

Report on Female Genital Mutilation as required by
Conference Report (H. Rept. 106-997) to Public Law 106-429
(Foreign Operations, Export Financing,
and Related Programs Appropriations Act, 2001)

PREVALENCE OF THE PRACTICE OF FEMALE GENITAL MUTILATION (FGM); LAWS PROHIBITING
FGM AND THEIR ENFORCEMENT; RECOMMENDATIONS ON HOW TO BEST WORK TO ELIMINATE
FGM

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The Conference Report (H. Rept. 106-997) to the Foreign Operations, Export Financing, and Related Programs Appropriations Act, Fiscal Year 2001 (P.L. 106-429) requires the Secretary of State to report to the House and Senate Committees on Appropriations by March 1, 2001 on the prevalence of the practice of female genital mutilation (FGM) and the existence and enforcement of laws prohibiting this practice, along with recommendations on how the United States government can best work to eliminate this practice.

The State Department has, over the past several years, obtained information on the practice of FGM from U.S. Embassies in countries where it is commonly practiced. The report that follows, prepared by the Office of the Senior Coordinator for International Women's Issues, includes much of this information.

The report also provides general background information on FGM, as well as on what the U.S. Government is doing to help eliminate this practice. In addition to the laws criminalizing FGM in countries where it is commonly practiced, the report also includes information on the laws of countries where immigrants who traditionally practice FGM have frequently settled. Finally, the report includes recommendations on how the U.S. Government can best continue its efforts to help eliminate this practice.

At the end of this report is a chart summarizing the estimated prevalence of FGM in countries where it is commonly practiced. The chart also shows the type of FGM practiced, the ethnic groups or areas that practice it and the presence or absence of legislation outlawing it. The chart further lists the outreach groups working to inform and educate the public about the harmful health effects of the practice with the ultimate goal of eradication.

BACKGROUND

The United States views female genital mutilation (FGM), also known as female circumcision (FC) and female genital cutting (FGC), as a harmful traditional practice. FGM threatens the health and violates the human rights of women. It also hinders economic and social development. It can have serious health consequences, leading to life-long pain and suffering or, at times, even death.

In countries where it is practiced, FGM affects a segment of the population that is critical for development, economic growth and prosperity. These development and health implications and concern over the violation of basic human rights make FGM a matter of pressing concern. FGM is also an important reproductive health issue, but it must be approached with clear understanding of the cultural context in which it is practiced.

The origins of this practice are unknown. It existed before the beginning of Christianity and Islam. It is not required by the Quran or the Bible. It crosses religious lines. It also crosses ethnic and cultural lines and is performed in many countries around the world, but is most prevalent in Africa. Estimates of the number of females who have been subjected to this practice range from 115 million to 130 million worldwide and an estimated two million girls are at risk each year.

FGM PROCEDURES

There are several types of female genital mutilation. The following is based on the World Health Organization (WHO) typology.

- 1. Type I (commonly referred to as clitoridectomy):** Excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.
- 2. Type II (commonly referred to as excision):** Excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips). This is the most widely practiced form.
- 3. Type III (commonly referred to as infibulation):** Excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood.
- 4. Type IV (Unclassified):**
 - Pricking, piercing or incision of the clitoris and/or labia.
 - Stretching the clitoris and/or labia.
 - Cauterization by burning of the clitoris and surrounding tissues.
 - Scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina.
 - Introduction of corrosive substances into the vagina to cause bleeding, or introduction of herbs into the vagina to tighten or narrow the vagina.
 - Any other procedure that falls under the definition of female genital mutilation.

In Type III, the girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue. In some communities where no stitching is used, adhesive substances including sugar, eggs, and in rare cases, even animal excreta are sometimes placed on the wound to allow it to heal. Overall, approximately 15 percent of women who have experienced FGM undergo this form. However, where it is practiced, it sometimes affects 90 to 100 percent of the women.

In cultures where FGM is practiced, it is usually practiced/performed by a traditional practitioner with a variety of crude instruments and without anesthetic. Among the more affluent sectors of society, it may be performed in a health care setting by qualified health personnel. When this is done, it is referred to as "medicalization." (Medicalization of the practice has been resisted by a number of outreach groups, as well as WHO, on the grounds that it might help to ingrain and legitimize the practice. They prefer to outlaw it altogether.)

Depending on the country and specific group involved, a variety of instruments, usually crude ones such as special knives and even sharp stones are used to perform this procedure. Razors are commonly used as well as scissors. If performed in a hospital or health clinic, regular surgical equipment is used.

In villages, instruments used to perform the procedure are usually not sterile. Often many girls are operated on during a single ritual ceremony. In these cases the same razor or knife is commonly used on a number of girls.

The practice is generally performed upon girls between the ages of four and 12, although it is practiced in some cultures as early as a few days after birth or as late as immediately prior to marriage, during pregnancy or after the first birth. There is a progressive decrease in the age at which girls are undergoing the practice.

FGM can have devastating and harmful consequences for a woman throughout her life. The health problems a girl can experience depend a great deal on the severity of the procedure, the sanitary conditions in which it was performed, the competence of the person who performed it and the strength of the girl's resistance. Old women and barbers who perform FGM are medically unqualified and can do

extreme damage to a woman or a girl, sometimes resulting in death. In cases where the procedure is carried out in unsanitary conditions and unsterile equipment is used, the dangers of infection are great. When it is performed in the sanitary conditions of a hospital by qualified personnel risk of infection may be reduced, but the long-term consequences remain.

Examples of short-term consequences include:

1. bleeding (often hemorrhaging from rupture of the blood vessels of the clitoris);
2. post-operative shock;
3. damage to other organs resulting from lack of surgical expertise of the person performing the procedure and the violence of the resistance of the patient when anesthesia is not used;
4. infections, including tetanus and septicemia, because of the use of unsterilized or poorly disinfected equipment;
5. urine retention caused by swelling and inflammation;
6. severe bleeding sometimes leading to death.

Examples of long-term consequences include:

1. chronic infections of the bladder and vagina. In Type III, the urine and menstrual blood can only leave the body drop by drop; the build up inside the abdomen and fluid retention often cause infections and inflammation that can lead to infertility;
2. dysmenorrhoea, or extremely painful menstruation;
3. excessive scar tissue at the site of the operation;
4. formation of cysts on the stitch line;
5. child birth obstruction, which can result in the development of fistulas; tearing in the vaginal and/or bladder wall; and chronic incontinence;
6. risk of HIV infection. (There is a growing speculation of a potential risk of HIV/AIDS associated with the procedure, especially when the same unsterile instruments are used on multiple girls. This, however, has yet to be scientifically proven.)

Reinfibulation must be performed each time a child is born. When infibulation (Type III) is performed, the small opening left in the genital area is too small for the head of a baby to pass through. Failure to reopen this area can lead to death or brain damage of the baby and death of the mother. The excisor must reopen the mother and restitch her again after the birth. In most ethnic groups the woman is restitched as before with the same tiny opening. In other ethnic groups the opening is left only slightly larger to reduce painful intercourse. (In most cases, not only must the woman be reopened for each childbirth, but also on her wedding night when the excisor may have to be called in to open her so she can consummate the marriage.)

Scientific studies are needed on the precise psychological effects of FGM on a girl or woman. However, changes have been observed in some girls who have been subjected to the procedure. Nightmares, depression, shock, passivity, feelings of betrayal are not uncommon among these girls.

PREVALENCE OF FGM

FGM is most associated with Africa where it is practiced in varying degrees in over half of the Sub-Saharan African countries. It also occurs in some Middle Eastern countries: Egypt, the Republic of Yemen (primarily coastal areas), Oman (in limited numbers throughout Oman but more widespread in the southern coastal region), Saudi Arabia (among a few immigrant women and among some Bedouin tribes and residents of the Hejaz) and Israel (among a very small number of women in a few Bedouin groups in the south). It also occurs in some Muslim groups in Indonesia where the most common form is a symbolic pricking, scraping or touching of the clitoris. It is reported by medical professionals to be practiced by a very small number of Malay Muslims in rural areas in Malaysia where it resembles a symbolic prick, a tiny ritual cut to the clitoris or where the blade is simply brought close to the clitoris. It also occurs to a very small extent among the Bohra Muslims in the largest cities of Sindh and Punjab provinces in Pakistan. Because the incidence is believed to be so small or information is not available, this report does not further discuss Malaysia, Oman, Saudi Arabia, Israel or Pakistan.

Some immigrants practice various forms of FGM in other parts of the world, including countries in Europe, the United States, Canada, New Zealand and Australia. Many of these countries have enacted laws banning the practice. (See section on Laws in Countries where Immigrants from Countries Practicing FGM now Reside.)

Exact figures of the number of women and girls who have undergone this procedure are not available, except in Uganda, largely because the cultural role of women in these countries inhibits public discussion or opposition to the practice. The following percentages are from studies and surveys that represent estimates of the percentage of women and girls in the country who have undergone the procedure; some figures may be based on anecdotal evidence. More specific information by ethnic groups and areas can be found in the chart at the end of this report.

<u>Country</u>	<u>Prevalence</u>
Benin	30-50 percent (Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) 1992 survey is 30%. WHO estimates 50%.)
Burkina Faso	71.6 percent (1999 Demographic and Health Survey of 6,445 women nationally)
Cameroon	Less than 5-20 percent (various estimates)
Central African Republic	43.4 percent (1995 Demographic and Health Survey of 5,884 women nationally)
Chad	60 percent (1995 UN report)
Cote d'Ivoire	44.5 percent (1999 Demographic and Health Survey of 3,040 women nationally)
Democratic Republic of the Congo	5 percent (various estimates)
Djibouti	90-98 percent (various estimates)
Egypt	78-97 percent (2000 Demographic and Health Survey of 15,648 women nation-wide. 97 percent of ever married women aged 15-49. 78 percent among daughters of women surveyed aged 11-19.)
Eritrea	90 percent (1997 Demographic and Health Survey of 5,054 women nationally)
Ethiopia	72.7 percent (1997 survey by National Committee on Traditional Practices in Ethiopia)
Gambia	60-90 percent (various estimates. Foundation for Research on Women's Health, Productivity and the Environment (BAFFROW) reports 7 of 9 ethnic groups practice FGM.)
Ghana	9-15 percent (1998 estimate by Gender Studies and Human Rights Documentation Center is 15 percent. Recent Rural Help Integrated study estimates 9-12 percent of women nationwide.)
Guinea	98.6 percent (1999 Demographic and Health Survey of 6,753 women nationally)
Guinea-Bissau	50 percent (various estimates)
Indonesia	No national figures available yet to know extent of the practice.

