radio, T.V., public speeches, books, articles, pamphlets, posters and integrated programmes of all sorts. The measures themselves include, among other things, emphasis on or call for legislation prohibiting all forms of female circumcision, intensification of general education of the public with special emphasis on the hazards of female circumcision, inclusion of courses on female circumcision as part of the curricula of certain educational institutions, intensification of educational programmes for special categories of personnel, e.g., midwives, health visitors, nutrition officers, etc., with a view to demonstrating the harmful effects of female circumcision and enlisting the support of these target categories for the campaign against female circumcision, and the integration of female circumcision issues with existing health and social programs designed to promote the status of women.

A survey such as the above leads to an apparent paradox regarding the campaign against female circumcision in the Sudan. On the one hand, it appears that a great deal of effort towards eradication of female circumcision has been expended. On the other hand, female circumcision, as indicated earlier in this paper, is still carried out in many parts of the country. This paradox, however could easily be explained away if it is realized that these efforts to combat female circumcision tend to be on the whole quite space-specific. In particular, they tend to be limited to the urban complex of Khartoum and other highly selected localities. Again, the recent efforts to eradicate female circumcision in the Sudan, with few exceptions, are not based on reliable systematic research. All this implies that if efforts to deal with female circumcision are to succeed they should have a much wider geographical coverage and should be based on scientific research. On the other hand, the lessons learned from the efforts carried out in the urban complex of Khartoum must be of central and crucial concern to the various organizations interested in circumcision-related issues and problems since these lessons can be useful when efforts are extended to the rest of the Sudan.

It is evident that a new strategy to eradicate female circumcision in Sudan must be based on reliable facts and interpretations of certain female circumcision-related problems and issues that should already identified as matters of concern and urgency. The space coverage of these issues and problems should be gradually enlarged to embrace different regions and populations of the whole of the Sudan.

Finally, to the extent that female circumcision is widespread in many African countries, concerned quarters in these countries must seek ways and means to exchange knowledge and experiences relating to this practice with a view to seeing the day it will be completely abolished.

Research and work in progress

Two surveys were undertaken in the Sudan, one by the Faculty of Medicine, University of Khartoum, and the other by the Sudan Fertility Association. Both are nation-wide, and both tackled many aspects of female circumcision (preference for the various types, attitudes toward it, complications ensuing from it, and justification given for the practice).

About 200 pieces of research, of different types, on various scales

have also been done, which include dissertations at the first degree and diploma levels, an M.Sc. thesis, and post-graduate professional research. A special project is being undertaken by the Medical Research Council to document and classify research on female circumcision and to suggest policies for future research on previous and current efforts to eliminate female circumcision.

Work Already Done Or In Progress

1. A national Workshop was held in 1981 in Khartoum to discuss female circumcision and to produce recommendations and strategies for the elimination of female circumcision.

2. Thereafter a follow-up committee was established as a Sub-Committee of the Babiker Badri Scientific association for Women's Studies. This committee is composed of both men and women and it has provided many public lectures and mass media activities.

3. A book on the proceedings of the Workshop, including all the recommendations made was published in 1983. It has been widely distributed, but there has been no detailed follow-up system to check whether each Ministry has fulfilled its obligations to accomplish the specific objectives of the Workshop.

4. The Babiker Badri Scientific Association has five current projects on female circumcision. Two workshops have already taken place.

5. Before the Dakar Conference took place, a National Committee had been formed which has held two meetings since September 1983. During these meetings it was recommended that a law should be enforced to forbid all forms of female circumcision and that the government should provide a state policy for the elimination of female circumcision. After the Dakar Conference the two men and two women who attended were supposed to form a National Committee to abolish female circumcision. It was decided, however, that as Sudan has already formed a National Committee, and two of those who went to Dakar were already members of it, there was no need to form another committee. No action has yet been taken by the National Committee.

Suggested Future Strategies By Organizations.

A.1. The BBSAWS should undertake 6 regional workshops in the 6 regions of the Northern Sudan to sensitise people in rural areas, to select highly motivated leaders from them and then to continue the work of the campaign by forming subcommittees of these to be responsible for the continuation of the work.

A.2. Work should be concentrated on a model area in the three towns of the capital to discover what results can be achieved to eliminate female circumcision, in one specific area. Checks should be made before and after the work in this model area in order to provide an efficient system of evaluation.

A.3. The integrated Women's Development Programmes should be extended to other villages.

A.4. Educational materials should continue to be produced and so should discussion groups continue to take place.

A.5. The project which has already begun should be completed so that midwives become supervisors of the work of motivating others to abolish female circumcision.

B. At the group and individual levels there should be

1. Research on the effects of female circumcision on fertility,

2. Research on the psychological impact of female circumcision children through long term research in rural Khartoum ;

3. Other research.

C. A league of university students should be formed for the elimination of female circumcision

D. The National Committee should be re-constituted so as to be smaller in number but to be composed of people really dedicated to the eradication of female circumcision.

E. Although the Sudan Government has no specific strategy, all Ministers concerned should publicly announce that female circumcision should be abolished. The Minister of Health in particular should ask all members of the medical services to take

action to combat it. All Public Health Programmes should include education for the elimination of female circumcision.

References

- Abu Shamma, A.O., et al, Female Circumcision in the Sudan, *Lancet*. Vol. 1. (1949).
- Badri, Amna El Shadik, Present Situation of Female Circumcision in the Sudan (A Paper presented to the Seminar on Traditional Practices Affecting the Health of Women and Children in Africa. Dakar (1984).
- Female Circumcision in the Sudan, *The Ahfad Journal*. Vol. 1 (1984).
- Badri, Badri Suliman, Knowledge and Attitude Towards Female Circumcision Among High School Girls. (Dissertation presented to Ahfad University College for Women) (1983).
- Badrim, Gasim Yousif, The Views of Gynaecologists, Midwives and College Students. (Proceedings on the Changing Status of Sudanese Women, Khartoum (1979).
- Barbour, K.M., *The Republic of the Sudan : A Regional Geography* London, (1961).
- Ba'ascher, T.A., Psycho-social Aspects of Female Circumcision. (Paper presented to World Health Organization Seminar on "Traditional Practices Affecting the Health of Women and Children. Khartoum (1979).
- El Dareer, Asma, *Women Why Do You Weep ? Circumcision and its Consequences*, London (1983).
- Complications of Female Circumcision in the Sudan, *Tropical Doctor* (1983).
- Farah, Abdel-Aziz Mohd; et al, Aspects of Population Change and Development in the Sudan; (Proceedings of the Second National Population Conference, Khartoum (1982).
- Hesken, F.P., Female Circumcision in Africa. *Victimology : An International Journal*. Vol. 2 (1978).
- International Labour Office (ILO), *Growth, Employment and Equity : A Comprehensive Strategy for the Sudan*. Geneva (1976).
- Modawi, Suliman, The Impact of Social and Economic Changes on Female Circumcision. (Proceedings of the Third Congress of Obstetrics and Gynaecology). Sudan Medical Association Congress Series N. 1. Reprinted (1974).
- Shandall, Ahmed Abu-el-Futuh, Circumcision and Infibulation of Females. *Sudan Medical Journal*, Vol 5 (1967).
- Taba, A.H., Female Circumcision. *World Health*. (1979)
- Verzin, J.A., Sequelae of Female Circumcision. *Tropical Doctor*. October (1975).
- Worsley, A., Infibulation and Female Circumcision : A Study of a Little-known Custom. *Journal of Obstetrics and Gynaecology of the British Empire*. Vol. 45 (1938)

Female circumcision in the Gambia

Aouzu Billahi Minash Shaitani Rajemm.
Bismillahi Rahmani-r-Racheem

My name is Mrs. Fatoumata Tambajang and I am from the Gambia, small country with a population of 696,886 of which 80% live in health hazardous rural areas and 70% of these are circumcised women and girls.

Madame chairperson, fellow participants on this note I wish to state that it is indeed a great pleasure and honour to be in your midst through the good will of the Babiker Badri Scientific association for Women's Studies in the Sudan. I am hereby representing the National Committee of Traditional Practices affecting the Health of Women and Children in the Gambia, in the capacity of secretary. Mrs. Safiatou Singhateh who was our

original representative to the Workshop is unable to attend due to other pressing official engagements. However, she has asked me to convey to the BBSAWS and the hospitable loving brothers and sisters of the Sudan with whom some of our ethnic groups at home share historical relationship, her personal gratitude for inviting us to the Workshop.

She also wishes us a successful deliberation in the Workshop.

If we all recall, the deliberations during Dakar UNFPA funded workshop on "Traditional Practices Affecting the Health of Women and Children in Africa" left us without any doubt as to that there was direct relationship between a mother and child.

The significant problem of female circumcision turns out to one of the major urgent and cruel clitoridictonuria practices in The Gambia needing our attention and combined efforts.

In the first instance, physical pain is inflicted upon a girl as well as life threatening consequences such as serious bleeding and infections leading to anaemia and tetanus respectively. The letter in most obvious cases emanate from the dirty and non-sterilized environment in which the operations are performed, as well as the knife or razor blade with which it is performed.

It is worth noting that the psychological complex of the need to comprehend natural delivery and affectionate parenthood is unique.

Besides, there can be psychological changes to a circumcised mother's natural reaction to sex. This may not be realised directly, but we should be ready to argue that the body's sex hormone composition is partially modified by the "sensitive organ" (clitoris).

As regard the child, it can be acknowledged that the injury to a child at delivery appears to be mainly due to the restriction of the mother's birth canal. This mostly ends up being a traumatic injury to both mother and child. Hence there is a suspected high morbidity and infant mortality rate in the Gambia as well as in other African countries where female circumcision is practiced.

