



African
Women's
Organisation

TRAINING KIT

Prevention and Elimination
of Female Genital Mutilation
among Immigrants in Europe



EU Daphne Project

Training Kit
Prevention and Elimination of
Female Genital Mutilation
Among Immigrants in Europe

Acknowledgement

All harmful traditional practices and in particular female genital mutilation affect the health and well-being of girl-children and women. This practice is deeply rooted in tradition and is now being practised also outside of the origin and prevalent areas of Africa and the Middle East. The only guaranteed and effective way of doing away with this persistent practice is through the change of values, norms and behaviours. This change can come only through information, education and communication. It is with this objective that the African Women's Organization in partnership with RISK (Sweden) and VON (the Netherlands) has prepared this kit with the support of EU Daphne, City of Vienna, Ministries of Interior and Social and Generation of Austria.

Breaking the taboo of FGM has been a major and bitter battle with input by selfless efforts and sacrifices of courageous women and NGOs. The harbinger and persistent work of Fran P. Hosken at the global level had been a bench mark for all those who followed her footpath in exposing the nature and magnitude of the problem. The Inter-African Committee on Traditional Practices Affecting the Health of Children and Women has mobilized a large force of women, youth and leaders at the grass root level to fight FGM and other harmful practices in risk countries. The practice is no longer limited to its area of origin. Migration has made it global. In Europe as a destination of a large number of immigrants, it is expected that this traditional practice will be maintained by immigrants as a bridge with their own communities. Experiences have shown that immigrants have not refrained from carrying out harmful traditional practices even though it is not an accepted practice in their host countries. Harmful traditional practices practised whether at home or host country should be challenged systematically. It is within this context that the African Women's Organization and its partners designed this kit using community and religious leaders and communicators/facilitators as the entry point to make a change – a change of values, norms and behaviours.

The kit has three modules reflecting the entry points but can be adaptable for any target group with some modifications in relation to the target population. The modules consist of 7 sessions covering all the important aspects of FGM. The kit can also serve as a source of information. The supplement on teaching aid can serve all purposes of training.

The African Women's Organization and its partners sincerely thank Dr. Ashenafi Moges, Dr. Isatou Touray and Prof. Günter Klingenbrunner for putting this kit together. We also thank all the experts from 13 different European countries who took part in the initial experts' meeting and workshop. We also thank Mag. Barbara Prammer, the 2nd President of the Austrian Parliament for her continuous advice and support. We are also grateful and thankful to Mrs. Berhane Ras-Work, President of the Inter-African Committee, Mrs. Karin Ortner of Amnesty Austria, Carlo Martingo (Portugal), Dr. Richter Ritter (Germany), Mag. Christina Brudder (Frauen Solidarität, Vienna), Prof. Adriana Kaplan (Spain), Linda Osarenren, and Abebech Alemneh (IAC Addis Ababa) for their critical comments and inputs on the draft version of the kit.

Finally, the African Women's Organization is grateful to our sponsors: EU Commission DAPHINE Programme, the City of Vienna, Ministry of Interior and Ministry of Social and Generation of Austria.

Contents

| | |
|--|----|
| Part I Introduction | 4 |
| Part II Objectives | 6 |
| Module I – Community Leaders | 7 |
| Session 1 – Culture and Traditions | 7 |
| Session 2 – Types of Traditions and Culture | 10 |
| Session 3 – What is Female Genital Mutilation? | 12 |
| Session 4 – Female Genital Mutilation and Health | 21 |
| Session 5 – Female Genital Mutilation and Violence | 25 |
| Session 6 – Female Genital Mutilation and Human Rights | 27 |
| • International Measures | 27 |
| • Legislation and FGM | 29 |
| Session 7 – Role of Community Leaders towards FGM Elimination | 33 |
| Module II – Communicators | 34 |
| Module III – Religious Leaders | 35 |
| Session 1 – Religion and Female Genital Mutilation | 35 |
| Part III Case Reports of FGM Experiences | 42 |
| Case 1. A Young Woman's Experience in the Sudan | 43 |
| Case 2. A Young Sudanese Med.I School Student, Univ. of Khartoum | 44 |
| Case 3. Initiation of a Young Woman from Mali | 45 |
| Case 4. An Ethiopian Living in the USA | 46 |
| Part IV Good Experiences on the Field | 48 |
| Case 1. Alternatives to female genital mutilation in Guinea-Bissau | 49 |
| Case 2. Circumcision through Words | 52 |
| Alternative Rite to Female Circumcision Spreading in Kenya | 53 |
| Case 3. The unkindest cut of all | 55 |
| Part V Notes for Trainers of FGM among Immigrants in Europe | 58 |
| Part VI Methodological and Technical Aspects of Training Sessions | 61 |
| Part VII | 65 |
| Glossary | 65 |
| Acronyms | 66 |
| Annexes | 67 |
| Resources | 79 |
| References | 80 |



Introduction

There are many cultural and traditional practices that affect the health and well-being of women and children. One of the main ones with severe consequences is female genital mutilation (FGM) which has evolved through time in certain communities. This traditional practice is deeply rooted and enshrined in taboos with the culture of silence and secrecy making it persistent in most communities involved in the practice. Female genital mutilation is one of the widespread harmful traditional practices prevalent in Africa and parts of the Middle East. However, this practice has transcended the boundaries of Africa and the Middle East through the movements of people and their families carrying along with them their culture and traditions – the good and the bad.

Outside Africa and the Middle East, FGM has become a concern as it has reached European communities through migration as a result of conflict, economic or other circumstances in the country of origin. Even though the EU Member States' constitutions affirm each individual's fundamental right to physical and mental integrity, immigrants from countries where FGM is a tradition still practised tend to carry out the practice.

The European Union Daphne Project estimates that there are around 270,000 girls and women victims or are at risk of being victims. With more migration taking place it is likely that this figure might increase unless it is abandoned in the origin areas. The lack of research in this area and the secrecy surrounding the practice makes it difficult to assess the extent of the phenomenon. However, estimates produced by various studies lead to the conclusion that it is not negligible: there are 30,000 victims of this practice in the UK, almost 28,000 in Italy, 20,000 women at risk in Germany (European Parliament, 2001:21). Despite, the existence of specific legislations and penal codes in some European countries to deter the practice of FGM, it is still persistent. The European Parliament Committee on Women's Rights and Equal opportunities has made very strong observations with regards to FGM thus:

"It is of course a fact that every individual in the EU Member States enjoys absolute protection under the law. The challenge the Member States face is therefore not that of promulgating specific ad hoc laws to prohibit FGM, but of strictly applying the existing constitutional provisions enshrining the rights of personal health and integrity as a fundamental right and the criminal law provisions prohibiting any deliberate act that violates this right. This necessarily implies that 'exceptions for cultural diversity' cannot be invoked to justify relativism or distortion of this fundamental right and the state's associated duty to provide legal protection. Allowing these practices in a medical context must not be tolerated under any circumstances" (European Parliament 2001:21).

There might be various reasons ranging from tradition and religion to social needs and norms why the practice continues and this is what the proposed kit will address alongside other aspects of the problem.

Activities addressing the harmful consequences of FGM in Europe target the immigrant population estimated at some 270.000 or more victims. This kit adopts a flexible and systems approach through information, education and communication (IEC) strategy, a process that will lead the immigrant community to a lasting and sustainable change of norms, values and behaviours in the elimination of FGM in Europe.

The kit adopts a systems approach to FGM by having several sessions on each module to cover a wide range of disciplines associated with the practice. It is intended to be simple, relevant and convincing for those using it. It is also expected that the people through their active participation, improvisation and adaptation to the context in which the immigrants live or find themselves will own the final outcome of the kit.

In order to be effective the kit is intended and targeted at three critical groups as its strategic entry point to be engaged with the efforts to eliminate FGM and other harmful traditional practices among the immigrant community. They are community leaders, religious leaders and facilitators/communicators. The kit can easily be modified to address other sectors of the community.

FGM is deeply entrenched in tradition, culture and religion which is associated with authority figures – community leaders, communicators, and religious leaders, individuals accepted and respected by the community. It is very important to have these sectors of the society enrolled in the campaign. They are likely and have the potential to influence change in the community at the grassroots level. It is envisaged that their involvement will create the platform and facilitate discussion on the issue by their kinsmen and women. Their words, suggestions, decisions, advices and participation can be more powerful than any other form of intervention, such as legislation.

In the European context the migrant population, especially in the major cities, are organized around their religious communities, national and local associations, social clubs, etc. Each of these communal gatherings, are headed by leaders of immense power and influence in the community. They are the ideal entry points for interventions against tradition and religion related harmful practices, in particular FGM. These target groups can bring and influence change because:

- They understand and have knowledge of their culture and community.
- They are sensitive to their community's problems, issues and needs.
- They have acceptance at the grass-root level and their leadership is accepted by the community.
- They most likely know the policies and procedures of their host country and have contact with the local authorities.
- As the issue being addressed involves tradition and culture, they cannot be accused of interference and,
- They are culturally and socially relevant.

Use of the KIT

The kit is divided into 3 modules and 7 sessions covering all aspects of FGM. The modules are presented in sessions and steps to enable the user to follow the logical sequence intended to gradually build up the ultimate objective of creating consciousness and convincing more and more people to join the campaign and advocate for the elimination of FGM among the immigrant community in Europe. The final objective is zero tolerance to FGM.

Each session provides the learning point for each of the modules and some explanatory notes. Each module will be accompanied by the relevant resource material but at the same time allowing for flexibility according to context.

A simple and general teaching guide is provided for the users as a supplement of the kit.

The Kit can be utilised by organisations who are concerned with the issue of FGM who are not immigrants and may be in a better position to do so. The European Network and other active participants in community life can be useful conduit through which this kit can be implemented.



Objectives

| Target Group | Overall Goal | General Objective | Specific Objective |
|---|---|--|---|
| <ul style="list-style-type: none"> Immigrant communities living in Europe from FGM practising countries. | <ul style="list-style-type: none"> To bring changes of values, perceptions, attitudes and behaviour about the harmful traditional practices, in particular FGM, through training, information and communication leading to the elimination of FGM in Europe. | <ul style="list-style-type: none"> To create awareness on harmful traditional practices with specific reference to FGM. To build awareness about FGM and other traditional/cultural practices affecting the immigrant community. | <ul style="list-style-type: none"> To train and create awareness about FGM among community leaders, religious leaders and communicators/facilitators from the immigrant community with a multiplying effect. |

Module I – Community Leaders

Module II – Communicators

Module III – Religious Leaders

Module I – Community Leaders

| Target Group | Overall Goal | General Objective | Specific Objective |
|---|--|--|---|
| <ul style="list-style-type: none"> Community leaders among the immigrant population in Europe. | <ul style="list-style-type: none"> To bring changes of values, perceptions, attitudes and behaviours about the harmful traditional practices in particular FGM through training, information and communication leading to the elimination of FGM in Europe. | <ul style="list-style-type: none"> To create awareness on harmful traditional practices with specific reference to FGM. To build awareness about FGM and other traditional/cultural practices affecting the immigrant community. | <ul style="list-style-type: none"> To train and create awareness about FGM among community leaders from the immigrant community with a multiplying effect. |

Module I

Session 1 – Cultures and Traditions

What Are Traditional/Cultural Practices?

→ Step One

- Allow participants to brainstorm and come up with their own understanding of the concepts and encourage them to give examples of their own.
- Define culture, traditions, attitudes, behaviours, practices, perceptions and beliefs.

→ Step One

Cultures and Traditions Definition:

A simple dictionary definition of culture is

"The totality of socially transmitted behaviour, patterns, arts, beliefs, institutions, and all other products of human work and thought".

Any individual is a product of the particular culture in which he or she is living in.

There are numerous definitions of culture reflecting the broadness and coverage of the subject matter. The following are some of the definitions in use (John Bodley):

- Culture consists of broad areas of community life, such as social organization, religion, economy.
- Culture is social heritage, or tradition, that is passed on from generation to generation without interruption.
- Culture is shared, learned human behaviour, and a way of life.
- Culture is ideals, values or rules for living.
- Culture is the way humans solve problems of adapting to the environment or living together.
- Culture is a complex of ideas, or learned habits, that controls impulses and distinguishes people from animals.
- Culture consists of patterned and interrelated ideas, symbols or behaviours.
- Culture is based on arbitrarily assigned meanings that are shared by a society (namely language).



Culture in short consists of:

- What people think and believe.
- What they do.
- The material product they produce and use.

Properties of Culture

Culture has several properties:

- It is **shared**, meaning it is a social phenomenon. It is a collective property, for example, customs, language, folk tales, music. Unshared cultures having no mass base gradually die. (*"No culture can live, if it attempts to be exclusive"* Gandi.)
- It is **learned not biologically inherited**. This is the essential feature of culture. The way it is taught and reproduced is part of culture itself. It is done by "enculturation" or "socialization" where the older generation encourages and compels the younger generation to adopt traditional ways of life. Parents and educators are the main transmitters of culture through the process of socialization. Culture may also reproduce through "diffusion" from one society to another – voluntary adaptation.
- It is **symbolic** with systems of meaning of which language is primary. Members of the society agree on the relationships and meaning between a word, behaviour or other symbol. For example, storm can symbolize troubled times in one culture or symbolize the blessing of the gods in another. Other symbols are globally applicable, such as traffic lights, wedding rings.
- It is **transmitted cross-generationally**. Individuals are born into and are shaped by a pre-existing culture. The influence that an individual may have on culture is itself determined by culture itself.
- It is **adaptive, organic, growing and changing** with the passing of time because of human interaction, innovations, changes of life style. It cannot be changed easily by force.

Dynamism of Culture

Culture changes dynamically over time and space. It is the product of ongoing human interaction, reflecting social, political and economic changes within communities. The factors that lead towards the dynamism of culture include:

- Voluntary adaptation of a foreign culture to a community.
- War of conquest.
- Integration into a new community.
- Trade at local, regional, or global level.
- Inter-marriage between partners of different cultures and traditions.
- Revolution in technology which result in changes of way of life.
- Education.
- Information on culture and tradition of other communities.
- Migration as well as tourism leading to exposure to different cultures and styles of life.

Conclusion

- Culture enables individuals to look and interpret the reality, relation with fellow human beings and the environment leading to appropriate responses to challenges and life.
- Culture establishes the value system of the community and helps individuals to differentiate between what is good and what is evil; what is legitimate and what is illegitimate in the community or society. The belief system sets the standard on how one should feel, think, and/or behave. Social institutions such as marriage, mourning, conflict resolution are determined by culture.
- Culture motivates community members to act or refrain from acting based on the value and belief systems of the society.
- Culture is the medium of communication consisting of language, physical gestures and modes of dress, music, etc.
- Culture establishes social institutions that maintain the orderly existence of society and promotes a system of values.

Value of Culture

Culture remains a significant part of people's lives. It is a mark of identity. It is a set of value systems that help an individual in his or her life to respond to the environment and other fellow human beings. Everyday practices and beliefs inherited is societies capital. The current generation need not generate a whole new set of norms, values and practices from scratch. One should be proud of what he or she has and develop it.

What one needs to examine, however, is whether the sets of beliefs and values and the consequent behaviours and actions are suitable to be followed at the existing economic, political and social situation of the community and the world at large. The world is no longer a small village. There are cultural interchanges and adaptations. Some cultures are becoming global and some are gradually dying out over time to be replaced with new ones.

Do the cultural/traditional practices benefit or harm an individual in any way – mentally, physically, etc? This is the question that needs to be answered. If the response is "negative", then this should be the main reason why action must be taken to eliminate it and replace it with a "positive" one. It must always be remembered that culture has no quality of unchangeability or permanence. It is not static. It is always on the change.

→ Activity

- Allow participants to list out all the practices they have in their communities of origin.
- List by classifying them under **beneficial and harmful practices and traditions.**

→ Activity



*Module I**Session 2 – Types of Traditions and Culture**1. Beneficial or Good Traditions*

Beneficial traditions are those that promote the well-being socially, physically and mentally of the individual and the community at large.

- Breast feeding.
- Care for orphans.
- Hospitality.
- Respect and support for elders.
- Mutual help (self-help associations).
- Conflict resolution through dialogue.

2. Harmful Traditions

Harmful ones are those that affect the health, physical and mental well-being of individuals, particularly women and children. Any practice that affects the entity of any individual is harmful.

Such practices include:

- Nutritional taboos focusing on pregnant women and girl-infants.
- Forced feeding of pregnant women.
- Preference of sons (leading to infanticide of girl-infants).
- Foot binding (China).
- Honour killing (the Middle East).
- Widow burning (India).
- Widow inheritance.
- Female genital mutilation (Africa/Middle East).
- Virginity test.
- Early and childhood marriage.
- Forced marriage.
- Abduction.
- Practices associated with child birth.

→ Activity**→ Activity**

- Allow participants to list as many as possible reasons for these practices.
- Allow participants to discuss reinforcing factors for harmful traditional practises (HTPs).

Factors Reinforcing Harmful Traditional Practices

- Ignorance.
- Traditional myths (ancestors' wishes).
- Fear – "A terrible fate is in store for those who defy custom or the wish of the ancestors".
- Tradition of silence and obedience.
- Religious misperception/misinterpretation.
- Social pressure (family members, community, friends, peers).
- Social institutions (marriage, bride price, etc.).
- Gender inequality.
- Lack of information.
- Lack of education on reproductive health and sexuality.
- Resistance to change.
- Fear of being cast out.
- Sense of belongingness.
- Politicisation of changes.
- Fear of change and of the future.
- Community enforcement mechanisms.

→ Analyse with participants the list of reasons from a gender perspective and relate to culture. →

→ Notes about Module I

- List all the practices.
- Categorize them into positive or beneficiary, negative or harmful depending on which word is more suitable for the context.
- Encourage discussion around the list.
- Group can be divided into small groups if too large to allow for maximum participation of all (small groups preferable).

→ Notes

→ Methods

- Brainstorm over the concepts and listing them.
- Questions and answers.
- Experience learning.
- History and testimonies.

→ Methods

→ Learning points about Culture

- Human beings are creators, interpreters and transmitters of culture.
- Culture/traditions can be both beneficiary and harmful.
- It is dynamic, not static.
- It changes with time and context.
- Can be discarded when it is not useful for people.
- FGM is a cultural/traditional practice that is harmful to women and girl-children.

→ Learning Points



Module I

Session 3 – What is Female Genital Mutilation?