Kenya	37.6 percent (1998 Demographic and Health Survey of 7,881 women nationally)
Liberia	10-50 percent (various estimates)
Mali	93.7 percent (USAID funded 1999 Demographic and Health Survey of 9,704 women aged 15-49. Commission for the Promotion of Women estimates 96 percent rural and 92 percent urban.)
Mauritania	25 percent (1997 Juene Afrique survey and 1996 UN Population Fund report)
Niger	4.5 percent (1998 Demographic and Health Survey of 7,577 women nationally)
Nigeria	25.1 percent (1999 Demographic and Health Survey of 8,206 women nationally)
Senegal	5-20 percent (1998 Environmental Development Action in the Third World study estimates 20 percent. Various other estimates range as low as 5 percent.)
Sierra Leone	80-90 percent (various estimates)
Somalia	90-98 percent (UNICEF estimates 90 percent. Other estimates are 96-98 percent.)
Sudan (northern)	89 percent (1991 Demographic and Health Survey of 5,860 women in northern Sudan.) 87 percent urban and 91 percent rural women according to survey conducted from 1996 to April 2000 by Sudan National Committee on Traditional Practices and Save the Children Sweden.)
Tanzania	17.9 percent (1996 Demographic and Health Survey of 8,120 women nationally. 2.9 percent in Mtwara to 81.4 percent in Arusha according to a 1999 report by the Tanzanian Legal and Human Rights Center.)
Togo	12 percent average (Ethnic groups vary from Gourma-12 percent to Cotocoli, Tchamba, Mossi, Yanga and Peul-85 to 98 percent according to U.S. funded 1996 research carried out by the Demographic Research Unit of Togo's University of Benin. Two of largest groups do not practice FGM. They are the Adja-Ewe and the Akposso-Akebou.)
Uganda	Less than 5 percent. Number of girls undergoing FGM in 1990-971 girls; 1992-903 girls; 1994-854

girls; 1996-544 girls; 1998-965 girls; 2000-742 girls.

Yemen

23 percent of women who have ever been married (USAID funded 1997 Demographic and Maternal and Child Health Survey)

COUNTRY-SPECIFIC RESPONSES

Most, if not all countries where FGM is practiced, have outreach groups within the country working to eliminate the practice. Some have active support from the government. Generally, the emphasis of many of these groups is to inform and educate the populace, both male and female, about the damages caused by the practice and the effect it can have on a woman's health. This is often done through mass media, seminars, classes, etc.

There are numerous national and international non-governmental organizations (NGOs) present in countries where FGM is commonly practiced that either sponsor programs or work directly to eliminate this practice. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), for example, has national committees in at least 26 African countries. These committees encourage governments to adopt clear national policies to abolish this practice. The committees are also working to provide information to the public about the harmful effects the practice has on the health of women and girls and urge its eradication. They aim at the grassroots level of women and men, community and religious leaders, community health and social workers, traditional birth attendants and traditional healers, students and youth organizations, policy makers and government officials. WHO also works in a number of countries on programs to eradicate this practice.

In The Gambia, the NGO, The Foundation for Research on Women's Health, Productivity and the Environment (BAFFROW), has initiated an alternative rite of passage program to eliminate FGM. It developed a comprehensive curriculum tailored to each ethnic group's social rites and customs but it focuses on "initiation without mutilation." In Kenya, the NGO MYWO (Maendeleo Ya Wanawake Organization) likewise has developed a non-cutting alternative rite of passage.

A successful program in Senegal utilizes skills training modules, including public health and women's health skills training modules, to provide information about the health effects of the practice while initially avoiding direct discussion of whether it is right or wrong. As a result of these courses, 174 villages have abandoned the practice.

Many other countries, including Egypt, Mali, Kenya and Burkina Faso also have success stories.

THE INTERNATIONAL RESPONSE

A number of international organizations and conferences have highlighted the dangers of FGM and declared support for efforts to eradicate the practice. The UN's Fourth World Conference on Women in Beijing, China in September 1995, recognized FGM as a harmful traditional practice against women and girls and called for action by governments and other organizations to eliminate it. The International Conference on Population and Development held in Cairo in September 1994 condemned FGM as a harmful practice and urged governments to prohibit the practice and to give vigorous support to efforts among NGOs and religious institutions to eliminate the practice. The World Conference on Human Rights in Vienna in 1993 addressed FGM as a violation of women's rights. Legal and human rights organizations are now including information on FGM in their training programs on women's rights and the law is being used to combat this harmful practice.

The World Health Organization (WHO) has assured governments of its readiness to support national efforts against FGM, as well as continuing research and distribution of information about it. WHO has consistently maintained that this practice must not be institutionalized (medicalized). No form should be practiced by any health professional in any setting, including hospitals and other health establishments. (This prohibition would not extend, of course, to provision of health-care services to those suffering as a result of FGM.)

Over the years, WHO's governing bodies have adopted several resolutions urging Member States to establish clear national policies to end FGM and requesting WHO to strengthen its technical and other support to the countries concerned. The Organization is developing its activities in this area in a holistic way, bringing together the work of different programs to ensure integration into health and development initiatives and activities.

In 1995, a WHO technical working group meeting on FGM was convened in Geneva. One outcome was the WHO definition and classification of FGM that is currently being used internationally. WHO's Regional Office for Africa launched a 20-year regional plan of action for accelerating the elimination of FGM in countries of the region in March 1997. WHO also published a joint statement on FGM in collaboration with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) in April 1997. Since then, African countries have started preparing plans of action, using a multisectoral approach to eliminate FGM.

In 1990, the Organization of African Unity (OAU) adopted the African Charter on Rights and Welfare of the Child, which protects many of the rights ensured by the Convention on the Rights of the Child. A provision in Article XXI applies to social and cultural practices, requiring governments to take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child.

In June 1998, the Heads of State and Government at the meeting of the OAU in Burkina Faso endorsed the 1997 Addis Ababa Declaration on Violence Against Women which includes a call for the eradication of the practice of female genital mutilation. A Symposium for Religious Leaders and Medical Personnel on FGM as a Form of Violence was organized by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children of The Gambia (GAMCOTRAP). This resulted in the Banjul Declaration of July 22, 1998, which declared that the practice has neither Islamic nor Christian origins or justifications and condemned its continuation.

A number of countries around the world support programs to eliminate the practice of FGM in Africa. For example, the Netherlands provides support to the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). Germany assists health projects that include the goal of elimination of FGM in Kenya, Burkina Faso, Guinea, Senegal, Mali the Central African Republic and Mauritania. The Australian Agency for International Development has funded a number of NGOs that are actively campaigning to stop the practice of FGM in Africa. The Danish Development Agency supports programs in Burkina Faso and Sierra Leone.

U.S. GOVERNMENT POLICY

The U.S. Government views FGM as a harmful, traditional practice that threatens the health and human rights of women, and hinders development. The United States aims at the total elimination of FGM through a policy that includes education, empowerment of women, enforcement of laws and evaluation of existing programs.

U.S. DEPARTMENT OF STATE

The Department of State is responsible for coordinating U.S. Government policies on international women's issues and, working with USAID, promotes programs designed to reduce, and ultimately, eliminate FGM. The State Department has chaired an Interagency Working Group (IWG) that coordinates U.S. Government programs on FGM.

The IWG includes representatives from the U.S. Agency for International Development (USAID); the Department of Health and Human Services (DHHS); the Treasury Department; the Immigration and Naturalization Service (INS); and various offices and bureaus within the Department of State including the Office of the Senior Coordinator for International Women's Issues, the Bureau of African Affairs, the Bureau of Democracy, Human Rights and Labor, and the Office of Population of the Bureau of Population, Refugees and Migration, as well as a number of individual country offices. It meets periodically with representatives of NGOs that are involved with this issue.

The State Department has also sponsored programs in various countries aimed at combating FGM. The Democracy and Human Rights Fund (DHRF) has provided funds for projects that focus on FGM in a number of countries including:

- Chad – Implementation of a plan to counter FGM.
- Djibouti – Anti-FGM projects.
- Ethiopia – Media campaign to discourage the practice of FGM and forced child marriages.
- Ghana – Education on specific issues including FGM; workshops on the health hazards of FGM; setting up a community watchdog program to increase vigilance on FGM; re-training practitioners of FGM; workshops to educate police, teachers and women leaders about the law that makes FGM illegal, as well as about the health hazards of the practice; and research throughout Ghana to document prevalence of the practice.
- Senegal – Theater to combat the practice of FGM; education program on FGM in light of 1999 law criminalizing FGM.
- Somalia – Education project on harmful effects of FGM.
- Togo – Assistance to the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in its campaign against FGM.

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

Female genital mutilation (FGM), referred to by USAID as female genital cutting (FGC), is addressed under two of USAID's main goals: 1) stabilization of global population and protection of human health; and 2) building democracy.

While USAID supports host country legislation against the practice of FGM, it recognizes that successful elimination must end the demand for the practice. Entire communities must be involved in efforts to eliminate FGM to create an enabling environment for dramatic social change. USAID encourages local and national NGOs, women's groups, community leaders and religious organizations to adopt culturally appropriate activities and reach out to all stakeholders, including men and boys.

USAID supports FGM elimination activities in a number of African countries including Burkina Faso, Egypt, Eritrea, The Gambia, Ghana, Guinea, Kenya, Mali and Senegal. These activities include policy development and advocacy; development, testing and assessment of strategies to end FGM;

training of health care workers to enable them to manage the complications of FGM as well as to engage in outreach to their communities to reduce the demand for the practice; and the collection and dissemination of data on the prevalence and harmful consequences of FGM. Examples of these activities include:

- Policy development and advocacy in Mali.
- Development and testing of strategies to end FGM, including the adoption of alternative rites or "circumcision with words" ceremony in Kenya and the Positive Deviance Inquiry approach pioneered in Egypt where emphasis is placed on working in local communities to create positive images of uncircumcised women as a strategy for advocating for discontinuing the practice.
- Training health care providers about the long-term complications of FGM, and improving their ability to advocate against FGM and to counsel clients and educate communities about the harmful consequences of FGM.
- Data collection and dissemination of data on the prevalence and harmful consequences of FGM under the Demographic and Health Surveys Program (DHS) in nine countries in Sub-Saharan Africa, and in Egypt and Yemen.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

DHHS refers to this practice as female genital cutting or FGC. Under P.L. 104-134 (enacted April 26, 1996), DHHS was required to undertake a study of FGM or FGC in the United States to determine the population at risk. (42 U.S.C.A. 241 note)

Based on the 1990 U.S. Census, it estimated that there were approximately 168,000 girls and women (mostly from Africa) in this country who had been or were at risk of being subjected to FGM. Of these, 48,000 were under the age of 18. Forty-five percent of those who had been or were at risk of being subjected to this procedure lived in metropolitan areas of the United States.

DHHS was also required under this legislation to carry out educational outreach to affected communities. In 1997, DHHS held community consultation meetings in seven cities (Washington, DC, New York, Boston, San Diego, Houston, Atlanta and Chicago) to foster a dialogue between health care providers, immigrant service agencies and members of African immigrant communities.

As a result of these meetings, DHHS provided funds under a number of its existing refugee women's health and family programs to educate immigrants about the health effects of this practice. These efforts focus on immigrant communities across the U.S. including particularly those in Los Angeles, San Diego, Houston, New York and Boston.

