Promoting Change, Well-being and Human dignity

Female Genital Mutilation: Information Pack

FORWARD

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Note: This information pack was written in 2002 so some of the information is out of date and more recent developments are not included in it, the most significant with regard to the situation in the UK being the 2003 Female Genital Mutilation Act. FORWARD is currently working on an updated version.

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Female genital mutilation: the facts

What is female genital mutilation?

Female genital mutilation (FGM), sometimes referred to as female circumcision (FC) or female genital cutting, is defined by the World Health Organisation (WHO) as the range of procedures which involve 'the partial or complete removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reason'.[1]

WHO classifies FGM into four types:

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

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

Type III excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening, also known as infibulation. This is the most extreme form and constitutes 15 per cent of all cases. It involves the use of thorns, silk or catgut to stitch the two sides of the vulva. A bridge of scar tissue then forms over the vagina, which leaves only a small opening (from the size of a matchstick head) for the passage of urine and menstrual blood.

Type IV includes pricking, piercing or incision of the clitoris and/or the labia; stretching of the clitoris and or the labia; cauterisation or burning of the clitoris and surrounding tissues, scraping of the vaginal orifice or cutting (Gishiri cuts) of the vagina and introduction of corrosive substances or herbs into the vagina.

It is estimated that approximately 138 million African women have undergone FGM worldwide, up to 80 per cent have undergone type I or II.

The procedure is, in most cases, carried out by an older woman with no medical training. Anaesthetics and antiseptic treatment are not generally used and the practice is usually carried out using basic tools such as knives, scissors, scalpels, pieces of glass and razor blades. Often iodine or a mixture of herbs is placed on the wound to tighten the vagina and stop the bleeding.

The age at which the practice is carried out varies, from shortly after birth to the labour of the first child, depending on the community or individual family. The most common age is

[1] World Health Organisation, (1996) *Female Genital Mutilation: An Information Pack*, WHO, Geneva.

between four and ten, although it appears to be falling. This suggests that circumcision is becoming less strongly linked to puberty rites and initiation into adulthood.

Where does FGM take place?

The majority of cases of FGM are carried out in 28 African countries. In some countries, (e.g. Egypt, Ethiopia, Somalia and Sudan), prevalence rates can be as high as 98 per cent. In other countries, such as Nigeria, Kenya, Togo and Senegal, the prevalence rates vary between 20 and 50 per cent. It is more accurate however, to view FGM as being practised by specific ethnic groups, rather than by a whole country, as communities practising FGM straddle national boundaries. FGM takes place in parts of the Arabian Peninsula, i.e. Yemen and Oman, and is practised by the Ethiopian Jewish Falashas, some of whom have recently settled in Israel. It is also reported that FGM is practised among Muslim populations in parts of Malaysia, Pakistan, Indonesia, and the Philippines.

As a result of immigration and refugee movements, FGM is now being practised by ethnic minority populations in other parts of the world, such as USA, Canada, Europe, Australia and New Zealand. FORWARD estimates that as many as 6,500 girls are at risk of FGM within the UK every year.

Origin of FGM

It is not entirely clear where or when the practice of FGM originated, although, there is some evidence suggesting that it originated in Ancient Egypt. An alternative explanation is that the practice was an old African rite that came to Egypt by diffusion. The most severe form of FGM – infibulation - was carried out in northern and central Sudan, Somalia, and Djibouti, where Arab and Black African cultures met. It is reported that infibulation was enforced on Black African women in the ancient Arab slave trade.[2] It has also been suggested that the practice originated in the deserts of north-east Africa, and was then transmitted between regions during phases when FGM practising populations made military conquests over non-practising groups. It is possible that FGM was introduced when the Nile valley was invaded by militant pastoral nomads around 3100 BC.[3] Later, FGM may have developed independently among certain ethnic groups in sub-Saharan Africa as a rite of passage into womanhood.

Why is FGM practised?

The reasons for FGM are diverse, often bewildering to outsiders, and certainly conflicting with modern western medical practices and knowledge. The justifications for the practice are deeply inscribed in the belief systems of those cultural groups that practice it. Custom and tradition are the main justifications given for the practice, and FGM is often carried out as part of an initiation into adulthood. It is considered an essential part of social cohesion.[4]

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[2] Muganda, J (1993) "Women Circumcised by Force", *Standard on Sunday*, Kenya.
[3] Demeo, J (1982) cited in Dorkenoo, E (1995) *Cutting the Rose*, *Female Genital Mutilation: the practice and its prevention,* Minority Rights Group, London, pp33.
[4] Amnesty International (1997) "What is Female Genital Mutilation?" in A *Human Rights Information Pack*, Amnesty International, London.

FGM is not an act of hate. It is carried out on children because their parents believe it is in their best interest. In the patriarchal communities where FGM takes place, marriage is necessary for a woman's honour and survival. An uncircumcised woman will stand very little chance of marriage and will not be accepted by her community. In these communities FGM is carried out to safeguard the chastity of a woman before marriage.[5] FGM is used as a means of controlling and de-sexualising women and repressing sexual desire, thus reducing the chance of sexual promiscuity in marriage on the part of the woman. FGM is also carried out for reasons of aesthetics and hygiene. The practice is often carried out as a means of purification and ensuring that a woman is clean.[6]

Many of the communities that practice FGM are Muslim and religion is often cited as a reason, despite the fact that neither the Qu'ran or any other holy text advocates for FGM. Also, FGM was practised before the advent of Islam, Judaism or Christianity. FGM is also practised by Christians of the Coptic Church in countries such as Egypt.

Suggested further reading

Abdalla, R. H. D. (1982) *Sisters in Affliction: Circumcision and Infibulation of Women in Africa*, Zed Books, London

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World Health Organisation (1998), *Female Genital Mutilation: an overview*, WHO, Geneva.

[5] Abdalla, R. H. D. (1982) *Sisters in Affliction: Circumcision and Infibulation of Women in Africa*, Zed Books, London.

[6] Boddy, J (1982) *Womb as Oasis: the symbolic context of Pharonic circumcision in rural Northern Sudan,* American Ethnological Society.

Health consequences of FGM

FGM is a procedure which causes a number of health problems for women and girls. There is a great deal of evidence indicating extremely detrimental long- and short-term health consequences. There is little documentation on the social, psychological and psycho-sexual effects of the practice, but it is clear, from anecdotal evidence of women's experiences, that FGM affects women adversely in these areas of their lives.

In the majority of cases FGM is performed with crude instruments, by untrained and elderly circumcisors, and with no anaesthetic.

Type I: excision of prepuce, maybe with excision of all/part of clitoris
Type II: excision of the prepuce and the clitoris, with the removal of all or part of the labia minora

The short-term health consequences include:

- extreme pain and shock (neurogenic shock)
- severe blood loss, possible haemorrhage
- infection of wound
- possible HIV infection
- death (WHO estimates that the child mortality rate as a result of FGM is high).

