Programma della Regione Emilia-Romagna
finalizzato alla attivazione, alla gestione e alla riorganizzazione dei consultori - Progetto n. 9

LE MUTILAZIONI GENITALI FEMMINILI (MGF) NELLA POPOLAZIONE IMMIGRATA

BIBLIOGRAFIA

Data	Autore	Titolo	Fonte	Riassunto
2003	Al-Hussaini TK.	Female genital cutting: types, motives and perineal damage in laboring Egyptian women.	Med Princ Pract. 2003 Apr-Jun;12(2):123-8.	OBJECTIVES: To study the prevalence of female genital cutting (FGC) in a nulliparous population admitted for childbirth. In addition, the type of FGC, the motives supporting FGC and perineal damage associated with this practice were evaluated. SUBJECTS AND METHODS: A prospective cross-sectional study was conducted in the labor ward, Department of Obstetrics and Gynecology, Assiut University Hospital, Assiut, Egypt. Two hundred and fifty-four primigravid women in active labor were recruited over a period of 20 months. The subjects responded to a questionnaire and obstetric and pelvic examinations were carried out. The type of cut (circumcision) and extent of tissue removal were recorded. Data was gathered concerning possible motives for FGC, rates of episiotomy and incidence of perineal tears. RESULTS: All women recruited had been circumcised; 51% had type I cut and 49% had type II. Adherence to tradition was the most common motive for the operation (46.5%). Ninety-five percent of the study population had an episiotomy. The incidence of perineal tears was 1.6%. CONCLUSIONS: Female genital cutting (only types I and II) was confirmed in all patients in the study. There was a low incidence of perineal tears and a high episiotomy rate (95%). Episiotomy should be performed in all cases where FGC has made the vulva/vagina inelastic.

2003	Chalmers B	Obstetric Care following female genital mutilation	in press	
2003	Coren C.	Genital cutting may alter, rather than eliminate, women's sexual sensations.	Int Fam Plan Perspect. 2003 Mar;29(1):51.	
2003	el-Azhary R.	Stop female genital mutilation. A perspective: religious rites vs. Cultural norms.	Int J Dermatol. 2003 Jan;42(1):28.	

2003	Essen B, Wilken-Jensen C.	How to deal with female circumcision as a health issue in the Nordic countries.	Acta Obstet Gynecol Scand. 2003 Aug;82(8):683-6.	
2003	Fernandez-Aguilar S, Noel JC.	Neuroma of the clitoris after female genital cutting.	Obstet Gynecol. 2003 May;101(5 Pt 2):1053-4.	BACKGROUND: Nerve tumors of the clitoris and particularly neuromas are extremely rare. CASE: A 27-year-old infibulated African woman suffering from chronic vulvar pain increasing with sexual intercourse presented for gynecologic care. Examination revealed a painful clitoral tumor. The tumor was surgically excised. The diagnosis of amputation neuroma of the clitoris was made by microscopic examination. CONCLUSION: This is the first well-documented case of clitoral amputation neuroma occurring after female genital cutting. Considering the high number of genital cuttings practiced, these tumors are probably under-reported in the literature.
2003	Herieka E, Dhar J.	Female genital mutilation in the Sudan: survey of the attitude of Khartoum university students towards this practice.	Sex Transm Infect. 2003 Jun;79(3):220-3.	BACKGROUND: Female genital mutilation (FGM) or female circumcision is the removal of variable amounts of tissue from the female external genitalia. It is practised all over the world on very young girls. This study was conducted in Sudan where FGM is a criminal offence and not a religious dictate. We assessed the knowledge, attitudes, and perceptions of this practice among Khartoum university students and compared the differences between male and female student responses. METHODS: An anonymised detailed questionnaire was distributed among the university students. In addition to the participant's age, marital status, course studying, details regarding their attitude, knowledge of the practice of FGM, and their own experiences were collected. RESULTS: Of the 500 questionnaires distributed, 414 (82.8%) were returned from 192 (46%) females and 222 (54%) males. 109 (56.8%) of the female respondents were themselves circumcised.18.8% of the male students and 9.4% of the female students thought FGM was recommended by their religion. Only 90 (46.9%) female students compared with 133 (59.9%) male students thought FGM was illegal. Though 16 (8.3%) female respondents thought FGM would increase their chances of marriage, the majority, 166 (74.8%), of the male students would prefer a non-circumcised female. CONCLUSIONS: This study shows that 109 (56.8%) female university students who responded were circumcised. Confusing religious messages and

				ambiguous laws seem to be responsible for the continuation of this practice. The study highlights the partnership that needs to be established between religious leaders and educationalists to end this medieval practice.
2003	Hoban V.	Tackling the taboo.	Nurs Times. 2003 Apr 15-21;99(15):40-1	
2003	Little CM.	Female genital circumcision: medical and cultural considerations.	J Cult Divers. 2003 Spring;10(1):30-4.	Female circumcision (FC), also known as female genital mutilation (FGM), is a procedure that involves partial or complete removal of external female genitalia. The definition given by the World Health Organization (WHO) states that female circumcision "comprise all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons" (WHO, 1998, p.5). The United Nations Children's Fund, the United Nations Population Fund, and the WHO have jointly issued a statement that FC and FGM causes unacceptable harm and issued a call for the elimination of this practice worldwide. The WHO also contends that female circumcision is a "violation of internationally accepted rights" (WHO, p.1). Female circumcision is a widespread cultural practice and affects millions of young women. Issues related to female circumcision that are of special concern are health consequences, civil rights, cultural considerations, and legal and ethical aspects. The purpose of this paper is to address the incidence of FC and FGM, the historical background, the procedure, the medical complications and cultural considerations. Legal and ethical issues of FGM will also be discussed.

2003	Mackie G.	Female genital cutting: a harmless practice?	Med Anthropol Q. 2003 Jun;17(2):135-58.	A recent article in Medical Anthropology Quarterly (Obermeyer 1999) argues that the "facts" about the "harmful effects" of female genital cutting (FGC) are "not sufficiently supported by the evidence" (p. 79). The article suggests three further hypotheses, among others: (1) FGC may be of minimal harm because the more educated continue the practice just as much as the less educated; (2) FGC may be of minimal harm because it is so widespread and persistent; (3) FGC may be of minimal harm because the supposed link between the clitoris and female sexual pleasure is a social construction rather than a physiological reality. I challenge these hypotheses. I say that by appropriate standards of evaluation, FGC is harmful. Finally, I submit that most FGC is a proper matter of concern because it is the irreversible reduction of a human capacity in the absence of meaningful consent.
2003	Mella PP.	Major factors that impact on women's health in Tanzania: the way forward.	Health Care Women Int. 2003 Sep-Oct;24(8):712-22.	Tanzania's health policy is to improve the health of all Tanzanians with a focus on those most at risk. One of the major objectives is to reduce infant and maternal morbidity and mortality and increase life expectancy. The life expectancy in Tanzania is 49 years for males and 53 years for females. Maternal mortality is recorded at 300-400 deaths per 100,000 women. The main causes are haemorrhage, sepsis, rupture of the uterus, anaemia, and others. The risk factors associated with the above causes include maternal height, age, child spacing, and number of births per woman; malaria and anaemia; imbalance of energy and food intake; HIV/AIDS; women's workload; and female genital mutilation (FGM). To address issues of women's health, the government has put in place many strategies, for example, a ministry to look after women's issues, the safe motherhood initiatives, improvement of the knowledge and skill of health care providers, as well as collaboration with nongovernmental organizations (NGOs) and private agencies. The health sector reform is important because it has negatively affected women's access to health care. To improve the health of women in Tanzania, health and health-related sectors should cooperate and collaborate in order to empower women in the areas of education, social status, and technology. Policies must also address poverty, nutrition, adolescent health, and violence and sexual abuse.

2003	Moller BR, Hansen UD.	Foreign bodies as a complication of female genital mutilation.	J Obstet Gynaecol. 2003 Jul;23(4):449-50.	
2003	Moszynski P.	Sudan to tighten law on female genital mutilation	BMJ. 2003 Sep 13;327(7415):580.	
2003	Ncayiyana DJ	Astonishing indifference to deaths due to botched ritual circumcision.	S Afr Med J. 2003 Aug;93(8):545.	

2003	No authors listed	Education needed to prevent female genital mutilation	Midwives (Lond). 2003 Mar;6(3):94.	
2003	Nour NM.	Female genital cutting: a need for reform.	Obstet Gynecol. 2003 May;101(5 Pt 2):1051-2.	
2003	Ogunlola IO, Orji EO, Owolabi AT.	Female genital mutilation and the unborn female child in southwest Nigeria.	J Obstet Gynaecol. 2003 Mar;23(2):143-5.	Female genital mutilation, despite efforts to abolish it, is still widely practised in Nigeria. The risk of female genital mutilation to a female child in southwest Nigeria was investigated by interviewing 430 consecutive pregnant women attending the antenatal clinic of Wesley Guild Hospital Ilesa, Nigeria between July 2001 to October 2001. The results show that 60% of the pregnant women studied had a type of genital mutilation. The decision to mutilate a female child is taken before she is born. Seventy-four (17.2%) of the women and 146 (34%) of their husbands would circumcise their female child. The decision to circumcise a female child is made between the husband and wife but the final decision comes mainly from the husband. Because the majority of the women (58.4%) were yet to decide whether or not to circumcise their female children, they could sway the decision either way before the husband makes up his mind. Therefore, every effort should be taken to involve men in the struggle to eradicate this unwholesome practice.

2003	Pikarinen U, Halmesmaki E.	Violence against women	Duodecim. 2003;119(5):389-94.	ARTICLE IN FINNISH
2003	Rogers, J.	Making the Crimes (Female Genital Mutilation) Act 1996, making the '(non) mutilated woman'	Australian Feminist Law Journal v.18 Jun 2003: 93-113	In 1996 an amendment to the Victorian Crimes Act 1958 made female genital mutilation a criminal offence. The author explores the discourses of female genital mutilation that were considered in the development of this legislation. She argues that this included the production of an unspeaking and unspeakable 'other', the mutilated woman. This form, she argues, resulted from the silencing of migrant communities that was part of the Family Law Council's consultation process and that has long been the practice in Western discourses of female genital mutilation.
2003	Taylor V.	Female genital mutilation: cultural practice or child abuse?	Paediatr Nurs. 2003 Feb;15(1):31-3.	

