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REVIEW OF FURTHER DEVELOPMENTS IN FIELDS WITH WHICH THE SUB-COMMISSION HAS BEEN CONCERNED

STUDY ON TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN

Final report by the Special Rapporteur,
Mrs. Halima Embarek Warzazi

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Introduction

1. At its thirty-sixth session, the Sub-Commission, by its resolution 1983/1 of 31 August 1983, recommended, through the Commission on Human Rights, to the Economic and Social Council to authorize the Sub-Commission to appoint Mrs. H.E. Warzazi and Mr. M.Y. Mudawi to carry out and present a study on all aspects of the problem of female mutilation, including the current extent and causes of the problem and how it might best be remedied.

2. At its fortieth session, the Commission on Human Rights, by its resolution 1984/48 of 13 March 1984, recommended that the Economic and Social Council should request the Secretary-General to entrust a working group composed of experts designated by the Sub-Commission on Prevention of Discrimination and Protection of Minorities, UNICEF, UNESCO and WHO with the task of conducting a comprehensive study on the phenomenon of traditional practices affecting the health of women and children. The Council endorsed the recommendation by its resolution 1984/34 of 24 May 1984.

3. At its thirty-seventh session, the Sub-Commission, in its decision 1984/104, nominated Mrs. H.E. Warzazi and Mr. M.C. Bhandare to serve as experts in the Working Group established to conduct a study of traditional practices affecting the health of women and children. The Working Group designated Mrs. Halima Embarek Warzazi as Chairman-Rapporteur of the Group. The Group had three working sessions in 1985 and in 1986 and submitted a report to the Commission on Human Rights at its forty-second session (E/CN.4/1986/42). The report referred to various traditional practices such as female circumcision, other forms of mutilation (facial scarification), forced feeding of women, early marriage, nutritional taboos, and traditional birth practices and the consequences of preferential treatment for male children.

4. By its resolution 1988/57 on traditional practices affecting the health of women and children, the Commission on Human Rights requested the Sub-Commission on Prevention of Discrimination and Protection of Minorities, at its fortieth session, to consider measures to be taken at the national and international levels to eliminate such practices, and to submit a report to the Commission at its forty-sixth session.

5. Pursuant to this request, the Sub-Commission adopted resolution 1988/34 on 1 September 1988 entitled "Traditional practices". In paragraph 1 of that resolution, the Sub-Commission requested one of its members, Mrs. Warzazi, to study on the basis of information to be gathered from Governments, specialized agencies, other intergovernmental and non-governmental organizations concerned, recent developments with regard to traditional practices affecting the health of women and children and to bring the results of her study to the attention of the Sub-Commission at its forty-first session.

6. The Special Rapporteur submitted a preliminary report to the forty-first session of the Sub-Commission (E/CN.4/Sub.2/1989/42 and Add.1). The report contained replies received from only 16 Governments, two United Nations

organs, one specialized agency and 12 non-governmental organizations. In view of the small number of replies received by the Special Rapporteur on this question, the Sub-Commission adopted resolution 1989/16 and recommended to the Commission on Human Rights, inter alia, to extend the mandate of the Special Rapporteur to enable her to present a more complete report; to undertake field visits to two countries where harmful traditional practices are prevalent. It also recommended that the Centre for Human Rights should organize regional seminars on the subject, in Africa and Asia. By its decision 1990/109, the Commission on Human Rights endorsed the recommendations referred to above. The present report is submitted pursuant to Sub-Commission resolution 1989/16.

Chapter I

TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN AND CHILDREN

A. Female circumcision and its health implications

7. According to the findings of the Working Group on Traditional Practices Affecting the Health of Women and Children, female circumcision can be defined as a practice which consists of the cutting away of all, or part, of the external female genital organs. The practice forms part of the initiation rite in some countries but the actual operation presents health risks. 1/

8. The origin of female circumcision could not be established since it is an old custom which predates Christianity and Islam in the countries where it exists. In the older days, it is believed to have existed in pre-Islamic Arabia, ancient Rome and Tsarist Russia. In England, it was practised in the nineteenth and twentieth centuries to treat psychological disorders. 2/

9. The types of female circumcision so far identified are:

(a) Circumcision: The circumferential excision of the clitoridal prepuce with the gland and the body of the clitoris kept intact;

(b) Excision: This involves the removal of the gland of the clitoris and the labia minora;

(c) Infibulation or "pharaonic" circumcision: This consists of excision and joining the two sides of the labia majora with thorns or needles. 3/

10. Those who practise female circumcision are usually old women most of whom serve as traditional birth attendants in their community. As instruments for the operation they use kitchen knives, razor blades, pieces of glass. To heal the wound they use herb mixtures, earth, cow dung, ashes etc. 4/

11. Female circumcision exists in at least 25 countries in Africa. In Somalia, Djibouti, the northern part of the Sudan, some parts of Ethiopia, Egypt and Mali, infibulation is practised. Excision and circumcision exist in the Gambia, the northern part of Ghana, Nigeria, Liberia, Senegal, Sierra Leone, Guinea, Guinea Bissau, Burkina Faso, parts of Benin, Côte d'Ivoire, parts of Tanzania, Togo, Uganda, Kenya, Chad, Central African Republic, Cameroon and Mauritania.

12. Outside Africa, a certain form of female circumcision exists in Indonesia, Malaysia and Yemen. 5/ Recent information has revealed that the practice exists in some European countries and Australia among immigrant communities.

13. The age at which circumcision is performed varies from a few days old, as in parts of Ethiopia, to seven years old in Egypt and to adolescence in West Africa. 6/

14. The effects of female circumcision have short-term and long-term implications. Haemorrhage, infection, acute pain are the immediate consequences. Keloid formation, infertility as a result of infection, obstructed labour, psychological complications are identified to be later complications. 7/

15. The reasons presented for maintaining the practice are religion, custom, decreasing the sexual desire of women, hygiene, aesthetic, facility of sexual relations, fertility etc. In general, it can be said that those who preserve the practice are largely women who live in traditional societies in the rural areas. Most of these women follow tradition passively. The level of education and schooling makes a marked difference in the attitude of women towards female circumcision. The educated women are in favour of eradicating it. A survey conducted in Alexandria in 1988 among informed urban women showed that the women disapproved the practice on ground of the violation of human rights, violation of the image of the women, marital problems and opposition to old customs. 8/

16. In the countries where the practice exists, most women believe that as good Muslims they have to undergo the operation. In order to be clean and proper, fit for marriage, circumcision is a precondition. 9/ Among the Bambara in Mali, it is believed that if the clitoris touches the head of a baby being born the child will die. The clitoris is seen as the male characteristics of the woman. In order to enhance her femininity this male part of her has to be removed. 10/ Among the women in Sudan, Ethiopia, Djibouti and Somalia, circumcision is performed to reduce the sexual desire of the girl and also to maintain her virginity until marriage. A circumcised women is considered to be clean.

17. Establishing identity and belongingness is another good reason advanced for the perpetuation of the practice. For example, in Sierra Leone and Liberia, girls of 12 and 13 years of the indigenous population undergo an initiation rite; accordingly, a group of girls are initiated by an older woman "Sowie": this involves education on how to be a good wife, a co-wife, the use of herbal medicine and the secrets of the women society; this education also involves the ritual of circumcision. Once the initiation is over, the girls are accepted as full members of the society and are eligible for marriage. An uninitiated girl is not fit for marriage. 11/ In this process, the educational part is a positive measure for proper social integration but the actual operation is a health risk. 12/

18. The underlying reasons for the persistence of the practice are lack of education and information on the part of women and their vulnerable social and economic status; marriage is the only social security for most women. It has been proved beyond any doubt that female circumcision does not ensure cleanliness or fertility; on the contrary, infection resulting from the operation can cause infertility. Prominent religious leaders have stated that female circumcision is neither a Muslim nor a Christian obligation. 13/

B. Preferential treatment for male children

19. The question of "son preference" was considered by the Working Group on Traditional Practices and detailed information of the discussion of the Group is contained in its report (E/CN.4/1986/42, paras. 139-171). The practice of son preference is prevalent among many societies in the world with varying degrees of manifestations. The dependent and low economic status of women including the underevaluation of their role in the society are the main factors which force families to prefer boys to girls. Almost all societies value sons more than daughters and exhibit preference for the male child. 14/

20. Girls suffer from this preferential treatment for boys right from the early part of their lives. According to WHO, the birth of a male child in countries of South Asia is always accompanied by ceremonies and rituals which is rarely so in the case of the female child. The occasion of the first haircut (Mundah), the religious thread ceremony, etc. practised in North India during infancy and childhood are all centred around the male child. In Taiwan, daughters were commonly referred to by epithets, such as goods on which one loses and water spilled on the ground. In Arabic, the term Abu-banaat, meaning the father of daughters, is an insult representing just one of the countless ways in which Middle Eastern women learn how little they are valued. Among the Iteso in Uganda, the euphemisms an aunt or grandmother would use if asked about a newly-born child in the family are: "It is the central pole" if it is a boy, and "It is only a prostitute" if it is a girl. The boy is the central pole because he will carry on the ancestral custom of building many huts with central poles to support the roof; the girl is a prostitute from the time of birth because she will be brought up to be married in exchange for cattle. In Bangladesh, to have a daughter is like "watering the neighbour's tree" - nurturing something whose profits will accrue to someone else. 15/