I am, at this juncture, glad to report to my fellow participant that the Gambia Women's Bureau has now, in light of the above, established a National Committee with a view to research, analyse and design strategies for the eradiction of female circumcision through a policy document to be proposed to our government. We shall communicate the outcome of this major undertaking as soon as possible.

The composition of our national committee

Our National Committee is comprised of Senior Representatives from the Government/Non-Government/UNDP in respect of the Women's Bureau ; the Ministries/Departments of Health, Labour and Social Welfare, Education, Youth, Sports and Culture, Information and Broadcasting, Justice cum Attorney General's Chambers, Agriculture and Natural Resources (extension workers) ; Gambia Family Planning Association ; Non-formal educational services ; Community Development (field workers) ; as well as representatives of traditional practitioners and female circumcisers.

The above listed parties have met already twice to discuss the implications and remedial measures geared towards ultimate eradication of female circumcision and have arrived at the conclusion that the best way to approach the cruel practice is through evaluation of the following points :

- The origin, causes and statistical data of female circumcision.
- The concept of female circumcision in respect to Gambia modern society including medical and religious point of view.
- The economic effect of the eradiction of female circumcision.
- Eventual substitutes of economic income activity for the female circumcisers.

The relevant questionnaire, hence studies funded by the OXFAM Foundation centered around the above issues, is underway, but the preliminary evaluation made shows that the origin of female circumcision is purely cultural and customary with the intention of preparing girls for "clean" womanhood. Our rough statistical

estimate is based on discussions and indicates that about 70 % (seventy per cent) of our Gambia population is involved in the practice of female circumcision. It is therefore important to note that the practices of female circumcision cannot be eradicated by short-term goals because of its pronounced tie to culture and custom.

A girl who is not circumcised, for example, can undergo strenuous psychological and social pressures and isolation from her social interaction group.

The National Committee has subsequently recommended that coordinated activities of continued education in the form of workshops, seminars and adult education should constitute the proper approach to a long-term goal of eventual eradication of female circumcision.

There is an undisputed medical supporting evidence that if the health hazards to mothers and children are effectively propagated to the general public, it would gradually result in self-withdrawal of the traditional practitioners as the clientele declines over the years.

Our proposal, which I hereby submit to the available funding agencies, will, if approved, greatly facilitate the implementation of our planned inter-divisional local training.

I now wish to end my presentation and thank you all sisters and brothers for your attention and continued cooperation.

Female circumcision in Ghana

Effort undertaken by Ghanaian participants at the Dakar conference to eradicate female circumcision

Among the countries strung along the Guinea Coast of West Africa is Ghana, found almost centrally placed. To the east of Ghana lies the Republic of Togo, beyond which are Benin and Nigeria. To the west are the Ivory Coast, Liberia, Sierra Leone in that order. To the north is Bourkina Faso, formerly Upper Volta and to the south is the Gulf of Guinea (the Atlantic Ocean).

The total area is 91,843 square miles and the population is about 12.5 million according to the recent 1984 census.

The country is divided into 10 regions, namely the Eastern, Central, Ashanti, Brong-Ahafo, Volta, Northern, Upper East, Upper West, and the Greater Accra regions which correspond generally with the main ethnic groups of the country, i.e. the Fantes, Ashantis, Ewes, Dagombas, Kusaisis, Ga Adangbes, etc...

The official language is English but each ethnic group has its own language spoken mainly in the geographical areas of the group.

Southern Ghana is predominantly Christian whilst the Islamic religion is practised in the Northern Sector. But both religions are spreading rapidly all over the country. In between these two great religions are various traditional religions as varied as the people who practise them.

The present day Ghanaian social structure consists of two sectors, the modern and the traditional. The dividing line is education. The educated live predominantly in the modern sector while the non-educated live predominantly in the traditional sector. The two sectors are not mutually exclusive; each impinges on the other. The traditional practices are found mostly in the traditional sector, but even here with modernization we find a lot of changes. Or may we say that at present the social structure consists of a Middle class, a Working class and a Peasantry which correspond generally with the level of education of the people.

The Middle Class is mainly made up of individuals with education equivalent to secondary school or higher, whilst the Working Class is made up of labourers, artisans, etc., and has educational levels lower than Secondary School.

The great majority of the peasants who live in the rural areas have had no formal education. As would be expected higher education has profound influence on the attitudes of individuals toward cultural practices which have a positive influence upon the health of women and children.

Southern Ghana is comparatively much more developed with more modern amenities than the northern sector, resulting in the downward migration of people from the north to the south and as they migrate they come with their cultural practices and settle down in small communities. Their beliefs and attitudes are gradually influenced by those of the major ethnic groups they come into contact with.

Female circumcision is practised among certain ethnic groups in the northern and upper regions of Ghana but the whole practice is so shrouded in secrecy that most people in southern Ghana are not even aware of its existence.

The Dakar Seminar in February 1984 set up an Inter-African Committee and each country was to set up a National Committee to follow up the various recommendations of the Seminar.

In pursuance of these recommendations, the representatives from Ghana, after consultation with a number of concerned women in the country, formed the "Ghanaian Association for Women's Welfare" (GAWW), the founding members being Gloria Aryee, President, Marjorie Bulley, Secretary/Treasurer, and Bertha Anatsui, member. Our Vice-President is Dr. Ababio, the Greater Accra Region Medical Officer of Health whose main interest is in the Training of Traditional Birth Attendants.

The Association is non-governmental and is made up of members drawn from the already existing Women's Associations, both governmental and non-governmental to serve as a focal body to achieve and maintain the aims and resolutions of the Dakar Seminar.

The Association is registered with the All Women's Association of Ghana (AWAG) which seeks to bring together all the existing women's organizations for the uplift of the image and welfare of all Ghanaian women. Our membership of AWAG puts us in a unique position to focus the attention of a cross section of women in Ghana on the traditional practices which affect their health and that of their children and thereby arouse national interest in the subject, generate debates which will help identify the harmful traditional practices and how best they can be eradicated. Fortunately, the chairman for AWAG is a member of the ruling Provisional National Defense Council (PNDC) so decisions taken will be seriously considered by the government. Positive traditional practices will be encouraged.

We have attached a copy of Constitution of the Ghanaian Association for Women's Welfare. But permit me to state the objectives of the Association:

- (a) To continue the work of the Dakar Seminar of February 1984 on Traditional Practices Affecting the Health of Women and Children in Africa.
- (b) To identify traditional practices in Ghana that affect the health of women and children.
- (c) To assess the traditional practices that have or may have positive or negative effects on the health of women and children in Ghana.
- (d) To focus attention on these practices.
- (e) To educate the public, especially women, on the effects of such practices with the aim of eradicating the harmful ones and encouraging these which have healthy effects.

Meetings

The question of female circumcision has been discussed at length at our meetings and strategies have been formulated for education and eradication of the practice.

On the whole, we have succeeded in making people aware of the existence of the practice with its attendant hazards and complications during child birth. The practice has been condemned by most people we spoke to, as most unnecessary sheer mutilation of the sex organs and the reasons advanced for its practice as most untenable and in the main a male induced

practice aimed at achieving ends that cannot be tolerated by modern society. A few people however see this as a cultural practice which is very sensitive and which must be left alone. But ritual murders and widowhood rights were once considered as cultural practices yet have all been abolished by law because modern society frowns on such practices. We believe that the greater majority of the people of Ghana would like to see the practice completely eradicated. The Ghanaian Association for Women's Welfare has therefore drawn up a research proposal which has been submitted to the President of the Inter-Africa Committee which has been accepted. We hope that funding could be found to carry out the research as soon as possible. (Copy of proposal attached).

There are as yet not reliable statistics to reveal the full extent to which female circumcision is practiced in Ghana or the type which is performed. We can only determine this by a thorough investigation.

Meanwhile we have three midwives who have been provided with materials to collect data on the incidences of female circumcision and to record the case histories.

In conclusion, I wish to state that the Ghanaian delegation at the Dakar Seminar have made contacts with the following organizations and individuals who have shown interest in our work and are willing to assist us :

1. The Ministry of Health
2. The Ghana Midwives Board
3. Various Women's Organizations
4. Members of Government, e.g., The Secretary for Information and a member of the ruling PNDG.
5. The National Council of Women and Development whose representative is participating in this workshop.
6. The Y.W.C.A.
7. Zonta International - (which is now reviewing its stand).

Miss Bertha Anatsui, who was one of the delegates to the Dakar Seminar, has written a play on Female Circumcision and part of this has already been published in the professional Midwife Educators Magazine which has a circulation of 4,000 in Ghana.

We plan to have posters depicting the harmful effects of female circumcision to educate the women and later, the general public. We shall require video tapes like the type shown at the Dakar Seminar to be shown at one of the meetings of the All Women's Association of Ghana.

We hope the Inter-Africa Committee will be able to find us the necessary funding to enable us to realize our objectives.

Thank you.

Meaning and purpose of female circumcision in Kenya

Female circumcision is known to be practiced in a number of African countries and the Arabian Peninsula. The practice does not only differ from one country to another, but even within one country, the practice differs from one community to another. In Kenya, circumcision for girls and boys is part of the initiation ceremonies that mark a rite of passage from childhood to adulthood for both boys and girls. Not all Kenya communities make this rite with circumcision. The term "circumcise" means the cutting round a circumference and it is well understood when used in connection with the cutting round the foreskin of a male organ. In Kenya, female circumcision is of three types :

- (a) The partial removal of the tip of the clitoris as was practised by some communities in Kikuyu land and by some ethnic groups near the coast.
- (b) The total removal of the clitoris and partial removal of the inner lips or labia minora, or the total removal of the clitoris and

removal of most of the labia minora and part of the labia majora as was practised by ethnic groups such as Kisii, Akamba, parts of Kikuyu, Meru and Embu.