2003	Thabet SM, Thabet AS.	Defective sexuality and female circumcision: The cause and possible management.	J Obstet Gynaecol Res. 2003 Feb;29(1):12-9.	AIM: To verify the effect of circumcision on female sexuality and to define the need for clitorolabioplasty in these cases. METHODS: Thirty uncircumcised controls, 30 minorly circumcised, 30 minorly circumcised mutilated, and 57 circumcised cases having clitoral cysts were selected on random bases at Kasr El Aini School of Medicine. Sexuality was assessed by a special questionnaire sheet prepared by the authors to fit the circumcised cases. Clitorolabioplasty and clitoral cyst excision were also done in cases of sexual defects. RESULTS: Sexuality was not affected in minorly circumcised cases. However, sexuality was markedly affected in the mutilated cases. The scores for sex desire and arousal and for orgasm were especially affected in such cases. These defects were not detected in cases having clitoral cysts until late, when cysts enlarged. The role of clitorolabioplasty in restoration of sexuality was confirmed. The loss of certain clitoral and labial bulk, necessary for orienting the woman towards her genitalia and initiating her interest in their function, was responsible for the occurrence of such defects; this was able to be restored by surgery. CONCLUSION: Counseling parents about these sexual defects and asserting the need for correcting the mutilation, which resulted from these circumcisions, are effective steps in banning such procedures.
2003	Thierfelder C, Hatz Ch, Bodiang CK.	In Process Citation	Schweiz Rundsch Med Prax. 2003 Jul 30;92(31-32):1307-14.	ARTICLE IN GERMAN Due to increasing international migration Switzerland hosts women who have undergone female genital mutilation. Complications of female genital mutilation call for a comprehensive medically, socially and culturally adapted care. Health care providers in Switzerland are not adequately prepared to meet the specific needs of the women concerned, particularly because they are rarely exposed and have no national guidelines to rely on. This article based on qualitative research provides recommendations with the aim to improve the care for concerned African immigrant women in the Swiss health care system.
2003	Toubia NF, Sharief EH.	Female genital mutilation: have we made progress?	Int J Gynaecol Obstet. 2003 Sep;82(3):251-61.	Interest curtailing the practice of female genital mutilation (FGM) has increased in the past 20 years. Although the political and legal environment towards the practice is more hostile, this awareness has yet to translate itself to measurable changes in prevalence. At the local level activities are shifting from a clinical, health risk, model to an understanding of the phenomenon in its social context. Under patriarchal structures of social control of sexuality and fertility, women and girls are the primary social group to suffer from as well as to perpetuate the practice of FGM. With appropriate investments in psychological and economic empowerment, women are also the most likely group to resist the practice.

2003	Toubia NF, Sharief EH.	Female genital mutilation: have we made progress?	Int J Gynaecol Obstet. 2003 Sep;82(3):251-61.	Interest curtailing the practice of female genital mutilation (FGM) has increased in the past 20 years. Although the political and legal environment towards the practice is more hostile, this awareness has yet to translate itself to measurable changes in prevalence. At the local level activities are shifting from a clinical, health risk, model to an understanding of the phenomenon in its social context. Under patriarchal structures of social control of sexuality and fertility, women and girls are the primary social group to suffer from as well as to perpetuate the practice of FGM. With appropriate investments in psychological and economic empowerment, women are also the most likely group to resist the practice.
2003	Vissandjee B, Kantiebo M, Levine A, N'Dejuru R	The cultural context of gender, identity: female genital, excision and infibulation.	Health Care Women Int. 2003 Feb;24(2):115-24.	Our goal is to explore the practices of female genital excision and infibulation as they relate to gender identity and the acculturation process in Canada. We examined relevant research on these issues and share the results of a nationwide project conducted in 1997-1999 among 162 Canadian immigrants from regions in Africa where practices of excision and infibulation are still in effect. Our discussion of gender identity is inextricably linked to notions about the ways in which girls, women, and virginity are socially constructed. The complexity of the acculturation process along with the integration within a host society is highlighted and the conflicting identities available to women are brought to the fore.
2002	Affara FA	Female genital mutilation is a human rights issue of concern to all women and men.	Int Nurs Rev. 2002 Dec;49(4):195-7.	

2002	Alexander J, Cheng O.	The case of female genital mutilation.	J Gend Specif Med. 2002 Jul-Aug;5(4):11-5.	
2002	Briggs LA.	Male and female viewpoints on female circumcision in Ekpeye, Rivers State, Nigeria.	Afr J Reprod Health. 2002 Dec;6(3):44-52.	One hundred and ninety five male and female volunteers across the social strata were interviewed using structured questionnaire. Data were analysed using frequency tables. The study revealed that 74.7% of female respondents were circumcised. They believe that the practice would help prevent sexual promiscuity, curb sexual desires and that it is a custom they cannot do without. Most of the men would not marry an uncircumcised female, while a substantial number of the respondents would like to circumcise their daughters. Community effort to eradicate the practice is very minimal. Based on the findings, it is suggested that communities where female genital mutilation (FGM) is practiced as a social norm should be involved in eradication campaigns with support from national and international organisations.
2002	Brunvatne R, Blystad H, Hoel T.	Health hazards for immigrants when travelling to their home countries	Tidsskr Nor Laegeforen. 2002 Jun 20;122(16):1568-72.	ARTICLE IN NORWEGIAN Vacations in the home country are important and positive events in the lives of immigrants, events that allow them to maintain contact with their culture, relatives and friends. However, vacations also carry certain health risks, though these risks can to some degree be prevented. Infectious disease is the greatest risk. Some children and adolescents also run the risk of female genital mutilation, forced marriage, and the risk og being left behind in the home country against their will. Among the notifiable diseases registered with the Norwegian Surveillance System for Communicable Diseases (MSIS), five stand out as having a higher incidence in people of foreign background than in people of Norwegian origin: malaria, hepatitis A, shigella infection, typhoid and paratyphoid fever. This higher incidence is partly the result of less use of pre-travel vaccines and malaria prophylaxis. Immigrants as a group are exposed to varied risks and should be given high priority in relation to vaccines and malaria prophylaxis for travel abroad. High priority should also be given to preventive health measures designed to reduce the risk of female genital mutilation and other violations against children and young people on visit to their country of origin.

2002	Collinet P, Stien L, Vinatier D, Leroy JL	Management of female genital mutilation in Djibouti: the Peltier General hospital experience	Acta Obstet Gynecol Scand. 2002 Nov;81(11):1074-7.	Female genital mutilation (FGM) is still performed on 98% of Djiboutian women. Infibulation (FGM type 3) is the most widely used method of FGM in Djibouti. Even though this operation is mutilating, illegal and sometimes results in death, it is still practiced at approximately the same rate as in the past. Mass immigration of African women to Europe, Canada, Australia and the United States in the past decade has brought the problems of FGM to these countries. Female genital mutilation is a problem unfamiliar to most Western obstetrician-gynecologists. A tight infibulation can be a high risk for the mother and fetus if not handled by a skilled operator. It can lead to an unnecessary cesarean section as a result of the fear of handling infibulated women. Therefore, Western physicians need to be informed. The aim of this article was to share our experience of FGM. It will focus on FGM in Djibouti, its types, epidemiology and health consequences. It will present the management of obstetric and gynecologic complications and discuss medico-legal and health service measures to combat these dangerous and unnecessary practices
2002	Cook RJ, Dickens BM, Fathalla MF.	Female genital cutting (mutilation/circumcision): ethical and legal dimensions.	Int J Gynaecol Obstet. 2002 Dec;79(3):281-7.	The practice better described as female genital cutting (FGC) is of long standing in some communities, and has spread to non-traditional countries by immigration. It is of varying degrees of invasiveness, often including clitoridectomy, but all raise health-related concerns, which can be of considerable physical and/or psychological severity, and compromise gynecological and obstetric care. The practice is not based on a requirement of religious observance, although parents usually seek it for their daughters in good faith. It is directed to the social control of women's sexuality, in association with preservation of virginity and family honor. FGC is becoming increasingly prohibited by law, in countries both of its traditional practice and of immigration. Medical practice prohibits FGC. In compromising women's health and negating their sexuality, FGC is a human rights abuse that physicians have a role in eliminating by education of patients and communities
2002	El-Gibaly, O., Ibrahim, B., Mensch, B.S. & Clark, W.H.	The decline of female circumcision in Egypt: Evidence and interpretation.	(2002). Social Science and Medicine 54:205-220.	

2002	Essen B, Bodker B, Sjoberg NO, Gudmundsson S, Ostergren PO, Langhoff-Roos J.	Is there an association between female circumcision and perinatal death.	Bull World Health Organ. 2002;80(8):629-32.	OBJECTIVE: In Sweden, a country with high standards of obstetric care, the high rate of perinatal mortality among children of immigrant women from the Horn of Africa raises the question of whether there is an association between female circumcision and perinatal death. METHOD: To investigate this, we examined a cohort of 63 perinatal deaths of infants born in Sweden over the period 1990-96 to circumcised women. FINDINGS: We found no evidence that female circumcision was related to perinatal death. Obstructed or prolonged labour, caused by scar tissue from circumcision, was not found to have any impact on the number of perinatal deaths. CONCLUSION: The results do not support previous conclusions that genital circumcision is related to perinatal death, regardless of other circumstances, and suggest that other, suboptimal factors contribute to perinatal death among circumcised migrant women.
2002	Gatrad A R, Sheikh A, Jacks H	Religious circumcision and the Human Rights Act	Arch Dis Child 2002;86:76–78	
2002	Gustavson KH.	The law against female circumcision a paper tiger?	Lakartidningen. 2002 Jan 10;99(1-2):85.	ARTICLE IN SWEDISH

2002	Jager F, Schulze S, Hohlfeld P.	Female genital mutilation in Switzerland: a survey among gynaecologists.	Swiss Med Wkly. 2002 May 18;132(19-20):259-64.	QUESTION UNDER STUDY: To evaluate the situation of Female Genital Mutilation (FGM) in Switzerland. METHODS: Through a questionnaire, Swiss gynaecologists were asked if they have been confronted to FGMs, if they have been asked to perform infibulations and FGMs. The health representatives (Kantonsarzte/medecins cantonaux) were interviewed on FGM activity at the Canton level. Swiss Medical Schools were asked if FGM was included in the pregraduate curriculum, and an estimated prevalence rate for FGMs in Switzerland was gathered. RESULTS: Among Swiss gynaecologists, 20% reported having been confronted with patients presenting with FGM and among them 40% had been asked about reinfibulation. Gynaecologists are occasionally asked about the possibility of performing FGMs in Switzerland. No activity concerning FGM is reported by health authorities in the Cantons. Teaching about FGM is not included in the curriculum of any of the Swiss medical schools. Approximately 6,700 girls at risk and women who have undergone FGM live in Switzerland. CONCLUSION: The extent to which gynaecologists are confronted to women with FGM may justify further action to try to better understand the situation in Switzerland. Improvement of care by better education of health care providers (guidelines) and prevention of new cases by women's education should also be considered.
2002	Jaleel H, Mia Huengsberg and David Luesley	Female genital mutilation - case report and discussion	International Journal of STD & AIDS; 13: 850-851	
2002	Johansen, R.E.	Pain as a counterpoint to culture: toward an analysis of pain associated with infibulation among Somali immigrants in Norway.	Med Anthropol Q. 2002 Sep;16(3):312-40.	This article focuses on how some Somali women experience and reflect on the pain of infibulation as a lived bodily experience within shifting social and cultural frameworks. Women interviewed for this study describe such pain as intolerable, as an experience that has made them question the cultural values in which the operation is embedded. Whereas this view has gone largely unvoiced in their natal communities, the Norwegian exile situation in which the present study's informants live has brought about dramatic changes. In Norway, where female circumcision is both condemned and illegal, most of the women have come to reconsider the practice--not merely as a theoretical topic or as a "cultural tradition" to be maintained or abolished but, rather, as part of their embodied and lived experience.