Introduction

The World Health Organization defines FGM as follows:

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

1. Background

Terminologies

This harmful traditional practice is known by various names. Each community has its own name for it, sometime shared with male circumcision. The one in use globally since 1994 is female genital mutilation and accepted by the WHO, UNICEF and UNFPA. The word originates from “mutilation” meaning to cut. This term expresses the magnitude of the consequences and implies the irreversibility of the operation. The term also clearly differentiates the operation from that of male circumcision which is not of the same magnitude and different objectives.

Other terms used for the operation include:

- Female circumcision.
- Excision.
- Female genital excision.
- Female genital cutting (used by UNFPA, USAID).
- Female genital mutilation/cutting (introduced by UNICEF as a compromise).

Origin of FGM

The period and area of the origin of FGM has been difficult to establish and still remains controversial and under discussion. The absence of historical records makes the task of determining its origin difficult. Some claim that it started in the Middle East or the Arabian Peninsula and then spread by Arab traders to parts of Africa. Herodotus from the 5 century BC places the origin in Ethiopia or Egypt (Smith 1995). Other sources indicate that FGM existed in Egypt as early as 163 BC (Hosken 1993). It is not conclusive but the general consensus is that it is likely that FGM originated somewhere in East Africa where its practice is still widespread, i.e. the Horn of Africa, Egypt and the Red Sea coasts. One form of FGM, the Pharaonic circumcision (infibulation) derives its name from the Egyptian Pharaohs some refer to it as the Sudanese circumcision. It is most likely that the practice spread from the Horn of Africa through trade, war of conquest and voluntary adaptation.

The reason it came into existence is also fully unknown. Smith (1995) points out the possible reasons for the origin of the practice. She believes that it was intended to serve as a means of birth control to reduce the number of consumers, a means to control the sexual function of women, and promote the patriarchal family system.

Procedure

The operation is usually performed by old women or traditional birth attendants, also known as circumcisers or excisors. They are mostly women except in some places such as Nigeria and Egypt where barbers do the operation. Mothers never circumcise their own daughters but assist the excisors by holding the hand or feet of their daughter. Men are rarely present at the operation of their daughters. Special knives, scissors, razor blades, kitchen knives or pieces of glass are used for the operation. The operations are done under unhygienic condition with the instrument of operation being used over and over without cleaning. In most cases anaesthetics and antiseptics are generally not used. Physical force is used when necessary to control a struggling girl during the operation.

In cases of initiation, where a group of similar age-groups under go the operation, it is usually performed at a site selected for the occasion. Individual operations may take place either at the home or work place of the excisor or the home of the individual to be excised. The places where the operations take place are usually unhygienic for any form of operation.

Age of Operation

The age at which the operation is performed varies from community to community and ranges from new born babies aged 7 or 8 days, as in Ethiopia and partly Nigeria, to puberty. Traditionally, in Africa as a puberty, initiation or coming of age rite it was performed at the age of 12 to 15 years, just before the onset of menstruation. Recent studies have shown that most parents have their children operated when they are within the age-group of 4 to 10 years, time period when the children are in no position to complain or rebel.

FGM Risk Countries and Prevalence

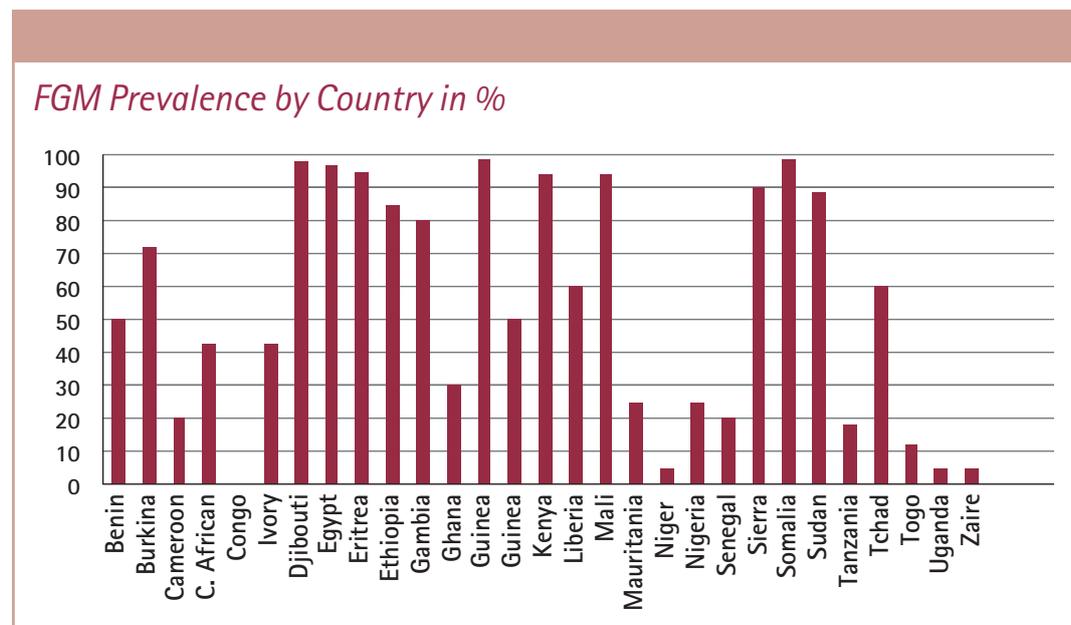
Assessing the magnitude and distribution of FGM is a challenge. Accurate statistical information of the affected population and its distribution by country is not easily available because of the sensitivity and secrecy surrounding the practice and inaccessibility of the risk population. Hosken provided the most extensive estimates of the prevalence of FGM with a regular update. Based on available information, field studies and estimates, there are now more than 150 million women and girls who have been mutilated and each year about 2 million are mutilated most of them being in 28 African countries. In East and North Africa it is prevalent in Egypt, Sudan, Somalia, Djibouti, Ethiopia, Eritrea, and Kenya. These countries have a prevalence ratio of over 90 %. Most of the West African countries: Burkina Faso, Benin, Ivory Coast, Gambia, Ghana, both Guineas, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, practice FGM. (See Map and graph)



Outside Africa FGM is practiced by small communities mostly Muslims in the Arabian Peninsula, Asia, Australia and Latin America. In the predominantly Islam countries such as Saudi Arabia, Iraq, Iran, the Gulf States, Kuwait, Algeria and Pakistan FGM is not practiced (Toubia 1993).

- Arabian Peninsula: Oman, United Arab Emirates, Yemen.
- Asia: India, Indonesia, Malaysia, Pakistan.
- Australia: a few Muslim groups.
- Latin America: Peru, Brazil, east Mexico. (Smith)

In the Western World where the practice has been introduced by African immigrants include Australia, Canada, France, Israel (mostly Falashas from Ethiopia), Italy, the Netherlands, Sweden, United Kingdom, and America (Toubia 1993). It is most likely that other European countries, such as Germany, Belgium, Austria, etc. have practising immigrants. In Europe at the moment it is estimated that there may be more than 270,000 victims at risk.



2. The Normal Female External Genitalia

The external female organ consists of the labia majora, the labia minora, the clitoris and the prepuce, urethra, vaginal opening and the perinum. Each of these organs is very sensitive to touch and have a role in protecting the internal reproductive organs.

The labia majora (the big or outer lip) is thick fatty folds of fleshy tissue. It is non-erectile and supplied with blood vessel. It provides a protective cover for the inner parts (clitoris, labia minora, entrance to the urethra, entrance to the vagina and hymen).

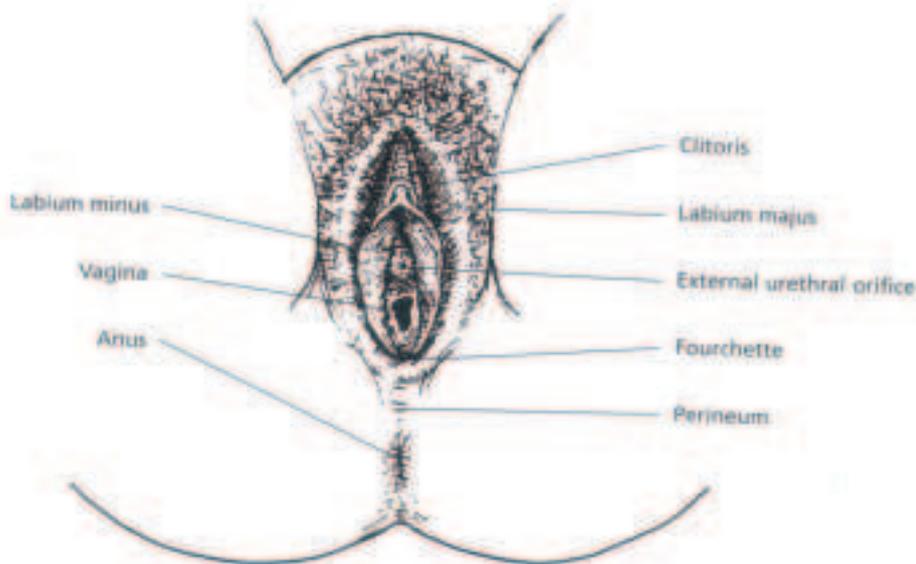
The labia minora, are two folds of skin between the labia majora. These inner lips consist of erectile tissues and capable of expanding and contracting and connected to the clitoris at the upper end. They are also well supplied with blood and are capable of expanding during child birth.

The clitoris is an organ covered with foreskin (prepuce). It is situated at the end of the labia minora. It consists of erectile tissues supplied with blood vessels and nerves. When it gets erect blood flows into the labia majora and the glands begin to excrete a liquid to facilitate sexual intercourse.

The vaginal opening and the urethra are openings leading to the womb and the urinary bladder respectively. The perineum is the stretchable skin between the anus and the genitalia.

It is these external female genitalia that are affected by any form of female genital mutilation. Any tampering with these organs will have immediate and long term effects. The individual will be denied the services provided by these organs.

Structure of normal external female genitalia



Source: World Health Organization (WHO)

→ Step Two

- Define FGM through discussions among participants (all participants should be encouraged to try to recall and recount what it means to them).
- Types of FGM (Get participants to mention the types that they are familiar within their community).
- List them.

→ Step Two

3. Types of female genital mutilations

FGM is basically physically altering the external female genital organ. This term more than the others in use (circumcision, excision, and cutting) describes the degree of damage the operation incurs. The term FGM covers many varieties of genital mutilation, depending on local customs.

The main classifications of this ritual include:

Type I - Clitoridectomy

Type II - Excision

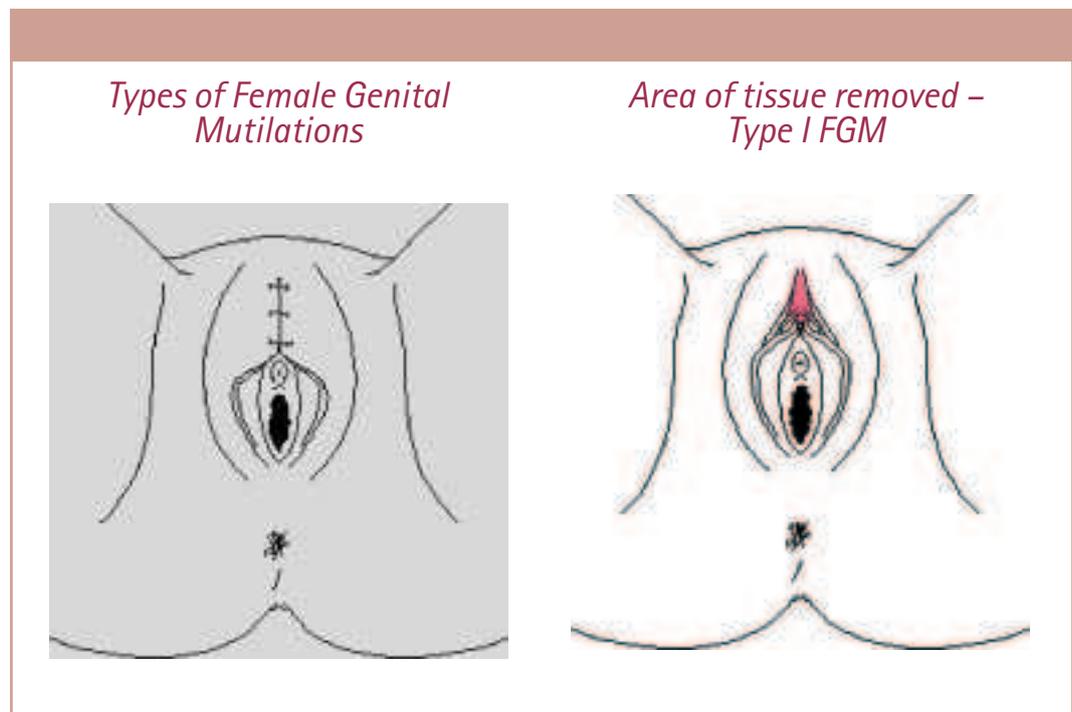
Type III - Infibulation

Type IV - Unclassified:

- Piercing/incision of clitoris/labia
- Cauterization by burning of the clitoris surrounding the tissues
- Angurya (scraping) or 'Gishiri cuts' (cutting) of the vagina.
- Introduction of herbal concoctions to the vagina

Type I

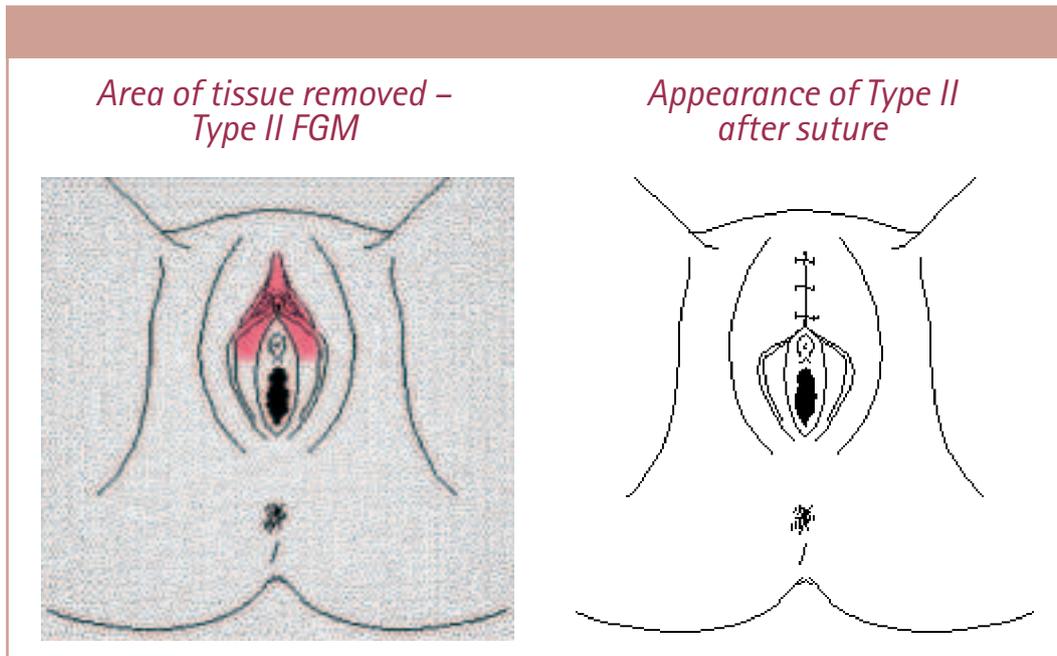
Excision of the prepuce (foreskin) with or without excision of part or the entire clitoris. This is referred to as **clitoridectomy** (also known among the Moslems as 'Sunna' meaning tradition). It involves excision of the prepuce with part or the entire clitoris or the excision of the prepuce without excision of the clitoris. Relatively, this is considered to be the mildest form of genital mutilation.



Source: World Health Organization (WHO)

Type II

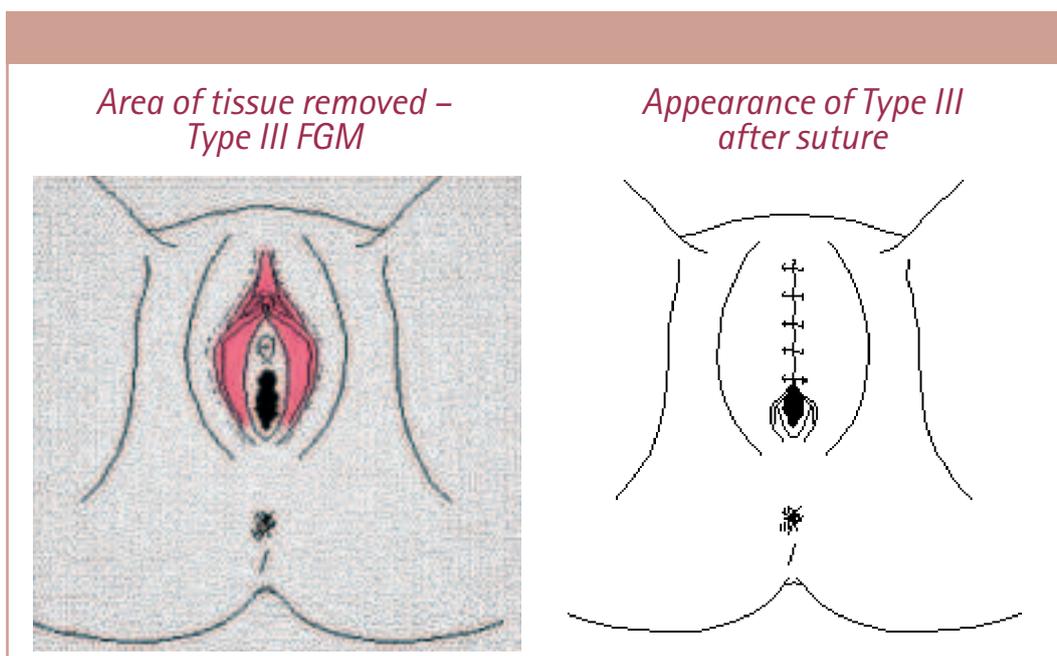
Excision of the prepuce and clitoris with partial or total excision of the labia minora (small lips). This form is known as **excision**. The amount of flesh removed depends on local customs and experience of operators. With Type I this form is the most common form of circumcision and account for 85 % of FGM cases.



Source: World Health Organization (WHO)

Type III

Excision of part or all of the external female genitalia and stitching/narrowing of the vaginal opening. It is known as **infibulation** also as Pharaonic circumcision (in some instances as Sudanese Circumcision).