Congress also required DHHS to develop and disseminate recommendations for students in medical and osteopathic schools. It sought to educate students and health professionals on FGM through the development and distribution of the technical manual, *Caring for Women With Circumcision*, which was developed in collaboration with the organization, RAINBO (Research, Action and Information Network for the Bodily Integrity of Women). The manual includes information on treating possible complications from this procedure, concerns during labor and delivery and suggestions for counseling women and girls on the issue. DHHS has distributed the manual to Schools of Nursing, Medicine, Social Work and Osteopathy and has made copies available to be ordered through the DHHS Office on Women's Health, National Women's Health Information Center (www.4woman.gov).

DHHS has also surveyed medical, nursing and social work schools and formed a Subcommittee on Health Professional Education. Through this Subcommittee, it is working on efforts to improve education about this subject among health professional students.

The Office of Refugee Resettlement at DHHS has funded several projects to improve the overall health and well being of Somali refugee families, which may indirectly impact the issue of FGM. Recipients of this funding interalia include the Somali Family Care Network in Virginia, the Bay Area Somali Consortium in California and the Somali Women's Association in Minnesota.

U.S. TREASURY DEPARTMENT

The Treasury Department has been working with the Multilateral Development Banks (MDBs) to address the practice of FGM. U.S. Executive Directors at the World Bank and the African Development Bank (AfDB) have been and will continue to advocate policies and programs aimed at changing the cultural practices that promote this practice. As a result of these efforts, the World Bank and the AfDB have developed programs to support grass roots efforts to combat this practice by supporting literacy campaigns, training and micro credit activities.

Specific World Bank FGM-related programs include a Poverty Assessment for Djibouti, financial support for legal and literacy programs in Togo, Mali and Mauritania, and health loans for Cote d'Ivoire and Eritrea. At the AfDB, FGM activities have been included in the Mali Poverty Alleviation project, the Senegal Poverty Alleviation project and the Mauritania Education project. The Treasury Department and the U.S. Executive Directors are continuing their advocacy work to raise awareness of this issue at the MDBs.

IMMIGRATION AND NATURALIZATION SERVICE (INS)

Section 644 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 requires INS, in cooperation with the Department of State, to provide information to visa applicants in countries where FGM is commonly practiced concerning the severe harm to health caused by FGM and the potential legal consequences in the United States for performing FGM or allowing a child under one's care to be subjected to it. (3 U.S.C.A. 1374)

Notices have been prepared in seven languages (English, French, Arabic, Swahili, Amharic, Somali and Portuguese) and were distributed to U.S. Embassies in countries where FGM is commonly practiced for distribution to visa applicants and for posting in visa waiting rooms at our Embassies.

In recent years there have been a number of asylum claims based on FGM. United States asylum law recognizes that forced female genital mutilation can be the basis for asylum. In 1996, INS advanced this position in the case of Matter of Kasinga. (21 I&N Dec. 357 [BIA 1996])

Additionally, on December 7, 2000 INS published a proposed rule that would codify interpretive principles that are key to the analysis of an FGM asylum claim. The rule proposes an analytical framework within which gender-related and other social group claims should be considered. Though applicable to all asylum and withholding cases, the proposed rule takes into account Department of Justice understanding of the circumstances surrounding persecution against women and clarifies interpretive issues that could impose barriers to gender-related claims. The proposed rule and supplemental information to the rule restates that gender can be the basis for membership in a particular social group.

The rule would also codify the Department of Justice's position that serious harm or suffering can amount to persecution, regardless of whether the persecutor intends to cause harm. This provision of the proposed rule would codify existing interpretations by both the Department of Justice and federal appellate courts, that a malignant intent on the part of the persecutor is not required. Under this proposed regulatory provision, FGM may constitute persecution regardless of a persecutor's ostensibly benign intent.

RECOMMENDATIONS

Background

The practice of FGM has been in existence for centuries and has deep cultural roots. It has been passed down from generation to generation. Many women and girls are unaware that it is not practiced universally by all women. When medical complications occur, they are not generally understood as having resulted from the practice of FGM.

For those who support FGM, it is considered a beneficial act. It renders a girl marriageable in societies where a woman's quality of life depends on her status as a wife and mother and a member of the community; it gives "respect" among peers to those women who do not marry. The procedure is perceived as an act of love to daughters that will ensure their full community recognition.

With this practice so firmly established in the local society, simply passing a law to prohibit it has little likelihood of success. When the majority of women of a country practice FGM, and have done so for generations, it is difficult for them to understand why it should be considered a crime. Stopping this practice thus involves radical cultural and social change. Such change requires long-term support involving education and comprehensive training at the field level, as well as legal reforms and programs that empower females.

In countries where FGM is commonly practiced, NGOs and many governments have been working for years to eradicate the practice. Education and information on the harmful health effects, as well as the human rights of women in general, are essential if this practice is to end. A comprehensive program which includes education, information and services regarding a full range of reproductive health issues, empowering women and helping countries enforce their laws is the best way to deal with reproductive issues, including FGM. The more knowledge the women, their husbands and the entire community have about the harmful effects of this practice, the more likely they will be to work to end it. It will be a community decision that is more likely to last.

Even in those countries that have passed laws against FGM and those that are in the process of passing such laws, education is necessary if these laws are to be effective and enforced. The public and those responsible for enforcement must be fully aware of the law and the reasons for it. In particular, the public must be aware of the harmful health effects of this practice.

There are success stories. Following the passage of the law criminalizing FGM in Cote d'Ivoire, the government and several NGOs launched an intensive campaign aimed at informing the population, law enforcement authorities and local government officials of the existence of the law and the negative impact of FGM on the health of women. As a result of the campaign, several excisors were arrested for performing this procedure.

In Senegal in 1991, the NGO Tostan (*breakthrough* in the Wolof language) began developing a non-formal education program for more than 450 villages. It emphasizes participation and empowerment of women and uses materials that draw on Senegalese culture and oral traditions. Instructional materials include games, small group discussion, theater, songs, dance, story telling and flip charts. Recognizing that women have other responsibilities in raising their families, the classes meet several times a week for two to three hours at a time. The drop out rate is almost nil. Classes are held in a number of villages, including villages whose residents frequently inter-marry. Modules for learning address such issues as literacy skills, problem solving, women's health and hygiene, management skills, leadership skills, negotiating skills and human rights. This program is currently being replicated in Sudan, Mali and Burkina Faso. A shortened version called the Village Empowerment Program, which uses those skills determined to be most important in the abandonment of FGM, problem solving, hygiene, women's health and human rights, is being implemented in a number of villages involving the entire village, both men and women.

At the outset, Tostan did not state whether FGM was right or wrong. It was the women themselves who, after taking the program, decided that they no longer wanted their daughters to be subjected to this practice. Using the skills learned in the program, they approached their husbands and

village leaders to engage the entire community to stop the practice. As of November 2000, the practice has been abandoned in 174 villages where women have participated in the Tostan program. This affects approximately 140,000 people.

These programs suggest that it is the women, men and leaders of the countries themselves who must bring about this cultural and social change. Governments and citizens of societies where FGM is practiced must take the initiative. It is clear, however, that outside support is often desired and helpful. The United States can best support eradication of FGM by providing financial aid and technical assistance.

Recommendations

U.S. policy remains based on the recognition that FGM is a serious health issue and an abuse of internationally recognized human rights standards. The U.S. Government approach towards FGM is part of a larger commitment to combat violence against women around the world and advance the status of women. The United States has joined international efforts to eradicate FGM through a strategy that rests on four pillars: education; the social, cultural, political and economic empowerment of women; enforcement of laws; and evaluation of programs. This policy recognizes that elimination of FGM is not simply a law enforcement issue, but also a profound cultural, social and economic issue. Programs aimed at eliminating FGM must therefore involve the entire community and be tailored to meet local conditions. Since limited funding is available, it is critical that these programs be carefully evaluated in order to ensure that the most successful strategies are adopted. Cooperation with other international donors and sharing of "best practices" among affected countries are also important elements in an effective overall strategy.

The following recommendations follow this four-pillar strategy.

1. EDUCATION

a) Support basic education programs for women and girls. This includes instruction drawn from local customs and oral tradition. Support efforts to keep young girls in school. Improve the status of women and girls as a valuable member of society.

b) Support education about sexually transmitted disease prevention and treatment, safe motherhood and sexual and gender-based violence prevention, which includes FGM.

c) Ensure that women and girls have access to information concerning the harmful health effects and risks to health posed by FGM. Provide health care and information pertaining to FGM including information about women's bodies, particularly sexual and reproductive health as well as the harmful effects of FGM such as infertility, pregnancy complications, fistulae and incontinence.

d) Support training for health care providers regarding the medical complications resulting from FGM, as well as the need to treat patients who have been subjected to this practice with sensitivity and understanding.

e) Support provision of health information, technical assistance and financial support to women and local women's organizations to empower them to oppose FGM.

f) Provide information about the harmful effects of FGM to members of the university community, particularly young men, who may be influential in changing social attitudes about this practice in the future.

g) Support regional and international initiatives to combat FGM, such as - conferences addressing FGM, model legislation, "best practices" in terms of programs that have successfully reduced the incidence of FGM and show the beneficial consequences of educating and empowering women and promoting women's human rights. Support the work of the UN Special Rapporteurs on violence against women and on traditional practices affecting the health of women and children.

h) Support and encourage intra-country, inter-country and regional sharing, dissemination and scaling up of "best practices" to end FGM.

i) Encourage UN agencies and other donors to work closely with local and technical organizations on FGM for greatest effectiveness on such a sensitive cultural issue.

j) Encourage, within countries where FGM is commonly practiced, governments to allow local NGOs and civil society groups to work freely at the grass roots level to bring about social change to eliminate FGM. In restrictive political conditions, no such work is possible.

k) Support networking among NGOs and grassroots organizations, as well as the testing of new models.

l) Support widespread public information media campaigns to educate all members of the community about the harmful effects of FGM. Efforts should be tailored to specific groups, including men, women, boys, girls, the elderly, religious leaders, community leaders and the practitioners who perform FGM.

2. EMPOWERMENT OF WOMEN

a) Support micro credit schemes for women.

b) Support job training for women.

c) Support training of former excisors in other occupations.

d) Support the provision of information on the human rights of women. Support women's right to bodily integrity.

e) Support efforts to increase women's participation in and access to decision-making in institutions of power and governance at local, national and international levels.

3. ENFORCEMENT OF FGM LAWS

a) Support host countries' efforts to draft, implement and enforce legislation pertaining to FGM.

b) Support dissemination of information about the law throughout the country in all local languages.

c) Support provision of graphic information about the law in those areas of the country with a high degree of illiteracy.

d) Include in any information campaign about the law, information on the harmful effects of FGM on a woman's health.

e) Support training for law enforcement officials, judges and lawyers about the law.