2002	Kasim YM, Abdul IF, Balogun OR.	Female genital mutilation and reproductive outcome.	Niger J Med. 2002 Jul-Sep;11(3):105-7.	One hundred and thirty cases of obstructed labour were managed amongst 1,860 deliveries over a period of 2 years. 34 cases were due to acquired gynaetraesia following female genital mutilation in infancy and childhood. This paper highlights the magnitude, prevalence of this negative traditional practice and the effect on reproduction. Measures to reducing this preventable cause of maternal mortality are suggested.
2002	Kedar M.	Islam and "female circumcision": the dispute over FGM in the Egyptian press, September 1994.	Med Law. 2002;21(2):403-18.	In September 1994, during the United Nations Population Conference in Cairo, CNN broadcast a report about the custom of clitoridectomy in Egypt. The televised report included footage of such a ceremony performed on a ten-year-old Egyptian girl in Cairo a few days earlier. This broadcast revived the public polemics on clitoridectomy in Egypt. Secular newspapers such as al-Wafd and al-Ahali opposed this practice while religious circles used the al-Sha'b newspaper to justify it. The religious argument is based on Islamic tradition although the origin of the practice is admittedly pre-Islamic. This position maintains that the type of clitoridectomy performed involves minimal excision, but in practice it is much more radical. There are voices from within the Islamic camp, mainly those of women, that call for the abolition of this practice, basing this demand on the fact that this act is a minor rather than major principle of Islamic Law. Although the secular educated classes in Egypt tend to avoid this practice, they are a minority. The public argument continues in a low key while in reality thousands of young girls daily undergo this traumatic experience which maims them in body and in soul. Unless there is a sustained public outcry against it, this mutilation is destined to remain part of the Egyptian reality for a long time. This paper discusses the positions of the two sides to the dispute, concentrating mainly on the opinions of the Islamic faction which upholds the continuation of genital mutilation. These opinions are expressed by male Islamic elders while opposing arguments are presented by women who decry this practice

2002	Larsen, U.	The effects of type of female circumcision on infertility and fertility in Sudan	(2002). Journal of Biosocial Science 34: 363-377.	
2002	Larsen, U. & Okonofua, F.E.	Female circumcision and obstetric complications.	(2002). International Journal of Gynecology & Obstetrics 77:255-265.	
2002	Legato MJ.	Rethinking circumcision: medical intervention, religious ceremony, or genital mutilation?	J Gend Specif Med. 2002 Jul-Aug;5(4):8-10.	

2002	Minnesota International Health Volunteers (MIHV)	Improving Primary Health Care Provision to Somalis: Focus Groups with Somali Women	MIHV booklet 9/20/02	
2002	Morrone A, Hercogova J, Lotti T.	Stop female genital mutilation: appeal to the international dermatologic community.	Int J Dermatol. 2002 May;41(5):253-63.	Female genital mutilation (FGM) is a traditional cultural practice, but also a form of violence against girls, which affects their lives as adult women. FGM comprises a wide range of procedures: the excision of the prepuce; the partial or total excision of the clitoris (clitoridectomy) and labia; or the stitching and narrowing of the vaginal orifice (infibulation). The number of girls and women who have been subjected to FGM is estimated at around 137 million worldwide and 2 million girls per year are considered at risk. Most females who have undergone mutilation live in 28 African countries. Globalization and international migration have brought an increased presence of circumcised women in Europe and developed countries. Healthcare specialists need to be made aware and trained in the physical, psychosexual, and cultural aspects and effects of FGM and in the response to the needs of genitally mutilated women. Health education programs targeted at immigrant communities should include information on sexuality, FGM, and reproduction. Moreover, healthcare workers should both discourage women from performing FGM on their daughters and receive information on codes of conduct and existing laws. The aim is the total eradication of all forms of FGM
2002	Moszynski P.	Sudan's media laws frustrate drives on AIDS and genital mutilation.	BMJ. 2002 Sep 21;325(7365):618.	

2002	Moszynski, Peter	Sudan's media laws frustrate drives on AIDS and genital mutilation	British Medical Journal .Volume 325, 21 September p 618	
2002	Msuya SE, Elizabeth Mbizvo , Akhtar Hussain, Johanne Sundby , Noel E. Sam and Babill Stray-Pedersen	Female genital cutting in Kilimanjaro, Tanzania: changing attitudes?	Tropical Medicine and International Health volume 7 no 2 pp 159-165	
2002	Nur, S.	Birthing and post-natal practices of African communities in Victoria	In: Journey through: newly arrived immigrant and refugee women's health: conference proceedings. Northcote, Vic: Working Women's Health, 2002, p28-31	Responding to the health needs of an increasing number of African and Middle Eastern women refugees has brought a new awareness among Australians of differences in social, cultural and religious practices. The author, a health worker, is responsible for increasing African women's access to health and community services. She describes different cultural attitudes and practices towards issues such as female genital mutilation, birth and confinement, and the role of men and the community in child birth and child care. She examines post natal depression in particular, and discusses ways in which African women can be encouraged to recognise and understand this condition, and to benefit from the support of health and community services in overcoming it.

2002	Okemgbo CN, Omideyi AK, Odimegwu CO.	Prevalence, patterns and correlates of domestic violence in selected Igbo communities of Imo State, Nigeria.	Afr J Reprod Health. 2002 Aug;6(2):101-14.	Three hundred and eight Igbo women were randomly selected to respond to a number of questions on experiences, patterns and attitudes to domestic violence. Data was collected using structured questionnaires that were complemented with focus group discussions. The results show that 78.8% of the women have ever been battered by their male counterparts, out of which 58.9% reported battery during pregnancy, while 21.3% reported having been forced to have sexual intercourse. The study further revealed that the practice of female circumcision is still common among this Igbo population, and 52.6% were of the view that it should be continued. Multivariate logistic regression identified the correlates of these forms of violence such as age, place of residence, age at first marriage, type of marital union, level of income of women, and level of education of husband against women in Imo State. While wife battery is more pronounced in the urban area, forced sexual relationship and female genital mutilation are more pronounced in the rural areas. We recommend education of women and integration of services in reproductive health care service delivery as appropriate measures to eradicate these practice
2002	Okonofua, F.E., Larsen, U., Oronsaye, F., Snow, R.C. & Slanger, T.E.	The association between female genital cutting and correlates of sexual and gynaecological morbidity in Edo State, Nigeria.	(2002). BJOG: and International Journal of Obstetrics and Gynecology 109:1089–1096	
2002	Penna C, Fallani MG, Fambrini M, Zipoli E, Marchionni M.	Type III female genital mutilation: Clinical implications and treatment by carbon dioxide laser surgery.	Am J Obstet Gynecol. 2002 Dec;187(6):1550-4.	OBJECTIVE: The purpose of this study was to examine clinical implications of type III female genital mutilation and to evaluate the use of carbon dioxide laser surgery to restore vulvar opening and to treat associated epithelial inclusion cysts. STUDY DESIGN: Twenty-five infibulated patients underwent carbon dioxide laser treatment. Seven of the women (28%) were pregnant, between 10 and 37 weeks of gestation. Vulvar examination revealed five cases of epidermal inclusion cysts. One pregnant patient, with a cyst that was 7 cm in diameter, was at 24 weeks of gestation. Deinfibulation was performed in an outpatient setting with local anesthesia. A colposcopy-guided laser beam was used to create an incision along the fusion midline of the labia majora. In case of vulvar epidermal inclusion cyst, the capsule was opened and emptied of sebaceous contents; the inner surface of the cyst was vaporized completely. RESULTS: The carbon dioxide laser procedure restored a complete vulvar opening in all 25 patients. The complete vaporization of

				cyst capsule was possible in all five cases. No case of intraoperative or postoperative complication occurred. The average duration of follow-up was 11 months. Four patients who underwent deinfibulation antenatally had labor with spontaneous vaginal delivery and no evidence of perineal trauma. CONCLUSION: On the basis of the advantages that were observed, deinfibulation treatment must be offered to all infibulated patients. The procedure is particularly appropriate during pregnancy to prevent childbirth complications. Laser carbon dioxide has been proved to be a suitable technique for the treatment of female genital mutilation when inclusion cysts are associated with it.
2002	Raufu A.	Nigeria recommends jail terms to eradicate female genital mutilation.	BMJ. 2002 May 4;324(7345):1056.	
2002	Slanger TE, Snow RC, Okonofua FE.	The impact of female genital cutting on first delivery in Southwest Nigeria.	Stud Fam Plann. 2002 Jun;33(2):173-84.	To date, data linking obstetric morbidity to female genital cutting in populations with less severe types of cutting have been limited to case reports and speculation. In this cross-sectional study, 1,107 women at three hospitals in Edo State, Nigeria, reported on their first-delivery experiences. Fifty-six percent of the sample had undergone genital cutting. Although univariate analyses suggest that genital cutting is associated with delivery complications and procedures, multivariate analyses controlling for sociodemographic factors and delivery setting show no difference between cut and noncut women's likelihood of reporting first-delivery complications or procedures. Whereas a clinical association between genital cutting and obstetric morbidity may occur in populations that have undergone more severe forms of cutting, in this setting, apparent associations between cutting and obstetric morbidity appear to reflect confounding by social class and by the conditions under which delivery takes place.

2002	Snow RC, T. E. Slanger, F. E. Okonofua, F. Oronsaye and J. Wacker	Female genital cutting in southern urban and peri-urban Nigeria: self-reported validity, social determinants and secular decline	Tropical Medicine and International Health volume 7 no 1 pp 91-100	
2002	Snow, R.C., Slanger, T.E., Okonofua, F.E., Oronsaye F. & Wacker, J.	Female genital cutting in southern urban and peri-urban Nigeria: self-reported validity, social determinants and secular decline.	(2002). Tropical Medicine and International Health 7(1):91-100	
2002	Stewart, H., Morison, L., & White, R.	Determinants of coital frequency among married women in Central African Republic: The role of female genital cutting."	(2002). Journal of Biosocial Science 34: 525–539.	

2002	Valderrama J	Female genital mutilation: why are we so radical?	THE LANCET • Vol 359, February 9, 529-530	
2002	Valderrama J.	Female genital mutilation: why are we so radical?	Lancet. 2002 Feb 9;359(9305):529-30.	
2002	Vangen, S., Stoltenberg, C., Johansen, R.E., Sundby, J. & Stray-Pedersen, B	Perinatal complications among ethnic Somalis in Norway.	(2002). Acta Obstet Gynecol Scand 81: 317–322.	