Type III: (infibulation) excision of all/part of the female genitalia and narrowing/stitching of the vaginal opening.

For short-term consequences see above. The long-term health consequences include:

- blood infections
- infection may spread to cause problems with uterus, fallopian tubes, and ovaries
- chronic pelvic infection
- infertility
- urine retention
- incontinence
- urinary tract infections
- permanent damage to reproductive organs
- vulval abscesses due to infected cysts
- keloid cysts, dermoid cysts
- vesico-vaginal and recto-vaginal fistulae
- painful sexual intercourse
- psychological problems
- difficulties in menstruation
- retention of menstrual blood.

Problems with pregnancy

- miscarried foetus may be retained in birth canal
- obstructed labour, resulting in fistulae.

Psycho-sexual, psychological and social consequences of FGM

Anecdotal evidence suggests that FGM carries with it a number of psycho-sexual and social complications. Not all attitudes towards FGM are negative, despite the obvious pain and

suffering the procedure causes. The procedure is accompanied very often by a ceremony, which brings with it personal pride and a sense of becoming a woman, for example among the Kamba, Meru and Luya tribes of Kenya. Grassivaro and Mollo (1985) noted that 'the circumcision is considered as an obligatory step towards the conquest of social identity by the Somali woman in order to avoid being an outcast'.[7] Most of the anecdotal evidence suggests, however, that the event is extremely traumatic and many women have been adversely affected psychologically.

Studies have been made about the effect of FGM on girls' self-perception. It is thought that the trauma of FGM is accompanied by associated meanings, which combine to shape the feminine self. Women who have undergone FGM establish an identity, which shapes their roles in society. It is therefore, a form of social conditioning, which actually prescribes gender identity and normalises pain for women. A woman's sexuality is affected as much by the meanings and social processes which are associated with the practice of FGM, as by the act of cutting and the physical damage.

In many cases it is women who perpetuate the practice of FGM because it forms a large part of their self-perception and their social and gender identity, which they wish to pass on to future generations.

Effects of FGM on women's sexuality

Much of the qualitative research which has been undertaken into the effect of circumcision on the sexuality of women has suggested that all types of FGM inhibit the sexual fulfilment and pleasure of women. However, FGM does not necessarily rule out the possibility of sexual enjoyment — in many cases, even during infibulation, some of the sensitive tissue of the labia minora and the clitoris may be left intact, and other parts of the body may become more sensitised. *The Hite Report* (1976) suggests that the clitoral system can be up to thirty times as large as the external clitoris, thus it may still be possible to achieve clitoral orgasm, although the scar tissue in the area could pose a problem.[8]

Sexual relations with men can become very strained. The man may have to cut the scar formed by infibulation before penetration can take place. Although in southern Somalia and Sudan it is considered a sign of virility and masculinity to penetrate a woman forcefully, it has had negative effects on some men, causing them to become impotent. A lack of sexual pleasure for both parties can result in husbands having extramarital affairs with women who are not circumcised.

Suggested further reading

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World Health Organisation (2000) *A Systematic Review of the Health Complications of Female Genital Mutilation*, World Health Organisation, Geneva

[7] Cited in WHO (1998) *Female Genital Mutilation: An Overview*, WHO, Geneva.
[8] Hite, S (1976) *The Hite Report*, Dell Books, New York.

FGM: the African situation

Country	Estimated prevalence (%)	General information
Benin	50	Excision mainly practised in the North. No legislation prohibiting FGM. IAC[9] has been campaigning against FGM since 1982, with the Ministry of Social Affairs and Health.
Burkina Faso	72	Excision. Law against FGM enacted 1997. 1998 -10 excisors and 30 accomplices prosecuted.[10] Widespread government campaign against FGM. National Committee for the Fight Against Excision set up in 1990.
Cameroon	20	Clitoridectomy and excision, in far north and south-west. IAC set up 1992, with government support.
Central African Republic	50	Clitoridectomy and excision. 10 out of 48 ethnic groups practice FGM. Legislation prohibiting FGM. Educational campaign by Ministry of Social Welfare.
Chad	60	Excision and infibulation, excision practised in all areas. Infibulation performed on eastern border with Sudan. Now law prohibiting FGM. IAC is active in outreach programmes, but little activity on the part of the government.
Cote d'Ivoire	60	Excision prevalent among Muslim women often performed as an initiation rite. High prevalence north, north-east and west. Law prohibiting FGM. December 1998 (five years imprisonment, ten if medical professional). No prosecutions have been made. 1996, creation of anti-circumcision committee (research and advocacy).[11]
Democratic Republic of Congo	5	Excision practised in the north. No specific legislation against FGM.
Djibouti	90-98	Excision and infibulation. 1995, penal code was amended to include a provision outlawing FGM. The Union Nationale des Femmes de Djibouti organises workshops to raise awareness.
Egypt	97	Clitoridectomy, excision, and infibulation practised by Muslims and Coptic Christians, infibulation prevalent in the south. 1958 prohibited FGM. 1996. Health Minister banned licensed health professionals from practising FGM. In 1997 ban was overturned. Egypt's medical syndicate appealed against the court's decision and Sheikh of Al-Azhar declared support for the ban.
Eritrea	90	Clitoridectomy, excision, and infibulation practised by almost all ethnic groups. Official opposition from the government, but no specific legal provisions against the practice. Eritrean People's Liberation Front (EPLF) undertook eradication campaign. FGM included in Eritrean Government's health and general education programmes.
Ethiopia	90	Clitoridectomy and excision, in areas bordering Somalia and Sudan infibulation is practised. Practised among most of Ethiopia's 70 or more ethnic groups (Muslims, Christians, minority Jewish community, Falashas, who now mostly live in Israel). No legislation prohibiting FGM, although constitution prohibits harmful traditional practices. National health and women's policy show Government support for elimination. The Revolutionary Ethiopian Women's Association (REWA) works against the practice, as does the Ministry of Health. IAC set up 1985, regional headquarters permanently established in Addis Ababa.

[9] Inter-African Committee on Traditional Practices Affecting the Health of Women and Girls
[10] Rahman , A and Toubia, N (2000) *FGM: A Guide to Laws and Policies Worldwide*, Zed Books, London.
[11] Ibid, p131.