21. In rural communities in Egypt, the boy's birth is announced and introduced to the neighbours and relatives in four different ceremonies, the most significant of which is the disposal of the umbilical cord ceremony. During the ceremony, the father buries the umbilical cord in his field or below the threshold of the Kuttab (the village Koran School). The birth of a girl is announced by saying "May she never sneeze" and her umbilical cord is buried without a ceremony below the threshold at the house or kept in a small box. The celebrations of baby births are symbolic and reflect the value attributed to each sex and their prospective role. 16/

22. If a girl is a first-born in the Middle East and North Africa region, she is likely to have a young mother who is insecure and subject to cultural and social pressures to have a boy. In response, the mother may curtail the period of breastfeeding to increase her chances of becoming pregnant again in the hope of bearing a boy. Her mother may also wean the baby girl abruptly, exposing her to pathogens causing more frequent diarrheal episodes as well as acute respiratory infections. She may be relatively neglected, given less food or protection than a boy in her position. When she is ill, the mother's response to her needs may be more delayed, with serious growth or even survival consequences. She may not be immunized at all or immunized too late. 17/

23. In societies where food is scarce and where there are too many mouths to feed, the most nutritional food is provided to the boy whose growth and well-being are carefully looked after. For the mother, a male child offers added security to her marriage and as such she offers maximum attention to him. She also considers her son as a possible guarantee for her own old age. Sex differential in nutrition is more prevalent among agrarian societies where the manpower need is strongly felt, boys offering future manpower. Male members of the family eat first the best part of the food while the females including the mother share what is left over. A study carried out in Bangladesh and Pakistan showed that more female children were severely malnourished than male children. Studies carried out in Pakistan, parts of Syria, parts of India and parts of Jordan indicated that at average the median weight of girls were below the median weight of boys. 18/

24. In addition to sex-biased nutritional differential which girls suffer from, they are less cared for during their sickness than boys. The latter have better chances of receiving medical treatment. 19/ "Various studies undertaken in Nigeria showed that the tendency to take boys to primary health clinics when sick was greater than when it concerned girls. Parents with little financial means preferred to spend for the health care of their boys than their girls". 20/ Similar studies undertaken in Egypt and Bangladesh demonstrated the same tendencies. Discriminative feeding and health care have serious health consequences on girls which in extreme cases can lead to female mortality. In extreme cases, son preference may lead to abandonment of the female infant or even female infanticide, but its most common form is neglect. Although male infants have greater vulnerability to illness and death at an early age, neglect of the female child reverses this natural trend. Available data reveals that female infant mortality is higher than male infant. 21/

25. Generally, gender disparities exist in educational opportunities where family means are scarce and school fees are mandatory. Families prefer to pay for their boys as a future investment for their own security. As such, in many third world countries, primary school enrolment demonstrates the disadvantaged status of girls. The drop-out rate of girls from school has been found to be higher than boys. Such gender disparities have meant a certain wastage of human resources of girls and the perpetuation of inequalities.

26. According to UNICEF, the expansion of educational opportunities, generally in the Middle East and North Africa over the last several decades, has clearly affected girls, although this has not been a result of deliberate policy to reduce gender disparities in educational access. Girls' education, measured by gross primary enrolment ratios, has improved substantially in the Middle East and North Africa region. Nevertheless, in 1990, the region still had 44 million illiterate mothers, a large and increasing backlog left from lower levels of school enrolment. Differences in primary school enrolment and competition between boys and girls are still very important in a number of countries. In countries where overall enrolment is much less than desired, girls are particularly disadvantaged. 22/

27. The result of this lack of education, and high illiteracy rate among mothers is one of the most serious causes of maternal and infant mortality and morbidity. Children from illiterate mothers have a 24 per cent higher probability of dying than do those of mothers with only the most basic literacy skills in low-income communities.

28. A girl is burdened with the domestic task of helping her mother at home and taking care of her younger siblings. She assists in the cooking, cleaning, fetching water, washing etc. and has little time left for recreation. Boys are allowed to spend more time playing outside and doing sports. This situation deprives the girl from talking, playing, showing love, elements essential for a child's physical, mental and emotional growth. 23/

29. Early marriage is another serious problem which girls face as opposed to boys: girls are given away for marriage at the ages between 11 and 13 and start producing children at an early age. This practice is prevalent in Asia and Africa among certain ethnic groups. The principal reasons for this practice are found to be virginity and the bride price; young girls are less likely to have sexual adventures and thus are bound to be virgins until marriage; this condition raises the family status as well as the dowry to be paid by the husband. 24/

30. Early marriage causes malnutrition for the young mother and her offspring. Often these young mothers are all undernourished from childhood; their bodies need proper food to reach full growth as well as for the growth of the baby during the time of pregnancy. Obstructed labour and fistula cases are common among young and undernourished mothers; birth to women between the ages of 11-13 who are not fully mature can permanently injure their health, and the maternal mortality rate is three times greater than that of the 20-24 year age-groups. 25/

31. Several reasons are attributed to the prevalence of especially strong son preference in some societies; the main reasons are cultural and economic.

(a) Cultural reasons

32. In many societies, the family lineage is carried on by male children. The preservation of the family name is guaranteed through the son(s). Except for a few countries (e.g. Ethiopia), a girl takes her husband's family name dropping that of her own parents. The fear of losing a name obliges families to wish to have a son. Some husbands marry a second or a third wife to be sure to have a male child. Among many communities in Asia and Africa, sons perform burial rites for parents. Parents with no male child do not expect to have appropriate burial which "secures their peace in the next world". In almost all religions, ceremonies are performed by men. Priests, pastors, sheiks and other religious leaders are men of great status to whom society attaches great importance; this important role which men play obliges parents to wish for a male child. Religious leaders have a major share in the perpetuation of son preference.

(b) Economic reasons

33. The deprived economic status of women and the low esteem society attaches to their economic contribution is a major reason for parents to prefer to have boys. Among agricultural societies, the need for strong labour force is one factor which perpetuates son preference. Sons bring their wives as additional hands to help in their parents' homes whereas daughters leave their families to join that of their husband's to render service. Inheritance is left to sons with the belief that they keep the family lineage and name; they are also believed to be better managers. Inheritance laws present a very serious handicap for women: after the death of parents, girls inherit hardly any property; wives have no right to inherit the property of their husbands when death occurs; this leaves women in a position of economic vulnerability and low social status, a common situation in many African and Asian countries.

C. Traditional practices related to child delivery

34. In the developing world, the birth of a child is awaited with a mixed feeling of anxiety, fear and happiness. Children are considered as assets for increasing the socio-economic status of their family. The more children a family has the more manpower it can deploy in different activities for more economic gain and social status. The birth of a child, especially that of a boy, is received with great joy. Boys ensure the continuity of the family lineage and name. They are also the ones who perform essential rituals and ceremonies. However, the sad reality to this is the high maternal and child mortality in the developing world. It is estimated that Africa has the highest rate with an average rate of 640 per 100,000 live births, as against 30 per 100,000 in the developed world. 26/

35. Among traditional societies the reason behind this unfortunate situation is attributed to supernatural powers and evil spirits. As such, pregnancy and child delivery represent anxiety, fear and uncertainty. In order to deter mishaps various kinds of practices are performed in addition to the observance of taboos related to nutrition and to refraining from doing certain daily tasks. 27/

36. According to WHO, more than half of the births in developing countries are attended by traditional birth attendants. 28/ The women are untrained persons whose skill is transmitted from mothers, grandmothers and other relatives: they provide important services in supporting a delivering mother. They are also the custodians of traditional practices. The lack of knowledge about the actual process of childbirth and the germ theory of illness are serious handicaps which traditional birth attendants face: they attribute sickness and death to evil eyes and evil deeds; to curb these they use herbal and other concoctions. Education specially targeted to these women about the germ theory of disease and about health practices related to delivery is vital in reducing maternal and child mortality.