2002	Widmark C,Carol Tishelman and Beth Maina Ahlberg	A study of Swedis midwives ' encounters with infibulated African women in Sweden	Midwifery: 18,113 -125	
2002	Young JS.	Female genital mutilation.	JAMA. 2002 Sep 4;288(9):1130.	
2002	Yount K.M., Balk D.L.	Health And Social Effects Of Female Genital Cutting1:The Evidence To Date	Departments of International Health and Sociology Emory University 1518 Clifton Rd. NE, Room 724, Atlanta, Georgia 30322	

2002	Yount, K.M	Like mother, like daughter? Female genital cutting in Minia, Egypt.	(2002). Journal of Health and Social Behavior, 43(3):336–358.	
2002	Zabus C	WRITING WOMEN'S RITES: EXCISION IN EXPERIENTIAL AFRICAN LITERATURE	Women's Studies International Forum, Vol. 24, No. 3/4, pp. 335–345	
2001	Akotionga M, Traore O, Lakoande J, Kone B.	Séquelles genitals externs del l'excision au centre hospitalier national Yalgado Ouedraogo (CHN-YO): épidémiologie et traitement chirurgical. [External genital excision sequelae at the Yalgado Ouedraogo national central hospital: epidemiology and surgical treatment]	Gynecol Obstet Fertil. 2001 Apr;29(4):295-300.	ARTICLE IN FRENCH By a prospective study in one year time, the authors noticed that female genital mutilation complications were 7.3 per cent of external gynecologic consultations and most complications were overdraft between 15 and 24 years old (36 cases out of 49). The main consultation motives were dyspareunia and difficult sexual relationship. Surgery under local anesthetic was very efficient (more than 90% success) and cheaper than surgery under general anesthetic.

2001	Allag F, Abboud P, Mansour G, Zanardi M, Quereux C.	Mutilations génitales rituelles féminines. La parole aux femmes [Ritualistic female genital mutilation. The sentiment of the women]	Gynecol Obstet Fertil. 2001 Nov;29(11):824-8.	ARTICLE IN FRENCH Female genital mutilation (FGM) is considered as the most dangerous custom still ritually practiced and 2 million girls undergo the ordeal each year. This practice is anchored and fixed firmly in numerous African people's culture and Western countries are confronted to it through African immigrants. In order to understand the justifications and the consequences of FGM we interviewed 14 genitally mutilated African women living in France. Unfortunately and despite the conscious knowledge of consequences and absurd side of such practice, yet it seems to be perpetuated over the descendants. Educational approach is the best solution to fight female genital mutilation fixed firmly in numerous African people's culture.
2001	Allam MF, de Irala-Estevez J, Fernandez-Crehuet Navajas R, Serrano del Castillo A, Hoashi JS, Pankovich MB, Rebollo Liceaga J.	Factors associated with the condoning of female genital mutilation among university students	Public Health. 2001 Sep;115(5):350-5.	Female genital mutilation (FGM) is practiced in Egypt, despite its recent ban, generally in rural and uneducated communities, under unsanitary conditions and by non-medical personnel. Immediate and long-term complications are frequent. The aim of this study was to gain insight into what beliefs or knowledge are conducive to supporting FGM.One thousand and seventy university students in Cairo, Egypt were randomly selected. A 32-item questionnaire was used to interview students regarding their knowledge and attitudes toward FGM. Multivariable analyses were performed to find factors associated with being against the abolishment of FGM.The response rate was 95% (n=1020). Twenty-eight percent of the students support FGM. The most significant factors associated with the condoning of FGM were believing FGM has a religious basis (OR=2.53), disagreeing that FGM is a custom with no other basis (OR=2.59), not believing it is harmful (OR=4.11), and ignoring that it is usually followed by complications (OR=5.14).Even in an educated population, a considerable amount of ignorance concerning FGM exists. Widespread education about FGM is important to dispel the myths that surround its practice and to bring the practice to an end
2001	Allotey, P.	Women in focus: an interview with Pascale Allotey	Working Well: Working Women's Health Newsletter Jul 2001: 7,15	This interview with Dr Pascale Allotey focuses on a research project, Reconciling Culture and Reproductive Health. She speaks about what she thinks will be the outcomes of the Project for the health and well being of migrant and refugee women from Sahel Africa and the Middle East. The women are mostly from developing countries where Islam is often the dominant religion, where women have limited access to reproductive health services and where female genital mutilation may be a traditional practice.

2001	Almroth L, Almroth-Berggren V, Bergstrom S	Need for more research on female circumcision. Lack of communication between women and men conserves the traditional practice	Lakartidningen. 2001 Nov 21;98(47):5355-8, 5360	ARTICLE IN SWEDISH Several studies in cultures in which FGM is widely performed have shown an emerging questioning of the value of performing the procedure, especially among the younger generations. Traditionally the practice has been said to be carried out by women in order to satisfy men. Recent research findings, however, indicate that men may have attitudes and preferences strikingly different from what has been ascribed to them in the literature. Thus men may play an important and positive role in future work to counteract the practice. Reinfibulation fter delivery implies repeated genital mutilation. Despite this, reinfibulation has attracted little research, and not very much is known about the practice. There is a need for systematic research about the extent of complications of FGM, especially long-term effects including effects on pregnancy, delivery and the newborn child. Our experiences from research on FGM in Sudan indicate that research findings might be very useful in intervention programs
2001	Almroth L, Almroth-Berggren V, Hassanein OM, Al-Said SS, Hasan SS, Lithell UB, Bergstrom S.	Male complications of female genital mutilation	Soc Sci Med. 2001 Dec;53(11):1455-60.	Female genital mutilation (FGM) is known to cause a wide range of immediate and long-term complications for women subjected to the practice. Male complications due to FGM have, however, not been described before. The objectives of this study were to explore male complications and attitudes with regard to FGM. A village in the Gezira Scheme along the Blue Nile in Sudan constituted the basis of the study. Interviews were carried out according to a pre-tested questionnaire, using structured questions with open-answer possibilities. Married men of the youngest parental generation and grandfathers were randomly selected from up-to-date election lists. All respondents except one agreed to be interviewed. A total of 59 men were interviewed, 29 young men and 30 grandfathers. Male complications resulting from FGM, such as difficulty in penetration, wounds/infections on the penis and psychological problems were described by a majority of the men. Most men were also aware of the female complications. More young than old respondents would have accepted a woman without FGM to become their daughter-in-law ($p < 0.03$). A majority of the young men would have preferred to marry a woman without FGM. This proportion was significantly higher than among the grandfathers ($p < 0.01$). Female genital mutilation can no longer be considered to be only an issue for women. The acknowledged male complications and attitudes described may open new possibilities to counteract the practice of FGM.

2001	Almroth L, Almroth-Berggren V, Hassanein OM, El Hadi N, Al-Said SS, Hasan SS, Lithell UB, Bergstrom S.	A community based study on the change of practice of female genital mutilation in a Sudanese village.	Int J Gynaecol Obstet. 2001 Aug;74(2):179-85.	OBJECTIVE: To investigate the practice of female genital mutilation (FGM), among young and old parents. METHODS: One hundred and twenty young parents and grandparents in a rural area in central Sudan were randomly selected for interviews carried out according to structured questionnaires with open answer possibilities. RESULTS: All female respondents had undergone FGM. Of the young respondents, 44% had decided not to let their daughters undergo FGM. Young fathers were more involved in the decision process than previously known, especially when decisions were taken not to perform FGM. Tradition and social pressure were the main motives for performing FGM. Sexuality was an important aspect, mentioned both as motives for and against FGM. Religious belief and education level significantly affected to what extent FGM was practiced. CONCLUSION: This is the first community based study of FGM indicating a significant shift in practice between generations, young parents starting to question the value of FGM.
2001	Andersson C.	Female genital mutilation--a complex phenomenon	Lakartidningen. 2001 May 16;98(20):2463-8	ARTICLE IN SWEDISH As of today, more than 130 million girls and women worldwide are genitally mutilated. Female genital mutilation (FGM) exists primarily on the African continent (along and north of the equator), but the practice is also carried out elsewhere. Clitoridectomy was performed in medicine both in the United States and in Europe as late as in the 1950s. From a socioeconomic perspective FGM is understood as a practice that forms an important part of girls' socialization. FGM is practiced in societies where women's social acceptance and survival is secured through marriage and childbearing. Without FGM, the woman cannot get married, with the consequence that she has no status or access to resources. Her body practically becomes her only form of capital. From a psychosexual perspective FGM is interpreted as a practice that has been made possible in patriarchal societies where the sexuality of women has to be controlled and where unequal gender relationships are preserved. FGM is practiced by people from various religious denominations, among them Copts, Animists, Catholics, Protestants and Muslims, something that goes against the relatively common belief that FGM is practiced only among Muslims. The resistance to FGM found in countries where the practice is rife clearly demonstrates that patriarchal structures and what gets defined as "culture" are indeed possible to change and renegotiate.

2001	Andersson C.	Female genital mutilation meets Swedish health care. Female genital mutilation is one of many forms of discrimination of women in the world	Lakartidningen. 2001 May 16;98(20):2470-3.	ARTICLE IN SWEDISH About 27,000 women from countries in which female genital mutilation (FGM) is a common practice are presently living in Sweden. This means that FGM is a phenomenon that directly affects the Swedish health care system. Knowledge and understanding of the background, meaning and consequences of FGM are a prerequisite for effective prevention, proper clinical handling and supportive reception of the women. To avoid a stigmatizing reception it is also important to understand the situation of genitally mutilated women, and to become aware of the identity crisis many of them experience when they come to Sweden and lose their identity as "normal" women. It is essential to remember that female genital mutilation is one of many forms of discrimination affecting girls and women around the world. This discrimination knows no national or cultural borders and varies in expression and extent. In order to offer optimal care and reception of women who have been socialized into a gender role that is often seen as completely different from the gender role that Swedish society is said to embrace, it is of the utmost importance to first take a critical look beneath the veil of alleged gender equality of Swedish women.
2001	Beckett C and Marie Macey	RACE, GENDER AND SEXUALITY: THE OPPRESSION OF MULTICULTURALISM	Women's Studies International Forum, Vol. 24, No. 3/4, pp. 309–319	
2001	Bonessio L, Bartucca B, Bertelli S, Morini F, Aleandri V, Spina V.	Female genital mutilation: FGM patients treated at the "Umberto I" polyclinic of Rome: 1985-1996	Clin Ter. 2001 May-Jun;152(3):171-7.	ARTICLE IN ITALIAN The article deals with the medical aspect regarding female genital mutilations (FGM). The cultural origin of this tradition is also considered. Such a practice lies in the partial or complete excision of the external genitalia: it is highly widespread in Central Africa, especially in Ethiopia and Somalia. Currently, approximately 130,000,000 women are involved worldwide. In Italy, it is estimated that about 30,000 women amongst the immigrant population are involved (1). Due to the increasing immigration of women from Countries with FGM tradition, knowledge of the pathologies related to such a practice has become urgently necessary to physicians of western Countries. The aim of this study was to analyze the short-term complications of FGM, which are severe and often even deadly, as well as the long-term ones, which are more likely to be faced in the clinical practice of a western Country physician. In particular, a sample of nine women who had undergone infibulation, amongst the patients admitted at the Departments of

				Obstetrics and Ginaecology of university of Rome "La Sapienza" during the period 1 January 1985-31 december 1996, has been analyzed. Five out of these women suffered form gynaecological pathologies, whilst four from obstetrical pathologies. Our data on complications associated with FGM are in agreement with those of the world literature and highlight how a more specific expertise is necessary for a correct health care of these women.
2001	Bosch X.	Spain considers improving law on female circumcision.	Lancet. 2001 May 12;357(9267):1510.	
2001	Brisson P, Patel H, Feins N.	Female circumcision.	J Pediatr Surg. 2001 Jul;36(7):1068-9.	Female circumcision, more accurately known as female genital mutilation, is still a common practice in parts of Africa. This ritual genital operation can involve partial or complete excision of the clitoris and labia minora as well as infibulation (labial fusion). The case reported here involves a 16-year-old African girl with a complication of this mutilating procedure.