Source: World Health Organization (WHO)

This is the most extreme form of genital mutilation. Infibulation consists of the removal of the prepuce, clitoris, labia majora and labia minora. After the removal of these parts, the scraped sides (the two labias) of the vulva are then stitched together with thorns, silk or catguts sutures to form a closure of the whole vulva region including the vaginal and urinary openings.

A small opening is left for the flow of urine and menstruation blood. The girl's legs are bound together from thigh to ankle for several weeks to help form scar tissues over the wound. Infibulated women have to be cut open, also known as defibulation, to allow intercourse and more cut during childbirth to allow safe passage of the child. Reinfibulation may take place afterwards.

It causes the worst damage on health and accounts for nearly 15 % of FGM cases and is mainly practised on all females in all of Somalia and Somalis living abroad, 80 % to 90 % in Sudan, Egypt and Djibouti and on a smaller scale in parts of Ethiopia and Eritrea along the Red Sea Coast, Mali and Gambia (see map - annex).

Type IV

WHO refers to this type as "unclassified" and others call it "intermediate".

It includes:

- Piercing or incision of clitoris and/or labia.
- Cauterisation by burning of clitoris and surrounding tissues;
- Scraping (angurya cuts) of the vaginal orifice or
- Cutting (gishiri cuts) of the vagina;
- Introduction of corrosive substances into the vagina to cause bleeding or
- Herbs into the vagina with the aim of tightening or narrowing the vagina.

→ Activities

→ Learning activities:

- Discussions
- Question and answers

→ Tools

→ Tools

- Slides/overheads (Genitalia, FGM types)
- Film
- Cases of Experiences (See Part III)

Factors that Maintain FGM

Generally the following factors have been popularly referred to justify FGM:

- Invocation of tradition and culture to insist on the continuity of the practice.
- Misperceptions and misinterpretations of FGM as a religious requirement both by Christians and Muslims.
- Ignorance of the negative sexual and reproductive implications of FGM on women and girl-child's health.
- Increases matrimonial opportunities.
- The payment of the bride price to a girl's parents depends on a woman fulfilling the traditional norms of the community – FGM being the important one.
- Belief that FGM helps to preserve chastity and virginity, prevents sexual immorality.
- The assumption that it helps gender identity – cutting the clitoris makes a woman feminine.
- The belief that FGM helps women to be faithful to their husbands
- The belief that it enhances the husband's sexual desire.
- Belief that it increases fertility and prevents prenatal mortality.
- The belief that it maintains family honour.
- Circumcised women are accepted by society and entitled to the privilege of adulthood.
- Where secret societies exist uncircumcised women cannot become members and benefit from membership.
- In communities where FGM is a rite of passage and a celebration, the practice is a binding force, hence a social cohesion among the people, which the community looks forward to.
- The circumcisers derive a lot of economic and social benefits from the practice.

→ Step Three

- Show participant the normal female genitalia and its reproductive use.
- Use transparencies on the types of FGM as classified by WHO and any other forms discovered.
- Allow participants to discuss the types and to come up with their opinions and probe them with the right questions around the issue at hand.

→ Resource Materials needed:

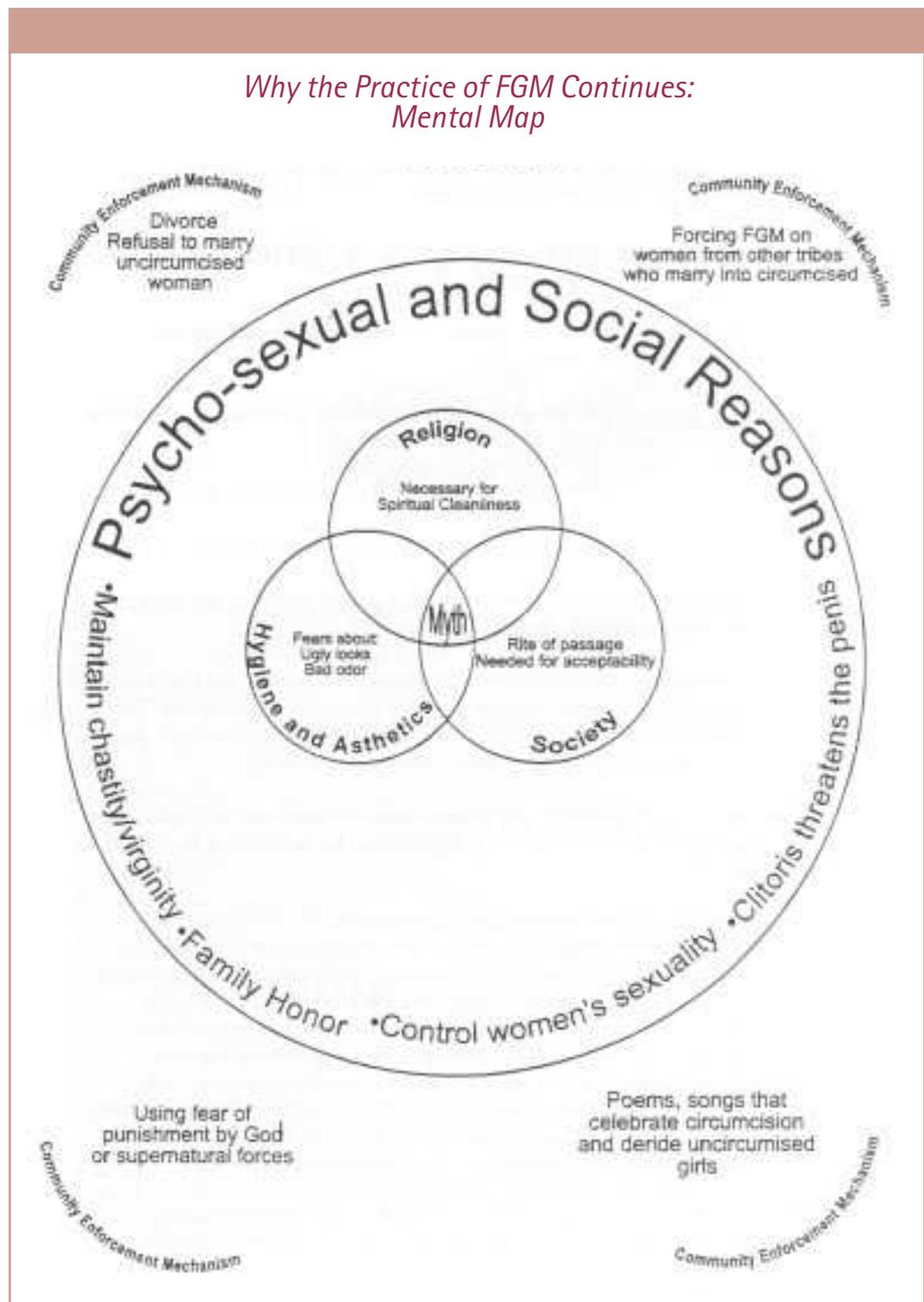
- Slides
- films
- transparencies on FGM, and normal female genitalia
- Anatomical model

→ Step Three

→ Materials



Why the Practice of FGM Continues: Mental Map



Source: WHO/CHS/WMH/99.5

Module I

Session 4 – Female Genital Mutilation and Health

→ Step Four**→ Step Four**

- Discuss FGM complications and consequences on female sexual and reproductive health.
- Allow participants to come up with the possible effects this may have on women and girl-children.
- Share information on short and long term effects of FGM.

Consequences and Complications of FGM

Introduction

All forms of FGM are harmful. Women suffer from FGM as young children at the time of the operation, as adults at the time of marriage and later during child delivery.

FGM affects the reproductive health of women during pregnancy and delivery, and has detrimental effects on the physical and psychological health of infants, girl-children and women. The consequences can be grouped into short- and long-term. The former manifests itself within a very short period beginning in minutes of the operation, such as bleeding and pain. Long-term complications are life-long, irreversible and require medical attentions to mitigate their effects.

1. Immediate Complications and Consequences

- Shock from bleeding, pain and stress resulting from cutting very sensitive and delicate area of the genitalia without the use of anaesthetic.
- Bleeding or haemorrhage: the cutting of the blood vessels in the vulva (clitoral artery) during the operation leads to bleeding. Serious bleeding can also cause shock. Protracted bleeding can lead to anaemia and even death.
- Urinary retention from fear of pain, tissue swelling or injury of the urethra cause pain and discomfort which could easily lead to bladder and urinary tract infections.
- Infection caused by the use of un-sterilized instruments in unhygienic environment may also lead to other complications and even to death. Infections can also cause pelvic inflammation. It could result directly in blood poisoning and in having tetanus, and if untreated finally death may follow. There is also high risk of HIV transmission through the use of the same instrument for multiple operations, for example during an initiation rite.
- Damage to organs such as the anus, urethra and the bladder from un-experienced circumcisers, or an uncooperative and struggling girl under operation.



With infibulation (deinfibulation, reinfibulation) the consequences are compounded by frequent cutting and stitching. Thus, bleeding and the risk of haemorrhage, pain, risk of infection and urine retention are more severe and serious.

2. Long-term Consequences

Infibulation and excision cause long-term complications of gynaecological, obstetrics and urinary tracts. The main ones are:

- Repeated urinary infection because of the narrowing of the urinary outlet which prevents the complete emptying of urine from the bladder.
- Extremely painful menstruation due to the build up of urine and blood in the uterus leading to inflammation of the bladder and internal sexual organs.
- Formation of scars and keloid on the vulva wound.
- The growth of dermoid cysts which may result in abscesses.
- Formation of fistula – the rupture of the vagina and/or uterus leading to inability to control urine.
- Vulval abscesses.
- Severe pain during intercourse which may consist of physical discomfort and psychological trauma.
- Difficult child birth which in case of long and obstructed labour may lead to foetal death and brain damage of the infant, especially in infibulated women.
- In the case of infibulation acute and chronic pelvic infection leading to infertility and/or tubal pregnancy.
- Accumulation of blood and blood clots in the uterus and/or vagina.

3. Childbirth Consequences

*It is what my grandmother called the three feminine sorrows,
she said the day of circumcision, and the wedding night and
the birth of a baby are the triple feminine sorrows.
As the birth bursts, I cry for help, when the battered flesh tears,
No mercy, push! They say, It is only feminine pain!*

(Dahabo Ali Muse, Somalia in "Female Genital Mutilation", NCTPE/EC, 1999)

- The other sexual problem related to FGM is the difficulty experienced during child birth in particular with infibulated women.
- The vaginal canal loses its elasticity due to excision and the vaginal opening is closed in cases of infibulation. This needs a cut to get the child out of a wall of flesh, which if done improperly will lead to bleeding, infection, fistula formation (inability to control urine).
- If the vaginal opening is narrow, the mother's labour will be prolonged and delayed which may be fatal to both mother and foetus.
- In the obstructed delivery the head is forced to press on the scar which may lead to arrest labour, rupture of the scar or uterine rupture, tearing of the vulva and perineum.

4. *Sexual Consequences*

- The mutilation of the sexually sensitive organ of women, results in the loss of woman's natural sexual sensitivity. This can lead to poor marital relationship, and create fear and suppression of interest and feelings during sexual intercourse and also affect child birth.
- The nerve endings of the clitoris are sensitive and serve the purpose of pleasure. Toubia describes the removal of the clitoris through excision or infibulation as follows: "In effect, the delicate area where female genital once existed is turned into tough scar tissue that bears more resemblance to cured hide than to human tissue. Women ... have no perception or experience of soft, tender female genitals on adult women."
- It is argued that in cases where the clitoris has been replaced by scar tissues, orgasm is difficult to achieve.
- The presence of the scar makes penetration difficult and the intercourse itself a painful ordeal for the woman.
- Women face fear during the first weeks of marriage from sexual intercourse especially in cases of infibulated women.
- Penetration in the case of infibulated woman may take weeks, and may even require the use of the "knife" to open the woman up.

5. *Psychological Consequences*

Of all aspects of FGM, the psychological or the emotional aspect is a less known area. Toubia (1993) cites three psychological cases: "anxiety state" originating from lack of sleep and hallucinations; "reaction depression" from delayed healing, and "psychotic excitement" from childlessness and divorce. Other problems include traumatic experience, sense of being betrayed by family members, elders, and joining peer groups by undergoing the operation, and the lack of sexual fulfilment derived from clitoral orgasm.

→ Notes:

This module can then be linked to the module on Violence.

→ Learning points:

- FGM affects the health of women and girl-children.
- It can cause infertility in women.
- It is painful.
- It can lead to un-enjoyable/unfulfilled sexual relations.
- It is irreversible.
- It causes difficulties at delivery time.

→ Resource Materials needed:

- Talk by a health care personnel
- Anatomical model
- Hosken's Child Birth Picture Book
- Film showing the complications of FGM during delivery
- Testimonies of victims on their health (see Part III)

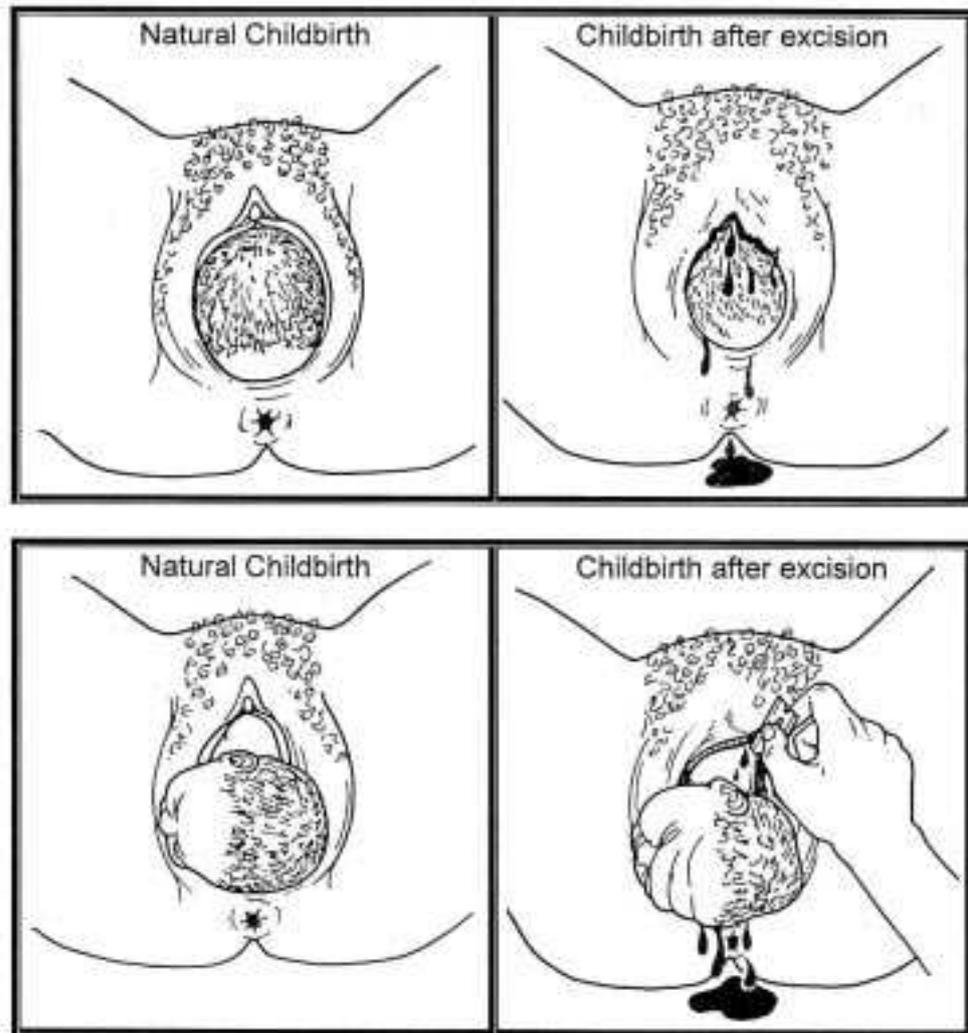
→ Notes

→ Learning Points

→ Materials



Effect of female genital mutilation on Childbirth



Source: Fran P. Hosken, *Childbirth Picture Book*, 1995

Top and bottom left show natural childbirth without FGM. In the case of FGM, the right side, the organ may tear as the head of the child forces to come out as shown on the top left or a cut must be made to get the child out.

Module I

Session 5 – Female Genital Mutilation and Violence

→ Step Five

→ Step Five

- Define what violence is.
- Identify forms/types of violence that exist in at the family, community and state level.
- Is FGM violence against women and girl-children?
(allow participants to brainstorm over these questions and categorize the types).
- Find out those who agree or disagree it is violence and try to centre the discussions towards a consensus on recognising that FGM is a form of violence on women and girl children.
- Gender analysis of violence.
- How can community leaders address the issue of violence in their community?
(List the various options provided by participants. This can either be in small groups and later shared in plenary for discussions).
- Find out from participants what measures are in place to prevent violence in their communities and list them.

1. International Conventions and Resolutions

Declarations on the Eliminations of Violence against Women

(UN Resolution 48/104 of 20 December 1993)

Article 1: "The term 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life."

Article 2: "Violence against women shall be understood to encompass, but not limited to, the following:

a) *Physical, sexual and psychological violence occurring in the family: wife-battering, sexual abuse of female children in the household, dowry related violence, marital rape, and female genital mutilation and other traditional practices harmful to women, non-spousal and violence related to exploitation.*"

Violence against women is the most common form of violence in society. The victims suffer from physical or psychological violence during their childhood and through their adult lives. It stems from their subordinate status and their subjugation due to their gender. It is an assault on the dignity, equality and integrity of the victims.



Violence manifests itself in different forms at different levels. Some examples include:

1. Violence against women in the family and household level
 - Bride price related violence
 - Early and childhood marriage
 - Male child preference
 - Female infanticide
 - Forced marriage
 - Female genital mutilation
 - Widow inheritance
 - Woman physical battering
2. Violence against woman in the community
 - Marriage by abduction
 - Forced feeding
 - Widow inheritance
 - Rape
 - Honour killing
 - Sexual violence
 - Virginitiy test
3. Violence against women by the state is perpetuated by law enforcement officials and includes torture and ill-treatment in prison, victimization during armed conflict and displacement, rape and sexual violence (The NGO Working Group on Violence against Women, 2004).

→ Learning Points

→ Learning points

- Gender based violence (FGM, wife battering etc.) are forms of violence and both men and women are involved in violence.
- It is about control of female sexuality.
- It is abuse of sexual and reproductive health and rights of women and girl-children.
- It violates the rights of children who are vulnerable.
- Domestic violence should not be considered as a private matter.
- It should be reported to concerned authorities to discourage the act.
- FGM must be seen from human rights perspective – physical integrity, freedom from discrimination, high standard of health of women and girls.
- FGM violates rights to non-discrimination, health and bodily integrity.

