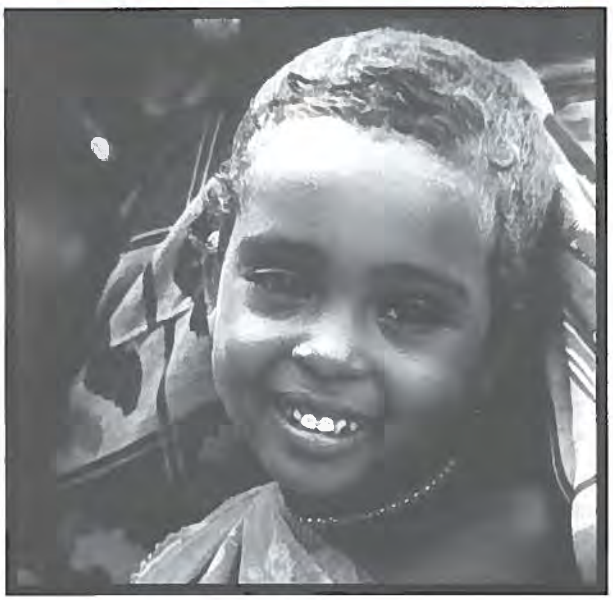
80

61

PATH
Program for Appropriate Technology in Health

THE FACTS
Female Genital Mutilation

Female Genital Mutilation (FGM)* is the partial or total removal of the female external genitalia.[1] External genitals include the clitoris, labia, mons pubis (the fatty tissue over the pubic bone), and the urethral and vaginal openings. The practice of FGM is often called "female circumcision" (FC), implying that it is similar to male circumcision. However, the degree of cutting is much more extensive, often impairing a woman's sexual and reproductive functions.[2] Between 85 and 115 million women and girls have undergone FGM; approximately 2 million are subjected to it annually.[3]



Newborns, Children, Adolescents, and Young Adults Are Affected

- Most girls undergo FGM when they are between 7 and 10 years old.[4] However, FGM seems to be occurring at earlier ages in several countries because parents want to reduce the trauma to their children. They also want to avoid government interference and/or resistance from children as they get older and form their own opinions.[5]
- Some women undergo FGM during early adulthood when marrying into a community that practices FGM or just before or after the birth of a first child (Mali and Nigeria).[6]

FGM Is Practiced Globally

- FGM is practiced in at least 26 of 43 African countries[7]; the prevalence varies from 98 percent in Somalia to 5 percent in Zaire. A review of country-specific Demographic and Health Surveys (DHS) shows FGM prevalence rates of 97 percent in Egypt[8], 94.5 percent in Eritrea[9], 93.7 percent in Mali[10], 89.2 percent in Sudan[11], and 43.4 percent in the Central African Republic.[12]
- FGM is also found among some ethnic groups in Oman, the United Arab Emirates, and Yemen, as well as in parts of India, Indonesia, and Malaysia.[13]
- FGM has become an important issue in Australia, Canada, England, France, and the United States due to the continuation of the practice by immigrants from countries where FGM is common.[14]

There Are Four Types of FGM

In 1995, the World Health Organization (WHO) developed four broad categories for FGM operations.[15]

Type I

Excision (removal) of the clitoral hood with or without removal of part or all of the clitoris.

Type II

Removal of the clitoris together with part or all of the labia minora.

Type III (infibulation)

Removal of part or all of the external genitalia (clitoris, labia minora, and labia majora) and stitching and/or narrowing of the vaginal opening leaving a small hole for urine and menstrual flow.

Type IV (unclassified)

All other operations on the female genitalia, including:
- Pricking, piercing, stretching, or incision of the clitoris and/or labia;
- Cauterization by burning the clitoris and surrounding tissues;
- Incisions to the vaginal wall;
- Scraping (*angurya* cuts) or cutting (*gishiri* cuts) of the vagina and surrounding tissues; and
- Introduction of corrosive substances or herbs into the vagina.

* *Female Genital Mutilation* is the terminology used by the World Health Organization and by PATH.