2001	Conn CH.	Female genital mutilation and the moral status of abortion.	Public Aff Q. 2001 Jan;15(1):1-15.	
2001	Dandash KF, Refaat AH, Eyada M	Female genital mutilation: a prospective view.	J Sex Marital Ther. 2001 Oct-Dec;27(5):459-64.	There continues to be a high rate of female circumcision being practiced in Egypt. A questionnaire covering circumcision status, circumstances of circumcision procedures, and attitudes towards circumcising their daughters was given to female students in nursing secondary schools. This population was chosen as a representative sample of future mothers who also will work in a very sensitive area related to female circumcision. Results showed that all the students surveyed were circumcised. The peak ages for circumcision performance were between 10 and 12 years. About 60% of operations were performed by physicians and about 80% were done under anaesthesia at home. Rural residence was the main variable influencing the continuation of this practice in a culture in which traditions and habits are strongly respected. This points to the difficulties that face any efforts to eradicate this process.
2001	El-Defrawi, M.H., Lotfy, G., Dandash, K.F., Refaat, A.H. & Eyada, M.	Female genital mutilation and its psychosexual impact.	(2001). Journal of Sex and Marital Therarpy 27(5):465–73	

2001	Epstein D, Graham P, Rimsza M.	Medical complications of female genital mutilation.	J Am Coll Health. 2001 May;49(6):275-80.	More than 130 million women are subjected to genital mutilation. Despite increasing efforts to reduce the practice, there are many obstacles to eliminating this 2,000-year-old practice, which is based on strong cultural traditions. As college health clinicians provide care to more international students from countries where female genital mutilation is performed, increased awareness and knowledge of the procedure will enable clinicians to understand and manage its complications. We report a case of obstructive uropathy resulting in hydronephrosis secondary to female genital mutilation and review the medical literature regarding this and other complications of genital mutilation "surgery."
2001	Ford N	Female genital mutilation in developed countries	THE LANCET • Vol 358 • October 6	
2001	Fuller J, Lewis D.	Female genital mutilation.	Br J Gen Pract. 2001 Apr;51(465):330.	

2001	Gausset, Q.	AIDS and cultural practices in Africa: the case of the Tonga (Zambia).	(2001). Social Science and Medicine 52(4): 509-18	
2001	Hakim LY.	Impact of female genital mutilation on maternal and neonatal outcomes during parturition.	East Afr Med J. 2001 May;78(5):255-8.	OBJECTIVE: To evaluate the impact of female genital mutilation on parturition and to create awareness of its implication on women and neonatal health. DESIGN: A cross-sectional study. Setting: Tikur Anbessa, St. Paul's and Ghandhi Memorial hospitals between January and December 1997. SUBJECTS: One thousand two hundred and twenty five mothers with and 256 without FGM who have had spontaneous, term, singleton and vertex vaginal delivery. Of these, 762 (51.5%) were primipara and 719 (48.5%) of them multipara. The parameters focussed upon included age, ethnicity, parity, type of circumcision, episiotomy, stages of labour, Apgar scores and related complications. RESULTS: The study revealed that 82.7% of the subjects had one form of FGM. The mean ages for the circumcised and non-circumcised were 25.9 +/- 5.9 and 21.8 +/- 4.5 years, respectively. The frequently performed genital mutilation was type II (85.5%). The mothers who required an episiotomy incision for foetal and maternal indications among the circumcised accounted for 43.0% whereas it was only 24.6% for the referent group. The mean duration of labour by conventional standards is prolonged in primiparae and multiparae both in the circumcised and non-circumcised groups, though the second stage is delayed more so for the circumcised category ($p<0.05$). The first and tenth minute mean Apgar scores seem to be more favourable for the non-circumcised ($p<0.05$) but the perinatal mortality rates are quite similar. More complications in terms of perineal tears, bleeding, incontinence and febrile illnesses are registered for the FGM. CONCLUSION: The study demonstrates the negative impact of FGM more on maternal than neonatal outcomes during parturition.

2001	Hofvander Y.	Circumcision or genital mutilation--more than a terminological dispute	Lakartidningen. 2001 May 9;98(19):2372.	ARTICLE IN SWEDISH
2001	Keita, D. & Blankhart, D.	Community-based survey on female genital excision in Faranah District, Guinea.	(2001). Reproductive Health Matters 9(18):135-42.	
2001	Knight M.	Curing cut or ritual mutilation? Some remarks on the practice of female and male circumcision in Graeco-Roman Egypt.	Isis. 2001 Jun;92(2):317-38.	Ancient texts and archaeological artifacts provide the starting point for a review of the surgical aspects of female genital mutilation (FGM) in ancient Egypt. Analysis of the ancient surgical procedure incorporates modern experience on the subject as well as ancient literary and cultural perspectives. Comparison of FGM with ancient Egyptian male circumcision and consideration of motivations for the practice contribute to our understanding of FGM. In particular, the documented association between male circumcision and generative ability suggests a novel comparison with a natural process in the female--the breaking of the hymen on first intromission--and ultimately a new hypothesis for the origin of ancient FGM.

2001	Leye E, Temmerman M.	Female genital mutilation.	Verh K Acad Geneeskd Belg. 2001;63(2):161-76	ARTICLE IN DUTCH Female genital mutilation is a collective name for all traditional practices concerning the cutting of the female genitals. Approximately 130 million are genitally cut worldwide, more than 100 million live in Africa. Annually, 2 million girls are at risk of being circumcised. FGM is deeply rooted in culture, tradition, religion and the identity. Hence, the struggle against FGM must be a combined effort of law enforcement, targeted information- and sensibilization campaigns, education and training activities for various target groups that aim at establishing behavioural changes.
2001	Lubker Strickland J	Female Circumcision/Female Genital Mutilation	J Pediatr Adolesc Gynecol 14:109-112	
2001	Mason C.	Exorcising excision: medico-legal issues arising from male and female genital surgery in Australia.	J Law Med. 2001 Aug;9(1):58-67.	Genital surgery is one of the most controversial and contested practices, yet it is frequently described and referred to with little or no attention to cultural and social context. This article examines the practice, performed on both men and women, and the extent to which it clashes with issues of consent and capacity, as well as multicultural concepts of toleration for minority group practices. It then questions why female genital surgery, unlike male genital surgery, is legally prohibited in Australia. It argues that such legal gender bias stems from a liberal conception of "tolerance" and the limits of consent in Australia, placing female genital surgery in an "unacceptable" category and male genital surgery in an "acceptable" category.

2001	Momoh C, Ladhani S, Lochrie DP, Rymer J.	Female genital mutilation: analysis of the first twelve months of a southeast London specialist clinic	BJOG. 2001 Feb;108(2):186-91.	OBJECTIVES: To analyse the sources and reasons for referral of women who have undergone genital mutilation to a recently established specialist clinic, and to determine the consequences of the genital mutilation procedure. DESIGN: Retrospective descriptive case series. SETTING: The maternity units of Guy's and St. Thomas's Hospital, London. POPULATION: One hundred and sixteen women attending the clinic over a one-year period. MAIN OUTCOME MEASURES: (1) sources and reasons for referral to the specialist clinic; (2) characteristics of the women attending the clinic; (3) acute and chronic complications of the genital mutilation procedure; (4) attitudes towards female genital mutilation. RESULTS: Complete case records were available for 108 women. Of the 86 women who could remember the procedure, 78% were performed by a medically unqualified person, usually at home (71%), at a median age of seven years. Acute and chronic complications were each present in 86% of women with Type III genital mutilation. Most women (82%) were referred by their midwife because they were pregnant, of whom 48% were primigravid. Eighteen non-pregnant women also attended the clinic to request either defibulation or for advice. None of the 89 pregnant women requested re-infibulation after delivery, but almost 6% were seriously considering having their daughter undergo genital mutilation outside the United Kingdom. In addition, fewer than 10% of the women refused to continue the tradition of female genital mutilation. CONCLUSIONS: During its first year, the recently established African Well Woman Clinic has provided specialist care for 116 women with genital mutilation. Such women may attend with a variety of common medical or psychiatric conditions and often do not volunteer that they have undergone the procedure. Doctors and midwives in particular, sh ould enquire specifically about genital mutilation when caring for women from high risk countries, and offer the services of specialist clinics for female genital mutilation.
2001	Morison L, Caroline Scherf, Gloria Ekpo, Katie Paine, Beryl West,Rosalind Coleman and Gijs Walraven	The long-term reproductive health consequences of female genital cutting in rural Gambia:a community-based survey	Tropical Medicine and International Health volume 6 no 8 pp 643-653 august	

2001	Nkwo PO, Onah HE.	Decrease in female genital mutilation among Nigerian Ibo girls.	Int J Gynaecol Obstet. 2001 Dec;75(3):321-2.	
2001	Nkwo, P.O. & Onah, H.E.	Decrease in female genital mutilation among Nigerian Ibo girls.	(2001). International Journal of Gynaecology and Obstetrics 75(3):321-322.	
2001	Patrick, I.	Responding to female genital mutilation: the Australian experience in context	Australian Journal of Social Issues v.36 no.1 Feb 2001: 15-33	The increasing number of migrant women and girls in Australia affected by female genital mutilation (FGM) presents a significant challenge for public policy. Addressing FGM requires an understanding of the practice, its incidence and consequences; as of the cultural patterns and belief systems that underwrite it in those countries where it is commonly practised. Australian policy and programmatic responses to FGM are placed in the context of both international initiatives and those in other countries of settlement, and the underlying principles that guide effective FGM policy development identified. (Journal abstract)