37. The following is the research finding of Dr. Thomas K. Kargbo of Sierra Leone: 29/ In most cases, the woman would have made the Kuigbagba string to be tied round her waist to prevent abortion. It consists of the

bark of the Helei tree (Bussea occidentalis), tied with white and black thread, with incantations to remove any curse or evil intention. She is then advised to refrain from eating the following food items:

Food	Believed to cause
Eggs, chicken	Frequent stools in babies
Fish	Ptyalism and mucus in babies
(a) Congo Nagoi (eel), Makondoi, Ndegbie	
(b) Gbigbi (electric fish, Gymnarchus niloticus)	Tetanus
Benni seed (Sesamum indicum)	Too much vernix on baby
Beans	Cord round the baby
Plantain (Musa paradisiaca)	(a) Retained placenta
	(b) In the male child, a large phallus
Intestine of animals	Abnormal skin pigmentation (discoloration)
Brain of animals	Purulent otitis media
Garden eggs (Solanum melongeanei)	Pemphigus
Coconut (Coconuti tolongangei)	Heavy post partum haemorrhage

The pregnant woman is also urged to refrain from certain activities:

Activity	Believed to cause
Standing at the doorway in pregnancy	Obstructed labour
Putting hands on the head	Difficult, prolonged labour due to deep transverse arrest
Setting out on a journey with a load on the head, going half-way and returning to the house again to collect something	Difficult labour and prolapsed hands
Not moving about during pregnancy	Uterine inertia

Wearing brassiere or wrapping the lappa round the neck	Umbilical cord round the neck
Lying in an easy chair or hammock or being nosey in other peoples' business	Face presentation
Standing at crossroads	Transverse lie
Putting or lighting old firewood in the wrong position	Footling breech (mahiteh)
Walking about at night without carrying a knife tied on the lappa as protection	(a) Footling breech (b) Foetal abnormalities
Bathing at night	Being seen by bad spirits which will cause foetal abnormalities
Throwing dirt at night	Being seen by bad spirits which will cause foetal abnormalities
Heavy work or lifting heavy loads	Abortion
Frequent intercourse and intercourse with another man	Abortion and ante partum haemorrhage leading to premature labour (Ndodia)
Using pit latrine	Buttocks presentation

38. African societies have several practices related to delivery. The use of herbs is quite widespread along with the magical treatment. Some of the herbs can be beneficial or benign while others could be dangerous, especially when taken in large dosage. This is an area which needs serious study to determine the nature and the quality of these herbs. 30/

39. The treatment of abortion and another pregnancy related complications involve largely drinking a mixture of medical herbs. One of the treatments of haemorrhage is the mixing of Ndopa Nei leaves (Tetracera alnifolia) with water and inserting it in the vaginal canal to clot the blood. In case of obstructed labour the abdomen may be massaged or pressed to force the baby out. If the difficulty persists the traditional birth attendant may resort to pulling the baby by force. Some birth attendants perform a surgical operation to extract the retained foetus. 30/

40. In some parts of Nigeria, the gishiri cut is practised if a traditional birth attendant believes that the birth canal is too narrow to allow normal delivery. She uses a knife or a razor blade to cut the labia minora and the vaginal opening. This practice can cause haemorrhage, infection and if the baby is engaged during the operation its head can suffer from an accidental cut. 31/

41. In Sierra Leone, if the obstructed labour continues in spite of all the magical as well as medicinal attempts, the woman is labelled a witch and is taken to the Sande bush. She suffers from rejection by her husband and by society. She is forced to confess her sins for having been the cause of crop failure, death or other misfortune which befell on the community. Her death is believed to be a punishment for her crime. In the bush, the birth attendant performs surgery to pull the baby out. A mother should never die with a baby in her womb. 32/

42. Foetal expulsion is accelerated by exerting pressure on the fundus of the uterus: to achieve this, the midwife sits astride the thorax of the woman in labour, with the following principal consequences: rupture of the uterus, premature separation of the placenta, foetal death and maternal death - either from expulsion of the placenta or the traction on the umbilical cord. 33/

43. Mrs. Alasebu Gebre Selassie gives the following description of the practice in Ethiopia:

> "The moment an expectant woman starts labour pains, a piece of new cloth and a razor blade she has already prepared for the occasion are placed within reach... If the labour takes more than a day, gun shots are fired several times from a spot near to where the woman in labour is in order to induce birth by shock. Once the baby is born, the umbilical cord is tied leaving a length of three fingers on the baby's side. Any size shorter than three fingers' length is considered to cause the baby to die from bleeding. On the side of the mother, the cord is tied to her leg and attached to her thumb by a long string. She is then asked to move the string back and forth to prevent the umbilical cord and the attached placenta from slipping back into the uterus. Until the dried umbilical cord drops off the baby, butter is used as dressing. If the placenta is not expelled readily, it is generally believed that it will move up to the mother's head, make her unconscious and eventually kill her. Hence, the midwife massages the abdomen with butter to accelerate the delivery. Once it is expelled, the placenta is closely inspected by the attending women and if it does not have a smooth surface, the midwife at once places a water jar with a long neck on the abdomen, and presses down until all the remains of the afterbirth are discharged". 34/

44. In the treatment of a retained placenta, special herbal mixtures are used. Sometimes the traditional birth attendant uses her hands to pull the placenta out. This practice can cause infection and serious haemorrhage. 35/ In some parts of Nigeria, a delivering mother is given a very hot bath and a salty diet. This practice is known to cause serious burn and heart failure. 36/

45. In Ethiopia, a newly born child is bathed with cold water and butter is pushed down its mouth in the belief that the baby will later on have a smooth voice. The cold bath can cause shock and respiratory problems if the baby catches cold. Among the highlanders, circumcision is performed seven days after the birth of the baby. Uvula cutting is also common around about this time. Although breastfeeding is a positive traditional practice, the baby does not get the first nutritious milk of the mother. Its yellowish tint is

considered to be unhealthy and is unfortunately poured out. Rubbing and massaging the baby are positive practices which need to be maintained. In Sierra Leone, oral medications are given in order for the baby to gain weight. These could be special roots of plants or leaves. 37/

46. Communal support is provided to the mother for some days after the delivery. She is fed with special food and is allowed a period of rest. In Ethiopia, a mother is encouraged not to move too much and engage in heavy work for 40 days. She eats fatty food to gain weight and replace the blood lost during the delivery. The psychological support and care the mother receives from her family and the community at large is a positive practice to be maintained.

Chapter II

VISITS TO THE SUDAN AND DJIBOUTI AND ORGANIZATION OF REGIONAL SEMINARS

47. In resolution 1989/16, the Sub-Commission recommended that field missions be undertaken to two countries where harmful traditional practices are prevalent; it is also recommended that international regional seminars be held in Africa and Asia on the subject of harmful traditional practices. Two field visits were made to Sudan and Djibouti and one seminar was organized in Africa.

A. Report of field missions to the Sudan and Djibouti

48. Pursuant to resolution 1989/16, the Centre for Human Rights, in consultation with the Special Rapporteur, selected the Sudan and Djibouti to be visited by an official of the Centre, Mrs. R. Hanna-Hussen, and a consultant, Mrs. B. Ras-Work. The Governments of the Sudan and Djibouti accepted the Secretary-General's request to permit the team to visit their countries.

49. The purpose of the field missions was to have discussions with the relevant government officials, national women's associations and with members of the international communities in order to obtain factual information on the various measures taken or planned for bringing about a speedy elimination of harmful traditional practices affecting the health of women and children. The team was to evaluate the progress of work undertaken and to assess the effectiveness of government policy to eradicate traditional practices, and in particular, female circumcision.

1. Mission to the Sudan
(25 November-30 December 1990)

50. Upon arrival in Khartoum, the team was received by the President of the Sudan National Committee on Traditional Practices, who was designated by the Government to assist the team to carry out its mandate. The team's visits to and discussions with selected ministries, unions, institutions and United Nations bodies are summarized below:

(a) Ministry of Health and Social Welfare

51. This Ministry, which combines Health and Social Welfare, is the government body which supports activities related to female circumcision. In 1984, the Ministry established a national committee for the eradication of female circumcision with different governments, as well as some non-governmental organizations as members. Unfortunately, this committee failed to accomplish its mandate effectively, and the need to reorganize it in order to give it a more autonomous structure was felt. In 1988, the Ministry supported the creation of the new Sudanese National Committee for the Eradication of Traditional Practices Affecting the Health of Women and Children (SNCTP) with NGO status. At present, collaboration between the Ministry of Health and Social Welfare and the National Committee is strong. The team met with Mr. Mohamed Zaki, Under-Secretary for Social Welfare. He

stated that in its four-year Plan of Action, his Ministry intends to integrate education on the harmful effects of female circumcision. Social workers are encouraged to implement the Plan of Action designed by the SNCTP through training and information campaigns. The Ministry has adopted a clear policy to support and encourage activities to eradicate female circumcision.

(b) Women's Unit, Ministry of Health and Social Welfare

52. Headed by Ms. Rabat Hamid El Meheina the Women's Unit runs programmes of training, workshops and income-generating activities. It also has a documentation unit set up in collaboration with the International Research and Training Institute for the Advancement of Women (INSTRAW). The training programmes are targeted to reach midwives, extension workers and women community leaders. In some of the programmes, information on traditional practices is integrated with an extensive use of educational materials provided by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). Extension workers and midwives receive special education on the effects of female circumcision and they in turn are encouraged to inform mothers and other members of the community. The need to expand the outreach of education and information to the rural areas being strongly felt, Ms. Rabat El Meheina proposes the setting up of regional centres equipped with sufficient documentation on female circumcision and other harmful practices.

(c) Ministry of Justice

53. A meeting was held with the Attorney-General, Mr. Ahmed Mohamed Hassan and his Legal Advisor, Mr. Subai. During the discussion, the team was informed about the old British Law of 1946, which banned the practice of infibulation; this Law proved to be ineffective since it was imposed by a colonial power. The Attorney-General was against criminalizing the act since he thought that this would arouse public uproar; instead, he felt that including it in the public health ordinance would give a better result as this would be followed by public education. Islamic law is against the practice. The Sudan has ratified the Convention on the Rights of the Child and this instrument protects children from traditional practices prejudicial to their health. In some areas in the South, customary law prevails over public law: native courts have their own way of punishing an offender by imposing fines. All these various local situations have to be studied before trying to impose judicial sanctions against harmful traditional practices.