(c) The total removal of the clitoris and the total removal of the labia minora and part of the labia majora and allowing the labia majora to grow together leaving just a small gap for menstrual flow as was practised in the Nubian communities in the North of Kenya.

Among the communities that practised female circumcision as part of the rite of passage to adulthood, people attached deep meaning to the act of initiating girls into adulthood. The excision of the clitoris or the labia majora or the labia minora by itself did not carry great significance. It was the teaching that accompanied the act as among the Meru. In Meru, initiation is regarded as the turning point from childhood to adulthood. Without that you will continue to be regarded as a child and your conversation and talk would be regarded as childish. Female initiation was taken seriously. All who were not circumcised were despised. An uncircumcised girl was thought to have no knowledge of anything and so was given no responsibility.

The Wapokemo did not circumcise girls but "when a girl reported to her mother about her first menstruation, the mother would contact the girls who were already menstruating in the village. These unmarried and menstruating girls were called "magalitama". The girls would wait until one day and they would go and carry the girl to the bush very early in the morning. The girl would be made to lie down and she would be rubbed around her private parts with "itching grass". The grass would cause the girl to scratch her parts and they became very swollen. As the girl scratched her parts and cried, the big girls would be abusing her but the girl was not supposed to say anything to her elders. In the evening the big girls would march the initiate home with her private parts swollen. At home the girl would go to sleep with her grandmother, who would now continue teaching her on responsible adulthood."

The Wataita circumcised girls when they were very young, from 3 to 6 months of age by making a very small excision of clitoral tissue, but when the girls were about to menstruate, they participated in a special training session called "mwari". This special teaching was so important that if a girl did not go through it, it was not possible for her to get married. The girls who had not received this teaching were referred to by a special name, "mkele". The session could be as long as one to two years. During that time the girls stayed in-doors and were taught many issues in responsible parenthood and issues just concerning their conduct. The "mwari" was not only for girls, but for boys as well, but boys did not stay in for a long time. A girl who had gone through mwari became a completely changed person.

It has been identified here that the most important thing in circumcision for girls was the teaching about responsible adulthood. Some communities, though, laid a lot of emphasis the clitoris in order to reduce sexual desire among girls. Our ancestors and our great-great grandparents may not have had our knowledge about the physiology of the sexual organs but they somehow knew that the clitoris helped in female sexual excitation.

This may have been observed from the fact that the clitoris also became erect when sexually stimulated. In many countries a woman was not supposed to show by action or otherwise that she was desirous of her husband. She was not supposed to show that she enjoyed the sex act.

Among the Wakamba it was believed that a girl who was not circumcised would become more desirous of men. The removal of the clitoris therefore would reduce that desire.

It was along the same lines that the Nubian community sewed up the labia majora after excision of the clitoris labia minora (infibulation). This was to prevent sexual relations before marriage. As long as the lips were sewed penetration by the penis was not easy and an operation was needed. This was happily done at the time of marriage not before.

The Nubian community thus had no problem of proving whether

or not the girl was a virgin at the time of marriage..... she was sewn up anyway. Some infibulation was made possible by simply placing tightly together the girls private parts..... removing the clitoris and the labia minora. The legs were tied together for two or three weeks to let the two parts..... this time the girl would receive special care to ensure that she was capable of urinating.

The clitoris

Situated at the end of the inner lips which are around the labia minora is the clitoris itself, which is an internal part of the structure. It consists of erectile tissue which are well supplied by nerves. The clitoris also has glands that prepuce and produces a white, thick, oily substance called smegma. During sexual excitement, the clitoris becomes just like a penis. It is also supplied with blood by artery called the dorsal artery. This artery has direct connections with blood from the heart and so if cut it can bleed and be difficult to stop. This is what is cut and a little removed completely during female circumcision.

The labia minora

These are inner lips made up of erectile tissue capable of expanding and contracting. The labia minora or inner lips are connected to the clitoris at the upper end. During childbirth these lips are capable of expanding to enable a baby's head to go through easily. In fact, some communities, e.g. Luhyas teach their girls to pull these lips until they are quite long. The process in part is believed to help the girl to be able to have an easy child birth. Sometimes a woman tears during child birth and a doctor has to use a stitch or two. The labia minora or inner lips tear. The inner lips, too, are well supplied with blood. This is what is partly removed or completely removed in some of the Akamba, Kikuyu, Kisii, Meru, Embu and Nubian circumcisions.

The labia majora

These are thick outer lips and consist of non-erectile tissue. The upper part of the lips are normally covered with hairs. It is also supplied with blood vessels. It provides a protective cover for the inner parts (clitoris, labia minora, entrance to the urethra, entrance to the vagina and hymen). This is what is also partly removed in the Kisii and Meru circumcision and is sewn or cut and brought to fuse together in the Nubian community.

The entrance to the urethra

This is situated very near the clitoris. In fact it is just below the clitoris. The urethra is the passage for urine and if the entrance is somehow blocked, it may interfere with the easy release of urine. Or if the entrance is very sore, urine may not come out easily. If urine cannot come out easily, it may go back to the blood and cause other complications inside.

The entrance to the vagina

This is situated just below the entrance to the urethra. It is normally covered by a thin protective skin called the hymen. The hymen is normally partially perforated or has a small opening at the side to allow the menses during menstruation to flow. When the labia minora are completely removed, this skin is also likely to be damaged. The hymen is highly valued in most tribes as a visible sign of virginity.

What happens when a girl is circumcised

(a) When the clitoris is removed, **even if only a little of it is removed** :

- (i) The prepuce is removed and also the glands and so the woman loses her rich supply of nerves and the part does not become very erotic during sexual stimulation.
- (ii) When the prepuce and the glans are removed the woman loses the smegma that normally flows during sexual stimulation and therefore her vagina remains dry. She can

only be lubricated by smegma from her husband if the husband is not circumcised.

(iii) The removal of the clitoris interferes with the dorsal artery and the girl may have heavy bleeding which can lead to:

- a. shock or instant death
- b. severe anaemia.

(iv) Removal of the clitoris which is very close to the urethra may cause injury to the urethra. If the urethra is damaged it may cause urinary retention with consequent destruction of the kidneys and possibly death.

(b) **When the labia minora are removed partially or completely, or when the parts are made to infuse or are sewn up**

(i) The girl may later experience difficult and painful sexual intercourse. This may be caused by lack of lubrication but also by the fact that inner lips are not now erectile because of scars.

(ii) The woman may experience difficult births. If the scar on the labia minor is very big, the scar will not stretch easily and the expulsion of the foetus (baby) will be difficult. In some cases the baby dies before delivery.

(iii) The removal of the labia minora may cause complications which may result in the woman passing urine through the vagina and therefore urinating all the time causing her to smell, or it may cause a condition whereby the faeces pass through the vagina.

(iv) When the parts are sewn up the woman will experience a very painful first sexual intercourse and also first childbirth. The pain may psychologically affect her subsequent love-making with her husband.

(c) In all cases of female circumcision, especially if the act is done by unqualified people, the patient may develop infection and this can make her sick. If she hides and does not go to hospital in time, she might even die from infection.

Dangers of female circumcision

While it is true that this is a long standing traditional practice in many communities, both in Africa and in Asian and other Moslem religious communities, the health authorities do not support the practice of female circumcision for many reasons. It is a very difficult practice to eradicate because of the great sentiment attached to it. There are two main reasons why this operation is carried out on a large scale amongst communities who do so. These are :

1. To establish the entry point into adulthood from childhood.
2. To perpetuate virginity in the female through infibulation as is done in the Moslem communities.

The dangers of this operation are :

1. Psychological trauma

This operation is often carried out on very young girls who have no appreciation of its underlying sociocultural basis. There are no preparations for it, they are just subjected to a harsh, cruel operation for which no reason is given and which is performed at the tender age of between 7 and 13 years. Not only is it physically painful, but it affects them psychologically. Many of them can become completely unprepared for the sexual act in adult life. They may develop fear of the adult members of the society who subject them to this type of torture. It should be noted that in some of the Moslem countries once the labia have been cut off the raw areas are brought together with thorns so that when healing takes place there is only a very tiny opening through which the blood of menstruation comes out. It therefore becomes necessary for the women to have a second operation prior to the wedding night. The poor girl is subjected to a lot of torture because the man performs intercourse through the raw area.

2. Dyspareunia (Pain during sexual intercourse)

Depending on the degree of mutilation carried out, when fully healed, those circumcised end up with scar tissue around the vaginal opening. This opening is not elastic enough due to the scar tissue to accommodate the penis and does not give way easily during penetration. This can be very painful to the female and can make her fearful of sex.

3. Urinary Tract Infection

The removal of the labia majora and minora which protect the urethral opening exposes the opening to the outside world and can allow easy entrance of bacteria from the outside especially where the vaginal opening may have been damaged and tampered with. It is also possible for the urethral opening to develop scar tissue if it is damaged during the operation which makes it narrow and hence the urine may not be able to completely empty from the bladder and urethra during urination.

Where body fluids remain static they become a rich area for bacterial growth. Urinary infection can spread from the urethra to the bladder up to the kidneys which become damaged, thus leading to high blood pressure (hypertension) and renal failure or cardio-vascular accident.

4. Obstructed Labour

When the labia majora and minora have been removed, the vaginal opening does not give way readily because of the scar tissue during delivery. This can lead to obstructed labour and if the female continues to push, especially when delivery is effected at home, very extensive tears of the perineum can occur which could lead to :

- Severe bleeding as the major vessels supplying the vagina can be torn.
- The tear could join the vaginal and rectum leading to recto-vaginal fistula (RVF). This would lead to the woman's faeces passing through the vagina also.
- The tear could link up the vagina with the bladder or urethra or both, leading to vasico-vaginal fistula. This could lead to urine being passed through the vagina.