2001	Refaat AH, Dandash KF, Lotfy G, Eyada M.	Attitudes of medical students towards female genital mutilation.	J Sex Marital Ther. 2001 Oct-Dec;27(5):589-91.	This study investigated the attitudes of medical students towards female genital mutilation (FGM). The students agreed that it is a priority health problem in the community. As physicians, 61% said they would not perform it on their patients and 17% would join any group fighting this practice. While still students, 52% said they would fight its practice within their families, and 26% planned to initiate action against it. It was not considered a problem at all by 22% of the students surveyed.
2001	Refaat, A., Dandash, K.F., el Defrawi, M.H. & Eyada, M.	Female genital mutilation and domestic violence among Egyptian women.	(2001). Journal of Sex and Marital Therapy 27(5):593-8.	
2001	Retzlaff C.	Female genital mutilation: not just over there.	J Int Assoc Physicians AIDS Care. 1999 May;5(5):28-37	AIDS: Female genital mutilation (FGM) is often associated with African and Muslim women, but dealing with its aftermath is a public health concern in the United States. There are several different types of mutilation, which are demonstrated with drawings. FGM is primarily practiced and enforced by women and has cultural significance. FGM is practiced in the United States among some immigrant groups, and women who have immigrated here often need specialized medical care as a result of the mutilation. The most extreme form of FGM is called infibulation which involves removal of all outside genitalia and near closure of the vaginal opening. Infibulated women often must be cut to allow intercourse and childbirth, and are sometimes re-infibulated after delivery, often after each child. Women who have had FGM suffer from a number of serious health complications, including anemia, chronic pelvic infections, infertility, abscesses and keloids, sexual dysfunction, menstrual disorders, urinary problems, and complications in pregnancy and childbirth. The psychological consequences have not been well studied. FGM can cause vaginal lacerations during intercourse, and anal intercourse is common in affected couples. The lacerations and anal intercourse raise concerns about HIV transmission in these women and also from the practice of performing FGM on a group of girls with the same unsterile tools. FGM is being re-introduced in the United States by some immigrant communities, and health care providers need to

				be sensitive to the needs of affected women. Several issues related to the need for cultural sensitivity are discussed
2001	Rouzi AA, Aljhadali EA, Amarin ZO, Abduljabbar HS	The use of intrapartum defibulation in women with female genital mutilation.	BJOG. 2001 Sep;108(9):949-51.	OBJECTIVE: To assess the use of intrapartum defibulation for women who have had female genital mutilation. DESIGN: A retrospective case analysis. SETTING: King Abdulaziz University Hospital, a teaching hospital in Jeddah, Saudi Arabia. SAMPLE: Two hundred and thirty-three Sudanese and 92 Somali women who were delivered at the hospital between January 1996 and December 1999. METHODS: The outcome of labour of women with female genital mutilation who needed intrapartum defibulation were compared with the outcome of labour of women without female genital mutilation who did not need intrapartum defibulation. RESULTS: One hundred and fifty-eight (48.6%) women had infibulation and needed intrapartum defibulation to deliver vaginally, 116 women (35.7%) did not have infibulation and gave birth vaginally without defibulation, and 51 (15.7%) women were delivered by caesarean section. There were no statistically significant differences, between women who underwent intrapartum defibulation and those who did not, in the duration of labour, rates of episiotomy and vaginal laceration, APGAR scores, blood loss and maternal stay in hospital. The surgical technique of intrapartum defibulation was easy and no intraoperative complications occurred. CONCLUSIONS: Intrapartum defibulation is simple and safe, but sensitivity to the cultural issues involved is essential. In the longer term, continuing efforts should be directed towards abandoning female genital mutilation altogether.
2001	Rouzi AA, Sindi O, Radhan B, Ba'aqeel H.	Epidermal clitoral inclusion cyst after type I female genital mutilation	Am J Obstet Gynecol. 2001 Sep;185(3):569-71.	OBJECTIVE: To document the occurrence of long-term sequelae after type I female genital mutilation (FGM) and describe the surgical treatment of epidermal clitoral inclusion cyst. STUDY DESIGN: Twenty-one women presented with epidermal clitoral inclusion cyst after type I FGM at the Department of Obstetrics and Gynecology at King Fahad Armed Forces Hospital, Jeddah, Saudi Arabia. The duration (mean +/- SD, range) of symptoms was 10.3 +/- 5.4, 2 to 20 years. They were treated by excision of the cyst with particular attention to preserve the remaining part of the clitoris. The technique involves making a vertical incision in the skin, dissecting and excising the cyst, removing the excessive skin, and reapproximating the skin edges. RESULTS: The procedure was done on all patients

				without intraoperative complications. All except one were discharged home on the second postoperative day. Follow-up showed no recurrence of symptoms. CONCLUSION: Long-term sequelae can occur after type I FGM. The surgical treatment of clitoral inclusion cyst is simple and effective
2001	Shell-Duncan B.	The medicalization of female ``circumcision'': harm reduction or promotion of a dangerous practice?	Social Science & Medicine 52, 1013-1028	
2001	Snow RC	Editorial: Female genital cutting: distinguishing the rights from the health agenda	Tropical Medicine and International Health volume 6 no 2 pp 89-91	

2001	Strickland JL.	Female circumcision/female genital mutilation.	J Pediatr Adolesc Gynecol. 2001 Aug;14(3):109-12.	Female circumcision/female genital mutilation (FC/FGM) refers to any alteration of the genitalia by excision or covering of the introitus done for nonmedical reasons. This procedure is widely prevalent in sub-Saharan Africa and is traditionally performed on children and young adolescents. FC/FGM is associated with acute and long-term genitourinary and reproductive disorders that may require medical intervention. Due to turbulent economic and political immigration patterns, Western physicians may be called upon to care for children or adolescents from this part of the world. This review explains the procedure and the resultant physical alterations as well as the cultural and historic basis of this ancient tradition. Emphasis is also placed on the elements of culturally competent and compassionate care for young women who have undergone FC/FGM
2001	WHO World Health Organization.	Integrating the prevention and the management of the health complications of female genital mutilation (FGM) into nursing and midwifery curricula - a teacher's guide.	Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.3 - WHO/RHR/01.16).	
2001	WHO World Health Organization.	Integrating the prevention and the management of the health complications of female genital mutilation (FGM) into nursing and midwifery curricula - a student manual.	Geneva, World Health Organization, 2001 (WHO/FCH/GWH/01.4 - WHO/RHR/01.17).	

2001	WHO World Health Organization.	Integrating the prevention and the management of the health complications of female genital mutilation (FGM) into nursing and midwifery curricula - a policy guideline.	Geneva, World Health Organization, 2001 (WHO/FCH/GWH/ 01.5 - WHO/RHR/01.18).	
2000	Abboud P, Quereux C, Mansour G, Allag F, Zanardi M	Stronger compaign needed to end female genital mutilation	BMJ 2000;320:1153	
2000	Abu Daia JM.	Female circumcision.	Saudi Med J. 2000 Oct;21(10):921-3.	It is uncertain when female circumcision was first practiced, but it certainly preceded the founding of both Christianity and Islam. A review of past and current historical, popular and professional literature was undertaken, and 4 types of female circumcision were identified. Typically female circumcision is performed by a local village practitioner, lay person or by untrained midwives. Female genital mutilation is not accepted by any religious or medical opinion, and is a violation of human rights against helpless individuals who are unable to provide informed consent and who must therefore be protected through education and legislation. Complications of female circumcision can present after many years. Any medical practitioner (either for adult or pediatric) can be confronted with this issue of female circumcision, even in countries where this custom is not present, thus mandating the understanding of this complex issue.

2000	Ahmadu, F.	Rites and wrongs: An insider/outsider reflects on power and excision.	In Shell-Duncan and Hernlund (eds), Female “Circumcision” in Africa: Culture, Controversy, and Change (pp. 283–312). Boulder: Lynne Reinner. 2000.	
2000	Allam M	Il dramma dell'infibulazione	La Repubblica 12 Febbraio 2000	
2000	Balk, D.L.	To marry and bear children? The demographic consequences of infibulation in Sudan.	In Shell-Duncan and Hernlund (eds), Female “Circumcision” in Africa: Culture, Controversy, and Change (pp. 55-71). Boulder: Lynne Reinner. (2000).	

2000	Bartman T.	Circumcision--the debate goes on.	Pediatrics. 2000 Mar;105(3 Pt 1):681; author reply 685.	
2000	Bonessio L, Bartucca B, Bertelli S, Morini F, Spina V.	Female genital mutilation and legislation	Minerva Ginecol. 2000 Nov;52(11):485-9	ARTICLE IN ITALIAN This article deals with the legal aspect concerning female genital mutilations (FGM). Such a practice (a partial excision of the external genitalia) is highly widespread in Central Africa, especially in Ethiopia and Somalia, and currently involves approximately 130,000,000 women worldwide and, in Italy, about 30,000 women amongst the immigrant population. Since 1982 the World Health Organization (WHO), which condemns such a practice as injurious to women's rights and health, proposed that laws and professional codes prohibit it in all countries. Legislation, although insufficient as a sole measure, is considered indispensable for the elimination of FMG. Since a long time some western countries (Sweden, Great Britain, Belgium and Norway), involved by immigration from countries with FGM tradition, legislated with regard to FGM. In Italy, a specific law does not exist; however, FGM are not allowed by the article 5 of the Civil Code. Nevertheless, recently, several cases of mutilations took place: this led some members of the Parliament to introduce a bill in order to specifically forbid FGM. The authors believe that legislation could effectively support the job of prevention and education, which physicians may carry out in order to save little girls from the risk of familial tradition of genital mutilations.
2000	Caldwell, J.C., Orubuloye, I. O. & Caldwell, P.	Female genital mutilation: Conditions of decline.	(2000). Population Research and Policy Review 19(3): 233-254.	

2000	Chalmers B, Hashi KO.	432 Somali women's birth experiences in Canada after earlier female genital mutilation.	Birth. 2000 Dec;27(4):227-34.	BACKGROUND: Women with previous female genital mutilation (sometimes referred to as circumcision) are migrating, with increasing frequency, to countries where this practice is uncommon. Many health care professionals in these countries lack experience in assisting women with female genital mutilation during pregnancy and birth, and they are usually untrained in this aspect of care. Somali women who customarily practice the most extensive form of female mutilation, who were resident in Ontario and had recently given birth to a baby in Canada, were surveyed to explore their perceptions of perinatal care and their earlier genital mutilation experiences. Method: Interviews of 432 Somali women with previous female genital mutilation, who had given birth to a baby in Canada in the past five years, were conducted at their homes by a Somali woman interviewer. RESULTS: Findings suggested that women's needs are not always adequately met during their pregnancy and birth care. Women reported unhappiness with both clinical practice and quality of care. CONCLUSIONS: Changes in clinical obstetric practice are necessary to incorporate women's perceptions and needs, to use fewer interventions, and to demonstrate greater sensitivity for cross-cultural practices and more respectful treatment than is currently available in the present system of care.
2000	Eke N.	REVIEW Genital self-mutilation: there is no method in this madness	BJU International 85, 295-298	
2000	Fathalla M.F.	The girl child	Int J Gynaecol Obstet. 2000 Jul;70(1):7-12.	The health of the girl child is a concern for obstetrician-gynecologists. Pediatric gynecologic conditions deserve special attention. The obstetric performance of the adult woman depends in large part on the health and healthcare of the girl child. Gender discrimination against the girl child violates her human rights and adversely impacts on her health and her life. The profession has a social responsibility to advocate for the girl child's right to health.