(d) Mother and Child Health Centre, Ministry of Health and Social Welfare

54. Managed by the Ministry with support from WHO and UNFPA, this centre runs programmes of health education, family planning and paediatric service; information on female circumcision is included in the training programme for mothers and health workers. The SNCTP provides material as well as technical support to this institution.

(e) School of Midwifery

55. Every 6 months, the school graduates 50 midwives who come from different regions of the Sudan. Education on the practice of female circumcision and other harmful traditional practices is incorporated in the curriculum. This measure is bound to have a far reaching effect since the trained midwives can convince mothers in their respective regions on their return.

(f) Babiker Badri Scientific Association for Women Studies (BBSAW)

56. This is an organization set up in 1979 by a group of volunteer women in order to enhance research and education on women's issues. It is linked to the Ahfad College for Women since both institutions are controlled by the Babiker Badri Association. This Association is one of the pioneer organizations in the fight against female circumcision. BBSAW organizes seminars, workshops and studies on the subject. It runs an income-generating project for mothers in which education on female circumcision is gradually introduced. The Ahfad College for Women which has over 3,000 female students has integrated education on female circumcision in its curriculum. The graduates from the college form the elite women in the Sudanese society.

(g) Sudanese Women's Union

57. This young organization set up to coordinate all activities related to women has a political and social office. Its policy on female circumcision stands for total eradication; it plans to collaborate with SNCTP in order to reinforce the activities. The Union's objectives are to provide social welfare for the disadvantaged sectors of the society including children and mothers. Concerning traditional practices, it deals with issues such as:

- The high rate of death among mothers and children especially during childbirth;
- The high incidence of malnutrition among mothers and children and the adverse effects it has on their health;
- The effects that exhaustion from unsuitable employment conditions has on the health of mothers psychologically, mentally and physically;
- The adverse effects of early marriage especially during the age of adolescence;
- Harmful traditional practices and their eradication;
- Child spacing and the use of contraceptives;
- Fatal diseases such as AIDS.

The Sudanese Women's Union organizes educational and cultural programmes in order to raise the awareness of the public in general and women in particular to existing harmful practices in the society (using the mass media, printed documents and posters).

(h) WHO Country Representative

58. A meeting with Dr. David Robinson demonstrated that not much is being done by his office in the area of traditional practices. Activities are concentrated on research on AIDS, health education, laboratory testing, counselling HIV patients, etc. The only entry point for female circumcision in the programme of WHO as proposed by the representative is the inclusion of related questions in the epidemiological survey on HIV transmission which the WHO office is conducting.

(i) UNFPA Country Director

59. Mr. Omer Ertur informed the team about two major projects for women: a Centre for income-generating activities and a high-level training at Ahfad University on population and women. UNFPA has also initiated and supported the production of TV spots on female circumcision, early marriage, child spacing, nutrition, etc. The Director plans to negotiate with the Ministry of Information for regular transmission of these materials which are highly informative and educational.

(j) UNICEF

60. Discussions were held with Mr. Richard Prado, UNICEF Project Officer and Mr. Mahendia Sheth, Officer-in-Charge of the Health Section, who informed that UNICEF had taken the initiative to include education on female circumcision in its five-year plan.

(k) Rädda Barnen

61. A meeting was held with the Resident Representative, Mr. Kjell Paulson and the Programme Officer, Mrs. Monica Paulson. Rädda Barnen and the Canadian Save the Children support the Sudanese National Committee for the Eradication of Traditional Practices Affecting the Health of Women and Children; the two donors plan to strategize their support in order to make it more effective. At present, their assistance involves administrative and transportation facilities.

(l) Canadian Save the Children

62. Mr. Robert Schmeider, Country Director informed the team of the support his organization provides to the SNCTP. Thanks to this grant, the Committee has a vehicle and a small office space from which it operates.

(m) Embassy of the Netherlands

63. During a courtesty visit, the team was received by a Women and Development Specialist who stressed the importance of an integrated approach in dealing with the problem of traditional practices. The Netherlands Government supports income-generating activities, training programmes for awarenesss-building among women and the building of infrastructure for women's programmes. She expressed interest in helping the SNCTP provided it is restructured to involve more dynamic and committed members.

2. Mission to Djibouti (2-6 December 1990)

64. The Government of Djibouti designated the National Committee for the Fight against Female Circumcision and Infibulation to receive the team. The Committee prepared a detailed programme for the team covering visits to selected ministries, women's unions, clinics and project sites. The discussions which took place during these visits are summarized in the following paragraphs:

(a) National Committee for the Fight against Female Circumcision and Infibulation

65. The Committee was set up in 1987 with members coming from the Ministries of Health, Justice, Education, as well as from the Red Crescent Society and the Union Nationale des Femmes de Djibouti (UNFD); at present, it works under the umbrella of the UNFD. It organizes national seminars, workshops, training for traditional birth attendants and information sessions for various target groups, such as religious leaders, mothers, fathers and policy makers. It makes an extensive use of the media to inform the public. It is playing advocacy for government legislation. The President of the Committee expressed concern over the lack of financial and human resources to implement various projects for the eradication of harmful traditional practices. She said that members of the Committee are volunteers and there are few remunerated personnel assisting the Committee. Unless the situation changes, the Committee may not be able to achieve its goals.

(b) Ministry of Health

66. The Minister of Health encourages the activities of the National Committee for the Fight against Female Circumcision and Infibulation. He assured the team that support will continue to be provided to the Union Nationale des Femmes de Djibouti (UNFD) in all its attempts to free women from infibulation. Officials of the Ministry participated in meetings and seminars related to traditional practices affecting the health of women and children. The Minister allows the use of clinics and health training centres for the diffusion of information related to female circumcision and other traditional practices. An ad hoc committee had been formed to design programmes for the promotion of safe motherhood. The Minister felt that the plan for mother and child health care could include information on traditional practices; he also proposed the organization of seminars for students as a means to sensitizing the youth.

(c) Ministry of Education

67. The Minister of Education informed the team that his Ministry and he himself are committed to the advancement of women and in particular to the eradication of infibulation. He thought that school radio programmes could be used to inform the public about the danger of female circumcision. He also pointed out the decisive role the UNFD can play in implementing a viable programme for the eradication of female circumcision and other harmful traditional practices; UNFD has a mandate to liberate women from such customary practices. He felt the sensitizing of students in schools could have a far-reaching effect.

(d) Ministry of Foreign Affairs

68. The team was made to understand that the issue of human rights and traditional practices was not considered as a priority since the Government deals with other basic human problems which need immediate attention. No law has been decreed against female circumcision since the experience of other countries regarding legislation on this issue resulted in a failure. Public education and information are considered as the most effective measures: recognizing the activities of the National Committee, the Minister stressed the importance of supporting the work being undertaken. He informed that Djibouti has ratified the Convention on the Rights of the Child. The team also met with the Head of Multilateral Relations Branch and exchanged information on activities being undertaken regarding traditional practices, at both national and international levels.

(e) Ministry of Justice and Islamic Affairs

69. The Minister was well informed about the question of traditional practices since he was previously Minister of Health. In his Ministry, a commission is being set up to revise the existing legal system; the question of female circumcision and other practices could be raised during the sessions of this commission. He mentioned the important role religious leaders could play in changing public attitude and suggested that a team could campaign in the mosques and other religious centres; he also felt that seminars specially targeted to sensitizing religious leaders could be useful.

(f) Ministry of Information

70. The team met with the Secretary-General of Information and the Director of Radio and Television. They informed the team of the wide media coverage of information related to conferences, seminars and workshops concerning traditional practices. The Secretary-General thought that the initiative to change public attitude should originate locally without pressure from outside; he mentioned the important part the media can play in educating the public. He and his colleague assured the team of their disposition to collaborate with the National Committee for the Fight against Female Circumcision and Infibulation.

(g) Meeting the First Lady

71. Mrs. Aïcha Bogoreh assured the team of her decision to fight against infibulation. She has spoken against it to religious leaders and policy makers. As the President of the Women's Union she supports the programme of the Union in relation to infibulation and also other issues concerning women. She congratulated the National Committee for the work it has done in this domain and pointed out the urgent need the Committee faces concerning transportation in order to cover areas outside of Djibouti city. She also realized the importance of having full-time employees in the Committee in order to advance the work, since voluntary service cannot be as reliable. She saw progress being made in changing public attitude regarding infibulation as a result of the carefully planned educational programme. She believes in gradual change.

(h) Union Nationale des Femmes de Djibouti (UNFD)

72. The Secretary-General informed the team of the various programmes the Union runs for women: these include literacy, sewing and handicraft for young girls, health education. The National Committee for the Fight against Female Circumcision deals with health projects. Education sessions on the effects of infibulation are organized in the different annexes of the Union's headquarters. She felt that integration of women's health programme in the plan of the Ministry of Health could be more effective. UNFD is pressing the Government for legislation against female circumcision. She felt that the Convention on the Rights of the Child should be widely distributed.

73. The team also met with the Vice-President of UNFD. She expressed her entire support to the work of the National Committee for the Fight against Female Circumcision. She also stressed the need for means of transportation so that the members can be more mobile to reach the nomadic population. Lack of financial means limits the activities of the Committee. Education materials are also lacking. She mentioned the need for the Committee to be more autonomous in order to implement programmes effectively and to be able to raise funds for its activities.