Gambia	60-90	Excision, infibulation in a small percentage. No specific law prohibiting FGM. In 1981 the Gambia National Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP) was set up. The Foundation for Research on Women's Health Productivity and the Environment (BAFROW) founded in 1991 also works against FGM.
Ghana	15-30	Excision. Most prevalent in Upper East, Upper West and North where prevalence is up to 75%. In 1994 FGM was made a criminal offence (punishable by three year prison sentence). Two practitioners have been convicted since enactment. The Ministry of Health explicitly discourages FGM and advocates for eradication programmes. The Association of Church Development Projects (ACDEP) and the Ghana Association for Women's' Welfare (GAWW), established 1984, is an affiliate of IAC.
Guinea	99	Clitoridectomy, excision, and infibulation widely practised among all ethnic and religious groups. The practice is illegal under Article 265 of the Penal Code. No prosecutions have been made to date. The Supreme Court works with the local Co-ordinating Body on Traditional Practices Affecting the Health of Women and Children (CPTAFE) to work for an amendment of the law specifically to prohibit FGM. High-level government officials, including head of state, have spoken out against the practice. CPTAFE and the IAC in Guinea are recognised by the government.
Guinea Bissau	50	Clitoridectomy and excision. Widespread among Fula and Mandinka. No specific legal provisions to prohibit the practice. 1992, government supported awareness-raising seminar, run by IAC. In 1995, proposal to outlaw FGM was defeated. Practitioners are criminally responsible if a woman dies as a result of the procedure.
Kenya	38	Clitoridectomy and excision, some infibulation in far eastern areas bordering Somalia and Somali refugee camps. Law prohibiting FGM enacted in December 2001. Government hospitals instructed by the government to cease the practice. A motion brought before parliament to ban FGM was defeated in 1996. Organisations working against the practice include National Council on Women in Kenya, the Kenyan National Committee on Traditional Practices and Maendeleo Ya Wanawake (MYWO).
Liberia	50-60	Excision practised by thirteen ethnic groups. Due to civil war it is estimated that prevalence of FGM may have dropped to 10 per cent. No law specifically prohibits FGM. In 1985, the Liberian National Committee was established to conduct research, training, and health education. Collaboration with government in awareness-raising campaign.
Mali	90-94	Clitoridectomy and excision, infibulation in the south. No specific anti-FGM legislation. Government formed National Action Committee in 1996 - information, training and support for NGOs, e.g. AMSOPT educates youth and religious leaders. The Association for Promoting the Rights of Women (APSD), the Action Committee for the Rights of Women and Children (CADEF), the National Women's Organisation (NOW) and the IAC are campaigning against the practice. National Council Against Violence Towards Women links NGOs campaigning against FGM and submitted draft action plan against sexual mutilation to Ministerial Council in 1999. Ministerial Council accepted recommendations and implemented plan to eliminate FGM by 2008.
Mauritania	25	Clitoridectomy and excision. Practised most commonly among Sominke and Halpular. No specific anti-FGM legislation. Prohibited in government hospitals. NGOs and public health workers educate women about FGM. Secretary of State for Women's Affairs formed committee in 1997 to work against FGM.
Niger	20	Excision practised, no legislation prohibiting FGM. Niger Committee Against Harmful Traditional Practices established 1990. Information, awareness-raising, research. Government participates in educational seminars. Minister of Health is keen to stop the practice.
Nigeria	50	Clitoridectomy, excision, in north-west some infibulation. Practised among all ethnic and religious groups. No specific legislation to prohibit the

		practice. National Association of Nigerian Nurses and Midwives has been active in the campaign against the practice. Educational activities conducted by medical professionals. In 1984 Nigerian National Committee (IAC) was set up, with support from Ministries of Health, Education and Information.
Senegal	80-90	Excision. 1988, study revealed practice is prevalent among Muslim population. January 1999, Senegal amended Penal Code to prohibit FGM. In the 1980s President Abdou Diouf of Senegal spoke out against the practice. In 1981, Capagne Pour L'abolition des Mutilations Sexuelles (CAMS), Campaign for the Abolition of Sexual Mutilation was formed in Paris. CAMS-International was later based in Senegal and organises seminars on violence against women and girls. The Senegalese Committee on Traditional Practices (COSEPRAT), the IAC National Chapter conducts medical research in collaboration with the Government.
Sierra Leone	20	Excision, all ethnic groups except Creoles (mainly Freetown). Practised among traditional communities know as Bundo (Secret Societies). Membership to such societies is only given to women if they have undergone FGM. Uncircumcised girls are considered outcasts. No law and no government support to eradicate the practice. In 1996 supporters of FGM received support from influential elite and in 1997 Sierra Leone's military ruler gave his support for the continuation of the practice. Sierra Leone Association of Women's Welfare set up in 1984 to advocate for education and legislation against FGM.
Somalia	98	Infibulation. No law specifically prohibiting FGM. The Somali Women's Democratic Organisation (SWDO) was set up in 1997, supported by the government with the specific function of eradicating FGM. Education programmes by The Somali Academy of Arts and Sciences and the Ministry of Education in the 1980s. The Italian Association and SWDO formed the Anti-FGM Programme for Women's Development. Project was abandoned at the onset of civil war.
Sudan	89 (north)	Infibulation practised among all ethnic and religious groups in the north. 1946, law enacted to prohibit infibulation but allows less severe forms of FGM, (i.e. excision of projecting parts of the clitoris); there is punishment of fine or imprisonment. Upon independence in 1957 the law was ratified again. The 1993 Penal Code contains no mention of FGM, making the status of the practice is unclear. NGOs working to eradicate FGM since 1940s. Today, an intensive campaign by NGOs, government, media, and religious groups - information and education focus. Medical professionals becoming involved, including eradication of FGM in community health curriculum at Khartoum Nursing College.
Tanzania	18	Excision, infibulation. Practised in five regions of Tanzania. April 1998, Tanzania enacted legislation specifically to prohibit FGM. Government programmes for eradication. National committee carries out education programmes and research. IAC chapter, set up in 1992, raises awareness and provides education, and does research into eradication strategy.
Togo	12	Excision practised in the north. In 1998 Togo passed a law prohibiting FGM. Togolese League for Women's Rights drafting law against FGM, and educate rural population on FGM. IAC set up 1984, with support of government - holds education workshops/seminars.
Uganda	5	Clitoridectomy and excision. One district, Kapchorwa, only. No specific law to prohibit the practice. Government condemns FGM. IAC campaigns against the practice with the many Ugandan NGOs. The UNFPA established a pilot programme to educate community youth, health workers, and traditional birth attendants.

Sources and suggested further reading

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World Health Organisation (2000) *Prevalence Rates for FGM, Geneva*

FGM as a human rights issue

'To succeed in abolishing the practice of FGM will demand fundamental attitudinal shifts in the way that society perceives the human rights of women'. (Efua Dorkenoo, *1994*).

FGM is carried out on young girls primarily because their parents feel it is in their best interests. However, FGM inflicts severe pain and suffering on the girl, and its consequences can be life threatening. Dorkenoo (1995) states that FGM 'represents one of the most extreme ways in which women are subordinated by men, and it is sufficiently horrifying to make men and women question practices which women endure in the name of culture and tradition'.[12] FGM is a clear manifestation of a gender-based human rights violation which aims to control women's sexuality and autonomy. FGM has internationally been recognised as a form of torture and violence against women. However, most governments in countries where FGM is practised have done little to put an end to it. Although the prohibition of torture has long been enshrined in international law, FGM has only recently been written into the international human rights agenda.