2000	Frances NG	Female genital mutilation; its implications for reproductive health. An overview	The British Journal of Family Planning, vol. 26, pagg. 47-51	
2000	Grossman S	New publication on female genital mutilation. Interviews with Nahid Toubia and Anika Rahman, co-authors of Female Genital Mutilation: a Guide to Laws and Policies Worldwide.	Reprod Freedom News. 2000 Sep;9(9):1-3.	PIP: Female circumcision/female genital mutilation (FC/FGM) is the collective name given to several different traditional practices that involve the cutting of female genitals. The WHO has grouped them in four categories: type 1: Clitoridectomy; type 2: Excision; type 3: Infibulation; and type 4: Unclassified. Reports indicate that an estimated 130 million girls and women have undergone FC/FGM and that it is practiced in 28 countries in the sub-Saharan and northeastern regions of Africa. As part of the growing movement to stop this human rights violation, numerous UN bodies and nongovernmental organizations such as the Center for Reproductive Law and Policy (CRLP) and RAINBO work together to monitor government responses. Presented in a questionnaire form, two authors Anika Rahman, CRLP's International Program Director, and Nahid Toubia, Director of RAINBO, discuss their recent book collaboration, "Female Genital Mutilation: A Guide to Laws and Policies Worldwide". The issues covered in the interview include the purpose of the book, reasons why FC/FGM is considered a human rights violation rather than a threat to women's health, role of international agencies in the eradication of the practice, and the effects of formal laws and policies in eliminating FC/FGM.
2000	Gustavson KH.	Girls in Sweden are circumcized in spite of more stringent notification law	Lakartidningen. 2000 Sep 6;97(36):3921.	ARTICLE IN SWEDISH

2000	Heatherly J.	Transcultural nursing and female circumcision.	Can Oper Room Nurs J. 2000 Mar;18(1):7-12.	
2000	Jones J.	Concern mounts over female genital mutilation	BMJ. 2000 Jul 29;321(7256):262.	PIP: According to estimates by the WHO, up to 140 million girls and women have undergone female genital mutilation (FGM), and each year another 2 million are thought to be at risk of it. Most girls who undergo this ritual live in Africa and to a lesser extent in Asia and the Middle East. However, there has been an increasing occurrence of genital mutilations among migrants from these countries who have settled in the US, Europe, and Australia. Although some countries prohibit the practice, evidence suggests that these laws are defied. In the UK, Baroness Ruth Rendell, the prime mover behind a cross-party parliament inquiry into FGM is convinced that some health professionals are still carrying out the operation on request. To this effect, she is advocating some prosecutions under the 1985 act. Rendell is also pressing for resources to be put into education and awareness campaigns for girls and women to have an informed choice as to whether to submit to the procedure or not.
2000	Kroll, G. L. & Miller, L.	Vulvar epithelial inclusion cyst as a late complication of childhood female traditional genital surgery.	(2000). American Journal of Obstetrics & Gynecology 183(2): 509-10.	

2000	Larsen, U. & Yan, S.	Does female circumcision affect infertility and fertility? A study of the Central African Republic, Cote d'Ivoire, and Tanzania.	(2000). Demography 37(3):313–321.	
2000	Lax, R.F.	Socially sanctioned violence against women: Female genital mutilation is its most brutal form	(2000). Clinical Social Work Journal 28(4): winter.	
2000	Leonard, L.	Interpreting female genital cutting: Moving beyond the impasse.	(2000). Annual Review of Sex Research 11: 158-191.	

2000	Magoha GA, Magoha OB.	Current global status of female genital mutilation: a review.	East Afr Med J. 2000 May;77(5):268-72.	OBJECTIVE: To provide an overview of the current global status of female genital mutilation (FGM) or female circumcision practised in various countries. DATA SOURCE: Major published series of peer reviewed journals writing about female genital mutilation (FGM) over the last two decades were reviewed using the index medicus and medline search. A few earlier publications related to the FGM ritual as practised earlier were also reviewed including the various techniques and tools used, the "surgeons or perpetrators" of the FGM ritual and the myriad of medical and sexual complications resulting from the procedure. Global efforts to abolish the ritual and why such efforts including legislation has resulted in little or no success were also critically reviewed. CONCLUSION: FGM remains prevalent in many countries including African countries where over 136 million women have been 'circumcised' despite persistent and consistent efforts by various governments, WHO and other bodies to eradicate the ritual by the year 2000 AD. This is as a result of deep rooted cultures, traditions and religions. Although FGM should be abolished globally, it must involve gradual persuasion which should include sensitisation and adequate community-based educational and medical awareness campaign. Mere repression through legislation has not been successful, and women need to be provided with other avenues for their expression of social status approval and respectability other than through FGM.
2000	Meniru GI, Hecht BR, Hopkins MP.	Female circumcision: at our doorsteps and beyond.	Prim. Care Update Ob Gyns. 2000 Nov 1;7(6):231-237.	Recent trends in international travel and emigration have brought the practice of female circumcision, also known as female genital mutilation, to the awareness of an increasing number of physicians and public policy agencies in developed countries. The main reason for the continuation of this practice is deeply held tradition. The high incidence of complications attending the procedure leads to a poor quality of life and potential life-threatening problems. Female circumcision serves no biologically useful purpose and perpetuates the subjugation and social deprivation of females. Suggestions for the eradication of this custom include universal education of females and public enlightenment campaigns; legislation tends to send the practice underground. This review is aimed at providing objective background information on female circumcision to residents in obstetrics and gynecology. An effective solution to this problem requires not just knowledge but also wisdom in order to offer a compassionate approach to the management of these women. The American women's health care specialist should be well informed on this issue because of the increasing likelihood of contact with these women. It is also hoped that health care providers will become sensitized to the point of designing and participating actively in effective schemes for the worldwide eradication of this practice.

2000	Missailidis K, Gebre-Medhin M.	Female genital mutilation in eastern Ethiopia.	Lancet. 2000 Jul 8;356(9224):137-8.	In Ethiopians at large, women and men are caught in a vicious circle of erroneous expectations and a mute consensus that maintains female genital mutilation (FGM). We have shown clear signs of erosion of this practice and the potential for further influence and change. PIP: This paper examines the incidence of female genital mutilation (FGM) in Harrar, eastern Ethiopia. The researchers studied three ethnic groups (Adere, Oromo and Amhara) using focus group interviews. A total of 24 women were interviewed, 8 from each ethnic group, at two hospitals in Harrar. The predominant types of FGM are clitoridectomy and excision, but infibulation is also practiced by some ethnic groups in the southeast. It is shown that the Adere and the Oromo perform FGM on women aged 4 years to puberty, while the Amhara perform it on the 8th day following birth. Both the Adere and Oromo practice infibulation, and the Amhara practice excision and clitoridectomy. Although the practice of FGM is widespread, signs of change of the practice are evident. However, these signs do not mean that the FGM problem is solved. All efforts must continue until the total global abolition of FGM is achieved.
2000	Moore, M.	Severity of genital cutting is linked to complications experienced later in life.	(2000). International Family Planning Perspectives 26(1):45-6.	
2000	No authors listed	Circumcision - The Debates goes on	Pediatrics, vol. 105, pagg.681-682	

2000	Patrick, I; Markiewicz, A.	Female genital mutilation: challenges for child welfare in an Australian context	Children Australia v.25 no.1 2000: 14-20	This article addresses the challenges facing the child welfare system in general, and child protection practice in particular, in responding to female genital mutilation (FGM) in an Australian context. Policy and programmatic responses to FGM are analysed to identify how child welfare concerns may be addressed in a culturally sensitive manner. (Journal abstract, edited)
2000	Richards D	Controversial issues: female genital mutilation.	Med Ref Serv Q. 2000 Winter;19(4):79-88.	As immigrant women from African countries enter the U.S., Canada, Australia, and Western Europe, western health care providers are beginning to see patients affected by the cultural practice of Female Genital Mutilation (FGM). Unfamiliar with the practice, either medically or culturally, these providers are turning to medical librarians for information. Complicating the issue are the strong negative feelings most western health care workers have about FGM, which appears to them to be both barbaric and cruel. These feelings may conflict strongly with those of their immigrant patients, who regard the practice as normal and desirable. Both medical and cultural information are needed for the professional to provide treatment of medical conditions, while also establishing a good relationship with the FGM affected patient. This article identifies and describes the most important refereed journal article databases, available now over the Internet, providing both medical and cultural information on FGM, and the most useful Web sites for health professionals, librarians, and interested laypersons who need information about this difficult multicultural issue.
2000	Rushwan H.	Female genital mutilation (FGM) management during pregnancy, childbirth and the postpartum period	Int J Gynaecol Obstet. 2000 Jul;70(1):99-104.	Female genital mutilation (FGM) is a traditional practice with serious health consequences to women that is still practiced in 28 countries with approximately 2 million girls exposed to the practice annually. The complications of FGM cause suffering to the woman all her life. Pregnancy, childbirth and the postpartum period are particularly important as there is increased risk of mortality and morbidity from FGM complications. Although the overall strategy should be to eliminate the practice completely, the healthcare providers and policy makers in the meantime should not only be aware but also well trained in the management of FGM complications to decrease the risk of mortality and serious morbidity.

2000	Rushwan, H.	Female genital mutilation (FGM) management during pregnancy, childbirth and the postpartum period.	(2000). International Journal of Gynecology and Obstetrics 70: 99-104.	
2000	Scherf, C.	Ending genital mutilation.	BMJ 2000;321:570	
2000	Shell-Duncan, B. & Herlund, Y.	Female 'circumcision' in Africa: Dimensions of the practice and debates.	In (2000). B. Shell-Duncan and Y. Hernlund (eds), Female "Circumcision" in Africa: Culture, Controversy, and Change. (pp. 1-40) Boulder, CO: Lyne Reinner.	

2000	Tinker A	Women's health: the unfinished agenda	International Journal of Gynecology & Obstetrics 70 149-158	
2000	Weir E	Female genital mutilation	CMAJ, vol. 162, pag. 1344	
2000	WHO World Health Organization.	A systematic review of the health complications of female genital mutilation, including sequelae in childbirth.	Geneva, World Health Organization, 2000 (WHO/FCH/WMH/ 00.2).	