Compiled by: Laura Reymond, Asha Mohamud, and Nancy Ali. Contributors: Kalle Makalou and Zohra Yakoub

Type I and Type II operations account for 85 percent of all FGM. Type III (infibulation) is common in Djibouti, Somalia and Sudan and in parts of Egypt, Ethiopia, Kenya, Mali, Mauritania, Niger, Nigeria, and Senegal.[16]

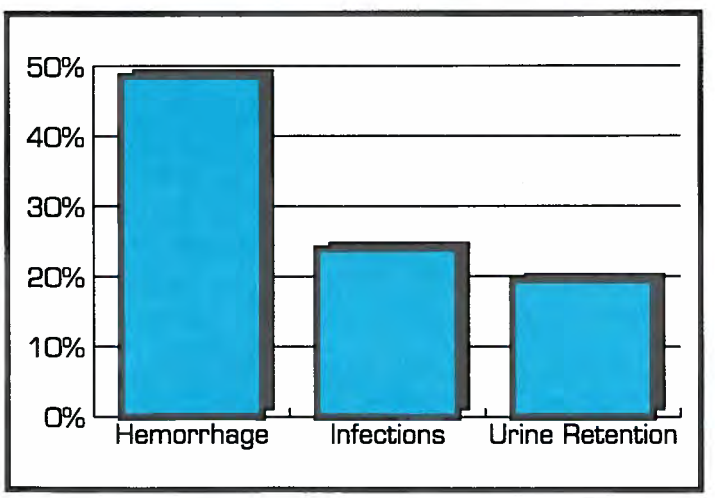
Complications Are Common And Can Lead to Death

The highest maternal and infant mortality rates are in FGM-practicing regions.[17] The actual number of girls who die as a result of FGM is not known. However, in areas in the Sudan where antibiotics are not available, it is estimated that one-third of the girls undergoing FGM will die.[18] Conservative estimates suggest that more than one million women in the Central African Republic (CAR), Egypt, and Eritrea, the only countries where such data is available, experienced adverse health effects from FGM.[19] One quarter of women in CAR and 1/5 of women in Eritrea reported FGM-related complications.[20] Where medical facilities are ill-equipped, emergencies arising from the practice cannot be treated. Thus, a child who develops uncontrolled bleeding or infection after FGM may die within hours.[21]

Immediate Physical Problems

- Intense pain and/or hemorrhage that can lead to shock during and after the procedure. A 1985 Sierra Leone study found that nearly 97 percent of the 269 women interviewed experienced intense pain during and after FGM, and more than 13 percent went into shock.[22]
- Hemorrhage can also lead to anemia.

Immediate FGM-Related Complications in Four Kenyan Districts



A 1991 survey of 1,222 women in four Kenyan districts indicated that 48.5% of the women experienced hemorrhage, 23.9% infection, and 19.4% urine retention at the time of the FGM operation.[23]

- Wound infection, including tetanus. A survey in a clinic outside of Freetown (Sierra Leone) showed that of 100 girls who had FGM, 1 died and 12 required hospitalization. Of the 12 hospitalized, 10 suffered from bleeding and 5 from tetanus.[24] Tetanus is fatal in 50 to 60 percent of all cases.[25]
- Damage to adjoining organs from the use of blunt instruments by unskilled operators. According to a 1993 nationwide study in the Sudan, this occurs approximately 0.3 percent of the time.[26]
- Urine retention from swelling and/or blockage of the urethra.

Long-Term Complications

- Painful or blocked menses. In 1983, 55.4 percent of women surveyed in Baydhaba, Somalia, reported abnormal menstruation.[27]
- Recurrent urinary tract infections. A 1983 study in the Sudan revealed that 16.4 percent of women who had the operation experienced recurrent urinary tract infections.[28]
- Abscesses, dermoid cysts, and keloid scars (hardening of the scars).
- Increased risk of maternal and child morbidity and mortality due to obstructed labor. Women who have undergone FGM are twice as likely to die during childbirth and are more likely to give birth to a stillborn child than other women.[29] Obstructed labor can also cause brain damage to the infant and complications for the mother (including *fistula formation*, an abnormal opening between the vagina and the bladder or the vagina and the rectum, which can lead to incontinence).[30] Among 33 infibulated mothers followed at Somalia's Benadir Hospital in 1988, all required extensive episiotomies during childbirth. Their second-stage labor was 5 times longer than normal, 5 of their babies died, and 21 suffered oxygen deprivation because of the long, obstructed labor.[31]
- Infertility. In the Sudan, 20-25 percent of female infertility has been linked to FGM complications.[32]
- Some researchers describe the psychological effects of FGM as ranging from anxiety to severe depression and psychosomatic illnesses.[33] Many children exhibit behavioral changes after FGM, but problems may not be evident until the child reaches adulthood.[34] However, little research has been done on this subject.
- FGM is likely to increase the risk of HIV infection — often the same unsterilized instrument is used on several girls at a time, increasing the chance of spreading HIV or another communicable disease.[35]

Complications Often Need Medical Attention

- According to a study conducted in a small rural village in Sierra Leone, 83 percent of women who had undergone FGM would require medical attention at some point in their lives for a condition resulting from the procedure.[36]
- A study of one hospital in Alexandria (Egypt) found that 1,967 hospital days were used in one year to treat FGM-related ailments.[37]
- According to a survey of 55 health providers in the Nyamira District of Kenya, almost half encountered women with chronic FGM-related complications (see chart to right) while over half treated recent FGM-related complications.