The types of damage mentioned in b. and c. above become the cause of the ostracism of the woman in their communities because they carry a very bad odour. They are likely to have ascending infection through the bladder to the ureters and kidneys or through the uterus into the fallopian tubes with the consequences of tubal blockage and sterility.

5. Foetal Death

Due to the scar tissue not allowing easy passage of the baby during delivery it is possible for the baby to be still-born.

6. Maternal Death

The tears through the major blood vessels can lead to sudden death during delivery. Subsequent infection as detailed above can easily lead to death.

7. Lack of Sexual Enjoyment

This comes about because of painful sexual penetration and excision of the clitoris or the labia which form the most sensitive erectile tissue of the female genital organs.

Modern circumcision limits itself to the excision of the top of the clitoris without any interference with the labia majora or minora. This is also a very painful operation as the clitoris has a very good supply of blood vessels. Many girls have died because of this blood loss, especially when they may be suffering from blood-clotting mechanisms problems.

All in all, female circumcision is an operation that should be condemned without mincing words because it is unnecessary and cruel. There are many traditional practices that our communities have abandoned for the development and betterment of their

individual and community welfare. This is one that has lagged behind for too long, and one where effort should be made to discourage it. It is one of the ways in which women are subjected to torture for no other reason than that they are female. It is a cruel operation.

The President, His Excellency Daniel Tereitich Arap Moi, has favoured abandonment of this cruel practice. It is important that health workers, religious leaders, politicians, social workers, teachers, in actual fact, everybody in the Republic who has an interest in women's development at heart, should fully support the President's stand by providing relevant education, especially to those communities that perpetuate female circumcision.

Those who publish the vernacular newspapers, those who preach from the pulpit and from the Mosque, those who play political roles should educate our people in these matters.

We can find better ways of initiating our youth into adulthood. Family life, education and responsible parenthood advocated by various organizations in this country are some of the ways of doing so because they aim at preparing our youth for their adulthood status and roles.

In the final analysis we should ask ourselves what we can do to eradicate the circumcision and we know that this will not happen overnight.

- What would be the substitute for youth ?
- Should we have Family Life Education ?
- Adult education programs including learning how to read and write and the integration of health education with the campaign to eradicate female circumcision.
- Health Education through maternal and child health.
- Family Planning Programmes.

We know the problems exist. What do we do ? To try to look for substitutes. For example : a prick in any part of the body. And this will be accomplished by the year 2000, to integrate the tradition of becoming an adult into the culture, without resorting to circumcision.

Female circumcision in Djibouti

The Republic of Djibouti is one of the smallest countries in Africa, with a surface of 23,0 km. It has been independent since June 1977. Its resources are limited, and the exploration and exploitation of them is still in an experimental stage.

Infibulation

Infibulation, one of the forms of female circumcision, consists of a clitoridectomy, together with the removal of the inner labia and the cutting of the outer labia, which are then joined together with accacia thorns, and the legs bound in order to ensure an almost complete occlusion of the vulvar opening.

The mother, sometimes with the help of the grandmother, is responsible for the upbringing of the children, especially girls.

The date of the ritual operation is decided upon by the mother. The age of initiation varies among both the nomads and settled people occurring between 6 to 10 years, but generally taking place at about the age of 7 or 8. The operation must always be performed before the first menstruation. There are, however, certain families who belong to the Djibouti minority of Yemeni origin who circumcise their daughters 7 days after birth, or between the 7th and 40th day after birth.

The operation is performed by Somali and Afar women who specialise in circumcision. These traditional practitioners carry out this operation as a secondary activity in addition to their normal family responsibilities.

Operating instruments:

razor blade, dwarf blade, a mixture of powdered myrrh and sugar or vegetable extracts.

The operation:

The operation always takes place in the family home, early in the morning, and involves one or more daughters. A number of girls are operated on at the same time. Along with the mother, other female relatives, friends and neighbours are invited. They take an active part in the proceedings, and act as witnesses to the mothers' respect for tradition. No men, not even the father or brother, are admitted.

Pharaonic circumcision, which is deeply rooted in the cultural system, affects young girls both physically by blocking their vulvar opening, psychologically by inhibiting their sexuality.

Complications of infibulation:

There are two categories of complications from infibulation, the immediate and the delayed.

Immediate complications

- haemorrhaging
- lesions of neighbouring organs
- acute urinary retention
- general and local infections

Delayed complications

- urinary infections
- acute urinary retention
- bladder stones

There are also gynaecological complications :

- keloid scar
- formation of cysts
- excessive bleeding
- dysmenorrhia
- cryptomenorrhia and hematocolpas
- chronic pelvic infection
- sterility
- complications of disinfibulation (which we look at later in the section dealing with the traditional practices affecting the health of the mother)
- obstetric complications (also detailed later)
- psychological complications

The list of complications following infibulation is extremely long. Some are serious and can prove fatal, both as far as the girl, the mother and the foetus are concerned. Complications and accidents are known to the public, especially to medical and para-medical bodies.

By the fact that this ritual operation is deeply rooted in customs, we are forced to look into the reasons for continuing such mutilation.

Reasons governing the continuance of circumcision

Many reasons are given for the continuation of this practice, but they can be divided into three main sections :

- Islamic religion
- cultural traditions
- disapproval of premarital sexual activities

Islamic Religion

Djiboutians are Muslims of the Chafeit Brotherhood (Sunna laws and Islamic tradition), Sunna laws being the recommendations of the Prophet Mohammed. "Sunna circumcision is for the honor of men and the dignity of women". The indication is that infibulation is in contradiction to Sunna law.

Cultural Traditions

The argument "I've been circumcised like my mother, my grandmother and other women, therefore my daughter will also be

circumcised," is often quoted. Circumcision is part of the traditional cultural education which is handed down from mothers to daughters and which assures the continuance of social values and the survival of the society.

Moral Disapproval of Premarital Sex

There are various aspects of this moral criticism :

- circumcision protects young girls, whether nomadic or settled, against rape
- it affects the dowry of a young girl, which is required by the in-laws
- by the in-laws
- it diminishes the risk of sexual promiscuity
- aesthetic criteria

Circumcision reinforces social and moral rules :

- complete sexual abstinence outside of marriage
- that the procreative function is the positive aspect of sexual relations between men and women (i.e., judgmental : sex is for procreation)

The position of religious and public authorities.

Religious and public authorities cautiously speak out against circumcision through the media, particularly the press.

Given that Djiboutians are Sunna Muslims, the Sunna circumcision is proposed as a religious tradition instead of the cultural tradition of infibulation.

Attitude of Parents

In spite of the lack of reliable statistics, it can be said that there are many families who speak out against pharaonic circumcision. This is because of the physical and psychological complications, and as a result of their own experience; These families favor Sunna.

It is precisely because the problem of excision is a socio-cultural problem of great importance and delicacy, and because it is linked to many centuries of well established tradition that it victimises women. This practice, which has adverse effects on the health of women and children, is considered as one of the most effective means of controlling the sexuality and reproductive capacity of women.

Having stated the negative side of the practice, the UNFD has decided to wage against excision, particularly in its most serious form, infibulation. The problem is one of approach, how to tackle the problem of excision without offending the sensibilities of the people or damaging their beliefs.

The Imam and Judiciary of the Republic of Djibouti do not encourage excision. A religious leader told us that although many cite Islam as a reason, the practice pre-dates Islam, and excision and infibulation are not prescribed by the Koran. They say that infibulation is a tradition inherited from pharaonic times, and it must be abolished in all its forms.

The Director of Health was approached to ascertain if a favorable reaction would be given in response to the UNFD request that the operation take place in a hospital to reduce the serious consequences attached to the practice (such as haemorrhage, shock, infection, tetanus, etc...). The response was very encouraging. So, in accordance with the recommendation of the seminar in Dakar, UNFD hopes that the operation will take place in a controlled environment under hygienic conditions.

UNFD decided to hold small seminars in the four districts of Djibouti, and we are pleased to be able to state that all the women approached attended. This indicates a willingness to discuss the problem, and reflects an extreme interest in it. We hold that there has thus been progress.

We have high hopes for all areas, apart from Tadjourah, where the women were not all willing to talk about female excision and who felt that it was an attack on their cultural values to ask about this. We hope that a campaign of consciousness-raising in the other three districts and with the women of Djibouti City, together with work in education, will cause the practice of infibulation to disappear because people will be convinced of its uselessness.

Since it is common nowadays to see a grandmother arranging for a granddaughter to be excised and infibulated in the absence of the parents and without their permission, we have decided to contact grandmothers and older women in order to attempt to abolish the practice.

It is common to observe urinary retention symptoms because of the pain associated with urinating when the wound is new or a girl or woman having spasms caused by the fear of pain. These spasms, together with the fact that the girl often struggles throughout the procedure, and because her genital organs are frequently very small, indicates that there are sometimes accidental injuries to parts of the vagina. There are other complications which cause slow healing and infections, especially in areas where there are no first aid facilities (usually rural areas), and where they use thorns to suture the wound after the operation. UNFD is very eager to begin an educational campaign, especially for nomadic women, with whom it is more difficult to make contact. It is much easier to reach urban women.

UNFD is determined to achieve positive results, and therefore we are appealing to all supporters to help our consciousness-raising and educative campaigns and to organise national seminars.

Disinfibulation :

- partial disinfibulation in marriage
- giving birth
- gynaecological complications of disinfibulation
- obstetrical problems of infibulation

At marriage in Somali areas disinfibulation consists of a partial incision with a razor of the closed vulvar, followed by forcible penetration with the penis. Among the Afar, defloration is achieved by the use of the penis alone. Fortunately, urban dwellers frequently request medical disinfibulation, wherein a doctor reverses the infibulation process under local anaesthetic. Sexual relations are established after the wound is healed.