4. EVALUATION OF PROGRAMS

a) Support documentation, review and evaluation of approaches and programs for eliminating FGM to determine effectiveness.

b) Support development and testing of new approaches that focus on the "demand and supply" issues of FGM.

c) Support analysis of data on FGM prevalence through Demographic and Health Surveys.

d) Support cross-national analysis of data on FGM prevalence collected in Demographic and Health Surveys, as well as qualitative studies on the process leading to the decision to circumcise or not to circumcise a female child.

LAWS/ENFORCEMENT IN COUNTRIES WHERE FGM IS COMMONLY PRACTICED

A number of countries where FGM is commonly practiced have laws specifically prohibiting it. However, the quality of these laws and breadth of protection afforded by them varies from marginal (e.g. Togo) to good (e.g. Burkina Faso and Ghana). Some countries have laws that, while not specifically addressing FGM, could be used against this practice. The majority of countries, however, do not have any laws against FGM. (See chart at end of report, which also includes information about outreach programs in all the countries.) Nine of the countries discussed below have specific national laws against FGM. Some of the countries have passed laws against this practice at the state and local levels. Nigeria, while having no national law, has a number of state laws against the practice. Likewise, one administration in Somalia, Puntland, has passed a law against FGM. Egypt, while having no national law against the practice, has a ministerial decree banning the practice.

Even in those countries where laws do exist, however, there have been very few instances of adjudicated cases (and punishment of the excisors). Enforcement of laws regarding FGM is extremely lax in most countries or even non-existent. Furthermore, the cultural norms in these countries or regions often render women unwilling to step forward and discuss FGM (let alone seek protection or compensation under the law). The following country-specific discussions bear this out.

1. Burkina Faso

A law prohibiting FGM was enacted in 1996 and went into effect in February 1997. Even before this law, however, a presidential decree had set up the National Committee against excision and imposed fines on people guilty of excising girls and women. The new law includes stricter punishment.

Under the law, a person who performs FGM can receive a prison sentence of six months to three years and/or a fine of from 150,000 to 900,000 francs (approximately US\$240-1,440). If death follows, the prison sentence is five to ten years. Similar sentences are applicable to those who request, incite to FGM or promote it either by providing money, goods, moral support or all other means.

Penalties will be applied to the fullest extent of the law if the guilty party belongs to the medical or para-medical corps. The judge can additionally forbid the guilty party from practicing his or her profession for a maximum of five years.

The law imposes a fine of from 50,000 to 100,000 francs (approximately US\$80-160) on all persons who knew the criminal behavior was to take place and did not warn the proper authorities.

Since the adoption of this law, there have been 60 convictions of both excisors and accomplices, resulting in sentences of imprisonment or fines. Imprisonment for excisors has ranged from one to ten months. One excisor received a ten-month jail sentence for cutting two girls. Accomplices have also received prison terms. Both have received fines of from 10,000 to 50,000 francs (approximately US\$15-80). In a number of cases, prison sentences were suspended.

2. Central African Republic

In 1996, the President issued an Ordinance prohibiting FGM throughout the country. It has the force of national law. Any violation of the Ordinance is punishable by imprisonment of from one month and one day to two years and a fine of 5,100 to 100,000 francs (approximately US\$8-160). We are unaware of any arrests made under the law.

3. Cote d'Ivoire

A December 18, 1998 law provides that harm to the integrity of the genital organ of a woman by complete or partial removal, excision, desensitization or by any other procedure will, if harmful to a women's health, be punishable by imprisonment of one to five years and a fine of 360,000 to two million

francs (approximately US\$576-3,200). The penalty is five to twenty years incarceration if the victim dies and up to five years' prohibition of medical practice, if this procedure is carried out by a doctor.

Before the 1998 law was enacted, existing provisions of the Criminal Code could be used to prohibit this practice. However, despite laws on the books governing crimes against the person, there were no Ivoirian cases of women challenging the practice in court.

Before the adoption of the 1998 law, the possibility of enforcing a law at the village level where the practice is most likely to take place was almost nil. The powerful association of this practice with religion and witchcraft made reporting and prosecuting excisors virtually impossible. Furthermore, the government had no interest in imposing the existing laws on unwilling families and antagonizing village elders and chiefs who are the guardians of tradition. This has begun to change.

Following the adoption of the law in 1998, the government and the various NGOs and institutions fighting this practice gave themselves some time to pursue information and education campaigns before requesting the enforcement of the law. In 1999, the Ivoirian Association for the Defense of Women's Rights (AIDJ) launched an intensive campaign aimed at informing the population, law enforcement authorities and local government officials of the existence of the law.

The campaign gathered momentum when AIDF's president was appointed Minister of Family and the Promotion of Women in January 2000. During 2000, her Ministry and AIDF held several seminars in the regions where the practice is most prevalent, working primarily with police officers and gendarmes, administrative authorities (Prefects and Sub-Prefects), as well as traditional, political and religious authorities.

AIDF focused on information dissemination and enforcement of the new law. The Minister received additional support from the Ministries of Interior and Security. In addition to the formal seminars, the Minister used every opportunity, such as the inauguration of economic projects, to talk to women and local authorities about the negative impact on women of harmful traditional practices. The Minister also initiated a basic management training and small economic projects implementation program for excisors willing to abandon the practice. The first beneficiaries of this program were women from Bangolo in the west and women from Kaniasso in the north.

As a result of this campaign, several excisors were arrested for performing this procedure in the north during 2000. Prior to these arrests, the arrest and prosecution of parents or of excisors only occurred following the death of the excised person. Two excisors from Guinea were arrested in Abobo on May 6, 2000 and jailed following the death of a young Burkinabe girl who had been excised. On July 12, 2000, two Ivoirian women were arrested in Kongasso and jailed in Seguela, in the north, for having excised girls aged 10-14.

4. Djibouti

FGM was outlawed in the country's revised Penal Code that went into effect in April 1995. Article 333 of the Penal Code provides that persons found guilty of this practice will face a five year prison term and a fine of one million Djibouti francs (approximately US\$5,600).

Enforcement to date is quite another matter. The UNFD (Union Nationale des Femmes de Djibouti) is aware of only one case in which a young woman had to be hospitalized after undergoing the operation where the "midwife" who performed the operation was given "counsel". She was advised not to continue her practice. Apparently, no formal charges were brought.

5. Egypt

There is no law in Egypt specifically against FGM. There are provisions under the Penal Code involving "wounding" and "intentional infliction of harm leading to death", however, that might be applicable. There have been some press reports on the prosecution of at least 13 individuals under the

Penal Code, including doctors, midwives and barbers, accused of performing FGM that resulted in hemorrhage, shock and death.

There also is a ministerial decree prohibiting FGM. In December 1997, the Court of Cassation (Egypt's highest appeals court) upheld a government banning of the practice providing that those who do not comply will be subjected to criminal and administrative punishments.

Issued as a decree by the Health Minister in 1996, the ban prohibits all medical and non-medical practitioners from performing FGM in either public or private facilities, except for medical reasons certified by the head of a hospital's obstetric department. We are unaware of any instance where this practice was certified. Perpetrators are subject to the loss of their medical licenses and can be subjected to criminal punishments. In cases of death, perpetrators are also subject to charges of manslaughter under the Penal Code.

6. Ghana

In 1989, the head of the government of Ghana, President Rawlings, issued a formal declaration against FGM and other harmful traditional practices. Article 39 of Ghana's Constitution also provides in part that traditional practices that are injurious to a person's health and well being are abolished.

In 1994, Parliament amended the Criminal Code to include the offense of FGM. Section 69A provides that whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person commits an offense and is guilty of a second degree felony and is liable on conviction to imprisonment of not less than three years.

There have been seven arrests under this law since 1994 and at least two practitioners have been successfully prosecuted and convicted. In March 1995, police arrested and charged the practitioner of FGM on an eight year old girl and the parents of the girl under the law. In June 1998, a practitioner was sentenced to three years in prison for having performed this procedure on three girls.

There is the opinion by some that the law has driven the practice underground.

7. Guinea

FGM is illegal in Guinea under Article 265 of the Penal Code. The punishment is hard labor for life and if death results within 40 days after the crime, the perpetrator will be sentenced to death. No cases regarding the practice under the law have ever been brought to trial.

Article 6 of the Guinean Constitution, which outlaws cruel and inhumane treatment, could be interpreted to include these practices, should a case be brought to the Supreme Court. A member of the Guinean Supreme Court is working with a local NGO on inserting a clause into the Guinean Constitution specifically prohibiting these practices.

8. Nigeria

There is no federal law banning the practice of FGM in Nigeria. Opponents of these practices rely on Section 34(1)(a) of the 1999 Constitution of the Federal Republic of Nigeria that states "no person shall be subjected to torture or inhuman or degrading treatment" as the basis for banning the practice nationwide.

A member of the House of Representatives has drafted a bill, not yet in committee, to outlaw this practice.

Most anti-FGM groups are refocusing their energies at the state and local government level. Edo State banned this practice in 1999. Persons convicted under the law are subject to a fine or to

imprisonment for not less than six months or both. Ogun, Cross River, Osun, Rivers and Bayelsa states have also banned the practice since that time.

A conviction in Edo State resulted in a 1000 Naira (US \$10) fine and imprisonment of six months. While opponents of the practice applaud laws like this one as a step in the right direction, they have criticized the small fine and lack of enforcement thus far.

The IAC in Nigeria is pursuing a state by state strategy to criminalize the practice in all 36 states. It first meets with the local government area Chairman about the harmful health effects of the practice. The Chairman is relied on to make contact with Council members, traditional rulers and other opinion leaders to discuss the problems associated with this practice and to work on alternative rites to satisfy cultural concerns. Only after consensus has been reached at this level, are all employed in the statewide campaign to ban the practice. IAC/Nigeria expects the campaign to take at least five years to reach all 36 states.

9. Senegal

A law that was passed in January 1999 makes FGM illegal in Senegal. President Diouf had appealed for an end to this practice and for legislation outlawing it. The law modifies the Penal Code to make this practice a criminal act, punishable by a sentence of one to five years in prison. A spokesperson for the human rights group RADDHO (The African Assembly for the Defense of Human Rights) noted in the local press that "Adopting the law is not the end, as it will still need to be effectively enforced for women to benefit from it."

The period since passage of the law in January 1999 has seen two arrests, but no convictions. In July 1999, the public prosecutor in Tambacounda ordered the arrest of the grandmother and mother of a five year old girl, following a complaint filed by the girl's father alleging the two women had ordered FGM performed on his daughter. The practitioner was also charged. Following emotional public outcry in the region, however, the cases were not pursued and no convictions resulted.

The press has suggested that the passage of the law has driven the practice underground.

10. Somalia

There is no national law specifically prohibiting FGM in Somalia. There are provisions of the Penal Code of the former government covering "hurt", "grievous hurt" and "very grievous hurt" that might apply.

In November 1999, the Parliament of the Puntland administration unanimously approved legislation making the practice illegal. There is no evidence, however, that this law is being enforced.