FGM May Impede Women's Sexuality

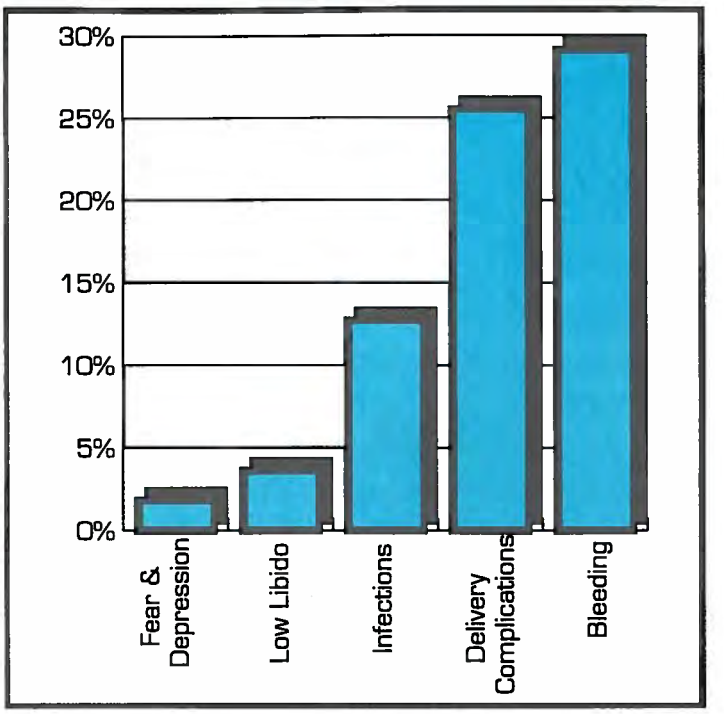
- Cultural values and ambiguities make women's sexuality very complex. This is also an area that has not been widely studied. Although it is difficult to verify reports of women's sexual experiences, physical complications from FGM often impede sexual enjoyment. FGM destroys much or all of the vulval nerve endings, delaying arousal or impairing orgasm.[38] Lacerations, loss of skin elasticity, or development of neuroma (a tumor or mass growing from a nerve) can lead to painful intercourse. In a 1993 Sudanese study, 5.5 percent of women interviewed experienced painful intercourse while 9.3 percent of them reported having difficult or impossible penetration.[39]
- In 1981, 1,545 Sudanese women who had undergone the operation were interviewed. Fifty percent of them said that they did not enjoy sex at all and only accepted it as a duty.[40]

Reasons for Supporting FGM Vary

Reasons for supporting FGM include the beliefs that it is a "good tradition", a religious requirement(s), or a necessary rite of passage to womanhood; that it ensures cleanliness or better marriage prospects, enhances male sexuality, facilitates childbirth by widening the birth canal, prevents promiscuity and excessive clitoral growth, and preserves virginity.

- Until the 1950s, FGM was performed in England and the United States as a common "treatment" for lesbianism, masturbation, hysteria, epilepsy, and other so-called "female deviances".[41]
- Religious affiliation can affect approval levels: A study in Kenya and Sierra Leone revealed that most Protestants opposed FGM while a majority of Catholics and Muslims supported its continuation.[42]