The Universal Declaration of Human Rights in (1948) documented the need for a universal framework for the protection of human rights. It was within this context that FGM was taken up as an issue by the United Nations (UN) in 1958. However, the failures of previous efforts to address the issue prevented FGM from featuring highly on the agenda of the UN for another 20 years.

It was not until 1979 that a WHO conference in Khartoum held a seminar on traditional practices affecting the health of women and children. This seminar took some major steps towards constructing firm recommendations for governments to eliminate FGM. Measures included setting up national commissions for the co-ordination of activities and the intensification of education. It also called for the formulation of legislation and outreach programmes involving health workers and traditional healers.

The UN Decade for Women further highlighted the need to address the status and health of women in developing countries. The 1980 World Conference on Women, held in Copenhagen, called on African governments and women's organisations to combat detrimental cultural practices.

In 1981 the Association of African Women for Research and Development held discussions with the Economic Commission for Africa, drawing attention to the issue of FGM. In 1982 WHO made a formal statement to the UN Human Rights Commission on its position regarding FGM, endorsing the recommendations of the Khartoum seminars of 1979. The WHO statement included the recommendation that 'governments adopt clear national policies to abolish the practice of FGM, and to inform and educate the public about its harmfulness'. It also states that 'programmes designed to combat the practice should recognise its association with extremely adverse social and economic conditions, and should respond sensitively to women's needs, with the involvement of women's organisations at a local level, since commitment to change must start with them'.[13]

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[12] Dorkenoo, E (1995) *Cutting the Rose, Female Genital Mutilation: the practice and its prevention,* Minority Rights Group, London.

[13] WHO (1996) "Actions for Eradication" in Female *Genital Mutilation: an Information Pack*, WHO, Geneva.

A human rights perspective obligates governments, local authorities, and other influential organisations to prevent, investigate and punish violence against women. It also requires the international community to take a share of the responsibility for the protection of the human rights of women and girls.

Under international human rights law, governments are bound by a number of duties:

- to modify customs that discriminate against women
- to abolish practices that are harmful to children
- to ensure health care and access to health information
- to ensure a social order in which rights can be realised.[14]

FGM represents a violation of the right to physical and mental integrity. This violation must be viewed in the context of the systematic denial of women's civil, political, economic and social rights. It is the clear obligation of states, as set out by international legal agreements, to put in place appropriate and effective measures to protect women from FGM. FGM is an act of violence against women, and cannot be separated from the many forms of gender-based discrimination which should be acted upon by governments. Although many governments have ratified human rights agreements condemning FGM, international human rights instruments have only been interpreted into effective and enforced legislation in a very small number of cases.

The table below gives details of the human rights declarations and conventions which are directly, or indirectly, violated by the practice of FGM.

The Universal Declaration of Human Rights (1949)	• asserts rights of all individuals to freedom, equality in dignity, rights, security and freedom from inhuman or degrading treatment • many nations have incorporated the provisions of the documents into their national laws and constitutions • however, traditional interpretation failed to recognise forms of violence against women, especially those inflicted within the home or community.
UN Convention on the Elimination of All Forms of Discrimination Against Women CEDAW (1981)	• Article 5 states that 'all parties shall take appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of …customary practices…based on the idea of inferiority or superiority of either of the sexes' • recommendation 14 calls on state parties to take appropriate measures towards eradicating FGM, including health and education strategies • recognises that women are denied their civil and political rights through such violent practices (e.g. FGM), and that the 'consequences of gender-based violence perpetuate the subordinate roles of women, contributing to their lower levels of participation and education'.
UN Convention on the Rights of the Child (1989)	• requires all states to take 'all appropriate measures with a view to abolishing traditional practices prejudicial to the health of children' • obligates all states to protect the child from all forms of physical or mental violence, injury or abuse.
The African Charter on the Rights and Welfare of the Child (1990)	• clear requirement that 'any custom, tradition, cultural or religious practice that is inconsistent with the right, duties and obligations contained in the present charter shall be null and void' • requires states to take appropriate measures to eliminate social and cultural practices 'harmful to welfare, normal growth and development of the child, in particular those prejudicial to the health and life of the child and those customs and practices discriminatory on the grounds of sex or other status'.
UN Declaration on the Elimination of	• Article 2 states that all violence against women shall be understood to include 'female genital mutilation and other traditional practices harmful to

[14] Rahman, A and Toubia, N (2000) *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*, Zed Books, London.

Violence Against Women (1993)	women' • Article 4 has direct relevance to FGM in that it requires that states should not prioritise any custom, tradition or religious consideration above their obligation to eliminate violence against women • this declaration calls on states to modify existing laws, regulations, customs and practices which discriminate against women • not legally binding, but establishes a strong basis for a legal framework for the implementation of eradication programmes.
The Vienna Declaration (1993)	• 1993 UN World Conference on Human Rights in Vienna stressed clearly that the 'human rights of women and of the girl child are an inalienable, integral and indivisible part of universal human rights' • stated the need to eradicate 'any conflicts which may arise between the rights of women and the harmful effects of certain traditional and customary practices'.
Beijing Platform for Action of the Fourth World Conference on Women (1995)	• condemned FGM and reaffirmed the need for government action to improve the status and health of women, and to eliminate gender-based violence.
New York Review meeting (2000)	• governments agreed to 'adopt and fully implement laws and other measures as appropriate, such as policies and educational programmes, to eradicate harmful customary or traditional practices including female genital mutilation and forced marriage'.

Medicalisation of FGM

It is firmly believed by a core group of human rights campaigners active in the field of FGM and Women's rights that the practice of FGM is a violation of the right to good heath and bodily integrity of African women and girls. This is an argument which is often put forward when discussing issues of medicalistaion of FGM, which can be said to reduce the harmful health consequences of the practice, but the question of human rights remains.

In many countries FGM is carried out by health professionals in government hospitals, as it is argued that FGM carried out in a sterile environment, using local or general anaesthetic, makes the practice safer. However, FORWARD believes that a practice which causes unnecessary harm should not be perpetuated or tolerated by health professionals, whose duty is to care and protect. FGM carried out by medical professionals gives a legitimate and acceptable face to a practice which damages women's and girls' reproductive, sexual and psychological health. Performing FGM in sterile conditions does not alleviate the long-term detrimental effects of FGM suffered by so many women.

FORWARD believes that health professionals should be recruited to the campaign to eliminate FGM and should not perpetuate the practice. One feature of FORWARD's work in the UK has been to train health professionals on the matter of FGM, assisting them to understand the practice and its implications. FORWARD's current educational project in Kenya also aims at targeting health professionals and encouraging them to oppose the practice.

In the UK there have been cases of doctors who have been willing to carry out the practice on young girls. Dr Faruk Sadik, who practised medicine in London, was struck off the medical register for offering to perform FGM, but his licence to practice was re-instated in 1997. In a similar case Dr Abdul Ahmed was struck off the general medical register in 2000 for his willingness to perform FGM on three Somali girls at his home in Manchester in 1997. The doctor was secretly filmed by a Somali undercover journalist, posing as a woman wishing to have her daughter circumcised.