11. Tanzania

Section 169A of the Sexual Offences Special Provisions Act of 1998 prohibits FGM. Punishment is imprisonment of from five to fifteen years or a fine not exceeding 300,000 shillings (approximately US\$380) or both. There have been some arrests under this legislation, but no reports of prosecutions yet.

12. Togo

On October 30, 1998, the National Assembly unanimously voted to outlaw the practice of FGM. Penalties under the law can include a prison term of two months to ten years and a fine of 100,000 francs to one million francs (approximately US\$160 to 1,600). A person who had knowledge that the procedure was going to take place and failed to inform public authorities can be punished with one month to one year imprisonment or a fine of from 20,000 to 500,000 francs (approximately US\$32 to 800).

During deliberations on the law, legislators called for a widespread information campaign on the harmful health consequences of the practice. At least one excisor has been arrested under the law, but the outcome of the case is unknown.

Following passage of the law, the Ministry of Social Affairs and the Promotion of Women and the Ministry of Health, in collaboration with WHO and the United Nations Population Fund, organized a seminar on the enforcement of the law.

Several ministries followed this example with smaller campaigns to inform the public about the health problems associated with this practice. National radio and television, as well as private radio stations, have broadcast information about the legal and health consequences of this practice.

13. Uganda

There is no law against the practice of FGM in Uganda. In 1996, however, a court intervened to prevent the performance of this procedure under Section 8 of the Children Statute, enacted in 1996, that makes it unlawful to subject a child to social or customary practices that are harmful to the child's health.

LAWS IN COUNTRIES WHERE IMMIGRANTS FROM COUNTRIES PRACTICING FGM NOW RESIDE

A number of countries to which persons from countries that practice FGM have immigrated have laws against FGM. For example, Sweden, United Kingdom, Norway, Australia and New Zealand have enacted legislation against the practice. Specific legislation also exists in Canada and the United States.

1. Australia

Criminal legislation in six of eight Australian states and territories have made FGM a crime. This includes Australian Capital Territory, Northern Territory, New South Wales, South Australia, Tasmania and Victoria. These laws prohibit the practice within the jurisdiction, as well as the removal of the child to another jurisdiction for the performance of the procedure. Punishments range from seven to 15 years imprisonment. Consent is no defense.

One case of child abuse was heard in Magistrates Court in Melbourne in December 1993 involving action against a father of two girls who were infibulated. Information on the outcome is unavailable.

The Government has implemented the National Education Program to prevent this practice in Australia. Focus is on community education, information and support; assistance for women and girls at risk of, or who have been subjected to this practice to minimize adverse health problems; and promoting consistent health approach in working with communities and facilitating support and access to health services. Each State and Territory reports biennially on the work of health departments with communities on this issue.

2. Canada

Canada passed a law that became effective May 26, 1997, amending the Criminal Code of Canada. Under Section 268, this procedure is considered an aggravated assault that is punishable by imprisonment for a term not exceeding fourteen years. Specifically, aggravated assault is committed when one "wounds, maims, disfigures or endangers the life" of a complainant. "Wounds" and "maims" are defined to include "...to excise, infibulate or mutilate, in whole or in part, the labia majora, labia minora or clitoris of a person..." There are limited exceptions. Consent is no defense.

The Criminal Code in Section 273.3(1) also makes it a crime to take a child who ordinarily is resident in Canada, out of Canada for the purpose of having FGM performed in another country. Punishment is for a term not exceeding five years. (Criminal Code, R.S.C. 1985, c. C-46, ss. 268, 273.3(1)(c))

In addition to legal penalties, medical associations in most Canadian provinces have passed prohibitions against performing this procedure. Canadian NGOs are active in efforts to provide education about dangers of this practice and its illegality in Canada, both in Canada and abroad.

Save the Children Canada focuses on finding an alternative traditional rite of passage for young girls. It promotes the "circumcision through words" rite of passage as an alternative to FGM. This program emphasizes education for younger women and involves the entire community to accept this alternative rite of passage. This program was the focus of a Canadian documentary produced in 1999 "Circumcision Through Words" that has been used by medical associations to educate health care professionals about the cultural beliefs of countries where FGM is commonly practiced.

3. France

There is no specific law outlawing FGM in France. There have been, however, since 1978, over 20 cases involving this practice successfully prosecuted under existing laws. This has included the

conviction and imprisonment of persons performing the procedure, as well as parents of girls subjected to it.

In 1983, the French high court recognized that FGM cases can be prosecuted under Article 312 of the Penal Code (comparable Article 222 of current Penal Code). This Article provides that acts of violence toward children that result in mutilation shall be tried in the highest criminal court (court d'assises). The penalty is 10 to 20 years imprisonment.

The Medical Ethics Code (1979) forbids the practice of FGM by medical doctors except where medically required. The French Medical Board is not aware of any breaches of the Code.

The most recent case involving this practice occurred in February 1999. A Paris court sentenced a Malian woman, who had been practicing female circumcision for 15 years in France, to eight years for cutting 48 girls between the ages of one month and ten years. Twenty-seven mothers and fathers who solicited her services received suspended sentences of from three to five years. The case was brought by a victim, aged 23, who told a judge in 1995 that the woman had performed this procedure on her and her sisters when they were children.

Previous cases include a 1991 circumcision that resulted in a five year prison sentence and the 1983 imprisonment of a woman who performed the procedure on her daughter.

Since 1983 the government and private groups have undertaken a campaign to inform immigrants that this practice is contrary to the law and will be prosecuted. These groups include Groupes des Femmes pour l'Abolition des Mutilations Sexuelles (GAMS), a group of African women in France who advise, support and inform African women and families in France about the practice; Commission International pour l'Abolition des Mutilations Sexuelles (CAMS), an associated member of UNICEF France that fights against this practice by creating educational materials for the African community in France and also provides legal services; Association Nationale des Medecins de Protection Maternelles et Infantiles (ANMPMI), an association that provides advice and medical treatment for women and children; Prefecture d'Ile de France, an organization concerned with women's rights in general with programs focused on FGM prevention and Movement Francais pour le Planning Familial, which is also involved in this prevention campaign.

4. New Zealand

An amendment to the Crimes Amendment Act of New Zealand making FGM a crime was passed in 1995 and became effective on January 1, 1996. Punishment can result in imprisonment for up to seven years.

A National FGM Education Program was established to prevent the practice through community education, support and health promotion. Guidelines have been established by this program and the New Zealand College of Obstetricians and Gynecologists for women who have undergone this procedure.

5. Sweden

Sweden was the first Western European country to outlaw all forms of FGM in 1982. The 1982 law was revised in July 1998 to make the penalties more severe. The penalty is between two and ten years imprisonment. In addition to the performance of the operation on a person being illegal under this law, attempts, preparations, conspiracy and failure to report crimes are treated as criminal in accordance with Section 23 of the Penal Code.

The law also makes it clear that a person resident in Sweden who arranges for the procedure to be performed in another country, can be sentenced in Sweden under the law even if the crime was committed abroad.

In Sweden there are immigrant populations from countries where FGM is practiced including Somalia, Ethiopia and Eritrea. The government of Sweden supports several education projects about this practice for professionals such as doctors, nurses, teachers, day care center staff, religious leaders, interpreters, social workers and others who work with immigrants. A number of NGOs work within the immigrant communities to help individuals understand the harmful health consequences of these practices and the fact they are illegal in Sweden.

6. United Kingdom

The United Kingdom's Prohibition of Female Circumcision Act of 1985 makes it an offense for any person to perform this procedure and for other persons to aid, abet, counsel or procure the performance of these acts. A person guilty of an offence is liable to a fine or to imprisonment for a period not exceeding five years or to both.

The Department of Health has supported NGOs to carry out awareness campaigns about this practice. In 1993, a doctor, who was charged with contracting to perform FGM, was brought before the General Medical Council, found guilty of seven charges of serious misconduct and had his license suspended. The Crown Prosecution Service did not proceed with the prosecution of the case citing lack of evidence.

7. United States

The performance of FGM on a person under the age of 18 was made a crime in the United States under section 116 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. (18 U.S.C.A. 116) The law, which was enacted September 30, 1996, provides in part that "whoever knowingly circumcises, excises or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than five years, or both." The law provides that no account shall be taken of the effect on the person on whom the operation is to be performed, of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual.

To date there have been no prosecutions under this law.

At the state level, sixteen states have passed legislation outlawing this practice. These include California, Colorado, Delaware, Illinois, Maryland, Minnesota, Missouri, Nevada, New York, North Dakota, Oregon, Rhode Island, Tennessee, Texas, West Virginia and Wisconsin.

OVERVIEW OF PRACTICE OF FEMALE GENITAL MUTILATION (FGM)

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
Benin	30%-50% IAC 1992 survey is 30%. World Health Organization (WHO) estimates 50%.	Type II	FGM widely practiced. The ethnic groups most affected - Bariba, Peul (Fulani), Boko, Baatonau, Wama, Nago. Found mostly in north in Alibori, Atacora, Borgou and Zou. Also occurs in south in Oueme.	No law against FGM. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) leads campaign against this practice since 1982 with workshops, seminars. It collaborates with Ministry of Social Affairs and Health. NGOs "Le Levier du Developpement" and "Dignite Feminine" also involved in anti-FGM campaigns. FGM treated as a community issue. Government permits distribution of informational materials in government-run clinics; undertakes sensitivity activities in rural areas.
Burkina Faso	71.6% from 1999 Demographic and Health Survey of 6,445 women nationally	Type II	All but a few of 50 ethnic groups practice FGM. Bella group and castes and some secret societies do not practice any form of FGM.	A 1996 law forbids FGM. It provides prison terms and fines. Sixty convictions since its adoption of both excisors and accomplices. Campaign against FGM since 1975. Government has been waging widespread campaign against this practice for years. National Committee set up by Presidential decree in 1990 does extensive work about FGM including workshops, plays, posters, pamphlets, full-length feature film, etc. There is a 24 hour SOS hotline on FGM.
Cameroon	Less than 5%-20% according to various estimates.	Type I and Type II	FGM practiced in areas of far north, east and southwest.	No law against FGM. Women's groups lobby for legislation. IAC-organized conference Aug. 4-5, 1997 called for law against this practice and instruction of men and women and practitioners on the harmful effects. National Committee of IAC actively campaigns against this practice. Their activities are supported by government. Government active