Chronic FGM-Related Complications Encountered by Health Providers in Kenya



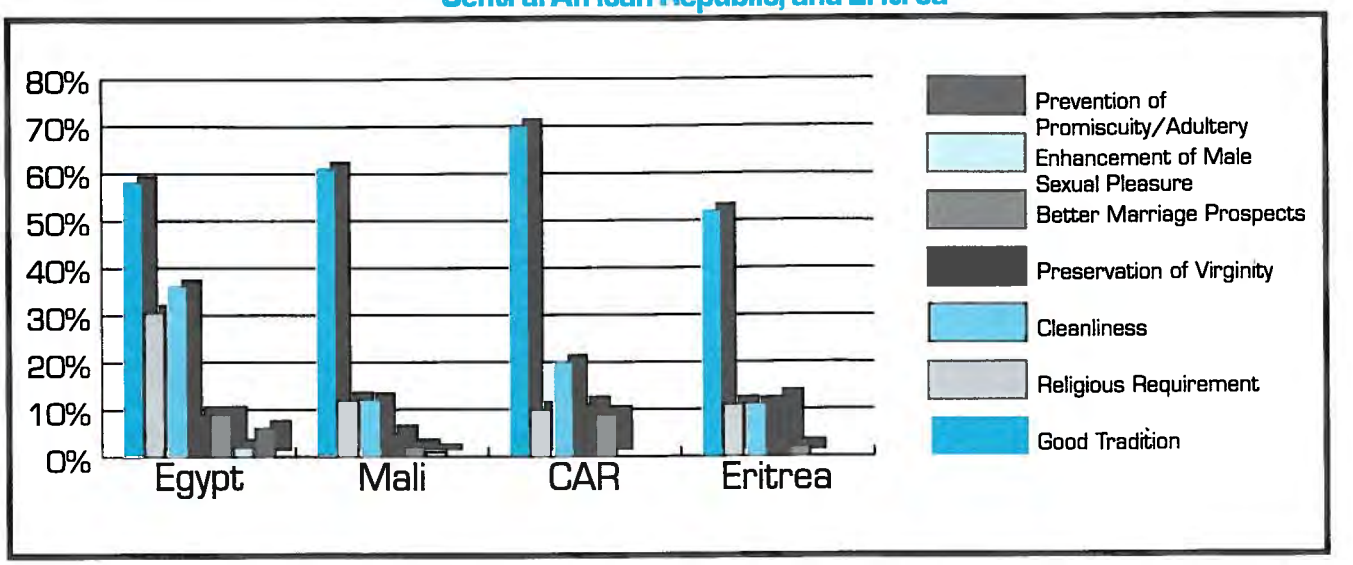
The chronic health problems encountered by 49.1% of health providers surveyed in Kenya are bleeding (29.1%); delivery complications (25.5%); infections (12.7%); low libido (3.6%); and fear and depression (1.8%).[43]

- There is a direct correlation between a woman's attitude towards FGM and her place of residence, educational background, and work status. DHS data indicate that urban women are less likely than their rural counterparts to support FGM. Employed women are also less likely to support it. Women with little or no education are more likely to support the practice than those with a secondary or higher education.[44] Data from the 1989 Sudanese survey (of women 15- to 49-years-old) show that 80 percent of women with no education or only primary education support FGM, compared to only 55 percent of those with senior secondary or higher schooling.[45] A woman's age does not seem to influence support.
- Most women who have had the FGM procedure are strongly in favor of FGM for their daughters.[46] In Egypt,

"Before, they used to circumcise older girls, but now they only circumcise babies."

Native Doctor/Traditional Birth Attendant, Edo State, Nigeria

Reasons for Supporting FGM in Egypt, Mali, Central African Republic, and Eritrea



Today, the most common reason evoked for supporting FGM is the belief that the practice is a "good tradition".[47] Other reasons include religious requirement(s); rite of passage to womanhood; cleanliness; prevention of promiscuity among girls; preservation of virginity; better marriage prospects; enhancement of male sexuality; prevention of excessive clitoral growth; and facilitation of childbirth by widening the birth canal.[48]

50 percent of the women surveyed reported that they had at least one daughter who had gone through the procedure, while 38 percent intended to do so in the future. In addition, most of these women want their daughters to undergo the same type of procedure they had.[49]

- Most women who favor ending the practice also feel they do not have enough information to convince men of the harmful effects of FGM.[50] Men help continue the practice by refusing to marry women who have not had FGM or by allowing or paying for their daughters' procedures. DHS data indicate that, in general, women believe that their husbands' attitudes toward FGM are similar to their own.[51] However, recent studies in Eritrea and Sudan found that men may actually be less supportive and more indifferent than women toward this practice.[52]

More Women Are Using Medical Staff, But Traditional Practitioners Are Still Active

- FGM is still predominantly performed by "traditional" female circumcisers (91 percent in Côte d'Ivoire, 95 percent in Eritrea, and 88 percent in Mali).[53] Typically, it is performed with sharp stones, broken glass, scissors, or unsterilized razor blades without anesthesia.[54]
- Health providers (such as doctors, nurses, and midwives) are increasingly performing FGM. In Egypt, girls are three times more likely (54.8 percent) to have FGM done by health providers than did their mothers (17.3 percent).[55] Although this trend might reduce the pain and/or the risk of infection, it will not prevent the other complications.