→ Materials

→ Resource materials needed

- Pictures and posters.
- A resource person from social welfare office, law enforcers, etc.
- Film on violence against women and children, etc.
- Narratives and stories from victims.
- Glossary of Violence against Women.

Module I

Session 6 – Female Genital Mutilation and Human Rights

Introduction

FGM and other harmful traditions are a form of violence against women and the girl-child. This is in breach of human rights, especially women's and children's rights: right to be free from all forms of discrimination, right to health, rights to life and physical integrity.

Internationally, there are political and legal instruments that are in place to protect the rights of women and children. These consist of international conventions, and treaties, declarations and resolutions. All parties to such instruments and conventions are expected to translate them in their national laws and constitutions.

→ Step Six

- How can the rights of women and girl-children be promoted and protected? (Allow participants to provide answers to the lead questions).
- List all the answers forwarded.
- Find out if they know of the existing laws/regulations with regards to FGM.
- Find out the local context (this could be either the country of origin or host country or both).
- Share information about the various countries that have legislations on FGM (see Annex).
- Then share information about the international context e.g., UN Conventions, UN Declarations, EU Resolution, Protocols to the African Charter on the Rights of Women in Africa etc (See Annex)

→ Step Six

The relevant international mechanisms in the case of FGM and other harmful traditional practices include:

1. International Conventions and Resolutions

Declaration on the Elimination of Violence against Women

(UN Resolution 48/104 of 20 December 1993)

Article 1: "The term 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life."

Article 2(a): "Violence against women shall be understood to encompass, but not limited to ... female genital mutilation and other traditional practices harmful to women."



UN General Assembly Resolution 53/117

(A/RES/53/117, 1 Feb. 1999)

3 (c) Calls upon all States: *"To develop and implement national legislation and policies prohibiting traditional or customary practices affecting the health of women and girls, including female genital mutilation, inter alia, through appropriate measures against those responsible, and to establish, if they have not done so, a concrete national mechanism for the implementation and monitoring of legislation, law enforcement and national policies."*

3 (d) Calls upon all States: *"To intensify efforts to raise awareness of and to mobilize international and national public opinion concerning the harmful effects of traditional or customary practices affecting the health of women and girls, including female genital mutilation, in particular through education, the dissemination of information, training, the media and local community meetings, in order to achieve the total elimination of these practices."* (A/RES/53/117, 1 Feb. 1999).

African Charter on the Rights and Welfare of the Child (1999)

Article 21 (1): *"States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular:*

*(a) those customs and practices prejudicial to the health or life of the child; and
(b) those customs and practices discriminatory to the child on the grounds of sex or other status."*

Platform for Action of the Fourth World Conference on Women (1996)

Paragraph 118: *"Violence against women throughout the life cycle derives essentially from cultural patterns, in particular the harmful effects of certain traditional or customary practices and all acts of extremism linked to race, sex, language or religion that perpetuate the lower status accorded to women in the family, the workplace, the community and society."*

Paragraph 224: *"Any harmful aspect of certain traditional, customary or modern practices that violates the rights of women should be prohibited and eliminated."*

Paragraph 232 (h): *Urges governments to "prohibit female genital mutilation wherever it exists and give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices."*

Children's Rights Convention (1990)

Article 19(1): *"States Parties shall take all appropriate legislative, administrative, social and education measures to protect the child from all forms of physical or mental violence."*

Article 24(3): *"States Parties [are to] take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."*

Programme of Action of the International Conference on Population and Development (1994)

Paragraph 5.5: *Recommends that measures be "adopted and enforced to eliminate child marriages and female genital mutilation."*

European Parliament Resolution 2001

1. *Strongly condemns FGM as a violation of fundamental human rights.*
 2. *Urges that the European Union and the Member States should work together for the sake of human rights, the integrity of the person, freedom of conscience and the right to health on the harmonisation of existing legislation and the drawing up of specific legislation on the subject (FGM).*
 4. *Confirms that FGM by its nature and consequences constitute a serious problem for society as a whole; nevertheless, the measures adopted must involve communities and tally with their situation so that members of the communities or groups affected become convinced of the need to eradicate such practices.*
- (2001/2035 (INI))

2. Legislations and FGM

Laws are important tools to deter from crime being committed. Laws make moral claims into legal rights. Laws define what a society thinks is proper and improper, what is legal and illegal and endorses specific expression of standards. Laws clearly state responsibilities and rights and have an educational effect. The results and its effectiveness depend on its proper implementation meaning that it is clearly understood, accepted and enforced. In the cases of HTPs and FGM, it must be preceded by sensitisation and change of values and attitudes. In the absence of awareness and understanding of the law by the practitioners, the criminalized activity may go underground making it difficult to control or make the necessary sensitization. It is essential that prevention through change of values should precede judicial intervention.

Most countries in Europe have penal codes and child protection laws which can be used where necessary in the fight against FGM. Some have specific laws (United Kingdom, Sweden, Norway and Belgium). All European countries are signatories to Women's Convention, Children's Rights Convention, Civil and Political Rights Covenant, Economic, Social and Cultural Rights Covenant, European Convention on Human Rights.

In the African context, some countries have legislation banning the practice of FGM and still some refer to their penal code, such as Sudan, Egypt, and Ethiopia. In Africa laws which include fine and imprisonment have been legislated in Burkina Faso, Central African Republic, Ivory Coast, Djibouti, Ghana, Guinea, Senegal, Tanzania and Togo, Kenya.

The laws specify the nature of the offence (FGM), the offenders and the nature of the punishment for offenders. Here are examples of European cases presented – Sweden, the Netherlands and Austria. (For others see Annex)

Sweden

Sweden passed the first act prohibiting female circumcision in 1982, thereby becoming the first western country to legislate against the practice. In 1998 the



law was revised with a change in terminology, from "female circumcision to "female genital mutilation" and more severe penalties for breaking the law were imposed. The law was further reformulated in 1999, to allow for prosecution in a Swedish court of someone performing female genital mutilation even if the act has been performed in a country where it is not considered criminal (removal off the principle of double incrimination).

Act Prohibiting the Female Genital Mutilation of Women 1982 (revised 1998) [Lag (1982:316) med förbund mot könsstympning av kvinnor]

Section 1: *Operations on the external female genital organs which are designed to mutilate them or produce other permanent changes in them (genital mutilation) must not take place, regardless of whether consent to this operation has or has not been given.*

Section 2: *Anyone contravening Section 1 will be sent to prison for a maximum of four years. If the crime has resulted in danger to life or serious illness or has in some other way involved particularly reckless behaviour, it is to be regarded as serious. The punishment for a serious crime is prison for a minimum of two and a maximum of ten years. Attempts, preparations, conspiracy and failure to report crimes are treated as criminal liability in accordance with Section 23 of the Penal Code.*

Section 3: *A person who violates this law is liable to prosecution in a Swedish court, even if Section 2 or 3 of Chapter 2 of the Penal Code is not applicable.*

According to a legal expert at a public prosecution authority, sections 2 and 3 of Chapter 2 of the Penal Code concern nationality and residency. It does not matter whether the offender or the victim are Swedish citizens. If the crime has been committed in Sweden, any person (asylum seeker, illegal, etc.) may be prosecuted in a Swedish court. If the crime has been committed abroad, the victim does not have to be a Swedish citizen for prosecution to take place, and neither does the offender. However, they should be or have been residents of Sweden.

The Act on FGM prohibits all forms of FGM. Further, performance of, participation in, facilitation of, attempts at, or procuring for FGM services, and also failure to report information concerning and knowledge about performed or future FGM is punishable.

Source: RISK

The Netherlands

Articles 300–309 and 436 of the Penal Code

Article 300 provides:

1. *Physical abuse is punishable by a term of imprisonment of not more than two years or a fine of the fourth category.*
2. *Where serious bodily harm ensues as a result of the act, the offender is liable to a term of imprisonment of not more than four years or a fine of the fourth category.*

3. Where death ensues as a result of the act, the offender is liable to a term of imprisonment of not more than six years or a fine of the fourth category.
4. Intentionally injuring a person's health is equivalent to physical abuse.
5. An attempt to commit the serious offence of physical abuse is not punishable.

Article 302 provides:

1. A person who intentionally inflicts serious bodily harm on another person is guilty of aggravated physical abuse and is liable to a term of imprisonment of not more than eight years or a fine of the fifth category.
2. Where death ensues as a result of the act, the offender is liable to a term of imprisonment of not more than ten years or a fine of the fifth category.

Source: Rahman, Anika and Toubia, Nahid (ed), *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*, Zed Books, 2000.

Austria

Provisions Relating to FGM in the Penal Code (Strafgesetzbuch)

Bodily injury (Körperverletzung)

§ 83. (1) *Whoever inflicts a bodily injury or an impairment of one's health upon another person is punished with imprisonment up to one year or with a fine of up to 360 day's rates.*

(2) *Likewise is punished who insults another person bodily and thereby negligently inflicts a bodily injury or an impairment of one's health upon the insulted person.*

Serious bodily injury (Schwere Körperverletzung)

§ 84. (1) *If the offence has caused impairment to the injured person's health lasting more than 24 days, or if the injury or impairment to one's health is serious in itself the offender is punished with imprisonment up to three years.*

(2) *The offender is punished likewise if the offence has been committed*

1. *with such means and in such a way, with which danger to life is involved as a rule,*
2. *by at least three persons acting in conspiracy,*
3. *with the infliction of particular agonies or*
4. *against a public official, a witness or an expert during or because of the exercise of his functions or the performance of his duties.*

(3) *The offender is punished likewise if he has committed three separate offences without understandable reason and using considerable violence.*

Bodily injury with serious, lasting consequences (Schwere Körperverletzung mit Dauerfolgen)

§ 85. *If the offence has caused*

1. *loss or serious impairment of the injured person's speech, sight, hearing or reproductive ability,*
2. *a considerable mutilation or a striking deformation or*



3. *a serious suffering, lingering illness or professional inability forever or for a long period of time, the offender is punished with imprisonment of six months to five years.*

Bodily injury resulting in death (Körperverletzung mit tödlichem Ausgang)

§ 86. *If the offence has caused the death of the injured person, the offender is punished with imprisonment of one to ten years.*

Purposely serious bodily injury (Absichtliche schwere Körperverletzung)

§ 87. (1) *Whoever inflicts upon another person a serious bodily injury (§ 84 (1)) purposely, is punished with imprisonment of one to five years.*

(2) *If the offence causes serious, lasting consequences (§ 85), the offender is punished with imprisonment of one to ten years, if it causes the death of the injured person, with imprisonment of five to fifteen years.*

Consent of the injured (Einwilligung des Verletzten)

§ 90. (1) *Bodily injury or endangering one's bodily safety is not illegal, if the injured or endangered person has consented to it and the injury or endangering as such does not violate good morals.*

(2) *A sterilization performed by a physician and with the consent of the sterilized person is not illegal if either the person is already 25 years old or the operation does not violate good morals for other reasons.*

(3) *It is not possible to consent to a mutilation or other injury of the genitals that may cause a lasting impairment of the sexual sensitivity.*

Source: BDP, Wien

→ Learning Points

→ Learning points for FGM and Human Rights

- Emphasise that all these laws and conventions are put in place to protect and promote the rights of women and girl children.
- The objectives of the laws are to deter communities from forcing their vulnerable groups to be circumcised.
- To respect women's and children's rights.
- The law does not allow the practice of any HTPs on children and women.

→ Note

→ Note:

At this point you can invite judiciary officers and law enforcers to provide detailed information and clarification to the participants with regards to the host country's stance on FGM. You can also share some of the opinions written by these countries as evidence of zero tolerance to FGM (see annex).

Module I

Session 7 – Role of Community Leaders towards the Elimination of FGM

Specify characteristics of community leaders in this session just as written in the session dealing with communicators on page 34.

→ Step Seven

This session is a way of testing the impact of the preceding sessions to see if the participants are convinced or not. One is not expecting that at the end of the training all the community leaders will be totally convinced about stopping the practice. However, in this session the facilitator can divide the participant into small groups to make statements about FGM as well as what they plan to do after the training.

The following lead questions can be used and depending on the context can be improved.

- How are you going to contribute towards the campaign?
- What plans do you have?
- Who are you going to work with in your community?
- Are you convinced that FGM should stop?
- How should it be stopped?

The opinions of community leaders can be recorded so that they can be used as cases to inform subsequent participants, and it can also serve as an evaluation for the training.

→ Step Seven

What is expected from the trainees after the training?

- After the completion of the training of trainers, the trainees should carry out a similar training in their communities. The purpose of the training is to have a role on effect.
- First identify the target group for the training in the community. This is an important step to help prepare and modify the teaching material to meet the needs of the group. Remember always that the new trainees are expected to do the same after completion of the training.
- Besides the use of the kit and the training guideline identify resource material locally available. These may include resource persons such as medical doctors, social workers, law enforcers, and media material such as video films. Before setting priorities make sure to go thoroughly through the guideline for a training session.
- Prepare a training schedule for at least two days covering all aspects of FGM. Allocate sufficient time for group works and discussions.
- Locate training site with sufficient space and services such as overheads, videos, flip charts.
- Send out invitations to the selected target groups well in advance of the training.



Module II – Communicators

| Target Group | Overall Goal | General Objective | Specific Objective |
|--|---|--|--|
| <ul style="list-style-type: none"> • Male and female communicators among immigrant population in Europe | <ul style="list-style-type: none"> • To bring changes of values, perceptions, attitudes and behaviour about the harmful traditional practices in particular FGM through training, information and communication leading to the elimination of FGM in Europe. | <ul style="list-style-type: none"> • To create awareness on harmful traditional practices with specific reference to FGM. • To build awareness about FGM and other traditional/cultural practices affecting the immigrant community. | <ul style="list-style-type: none"> • To train and create awareness and strengthen the capacity of communicators to enable them take on effective role in the campaign to eliminate FGM among immigrant communities in Europe. |

→ Sessions 1 to 7
p. 7 ff.

→ The first part of this module is the same as for community leaders. Please follow the same sessions as in module one, start from page 7.

Emphasis on Communicators' Characteristics

- Must understand and have knowledge of the community and its culture, and tradition.
- Must be sensitive to the community's and immigrant's issues.
- Must be neutral politically and religiously.
- Must be committed to the cause.
- Must be preferably an information officer, teaching background, social worker.
- Must have knowledge and experience on FGM.
- Must integrate FGM with other issues and problems of the community to gain the immigrants' trust.
- Must know the policy and procedures of the host country.
- FGM must be in the centre of all the issues.
- To know how to network and capacity building.
- Approach at the grassroots level and understand the context.
- Must have respect and acceptance by the community.

Module III – Religious Leaders

| Target Group | Overall Goal | General Objective | Specific Objective |
|---|---|--|---|
| <ul style="list-style-type: none"> Religious leaders among the immigrant population in Europe. | <ul style="list-style-type: none"> To bring changes of values, perceptions, attitudes and behaviour about the harmful traditional practices in particular FGM through training, information and communication leading to the elimination of FGM in Europe. | <ul style="list-style-type: none"> To create awareness on harmful traditional practices with specific reference to FGM. To build awareness about FGM and other traditional/cultural practices affecting the immigrant community. | <ul style="list-style-type: none"> To strengthen the capacity of religious leaders to enable them take on effective role in the campaign to eliminate FGM. Demystify the misperception and misinterpretation that the practice of FGM is sanctioned by religion and show that the traditional practice of FGM cannot be reconciled with the teachings of the great religions of Christianity and Islam. |

It is expected that religious leaders are at this point exposed to the preceding modules on community leaders. Here the emphasis is on the religious aspect of it.

→ After completing Session 1 of this module continue with Session 1 of Module 1 on page 7.

→ Session 1 p. 7

Module III

Session 1 – Religion and Female Genital Mutilation

The Need for Religious Leaders' Intervention

FGM affects the physical, sexual and psychological well-being of women and girl-children. Its practice is cross-religion and cross-cultural. Based on grass-root surveys, the main myths and justifications surrounding FGM include religion and tradition. Often, both the Muslims and Christians and the Falashas (Ethiopian Jews a.k.a. Bete Israel) claim that FGM is their moral obligation giving it a religious significance and spiritual justification.

One of the most common misconceptions is the connection of female genital mutilation with the teachings of the two great world religions of Christianity and Islam. Recent discussions on this subject by religious leaders have clearly shown that religion has nothing to do with the practice of FGM and that in reality it violates the basic principles of Christianity and Islam.



The misconception and misinterpretation of the scriptures needs to be clarified as most of the practitioners have no opportunity or the qualification to personally check the authenticity of what they have been preached by referring to the scriptures of their religion. This task falls on the religious leaders – Christians and Muslims and others – who have a central role in interpretation of the scriptures and in bringing forth a change.

Religious leaders have important responsibilities and role to play towards the elimination of FGM and other harmful practices in their communities because:

1. It is the responsibility and duty of religious leaders to interpret the scriptures and pass on the authentic messages to their followers. This cannot be done easily by a lay person without proper training and mandate.
2. Religious leaders are often the vanguards of social changes, promotion of social welfare and fight for equality, peace and human dignity. They have the responsibility and mandate to protect and promote the lives of their followers.
3. Religious leaders have moral authority within their communities. They have the respect and acceptance of their community. In some cases they are more powerful than secular leaders. This situation gives them an additional opportunity, power and responsibility to help in the fight against harmful traditional practices which are not sanctioned by the scriptures.

FGM and Religion

In FGM risk countries, FGM is practised by followers of Christianity, Islam and traditional religions (see Annex). FGM preceded both Christianity and Islam, and both may have been forced to tolerate the practice of FGM by local circumstances during the process of evangelization. In some countries like Ethiopia and Egypt both the Christians and Muslims practice it. FGM is wrongly identified with Islam; however, in the Muslim world all countries do not practice FGM, for example, the origin of Islam, Saudi Arabia, Iraq, Iran, Syria and many others. Had it been a religious requirement all Christians and Muslims would have been practising it. It is more of a cultural/traditional practice than a religious one.

FGM IS NEITHER ISLAMIC NOR CHRISTIAN.