A median incision of the closed vulva is essential at childbirth. This only takes place in the final stages of labor, as the women do not permit it to occur earlier.

Gynaecological complications of disinfibulation :

- damage to neighbouring organs, urethra, bladder, vagina rectum, perineum
- infections and haemorrhage
- dyspareunie

Obstetric complications of infibulation :

- essential median incision of closed vulva
- perineal tearing and recto-vaginal or bladder-vaginal fistules
- damage to adjacent organs or the foetus

Conclusion

Infibulation, which is an integral part of the cultural and social mores of Djiboutian society is being fought with patience and perseverance. At the moment, Sunna circumcision - a religious tradition, is promoted, rather than infibulation, which is a cultural tradition.

Female circumcision in Liberia

Introduction

The Republic of Liberia, which covers an area of 43,000 square miles, is situated on the West Coast of Africa and is bordered by Sierra Leone on the west, Guinea on the north, the Ivory Coast on the East, and the Atlantic Ocean on the south. The total population of Liberia is approximately two million with an estimated 30 percent living in urban areas (1974). In 1982 approximately 30 percent of the population was estimated to be literate.

Liberia, unlike most other African countries, was never formally annexed by a colonizing power but was founded by repatriated black Americans in the early part of the nineteenth century. The population is comprised of 16 major tribal groups each having their own traditional practices, although some similarities exist. An important institution common to almost all Liberian tribal groups, with the exception of two, is the traditional or "bush" school and a section for girls called the Sande School. The purpose of these schools of initiation is to give protection against witchcraft, prepare and train the child for his or her role as an adult by teaching the rules, values, norms and practices of the society. Despite the erosion of traditional Liberian societies by western and other influences, and the subsequent changes in traditional values, rules, norms and practices, the Poro and Sande still have a strong social influence.

The data

Unfortunately, information on traditional practices in Liberia that affect the health of women and children has not been documented. Consequently, in preparation for the Dakar Seminar, a mini-survey was conducted to collect information related to childbirth and delivery practices, dietary taboos, forced feeding of children and female circumcision. For the purpose of this survey, a questionnaire was administered to randomly selected health care personnel at 6 major institutions and other professionals working in the area of health in Monrovia, the capital city. The questionnaire includes specific questions on each of the traditional practices being investigated but no questions on the origins or rationale for the practices. The 23 questionnaires administered, only 12 were returned. Four of the respondents were midwives, one a physician, one a nurse, one a secretary and one a sociologist. The remaining four respondents did not indicate their professions.

Female circumcision

In Liberia female circumcision is practiced as an initiation ritual during the attendance of "bush" school (Sande). Consequently this practice is a closely guarded secret which Sande members must not reveal to non-Sande members. The secret connected with female circumcision therefore makes it an extremely difficult subject to research and document. In this connection, it is significant that the response rate to items on the questionnaire about female circumcision was low.

It is known that female circumcision is practiced in many areas of Liberia (only three ethnic groups do not practice it).

Respondents to the questionnaire estimated that between 50 to 70 per cent of all girls and women have undergone the operation which consists of a clitoridectomy (also known as excision-the removal of the clitoris and the labia minora). It is believed that the operation is performed at an early age, probably between 6 and 8 years.

The health hazards of female circumcision as practiced in Liberia are not clearly known. Some respondents reported that the short term effects are haemorrhaging, difficulty in urinating and tetanus, sometimes resulting in death; of the other hand, some respondents noted that they had not encountered any serious immediate complications as a result of the operation.

These different observations may perhaps be attributed to regional variations in the practice. With regard to long term effects, some

complications were reported by respondents. These include obstruction during labor due to scar tissue, vaginal atresia and anterior lacerations.

Only three respondents out of twelve felt that female circumcision does not constitute a health problem in Liberia. Two respondents suggested that some changes should be made in the operation to make it safer while four respondents advocated the eradication of the practice. Most of those interviewed felt that any efforts to make changes in the practice should be made by Sande society members and traditional leaders.

Upon our return from the Dakar Meeting, a National Non-Government Committee on Traditional Practices Affecting the Health of Women and Children was organized. Prior to the organisation of the National Committee, a small group comprised of health personnel and non-health personnel organized themselves into a voluntary organization called the Health Action Group. This group organized a one day symposium. The purpose was to discuss female circumcision and its implications for health. Unfortunately, this activity ended the action of the Health Action Group. This local group is now dissolved and the individuals are the nucleus of the National Committee. The National Committee has prepared a three year project proposal which has been submitted to the Inter-Africa Committee for consideration.

The main activities of the project are (1) a knowledge, attitude and practice research component, (2) awareness meetings, (3) training of volunteers, (4) preparation of health education based on the results of the survey, (5) translation of the health education material into the major national languages, (6) development of collaboration with the Ministry of Health and Social Welfare, and other non-governmental organizations with interest and/or activities related to services for mothers and children and (7) lastly, and not the least, the integration of female circumcision as a component of PHC and MCH programs of the Ministry of Health and Social Welfare.

I am pleased to state that a cross section of persons, including men indicated their interest in the topic and are willing to be associated with the National Committee. We hope that within the next five years there will be increased awareness of the incidence and the effects.

Survey of female circumcision in Ibadan, Nigeria

Nigeria is the largest black African country situated in the west coast of Africa and is bounded on the west by Togo, on the east by Cameroun, in the south by the Atlantic Ocean and in the North by Niger.

Nigeria is an extremely diverse and heterogeneous country in terms of ethnic groups, culture and language, and has a population of 87 million. Literacy rate is 34%, GNP/capita per annum is low - approximately 450 U.S. Dollars. Maternal mortality rate is 3 to 6 per 1,000 total births (that is 5 to 10 times the rates reported in Europe and North America), and infant mortality rate is 150 to 200 per 1,000 live births (that is 10 to 20 times the rates reported from the developed countries like U.K., U.S.A. and Sweden).

In Nigeria there is a lack of accurate data with regard to the current practice of female circumcision. Dr. Stephens in 1931 in the **Lancet** stated that "I have never seen any ill effects due to circumcision in Nigeria", yet some authors have more recently reported sporadic cases of severe complications, 2 - 9, while others, including a former Nigerian State Governor has clamoured for legislative law banning the archaic practice.

The study which is hereby reported was therefore designed to find out the extent to which female circumcision is still being practiced in Nigeria, to study the socio-cultural factors responsible for the

perpetuation of this custom and to determine the morbidity, and mortality, if any, arising from the practice, so as to formulate guidelines which will serve as a basis for an action program geared towards eradication of female circumcision.

The survey was carried out in Ibadan, the largest city in black Africa. Ibadan is the capital of Oyo State, situated in the western part of Nigeria and has a population of 5 million, about 2/3 of which are women and children. A questionnaire interview was carried out on samples of women attending the antenatal clinics of the largest general hospital in the city as well as a large child welfare clinic in the city.

Results

The results of the survey have revealed that female circumcision is still widely practised and favoured by quite a large proportion of Nigerians as well as other African countries. Over 70 % of the women interviewed had themselves been circumcised ; 67 % of them still favour the idea of female circumcision. Almost half of the respondents had their daughters circumcised and almost a quarter (25 %) of them said that they will spare no pain to see that their daughters are circumcised. It is the mild form (cutting of the clitoris) that is done in Ibadan.

It was shown from the survey that the age of the respondents did not seem to have influenced their attitude to the practice of female circumcision. Both old and young favour the practice though in our survey a high proportion of the respondents were young and below the age of 35 years, and a significant proportion of them favour female circumcision.

Although the majority (72.6 %) of the respondents who favour female circumcision were illiterates, yet it is noteworthy that almost 30 % of those who favour the practice are literate, and as many as 10 % of the literate have had a minimum of secondary education. Thus, the fact that opposition to the practice of female circumcision comes from women who have received some education which has been reported by some workers, 12 has not been clearly demonstrated in this survey. The pattern observed in this survey is surely a reflection of the strong cultural attitude towards female circumcision among Nigerian respondents. Furthermore, it was observed that even among the educated women who do not favour the practice, family and social pressures are often so great that the women might eventually have to give in and submit their daughters for circumcision. In these instances, the mother-in-law or some paternal grandmother or aunt insisted that it must be done.

In this study although more than 80 % of the respondents were indigenes of Ibadan and its environs, it is generally known that the practice of female circumcision is ethnically linked in Nigeria.

Survey - Ibadan, Nigeria

Ethnic groups such as Ijebus and Egbas (also in the western part of Nigeria) do not favour female circumcision, while the practice is highly prevalent among the Ibadans, Ijeshas, Ebitts in the west, the Benins and Itshekiris in the midwest, Igbos in the east and some tribes in the northern parts. This ethnic differences was also observed by other researchers from other countries, e.g. Sudan and Kenya.

About 70% of the respondents who favour female circumcision are Muslims while 29 are Christians and 1% are traditionalists. Religion, per se, does not seem to play an important role in influencing the people's attitudes toward female circumcision. The sample employed in this study is predominantly Muslim and this is reflected in the results obtained.

Almost 95% of the female circumcision carried out in Ibadan was done by traditional circumcisionists. Nurse/midwives and traditional bith attendants were said to have carried out 4% and 1% respectively of the female circumcisions. The instruments used include sharp knives, scalpels or blades. The operation is usually carried out in the first two weeks of life, or when the child is few months old. In Bendel State (Midwest Region) it is done on the woman at the 7th month of her first pregnancy if she was not

circumcised as a child.

With regard to complications, only 8% of the respondents reported complications from female circumcision performed by the native circumcisionists.