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
				against the practice. Public campaign to eradicate this practice in 15-20 years started in March 1997. This includes public discussion and information programs on the subject. State-run television and newspaper have programs and articles about this practice. Ministry of Women's and Social Affairs and Cameroon's NGOs continue to make concrete and strong efforts to combat the practice.
Central African Republic	43.4% according to 1995 Demographic and Health Survey of 5,884 women nationally.	Type I and Type II	Practice found in 8 to 10 of 48 ethnic groups.	Since 1966 there has been a law against FGM. Arrests unknown under the law. Government is active in campaigns to inform the public about health problems and has taken measures against this practice. Government adopted in 1989 policy to improve position of women and a program 'Women-Nutrition-Development for Children', all of which address this problem.
Chad	60% according to 1995 UN report.	Type II common in all parts of the country. Type III confined to eastern part of country in area bordering Sudan.	In all areas of the country but strongest in the east and south. Crosses ethnic and religious lines. Practiced by Christians, Muslims, Animists in roughly equal proportions. Frequency higher in rural areas.	No law specifically makes FGM punishable. Practice might be prosecutable as involuntary physical assault against a minor under existing Penal Code. Draft law expected to go before Parliament in 2001 would criminalize this practice. In 1995, a government published policy opposing the practice was enacted into law. This includes provisions to increase awareness of the problem, protect women against this practice and initiate punitive measures against those who continue it. Both the government and NGOs are active in conducting public awareness campaigns and seminars

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
				<p>about the practice. Ministry of Social Action and the Family coordinates activities concerning this practice. In FY 2001 budget, line item supports activities of leading NGO, Chadian Association for Family Well Being, in combating this practice. NGOs work for eradication, including several NGO-led seminars on the subject. Education programs have been initiated. IAC National Committee active in outreach programs. U.S. Embassy supported local NGO program to get decision makers, traditional Leaders and officials involved. Seminars are planned throughout country about the practice plus publicity campaign on radio and in print media. Conference held March 1997 with widespread media coverage. The World Health Organization (WHO) is active in mobilizing government and private efforts to halt the practice.</p>
Cote d'Ivoire	44.5% according to 1999 Demographic and Health Survey of 3,040 women nationally.	Type II	Prevalent among Muslim women and rooted in Animist initiation rites in western, central and northern Cote d'Ivoire. Muslim groups practicing FGM include the northern Mande (Malinke, Foula, Bambara, Dioula) and some members of the Voltaic groups of the north (Senuofo, Tagwana, Djimini,	1998 law against FGM. Punishable by fine and imprisonment. Law enforced. Four excisors arrested and jailed in 2000. After enactment of law and before enforcement, government and NGOs such as AIDF (Ivoirian Association for Defense of Women's Rights) launched major information campaign about the law for general population, law enforcement authorities, local government officials. Government heavily involved in campaign to eradicate this practice through Ministry of Women's Affairs and Family and the Ministry of Public Health. NGOs campaign against the practice. AIDF is

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
			Lobi, Birifor, Koulango) and southern Mande of the west (Dan, Yacouba, Toura, Gouro), many of whom are not Muslim, the We from the Krou group and Baoule in some villages around city of Bouake.	most active NGO. It works to raise awareness; holds seminars on the subject; leads fight against medicalization of FGM. IAC aims its work of fighting this practice at community institutions – institutions for female education, youth hostels, etc. Gynecological and Obstetrical Society and the National Federation of Midwives and the Association for the Well Being of the Family take action via radio and newspapers to inform public about this practice.
Democratic Republic of the Congo (formerly Zaire)	5% estimate	Type II	Practiced in ethnic groups living in the northern part of country above the equator.	No law prohibits FGM. Outreach efforts unknown.
Djibouti	90%-98% according to various estimates.	Type II and Type III	Afars and Issa practice Type III. Girls of Yemeni extraction subjected to Type II.	Effective in 1995, Penal Code outlaws FGM with prison term and fine. Government incorporated awareness of this practice into national program to promote safe motherhood. NGO outreach groups campaign to eradicate the practice. Government allows use of its facilities; encourages use of the media. The Union Nationale des Femmes de Djibouti (UNFD) holds workshops to increase awareness of health consequences of FGM. Association for the Equilibrium and Promotion of the Family (ADEPF) and UNFD work to raise awareness in schools and women's groups. WHO, UNICEF, Caritas and the Red Sea Team International are involved in this work.

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Egypt	78%-97%. 2000 Demographic and Health Survey of 15,648 women nation-wide showed figure to be 97% among ever married women aged 15-49 and 78% among daughters of the women surveyed aged 11-19.	Type II and Type I throughout country. Type III concentrated in a few ethnic groups in southern part of country.	Practiced by both Muslims and Coptic Christians; across ethnic lines.	Ministerial decree in 1959 prohibited FGM making it punishable by fine and imprisonment. Changes made over the years. In December 1997, the Court of Cassation upheld a government ban on FGM. Issued as a decree in 1996 by Health Minister, ban prohibits medical and non-medical practitioners from performing FGM in public or private facilities, except for medical reasons certified by head of hospital's obstetric department. Government committed to eradicating FGM through education and information. Some provisions of Penal Code on "wounding", "intentional infliction of harm leading to death" might be used. Reports of prosecution of at least 13 persons for FGM in 1995, 1996 under the Code. Many NGOs doing outreach to teach about the harmful effects. In 1982, a project by the Population Crisis Committee and Cairo Family Planning Association produced material on harmful effects and carried out training for doctors, nurses, midwives and social workers. National Committee of IAC active in anti-FGM activities since 1985. Task force targets mothers' clinics, family planning centers, secondary school students, etc. Current efforts focus on community-based Approaches and the Positive Deviance Approach that uses individuals who have deviated from tradition and stopped, prevented, oppose the procedure to advocate change. The U.S. Agency for International Development (USAID), in cooperation with Egyptian government,

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
				is funding projects to train health providers on dangers of the practice and providing grants to NGOs to increase public information about this subject. Government and NGOs use media to disseminate information on health risks.
Eritrea	90% according to 1997 Demographic and Health Survey of 5,054 women nationally.	Type I, Type II, Type III	Some form of FGM practiced by almost all ethnic and religious groups.	No law prohibits FGM. Government uses education and persuasion to eliminate this practice. Ministry of Health carries out campaign to eradicate practice. Government supports groups working to end the practice including National Union of Eritrean Women and the National Union of Eritrean Youth and Students. The Eritrean People's Liberation Front (EPLF), which led fight for independence, has worked since 1988 to eradicate practice. Women fighters (30% of EPLF) are vocal in effort not to re-establish traditions harmful to women, including FGM. In 1996, government policy was enunciated to eliminate this and other harmful traditional practices; to create and enforce legislation prohibiting these practices; to include in women's health care, prevention of practices such as FGM; and to provide treatment, counseling and rehabilitation for women suffering negative effects of this practice. Government makes information on this practice part of its health and general education programs. Ministry of Health carries out government policy on this practice and provides in-service training to all primary health care coordinators throughout country on the subject, including training

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				Materials (visual aids and documents). In 1996, workshop on safe motherhood focused on negative health aspects of the practice. Health Ministry, with USAID, UNICEF and UNFPA, is designing a national and local level campaign against this practice. During independence struggle, EPLF tried to prohibit the practice in areas it controlled. Result was practice went underground. Because of this, government now believes best approach is through education, rather than laws, to eliminate practice.
Ethiopia	72.7% according to a 1997 survey published in 1998 by the National Committee on Traditional Practices in Ethiopia (NCTPE).	Type I and Type II. Type III in areas bordering Sudan and Somalia. Mariam Girz (Type IV) blood letting with a sharp needle practiced to lesser extent.	Type I practiced among Amharas, Tigrayans and Jeberti Muslims living in Tigray. Type II practiced by Gurages, some Tigrayans, Oromos, and Shankilas. Type III practiced among the Afar, the Somali and the Harari. Mariam Girz (Type IV) practiced in Gojam (the Amhara region). No form of FGM is practiced among Bengas of Wellga, the Azezo, the Dorze, the Bonke, the Shama and some population groups in Godole, Konso and Gojam. By region:	No law prohibits any form of FGM. Law being drafted. Constitution prohibits harmful traditional practices. Government national policy on women is strongly against FGM and other harmful practices. 1960 Penal Code prohibits torture and cutting off any body parts. Wide range of grassroots outreach activities by NGOs. Government very active in outreach. 1993 National Policy on Women takes strong stance against these practices. Government has followed up with support and action by its various ministries and bureaus, including mandating educational materials discouraging the practices be included in primary school curricula. (Such materials used in curricula since 1994.) The government's National Committee on Traditional Practices in Ethiopia (NCTPE), a chapter of the IAC, does extensive work throughout the country on this subject, including courses to raise awareness about the

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			Afar-94.5%; Harare-81.2%; Amhara-81.1%; Oromia-79.6%; Addis Ababa City-70.2%; Somali-69.7%; Beneshangul Gumuz-52.9%; Tigray-48.1%; Southern-46.3%.	practices in secondary schools. Some positive results are being seen in stopping FGM. Ethiopian Women Lawyers Association very active on updating laws, including writing provisions into new criminal code (as yet unratified) that will criminalize FGM.
Gambia	60%-90% various estimates. BAFFROW reports seven of nine ethnic groups practice FGM.	Type I and Type II. Type III in very small percentage of women and girls. Also special "sealing" performed.	Mandikas, Hausas, and Jolas practice Type II. Sarahulis practice modified form of Type II. Fulas practice "sealing" analogous to Type III. Bambaras practice Type III. Wolofs, Akus, Sereres and Manjangos do not practice any form of FGM.	No law prohibits any form of FGM. In 1999, the President announced that FGM would not be banned and that FGM is part of the country's culture. NGOs working to provide information to the public and eradicate all forms using workshops, seminars, theater, media, etc. Gambia Committee against Traditional Practices (GAMCOTRAP) focuses on community workshops. Foundation for Research on Women's Health, Productivity and the Environment (BAFFROW) developed curriculum for schools on "initiation without mutilation". The government has recognized harmful effects of FGM and supported NGO outreach. After Director of Information and Broadcasting ordered ban on anti-FGM radio and TV programs, Vice President stated that government policy was to discourage such harmful practices as FGM. That was before the President's 1999 statement. Government does allow reproductive health issues such as FGM to be discussed on national radio and television networks. NGOs can use government media to address these issues.