The WHO issued a statement in 1982 stating that: 'The WHO has consistently and unequivocally advised that FGM should not be practised by any health professionals in any setting – including hospitals and other health establishment'. This position is supported by the IAC, which is the main NGO working on FGM in Africa, as well as by the International Federation of Gynaecology and Obstetrics (FIGO), the International Council of Nurses and the Royal Colleges of Obstetrics and Gynaecology (RCOG). In addition, a study done by the International Centre for Reproductive Health revealed that the majority of European health professionals are against the medicalisation of the practice. Only 12.3 per cent believe that medicalisation is a good way of reducing complications.

FGM and asylum

The increasing international awareness and recognition that FGM is a violation of human rights is reflected in a statement by the UN High Commissioner for Refugees made in July 1994. The letter states that:

'FGM which causes severe pain as well as permanent physical harm, amounts to a violation of human rights, including the rights of the child and can be regarded as persecution. The toleration of these acts by the authorities, or the unwillingness to provide protection against them, amounts to official acquiescence. Therefore a woman can be considered a refugee if she or her daughter/daughters fear being compelled to undergo FGM against their will; or, she fears persecution for refusing to undergo or allow her daughters to undergo the practice'.[15]

FGM can be categorised as persecution on the grounds of a person's adherence to a particular social group. The Immigration Appellate Authority's "Asylum Gender Guidelines" illustrate this provision as part of gender-based violence.

The guidelines state that 'the fact that violence and/or discrimination against women occurs in every country…or is endemic and/or culturally/socially accepted is irrelevant when determining whether gender-specific forms of harm amount to "serious harm"'.

It also states, that 'gender-specific harm does not differ analytically from other forms of ill-treatment and violence that are commonly held to amount to persecution and may constitute torture or cruel inhuman and degrading treatment or punishment'. FGM is mentioned specifically when it is stated that 'gender-specific harm may include, but is not limited to, sexual violence and abuse, female genital mutilation…'[16]

The UK Home Office has publicly condemned the practice, stating that any woman or child fearing this violence should have grounds for asylum. For example, Ann Widdecombe MP, during the debate on the Asylum and Immigration Bill, stated that 'forcible abortions, sterilisation, genital mutilation and allied practices would almost always constitute torture … There is no doubt in my mind that anyone making a case to us on these grounds would have an extremely good case for asylum.' [17]

However, only a very small number of women have been granted asylum on the grounds of FGM. Many obstacles hinder the protection of women fleeing this violation of their bodily

[15] Amnesty International (1997) "Female Genital Mutilation and Asylum" in *A Human Rights Information Pack*, London
[16] Bekowitz, N and Jarvis, C (Nov 2000) *Immigration Appellate Asylum Seeker Guidelines*, Crown Copyright, London
[17] Ann Widdecombe MP, 15/7/96 "Consideration of Lords Amendments to the Asylum and Immigration Bill" 1995/6, *Hansard* Col 842 and 844

integrity, not least of which are concerns about cultural imperialism.[18] Other obstacles include credibility and a lack of firm evidence. In the famous case of Fauziya Kassindja from Togo, who claimed that she was at risk of having FGM performed on her, a US immigration judge initially rejected her asylum claim, saying that 'this alien is not credible'. The decision was later overturned and refugee status was granted. This stigma is associated with a lack of knowledge and awareness of the complexity of the issues surrounding the practice.[19]

Suggested further reading

Human Rights

Amnesty International (1997) *A Human Rights Information Pack*, London.

Rahman, A and Toubia, N (2000) *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*, Zed Books, London.

United States Department of State (1999) *Country Reports on Human Rights Practices for 1999*, Department of State, Washington DC.

Toubia, N (1995), Female Genital Mutilation: A call for global action, RAINBO, New York

Medicalisation

Shell-Duncan, B and Hernlund, Y (2001) *Female "Circumcision" in Africa: culture, controversy and change*, Lynne Riener Publishers, London. Chapters 5 and 6.

Asylum

Amnesty International (1997) "Female Genital Mutilation and Asylum" in *A Human Rights Information Pack,* Amnesty International, London.

Kassindja, F (1998), *Do They Hear You When You Cry,* Bantum Books, London.

Crawley, H (2001) *Refugees and Gender: law and process*, Jordans Publishing Ltd, Bristol

[18] Crawley, H (2001) *Refugees and Gender: Law and Process*, Jordans Publishing Ltd, Bristol, pp183.
[19] Kassindja, F (1998) *Do They Hear You When You Cry*, Bantum Books, London.

FGM: the European situation

Due to civil wars and massive labour movement during recent decades, Europe has been the destination for many thousands of immigrants and refugees from African countries where FGM is practiced. This has produced growing concerns over the adequacy of means to prevent the continued practice of FGM within immigrant communities living in Europe. As a result, efforts have been made to establish a European network for the prevention of FGM, including activities such as sharing community experiences and disseminating models of good practice at community level, developing guidelines for health care professionals and setting a research agenda for FGM in Europe.

A hearing on FGM took place at the European Parliament on Wednesday 29 November 2000, which became earmarked as the International Day against FGM. A motion for a resolution denouncing FGM was tabled at the European Parliament, proposing that EU member states provide asylum for all women escaping this threat to their bodily integrity.

The motion invites the council, the commission, and the member states to:

- treat FGM as a crime against personal integrity
- establish the significance of the problem within the member states and promote information and prevention measures
- recognise the risk of FGM as a criterion to provide asylum or humanitarian protection
- consider the fight against FGM as a priority in relations with the developing world through the human rights clause
- support NGOs working for the elimination of this practice in countries where it is justified by cultural and/or religious motivations.

When the motion has been signed by the absolute majority of the European Parliament, it will be assigned to a parliamentary committee and will be followed up by concrete measures to prevent FGM throughout Europe

On 16 May 2001, a further meeting was held in Strasbourg, France, in order to draft a joint action agenda to prevent and eliminate FGM in Europe. The agenda was used in a report from the Committee on Women's Rights and Equal Opportunities from the European Parliament, which was published in September 2001. The expert meeting aimed to strengthen international co-operation between the EU and NGOs active in the field. The meeting also aimed to put FGM formally on the agenda of the EU, and finalise the joint agenda for action.

If these recommendations are acted upon by the European Commission and member states, it could mean a greater unified effort between governments and NGOs working towards the prevention and elimination of FGM throughout Europe.

FGM and the law in Europe

In most European countries today there are no specific laws covering FGM. Arguably, FGM could be prohibited through various other laws. For example, in France there is no specific legislation prohibiting FGM, yet there have been at least 25 prosecutions since 1978 of providers of FGM or parents of girls affected, under provisions of the penal code. In spite of this, there have been very few prosecutions regarding FGM in Europe. In the table below we can see that only the UK, Norway and Sweden have legislation specifically criminalising the practice, yet no prosecutions have been made.