Attitudes Are Gradually Changing

- FGM prevalence rates are slowly declining in some countries, as indicated by lower prevalence rates among adolescents (compared to older women). In Kenya, a 1991 survey showed that 78 percent of adolescents had undergone FGM, compared to 100 percent of women over 50.[56] In the Sudan, another study revealed that the prevalence among 15- to 49-year-old women dropped from 99 percent in 1981 to 89 percent in 1990.[57]
- People are choosing less severe forms of FGM. A 1991 study in Kenya showed that 62.3 percent of women over age 50 had Type II FGM, while only 38.9 percent of the 15-19 age group underwent the same type (most of the remainder underwent Type I).[58] A 1981 Sudanese survey of women – 94 percent of whom had undergone FGM — reported Type III FGM among 94 percent of the respondents' mothers, 83 percent of the respondents themselves, and only 51 percent of their daughters.[59]
- Attitudes are also following this pattern of slow change. Eighty-two percent of 15- to 44-year-old women participating in a 1981 Sudanese study supported FGM. Almost a decade later, in 1989-90, only 78 percent favored its continuation.[60] Considering how deeply engrained the

practice is in the social fabric, this 4 percent change of attitude is significant. A recent study found that about 4 out of 10 Eritreans want to see FGM discontinued.[61] In Sierra Leone, survey respondents who had learned of the health risks associated with the practice generally favored modifying FGM to make it less painful or dangerous, or abolishing it altogether. Of those with college, university, or postgraduate education, 79 percent favored ending the practice.[62]

- Recent research in Kenya reveals numerous reasons for a decline in FGM. For example, secondary education is associated with a four-fold increase in disapproval of FGM. Other reasons include: girls' refusal; greater access to health education; modernization with its resulting changes in lifestyle; fear of anti-FGM laws; public ridicule; and realization that FGM has no effect on girls' behavior.[63]
- Among women who are against FGM, the main reasons given are medical complications and pain. Other reasons include: it is seen as a negative tradition; it counters religious belief; it prevents sexual satisfaction; and it diminishes a woman's dignity.[64]
- Djibouti and Sudan restrict types of FGM, which has legitimized the practice and has led to medicalization instead of eradication.[65] In some countries, FGM is available under more sterile conditions involving less "cutting", in an effort to lessen the immediate health complications. WHO, and many other agencies including PATH, however, oppose the modification of FGM and call for its complete eradication on the grounds that all FGM threatens the mental, physical, and psychological health of women and girls and violate human rights standards.

Global Efforts to Stop FGM Are Increasing

Programs

- In more than 20 African countries, the Inter-African Committee on Traditional Practices (IAC) with the collaboration of local non-governmental organizations (NGOs) has launched an extensive educational campaign aimed at eliminating FGM. Women in Egypt and Sudan recommended education as the best means to end this practice.[66]
- Various African NGOs are involved in research and eradication campaigns. These include The Comite National de Lutte contre la Pratique de l'Excision in Burkina Faso, the National Association of Nigerian Nurses and Midwives, the Maendeleo Ya Wanawake Organization in Kenya, the National Research Network in Senegal, the National Union of Eritrean Youth, and the Seventh Day Adventist Church in Kenya.
- Technical assistance, advocacy, and funding are being provided by various national and international development agencies such as PATH (Program for Appropriate Technology in Health), RAINB ♀ (Research, Action, and Information Network for Bodily Integrity of Women), Equality Now, the Centre for Development and Population Activities (CEDPA), Population Council, Wallace Global Fund, and Women's International Network.
- Education about the harmful effects of FGM and its illegality is provided to African immigrants in Australia, Canada, France, Holland, Norway, Sweden, the United Kingdom, and the United States.
- United Nations agencies (UNICEF, UNFPA, and WHO) issued a joint position paper and are increasing their efforts to eradicate FGM. WHO recently launched a 15-year strategy to accelerate these efforts.
- The United States Agency for International Development (USAID), recently reviewed its FGM programming and increased its support for FGM eradication programs by working with technical agencies such as PATH, RAINB ♀, International Center for Research on Women, CEDPA, The Focus Project, and the Population Council.

> ***"...if it were possible for me to wave a wand and stop female circumcision, I [would] have done it a long time ago because I know it is not safe for our women..."***
>
> **Community Leader, Rivers State, Nigeria**

Human Rights Efforts

FGM violates human rights conventions that protect women and children from cruelty and violence and ensure them "bodily integrity" and access to health care, education, and self-realization.[67] Some of these conventions are:

- The Universal Declaration of Human Rights (1948)
- The United Nations Convention on the Rights of the Child (1959)
- The African Charter on Rights and Welfare of the Child (1990)
- The United Nations Convention on the Elimination of All Forms of Discrimination Against Women (1992)
- The United Nations Declaration on Violence Against Women (1993)

- The World Conference on Human Rights, Declaration and Programme of Action, Vienna (1993)
- The United Nations High Commission on Refugees, Statement Against Gender-Based Violence (1996).

FGM eradication has also been included in resolutions and action plans at various international conferences, including the 1994 International Conference on Population and Development and the 1995 U.N. Fourth World Conference on Women. FGM is recognized as a human rights violation in the U.S. State Department's annual country reports.