74. The team visited a clinic run by UNFD where girls were brought in for circumcision; the operation was done by a traditional circumciser; before the operation, the girls are given local anesthaesia for a "mild" form of circumcision. The team was informed that most of the time grandmothers took the girls back home complaining that the circumcision was not complete enough, since no infibulation was performed. The clinic is designed to be a centre for sensitizing mothers about the danger of female circumcision in all its forms.

75. The team also visited UNFD centres in the village of Arta, outside Djibouti, where training and information campaigns had been conducted by the National Committee. The villagers, women and men, were given information sessions for five days. At the end, seven members were selected to be trainers to continue the sensitization programme. The villagers seemed to be conscious of the problem of female circumcision and ready to fight against it progressively. The team visited a centre of literacy campaigns for women where information on harmful traditional practices was given. The women appeared to have sufficient information about the danger of female circumcision, early marriage and nutritional taboos.

(i) WHO

76. Dr. Habila Wassef, WHO Representative, showed great interest in the work of the National Committee and expressed her disposition to support its activities. She had already assisted the Committee to organize a national seminar; an expert was brought in from the WHO Alexandria office to help during the seminar. Dr. Wassef informed the members of the Committee who accompanied the team about the possibility of funding for projects which could be secured from various donor countries. She encouraged the members of the Committee to design a viable project and to present it to the WHO office in Djibouti.

(j) UNICEF

77. Efforts were made to contact the UNICEF representative, but he was unfortunately not available at the time.

(k) UNDP

78. The team discussed with Mrs. F. Mohammed, officer from UNDP, the Women's Development Section. She revealed that UNDP could finance training programmes which could provide alternative sources of income for traditional practitioners. This proposal has to be followed up by the National Committee.

(l) Other relevant visits

79. The team visited the home of a traditional practitioner who was busy cutting the uvula of a young child with an old knife; this was done in a very unhygienic way without anaesthesia. She received payment for her services. The mother and grandmother of the child who were present said that hospitals refuse to do such an operation.

80. The team visited also the Dar Hassan maternity hospital. Mothers who come to the hospital receive information and educational material about female circumcision with the use of visual aids. Some members of the National Committee who are professional midwives use this hospital to spread information on harmful practices.

3. General conclusions

(a) The Sudan

81. In the Sudan, the Government policy regarding harmful traditional practices is favourable to undertaking activities of public education and information. Since the issue of human rights seems to be a sensitive topic, the rights to health for women could be a less controversial entry point for ensuring government collaboration. Most of the programmes so far conducted are largely efforts made by non-governmental organizations.

(b) Djibouti

82. With regard to Djibouti, there is definitely progress made in the area of public education regarding the problem of infibulation. The Government considers the UNFD as the only organization which should deal with the problem. This puts a great deal of responsibility on the UNFD which is not fully equipped to handle all problems related to women. The support and encouragement of the First Lady have helped the National Committee to advance the campaign. The National Committee needs full-time experts in order to deal with the problem from its various aspects, i.e. religious, legal, economic and social. A regional seminar on traditional practices would certainly open the door for discussing the problem with policy makers.

4. General recommendations

83. The two field missions to the Sudan and Djibouti have led the team to make the following general recommendations:

(a) The study undertaken and other activities accomplished by the Centre for Human Rights should reach relevant government ministries, in addition to the Foreign Ministry. The Centre should find effective ways and means to ensure that documents are channelled to the right government agencies and non-governmental organizations;

(b) Effective mechanisms need to be set up for better liaison between the Centre for Human Rights, concerned specialized agencies and non-governmental organizations dealing with the problem of traditional practices affecting the health of women and children;

(c) United Nations programmes designed to raise the status of women in general and their health status in particular should include information on the harmful effects of genital mutilation, nutritional taboos, early marriage, son preference and other such practices;

(d) More efforts should be made by the Governments of the two countries to raise the level of awareness of women about their basic human rights, in particular their rights to health and general well-being;

(e) Governments should adopt legislative measures to protect mothers and children from harmful traditional practices. This should be backed by intensive public education;

(f) The activities of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children and its affiliates, both at national and international levels, deserve support from Governments, WHO, UNICEF and the Centre for Human Rights, with a view to strengthening the educational campaign which at present is showing positive results.

B. Status of the regional seminars on traditional practices affecting the health of women and children to be held in Africa and Asia

1. Africa

84. Pursuant to Sub-Commission resolution 1989/16, as approved by the Commission on Human Rights in its decision 1990/109, the first regional Seminar on Traditional Practices Affecting the Health of Women and Children was organized by the Centre for Human Rights in cooperation with the Government of Burkina Faso. The seminar was held in Ouagadougou, from 29 April to 3 May 1991. The objective of the seminar was to assess the human rights implications of certain practices such as female circumcision, the preference of the male child and traditional delivery practices. It was also aimed at gathering information on measures undertaken to combat and eliminate such harmful practices. Invitations were sent through UNDP to 25 African countries. Relevant international organizations and non-governmental organizations were also invited to attend. The report of the seminar (E/CN.4/Sub.2/1991/48) is placed before the Sub-Commission for consideration.

2. Asia

85. In view of the lack of necessary resources to fulfil the various mandates given to the Centre for Human Rights, the Secretary-General was unable to organize the second seminar on this subject in 1991. However, every effort is being made to hold such a seminar in early 1992. The Secretary-General has drawn up the following provisional agenda for the regional seminar to be held in Asia:

I. Son preference and its implications on the status of the girl child

(a) Physical growth and development, including nutritional status;

(b) Educational opportunities;

(c) Health care;

(d) Recreation.

II. Marriage and related traditional practices

(a) Early marriage and early pregnancy and the health consequences;

(b) Dowry and its socio-economic consequences on young women;

(c) Child delivery and traditional practices;

(d) Status of divorced women.

III. Violence against women, including mutilation and bride burning

IV. Conclusions and recommendations

CHAPTER III

SUMMARY OF INFORMATION RECEIVED ON MEASURES TO ELIMINATE HARMFUL PRACTICES

86. On 17 October 1990, the Secretary-General addressed note verbale G/SO 234 (17-5) to Governments and concerned organizations requesting them to provide information on any recent developments, including any measures taken or envisaged to eliminate practices injurious to women and children, and any information relating to legislation, public education and research. The following sections contain a summary of information submitted by 12 Governments, 2 specialized agencies and 8 non-governmental organizations.

A. Information received from Governments

1. Bangladesh

87. With regard to recent developments and measures taken to eliminate practices injurious to women and children, the Government states that discrimination in the treatment of male and female starts at birth and continues through the different phases of life. Gender inequality is established through socio-economic inequality and distribution of authority and assets between sexes as determined by the family organization and stratification of society. Even within the same socio-economic class, women are worse off than men in nutrition, health, education and social status and gap widening over time.

(a) Policies and measures

88. The Ministry of Women's Affairs has been adopting policies and undertaking measures for ensuring participation of women in the socio-economic activities and to raise their status.

89. Education is viewed not merely as an individual's right to enlightenment but also as an investment in human resource development. Special emphasis has been laid on equalizing educational opportunities for both men and women. The Government has taken some important steps for greater participation of girls in educational institutions. The Government has enacted the primary Education (Compulsory) Act 1990 to introduce compulsory primary education for both boys and girls in the country. To promote girls' enrolment at the primary level the Government has adopted a policy to fill up 60 per cent of the vacant posts of primary teachers by female candidates. Moreover, education up to grade 8 has been made tuition-fee free for female students of outside the municipal areas.

90. Due to improved medical facilities provided by the Government, infant and child mortality, and maternal mortality have shown a downward trend even in the face of lower intake of nutritional inputs. Moreover, the mortality rate is declining.

(b) Measures for protection of women's rights and status

91. The Constitution of Bangladesh clearly upholds the principle of equality between men and women and forbids discrimination against women. To protect

their legal rights and to stop violence and repression against women, the Government has taken a large number of measures which include the following:

(i) Dowry Prohibition Act, 1980, provides for punishment for giving, taking or abetting of dowry.

(ii) Cruelty to Women (Deterrent Punishment) Ordinance, 1983, provides for punishment by death/transportation/R.I. for 14 years for kidnapping or abduction of women for unlawful purposes, trafficking in women and for causing death or attempting to cause death or causing grievous hurt to the wife for dowry.

(iii) Child Marriage Restraint Act Amendment Ordinance, 1984, which raises the marriageable age of women from 16 to 18 years and men from 18 to 21 years. It also provides for punishment for marrying or giving in marriage of a child.

(iv) The Muslim Family Laws Ordinance, 1961, (as amended in 1982), provides for increased punishment in cases of polygamy and divorce in violation of the statutory provisions.

(v) In recent years, women have become the worst victims of acid throwing. The Penal Code (Second Amendment) Ordinance provides for capital punishment for voluntarily causing grievous hurt to the victims.

2. Cameroon

92. Female circumcision, early marriage and nutritional taboos exist in certain parts of the country. The Government has set up a National Committee which conducts programmes of education and sensitization among the population. The Committee is also asked by the Government to propose effective measures to deal with the problem.

3. Congo

93. The Government of the Congo states that there is effective participation of women at all levels of political, economic and socio-cultural life. A department of women's integration in development has been set up within the Ministry of Planning and Economic Affairs.