Country	Anti-FGM legislation	Prosecutions made
Belgium	No specific law (applicable under child protection laws)	None
Denmark	No specific law (Para 245 of Danish Criminal Code may apply)	None
France	No specific law (Article 22 of the French penal code may apply)	Since 1978, 25 prosecutions of circumcisors/ parents
Germany	No specific law (FGM illegal under Article 224 (serious bodily harm) and Article 226 (grievous bodily harm) of the German penal code)	None
Italy	No specific law (FGM illegal under Article 582 (personal injury) of Italian penal code)	Information not available
The Netherlands	No specific law (Articles 300-306 and 436 (serious bodily harm) of penal code apply)	None
Norway	Specific anti-FGM law (Law 74 of 15 December 1995)	None
Sweden	Law criminalising FGM 1992, revised 1995 (penalties more severe)	None
United Kingdom	Prohibition of Female Circumcision Act 1985	None

Suggested further reading

Rahman, A and Toubia, N (2000) *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*, Zed Books, London.

European FGM Network, (2000) *Workshop Report "Female Genital Mutilation in Europe: developing frameworks for the health sector",* International Centre for Reproductive Health, Ghent, Belgium.

European FGM Network, (2000) *Workshop Report "Exchanging Experiences and Information at Community Level*, International Centre for Reproductive Health, Ghent, Belgium.

Leye, E, de Bruyn, M, Meuwese, S (1998) *Proceedings of the Expert Meeting on Female Genital Mutilation*, International Centre for Reproductive Health, Ghent, Belgium.

FGM: the UK situation

FORWARD was one of the first organisations established in the UK to campaign against FGM among African minority communities in the UK. FGM was made illegal in the UK, under the Prohibition of Female Circumcision Act, as a direct result of FORWARD's campaign. The Act made all forms of FGM illegal in the UK, except on specific physical and psychiatric grounds. Despite the legislation and the efforts of FORWARD and other NGOs to raise awareness of FGM, evidence suggests that the practice still occurs in the UK. A Department of Health funded survey, assessing the situation of FGM among local social services in the UK, found that FGM is more widespread than previously believed. Out of sixty-five local social service departments in the survey, ten reported casework interventions because of suspected FGM cases and a further eighteen were concerned about communities practising FGM.[20]

Another estimate by Boot (1991) suggested there are 3000-4000 new cases of FGM every year in this country. In 1998 a survey by London Black Women's Health Action Project, in collaboration with the London School of Hygiene and Tropical Medicine, examined the experiences, attitudes and views of young, single Somali women towards FGM. The study found that medical professionals in the UK had illegally circumcised a substantial number of Somali girls.[21]

The issue of FGM in the UK has been highlighted by the media through documentaries such as *Black Bag: Cutting the Rose,* which exposed a medical doctor in Manchester who was willing to perform the practice on three young Somali girls. A Yemeni steelworker from Sheffield was also found to be circumcising girls within the city. The doctor has since been removed from the general medical register.

FORWARD estimates that there are presently 86,000 first generation immigrant and refugee women and girls in the UK who have undergone FGM in their countries of origin, with more than 7,000 girls at risk.[22] Most of the women and girls from practising communities live in the major UK cities, including London, Manchester, Sheffield, Liverpool, Birmingham and Cardiff. These numbers are increasing with the influx of refugees from Somalia, Sudan, and Sierra Leone, countries affected by civil wars and with large FGM practising communities. A report from Northwick Park's African Well Women Clinic shows the number of Somali women visiting the clinic between 1988 and 1998 increased from 1.8 per cent to 13.6 per cent.[23] Overall the number of immigrants settling in the UK from African countries is on the increase. From 1997 to 1998 the total number of Somali entrants per year rose from 1,780 to 2930. Using *Labour Force Survey 1999*, FORWARD estimates that there are over 15,000 Somali women currently living in this country who may have been genitally mutilated.

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[20] Read, D (1998) *Out of Sight, Out of Mind? A survey into the inter-agency policies and procedures relating to female genital mutilation in England and Wales*. FORWARD, London.
[21] William, L et al (1998) *Experiences and Views of Young Somalis Living in London on Female Circumcision*. London Black Women's Health Action Project and London School of Hygiene and Tropical Medicine, London.
[22] Office of National Statistics, *Labour Force Survey*, *1999.*
[23] Gordon, H (1998) "Female Genital Mutilation (female circumcision)". *The Diplomate*, 5 (2), pp 86-90

FGM: the UK Government position

As a result of lobbying on the part of FORWARD and other NGOs, the UK government implemented the Prohibition of Female Circumcision Act 1985. Despite intense activity within the voluntary sector, government commitment to eradicate the practice of FGM is very important. In a UK Select Committee on International Development in 1999, the issue of FGM was raised. The report stated that 'FGM is an important development issue which must be included in any discussion of women and development'. The committee also stated that although cultural sensitivity is important 'culture can no longer be used as an excuse for inaction on securing women's rights'.

The government has addressed FGM in child protection literature. The 1999 report, *Working Together to Safeguard Children*, issued jointly by the Department of Health, the Department for Education and Employment and the Home Office, stated that 'under s.47 of the Children Act 1989…in local areas where there are communities or individuals who traditionally practice FGM, Area Child Protection Policy should focus on preventative strategy involving community education'.

UK Parliamentary Hearings

In May 2000, the Parliamentary Hearings on FGM, implemented by the All-party Parliamentary Group on Population Development and Reproductive Health, were held. The aim of the hearings was to raise awareness of FGM in the UK and abroad, and to generate government support for FGM prevention and eradication programmes. It is hoped that the recommendations which emerged from the hearings will be fully implemented, and that FGM will become an integral part of the policy agenda.

The parliamentary hearings were accompanied by a survey, conducted among organisations working on the campaign against FGM in the UK and abroad, as well as among local authorities, medical professionals, refugee councils, social workers and representatives for the UK and WHO.

The hearings recommended that FGM should be categorised as a form of abuse in child protection literature, that all social services departments should receive training on FGM, and that the UK law should be amended to prosecute those taking their children out of the country for FGM. The recommendations also include raising awareness of the law among FGM practising communities and health professionals, through a widespread information and media campaign. In terms of organisation, it was suggested that the government provide more financial and technical support to encourage sustainable community programmes, and that religious and community leaders would be involved in training and education programmes. Men should also be involved. It was noted that under no circumstances should FGM be medicalised as it makes an unnecessary and harmful practice acceptable. It was recommended that the Department of Health should co-ordinate an inter-agency approach to ensure that good practice guidelines on FGM are fully implemented. Each Health Authority and Trust should employ an FGM specialist who is responsible for training health professionals. It was recommended that DfID take a lead role in making collaborative links between donor states to eliminate FGM. This would include co-ordinating a global health policy on FGM. Finally, it was recognised that there is a severe shortage of prevalence data in the UK and that the little research that has taken place so far has been restricted to small-scale qualitative work.