The possibility of gross under reporting of the outcome of the cases performed by these circumcisionists should nevertheless not be overlooked. On the other hand, some post-operative medications are usually applied to the wound by the circumcisionists which include local herbal preparations as well as penicillin ointment. However, from clinical observation and surveys carried out in hospitals and clinics, some of the complications that have been reported among girls who have been circumcised include shock from severe pain and haemorrhage, infection, especially tetanus.

Urinary retention, damage to the urethra giving rise to urinary incontinence, damage to the anus resulting in fistula-in-ane and fecal incontinence, as well as cysts of the clitoris. (10, 11) Others serious gynaecological and obstetrical complications such as chronic pelvic infection an calculi formation and subsequent infertility, obstructed labour as a result of labial adhesions, severe fibrosis and scarring leading to narrowing of the vaginal orifice had also been recorded. (13-17) Such cases of obstructed labour could end up in ruptured uterus and severe haemorrhage, causing the death of both mother and child.

Some of the reasons which the respondents gave in **favour** of female circumcision were :

1. "Female circumcision which involves the cutting of the clitoris will dampen sexual desire" and thus help to prevent promiscuity and maintain chastity between the age of the puberty and the time of marriage, and it will also ensure fidelity in a married woman.

2. Female circumcision is "an essential ritual" a woman must undergo as a child (or in any case before the birth of her first child) in order to ensure a quick and easy labour during child birth. It is felt that the clitoris may swell during childbirth and thus obstruct the delivery of the head of the baby.

3. Prevention of the development of a large head (Hydrocephalus) of the baby, as the "contact between the clitoris and the baby's head might give rise to congenital hydrocephalus, and consequent infant death".

4. Excision of the clitoris will reduce excessive vaginal secretion which is thought to cause vaginal irritation and rashes in the pelvic area.

The respondents who do **not favour** female circumcision gave the following reasons :

1. "It is a cultural/traditional heritage that should be discarded, as it is barbaric."

2. "It is an absolutely unnecessary procedure (which like tribal facial marks) only causes severe pain and suffering for the child".

3. "It is 'disvirgining' at childhood ; tampering with a child's genitalia".

4. "It is a denial of a woman's self-fulfilment, as it greatly reduces a woman's sexual pleasure.

Conclusions

In this study, it was generally felt by the respondents that the practice of female circumcision helps to promote sexual morality among women, and also contributes to safe delivery among them as well as to ensure infant survival.

The implication of this therefore, is that any measure being planned to discourage the practice of female circumcision must be an endeavour to invalidate these two claims by intensive health

education, and community motivation, whilst highlighting the apparent dangers of female circumcision.

Actions taken since the Dakar Conference

Since the Dakar Conference, a National Committee has been set up in Nigeria with representatives from the 19 states of the federation and representatives from the various pressure groups in the country namely, the Islamic and Christian organizations, the Nigerian Red Cross Society the National Council of Women's Societies, the University Women's Association, the Medical Women's Association of Nigeria, the Market Women's Association, as well as the Traditional Practitioners' Association. the Committee plans to meet next month to deliberate and formulate some guidelines for policy decisions which will be submitted to the Nigerian Government for an action plan.

In the meantime, I am working towards achieving a closer link with all the circumcisionists in Ibadan City, Capital of Oyo State and knowing more about their characteristics and persons with a view to using them as change agents. In other words, if they could be made to appreciate the dangers inherent in their practice, then they may be inclined to discourage client who may bring them their daughters to be circumcised.

Madam Chairperson, distinguished guests, my dear sisters and brothers, what I would like to suggest is that may be we need to apply a three-pronged attack on the problem of female circumcision:

1) Acceleration of Public Enlightenment

Working with the general public to discourage the people from taking their daughters for circumcision.

2) Integrated Approach Through Closer Collaboration with the Circumcisionists

Working with the traditional practitioners themselves, not only to cease from circumcising girls, but also to act as agents for enlightening parents and discouraging them from subjecting their daughters to female circumcision.

3) Integration of Female Circumcision Campaign into School Health Education Program

Working on and with the younger generation in order to achieve a positive change in societal attitudes toward female circumcision so that the practice will be strongly opposed by them and eventually eradicated.

References

1. Stephen, J.R.C. (1931) "Female Circumcision" : Lancet, Vol. II, 1159.
2. Worsley, A. (1938) "Infibulation and Female Circumcision : A Study of a Little Known Custom". British Journal of Obstetrics and Gynaecology, 45, 686-691.
3. Cook, Robert (1976) "Damage to Physical Health form Pharaonic Circumcision (Infibulation) of Females", A review of Medical Literature. WHO/EMBRO Tech. Publ. 2, Vol. 12, 138-144
4. Salah Abu Bakre (1952) "Circumcision and Infibulation in Sudan", WHO/EMBRO Tech. Publ. 2, Vol. 12, 145-154.
5. Editorial (NEWS) "Female Circumcision" - A Serious Threat to the Child". Tropical Doctor 9, 4, 230.
6. Wright, Helena (1980) "Medical Dangers of Female Circumcision". IPPF Medical Bulletin 1-3.
7. Ofodile, F.A. and Oluwasanmi, J.O., (1979) "Post-Circumcision Epidermoid Inclusion Cysts of the Clitoris". Plast Recenstr. Surg. 63, 4, 485-6.
8. Aziz, F.A. (1980) "Gynaecologic and Obstetric Complications of Female Circumcision". Gynaecol. Obstet. 17, 6, 560-3.
9. Iregbulem, L.M. (1980) "Post Circumcision Vulva Adhesions in Nigeria". Brit. J. Plast. Surg. 33, 1, 83-86.
10. Ajao, O.O. (1983) "Female Circumcision : It is archaic". Sunday Sketch, Feb. 6 th, 5.

11. Aku Akpa (1983) Daily Sketch, Oct. 28th, 3.
12. WIN NEWS (1977) "Female Circumcision", Lexington, Mass.

Female circumcision in Sierra Leone

The country

Sierra Leone is situated on the bulge of the West African Coast. It is bounded by the republic of Guinea on the North East and North West and by the Republic of Liberia on the South East and by the Atlantic Ocean on the West and South West.

The country is divided into areas, namely the Western area in which lies the capital city of Freetown. The other areas are the Northern, Southern and Eastern areas.

Literacy rate is 5 - 7%. Illiteracy is 90 - 95%. The population is 4.2 million and of this 80% live in the rural areas. The practice of female circumcision affects 90 % of our female population.

There are four major ethnic groups in the country, inhabiting the 4 areas already noted. The Krio, 8% the whole female population, live in the Western area and are the only ethnic group who do not practice female circumcision. The other ethnic groups, the Mendes, Temnes, Limbas all practice the act of female circumcision. I must point out these ethnic groups consist of Muslims, Christians and Animists. Therefore the practice of female circumcision is not a religious rite, but it is a culture rite or a rite of passage from Childhood to adulthood.

Introduction

Female circumcision has been practiced in Sierra-Leone for ever 200 years. The practice is believed to have originated because Communities required women to be virtuous until marriage, and after Marriage to remain faithful to their husbands.

The communities believed that female circumcision removed the Organ responsible for sexual excitement and renders the female unresponsive to other males seeking sexual adventure. They also believed :

- that it keeps the genital area clean
- that it prevents promiscuity
- that it increases matrimonial opportunities
- that it promotes social and political integration
- that it increases fertility
- that it improves males' sexual performance and enjoyment
- that it preserves virginity.

Although examination of all these reasons has shown that they have no real scientific or logical basis for continuing the practice, they still persists.

There are 3 types of Female Circumcision :

Type I - Clitoridectomy

This is practiced by the Krio Muslims as a religious rite, according to Koranic Law. It is practiced in the Western area of Sierra-Leone.

Type II - Excision

Excision is practiced by the rest of the ethnic communities over the country. It is performed as part of an initiation rite in which girls are elevated from childhood to womanhood :

During the past few years some communities performed the practice on younger girls and even on female babies between the age of one week and one year. The Susu tribe practice this type

Type III - Infibulation

Infibulation is not practiced in Sierra-Leone, except at the border with Guinea in the Northern part of the country.

Child mortality in the 3 areas where the practice is dominant is between 230-250/1,000. Obstructed labor is very high in the

provincial areas. Maternal mortality in this area is higher in the same area, as compared to 40-60/1,000 in the Western area.

Complications are poorly reported because of the code of the Secret Society involved. They include :

- bleeding and shock
- infections
- urinary infection
- tetanus

Death is not reported at all. Instead, the child who dies is proclaimed to be a devil who brings bad luck into the Society. Her parents have to pay substantial amounts of money to retrieve her name.

After the Dakar Conference these of us who attended formed a National Committee of Concerned Health Professionals, incorporating staff from the Ministries of Health, Education, Social Welfare, Development, UNICEF and WHO. We have met only once and plans are a foot to draw up strategies on how to approach the head of "Bundo Bush" Sowes and her staff (TBA) considering its secret society and the fact that most of the National Committee are not members of the Bundo Bush, but we are going to have a workshop in December whereby the Traditional Birth Attendants, i.e. circumcisers will be invited to the members and we can learn from them ways and means of eradicating the practice in Sierra-Leone, having as our goal the WHO "Health for all by the year 2000".

I have a proposal drawn up which consists of a team of 7 health professionals to collect information and sensitize the population to the health hazards of female circumcision. The method used will be face to face interview using specially designed questionnaires and physical examination of selected patients at health centres and hospitals. From the findings we hope to develop strategies first to decrease the number of young girls being circumcised and later on to eradicate the practice altogether from Sierra-Leone.

Togo Paper

Ladies, gentlemen and honorables invitees,

It is a real pleasure for me to be able to speak in this seminar workshop, and to converse with you on a subject which shakes up a lot of women in Africa today : "Feminine Excision".