94. The People's Republic of the Congo is a signatory to the Convention on the Rights of the Child and, in spite of the economic crisis, is actively promoting children's welfare by such measures as: the establishment of a Family Welfare Association; the holding of a vaccination campaign in 1986; the building of play centres and pre-school education centres in the regions; the broadcasting of radio and television programmes for mothers and children; and the holding of a children's day, without distinction as to sex.

95. Such practices as female excision do not exist in the Congo.

4. France

96. As regards the problem of sexual mutilation, the French Government states that such acts fall within the purview of, and are very severely punished under, the French Penal Code in accordance with article 312-3, as amended by Act No. 81-82 of 2 February 1981:

> "Any person deliberately striking a child under 15, or exercising violence against him or committing an assault upon him, unless the degree of violence used be slight, shall be punished in accordance with the following scale of penalties: (...)
>
> (3) By rigorous imprisonment for 10 to 20 years if the result has been mutilation, amputation or loss of use of a limb, blindness, loss of an eye or other permanent disabilities, or death not intentionally caused by the perpetrator."

97. These penalties are increased to rigorous imprisonment for life in two sets of circumstances: (a) where the perpetrators are the legitimate, natural or adoptive father and mother or other persons having authority over the child or responsible for his care (art. 312, para. 5-3); and (b) where the violence concerned has been habitually practised (art. 312, para. 5-3).

98. The Criminal Division of the Court of Cassation decided, by a judgement of 20 August 1983, that ablation of the clitoris resulting from wilful violence constituted a mutilation in the sense of article 312-3 of the Penal Code. While the phrase "female sexual mutilation" is not used in the Penal Code, this decision makes it quite clear that such practices fall within the purview of the enactment.

99. France has moreover signed and ratified the United Nations Convention on the Rights of the Child, which provides in particular (art. 19) that States parties shall take all appropriate measures to protect the child from all forms of physical or mental violence, maltreatment, including sexual abuse, while in the care of parents or any other person who has the care of the child.

5. Madagascar

100. The Government of Madagascar states that Malagasy tradition attaches great importance to procreation and women's fecundity. It is by motherhood that a Malagasy woman achieves adulthood, and she does not voluntarily cease child-bearing when her family has reached the desired number of children. She is generally subject to natural fertility and bears children as long as her physiological condition enables her to do so.

101. Malagasy women marry very young. According to the most recent census (1985), 32 per cent of women aged between 15 and 19 are already married. At present, early marriage may still be legally contracted (from 14 years of age) with the consent of the parents. Traditional marriage is thus largely sanctioned.

102. Infant mortality, which remains high in Madagascar, varies according to the order of birth of the child (from 80 to 120 per 1,000 for the first and second). The functional and organic changes imposed on the mother's body by the birth process are major factors in this mortality, particularly where living conditions are poor, as in the case of rural families.

103. Given below is an outline of traditional practices relating to early marriage and maternity which have harmful effects on the health of Malagasy women and children. These practices (which do not include excision) are still current, albeit to a limited extent, in rural areas. At the present time, the improvement in health, education and living conditions in these areas is leading to the gradual disappearance of these practices.

(a) Traditional marriage, and maternity and delivery problems

104. In traditional Malagasy circles, parents have absolute power over their children's choice of marriage partner. This family authoritarianism finds its extreme manifestation in forced marriage, known as Tretreka or Keliloha marriage, whereby the union wished by the parents is contracted even where there is express unwillingness on the part of the couple concerned. As a result of the joint educational and public-awareness efforts of the Malagasy Government and non-governmental organizations, but mainly thanks to young people's growing aspirations to emancipation, the absolute power of parents is being steadily eroded.

105. Large families have always been a mark of honour in Madagascar, and the greatest misfortune for a women is to be sterile. Consequently, women will stop at nothing in order to become pregnant, and the most irrational means and abhorrent practices are regarded by them as justified in their desire to have children.

106. New obligations are imposed on a woman from the start of pregnancy until the time of birth: there are certain things she must do and others she must refrain from doing (fady) for the sake of her own health and that of her unborn child.

107. In the event of obstructed labour, the cause is attributed to evil spells cast by an enemy. The midwife has no inkling that what is involved may be a narrow pelvis, and since she has no precise idea of the anatomy of the maternal organs and of foetal positions, she can only have vague and limited notions of exploratory techniques generally used to diagnose the position and presentation of the foetus. Consequently, the original positions and presentations are never recognized in advance, and are only diagnosed at a very late stage of foetal development, and even then the midwife can only identify the presentation by the parts of the foetus she can see.

(b) Children born during the lunar months of Alakaosy and Asorotany

108. We must now refer to an extremely barbarous custom, which has apparently not entirely disappeared in some provinces. It concerns children born in months when the fates are potent and hostile (Asorotany and Alakaosy). Unlike the Gregorian calendar, the traditional Madagascar calendar is closely linked to the lunar cycle and positions of the stars.

109. Children born in Alakaosy are considered to be endowed with an occult power capable of causing the death of one or both parents at an early date, more commonly the parent of the same sex as the child. Consequently, in spite of the general desire to have offspring, if a child is born in Alakaosy, the parents do not hesitate to get rid of it by one of the following methods:

(i) The first, and most lethal, is employed by those for whom efficiency is the prime consideration. The baby is placed on a tray with its belly turned towards the sun, and water is poured in until it reaches the edge of the tray, which may or may not be covered with a basket. If the baby dies, it is a sign that its continued existence would have proved fatal to its parents.

(ii) The other method is perhaps less effective, but no less cruel and barbarous. The body is laid on its back at the entrance to the yard where the oxen are kept, and they are then driven out. If the child is not trampled, it is taken up and reared but is given the name Tsimandresy (one that kills not).

It should be noted that the Madagascar Penal Code covers and provides for the punishment of both infanticide and child abandonment.

110. The Malagasy Government draws attention to the fact that the combined effects of education, the increasing availability of medical services, and improvements in hygiene and general health conditions in Madagascar have contributed to the significant changes now apparent throughout the country.

6. Morocco

111. The Government of Morocco states that the information supplied below in the reply by the Moroccan Ministry of Public Health relates primarily to the following two points:

(a) Preference for children of the male sex

112. While this phenomenon can be observed at the cultural level, the consequences referred to do not apply to Morocco:

(i) As far as nutrition is concerned, the 1987 national survey "Population and Health" did not indicate that girls suffer from serious malnutrition more commonly than boys;

(ii) As regards mortality, there is no greater mortality of female children.

(b) Traditional methods of delivery

(i) There are no traditional food restrictions for women;

(ii) The problem of traditional midwifery practices, the lack of training of midwives, and the consequences for mother and child are among the concerns of the Ministry of Health, which has launched a campaign to

identify and train women undertaking this work. In order to improve the training of traditional midwives, Morocco proposes to hold a Maghreb conference on "Motherhood without risk" in April 1991.

7. Mauritius

113. The Government states that traditional practices such as female circumcision do not exist in Mauritius. About 8 per cent of deliveries are performed by traditional birth attendants, some 200 of whom have received training on hygienic procedures and have been given a UNICEF Traditional Birth Attendant Kit.

114. In general, children of both sexes receive the same treatment. At present, there is national legislation to protect the health of mothers and children and the Government foresees new legislation in this area.

115. Public Health Education is the top priority of the Ministry of Health. National seminars have been held for the promotion of the health of mothers and children, and surveys and research are conducted for the further improvement of health services.

8. Niger

116. The Government of Niger states that the principal traditional practices harmful to women and children in the Niger are the following:

Nutritional taboos and forbidden foods;

The forced feeding of baby girls;

Forced early marriages and early pregnancies;

Delivery in the family of the first child;

Constraints on the role of women in Niger society;

Excision.

The following measures are being taken to combat these practices:

(a) Information, education and use of the media

117. Public awareness, education and information through the media on the harmful consequences of early marriage and forced feeding. People are told of the need to delay the first marriage until the woman is older, and even more so the first pregnancy (by women under 18 taking the pill), and of the need to lighten the work of pregnant women. Mothers are encouraged to continue breast-feeding their children as long as possible and to practise gradual weaning. The lifting of food taboos is also being advocated.

118. Midwives are trained at the village level and have the task of combating bad practices as one of their duties. Both they and the general public are

informed of the necessity for prompt decisions to have pregnant women in general, but especially primiparous women, delivered with medical attendance.

(b) Political measures

119. It is essential that women should become increasingly involved in socio-economic, medical and political activities. The following are the measures contemplated:

(i) The formulation and finalization of a family code, which awaits adoption by the Assembly;

(ii) Much remains to be done regarding the school enrolment of girls, which will undoubtedly delay first marriage, and consequently first pregnancy;

(iii) The entry of women into government and their participation in the National Assembly are concrete manifestations of the political will of Niger leaders to re-establish the rights of women to manage their own affairs.

9. Pakistan

120. The Government of Pakistan states that the Special Education and Social Welfare Division has been making all-out efforts to improve the state of children, especially in the areas of health, education and social welfare without any discrimination. It has formulated a national plan of action for child welfare and development which encompasses children's needs and problems and offers community-based tangible services to improve their quality of life. The plan of action will serve the following goals:

(a) Empower communities in general and especially mothers with the knowledge required for improved care and development of children;

(b) Introduce community-based services for improving the health of mothers and children in order to reduce infant mortality, prevent malnutrition, childhood diseases and disabilities;

(c) Introduce early education and greater enrolment of children, especially girls in rural as well as urban areas;

(d) Offer community-based educational and development programmes for school drop-out children;

(e) Prevent exploitative nature of child labour and extend health, education and recreational facilities for children to their workplaces;

(f) Improve institutional care and welfare of abandoned, destitute and orphan children;

(g) Promote reformatory services for juvenile delinquents and young offenders.