Suggested further reading

All-Party Parliamentary Group on Population, Development and Reproductive Health (2000), *Parliamentary Hearings on Female Genital Mutilation – Hearings Report*, APPG Population, Development and Reproductive Health, London

All-Party Parliamentary Group on Population, Development and Reproductive Health (2000), *Female Genital Mutilation – Survey Report and Analysis*, APPG Population, Development and Reproductive Health, London

Read, D (1998) *Out of Sight, Out of Mind? A survey into the inter-agency policies and procedures relating to female genital mutilation in England and Wales*. FORWARD, London.

William, L et al (1998) *Experiences and Views of Young Somalis Living in London on Female Circumcision*. London Black Women's Health Action Project and London School of Hygiene and Tropical Medicine, London.

Dorkenoo, E and Hedley, R (1996) *Child Protection and Female Genital Mutilation: advice for health, education and social work professionals*, FORWARD, London.

FORWARD, (1999) Moving FORWARD: *Report on the Conference on Female Genital Mutilation in the UK*, FORWARD, London.

FORWARD, (1997) *A Report of the Inter-agency/Non-governmental Organisations Forum: The Way FORWARD: Female Genital Mutilation in the UK*, FORWARD, London.

Community research in the UK

Despite a need for basic social scientific research into this area, due to the sensitivity of this subject systemic surveys have not been undertaken. Much of the research that has been undertaken surrounding FGM has been qualitative. It has been used to gather, analyse and communicate the social, economic and cultural issues associated with FGM. Such information is useful for determining what motivates communities to practice or not to practice FGM.

Appropriate eradication campaigns can be implemented once there has been an assessment of how social, cultural and religious values affect behaviour among individuals and communities with regard to FGM.

Community research in the UK on the issue of FGM has been extremely limited — to date there has been no thorough statistical research on the prevalence of FGM. Much of the qualitative research has been undertaken by NGOs such as FORWARD and London Black Women's Health Action Project. All of the studies have used very small, unrepresentative samples. It is not possible, therefore, to make any generalisations from the data compiled in the studies, which are outlined below.

The Switch Project

In 1999, FORWARD conducted a study among 15 Somali women in Manchester. The women were asked about their experience of, and attitudes towards, FGM. The study also assessed respondents' perceived access to health services and their awareness of community groups active in the field.

The results revealed that FGM is an important practice among 26 per cent of the respondents, due to its cultural significance. Forty-four per cent felt that it was not an important practice, mainly due to pain and health consequences. More older than younger women claimed that FGM was important.

'**The problem with "our" female circumcision (infibulation), it brings about many problems, especially when one is having children.'**

The majority of the women in the survey had been genitally mutilated. Forty-seven per cent felt it had not affected them at all, six per cent reported painful periods and thirteen per cent experienced pain during sex. Forty per cent had problems passing urine and suffered severe blood loss and immediate infection. Many claimed to have problems with childbirth and many women felt distressed and hurt:

'My mother has now died but I can never forgive her for what she did to me, she ruined my life.'

Forty per cent of respondents said they would be willing to be re-opened, although only twenty-seven per cent of women knew where to access this service.

Asked whether they felt the practice should be abolished, 73 per cent agreed it should be, while 27 per cent felt it should be retained as a part of their culture. A third of respondents said they would have their daughters circumcised, stating:

'I had it done to me and I want my daughter to have it… it is an important part of our culture.'

The outcome of this project has been used to develop FORWARD's wider national programme of creating educational materials for FGM practising communities, survivors of the practice and those professionals who are working with them.

FGM: a case study in Birmingham

A second study was carried out by FORWARD among FGM practising communities in Birmingham. This study sampled a bigger population, with men and women from four African communities - Somali, Ethiopian, Sudanese, and Eritrean. These communities are known to practice the most severe form of FGM (infibulation) and as many as 98 per cent of women are circumcised in these countries.

Similar to the research findings in Manchester, 30 per cent of those interviewed felt that FGM was an important practice because of its cultural significance. However, 61 per cent of respondents felt that FGM should be stopped. Of the 48 per cent of female respondents who were infibulated, 58 per cent confirmed they would have a reversal operation and 32 per cent said they would not. Almost 70 per cent of female respondents felt that FGM had made them a better person, in the majority of cases because they had followed the requirement of their tradition or religion.

When asked, 62 per cent claimed they would not continue the practice. This is partly because over 50 per cent of respondents were aware of the health complications of FGM. Almost 20 per cent of women who had been circumcised reported depression and anger, and many respondents, both men and women, encountered sexual problems. Ten per cent of women were divorced by their husbands, who later married uncircumcised women. Despite this seven per cent of women claim they would never have been married if they had not been circumcised, but over ninety per cent of men said this was not the case.

When asked about access to health services over half reported that they did not have any knowledge of health services at all and 20 per cent of them reported that the services they require are not available to them. One third of respondents reported that they required specialist services provided by an African well-women clinic. Overall, language constituted the largest barrier to women's access to health services.

Experiences, attitudes and views of young Somalis in London

A study was conducted in 1998 by the London School of Hygiene and Tropical Medicine, in collaboration with London Black Women's Health Action Project, among Somalis living in London. The study found those who had been born in Great Britain or had arrived in the country before the age of eight, were almost half as likely to undergo FGM as those who arrived aged nine or more years. Many of the women had undergone FGM in Somalia, although a substantial number had been illegally mutilated by health professionals in the UK.

Although many of the female respondents believed that infibulation was bad, a substantial proportion believed that sunna (which may involve removal of all or part of the clitoris) was a religious requirement.

The study also revealed that males were almost twice as likely as females to report that they would circumcise their daughters, although this varied with the length of time the men

had lived in the UK. Many respondents also wanted their sons to marry a circumcised woman.

Those who were against the practice were in favour of legislation, although a number of respondents reported that legislation would not deter them from allowing their daughters to undergo FGM. Several respondents were not aware there was a law, as a number of women had been circumcised since the law was enacted.

Suggested further reading

Mwangi-Powell, F (1999) *The Switch Project*, FORWARD, London.

Mwangi-Powell, F (2001) *FGM: A Case Study in Birmingham,* FORWARD, London.

Williams et al (1998) *Experiences, Attitudes and Views of Young, Single Somalis Living in London on Female Circumcision*, London School of Hygiene and Tropical Medicine.

The work of FORWARD

Much of the work to counter FGM would not have been possible without the collaboration between national and international NGOs, such as the IAC, Rainbo and Equality Now, amongst others. These organisations, alongside FORWARD, have made huge contributions in the area of research, awareness-raising, funding of grassroots activities, as well as training, lobbying and advocacy.