I thank the organizers of this meeting for having requested presence here.

Presentation and personal activities in the field

The organization known as WORLD NEIGHBOURS or "Voisins Mondiaux" is a non-governmental non-profit organization which has been working in Togo for more than 10 years, and which helped in the founding in 1979 of a consultative service for Family Health in West Africa, which I have the honor to manage.

The goal of this Consultative Service is to enable the organization to effectively assist social development projects in the sub-region of West Africa.

Its action include :

- 1 knowing the West African sub-region
- 2 knowing the needs of the populations and families
- 3 doing everything possible for the well-being of families, especially women and children
- 4 furthering family health by-
 - a) responsible relation
 - b) maternal and infantile protection
 - c) nutrition
 - d) family planning
- 5 food production
- 6 revenue increase

All this in the context of the well-being of communities in the sub-region.

A. Activities for the well-being of the rural people

The activities of our consultative service go far beyond the limits mentioned above, the terms of reference of our duties, because it appeared that the activities in favor of women concern a context which is often badly defined or badly interpreted.

In fact, as a woman, it is a right and even a duty for me to help other women by a global animation.

My ways of reaching the womenfolk are so numerous that I will speak here of a few only.

My office is the car in which I travel to villages in order to visit families who really fall under our objectives, especially women farmers, in order to help them find out and discuss with them problems and difficulties which confront them permanently.

To make this situation clear to you, I will give you an example of our health care service.

On this particular subject, I will say that in the village of Kati in Togo, I use the approach in which the inhabitants take part. This approach makes the people aware and motivated. They organized themselves into village health committees and they sank their own wells to obtain good drinking water to eliminate the sickness caused by Guinea Worm, which attacks them regularly. This sickness prevents them working in their fields for several months. This hold-up brings with it at times shortage of primary foodstuff produced by the people themselves for their subsistence.

Another example concerning food is that the people suffer from bad weather and are short-supplied with Néré, a produce used for making mustard, the principal food in the region. In this sphere, the women organized themselves and found out that they could prepare mustard with soya, a product that they did not know until recently.

As soon as they knew the techniques of cultivating this plant, and its high nutritional value, they cultivated it either on individual or collective bases.

B. Activities for the well-being of the well-being of women and children

With regard to activities concerning the well-being of women and children, our Consultative Service informs women of the risk to have unwanted pregnancies and or births too close, without forgetting the complications of feminine excision practised all over West Africa.

On this point, women in villages are made aware and motivated. They organize debates and discussions on the function of their bodies and try to know more about the impact which multiple pregnancies and too close births will have on their health.

Chapter 11 - Transition: What has feminine excision to do with the present workshop?

From all the preceding examples, what do we do for women and through them for children, especially in the field of elimination of feminine excision ?

Our first worry is to arouse the will of women to free themselves. We should well understand ; this freedom concerns men as well as women. A woman who does not eat well is not free, and her child is not free either.

A woman bleeding excessively during child-birth, because she has no clitoris is not free, her husband also.

However, the very fact that the rate of participation of a woman in production (70 to 80 %) for the progress of the community and even of her country is not to be neglected ; it is necessary that she should be made aware in the first place, of problems and thereby guided to discover for herself the solutions which she can easily offer.

What can we do precisely ?

Since the beginning of our meeting I hear people talking of hospitals, doctors, experts, etc... for the elimination of feminine excision.

But how many of these luxuries of our big cities do we have in the rural areas ?

In many countries, especially in the third world there is only one physician to 300 000 inhabitants. If this is proved to the contrary, the solutions will not come by miracle, and women taking charge of their own problems will surely be indispensable.

The method whereby women take part in the solution of their own problems will lead them to eat things locally produced, in varying what they eat this will enable them to know the functioning of their body, etc.

This can suggest to them that they vary their agricultural production. But the precise case which is the subject of our meeting today is that there are certain ancestral traditional practices, such as excision, that are detrimental to the health of mothers and children. These practices must be abandoned, even eradicated, through a general awareness-raising exercise.

If a mother is in good health, there is no doubt that her child is healthy also.

"If women are integrated in the development exercise in a correct and balanced manner, there is no doubt that the future of Africa will be assured", said René Dumont and Marie Moutin in their book entitled "L'Afrique Etranglée" (Strangled Africa). And the future is for children who will be responsible for the world of tomorrow.

If these children are healthy and if the infantile mortality is diminished, our responsibility will only be to increase production all round : building schools, specialized institutions, training leaders, teaching illiterate women to read, making the rural people aware so as to take development into their own hands for self-sufficiency.

You will see now why our action in the field is global.

We are concerned with the problems of feminine excision, but mother and childhealth, nutrition, and especially family planning, not forgetting food production and training of local leaders, such as volunteers health promoters, traditional midwives (matrons) etc. are also of interest to us.

Struggle against feminine excision and its effects on mother and child in West Africa

Coming back to the topic which is occupying our attention today, I must confess that the problem is real. A study of the problem has revealed that in my own country (Togo) just like other countries where we operate, that is : Chad, Ghana, Benin, and Burkina Faso (Upper Volta) feminine excision thrives.

To speak about Togo, the problem as a traditional practice (excision of clitoris) exists acutely, and at the present moment commissions of local groups have been formed to make women aware that this tradition should be ignored from all other ancestral traditional practices.

Since the Dakar conference of 1982 on the subject of traditional practices which have an effect on the health of women and children in West Africa, a commission has been formed in Togo. This national commission has already obtained help from Madame Linander and Madame Ras Work, who have agreed to equip it with appropriate visual aid materials to help combat this practice among different social categories of the country. These include religious, political and medical leaders, the population itself (men and women) etc...

Many awareness-raising meetings have been held. The National Union of Togolese Women, through public manifestations which it has organized since 1972 for all women, speaks at gatherings about the bad effects of ritual excision. These women also welcome the resolutions and recommendations of the Dakar conference, and are really ready to intensify the awareness-raising campaigns on the subject.

Also at Sokodé, in the Northern part of Togo during the visit of

the Inter-Africa Committee members, Mmes. Ras-Work and Linander, there was a meeting of women leaders in the districts, district leaders and muslim religious leaders (because excision here in Togo is practised only by the muslim population, who attach the practice to religion).

The resolutions and recommendations of the Dakar conference were highly acclaimed by the participants and they arrived at the following decisions :

1. Excision is a traditional practice which has no source in the islamic religion.

2. It is the women who like to be excised, as non-excised women were not well thought of in the cultural group.

Our working group organized to this effect has been supported by other organizations of the country. These are :

- L'Association Togolaise pour le Bien-Etre familial
- Les Mouvements de Jeunesse
- Les Services de la Santé Publique
- La Commission Nationale de la Croix-Rouge

As a result of all these meetings the following plan for action to be taken was drawn up :

- a) the creation of teams of awareness-raising catalyts
- b) the training of these teams
- c) the elaboration of a programme for a 1984 campaign for awareness-raising
- d) follow-up and evaluation
- e) recommendations for 1985

The training of the teams will be undertaken by two midwives, members of the National Committee already created, assisted by teaching aide produced by the working-group on **"Traditional Practices having a bad effect on the Health of Mothers and Children"**.

To conclude, I believe international cooperation is indispensable in order to support the national action.

The Togo working group has already submitted a project by region to the International Committee.

We hope that a contribution supporting us will be given in order to enable us to bring our action already started to perfection.

I thank you for your attention.

Summary of research in Ethiopia

The prevalence of female circumcision in the areas covered by the survey was high.

- Basic socio-cultural and medical data covering five regions of Ethiopia was collected from persons of both sexes generated by the Survey on Female Circumcision in Ethiopia. it showed that 86 per cent of the total female respondents and 87 per cent of the women who were medically examined had undergone one of the three types of female circumcision (Sunna, excision or infibulation).
- Types of female circumcision practised seemed to be influenced by the status of women in each area studied ; ethnicity ; religious affiliations and the mode of life (farmers, nomadic, traders, etc...) of those resorting to the different forms of the practice.
- Medical complications observed among those who had undergone female circumcision include cases of clitoral cyst, urethral infections, deep scar tissues and keloid formations leading to easy tears during delivery, some causing fistula and others resulting in the excessive blood loss.
- More than 20 per cent of those studied admitted to have witnessed complications due to female circumcision and half of these respondents revealed that complications they had witnessed led to fatal and/or irreparable damages.
- Traditional justifications for practicing female circumcision

WOMENS GROUP FOR THE ABOLITION OF SEXUAL MUTILATIONS (C.A.M.S.)

(Fench Section of the International Commission for the Abolition of Sexual Mutilation)

Extract from summary of report presented by Mrs Coumba Tour{, to the Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa, 6-10 April 1987, Addis Ababa, Ethiopia.

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

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

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

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

In France, C.A.M.S.

- organised instruction at the University of Paris VIII on the subject of sexual mutilation of females;
- participated in the working group set up by the Ministry of the Rights of Women (1982-84) and has drawn up a large part of the report made on the situation in France;
- sensitizes professional health workers (doctors, midwives, paediatric nurses, social workers...) by participating in their initial or continued training;
- informs the immigrant population by interceding in African meetings and festivals;
- proposes, in particular to Mother and Child health care teams, a health programme adapted to immigrant families;
- takes part in numerous informative meetings organised by associations, communes, women's groups and so forth.

At the international level, C.A.M.S. has taken part in many meetings of health officers as well as women's groups".

The above is taken from pages 101-2 of Report on the Regional Seminar on Traditional Practices Affecting Health of Women and Children in Africa, 6-10 April 1987, Addis Ababa, Ethiopia.