Policy and Legislation

- Countries with laws or regulations against FGM include Burkina Faso, Central African Republic, Djibouti, Ghana, Great Britain, Guinea, Sudan, Sweden, and the United States.[68]
- Existing laws against assault and child abuse cover FGM in Canada, France, and the United Kingdom.[69]
- Governments that support FGM eradication include Benin, Burkina Faso, Cameroon, Central African Republic, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Niger, Senegal, Sudan, Tanzania, Togo, and Uganda.[70]

The U.S. Congress Passed Legislation Against FGM

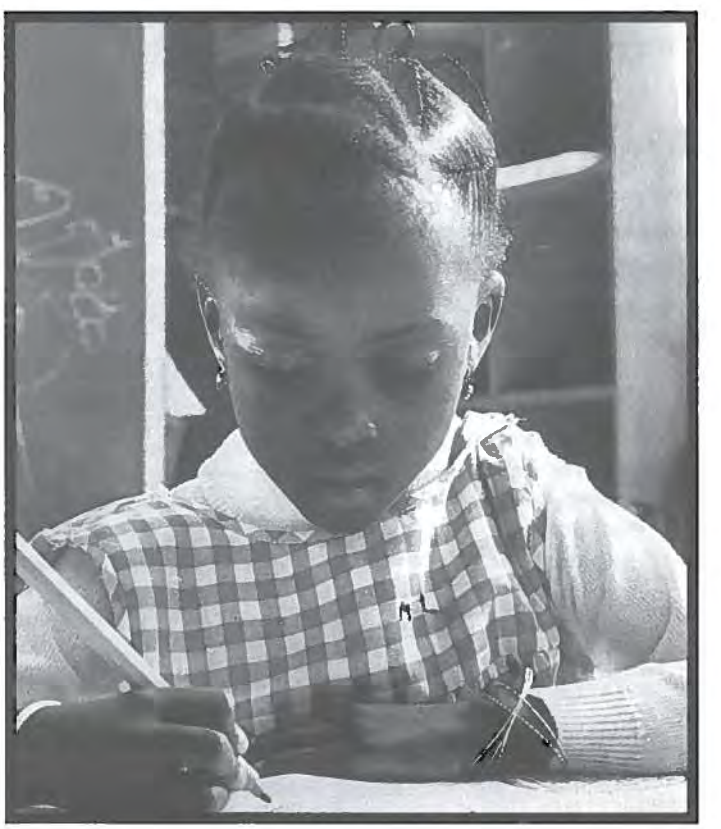
- The practice of FGM on person(s) under the age of 18 is now a federal crime, unless the procedure is necessary to protect a young person's health. The penalty for violating this law is a fine, imprisonment for up to five years, or both.[71]
- Congress has directed the Department of Health and Human Services to undertake several FGM-related interventions. These include compiling data on the extent of FGM in the United States, engaging in education and outreach activities to relevant communities, and developing recommendations for medical and osteopathic students on FGM and its complications.[72]
- The U.S. Immigration and Naturalization Service must provide information on the harmful effects of FGM as well as on the legal consequences of FGM under criminal or child protection statutes to all aliens issued U.S. visas.[73]
- Congress enacted legislation requiring U.S. executive directors of international financial institutions to actively oppose non-humanitarian loans to countries that have not taken measures to prevent FGM.[74]
- Since 1994, seven states (California, Delaware, Minnesota, North Dakota, Rhode Island, Tennessee, and Wisconsin) passed legislation against the practice of FGM. Legislation is pending in Colorado, New Jersey, New York, and Oregon.[75]

"If the government can prove to us that our children will not die if their mothers are not circumcised, then we will accept it."

Abua Chief, Rivers State, Nigeria

What You Can Do

- You now have a lot of facts about FGM.
- Contact PATH or other organizations working on this issue for more information and to learn how you can support specific FGM eradication efforts.



References

1 World Health Organization. (1995). "Female Genital Mutilation: Report of a WHO Technical Working Group". Geneva: World Health Organization; pp. 9.

2 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink; pp. 9.

3 Ibid., pp. 5.

4 Demographic and Health Survey - Egypt. (1995). Calverton, MD: Macro International Inc. pp.175.

5 Hosken, F. (1993). The Hosken Report: Genital and Sexual Mutilation of Females, fourth edition. Lexington, MA: Women's International Network; pp. 35.

6 Ibid.

7 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink; pp. 42.

8 Demographic and Health Survey - Egypt. (1995). Calverton, MD: Macro International Inc. pp. 171.

9 Demographic and Health Survey - Eritrea. (1995). Calverton, MD: Macro International Inc. pp. 166.

10 Demographic and Health Survey - Mali. (1995). Calverton, MD: Macro International Inc. pp. 186.

11 Demographic and Health Survey - Sudan. (1989-1990). Calverton, MD: Macro International Inc. pp. 118.

12 Demographic and Health Survey - Central African Republic. (1995). Calverton, MD: Macro International Inc. pp. 201.

13 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink; pp. 44.