121. To create awareness among concerned organizations about institutional and legal protection for children, existing legislation for preventing child abuse and neglect is being compiled through UNICEF. The legislation is also simultaneously being reviewed in order to assess the extent of its enforcement and the difficulties encountered in this regard. As a result of this review, recommendations will be made for effective enforcement of the legislation in order to protect children from abuse and exploitation.

122. A joint UNICEF/Government of Pakistan national framework has been formulated for development services for children under difficult circumstances. Development programmes for working children, children in institutions, abandoned, destitute and neglected children, will be covered under this programme.

123. In view of Pakistan's commitment for implementation of the decisions of the World Summit for Children, 1990, a task force to facilitate follow-up and coordination with other ministries, divisions, provincial governments and non-governmental organizations has been established.

10. Sweden

124. The Swedish Government states that there is no evidence of the use of traditional practices affecting the health of women and children in Sweden; therefore, no specific measures are needed to eliminate them. However, there is legislation for the protection of women and children with specific references to traditional practices.

125. Female circumcision is forbidden. The Government recognizes the important contribution made in this area by non-governmental organizations, as well as the Convention on the Rights of the Child, article 24, paragraph 3. Sweden has contributed to Save the Children and other funds designed to combat these practices.

126. Non-authorized health-care providers are forbidden to treat persons with contagious or other serious diseases, as well as children under 8 years of age. It is also forbidden to treat pregnant women or to assist at giving birth, if the woman has any kind of disease or ill-health. Violations of these regulations are very rare.

127. Sexual abuse and child chastisement (including spanking by parents) are prohibited by law. The police are notified of about 2,000 cases of maltreatment each year.

128. Although abortions are legal in Sweden, health education, family planning, counselling on sexual relations, etc. are considered important to prevent abortions, particularly among teenage girls. During the last few years, abortions among younger age-groups have increased. To combat this, the Government is intensifying programmes for the prevention of abortion among young persons.

11. Tunisia

129. The Tunisian Government transmits herewith the following information communicated by the Ministry of Public Health regarding traditional practices harmful to the health of women and children.

130. Since independence, the Tunisian Constitution and the Code on Personal Status have guaranteed the equality of citizens of both sexes and have not allowed any discrimination between them. The traditional practices in question have never been current in Tunisia and do not exist at the present time. Accordingly, the Tunisian Government has not had occasion to take legislative measures to eliminate them.

131. Furthermore, numerous measures - legislative and other - have been adopted by the Tunisian Government since 1956 to promote female emancipation, for example: the abolition of polygamy, school enrolment for girls; the execution of national health programmes specifically intended to promote the health of mothers and children, and a national family planning programme.

12. United States of America

132. The Government of the United States has been concerned about female genital mutilation since the early 1970s, as it is considered to be harmful to women's health and a violation of women's human rights. It encouraged the World Health Organization to convene the 1979 seminar on traditional practices held in Khartoum, Sudan. This was the first time the United Nations dealt with this issue in depth. The United States supports the recommendations of the Khartoum seminar that governments adopt clear national policies to abolish female circumcision and intensify educational programmes to inform the public about the harmful effects of female circumcision.

133. The United States fully supports the following statement made by the WHO in 1982: "WHO has consistently and unequivocally advised that female circumcision should not be practised by any health professionals in any setting, including hospitals or other health establishments". The United States believes that efforts to eradicate female circumcision can be successful only if the call to abolish it comes from the countries where the practice occurs. Thus, the United States has worked with other Governments and international organizations to promote the study and publicity of the harmful medical effects of female circumcision.

134. There has been growing concern in the United States over human rights abuses against women: such abuse is a violation of human rights as defined in existing legislation. Noting that government tolerance of violence and abuse against women appears to be widely practised and tacitly condoned in many parts of the world, the United States Senate Foreign Relations Committee called on the Department of State to pay special attention to human rights abuses against women in country reports on human rights practices. Accordingly, since 1989, these reports have specifically addressed violence and abuse against women, including genital mutilation. The United States hopes that these reports will heighten the awareness of how widespread the practice of female circumcision is, and encourages Governments to adopt clear national policies to abolish it.

B. Information received from specialized agencies

1. United Nations Children's Fund

135. The United Nations Children's Fund has adopted a policy to support activities carried out by Governments and non-governmental organizations. It collaborates with the non-governmental Working Group on Traditional Practices Affecting the Health of Women and Children, and the Inter-African Committee. It supports research activities, workshops and training programmes in the countries where the practice exists.

2. World Health Organization

136. The World Health Organization adopted a position condemning female circumcision as a serious health risk which needs to be abolished. It called upon medical personnel to refrain from performing it. In 1979, it organized in Khartoum the first regional seminar on traditional practices affecting the health of women and children. At the seminar, it was recommended for Governments to take action to stop the practice. The establishment of a national commission for coordinating activities was proposed. WHO expressed its disposition to support government actions aimed at eradicating the practice.

137. WHO reports on its continued commitment to the elimination of traditional practices affecting the health of women and children.

(a) In May 1984, WHO issued a statement on its positions and activities.

(b) In September 1988, the thirty-fifth session of the WHO Regional Committee for the Eastern Mediterranean passed a resolution on maternal and infant mortality (socio-economic implications) which stated, inter alia, that women's health must be safeguarded by ensuring the elimination of harmful traditional practices, including female circumcision.

(c) At the thirty-ninth session of the WHO Regional Committee for Africa in September 1989, a resolution on traditional practices affecting women and children was passed. The resolution recommended that Member States concerned should adopt appropriate policies and strategies to eliminate female circumcision, organize educational and international activities in line with local cultural contexts, prohibit the medicalization of female circumcision, include in training programmes for health personnel and traditional birth attendants relevant information on the dangers of female circumcision, encourage research projects and put into practice the various recommendations made at the national and international levels in this area. The Regional Director was requested to provide appropriate support.

(d) Under the Women's Health and Development Programme of WHO, a report by the Director-General was issued as WHO Offset Publication No. 90, in 1985. The resolution adopted by the Thirty-eighth World Health Assembly on 17 May 1985 (resolution WHA38.27 on "Woman, health and development") is mentioned in the beginning of this report. The resolution calls for WHO and

Member States to pay close attention to and cooperate with each other in protecting and promoting women's physical and mental health, particularly by intensifying women's participation in this venture.

(e) More recently, in May 1989, at the forty-second World Health Assembly, resolution WHA42.42 was passed on Women's Health reflecting the earlier resolutions and emphasizing that the physical, social and mental health of women in many countries continues to be threatened by discrimination and insufficient priority given to the development and maintenance of relevant health and social services of women.

138. WHO has cooperated very closely and continues to collaborate with the NGO Group (NGO Sub-Committee on the Status of Women, Working Group on Female Circumcision) established under the auspices of the Commission on Human Rights, in order to coordinate action of NGOs on this subject. Also, the programme area of Women's Health and Development collaborates very closely with other United Nations agencies and non-governmental organizations involved in this field.

139. In collaboration with the International Planned Parenthood Federation (IPP), WHO is in the process of preparing a "focus article" on female circumcision. This short article is intended to draw the attention of professional health personnel, especially obstetricians/gynaecologists, to the complex problem of circumcision and their role in its prevention and will be published in various international, regional and national obstetrics/gynaecology journals.

C. Information received from non-governmental organizations and other organizations

1. International Federation of Business and Professional Women

140. The International Federation of Business and Professional Women passed a resolution at its Congress in 1989 in the Bahamas calling for the eradication of female circumcision.

2. International Council of Women

141. The International Council of Women was one of the first NGOs working on this issue, and is a member of the NGO group headed by Mrs. Berhane Ras-Work which develops educational programmes in this field. Through its permanent member to the WHO and its Standing Committee, ICW has initiated programmes for its members on the national, regional and international levels.

142. In 1979, the International Year of the Child, an international seminar was held in Nairobi on proper dietary habits for mothers and children and a leaflet was published and translated by ICW into their respective languages. Since then, information was sent to all affiliates on oral rehydration, food hygiene, AIDS, and several other matters.

143. While combating the dangers of practices which are detrimental to health, ICW notes the delicate issues rooted deep in tradition. ICW is dedicated to educating its members (through written information, seminars and other projects) as to their right to know their needs, their children's needs, and their rights to demand answers and recognition of their equal rights.

3. Zonta International

144. Zonta International states that unfortunately, until 1986, they had not taken action in the international arena on the subject of traditional practices affecting the health of women and children because of differing opinions among their African Clubs as to the necessity of such action. For this reason also, Zonta International was not authorized to officially participate in the NGO Working Group sessions on this question. Since then, the organization has become a member of the Group, following its work with great interest, and has co-signed several declarations at the Sub-Commission and the Commission on Human Rights.