Religious Viewpoints on Female Genital Mutilation

• The African Traditional Religions

Besides the formal religions of Christianity and Islam, all countries in Africa, with the exception of the Magreb countries, Djibouti and Somalia, practice African Traditional Religions (also referred to as Animism, Ancestral African Religions). It accounts for more than 20 % of the African population with over 50 % of the population in Benin, Burkina Faso, Central African Republic, Guinea Bissau, Liberia and Togo. (See annex [table] for the distribution by religion and country)

Unlike Christianity and Islam, it has no sacred writings and is expressed in rituals, ceremonies, beliefs or customs, arts and symbols, etc. African Traditional Religions are lived as cultures and its propagation is carried out by living it. Its influence covers all aspects of life and there is no dichotomy between life and religion. Religion plays a central role in promoting and realizing of harmonious inter-relationship among individual and the community through transmission of religious ideas and beliefs, initiation practices, ritual activities and public institutions.

The main elements of the religions include belief/worshiping of ancestors who are considered to be guardians of customs, traditions and ethical norms and taboos and the link between the physically living and the spirit world. Norms are strictly adhered to in order not to offend ancestors. Other features also include: rites as an essential part of social life – rites of passage, of initiation and of consecration. The sacredness of life is guarded by taboos and rituals. Initiation rites have significant importance and are the means of socialization and transmission of key beliefs, ideas and values of the community.

FGM is not practised only by Muslims and Christians but also by followers of African Traditional Religions. The following table, a survey of 8 countries, clearly shows that FGM is cross-religious and has to do more with tradition rather than religion.

Women ages 15-49 who have undergone the operations by region

| Country | Muslim % | | Christian % | | Traditional/other % | |
|---------------------|-------------|---------|----------------|---------|------------------------|---------|
| | Surveyed | Circum. | Surveyed | Circum. | Surveyed | Circum. |
| Burkina Faso | 56 | 78 | 27 | 66 | 17 | 61 |
| Central A. Republic | 9 | 50 | 90 | 43 | 2 | 42 |
| Egypt | 95 | 98 | 5 | 88 | - | - |
| Eritrea | 38 | 99 | 62 | 92 | - | - |
| Kenya | 5 | 28 | 92 | 38 | 3 | 31 |
| Mali | 91 | 94 | 3 | 85 | 6 | 90 |
| Sudan | 98 | 90 | 2 | 47 | - | - |
| Tanzania | 31 | 14 | 57 | 19 | 12 | 22 |

Source: Population Reference Bureau quoted from Win News Vol. 29 No. 3, 2003.



- *Judaism*

There is no specific mention of female circumcision in the Torah, the Holy Book of the Jews.

Bedouins of Israel and Ethiopian Falashas, also known as Bete Israel, claim that female circumcision is an obligation in Judaism. (This is probably an outcome or influence of local tradition rather than religious requirements as Falashas used to live in part of Ethiopia where FGM is widespread).

Followers of Judaism do not practice female genital mutilation. However, in Judaism male circumcision is a must and an ultimate statement of Jewish identification.

Of all the commandments in Judaism, the brit milah (literally Covenant of Circumcision) is the most universally observed and is based on the covenant made between God and Abraham. This commandment specific to Jews is given in Genesis 17:10-14, and Lev. 12:3. (This covenant is accepted both by the Christians and the Muslims.) It is an outward physical sign of the eternal covenant between God and the Jewish people. A Jewish male who is not circumcised is regarded as spiritually cut off from God and the Jewish people. The removal of the foreskin is itself a religious ritual that must be performed by someone religiously qualified and is performed on a Jewish male eight days after he is born.

The ritual of female circumcision has never been part of Judaism.

- *Christianity*

Female circumcision has not been mentioned in the Bible, be it in the Old Testament or the New Testament.

Christianity is based on the New Testament and does not in any place recommend or mandate female genital mutilation. However, the Old Testament mentions male circumcision as an agreement pact between God and Abraham (cited also by the Muslims and Jews). The scripture is very specific by stating "every male should be circumcised" and does not say anything about female circumcision. It even states the time of the operation – eight days old.

"And God said to Abraham, as for you, you shall keep my covenant, you and your descendants after you throughout their generations. This is my covenant, which you shall keep, between me and you and your descendants after you: Every male among you shall be circumcised. You shall be circumcised in the flesh of your foreskins, and it shall be a sign of the covenant between me and you. He that is eight days old among you shall be circumcised.... Any uncircumcised male who is not circumcised in the flesh of his foreskin shall be cut off from his people; he has broken my covenant." (Genesis 17:9-14)

Christians have rejected circumcision at the Council of Jerusalem. St Paul taught parents that they should not circumcise their children. In a letter to Titus, St Paul wrote "For there are many insubordinate men, empty talkers and deceivers, especially the circumcision parts; they must be silenced, since they are upsetting whole families by teaching for base gain what they have no right to teach (The Letter of Paul to Titus 1:10-12). In the New Testament, the Mosaic Law was not to be imposed on Gentile Christians, and that circumcision became no longer a religious requirement for the baptized.

"In Christ Jesus neither circumcision nor the lack of it counts for anything; only faith, which expresses itself through love." (Galatians 5:6)

"Only let everyone lead the life which the Lord has assigned him. This is my rule in which God has called him. This is my rule in all the churches. Was anyone at the time of his call already circumcised? Let him not seek to remove the marks of circumcision. Was anyone at the time of his call uncircumcised? Let him not seek circumcision. For neither circumcision counts for anything nor un-circumcision, but keeping the commandments of God. Every one should remain in the state in which he was called." (I Corinthians 7:17-20)

Nowhere in the scriptures is there any mention of FGM. Even male circumcision became unnecessary according to the New Testament where the covenant was based on faith and keeping the commandments.

The practice has been maintained due to ignorance of the scriptures. The absence of proper interpretations and clarifications, give to the lay person the impression that it is allowed.

FGM defies and deforms God's creation. Every part of a human being has a purpose and mutilating any part is interference in God's creation. Could man know better than God to change His creation?

FGM is not a religious injunction and the Christian faith does not sanction it.

- *Islam*

Female circumcision is neither required, nor is it an obligation nor a sunna in Islam

It is very often stated and assumed that Islam is at the root of FGM. This is a totally wrong assessment and interpretation originating from ignorance about the essence and practice of Islam and denying the fact that FGM preceded both Christianity and Islam. It also refutes the fact that the practice is connected primarily with tradition rather than religion.



Islam stands for truth, justice, love and a healthy wholesome life for all people. It has its own laws and values clearly set out in the Holy Koran and the Hadith, the latter being the words and deeds of Prophet Mohamed.

No direct or indirect mention of female circumcision is to be found in the Koran. There is also no known authentic Hadith that requires female circumcision. However, supporters of the practice cite references to a couple of Hadiths which many religious scholars see as lacking authenticity. One states "circumcision is a commendable act for men (Suna) and an honourable thing for women (Makromah). This Hadith does not require female circumcision and appears to accept it by giving it a weaker description (Makromah) and it implies it is not a religious obligation. According to Hadith scholars it is of a weak authenticity (www.jannah.org). The often quoted Hadith refers to the conversation between a circumciser (Umma Attia) and Prophet Mohamed. It is claimed that the Prophet had said "... restrict yourself to a sniff and do not overstrain; (this way), it is more pleasant in appearance and more satisfactory to the husband." If the Prophet had said so, He did not ban it or ordered it but showed his compassion and sensitivity to women's needs and matrimonial happiness. The Hadith does not say it is to be encouraged or compulsory.

Islamic legal rulings (the Sharia) are based on the Koran, authentic Hadiths, jurisprudence scholars who provide the interpretation of the original texts and an application of what they say to actual cases; and meeting of the actual conditions (analogy). The case of female circumcision does not meet any of these cases. It is not in the Koran or in any of the authentic Hadiths. The Hadith referring to female circumcision are questionable as they miss a link in the chain of transmission in that quoted sources were no original companions of the Prophet.

Scholars are still debating over the Hadith. However, according to former Sheikh of M-Azhar in Cairo, most believe that "Islamic legislation provides a general principle, namely that certain issues should be carefully examined and if these are proved to be definitely harmful or immoral, then it should be legitimately stopped, to put an end to this damage or immorality. Therefore, since the harm of excision has been established, excision of the clitoris is not mandatory nor a so-called 'Suna' [duty]." (www.fgm/org/sudanstruggle.html).

The laws, values and behaviours for all Muslims are set in the Koran and the Hadith. However, cultural traditions of the locality determine the implementation of laws and values following the religious texts. Consequently, culture determines the interpretation of the texts. Within Islam there are several sects of Muslims – Suni, Sufi, Shia, etc. – some conservative, some radical, some moderates. They differ in their belief and commitment to maintain their local tradition. Each culture interprets the scriptures in a way fitting to the local situation and how religion should be followed at the local level. That is why not all Muslims do not practice FGM. If FGM were an Islamic requirement, all Muslim countries would have adopted it.

Prophet Mohamed did not impose female circumcision but ordered that women should not be harmed, and reduce the harm it brings.

This goes in line with Islam's fundamental principle – not harming oneself or others.

"And spend of your substance in the cause of Allah, and make not your own hands contribute to (your) destruction but do good; for Allah loves those who do good". (Sura, verse 195).

Religion is not the source for the ritual of female genital mutilation

→ Learning points

- FGM is not a religious injunction and the Christian and Islamic faiths do not sanction it. The Hebrew Scriptures (The Old Testament), the Christian Scripture (The New Testament) and the Koran say no word about FGM.
- FGM is a custom/tradition, and as such is not common in all Islamic countries.
- FGM defies and deforms God's creation. Every part of a human being has a purpose. Mutilating any part is interference in God's creation.
- "In Christ Jesus neither circumcision nor the lack of it counts for anything; only faith, which expresses itself through love." (Galatians 5:6)

→ Learning Points



Case Reports of FGM Experiences

Case I – A Young Woman's Experience in the Sudan

*Case II – A Young Sudanese Medical School Student,
University of Khartoum*

Case III – Initiation of a Young Woman from Mali

Case IV – An Ethiopian Living in the USA

Case I

A Young Woman's Experience in the Sudan

"I was infibulated first when I was 5 years old. I remember every bit of it still – the terrible pain and lying tied up for several weeks. It hurts so much that I cried and cried. I could not understand why this was done to me.

When I was nearly 12, my aunts one day examined me. They declared that I was not closed enough. They took me to the midwife who lives a few streets away. When I noticed where they were taking me, I tried to run away; but they held me tight and dragged me into the midwife's house. I screamed for help and tried to free myself; but I was not strong.

They held me down and they put a cover over my mouth so I could not scream. Then the midwife cut me again; and this time, the woman who operated on me made sure it was closed.

They carried me home. The pain was terrible. My legs were tied together and I could not move. I could not urinate, and my stomach became all swollen. I was terribly hot one moment, then shaking with cold. This was during the dry season of the sandstorms, when it is hard to breathe. I don't know how many days I was lying there. Then the midwife came again. I screamed as hard as I could, as I thought she was going to cut me again. Then I lost consciousness.

I woke up in a hospital ward. There were moaning women all around me. I was terrified; I did not know where I was. I was in terrible pain; my legs and my genital area were terribly swollen and I hurt all over.

Later I was told that the infibulation had been cut open to let the urine and the puss out. I was too weak to even cry; I did not care anymore. I wanted to die. Why would my mother do this to me? What had I done to be so terribly hurt?

It is years later now. The doctors told me that I could never have children because of the infection which continues to cause me pain. Therefore, no one will marry me; no one wants a wife who cannot have a child. I do not want to get married because I am afraid that I shall be hurt again. I sit at home alone and cry a lot. I look at my mother and at my aunts, and ask them: "Why did you do this terrible thing to me?"

Source: Fran P. Hosken, *STOP Female Genital Mutilation – Women Speak*, WIN, 1995



*Case II**A Young Sudanese Medical School Student at the University of Khartoum*

"I have undergone complex excision – that is, my clitoris and labia minora were cut out when I was seven. Fortunately, I was not infibulated. I remember every detail of this terrible ordeal and the days of suffering that followed which at the time I managed to bear as I was told that I had to be excised to become a real woman and get married. It was said that without the operation girls are unclean and all men would reject them. Of course, I believed what I was told – I had no way to learn the truth. I had heard all kinds of stories from my girl friends.

Early one morning, I was still asleep; I was taken from my bed and carried to the backyard where a group of women were ready for me. They held me down and opened my legs. The operator with a razor blade set to work immediately, and before I could even cry my blood was spurting all over my legs and a terrible pain pierced me through and through. I had never felt such an overwhelming sensation and lost consciousness.

I continued to bleed for some days. My mother and her sisters got very worried; I could not even raise my head. After some days, I slowly began to regain some strength to drink and eat a little. But when I had to urinate the unbearable searing pain returned. Slowly the wound healed and I was very happy that now I was pure and clean and would become a real woman. Of course by now I know that these are all myths, and I was made to suffer this terrible ordeal for nothing. Worse, the operation would most likely cause terrible problems if and when I have children.

I don't know that I want to get married at all. I have no interest in the male students I work with in the medical school. I can't imagine allowing a man to touch me. Let alone have sexual intercourse; the very idea I found revolting when I first learned about it in medical school. I still live with my family, I have no alternative. In our society a woman cannot live alone or share a house with other female students.

Everyday I pass the place in the yard where I was excised more than 20 years ago – and my younger sisters after me, I still hear their cries, and their wailing went on for days. I could not help them at the time. But this is why I insisted on studying medicine. I don't know what I shall be able to do as everyone still believes in the operations, they are going on all the time, all my friends are excised or infibulated.

The wealthy people now go to doctors to have their daughters done; there are many private clinics, and the people who do the operations become rich – even women physicians now do it. I am determined to find a way to stop it. Soon I shall have my medical degree, but that is only the first step. Of course I know that here in the Sudan many previous attempts to stop the mutilations have failed even in the city of Khartoum. But I am determined to succeed even it takes the rest of my life ..."

Source: Fran P. Hosken, STOP Female Genital Mutilation – Women Speak, WIN, 1995

*Case III**Initiation of a Young Woman from Mali*

"I remember every detail of this terrible affair. In our village it is the custom that several girls of the same age, about 9 to 12 years old, are operated on the same time and this takes place at the house of an excisor. The village people come together to celebrate this occasion. The night before, the drums were beaten until late.

Very early in the morning, two of my favourite aunts took me to the house of the excisor, an old woman from a blacksmith caste. In Mali, the women from this caste traditionally do genital operations, both clitoridectomy and infibulation.

Once inside the house of the operator I became terribly frightened, though I had been assured that it would not hurt. I did not know what excision meant though I had seen some girls who had been excised walking along, their backs were bent and they scarcely could hold themselves up. I was told to lie down on a mat on the floor. Immediately, some big hands fastened themselves on my thin legs and opened them wide. I raised my head, but two women held me down to the floor, I could not move.

I felt something being sprinkled on my genital area. Later, I learned this was sand, which is supposed to make excision easier. I tried to escape but they held me tight. I was terrified. Suddenly, some fingers pulled on my genital organs. A searing pain pierced me through and through. The excisor cut and cut: it took an interminable time, I felt as if I were being torn to pieces. The rule says that one must not cry during this operation. But I screamed and cried, and I was bleeding all over. Finally, the operator put a mixture of herbs and butter on the wound to arrest the bleeding – I have never felt any pain as overwhelming as this.

Next the women who had held me down let go of me; but I couldn't get up. The voice of the operator called: "It is finished. You can get up. You see, it didn't hurt much." With the help of two women, I was put on my feet. I was made to walk to where the other girls who had been excised before me were waiting. Under the orders of the women in charge we were pushed to join a group of villagers who had gathered for this occasion to see us dance. I can't tell you how I felt.

I was burning all over. In tears, I tried to hop about a little, together with the other girls. We all were bleeding and hysterical from pain while being forced to dance. I shall always remember the terror of this monstrous affair, my friends and I with blood running down our legs and writhing in pain, being forced to jump around in a cloud of dust surrounded by gleeful clapping villagers. Then everything began to reel about me. I remember nothing more.

When I came to, I was stretched out in a hut with several people around me. Later, the most terrible moments of my life were when I had to urinate. It took a whole month before I healed. When I was well again, I was ridiculed by all the villagers because they said I wasn't courageous."

Source: Fran P. Hosken, STOP Female Genital Mutilation – Women Speak, WIN, 1995



*Case IV**An Ethiopian Living in the USA*

"My name is Aisha, my family lives in Ethiopia in a town in the eastern part of the country inhabited by people of Somali origin. When I started to go to school the girls talked about the presents they hoped to receive when they would undergo some mysterious operation. I did not know what they were talking about, so one day I asked my mother, but she was reluctant to answer and said I was too thin; she was afraid that there might be problems. But some months later she called the local midwife and invited the whole family and friends for the initiation of me and my little sister, age 5. My mother told me be brave, it will hurt, but every girl has to have it done to become a woman. She prepared the whole house for the occasion and got beautiful cloths of satin with ribbons ready for us; there was perfume and incense and many sweets for the guests including my school friends.

The midwife and her helpers came before the guests; I was put on a table in a back room with my hands behind me, one woman opened my legs, two women held my left and right shoulders. I was determined to be courageous and happy because I know something very special was about to happen; so the girls in school had said, though I did not know what. I had put a roll of cloth in my mouth so my friends who now were arriving in the yard would not hear me cry.

The midwife excisor, an old woman, took a little knife she had brought out of a special pocket and began the cutting. A piercing pain shook my whole thin body; the overwhelming pain of the cutting went on and on but I could not move as I was held down by strong hands. Finally, the midwife began to sew me up. At last she closed my legs and tied them together with wide bandages after inserting a little stick so I would be able to urinate after the scar formed. I heard the noise of the celebration going on in the yard but I hurt too much and did not want to see anyone.

I had to lie still for what seemed an endless time. Finally, many days later I was allowed to stand up and hop about like a bird with my legs closed, holding onto a large stick. All the time I only ate some rice and drank as little as possible as urination caused dreadful pains. Then one day I stumbled and fell and the scar broke. My mother forced me to have it to resown though I was afraid of the pain. But she said I could never get married if I was not closed and all girls must have it done. Not until I went to university in Europe, years later, did I find out that girls in most countries of the world are not closed and never go through these terrible operations.

When you start menstruating more problems come. Fortunately, I did not have much trouble though I had great pain each month. But my younger sister had blood clots because the blood could not come out and hardened and caused constant pain. With some girls it gets so bad that they have to go to the midwife to be opened and have the blood clots taken out.