14 Ibid., pp. 21.

15 Ibid., pp. 11.

16 Hosken, F. (1993). The Hosken Report: Genital and Sexual Mutilation of Females, fourth edition. Lexington, MA: Women's International Network; pp. 3.

17 Ibid., pp. 37.

18 Women's Policy, Inc. (July 12, 1996). "Female Genital Mutilation". *Women's Health Equity Act of 1996: Legislative Summary and Overview*. Women's Policy, Inc. pp. 48.

19 "Female Genital Cutting: Findings from the Demographic and Health Surveys Program". (1997). Calverton, MD: Macto International Inc. pp. 39.

20 Ibid.

21 Koso-Thomas, O. (1987). The Circumcision of Women: A Strategy for Eradication. London: Dotesios Ltd.; pp. 29.

22 Koso-Thomas, O. (1987). The Circumcision of Women: A Strategy for Eradication. London: Dotesios Ltd.; pp. 54.

23 Maendeleo Ya Wanawake Organization and the Program for Appropriate Technology in Health. (1993). "Quantitative Research Report on Female Circumcision in Four Districts in Kenya". Nairobi: Maendeleo Ya Wanawake Organization.

24 Hosken, F. (1993). The Hosken Report: Genital and Sexual Mutilation of Females, fourth edition. Lexington, MA: Women's International Network. pp. 253.

25 Institute for Development Training. (1986). "Health Effects of Female Circumcision: A Training Course in Women's Health". Chapel Hill, NC: Institute for Development Training; pp. 15.

26 Rushwan, H. (1996). "Female Genital Mutilation: Overview and Framework for the Integration of Activities into UNFPA Three Core Program Areas". Unpublished working paper for UNFPA technical consultation on female genital mutilation; pp.9.

27 Ministry of Health - Somalia. (1985). Fertility and Family Planning in Urban Somalia 1983. Somalia: Westinghouse Public Applied Systems; pp. 95.

28 Rushwan, H. (1996). "Female Genital Mutilation: Overview and Framework for the Integration of Activities into UNFPA Three Core Program Areas". Unpublished working paper for UNFPA technical consultation on female genital mutilation; pp. 10.

29 World Health Organization. (1993). "Female Genital Mutilation: World Health Assembly Calls for Elimination of Harmful Traditional Practices". Press Release. Geneva: World Health Organization; pp.1.

30 Koso-Thomas, O. (1987). The Circumcision of Women: A Strategy for Eradication. London: Dotesios Ltd.; pp. 27.

31 Warsame, Mohamed. (1989). "Medical and Social Aspects of Female Circumcision in Somalia," in Female Circumcision: Strategies To Bring About Change by the Italian Association for Women in Development and the Somali Women's Democratic Organization. Rome: The Italian Association for Women in Development; pp. 97.

32 World Health Organization. (1986). "A Traditional Practice that Threatens Health: Female Circumcision". *WHO Chronicle*. Vol. 40 (1): pp. 31-36

33 Koso-Thomas, O. (1987). The Circumcision of Women: A Strategy for Eradication. London: Dotesios Ltd.; pp. 27-28.

34 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink; pp. 19.

35 Ibid., pp. 13.

36 Koso-Thomas, O. (1987). The Circumcision of Women: A Strategy for Eradication. London: Dotesios Ltd.; pp. 29.

37 Hosken, F. (1993). The Hosken Report: Genital and Sexual Mutilation of Females, fourth edition. Lexington, MA: Women's International Network; pp. 48.

38 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink.; pp. 17.

39 Rushwan, H. (1996). "Female Genital Mutilation: Overview and Framework for the Integration of Activities into UNFPA Three Core Program Areas". Unpublished working paper for UNFPA technical consultation on female genital mutilation; pp. 10.

40 Dareer, A. (1981). "An Epidemiological Study of Female Circumcision in the Sudan". Khartoum, Sudan: University of Khartoum; pp. 81.

41 Hosken, F. (1993). The Hosken Report: Genital and Sexual Mutilation of Females, fourth edition. Lexington, MA: Women's International Network; pp. 39-40.

42 Koso-Thomas, O. (1987). The Circumcision of Women: A Strategy for Eradication. London: Dotesios Ltd.; pp. 57.

43 Program for Appropriate Technology in Health and Seventh Day Adventist-Rural Health Services. (1996). "Qualitative Research Report on Health Workers' Knowledge and Attitudes About Female Circumcision in Nyamira District, Kenya". Nairobi: PATH; pp. 8.