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Ghana	9%-15%. Various estimates. 1998 estimate by Gender Studies and Human Rights Documentation Center is 15%. Recent UNFPA funded study by Rural Help Integrated estimates between 9 and 12% of women nationwide.	Type I, Type II, Type III. Type II most common.	Practice most common in Upper East Region. Also practiced in remote parts of Northern Region, Upper West Region and northern Volta Region. Also prevalent among migrants of bordering countries in south. Found in both Muslim and Christian communities. Ethnic groups known to practice FGM include Kussasi, Frafra, Kassena, Nankanne, Bussauri, Moshie, Manprusie, Kantansi, Walas, Sissala, Grunshie, Dargati and Lobi. Less prevalent among the educated in urban areas.	1994 law prohibits FGM. Sec. 69A of Criminal Code makes it second degree felony with fine and imprisonment. Art. 39 of Constitution abolishes injurious and traditional practices. History of enforcement of this criminal law. There have been seven arrests since 1994. Two practitioners convicted of second degree felony. One was sentenced to three years in prison. In a 1995 case, the parents of the girl were also charged for having FGM performed on their daughter. Extensive outreach by groups in collaboration with government to eradicate this practice. Government at all levels publicly supports eradication. Ghana Association of Women's Welfare (GAWW) active in projects in the north to inform the public about effects of the practice and for its eradication. WHO, GAWW and Muslim Family Counseling Services in 1997 toured and identified 18 practitioners in Volta region to teach them about harmful effects of FGM. They work with Ministry of Education to incorporate education about practice into public school health curriculum. Voluntary watchdog committees intervene to stop impending FGM ceremonies. There is little real protection to turn to, however, in many rural areas.
Guinea	98.6% according to 1999 Demographic and Health Survey of 6,753 women nationally.	Type I, Type II, Type III	Peul, Malinke, Soussou, Guerze, Toma and Nalou practice one of these forms of FGM.	Art. 265 of Penal Code prohibits all forms of FGM. Art. 6 of Constitution prohibits cruel and inhumane treatment. Supreme court preparing clause for Constitution prohibiting FGM. Outreach groups work with government to

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
				<p>eradicate the practice through films, TV, seminars, etc. Government initiated a 20 year strategy (1996-2015) to eradicate this practice in collaboration with WHO's Africa regional efforts. This is to reinforce and institutionalize efforts with NGOs using communication and education mediums to inform public about this practice.</p>
Guinea-Bissau	<p>50% average; Various estimates. 70%-80% in Fula and Mandinka areas; 20%-30% in urban Bissau.</p>	Type I and Type II	<p>Fulas, Mandinkas, Peul practice Type I or Type II. Practiced on adolescent girls and babies as young as 4 months old.</p>	<p>No law prohibits FGM. In 1995, a law proposed to outlaw this practice was defeated. Assembly did approve proposal to hold practitioners criminally responsible if woman dies as result of one of these procedures. Government, with assistance of the Dutch, Swedish and UN aid agencies and high level support from Ministers of Health and of Social Affairs and Women, in January 1997 implemented a 2-year nationwide program targeting female leaders, excisors, traditional and religious leaders, educators and youth. Government gives support for outreach groups doing informational seminars, publicity, etc. Government formed National Committee to conduct Nationwide education campaign to discourage this practice. U.S. Embassy funds are used to finance regional committees to carry out campaigns in rural areas, on radio and TV spots and by production of a play to be performed in regional centers. The Swedish group Radda Barnen and Plan International, as well as domestic NGOs such as Friends of Children and Sinim Mira Nasseque, work through the National Committee to</p>

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				eliminate this practice. The efforts of these groups, suspended after outbreak of fighting in June 1998, resumed in many parts of the country in February 1999.
Indonesia	No national figures available. Study by University of Indonesia's Women's Research Graduate Program in 1998 in Jakarta and West Java of 200 mothers, found most girls circumcised but often with less invasive procedures used.	Type I and less invasive Type IV forms such as scraping or touching clitoris to draw drop of blood or cutting a plant root symbolically without touching child.	Practiced in parts of East, Central and West Java, North Sumatra, Aceh, South Sulawesi and on Madura Island.	No law against this practice. Public awareness of this practice is low. Government included this practice as a gender issue in its National Action Plan to End Violence against Women, published in Nov. 2000. Commits Ministry of Women's Empowerment and Ministry of Religion to conduct research on religious teachings that impede women's rights. FGM heads Action Plan's list of religious teachings requiring investigation and modification. Indonesian Government, National Ulemas Council, religious leaders, women's groups and health practitioners are to develop guidelines for health practitioners and midwives on non-invasive techniques. Awareness campaign planned.
Kenya	37.6% according to 1998 Demographic and Health Survey of 7,881 women nationally.	Type I and Type II. Some Type III in far eastern areas bordering Somalia.	FGM practiced in 30 of Kenya's 40 ethnic groups. Not practiced among 2 largest groups in far west-Luos and Luhyas. Examples of ethnic groups include Kisii-97%; Masai-89%; Kalenjin-62%; Taita and Taveta-59%; Meru/Embu groups-54%;	No law prohibits FGM. In 1982 and 1989, presidential decrees were issued banning this practice. A vote in 1996 by Parliament defeated a motion to outlaw it. Government forbids government hospitals and medical clinics from performing any of these procedures. Ministries of Health and Culture discourage this practice; encourage adoption of alternative rites of Passage. Government encourages enactment of legislation to eradicate practice. Many NGOs working to eradicate practice.

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
			<p>Kikuyu–43%; Kamba–33%; Miji Kenda/Swahili–12%. Widely practiced among Muslims of northeastern province, particularly Somalis, Borans and Gabras. Declining among the educated and in urban areas.</p>	<p>National Committee on Traditional Practices (now the Kenya National Council on Traditional Practices) does outreach to inform population about this subject, as do other groups. Seminars have been held. Materials are provided on the practice. MYWO, the national women’s organization closely aligned with the ruling Kanu party, is one of most active organizations working to eradicate the practice. MYWO focuses on informing community about the harmful health effects. It has also developed alternative initiation rites without “the cut” and is retraining excisors in other lines of work. Media helps campaign to eradicate practice. Schools include this subject in curricula. USAID is funding programs for research and eradication of the practice in several targeted areas. UNICEF and UNDP are also working to eradicate this practice. They focus on key local level officials and building local support. In March 1997, UNICEF organized meeting of donors, NGOs and UN agencies to coordinate eradication campaigns in Kenya. Information, training and persuasion are to be the tools to change practice at grassroots.</p>

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Liberia	50% of females over 18-pre-civil war 1989 estimate. 10%-estimate during civil war (1990-1996). Update unavailable.	Type II	Major groups including the Mande speaking people of Western Liberia such as Gola and Kisii practice Type II. Not practiced by the Kru, Grebo or Krahn in Southeast, by Americo-Liberians (Congos) or by Muslim Mandingos.	No law specifically prohibits FGM. Section 242 of Penal Code might cover it. No cases to date. The IAC Liberian National Committee conducted research, trained volunteers and provided health training about harmful effects of this practice. It collaborated with government to integrate awareness of consequences of FGM into programs for mother and child care and primary health care. It continued to provide information and training about the dangers of FGM during the civil war. Liberian Action Network also worked in campaign gathering information and recommending programs, seminars, workshops and meetings. Media is used to address damage caused by FGM. Campaigns during pre-civil war period had little effect in stopping FGM.
Mali	93.7% according to USAID-funded Demographic and Health Survey of 9,704 women aged 15-49. Commission for the Promotion of Women estimates 96% rural and 92% urban women have undergone this procedure.	Type I, Type II, Type III (southern part of country)	Most groups, including the Bambara, Dogon, Senoufo, Soninke, and Peul practice some form of FGM. The Songhai, Tuareg and Moor populations generally do not practice any form. The practice is lowest among ethnic groups in north. In south over 95%. For example, Bamako-	No specific law prohibits FGM, but Penal Code outlaws assault and grievous bodily harm. Law being drafted to outlaw this practice. Government formed National Action Committee in 1996 to promote eradication of harmful health practices against women and children. Engages in information activities, training, support of NGOs combating harmful practices, etc. In 1997, Committee devised first phase of Plan of Action for the Eradication of FGM by 2007. Many NGOs campaign and provide extensive programs on subject throughout country. Government

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
			95.3%; Koulikoro-99.3%. Very low percentage in north. For example, Tombouctou and Gao-9.3%.	regional offices support these activities.
Mauritania	25% according to 1997 Juene Afrique survey and 1996 UN Population Fund report.	Type I (more common among the Soninkes) and Type II (more common among Toucouleurs) . Also symbolic Type IV using gum arabic plant based product mixture to shrink the clitoris.	A 1992 government funded national survey indicated that 93% of Pulaar women; 78% of Soninke; 69% of Moors (who make up 70% of the population) and 12% of Wolof practiced FGM.	No law prohibits FGM. Secretariat of State for Women's Affairs, a cabinet post, directs government efforts to eliminate this practice. The practice is banned from government hospitals. NGOs and public health workers, medical doctors provide education and information to women about the harmful effects and the fact FGM is not a requirement of Islam. Secretary of State for Women's Affairs formed Committee in June 1997 to coordinate activities against this practice. UNICEF and UNFPA working in country on FGM projects. In 1996, U.S. funded publication and distribution of booklet on women's rights, including information on FGM that was launched through public campaign in all regions of country. Prominent in campaign is an eminent Imam, member of higher Islamic Council of Mauritania, who carries message that this practice are not a religious requirement of Islam.
Niger	4.5% according to 1998 Demographic and Health Survey of 7,577 women nationally.	Type II	Most prevalent in the Tillaberi and Dosso areas, along the Niger river and among Arab communities in the Diffa region.	No law prohibits FGM at this time. Government has drafted proposed amendment to Penal Code that would outlaw FGM and carry a sentence of 3-20 years prison term. Must now be submitted to Parliament. Government decree in 1990 established committee to

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
			<p>Communities/ethnic groups practicing FGM are Arabs (known locally as "Shoua"), Kanuris and Zarma-Sonrhais. Also by the Peul, Songhai, Kourtey and Wago.</p>	<p>campaign against FGM called Nigerian Committee against Harmful Traditional Practices (Lute Contra les Pratiques Traditionnelles Nefastes or CONIPRAT). It is the leading NGO in the fight against FGM. It carries out publicity campaigns to raise awareness; disseminates information on this practice in local languages; participates in research. With UNICEF funding and government participation, CONIPRAT held several seminars on the harmful effects of these and other traditional practices. It is working to strengthen its presence at regional and local levels. Organized ceremony in rural Tillaberi department where excisors turned in their knives and pledged to discontinue practice of FGM. Received prominent coverage in government media. Government participates in information seminars, publicity. March 1997, Minister of Health announced the government will do whatever it can to halt the practice of FGM. Government created in Ministry of Social Development, a division for protection of women and children that works closely with CONIPRAT on this issue. UNICEF and Care International support CONIPRAT's efforts.</p>
Nigeria	25.1% according to 1999 Demographic and Health Survey of 8,206 women nationally.	Type I, Type II and Type III throughout the country. Type III more predominant in the north. Type I and Type II more predominant in the south. Another Type IV form practiced to a lesser extent uses a	Practiced across ethnic groups and religions. Practiced by almost all ethnic groups. Among the largest ethnic groups that practice some form of FGM are the	No federal law prohibits FGM. Opponents use Sec. 34(1)(a) of 1999 Constitution instead. There are state laws against this practice. Edo State banned practice in Oct. 1999. There has been one conviction under Edo State law. States of Ogun, Cross River, Osun, Rivers and Bayelsa also