The next problems arise when you get married. According to tradition, the husband is supposed to open the bride using his penis as battering ram. The bride is chosen by his family and is inspected to make sure she is properly closed. But first the bride price must be paid in full. Fortunately this did not happen to me personally as I was sent abroad to study, and before I got married to a fellow student I went to a surgeon who opened me under anaesthesia. But usually it is an old woman from the husband's family who cuts open the bride with a knife – recently a razor blade – and then the new husband has to have intercourse frequently through the bleeding wound to keep from closing again.

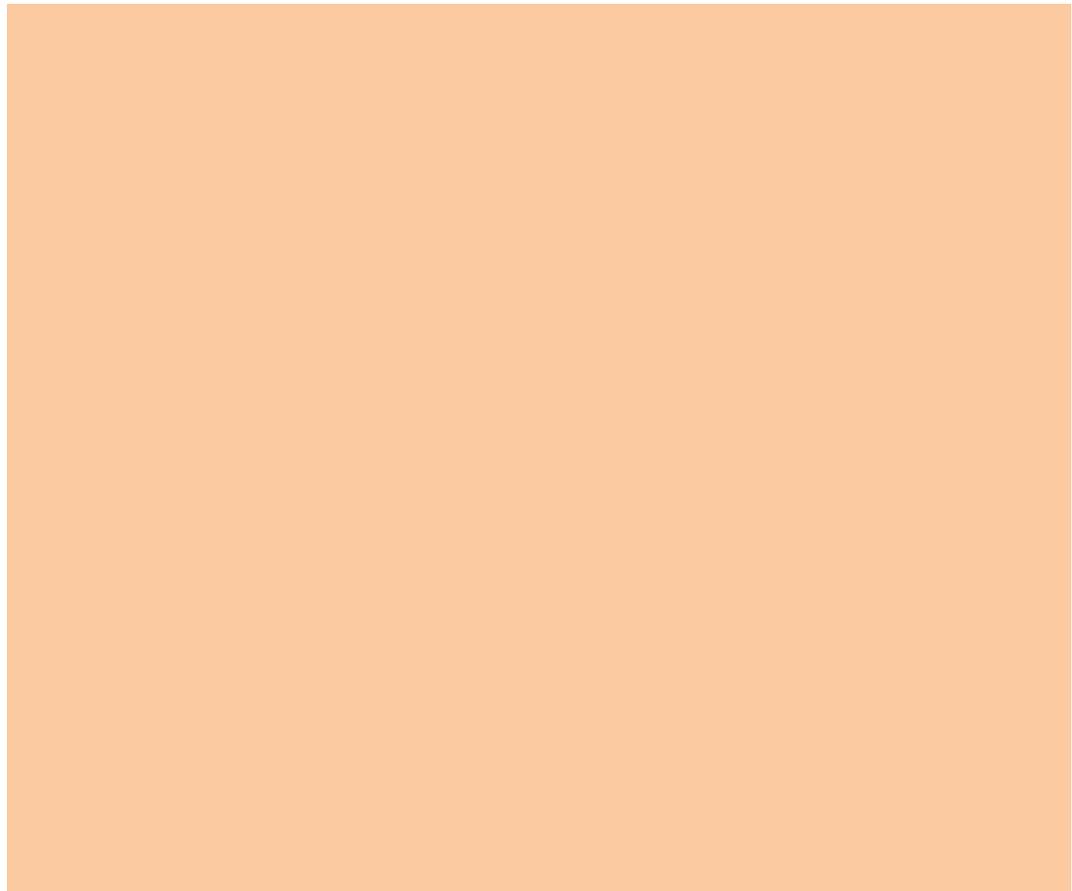
I assisted at the marriage of very good friend of mine when I came home, a beautiful woman. She was never even asked when she was married to a stranger her father had picked. She was made to produce children without being asked; she was used like an object and became like a vegetable and never revolted. She was literally dead – an ideal wife from the prevailing male view in our society. I have a little feeling left, but I don't like sex; I wonder what it is like to really feel like my friends at the university who tried to tell me about what I have lost forever:"

Source: Fran P. Hosken, STOP Female Genital Mutilation – Women Speak, WIN, 1995



Good Experiences of Fighting Female Genital Mutilation

"Young women do not become mature by being cut, but by education."



*Case I – Alternatives to Female Genital Mutilation in
Guinea-Bissau*

Case II-1 – Circumcision through Words

*Case II-2 – Alternative Rite to Female Circumcision
Spreading in Kenya*

Case III – The Unkindest Cut of All

Case I

Alternatives to Female Genital Mutilation in Guinea-Bissau

(afrol News, 22 January) "Sinim Mira Nassigue" means, "we think about the future," and it also means the hope of avoiding female genital mutilation for an increasing number of young women in Guinea-Bissau. The non-governmental organisation is presenting alternative rites to traditional rural societies.

Engaged Guinean women and men with a very limited funding established Sinim Mira Nassigue a few years ago. It now has established support centres in Buba, Gabú and Massabá, where its members daily go from house to house to sensitise the communities about the harmful consequences of female genital mutilation (FGM).

Mothers believe they cannot marry off their daughters otherwise, says Maria Augusta Baldé, founder of the organisation. According to some local traditions, uncut women are not even clean enough to prepare food.

Mrs Baldé earns her living from her job in the Ministry of Health, but her spare time is devoted to Sinim Mira Nassigue, which is not able to pay salaries to its volunteers. The workload is tough, but it pays off in practical results.

The organisation recently supervised a "fanado modelo", an alternative initiation rite for 35 young girls. All traditional parts of the ceremony were followed and the girls left the scene accepted as pure, but without being mutilated.

Speaking to the 'Berliner Zeitung' recently, Mrs Baldé told the German daily how they invite the girls, the women who perform the cut and a drummer. "Then, all what belongs to the ancient initiation rites happens, but the body remains untouched," Mrs Baldé said. "Knives and blades are banned. One has to preserve the cultural aspect and get rid of the brutal part," she concluded.

The organisation emphasises on the importance of including the "fanatecas" (the female circumcisers) in the process. These women have strong commercial interests in maintaining the practice and it would be unwise and unfair to deprive them of their income and high social status. Further, the fanatecas play other important social roles, such as the passing of women's traditions and experiences through their large network. When the fanatecas start supervising the alternative rites, these will be even more easily spread and the tradition bearers are assured of their future income, the organisation maintains.

The debate on FGM only started in the early 1980s in Guinea-Bissau, as in neighbouring countries, and was an "imported" issue. International gender and human rights organisations, together with UN agencies, pinpointed the issue, which soon



became an issue of public debate, at least in urban areas. Actions started with the National Committee for the Elimination of Harmful Practices against Women and Children, which was set up by the government in the early 1990s.

In 1995, a government proposal to outlaw FGM was defeated in parliament, but practitioners were to be held criminally responsible if a woman dies as a result of FGM. As the Guinean government has shown little interest in following up the fight against FGM, Sinim Mira Nassique has developed into the main driving force in this fight.

Although the practice is widespread in Guinea-Bissau, its prevalence and forms are different from area to area and from people to people. Amnesty International has estimated that around half of the Guinean women undergo FGM, both clitoridectomy and excision. In areas inhabited by the Fula and Mandinka people, FGM prevalence reaches up to 80 percent. In urban areas, however, the prevalence has now dropped to 20-30 percent.

Sinim Mira Nassique also finds it easier to campaign against FGM in urban areas, as the issue is well known there and a majority rejects the practice. Most urban men and women see the practice as barbaric and outdated.

In rural areas, the situation is different. Little information about the health risks and the religious framework has reached out to Guinean villages. A recent study by the Austrian Society for Family Planning (ASFP) concluded that especially rural women in Guinea-Bissau still had strong arguments for exposing their daughters to the harmful cut.

Guinean women told ASFP the principal justification for going on with FGM were moral or religious; maintaining virginity; bride prices or family honour; anatomic/aesthetic reasons; need for social integration; preventing child mortality; and hygienic reasons.

A group of women from Guinea-Bissau told ASFP; "As good Muslims we must be circumcised. In that way we will be ensured to have a proper Muslim burial ceremony. As wives, we need to be cleaned by the circumcision ritual in order to be able to prepare food for our husbands."

Especially among the Fula and Mandinka people the popular belief is widespread, the FGM practice is an essential part of Islam, a point of view without any base in the Holy Koran or among the majority of Muslim clergy. That the connection made between FGM and Islam is unreasonable is underlined by the fact that FGM has a significantly higher prevalence in Guinea-Bissau (where only 37 percent of the population is Muslim) than in neighbouring Senegal (85 percent Muslims). Informing about these misconceptions in rural Guinea-Bissau is the biggest challenge of Sinim Mira Nassique. Activists visit villages; talk to local clerics, village elder's councils and single families. "Step by step it becomes possible to

analyse the problem of FGM, examine religious and medical justifications and talk about the alternatives," the group explains its work.

An activist tells that "many young women do not see any connection between their circumcision and later medical complications ... and sexual problems," thus concluding that the information work is an enormous task.

Mostly, rural men, including religious leaders, are open to the input received from the activists and are shocked by learning about the health risks attached to FGM. Rural women are often more difficult to win for the task, mistrusting young men's intentions and believing their daughters will not become married. It was only by presenting an alternative ritual that Sinim Mira Nassigue started noting successes among rural mothers.

Mrs Baldé believes the campaigns are bearing fruit, and the recent "fanados modelos" supervised by her group demonstrate they are on the right path. They however still hope for better funding and more active support from the government. That government support makes a great difference is demonstrated in neighbouring Senegal.

Action against FGM in general has been more vigorous in Senegal, and Senegalese President Wade himself in October last year launched a campaign to "eliminate the practice in the country within the next four years." The campaign was presented in Tambacounda, close to the border with Guinea-Bissau, one of the few areas in Senegal where FGM is widely practiced.

Meanwhile, the Guinean government only gives some limited support to groups conducting educational seminars and publicity on FGM. Its own actions against the practice have been virtually non-existent the last years, in contrast to Senegal and in contrast to Mrs Baldé's group.

Source: <http://www.afrol.com/html/>



Case II-1

Circumcision through Words

Alternative rituals raise hope for eradication of female genital mutilation

PATH press release, 20 October 1997

Young African women facing ritual female circumcision or female genital mutilation (FGM) now have an alternative, due to pioneering work by grassroots African organizations and PATH (Program for Appropriate Technology in Health) a Seattle nonprofit.

The local group calls itself "Ntanira na Mugambo" which loosely translates as "circumcision through words." With support from their local community the women have devised a new approach to initiation into womanhood that includes song, education, celebration, and a week of seclusion.

The new "circumcision through words" ceremony was first performed in early 1996 for a small group, followed later that year by a larger ceremony for 50 young women and their families. On Aug. 15 of this year, an even larger ceremony was held for 70 young women.

The new ceremonies were developed through a series of workshops conducted by the communities and the women's organizations, with support from PATH. The groups developed an array of new materials, including poems, skits, and songs, as well as information sheets. The new ceremonies were first instituted in the Tharaka Nithi district of central Kenya.

In August, the actual ceremony of initiation was preceded by a "week of seclusion," which emulated the traditional healing period after circumcision. The young women were accompanied by female mentors during this week, who taught them skills they will need for their own families. Other community trainers instructed the young women on issues such as sexually transmitted diseases, relationships, and reproductive anatomy.

This period ended with a colourful ceremony attended by hundreds of community members and leaders. Festivities included singing, dancing, and dramatic presentations by the young women. The presentations included messages such as "female circumcision is outdated in modern life. Young women do not become mature by being cut, but by education."

The young women gave gifts and were showered with presents. They received new clothes and feasted with the guests on traditional food commonly served at circumcision ceremonies.

Case II-2

Alternative Rite to Female Circumcision Spreading in Kenya

Malik Stan Reaves, Africa News Service November 1997

New York - A growing number of rural Kenyan families are turning to an alternative to the rite of female circumcision for their daughters.

The new rite is known as 'Ntanira na Mugambo' or 'Circumcision through Words'. It uses a week-long program of counselling, capped by community celebration and affirmation, in place of the widely criticized practice also known as female genital mutilation (FGM). Next month, residents of some 13 villages in central Kenya will celebrate the fourth instalment of this increasingly popular alternative rite of passage for young females.

The first Circumcision through Words occurred in August 1996, when 30 families in the tiny village of Gatunga, not far from Mount Kenya [this is east of Meru], ushered their daughters through the new program. Some 50 families participated in the program in December followed by 70 families this past August.

Circumcision through Words grows out of collaborations between rural families and the Kenyan national women's group, Maendeleo ya Wanawake Organization (MYWO), which is committed to ending FGM in Kenya.....

.....Yet female circumcision encompasses more than the practice itself. It is often a deeply entrenched in the culture, wrapped in a complex shroud of assumptions, taboos, and beliefs that impact a woman's social status and personal identity.

Indeed, it seems the central defining achievement of Circumcision through Words is not that it saves young women from the dangers of FGM but that it captures the cultural significance of female circumcision while doing away with the dangerous practice itself.

"People think of the traditions as themselves," said Leah Muuya of MYWO. "They see themselves in their traditions. They see they are being themselves because they have been able to fulfil some of the initiations," said Muuya in "Secret and Sacred," a MYWO-produced videotape, distributed by PATH, which explores the personal dangers and harmful social results of FGM. The tape explains that female circumcision has traditionally signalled when a young woman is ready for the responsibilities of adulthood.

In answer to that, Circumcision through Words brings the young candidates together for a week of seclusion during which they learn traditional teachings about their coming roles as women, parents, and adults in the community, as well



as more modern messages about personal health, reproductive issues, hygiene, communications skills, self-esteem, and dealing with peer pressure.

The week is capped by a community celebration of song, dancing, and feasting which affirms the girls and their new place in the community. Indeed, after witnessing the community's response to the first celebration, MYWO Chair Zipporah Kittony said she was "overjoyed" and believed it was a critical achievement in their efforts to eradicate FGM.

The original proponents of the new rite have since incorporated and are seeking support from international donors in order to continue and expand their efforts. Indeed, it was such broad-based cooperation that led to the effort's creation in the first place.

In addition to the initiative of the local population, the development of Circumcision through Words is rooted in cooperation between the national women's group and PATH. Under MYWO's direction, the groups conducted surveys in 1990 and 1991 that examined the dimensions of FGM in four districts of central Kenya. Funding came from several international donors including the Ford Foundation, the Moriah Fund, Population Action International (PAI)/Wallace Global Fund, Public Welfare Foundation, and Save the Children - Canada.

MYWO and PATH have also developed public awareness campaigns that spread information on the harmful effects of female genital mutilation. According to Dr. Asha Mohamud, a PATH Senior Program Officer focusing on FGM, the two organizations agree that information, education, and public discussion are more effective tools against FGM than direct, prohibitive action...

...Efforts like Circumcision through Words offer a promising approach to resolving this controversial issue, at least within practicing communities, said Dr. Mohamud, since there are many people who would like to end the practice yet are not able to face the social ostracism that would entail. Yet, despite the continuing successes of Circumcision through Words, proponents of traditional circumcision are still numerous in these communities.

"You cannot change Culture overnight," said Peter Kali, District Officer in the Gatunga area of Kenya, during the recent celebration.

This page is part of Jens Finke's Traditional Music and Cultures of Kenya <http://www.bluegecko.org/kenya/>.

Case III

The Unkindest Cut of All

Ruth Evans

Hanging on the wall in Fatoumata Sire's office is a propaganda poster against female circumcision. On the desk is a framed photo of her receiving the Legion D'Honneur. Outside, a queue of women waits their turn to see this dynamic woman, who has spent the last 20 years of her life campaigning against female circumcision in Mali.

Her involvement started when her own baby daughter was circumcised without her permission or knowledge by one of her father's co-wives. Since then she has campaigned tirelessly against this ancient but previously taboo cultural practice.

Mali is now perhaps the only country in West Africa that has not introduced a law against female circumcision. It is estimated that perhaps 80 percent of young girls are still circumcised, and here the ceremony involves cutting off a girl's clitoris as a way of initiating her into womanhood and preparing her for marriage.

"I prefer to use the term female genital mutilation," says Fatoumata, "because circumcision suggests that nothing important is cut, whereas female genital mutilation acknowledges that a girl is deprived of a very important part of her body."

Fatoumata Sire's campaign has given her a very high profile in Mali. She is controversial figure who is either loved or loathed by her countrymen. Efforts to draft legislation for the government have resulted in a backlash from conservative forces in the country.

"I have death threats against me," she says, "there have been attempts to burn down my house, I have been in three car crashes and every day, Islamic radio here in Bamako broadcasts curses against me." But she is undaunted by what people think of her, and she gives the distinct impression that nothing will deflect this determined woman from her campaign. ...

Clearly, it is going to be a tough job to change attitudes and traditions that are not only so deeply entrenched but also so sensitive and taboo. But Fatoumata says that one effective way of doing this is to persuade the women who perform the circumcisions to stop. "Persuading one female performer to stop could save the lives of hundreds of young girls," she says.

Alternative income

The town of Segou is a couple of hours' drive from the capital, with wide dusty boulevards adjacent to the River Niger. Here Fatoumata's organization has set up a weaving project, which aims to give women who used to perform circumcision for



a leaving, an alternative source of income. It is also a potent signal of gender empowerment, as weaving is traditionally a male preserve in Mali's high complex and stratified society.

Fanta sits at a large loom, weaving a blue and white-checked cloth, against a backdrop of anti-circumcision posters. She's a gentle, quietly spoken-woman with a warm smile. She says she used to earn about 1.000 CFA (about one pound) for each circumcision she performed, and often used to do several in one day. Her mother and grandmother before her had performed circumcisions and it was a highly respected job in the community. She explained that the operation was traditionally performed after months of preparations and initiation into womanhood, as a way of "keeping little girls clean and stopping them running after men."

Once she learned of the dangerous consequences from infections and potential loss of life, she had stopped because she now realised circumcision constituted violence against women.

Another effective way of changing attitudes is through theatre. We went to the southern village of Mana with Theatre Don, a travelling troupe of dancers and actors who put on performances about development and health issues in villages that have never before seen theatre. Director Karim Togola says theatre is a popular and effective vehicle for getting messages like this across, and that certainly seems to be the case if the response of the villagers of Mana is anything to go by. Hundreds of men, women and children gathered together under a starlit sky to watch the players dance and sing a play that tackled the sensitive issues of circumcision head on, illustrating the medical dangers and social taboos. It was a lively tour de force, full of humour and music that had the audience shouting and clapping along as they recognised familiar scenes.

Afterwards, the chief of Mana village, a dignified old man in a green woolly bobble hat, emulated his theatrical counterpart in the performance, by announcing that now they understand the dangers of circumcision, the village would put a stop to the practice.