145. Different members of African Zonta Clubs play an important role in the struggle against traditional practices. In addition, Dr. Olayinka Kosso-Thomas, member and ex-president of Zonta Club of Freetown is president of the national committee of the Inter-African Committee in Sierra Leone, and has written a book entitled "The Circumcision of Women - A Strategy for Eradication" (1987).

146. Several years ago, the Zonta Clubs of Paris became involved in work being done by the G.A.M.S (Groupe femmes pour l'abolition des mutilations sexuelles) concerning immigrants. In collaboration with Swiss members, the Paris Zonta Club financed the participation of a G.A.M.S. member in an Inter-African Committee seminar in Addis Ababa (6-7 April 1987).

147. Finally, during the last World Convention of Zonta International, in June 1990, Dr. Kosso-Thomas sold copies of his book. This focused more attention on the problem, in particular to their American members who, for the most part, ignore it. This organization hopes that in time, in light of the remarkable progress made by the Inter-African Committee, the African members of Zonta International will adhere more and more to the movement, which is indispensable in the positive development of the condition of women.

4. Rädda Barnen International

148. Rädda Barnen International supports the Inter-African Committee (IAC) and six different non-governmental organizations in six countries: Egypt, Ethiopia, Kenya, Mali, Somalia and in the Sudan. The policy of Rädda Barnen has been to support the fight against harmful practices financially and morally, but respecting the wishes of the African women by avoiding direct involvement in the planning and implementing process.

5. Commissioner for Human Rights

149. The organization is greatly concerned about the situation of women faced with these "crimes of gender", and has recently begun research into traditional practices affecting the health of women. They are in contact with

various women's organizations working on the issue. Their first step is to increase their constituency's awareness of these crimes, especially female genital mutilation. They are currently drafting a resolution on the issue, and hope to present it to their international board in a few months. Also, they are creating an education packet on "Fundamentalism and the Human Rights of Women: Barriers to Development" which will include information on traditional practices and religion. They are planning an international humanist women's dialogue for August 1991 that will address the issue of the effects of fundamentalism on the lives of women.

6. Inter-African Committee on Traditional Practices Affecting the Health of Women and Children

150. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was set up in 1984 at the Dakar Seminar. Its mandate is to fight against harmful traditional practices such as female circumcision and to promote positive practices such as breast feeding. It conducts programmes of education, training and information through national affiliates in 22 countries. It produces visual aids such as anatomical models, flannelgraphs, viewers with slides and films. It organizes seminars and workshops. It publishes a biannual newsletter in English and French. It collaborates with other organizations to enhance the work related to traditional practices. It lobbies at relevant meetings to ensure that the issue of traditional practices is given sufficient attention. It organizes training programmes for opinion leaders, women in decision-making positions, health workers and traditional birth attendants.

151. In November 1990, it organized a regional conference in collaboration with the Economic Commission for Africa, the Organization of African Unity and the Government of Ethiopia. The report of this Conference is being widely distributed. The efforts being made by the Inter-African Committee and its national affiliates have created awareness on the part of many Governments and the public at large. Replies received from Governments to the letter of the United Nations Secretary-General regarding the evolution of work in the domain of traditional practices demonstrate the situation in each of the countries and the measures undertaken.

7. The Swiss Association for Women's Rights

152. The Association states that they have not considered specifically traditional practices which affect the health of women and children. However, they have distributed the following two brochures concerning women's rights: "RU486 - Interruption of early pregnancy: a woman's right to choose the method", and "Interruption of pregnancy in Switzerland, law, practice and prevention". Also, they have participated in a recent public colloquium on this subject.

8. World Watch

153. This organization published an article on female circumcision in March-April 1989. They continue to be concerned with this traditional practice, and urge the United Nations to take action to combat it.

Conclusions and recommendations

154. The various reports received from Governments, concerned United Nations agencies and non-governmental organizations served as valuable sources of information which enabled the Rapporteur to assess the progress of work in the area of traditional practices affecting the health of women and children. Through the field missions, it was possible to examine the problem with those individuals and groups who are directly affected by harmful traditional practices and to look at the issue within its cultural contexts. The study raises a number of challenging questions especially related to cultural self-determination and the right of the individual; this is an area which merits further study. The information received and the consultations which took place have led the Special Rapporteur to make the following recommendations:

1. There is noticeable progress in the degree of public awareness about the harmful effects of genital mutilation, nutritional taboos and practices related to delivery.

2. Son preference and its implications have not yet sufficiently been studied and dealt with.

3. Early marriage and early pregnancy are identified as risks to safe motherhood.

4. The efforts made by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children and its affiliates at the national level have succeeded in breaking the taboo about harmful traditional practices through education and information campaigns.

5. More Governments are demonstrating willingness to tackle the problem of traditional practices affecting the health of women and children in Africa, including through legislative measures prohibiting harmful practices.

6. More Governments should be called upon to adopt legislative measures for the protection of women and children from harmful traditional practices, such as genital mutilation, son preference, early marriage and taboos which hamper proper nutrition.

7. Better coordination of efforts should be made between the Centre for Human Rights, WHO, UNICEF and UNESCO for effectiveness of action related to traditional practices.

8. Sustained follow-up should be made by the Centre to monitor the progress of work undertaken by Governments, United Nations specialized agencies and non-governmental organizations in this domain.

9. The Centre should have the service of a full-time professional staff for effective follow-up in terms of gathering information, writing reports, organizing seminars, dispatching documents and liaising with relevant organizations.

10. The subject of traditional practices should be kept on the agenda of the Sub-Commission for sustained follow-up.

11. At least two more regional seminars should be organized in Africa in order to encourage Governments to focus on the problem and to create more public awareness.

Notes

1/ Report of the Working Group (E/CN.4/1986/42, para. 25); see also Olayinka Kosso-Thomas, The Circumcision of Women - A Strategy for Eradication, 1987.

2/ Professor Paul Corréa, "*Female Circumcision*", Report of the Seminar on Traditional Practices Affecting the Health of Women and Children (Dakar, 6-10 February 1984).

3/ Ibid., p. 61.

4/ Kosso-Thomas, op. cit.

5/ Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), Report of the Regional Seminar on Traditional Practices Affecting the Health of Women and Children in Africa, (Addis Ababa, 6-10 April 1987).

6/ WHO/EMRO, Report of the Seminar on Traditional Practices Affecting the Health of Women and Children, (Khartoum, February 1979) Technical Publication No. 2, Vol. 2, Alexandria, 1982.

7/ Corréa, op. cit.

8/ For more details concerning the evolution of the practice, see the report of the Working Group on Traditional Practices Affecting the Health of Women and Children (E/CN.4/1986/42, paras. 59-73).

9/ IAC Mission Report to Guinea Bissau, 1987.

10/ Report of the Seminar on Traditional Practices Affecting the Health of Women and Children in Africa (Dakar, 6-10 February 1984).

11/ Kosso-Thomas, op. cit.

12/ IAC, Report of the Regional Seminar on Traditional Practices Affecting ... (Addis Ababa, 6-10 April 1987).

13/ Ibid.

14/ Health implications of sex discrimination in childhood. A review paper and an annotated bibliography, Geneva, 1986, (WHO/UNICEF/FHE 86.2), p. 1.

15/ Ibid., p. 4.

16/ UNICEF Regional Office for the Middle East and North Africa, Sex differences in child survival and development, Evaluation Series No. 6, 1990, p. 7.

17/ Ibid., p. 2.

18/ Health implications of sex discrimination ..., pp. 5-7.

19/ Ibid., p. 10.

20/ Akesode F.A., "Factors affecting the use of primary health clinics", Journal of Epidemiology, 1982, p. 310.

21/ Health implications of sex discrimination ..., p. 11.

22/ UNICEF Regional Office for the Middle East and North Africa, Sex differences ..., p. 2.

23/ Health implications of sex discrimination ...

24/ Report of the Seminar on Traditional Practices ... (Dakar, 6-10 February, 1984).

25/ WHO, "Women, health and development", WHO offset publication No. 90, 1985, p. 7.

26/ Professor Samba Diarra, "Traditional Birth Practices", background paper presented at the United Nations Seminar on Traditional Practices Affecting the Health of Women and Children (Ouagadougon, 29 April-3 May 1991).

27/ Report of the Seminar on Traditional Practices ... (Dakar, 6-10 February 1984).

28/ Dr. Leila Mehra, WHO Geneva, "Activities Regarding Traditional Practices Affecting the Health of Women and Children", paper presented at the United Nations Seminar on Traditional Practices Affecting the Health of Women and Children, (Ouagadougon, 21 April-3 May 1991).

29/ Dr. Thomas K. Kargbo, "Practices related to delivery", Report of the Seminar on Traditional Practices Affecting the Health of Women and Children in Africa, Dakar, 6-10 February 1984), pp. 23-29.

30/ Ibid.

31/ Ibid p.29.

32/ IAC Report of the Regional Seminar on Traditional Practices Affecting ... (Addis Ababa, 6-10 April 1987).

33/ Kargbo, op. cit., p. 34.

34/ Diarra, op. cit.

35/ Alasebu Gebre Selassie, "Rituals of Childbirth in Tigrigna Traditions of Ethiopia, Newsletter No. 2 Inter-African Committee on Traditional Practices, 1988.

36/ Kargbo, op. cit., p. 35.

37/ Mehra, op. cit.

38/ Kargo, op. cit.