44 Demographic and Health Survey - Egypt. (1995). Calverton, MD: Macro International Inc. pp. 182.

45 Kheir, H.M., Kumar, S. and Cross, A. "Female Circumcision: Attitudes and Practices in Sudan". pp. 7.

46 Demographic and Health Survey, Sudan. (1989/90). Calverton, MD: Macro International Inc. pp. 121.

47 Demographic and Health Survey – Egypt. (1995). Calverton, MD: Macro International Inc. pp. 173.

48 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink; pp. 21.

49 Demographic and Health Survey - Egypt. (1995). Calverton, MD: Macro International Inc. pp. 173.

50 Maendeleo Ya Wanawake Organization and the Program for Appropriate Technology in Health. (1991). "Qualitative Research Report on Female Circumcision in Four Districts in Kenya". Nairobi: Maendeleo Ya Wanawake Organization; pp. 10.
51 Demographic and Health Survey - Sudan. (1989-1990). Calverton, MD: Macro International Inc. pp. 124.
52 "Female Genital Cutting: Findings from the Demographic and Health Surveys Program". (1997). Calverton, MD: Macto International Inc. pp. 9.
53 Ibid., pp. 37.
54 Hosken, F. (1993). The Hosken Report: Genital and Sexual Mutilation of Females, fourth edition. Lexington, MA: Women's International Network;
pp. 3.
55 Demographic and Health Survey - Egypt. (1995). Calverton, MD: Macro International Inc. pp. 176.
56 Maendeleo Ya Wanawake Organization and the Program for Appropriate Technology in Health. (1991). "Qualitative Research Report on Female Circumcision in Four Districts in Kenya". Nairobi: Maendeleo Ya Wanawake Organization; pp. 18.
57 Kheir, H.M., Kumar, S. and Cross, A. *Female Circumcision: Attitudes and Practices in Sudan*. pp. 5.
58 Maendeleo Ya Wanawake Organization and the Program for Appropriate Technology in Health. (1991). "Qualitative Research Report on Female Circumcision in Four Districts in Kenya". Nairobi: Maendeleo Ya Wanawake Organization; pp. 18.
59 Kheir, H.M., Kumar, S. and Cross, A. "Female Circumcision: Attitudes and Practices in Sudan". pp. 15.
60 Ibid., pp. 7.
61 "Female Genital Cutting: Findings from the Demographic and Health Surveys Program". (1997). Calverton, MD: Macto International Inc. pp. 7.
62 Koso-Thomas, O. (1987). The Circumcision of Women: A Strategy for Eradication. London: Dotesios Ltd.; pp. 57.
63 Njeru, E. and the Program for Appropriate Technology in Health. (1996). "Female Circumcision in Nyeri, Embu and Machakos Districts of Kenya: Report on Key Informant Interviews". Nairobi: Program for Appropriate Technology in Health; pp. 42-43.
64 Demographic and Health Survey - Egypt. (1995). Calverton, MD: Macro International Inc. pp. 172.
65 Kiragu, K. (1995). "Female Genital Mutilation: A Reproductive Health Concern". *Population Reports Supplement*. Baltimore, MD: John Hopkins Population Information Program; pp. 3.
66 "Female Genital Cutting: Findings from the Demographic and Health Surveys Program". (1997). Calverton, MD: Macto International Inc. pp. 9.
67 Ministry of Foreign Affairs - Danida. (1995). "Report from the Seminar on Female Genital Mutilation". Copenhagen: Axel Nielsen & Son; pp. 17.
68 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink; pp. 44.
69 Kiragu, K. (1995). "Female Genital Mutilation: A Reproductive Health Concern". *Population Reports Supplement*. Baltimore, MD: John Hopkins Population Information Program; pp. 4.
70 Toubia, N. (1993). Female Genital Mutilation: A Call for Global Action. New York: Women, Ink; pp. 44.
71 Congressional Record -House. (September 28, 1996). H11829 / SEC. 645. Criminalization of Female Genital Mutilation.
72 Center for Reproductive Law and Policy. (1997). "Legislation on Female Genital Mutilation in the United States". New York, NY: In Focus. pp. 5.
73 Ibid.
74 Ibid.
75 Center for Reproductive Law and Policy. (1997). "Legislation on Female Genital Mutilation in the United States". New York, NY: In Focus. pp. 4-7.

For further information, contact:

PATH
(Program for Appropriate Technology in Health)
1990 M Street, N.W., Suite 700
Washington, D.C., 20036
Tel: (202) 822-0033 Fax: (202) 457-1466
World Wide Web: http://www.path.org

Funding for this publication was provided by The Wallace Global Fund.

Cover photo was provided by Dr. Asha Mohamud.
Photo p.6 was provided by PAHO/WHO.

December 1997