The following morning, sitting in his compound surrounded by village elders as three young girls pounded millet under a nearby tree, the chief reiterated this pledge. But he also quoted a Bambara proverb to the effect that these things would not change overnight.

Changes will certainly come slowly if methods like these are all campaigners have to rely on. A more effective means to an end, argues Fatoumata, would be to introduce a law banning circumcision outright. But government has been sitting on draft legislation for some time, and Fatoumata believes this is because it is nervous of fundamentalist Islamic reaction.

High up on the hill overlooking the red dust that permanently envelops Bamako sits the seat of government and Presidential palace. Here in the oak panelled office,

Pascal Babu Couloubaly, the Chef de Cabinet of the President's Office, explains that in his opinion a law would not be effective because literacy rates in Mali are low few people would be able to read it and it would therefore be unenforceable. Besides, he says, now wearing his other hat as an anthropologist, circumcision has today largely lost its meaning as part of the rites of initiation and marriage. Marriages are no longer arranged and these rites have died away, so that all that is left is the operation, which is being performed at an earlier and earlier age, sometimes on young babies, and this means it has completely lost its meaning.

"Circumcision will disappear of its own accord," he says, "because it has lost its *raison d'être*." ... "The best way to deal with this is not to lecture to people but to allow them to reach their own conclusions with dignity and humour, through things like theatre and education, and that way circumcision will disappear," argues Pascal.

Source: <http://europa.eu.int/comm/development/body/publications>.



Notes for Trainers of FGM among the Immigrant Communities in Europe

General Target

- The general target groups are immigrants in Europe originating from FGM practicing communities in Africa and the Middle East having the possibility or the urge to continue the practice on religious, cultural or other reasons.

General target will consist of:

- The family
- Single women and men
- Youth 11-17 years old
- People in decision making positions
- Law enforcers, social workers, immigration officers, etc.
- Out of school youth
- School children

Specific Targets

- This should be very specific and focussed on only the group you are interested in at the moment. In this kit, it is the community leaders, religious leaders and communicators/facilitators. However, this can change depending on who are the primary/specific target groups.

About Objective

- The objective(s) should follow the following principle

- | | |
|----------|-----------------|
| S | Specific |
| M | Measurable |
| A | Action oriented |
| R | Realistic |
| T | Time-bound |
| G | Gendered |

This part of the kit is to help its users to have some understanding of the concepts and some of the principles involved in teaching and training. It can be adapted to any context depending on the intended outcome that one aims to achieve.

→ About Learning Points:

- You can update and improve your learning points with the modules you are dealing with. It is meant to summarise the session and to convey the important message for that activity. You can generate a lot of information from the participants to improve and update the list.

→ Learning Points

→ About Resource Materials:

- This covers a range of things for teaching and in the context of FGM it means the relevant materials that can assist you in effectively conveying your message: slides, video tapes and films, cassettes and equipment. However, under each module the most relevant resource materials should be identified.
- As you progress in the training participants are likely to provide more appropriate suggestions for resource materials to update and build upon what already exists.
- Some resource materials have universal acceptability and others have context specific recognition. The trainer should be able to select given the target group it is intended for.

→ Materials

→ Fundamental Principles (Things to take note of)

- Every participant is important for the campaign to eliminate FGM among the immigrant community.
- Allow the participation of all no matter how heated the discussions are.
- Detect the introverts and throw questions at them if necessary.
- Be in control.
- Use different techniques/methods - audio visuals, tapes, slides, films, etc.
- Use participatory approaches - case history, poems, testimonies, works of art, role play, etc.
- Note that some techniques may be more effective and appropriate in some modules than others.
- Use your discretion and be consultative.
- Don't put value judgements.
- Don't rush.

→ Notes



→ Issues

→ Issues of concern as a trainer

Dealing with 'apparent' or 'subtle resistance' when training on FGM and HTPS.

- Training around sexuality especially on gender specific issues such as FGM, early marriage, and girls' education can be very sensitive and emotive particularly among community leaders and religious conservatives. As a trainer, you must recognise some of the signs of resistance or distractions from some of the participants. FGM seem to be rooted in culture and traditions with religious beliefs wrongly associated with it. Present the facts and it is advisable not to place any value judgement. Allow the participants to unpack the issues and to finally reach conclusions to resolve the discussions.
- You must not expect to always reach a consensus. The fact that the issue is open to debate is towards the right direction.
- The training material on FGM must be cautiously presented in such a manner that the religious and traditional aspects do not become an issue. However module one is expected to address this.
- To enable people to own and identify with the outcome of the activities, they must be allowed to participate effectively to elicit information for them. This way they are likely to identify and own the outcomes.
- The success of the kit will be based on Paulo Freire's observations on adult learners/participant thus:

"... An approach in which everyone participates as equals and co-learners (educators included) in an 'authentic dialogue', encouraging people to emerge from their 'cultural silence'."

Methodological and Technical Aspect of Training Sessions

In any training situation it is important to have a certain setting and have people prepared to do the training. The main and key thing is that a trainer should be prepared properly to do his or her job. Very often a trainer has a lot of material to present whether it is posters, slides, pictures, books, all kinds of paper information. Then you are stuck with a situation of what to select. What do you select from this whole bunch of information? There are other trainers who just walk in the door and say let us do something and ask the people what they want. You need a proper preparation without being too rigid with the contents of your presentation. You should not be strictly thinking I have to do this or that and forget the audience. If you do this they will not accept your teaching. There should be also a possibility that people have the option to be creative, to adjust to the audience and do what they need to do. You can be creative.

The following points can be considered when engaged in the training, seminars or workshop situations.

1. The first and important thing is the question of how to start a seminar or a workshop. It is all about setting the whole thing, situation, the framework, and the rules and also to introduce the program of the session. Remember that you are not the only knower. There are lots of expertises and people can share their experience. It is much more important to share and to work together on an issue and not that one person is giving inputs for two or three days and the others just listening. To give a technical input is always very important. Give the input as information but immediately try out with the group to do it. So it is a sort of what is called "learning by doing". It will be very important to try out various techniques, how you can start something that it is important, interesting, and catch people's interest.
- 2) The second is that the groups listening are not a sort of one group; they don't know each other. You have to introduce each other; you have to know who you are working with. The trainer has to introduce himself and also participants have to introduce themselves. There are many different techniques of introducing.
- 3) You also have to ask the participants what are their needs, what are their expectations, what are their fears and may be certain apprehensions. That should be collected as well. You can do this on a flip chart, discussions, etc. People should be able to express their fears, needs and expectations using various techniques such as brain storming, writing little cards, putting down questions, etc. These should be discussed and agreed upon as well as revisited at the end of the programme.
- 4) There are many frameworks as there are many teachers or facilitators. The following guidelines can be of help:
 - What do you do? So you must know the exact content of the training session.
 - What type of methods can you use? How do you guide your training session?
 - What kind of material or media are you addressing your audience with?
 - What should come out at the end of the session?
 - What is the target group? For whom do you organise this training?



5) It is a training session and you should talk about different methods. There is no single one correct method to do something. There are a variety of methods. One can't copy another person's presentation because of difference of personality, attitude, and approach. You have a whole set of methods that are good for this type of training sessions, for instance, brain storming, group work (small group or pair work), presentation with material, discussions, etc. Then you immediately talk about advantages and disadvantages of certain methods. Again this is not the input from the teacher or the presenter it should be the experience of the audience. Collecting all these at the end will help future trainers and leaders in a form of set of methods like a tool box that they can carry with them.

6) You collect all the good material and media you have produced. Preference may vary on material: slides, videos, blackboard, overhead projector, foils, handouts, drawings on whiteboards, posters. Each material has its own advantages and disadvantages. Like in point 4, you should assess the value of your material in relation to your specific objective. Through brain storming and group work find out the advantages and describe the material that can be used.

7) People should be activated. You have to combine visual and hearing aspects. A very important aspect of all training sessions is the visualisation. You have to use both channels – you have to use speaking and be able to look and watch at the same time. You have to prepare whether it is a poster or flip chart. There is also theory and practice and you have to try out the different possibilities of visualisation. You have to look in your workshop how to write a poster, how to produce posters, pictures, etc. There are many prepared posters, pictures and not all of them are fitted for all groups. You cannot use the same thing for everyone. Sometimes, you have to be creative to create your own material, visualise with your own possibilities and talent. It is important to note that in different cultures symbols have different meanings. Colours have also specific symbolism in different cultures. Visualisation is important because what an individual thinks is 100% of the message, what comes out of his mouth is already 20% less (already minimised to 80%). Then what the audience is able to hear is another reduction of 20% (they hear about 60% of the original idea), and what they understand is again a reduction. So we minimise the original idea to about 40%. You have to use techniques to minimise that loss of information.

8) You have to look at all the circumstances. To give examples, in Papua New Guinea there were about 300 students sitting in an audience hall. It was a good preparation; there were slides and speakers. All of a sudden a tropical rain lasting about two hours started and no one could hear a single word because it was so noisy. So you have to look at all the circumstances. You have to look at all the advantages and disadvantages of the environment, for instance hierarchy. Once there was a meeting in the former Eastern Germany which started with a brain storming. The trainer introduced and said let us start, let us collect our fears and our expectations. Nobody said a word, totally quiet. So he said ok, don't be shy, we are all the same; we just want to learn something. No word, then one gentleman got up and said "that is not the way we do it". Then the trainer found out all

these were former soldiers and this man was an officer. So he was the first to talk not the others. So you have to look at the various hierarchies. If you go out in a village who is the one able or allowed to speak for the group – not everybody – in some groups women, men, young people are not allowed to say something in front of the elders. So you have to look at the various hierarchies.

Another point of disturbance could be that the teacher all of a sudden may have a blackout. He loses his mind and he does not know what the next thing was. This can happen to anyone. So you have sometimes to be able to handle certain disturbances. That is one point or difficulties you can talk about.

If you have a discussion, sometimes people don't say a word and others talk permanently. How do you deal with these people? Some people you have to mellow down and other people you have to encourage to say something, to contribute their ideas or thoughts.

There is one thing called "energisers". There would be small things, not games in the real sense of the word, but getting up, moving a little bit and do something that you know if people are getting tired to catch their attention again. There are hundreds of possibilities. There is also a possibility of teaching people some sort of energisers – something for your toolbox.

9) Leading discussions: If we watch TV, we all know that five or six people discussing certain things, but six people are talking at the same time. Nobody can listen and nobody can follow. We don't call it a discussion. So there are certain rules on how to lead a discussion. It is important for a trainer to know how to do it. After the discussion you have to make a conclusion, put it together, follow a certain structure for a discussion. This is also something you can teach. How do you lead a feedback? It is important to get a feedback. It has certain rules and points to follow. There are certain methods of evaluating something. If you teach a seminar it should be good, maybe a little like this, but never like that. This is a possibility of evaluating. Then you collect the ideas of the audience and for your next preparation you have to adjust your teaching. You cannot just say I am not interested if they like it or not. This is a lack of respect. The important thing is you have to adjust your preparation for the workshop. You cannot do the same thing 20 times exactly the same way.

10) Certain tips and tricks have to fit the situation. Tips and tricks are more or less of how to use materials, how to use methods. If they are disadvantages there are tricks to cope with them.

Our main emphasis would be that it would not be very helpful to present a whole booklet and say ok, you follow points 1, 2, 3... This whole workshop lives by the participants. If they give their input, then that is how it is working, not as much as an academic instrument. It is more or less a guideline and then together it becomes alive.

How to approach a natural or elected leader

First of all make a person to person contact and use all means to explain your problem with clarity and precision. It depends on how one approaches different people with different techniques.



If you approach a religious leader, for example, you must have sense of belonging to that group. For example, you can't send a Muslim to approach a Christian religious leader, and vice versa. You approach a bishop or a sheikh through your affiliation. A Christian, for example, can reach his priest and through him his bishop or patriarch or other high officials of the church, and likewise for the Muslims. There are procedures that must be followed but must be based on belongingness or affiliation. This involves understanding, sentiment and trust. Affiliation to a religion or a community must be used as a tool.

There are chains of procedures to approach leaders

- You just can't say this man/woman is a leader so let me go and speak to him/her. You must prepare yourself with questions you will be discussing – brief, clear and to the point. Raise only the important issues when you approach them. They may not have the time.
- You have to ask yourself whether the leader is sympathetic to your problem. Does he/she understand it the issue and the problem?
- Assess the impact of the leader in the community. Is he/she able to talk to other people and leaders?
- Assess his/her sphere of influence. Is he/she able to change the situation himself/herself or does he/she depends on others?

Leaders in any community are persons accepted by their community. In order to approach them, it is necessary to get introduced into the community. This can be done by participating in ceremonies such as baptism, weddings or meetings. Only leadership qualities are not enough, the person must always have credibility in his/her respective community.

In regards to professionals, religious leaders, preachers, you must bear in mind that they have their own hierarchies, for example, preachers have to obey their bishops. And bishops or a Muslim religious leader must decide to what the preachers can and cannot preach, e.g. on HIV/AIDS and FGM. Their involvement is essential.

As concerns political leaders, how do you approach them with a new issue? You should first pick out sympathizers and organisations and send them information material, invite them to meetings and conferences. The participation of politicians at all levels is desirable.

Women can mostly be reached sometimes in gender specific spaces such as coffee/tea ceremonies, preparation of traditional food or other cultural events. However, this does not apply to all immigrant women as they come from different cultural backgrounds. The facilitator should be able to assess the context and the groups he/she will be dealing with.

Glossary, Acronyms, Annexes, References, Resources

Glossary

Clitoris: The most sensitive organ of the female body and located in front of the vaginal opening.

Clitroectomy: Type I FGM - removal of the clitoral prepuce and the tip of the clitoris.

Culture: material, social, spiritual and intellectual features that characterize a society or social group and include modes of life, value systems, beliefs and behaviours.

De-infibulation: cutting of the stitched vaginal opening (the reverse of infibulation)

Excision: Type II FGM - removal of the clitoris together with partial or total excision of the labia minora.

Female genital mutilation: partial or total removal of the external female genitalia.

Harmful traditional practices: practices that affect the physical, mental well-being of an individual or the community at large.

Infibulation: Type III FGM - removal of part or all of the external genitalia and stitching of the vaginal opening.

Labia majora and minora: outer and inner skin folds covering the entrance to the vagina and urinary opening.

Tradition: opinions, beliefs, customs handed down from generation to generation.

Vagina: tube shaped, hollow organ leading to the womb.

Violence: any physical, sexual or psychological harm or suffering incurred on an individual.



Acronyms

| | |
|---------------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| AI | Amnesty International |
| AWO | African Women's Organization |
| CEDAW | Convention on the Elimination of Discrimination against Women |
| EU | European Union |
| FGM | Female Genital Mutilation |
| HIV | Human Immunodeficiency Virus |
| HTP | Harmful Traditional Practice |
| IAC | Inter-African Committee on Traditional Practices Affecting the Health of Children and Women |
| IEC | Information, Education, Communication |
| NGO | Non-governmental Organization |
| RISK | Risksföreningen Stoppa Kvinnlig Könsstympning (National Association for Ending Female Genital Mutilation) |
| UNFPA | UN Population Fund |
| UNICEF | UN Children's Fund |
| VON | Vluchtelingen Organisaties Nederland (Refugee Organisations in the Netherlands) |
| WHO | World Health Organization |

Annex I

*FGM Prevalence by Country and Religion**FGM Prevalence by Country and Religion (in %)*

| Country | Prevalence | Est.Fig. (000) | Muslim | Christian | Traditional | Others |
|-----------------|------------|----------------|--------|-----------|-------------|--------|
| Benin | 50 | 1,712 | 15 | 15 | 70 | |
| Burkina Faso | 72 | 4,783 | 50 | 10 | 40 | |
| Cameroon | 20 | 1,613 | 20 | 40 | 40 | |
| C. African Rep. | 43 | 854 | 15 | 50 | 24 | 11 |
| Congo | | | 2 | 50 | 48 | |
| Ivory Coast | 43 | 3,507 | 60 | 22 | 18 | |
| Djibouti | 98 | 346 | 94 | 6 | | |
| Egypt | 97 | 34,951 | 94 | 6 | | |
| Eritrea | 95 | 1,977 | | | | |
| Ethiopia | 85 | 30,246 | 45-50 | 35-40 | | 3-8 |
| Gambia | 80 | 576 | 90 | 9 | 1 | |
| Ghana | 30 | 3,154 | 30 | 24 | 38 | 8 |
| Guinea Conkary | 99 | 4,169 | 85 | 8 | 7 | |
| Guinea Bissau | 50 | 378 | 45 | 5 | 50 | |
| Kenya | 94 | 6,142 | 7 | 66 | 26 | 1 |
| Liberia | 60 | 1,011 | 20 | 40 | 40 | |
| Mali | 94 | 6,165 | 90 | 1 | 9 | |
| Mauritania | 25 | 366 | 100 | | | |
| Niger | 5 | 296 | 80 | + | + | |
| Nigeria | 25 | 15,390 | 50 | 40 | 10 | |
| Senegal | 20 | 1,016 | 92 | 2 | 6 | |
| Sierra Leone | 90 | 2,277 | 60 | 10 | 30 | |
| Somalia | 99 | 4,784 | 100 | | | |
| Sudan | 89 | 14,864 | 70 | 5 | 25 | |
| Tanzania | 18 | 3,359 | 35 | 45 | 20 | |
| Tchad | 60 | 2,606 | 50 | 25 | 25 | |
| Togo | 12 | 297 | 10 | 20 | 70 | |
| Uganda | 5 | 649 | 16 | 66 | 18 | |
| Zaire | 5 | 1,332 | 10 | 70 | 10 | 10 |

Sources: FGM Prevalence: World Health Organization (WHO), updated 2001, includes most reliable, questionable and other estimates. Religion: (<http://www.geohive.com/global/religion/php>) FGM affected population estimate is for 2003 and based on "The World Fact Book" 2002-2004 CIA.



FGM practising Countries in Africa



Annex II

Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa

(As adopted by the Assembly of the African Union, Second Ordinary Session, 10–12 July 2003, Maputo, Mozambique)

"Article 2: Elimination of Discrimination against Women"

States Parties shall combat all forms of discriminations through appropriate legislative, institutional and other measures.

"Article 5: Elimination of Harmful Practices"

States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards.

States Parties shall take all the necessary legislative and other measures to eliminate such practices, including:

- a) Creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;
- b) Prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, "medicalisation" and "para-medicalisation" of female genital mutilation and all other practices and forms of violence against women in order to eradicate them;
- c) Provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;
- d) Protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.