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		corrosive substance on the female genitalia.	Yoruba, Ibo, Ijaw, Hausa, and Kanuri. The Fulanis do not practice any form. Practice among states of Nigeria vary from 0%-1% in Yobe to 90%-100% in Benue and 90%-98% in Ondo.	banned practice since that time. Government publicly opposes this practice. Federal Health Ministry and Federal Ministry of Women's Affairs support nationwide study of the practice. Many NGOs- international, national and local organizations, including the National Association of Nigerian Nurses and Midwives; Nigerian Medical Women's Association; Nigerian Medical Association; WHO and UNICEF campaign and teach about dangers of this practice. IAC/Nigeria has programs throughout the country on the subject. It is pursuing a state by state strategy to criminalize the practice in all 36 states.
Senegal	5%-20%. 20% according to 1988 Environmental Development Action in the Third World study. Various other estimates range as low as 5%.	Type II and Type III	Toucouleur, Sarakole, Peul and Bambara, the Halpular, Mande, Diolas (mostly rural), Mandingos (mostly rural) and the Tenda practice one of these forms. It is not practiced among the Wolof plurality-43% and the Serere-15% and most Christians, regardless of ethnicity. Minority Halpularen, Puel and Toucouleur in rural areas of eastern and southern Senegal-88%. Urban Halpularen-20%. Becoming less	Law passed in 1999 prohibits FGM. President has spoken out against this practice. Outreach groups conduct seminars, publicity campaigns, surveys, workshops on the subject. The NGO Tostan, with assistance of the government, UNICEF and the American Jewish World Service has sponsored skills training courses including courses on literacy, problem solving, women's health and hygiene, management, leadership, negotiating and human rights that provide information about the harmful health effects of this practice. Following these courses, the Bambara village of Malicounda abandoned these practices, with the endorsement of the Imam. As of November 2000, 174 villages had abandoned the practice, following completion of the Tostan program. This affects about 140,000 people. Tostan program being

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
			common in urban areas.	replicated in Sudan, Mali and Burkina Faso. Ministry of Women, Children and the Family sponsors public awareness programs on the practice.
Sierra Leone	80%-90%. Various estimates.	Type II	All ethnic and religious groups except Krios practice FGM.	No law prohibits FGM. NGOs carry out instructional programs and work to eradicate the practice. The Sierra Leone Association on Women's Welfare (SLAWW) has advocated instruction and information against FGM since 1984. Grassroots programs include teaching about the harmful effects of FGM and eradication of the practice. Seminars held with primary and secondary school teachers on dangers of this practice.
Somalia	90-98%. UNICEF estimates 90%. Other estimates are 96-98%. 1999 CARE International survey estimates 100% for Somaliland (northwest Somalia).	Type III is most common. Also Type I (also called "sunna").	Most if not all ethnic groups. Type I mainly in coastal towns of Mogadishu, Brava, Merca and Kismayu	No national law against FGM. However, the administration of Puntland passed law against practice November 1999. Outreach groups campaigned to eradicate this practice since 1977. Former Barre government appointed group to eradicate the practice. Instructional and learning programs existed since Somalia Academy of Arts and Sciences began studies on the subject in 1980s. Extensive work by former government's Ministry of Education. Institute of Women's Education (IWE) set up in 1984. It engaged in activities to eradicate FGM in a general health program – Family Planning Project. In 1987, the Italian Association for Women and Development and Somali Women's Democratic Organization founded an anti-FGM project. Information packets and audio visual material were

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
				<p>produced; workshops set up; seminars held. Technical basis destroyed in 1991 with overthrow of government. UNICEF conducted workshops in Mogadishu, Galgaddud and Mudug regions in 1999-2000 to eradicate practice. UNICEF-Somalia has sponsored awareness seminars since 1996 to end FGM. U.S. Embassy in 2000 provided grant to Voice of Midwives Association for public awareness campaign. In 1998, U.S. Embassy provided grant to UNICEF for FGM project in four communities in Somaliland.</p>
Sudan (northern)	<p>89% according to 1991 Demographic and Health Survey of 5,860 women nationally. 87% urban - 91% rural of northern Sudanese women and girls according to survey conducted from 1996 to April 2000 by Sudan National Committee on Traditional Practices (SNCTP) and Save the Children Sweden.</p>	<p>Type III predominates. Some are switching to Type I or Type II.</p>	<p>All ethnic and religious groups practice one of these forms throughout the northern, northeastern and northwestern regions.</p>	<p>Today there is no law forbidding FGM per se, although Sudan was the first African country to outlaw this practice in 1946. A 1946 amendment to the 1925 Penal Code prohibited infibulation (Type III) but allowed less severe form. Ratified again in 1956. Prohibited infibulation but allowed removal of projecting part of clitoris; punishment of fine and imprisonment. The 1991 Penal Code does not mention any form of FGM. Other provisions of the Penal Code covering "injury" might cover FGM. Reports that some practitioners arrested, but no further information available. Outreach groups have been working to eradicate the practices for 50 years. Intensive campaign today. NGOs, government, religious groups and media work to eradicate practices. Focus on information, workshops and seminars. Medical profession becoming involved. Eradication of FGM worked into curriculum for community health at</p>

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Tanzania	17.9% according to 1996 Demographic and Health Survey of 8,120 women nationally Percentage is between 2.9% in Mtwara to 81.4% in Arusha according to a 1999 report by the Tanzanian Legal and Human Rights Center.	Type II and Type III	Practiced in approximately 20 of country's 130 main ethnic groups. Government data shows incidence varies by region with the most affected being: Arusha-81.4% of women; Dodoma-67.9%; Mara-43.7%; Kilimanjaro-36.9%; Iringa-27%; Singida-25.4% and Kilosa-20.2%. The percentage in Mtwara is only 2.9%. It is not practiced in Zanzibar. Practice almost non-existent in rest of the country.	Khartoum Nursing College. Sec. 169A of the Sexual Offences Special Provisions Act of 1998 prohibits FGM. Punishment by fine or imprisonment or both. Government supports campaign to end this practice. There are government efforts to eradicate this practice. There are extensive programs, surveys, studies, research on this practice. National Committee on Traditional Practices (NCTP) is directed toward awareness raising. It did research to design means to combat this practice. It is seeking to inform youth and incorporate information about it into school curriculum. Instruction on dangers of this practice sometimes included in health science in secondary schools. Ministry of Health conducting campaign to prevent this practice as part of their "Safe Motherhood" initiative. Seminars sponsored by governmental and non-governmental organizations regularly held to provide information about the practice. The Dodoma Traditional Practices and Beliefs Committee that received a grant from WHO began a program to eliminate FGM in the region within 20 years. USAID funded the NGO TAMWA to conduct workshops on eradication of this practice. The Legal and Human Rights Center report suggests the practice is on the decline.
Togo	12% average. Ethnic groups vary. Cotocoli, Tchamba,	Type II	Cotocoli, Tchamba, Peul, Mossi, Yanga, Moba, Gourma, Ana-	A law banning FGM was passed on October 30, 1998 by the National Assembly with prison term and fine.

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
	Mossi, Yanga and Peul- 85-98%; Moba-22%; Gourma-12%, according to U.S. funded 1996 research carried out by the Demographic Research Unit of Togo's University of Benin.		Ife practice Type II. Two of the largest ethnic groups, Adja-Ewe and Akposso-Akebou, do not practice any form. Highest regional incidence is the Central Region at 33%, home of the Cotocoli and Tchamba. By religion: Muslim-63.9%; Christian-3.2%; Animists-6.1%; other-10%,	One excisor arrested under the law. Human rights and women's organizations provide information to rural populations on harmful effects of the practice. Since 1984, with help of government, National Committee of IAC holds seminars, workshops to teach about the subject. Anti-FGM documentary shown on National (government controlled) television. Government held seminars after law passed on enforcement of the law. Also informed public about health problems associated with FGM. Major campaign by Togalese Association for the Well Being of the Family in 1999 to educate public about the law. NGO Group of Reflection and Action for Women in Democracy and Development work to protect women from this practice.
Uganda	Less than 5% of female population. Number of girls undergoing Type I or Type II in recent years are: 1990-971 girls; 1992-903 girls; 1994-854 girls; 1996-544 girls; 1998-965 girls; 2000-742 girls. Initiation ceremonies take place in December of even numbered years on girls between ages of 14 and 16.	Type I and Type II	Prevalent in rural district of Kapchorwa in the east among the Sabinu ethnic group. Also practiced by the Pokot group, also known as the Upe, located along the remote northeastern border with Kenya. Approximately 10,000 Sabinu and 20,000 Upe live in the country.	No law yet prohibits FGM. Government, however, is formulating a law banning this practice throughout the country. Constitution in theory protects women and girls from this practice. Section 8 of the Children Statute, enacted in 1996, makes it unlawful to subject a child to social or customary practices that are harmful to child's health. In 1996, a girl upon whom FGM was to be performed secured intervention of a court and the procedure was prevented under this statute. Government publicly condemns FGM and says it would protect any woman bringing a claim to its attention. National Committee of IAC works to eradicate this practice and inform the public about its harmful effects. United

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
				<p>Nations Population Fund (UNFPA) pilot program called "Reach" (Reproductive, Educative and Community Health program) in 1995 in Kapchorwa, focused on information, education and instruction about this practice. It also focused on rallying support of key members of society (such as Elders Association); informing community youth through peer educators; training health workers and finally instructing traditional birth attendants and excisors. Program resulted in a substantial decline in the practice from 1994 to 1996. Government has fully supported the UNFPA program. Sabiny Elders Association now is very active in campaign to abolish FGM and replace it with a symbolic ritual. Chairman of the Association was awarded the UN Population Award for work of the Sabiny Elders to eradicate this practice in the remote Kapchorwa region.</p>
Yemen, Republic of	23% of women who have ever been married, according to a USAID funded 1997 Demographic and Maternal and Child Health Survey.	Type II. Type III practiced only among small community of East African immigrants and refugees.	Primarily women living in coastal areas, but also practiced to lesser extent in the mountainous region and in the plateau and desert region. In the Tihama region along Red Sea coast, 69% of women were circumcised; 15% of women in highlands; 5% in central plateau and desert regions to	No law prohibits FGM. Ministerial decree effective January 9, 2001, prohibits the practice in both government and private health facilities. The government published the recent Demographic Health Survey on the incidence of FGM. Some government health workers actively and publicly discourage this practice, including the Minister of Public Health. Some women are doing research to launch a public campaign against the practice. Ministry of Public Health sponsored two day seminar January 9-10, 2001 entitled "Female

Country	Prevalence of FGM	Type of FGM	Ethnic Group/Area	Law/Outreach
			<p>the east. Ministry of Public Health survey in five governorates. Results show over 96% of women in Hodeidah, Hadraumaut and Al-Maharah had been circumcised. In Aden it was 82% and in Sana'a City 45.5%.</p>	<p>Health" on FGM. Nearly 150 academics, health professionals, government officials, donors and clerics attended. First time FGM had been publicly discussed in Yemen. Conference Plan of Action includes 1)religious leaders to provide legal opinion on FGM in consultation with doctors; 2) Ministries to develop public awareness campaign in areas most affected by practice; 3) Ministry of Public Health to conduct nationwide study to determine extent of the practice; 4) plan to be developed to include FGM in curricula at medical schools, health institutes and literacy centers; 5) a law to be promulgated to prohibit FGM.</p>

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