For further information write to:

CAMS-F (Section Francaise de la Commission Internationale pour l'Abolition des Mutilations Sexuelles),
36, rue Campo-Formio, 75013 Paris, FRANCE;
Tel.: 43 31 99 89

seem to enjoy safe haven in traditional myths surrounding the allegedly wild behaviour of the uncircumcised female, the question of odour, lack of poise, cleanliness and esthetic beauty of the female organ which is sure to be viewed during child delivery and is said to cause the disgust of the traditional birth attendants.

- The study has shown that a strong correlation exists between resorting to being exposed to and advocating for female circumcision among those studied.
- Influences of female education, adult education or urbanization do not seem to have much impact in the case of those studied as far as female circumcision goes. This generalization is based on the fact that over 70 per cent of those with "three Rs" had indicated that they would have their female child undergo circumcision. 83 per cent of women with elementary education and above who were interviewed one day after they had delivered babies indicated their plan to have their female children undergo circumcision.
- More than half of the (over 200) male respondents referred to as "elder", and students attending higher educational institutions referred to as "youth", saw very little reason to worry, if a traditional practice such as female circumcision is done to female children.
- Among recommendations suggested for action programmes, informational campaigns geared toward raising the consciousness of women thereby changing their values and KAP, and having programmes questioning values, and myths about female circumcision. As a result of the survey a plastic model which vividly portrays the various medical complications caused by female circumcision was prepared to serve as one of the sets of teaching materials recommended by the survey.

Female circumcision in Mali

Madam president, distinguished participants of the conference, first of all, I should like to introduce myself, Mme. Dialle Kankou Dialle, member of the National Executive Committee of the National Union of the Women of Mali - (NUWM). I should also like to thank the Babiker Badri Association for their invitation and also my Sudanese sisters for the warm welcome and kind hospitality that they have shown us. On behalf of the women of Mali, I warmly greet all my sisters here.

Mali is a vast, land-locked country : 1,140.192 square kms., bordering on 7 countries (Mauritania, Algeria, Burkina Faso, Guinea, Ivory Coast, Senegal and Nigeria). Bamake is 1290 kms. from Dakar, 126 kms. from Abidjan, 1006 kms. from Conakry. There are close to 7;500,000 inhabitants with 44 % under 14 years of age, 85 % live by farming. The majority are Moslems.

The National Women's Union of Mali is the only organization of women where no distinction is made on the basis of race or religion. The main aim of the NUWM is to fight for the emancipation of Mali women and to bring about their complete participation in the dynamic factor of development. In order to do this it is essential that Malian women are free from certain socio-cultural practices which can seem to be a sort of discrimination with regard to women and thus a hindrance to their complete development. It is within this framework that the NUWM has undertaken a research programme on women.

Excision is one of the chosen topics. Before Dakar we have already begun our research programme on excision. Today we can report on the findings on which the NUWM is going to base its planning in the fight against excision. In fact we were obliged to carry out a questionnaire survey before we began. In Mali excision is a practice which is deeply rooted in our socio-cultural traditions ; it consists of the ablation of the clitoris and is considered to be a rite of passage marking a young girl's entry into a state of puberty and also permits her integration into the

women's group:

Questionnaires were sent out to all provinces in Mali and the District of Bamake (in all 46 provinces plus the District). We received replies from 39 and from the District of Bamake - Mali being divided into 7 administrative regions as well as the District of Bamake. We can say that we received a representative cross-section from all regions. Of the respondents 43.3 % were male and 56.7 % female. Many of the questions were concerning the reasons for excision, both in the past and at present ; the age of the girls at excision ; methods used ; treatment after excision ; healing time ; resulting problems, number of tribes not practising excision, etc... An ethnographical survey showed that 85.1 % of Malinka women had been circumcised ; 75 % Khassanka ; 67.8 % Poeul ; 62 % Sarcekoll ; 61.6 % Bamb ; 0.5 % Savais and Tamachecks ; 9 % Maurs and Touaregs ; .2 % Bobos. The final important question raised concerned the future of excision. We noted the following results : 54 % of the women and 52.7 % of the men still wish to circumcise daughters in the future, and these figures bear no relation to the level of education or the age of the respondents. Generally speaking, attitudes to circumcision have not changed very much. We have only noticed a certain development with regard to the age at which excision is carried out (girls are taken at a very early age, almost 40 days after birth) and with regard to the circumcision care given to these children. In Mali the majority of the respondents were in favour of keeping the practice, largely the sake of customs ; a fact which is hardly surprising in a country like Mali where people are very strongly attached to the custom.

Thus, this questionnaires survey permit us, as I have already mentioned, to outline a campaign to be adopted with regard to circumcision in Mali.

In effect this means that we shall have to work on developing in this area. This is not an easy task, especially in Mali where circumcision is not a **problem for women**. I might even go so far to say that the alarm bell was rung by people outside the country (the case of the young Mali girl in Paris - where there were doubt as to the skill of the woman who carried out the excision). This certainly helped us to bring the problem of circumcision out into the open. Also, given the present economic situation in Mali, men and women say that circumcision is in fact of secondary importance and that they have other priorities. Women will simply tell you : "... instead of coming to us talking about circumcision bring us a mill or dig us a well etc...". For us in Mali then it is question of organizing a vast campaign for the dissemination of awareness and information. To this end we are hoping above all to use radio and TV - by means of discussion programmes and television debates ; we shall also use all existing women's groups (for example co-operatives, literacy classes, training centres for rural circumcisionists etc...). And the raising of awareness must first start with older people i.e. the parents.

We can count on the assistance of religious leaders and especially on an institution such as the MAUPI (Mali Association for the Unification and Progress of Islam) which is popular in the country and is willing to broadcast programmes and even give conferences to enlighten people and rid them of the idea that excision is prescribed by the Koran. Our activities are strongly supported by the Paibi, the government and the women's organizations. Nevertheless, it must be admitted that tradition is stronger than all of this and we must proceed slowly but surely and in ensuing generations we believe that the practice will die out of its own accord. The National Women's Union of Mali has taken part in this conference in order to support our sisters in Sudan and elsewhere where female circumcision has taken on an alarming aspect. I have been speaking on behalf of the women of Mali who are in favour of all recommendations for the eradication of female circumcision.

Thank you all very much.

Female circumcision in Eritrea

Ladies and Gentlemen :

It is indisputable that a woman is a very much disadvantaged and oppressed part of today's society. The degree of her oppression might differ with the socio-economic development of any one country. In the Third World, where peasant economy dominates, and feudal relationships form the dominant socio economic mode, the oppression of women assumes a crude form and is obvious, while the oppression of women in the developed world is more subtle and systematic.

One of the ugly and cruel practices of women's oppression is circumcision, practised in a large part of the third world. That circumcision is ugly, cruel and totally inexcusable is indisputable, and has been described as so in many of the papers presented by all the delegates who have spoken here in the seminar. Many books have also been written recently exposing the ugly features of circumcision.

In Eritrea, too, circumcision of females in its various forms is practised widely. The issue is not whether it is practised, but how to eradicate it. Can you attack circumcision alone without attacking the root cause and the foundation of the practice ?

Circumcision of females is rooted in centuries -old tradition, and is given a positive interpretation by a backward society dominated by the male.

We in Eritrea have said that without attacking the root cause of our problems we can only make some reforms and treat symptoms without solving the main problems, and this can be ever on-going and expensive practice.

We have said that unless we bring about a fundamental socio-economic transformation in Eritrea, unless we change our society from being a backward and highly traditional one into a progressive, enlightened one, which has access to free education, health services, and is independent economically, we shall not achieve our aim, however good we might be at identifying our problems, be it hunger, circumcision, or disease.

Eritrea is a Third World country which has the unfortunate history of being a victim of colonization for centuries. Because of its strategic location on the Red Sea Coast, various powers have tried to occupy it, starting with the Turks in the 16th century ; followed by the Pharaenic Egyptians ; modern colonizers, the Italians and the British ; and after them, the current colonizers, the Ethiopians. Throughout the centuries then, the Eritrean people have been fighting for their freedom and independence both peacefully and for the last 23 years by armed warfare.

In 1970 when the Eritrean People's Liberation Front (EPLF) was formed, it clearly identified the cause of our people's misery and backwardness to be not only colonialism, but also feudalism, and declared that we cannot wait until we win the war to do away with oppression and backwardness, but that the process of social change must begin now. It declared that women's liberation and equality is an indispensable part of our freedom and liberation.

Thus, the EPLF set about to organize the population, to educate them and to make them masters of their own destiny.

One of the important mass organizations in Eritrea today is the National Union of Eritrea Women (NUEWMN). Unless the attitudes of our society change unless women are given an equal chance in the economic and social factor in our country, women are now given their equal share of land, which was not the case before. Women are now participating in the armed struggle without any discrimination based on sex ; women are participating in education, health services facilities and in organizing their people. Through their organization, women can now fully participate in the affairs of their village, can vote and be voted into the Village Assembly or any other local administrative body. The NUEWMN maintains and pushes forward all the advantages gained by our struggle.

It is within this context that circumcision is fought in Eritrea. It is one aspect, though ugly and cruel, of our oppression, and by

handling it within the socio-economic context by discussing its uselessness and negative effects in our women meetings throughout Eritrea, it has started to diminish and will eventually disappear as a practice. Again, what we want to stress here is that unless we change the socio-economic situation of our country and people, we shall never be able to change all the backward negative and harmful traditions, practices and values of our people.

The NUEWMN, together with the EPLF and its mass organization the NUEW, NUEP and NUES is committed to bring about a socio-economic transformation in our country and thereby eradicate female circumcision and its ugly features. We will continue along this road, despite the Ethiopian military government's efforts to wipe us out by military force, from the face of the earth and we shall succeed.

Because what we are trying to do is just and correct and our people are only trying to practice their human right, the right to be free and independent, to live in justice and peace, we shall succeed.