A brief history of FORWARD

FORWARD was founded by Efua Dorkenoo OBE, as a working group within the human rights organisation *The Minority Rights Group.* Its focus was to raise the issue of FGM as a human rights issue. Efua Dorkenoo decided to establish an independent organisation which would undertake fieldwork, research and publishing around the issue of women's health. FORWARD became an official charity in 1985.

FORWARD's functions

FORWARD:

- supports the elimination of harmful traditional practices such as FGM and early marriage, and promotes reproductive rights, by sponsoring local health, socio-economic and educational programmes in the countries where FGM takes place
- advocates remedial policies in countries where harmful traditional practices have a strongly negative or even fatal impact on the health of women and children
- provides information and advice to health, education, child protection and social services professionals in the UK and in Africa
- publishes and distributes training material for professionals and community workers internationally
- collaborates with international organisations and African NGOs working to eliminate harmful traditional practices.

FORWARD's achievements

- As a result of FORWARD's lobbying activity, the Prohibition of Female Circumcision Act was enacted in 1985 in the UK
- FORWARD has been recognised as one of the leading organisation working against FGM in the UK and is funded by the Department of Health. FORWARD is recommended to all those who are working with FGM issues in child protection
- FORWARD has assisted the UK government to integrate FGM prevention into child protection procedures
- FORWARD has worked with the WHO to produce the WHO/UNICEF/UNFPA joint statement on FGM
- FORWARD was active in the campaign that led to FGM being recognised as a violation of human rights by the UN
- The core framework developed by FORWARD in the UK has been adopted by the WHO for use as a model of prevention of FGM in the Western world

- FORWARD has worked with the Ministry of Health in Australia and Sweden to develop a strategic framework for implementing a preventative FGM programme for African and refugee communities.
- In the UK FORWARD has been the leading training organisation for professionals in health, social services, education sectors, and the police force.
- FORWARD was instrumental in the implementation of the All-party Parliamentary Hearings on FGM, held in May 2000.

FORWARD in the UK

FORWARD works in the UK to support and promote the rights and health of African immigrant and refugee communities. We have carried out a number of research studies into the knowledge, attitudes and practice of practising communities and into their perceived access to health care. Case studies among Somali and other African communities have taken place in Manchester, London and Birmingham. These studies have been used to help initiate a programme of culturally sensitive training and information provision for professionals and to encourage appropriate services for affected women. The study in London allowed FORWARD to initiate a programme to train peer educators from communities so that they can run workshops on women's health and FGM.

FORWARD has conducted many training sessions around the country for professionals in education, the police force, universities, NGOs and community groups, and is now aiming to provide good quality training systematically throughout the UK.

FORWARD in Africa

FORWARD's work in Africa has included projects in Kenya, The Gambia, Nigeria and Ghana. These projects have included efforts to mobilise men in the campaign against FGM, enhancing gynaecological and sexual health services for women, increasing awareness about the harmful effects of FGM within the practising communities and training health professionals and community mobilisers. FORWARD has also carried out much needed research on the topic, as well as implementing education programmes.

For more information on FORWARD's programmes in Africa and the UK please contact FORWARD or visit www.forwarduk.org.uk.

Additional FORWARD FGM Resources

A list of FORWARD publications, videos and other resources can be located on the website.

Organisations and contacts

Europe

AIDOS	Associazionne Italiana Donne Per Lo Sviluppo

Address: Via dei Giubbonari 30
I-00186 Rome, Italy

Tel: +39 06 687 3214
Fax: +39 06 6872549
Email: aidos@aidos.it

FORWARD	Foundation for Women's Health, Research and Development

Address: Unit 4, 165-767 Harrow Road
London, NW10 5NY, UK

Tel: +44 208 9604000
Fax: +44 208 9604014
Email: forward@forwarduk.org.uk

FORWARD	Germany

Address: Martin-Luther Strasse 35
D-60389 Frankfurt am Main, Germany

Tel: +49 69 459660
Fax: +49 69 464069
Email: levin@em.uni-frankfurt.de

GAMS	Groupe Femmes Pour L'Abolition Des Mutilations Sexuelles

Address: 66 Rue des Grands-Champs
F-75020 Paris, France

Tel: +33 1 43481087
Fax: +33 1 42095299/43480073
Email: association.gams@wanadoo.fr

IAC	Inter-African Committee on Traditional Practices (Head Office)

Address: Rue de Lausanne 14
CH 1202
Geneva

Tel: +41 22 731 2420
Fax: +41 22 738 1823

Email	cominter@iprolink.ch

RAINBO	Research Action information Network for Bodily Integrity of Women

Address	Suite 5A, Queens Studios 121 Salusbury Road London NW6 6RG
Tel	+44 30 7625 3400
Fax	+1 212 477 4154
Email	info@rainbo.org

RISK

Address	Risk, PO Box Uppsala 750 23 Uppsala, Sweden
Tel	+46 18 242162
Fax	+46 18 5684244
Email	femaleintegrity@telia.com

USA

Equality Now

Address	PO Box 20646, Columbus Circle Station New York NY 10023, USA
Fax	+01 212 5861611
Email	info@equalitynow.org

WIN	Women's International Network

Address	187 Grant Street Lexington MA 02420-2126, USA
Tel	+01 781 862 9431
Fax	+01 781 8621734
Email	winnews@igc.org

Australia

Western Sydney Health - Multicultural Health Unit

Address	Cumberland Hospital, 5 Fleet Street North Parramatta NSW 2151 DX 28412 Parramatta
Tel	+02 9840 3768
Fax	+02 9840 4100

Africa

BAFROW	Foundation for Research on Women's Health, Productivity and the Environment

Address 214 Tafsir Demba Mbye Road
Tobacco Road Estate, Banjul
P.O. Box 2854, Serrekunda, The Gambia

GAMCOTRAP	The Gambian Committee on Traditional Practices Affecting the Health of Women and Children

Address 49 Garba Jahumpa Road, Bakau New Town
P.O. Box 2990, Serrekunda, The Gambia

Tel +220 497416
Fax +220 497781
Email gamco@qanet.gm

IAC	Inter-African Committee (IAC) on Traditional Practices

Address c/o ECA/ICA
P.O. Box 3001, Addis Ababa, Ethiopia

Tel +251 1515793/517200 ext 33127
Fax +251 1514682

PATH	Program for Appropriate Technology in Health

Address 30 Ole Odume Road
P.O. Box 76634, Nairobi, Kenya

Tel +254-2 577177/80/89
Fax +254-2 577172
Email info@path-kenya.or.ke

Tostan

Address 777 N Capitol St. NE, Suite 807
Washington D.C. 20002 USA

Email tostan.dc@gmail.com

Useful web sites

Equality Now	www.equalitynow.org
FORWARD	www.forwarduk.org.uk
RAINBO	www.rainbo.org
WHO	http://www.who.int/topics/female_genital_mutilation/en/
Rising Daughters Aware	www.fgm.org
Tostan	www.tostan.org