"Article 6: Marriage"

States Parties shall ensure that women and men enjoy equal rights and are regarded as equal partners in marriage. They shall appropriate national legislative measures to guarantee that:

- a) No marriage shall take place without the free and full consent of both parties;
- b) The minimum age of marriage for women shall be 18 years;
- c) Monogamy is encouraged as the preferred form of marriage and that the right of women in marriage and family, including in polygamous marital relationships are promoted and protected;
- d) Every marriage shall be recorded in writing and registered in accordance with national laws, in order to be legally recognised;
- e) The husband and wife shall, by mutual agreement, choose their matrimonial regime and place of residence,



- f) A married woman shall have the right to retain her maiden name, to use it as she pleases, jointly or separately with her husband's surname;
- g) A woman shall have the right to retain her nationality or to acquire the nationality of her husband,
- h) A woman and a man shall have equal rights, with respect to the nationality of their children except where this is contrary to a provision in national legislation or is contrary to national security interests;
- i) A woman and a man shall jointly contribute to safeguarding the interests of the family, protecting and educating their children,
- j) During her marriage, a woman shall have the right to acquire her own property and to administer and manage it freely.

"Article 14: Health and Reproductive Rights"

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

- a) The right to control their fertility;
- b) The right to decide whether to have children, the number of children and the spacing of children,
- c) The right to choose any method of contraception,
- d) The right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS,
- e) The right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
- f) The right to have family planning education,

2. State Parties shall take all appropriate measures to:

- Provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
- Establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;
- Protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the unborn child.

"Article 20: Widows' Rights"

States Parties shall take appropriate legal measures to ensure that widows enjoy all human rights through the implementation of the following provisions:

- a) That widows are not subjected to inhuman, humiliating or degrading treatment,
- b) A widow shall automatically become the guardian and custodian of her children, after the death of her husband, unless this is contrary to the interests and the welfare of the children,
- c) A widow shall have the right to remarry, and in that event, to marry the person of her choice.

Annex III

Legislation by Country

Legislations and Provisions Related to FGM in Europe

1. Specific anti-FGM Laws

Belgium

"Article 409-§1. Anyone who practises, facilitates or promotes any form of mutilation of the genital organs of a person of the female sex, with or without the latter's consent, shall be punished by three to five years' imprisonment. Any such attempt shall be punished by imprisonment lasting between eight days and one year.

§ 2. If the mutilation is practiced by a minor or to make a profit, the punishment shall be five to seven years' hard labour.

§ 3. When the mutilation has caused an illness, which appears incurable, or a permanent work-related disability, the punishment shall be five to ten years' hard labour.

§ 4. When the mutilation practiced without any intention of causing death nevertheless causes death, the punishment shall be ten to fifteen years' hard labour.

§ 5. If the mutilation referred to in § 1 has been practiced on a minor or a person who, owing to her physical or mental state, was not able to look after herself, by her father, mother or other ascendants, any other person with authority or custody over the minor or incapacitated person, or any person who cohabits occasionally or habitually with the victim, the minimum punishment provided for in §§ 1 to 4 shall be doubled in the case of imprisonment and increased by two years in the case of hard labour."

Source: www.stopfgm.org

Norway

Law No. 74 of December 15, 1995 prohibiting female genital mutilation

Any person who intentionally performs an intervention on a woman's sexual organs, thereby damaging those organs or causing them to undergo permanent changes shall be convicted of sexual mutilation. The penalty imposed shall be imprisonment for a maximum period of three years, or six years if the intervention results in disease or an incapacity to work of more than two weeks' duration or if the intervention is the cause of an incurable deformation, defect, or injury, and imprisonment for a maximum period of eight years if the intervention results in death or considerable damage to the body or health of the person concerned. Assisting in such activities shall be punishable in the same manner.



The reconstruction of a sexual mutilation shall be punished in the manner described in the first paragraph.

Consent shall not be a ground for exemption from sanctions

Source: Rahman, Anika and Toubia, Nahid (ed), Female Genital Mutilation: A Guide to Laws and Policies Worldwide, Zed Books, 2000.

United Kingdom

Female Genital Mutilation Act 2003

1. Offence of female genital mutilation

(1) A person is guilty of an offence if he excises infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minor or clitoris.

2. Offence of assisting a girl to mutilate her own genitalia

A person is guilty of an offence if he aids, abets, counsels or procures a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.

3. Offence of assisting a non-UK person to mutilate overseas a girl's genitalia

(1) A person is guilty of an offence if he aids, abets, counsels or procures a person who is not a United Kingdom national or permanent United Kingdom resident to do a relevant act of female genital mutilation outside the United Kingdom.

4. Extension of sections 1 to 3 to extra-territorial acts

(1) Sections 1 to 3 extend to any act done outside the United Kingdom by a United Kingdom national or permanent United Kingdom resident.

5. Penalties for offences

A person guilty of an offence under this Act is liable –

(a) on conviction on indictment, to imprisonment for a term not exceeding 14 years or a fine (or both),

(b) on summary conviction, to imprisonment for a term not exceeding six months or a fine not exceeding the statutory maximum (or both).

Note: This Act replaces "The Prohibition of Female Circumcision Act 1985)

Source: Queen's Printer of Acts of Parliament, 2003.

2. Other provisions – Penal Codes

Denmark

Paragraph 245 of the Danish Criminal Code

(1) Any person who commits an assault of a particularly heinous or brutal or dangerous character or who is guilty of cruelty shall be liable to imprisonment for any term not exceeding 4 years.

(2) The same penalty shall apply to any person who, in circumstances other than those covered by subsection (1) above, causes damage to another person.

Germany

Sections 224 and 226 of the German Penal Code

§ 224 Serious Bodily Harm

(1) Any person who causes bodily harm

1. through administration of poison or other substances harmful to health
2. by means of a weapon or another dangerous instrument
3. by means of a deceitful attack
4. with another person acting in concert or
5. by means of a life-endangering treatment shall be punished by imprisonment from six months to ten years, in less severe cases, from three months to five years.

(2) Attempt is punishable

§ 226 Grave Bodily Harm

(1) If the bodily harm has as a consequence that the injured person

1. loses sight in one or both eyes, hearing, capacity for speech or capacity to procreate, loses an important limb or permanently loses the ability to use such a limb or
3. is permanently disfigured in a significant manner or deteriorates into infirmity, paralysis or mental illness, then the punishment is imprisonment for one year to ten years.

(2) If the perpetrator causes any of the results listed in paragraph (1) intentionally or deliberately, then the punishment is imprisonment for no less than three years.

(3) In less serious cases under paragraph (1) the sentence shall be imprisonment from six months to five years; in less serious cases under paragraph (2), the sentence shall be imprisonment from one year to ten years.

Source: Rahman, Anika and Toubia, Nahid (ed), Female Genital Mutilation: A Guide to Laws and Policies Worldwide, Zed Books, 2000.



Italy

Article 582 on Personal Injury (punishment by imprisonment from three months to three years.

Article 583 aggravating circumstances

Personal injury shall be serious, and imprisonment for from three to seven years shall be imposed:

- (1) if the act results in an illness which endangers the life of the victim, or an illness or incapacity which prevents his attending to his ordinary occupations for a period in excess of forty days;
- (2) if the act produces the permanent impairment of a sense or organ; ...

Personal injury shall be very serious, and imprisonment for from six to twelve years shall be imposed, if the act results in:

- (1) an illness which is certainly or probably incurable;
- (2) the loss of a sense;
- (3) the loss of a limb, or mutilation which renders the limb useless, or the loss of the use of an organ or the ability to procreate.

France

Acts of violence resulting in a mutilation or a permanent disability are punishable by imprisonment for 10 years and a fine of 1,000,000 francs [approximately US\$ 160,000]. [Art. 222(9)]

The offence defined in Article 222-9 is punishable with 15 years of criminal imprisonment [reclusion criminelle] when it is committed:

1: Against a minor under the age of 15 years... The penalty incurred by a violation of Article 222-9 is raised to 20 years of imprisonment [reclusion criminelle] when the crime is committed against a minor under the age of 15 by a legitimate, natural or adoptive ascendant or by any other person having authority over the minor. [Art., 222(10)]

Source: Rahman, Anika and Toubia, Nahid (ed), Female Genital Mutilation: A Guide to Laws and Policies Worldwide, Zed Books, 2000

Spain

Articles 147-150 of the Penal Code

Article 149:

1. The one that causes to another, through any way or procedure, the loss or uselessness of an organ or principal member, or of a sense of powerlessness, sterility, a serious deformity, or a serious illness somática or psychic, will be punished by imprisonment from six to 12 years.

2. The one that causes genital mutilation in anyone of its manifestations, will be punished by prison from six to 12 years. If the victim is a minor or incapable, incapacitation will be applicable special for the exercise of the native power, tutelage, guardianship, from four to 10 years, if the Judge considers it adapted to the interest of the incapable minor. "

Note: This is free translation from the Spanish original.

3. FGM Legislations in African Countries

Burkina Faso (1996) offenders are punishable by fine and imprisonment for a period of 6 months to three years, and in case of death of the victim the imprisonment shall be 5 to 10 years.

Central African Republic: (1966) fine and imprisonment of 1 month and 1 day to 2 years.

Ivory Coast (Dec. 23, 1998) fine and imprisonment of 1–5 years, and in case of death 5 to 20 years. The punishment will be double for medical and paramedical persons.

Djibouti (amended 1995 Penal Code) fine and imprisonment for 5 years.

Ghana (amended 1994 criminal code Article 69A) imprisonment of not less than 3 years.

Guinea (Article 265 of Penal Code) imprisonment with hard labour for life, and in the case of death of the victim, death for the offender.

Senegal (1999 Art. 299) imprisonment from 6 month to 5 years and in the case of death hard labour for life.

Tanzania (169 A of the Penal Code 1998) fine and imprisonment of not less than 5 years and not exceeding 15 years.

Togo (1998) fine and/or imprisonment of 2 months to 5 years and in the case of death jail term of 5 to 10 years.

Ethiopia penal code updated and includes imprisonment.

Source: The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC).



*Annex IV**The Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children**Address of National Committees***Angola:**

Comité Angolais sur les pratiques Traditionnelles (CAPT-CI-AF),
captciaf@yahoo.fr

Bénin:

CI-AF Bénin,
ciafbenin@yahoo.fr

Burkina Faso:

a) Comité National de Lutte contre la Pratique de l'Excision (CNLPE),
cnlpe@fasonet.bf
b) Voix de Femmes, vofemme@yahoo.fr

Cameroon:

CI-AF Cameroon,
ceffiom@yahoo.fr

Congo:

Comité National des Droits des Femmes,
onangawomensrights@yahoo.fr

Côte d'Ivoire:

CI-AF Côte d'Ivoire,
imam-cissé@yahoo.fr

Djibouti:

Comité National de Lutte contre les Pratiques Traditionnelles (CNLCPT),
unfd@intnet.dj

Egypt:

a) Egyptian Society for the Prevention of Harmful Traditional Practices (ESPHP)
b) Care for Girls Committee (CGC),
caregirls@hotmail.com

Ethiopia:

National Committee on Traditional Practices of Ethiopia (NCTPE),
nctpe@telecom.net.et

Gambia:

Gambia Committee on Traditional Practices (GAMCOTRAP),
gamco@qanet.gm

Ghana:

Ghanaian Association for Women's Welfare (GAWW),
gaww255@yahoo.co.uk

Guinea: Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Santé des Femmes et des Enfants (CPTAFE), dsr@sotelgui.net.gn

Guinea Bissau: Comité National de Lutte contre les Pratiques Néfastes, sininmiranasseque2001@yahoo.com.br, augustabalde@yahoo.com.br

Kenya:

a) SETAT Women Organization,
setatwo@multitechweb.com
b) Kenya National Committee on Traditional practices (KNCTP),
kentrapnc@hotmail.com

Liberia:

National Association on Traditional practices Affecting the Health of Women and Children (NATPAH),
gussesay@yahoo.com,
phylliskimba@yahoo.com

Mali:

a) Association Malienne pour le Suivi et l'Orientation des pratiques Traditionnelles (AMSOPT),
amsopt@datatech.toolnet.org
 b) Association pour le Progrès et la Défense des Droits des Femmes Maliennes (APDF), apdf@datatech.net.ml

Mauritania:

Association Mauritanienne sur les Pratiques Traditionnelles Affectant la Santé des Femmes et des Enfants (AMPTSFE), mariem.sy@mauritel.mr

Niger:

Comité Nigérien sur les Pratiques Traditionnelles (CONIPRAT),
coniprat@intnet.ne

Nigeria:

Inter-African Committee on Traditional Practices (IAC)-Nigeria,
iac_nigeria@vgccl.net

Senegal:

Comité Sénégalais sur les Pratiques Traditionnelles (COSEPRAT),
Coseprat@sentoo.sn

Sierra Leone:

Sierra Leone Association on Women's Welfare (SLAWW), ykosot@yahoo.com

Somalia:

Inter-African Committee on Traditional Practices (IAC) Somalia,
Shirdon@hotmail.com

Sudan:

Sudan National Committee on Traditional practices (SNCTP),
snctpiac5@hotmail.com

Tanzania:

National Committee on Traditional Practices, diacdodoma@hotmail.com;
jupach2001@yahoo.com,
iachtpsarusha@hotmail.com

Tchad:

Comité National du CI-AF (CONA-CIAF),
cona_ciaf@yahoo.fr

Togo:

Comité National du Togo (CI-AF Togo),
anapoe@yahoo.com

Uganda:

Uganda National Committee on Traditional Practices (NCTPU),
ways@afsat.com

Central African Republic:

Committee to be reorganized

IAC Group Sections/Affiliates**Austria:**

African Women's Organization in Vienna

Belgium:

Groupe Femmes pour l'Abolition des Mutilations Sexuelles (GAMS Belgique)

France:

Groupe Femmes pour l'Abolition des Mutilations Sexuelles (GAMS France)

Netherlands:

a) Federation of Somalian Associations in the Netherlands (FSAN)
 b) Pharaohs Foundation
 c) The World population Foundation (WPF)



New Zealand:

FGM Network in New Zealand

Spain:

Women's Association against Mutilations (AMAM)

Sweden:

- a) National Council of Immigrant Women's Association (RIFFI)
- b) National Association for ending FGM (RISK)

United Kingdom:

London Black Women's Health Action Project (LBWHAP)

Canada:

Inter-African Committee-Canada

Japan, WAAF:

Women's Action against FGM, Japan

In addition, the IAC represents hundreds if not thousands of volunteers, from high African government officials to traditional leaders and young women in rural villages of Africa, sometimes illiterate but always determined to ensure the health and well-being of women and children.

Visit IAC website: <http://www.iac-ciaf.ch>

Resources

Video Materials

- Female Circumcision Belief and Misbeliefs (Inter-African Committee)
- Scared for Life
- Infibulation: The worst types of Female Genital Mutilation(IAC)
- The Road to Change (WHO)

Websites

African women's Organization Vienna <http://african-women.org/>

Bridge <http://www.ids.ac.uk/bridge/>

European Commission – Justice & Home Affairs

http://europa.eu.int/comm.dgs/justice_home/index_en.htm

Inter-African Committee iac-ciaf.ch/

International Amensty <http://www.amnesty.org>

Rising Daughters Aware <http://www.fgm.org>

Siyanda <http://www.siyanda.org>

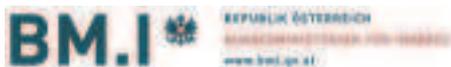
World Health Organization who.int/health-topics/female-genital-mutilation/en/



References

- Admason, Fiona**, Female Genital Mutilation: A Counselling Guide for Professionals, FORWARD Ltd., London, 1992.
- African Women's Organisation**, Female Genital mutilation: General Background, October 2000 Vienna.
- African Women's Organisation**, Proceedings of Vienna international Conference on prevention and Elimination of FGM, October 31st and 1st November, 2000, Vienna.
- Dorkenoo, Efua**, Cutting the Rose: FGM the Practice and its Prevention, Minority Rights Group, London, 1994.
- Dorkenoo, Efua**, Tradition! Tradition: A Symbolic Story on FGM, FORWARD Ltd., London, 1992.
- El Dareer, Asma**, Woman, Why Do You Weep? Circumcision and Its Consequences, Zed Books, London, 1982.
- European Parliament** 1999-2004, Committee on Women's Rights and Equal Opportunities, Final Report on Female Genital Mutilation, July 2001. (Session document).
- Hosken, Fran P.**, Stop Female Genital Mutilation: Women Speak; Facts and Actions, WINNEWS, Lexington, M.A., 1995.
- Hosken, Fran P.**, The Hosken Report, 4th edition rev., WINNEWS, Lexington, M.A., 1994.
- Hosken, Fran P. and Williams, Marcia, C.**, The Universal Childbirth Picture Book, WINNEWS, Lexington, M.A., 1995.
- Koso-Thomas, Olayinka**, The Circumcision of Women: A Strategy for Eradication, Zed Books, London, 1987.
- Leye, Els and Deblonde Jessika (coord)**, Legislation in Europe Regarding Female Genital Mutilation and the Implementation of the Law in Belgium, France, Spain, Sweden and the UK, International Centre for Reproductive Health, 2004.
- Rahman, Anika and Toubia, Nahid (ed)**, Female Genital Mutilation: A Guide to Laws and Policies Worldwide, Zed Books, 2000.
- Smith, Jacqueline**. "Visions and Discussions on Genital Mutilations of Girls", Netherlands 1995.
- The NGO Working Group on Violence against Women** "Glossary of Violence against Women", 2004
- Touray, Isatou**, Reconceptualising Traditional Practices: The Case of Female Genital mutilation in The Gambia. 1993, Institute of Social Studies, The Hague.
- World Health Organization (WHO)**, Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery – A Student's Manual, Geneva, 2001.
- World Health Organization (WHO)**, Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery – A Teacher's Guide, Geneva, 2001.

Supported by



Partners



Impressum:

Editor, printer and publisher: AWO African Women's Organisation
c/o Afro-Asiatisches Institut, Türkenstraße 3/2/201, A-1090 Vienna
Tel. 01 319 26 93, Fax 01 310 51 45 312, E-Mail: afrikanisc.frauenorganisation@chello.at, www.african-women.org
Compilation: Karin Ortner, Ashenafi Moges
Cover: © Gouache by Mela Beer
Layout: Gerda Decker
Vienna 2005