2000	WHO World Health Organization.	Female genital mutilation: A handbook for frontline workers.	Geneva, World Health Organization, 2000 (WHO/FCH/WMH/ 00.5).	
2000	Zoossmann-Diskin A.	Ending genital mutilation. Male genital mutilation in any society is surely abhorrent too.	BMJ. 2000 Sep 2;321(7260):571.	
1999	al-Krenawi, A., & Wiesel-Lev, R.	Attitudes toward and perceived psychosocial impact of female circumcision as practiced among the Bedouin-Arabs of the Negev.	(1999). Family Process 38(4):431-43	

1999	Baaij M, Kagie MJ.	Female circumcision; histories of 3 patients.	Ned Tijdschr Geneeskd. 1999 Aug 21;143(34):1721-4.	ARTICLE IN DUTCH Three Somali women presented with problems of the infibulation they had undergone when they were girls. The first one was 22 years old and had problems with coition, the second one was 21 years old and had problems with parturition, the third one was 28 years old and had an epidermal cyst near the ventral commissure of the vulva. Infibulation is a form of female circumcision, in which the clitoris, labia minora and labia majora are removed and the ostium vaginae is reduced to less than a centimeter. In the Netherlands the Ministry of Health, Wellbeing and Sport and the Association of Obstetricians and Gynaecologists have declared themselves opponents to female genital mutilation carried out by Dutch physicians. The association decided also to not carry out reinfibulation, e.g. after parturition.
1999	Barstow DG.	Female genital mutilation: The penultimate gender abuse	Child Abuse Negl. 1999 May;23(5):501-10.	OBJECTIVE: The five goals established for the development of this article were to: (1) provide an historical overview of the practice, (2) describe the procedure and its sequelae in realistic terms, (3) explore cultural justifications for the continuation of this action, (4) evaluate inherent moral/ethical/legal issues and, (5) focus worldwide professional attention on a gender-specific child atrocity. METHOD: A review of the past and current historical, popular and professional literature was undertaken to determine the precursors, magnitude, settings, rationale, and moral-ethical-legal-treatment issues associated with this mutilating procedure. RESULTS: Four forms of female genital mutilation were identified. These are: (1) sunna (removal of the prepuce of the clitoris); (2) clitoridectomy (removal of the prepuce and the clitoris); (3) excision (removal of the prepuce, clitoris, upper labia minora and perhaps the labia majora); and, (4) infibulation (removal of the prepuce, clitoris, labia minora, and labia majora). The "surgery" is performed most frequently by untrained midwives who use sharp rocks, razor blades, kitchen knives, broken glass, or even their teeth. As a rule, no anesthetics, antiseptics, analgesics or antibiotics are available to victims. Consequently, these females typically suffer from massive short-term and long-term physical, emotional, sexual and obstetrical sequelae. CONCLUSIONS: The justifications tendered by proponents do not withstand moral-legal-ethical scrutiny. Female genital mutilation is a violation of human rights and an atrocity perpetrated against helpless individuals who are unable to provide informed consent and who must therefore be protected through education and legislation.

1999	Bloom LD, Kern IB, Lewin RJ, Robinson DI, Wise WL.	Female genital mutilation: responding to health needs.	Med J Aust. 1999 Mar 15;170(6):286.	
1999	Brady M.	Female genital mutilation: complications and risk of HIV transmission.	AIDS Patient Care STDS. 1999 Dec;13(12):709-16	There are over 100 million girls and women who have undergone female genital mutilation (FGM). The World Health Organization (WHO) estimates that another 2 million are subject to it every year. FGM is practiced in many countries, especially Africa and parts of the Middle East. Various degrees of FGM are prevalent, the most mutilating one being infibulation (pharaonic). With infibulation there are numerous life-long health problems such as hemorrhage, infection, dyspareunia, genital ulcers, and gynecological and obstetrical complications. It has been postulated that FGM may also play a significant role in facilitating the transmission of HIV infection through numerous mechanisms. In this article several of the most common complications are discussed and helpful suggestions for management during pregnancy and delivery are explored. Included are the legal and ethical ramifications.
1999	Ciment J	Senegal outlaws female genital mutilation	BMJ, vol. 318, pag. 348	

1999	Cohen AK	Femal genital mutilation: responding to health needs	MJA, vol. 170, pagg. 285-86	
1999	Cohen AK, Gubbay SS, Kamien M, Landau LI.	Female genital mutilation: responding to health needs.	Med J Aust. 1999 Mar 15;170(6):285-6.	
1999	Davis, G., Ellis, J., Hibbert, M., Perez, R.P. & Zimbelman, E.	Female circumcision: the prevalence and nature of the ritual in Eritrea.	(1999). Military Medicine 164(1): 11-16.	

1999	de Marquiegui A	A woman's sexual life after operation	BMJ, vol. 318, pagg. 178-181	
1999	Eke N, Nkanginieme KE.	Female genital mutilation: A global bug that should not cross the millennium bridge	World J Surg. 1999 Oct;23(10):1082-6; discussion 1087	Female genital mutilation (FGM) has been practiced worldwide, clothed under the tradocultural term "circumcision." Indications for its practice include ensuring virginity, securing fertility, securing the economic and social future of daughters, preventing the clitoris from growing long like the penis, and purely as a "tradition." Outlawed only in the United Kingdom, Sweden, and Belgium, no law forbids it in most other countries. Classified into four identified types, the current perpetrators are mainly quacks, but trained medical personnel still connive at and encourage FGM. Early complications include hemorrhage, urinary tract infection, septicemia, and tetanus. Late complications include infertility, apareunia, clitoral neuromas, and vesicovaginal fistula. Reasons for the ritual persisting include fear that legislation would force it underground and it will be performed in unsterile conditions, belief that it is racist to speak out against FGM, "tolerance" by health professionals, continued use of the term "female circumcision," lack of awareness of the culture of immigrants by the physicians in areas where FGM is not culturally practiced, and sporadic or uncommitted eradication efforts. We believe there is no reason for the continued practice of FGM. It should incur global abolition, the same way slave trade or Victorian chastity belts have done. We advocate that in medical communications the term "female genital mutilation" be used in place of "female circumcision." World leaders should include unacceptable cultural practices such as FGM in the "world summit" agenda. The year 1999 should be declared the year for global eradication of FGM.

1999	El-Gibaly, O., Ibrahim, B., Mensch, B.S. & Clark, W.H.	The Decline of Female Circumcision in Egypt: Evidence and Interpretation.	(1999). Policy Research Division Working Paper No. 132, The Population Council, New York, NY.	
1999	Enany R, Graf P, Hoss C, Sautter R, Kolta K.	Female circumcision: historical, sociological and medical aspects	Handchir Mikrochir Plast Chir. 1999 Jan;31(1):47-50.	ARTICLE IN GERMAN Female circumcision is a very old tradition still widely practised in Africa. The extent of female circumcision ranges from resection of the clitoridal prepuce (= sunnitic circumcision) to resection of labia minora and majora as well as clitoridectomy (= pharaonic circumcision). Wound approximation by sutures or scar contraction may cause partial closure of the vaginal orifice (=infibulation). Historical, sociological as well as medical aspects are discussed and reconstructive procedures described.
1999	Farmer A.	Outlawing FGM in the USA.	Reprod Freedom News. 1999 Nov;8(10):1, 3	PIP: This article discusses the outlawing of female genital mutilation (FGM), otherwise known as female circumcision in the US. FGM has been practiced for centuries, accounting for 130 million cases worldwide. The practice ranges from removal of all or part of the clitoris to removal of the clitoris and genital area, leaving only a passage for urine. The practice is commonly performed on girls aged 4-12 years. Short-term complications of FGM include severe pain, risk of hemorrhage, and death. Long-term complications include urine retention , menstrual obstruction, painful sexual intercourse, and labor and delivery problems. On the other end, the issue points out that although FGM was viewed as a violation to human rights, parents do this on their daughters because of love and respect for tradition. Based on this premise, access to information and support were viewed as important determinants to the choices of parents on whether or not to involve their daughter in FGM. The bill passed in Colorado, which renders FGM a crime, includes provisions for public health education in the state on this practice.

1999	Ferguson, B, ed.; Pittaway, E, ed..	Nobody wants to talk about it: refugee women's mental health.	Paramatta, NSW: Transcultural Mental Health Centre, 1999, 114p, tables, figures	The chapters in this book address topics relevant to refugee women's health and mental health. They illustrate the fact that while there are commonalities in the experience of refugee women, each group also has unique issues derived from the particular cultural, historical and geopolitical context which generated their flight. The Last Post by Chris Murphy is presented and the following chapters are individually indexed. Refugee women - the unsung heroes by Eileen Pittaway; The shadow hanging over you: refugee trauma and Vietnamese women in Australia by Barbara Ferguson; English acquisition and mental health for Somali women by Felicia Paul; Working towards well-being: the link between employment and mental health problems experienced by refugee women by Velvy Holden; Unuttered screams: the psychological effects of female genital mutilation by Juliana Nkrumah; Iranian refugee women in Australia: their experience of marriage, divorce and gender roles by Cherie Lamb; a delicate issue: perceptions of sexual assault in yhe Vietnamese community by Jan Thompson
1999	Fourcroy JL	Female Circumcision	American Family Physician, vol. 60, n.2, pagg.657-658	
1999	Fourcroy JL	Female circumcision.	Am Fam Physician. 1999 Aug;60(2):657-8.	

1999	Hassan SS	Le mutilazioni sessuali femminili: tipologia e conseguenze fisiche (Brani antologici dal libro "La donna mutilata")	http://www.ecn.org/reds/mutilazioni.html	
1999	Hopkins S	A discussion of the legal aspects of female	Journal of Advanced Nursing, vol. 30, pagg. 926-933	
1999	Hopkins S	A discussion of the legal aspects of female genital mutilation	Journal of Advanced Nursing, 30(4), 926-933	

1999	Isa, A.R., Shuib, R. & Othman, M.S.	The practice of female circumcision among Muslims in Kelantan, Malaysia.	(1999). Reproductive Health Matters 7(13): 137–143.	
1999	Jones H	Female Genital Cutting Practice in Burkina Faso and Mali and their negative health outcomes	(1999). Studies in Family Planning 30(3):219-229	
1999	Kamien M	Femal genital mutilation and the use of unsighted references	MJA, vol. 171, pag. 336	

1999	Kamien M, Gubbay SS.	Female genital mutilation and the use of unsighted references.	Med J Aust. 1999 Sep 20;171(6):336.	
1999	Kandela P	Clitoridectomy	The Lancet, vol. 353, pag. 1453	
1999	Knight R, Hotchin A, Bayly C, Grover S.	Female genital mutilation--experience of The Royal Women's Hospital, Melbourne.	Aust N Z J Obstet Gynaecol. 1999 Feb;39(1):50-4.	This study was performed to improve our knowledge and understanding of the needs of women affected by female genital mutilation. We looked at the types of complications of these practices which present to a large metropolitan women's hospital in order to determine how we can appropriately treat and support affected women. This was an observational study of women from countries with a high prevalence of female genital mutilation who presented to the Royal Women's Hospital between October, 1995 and January, 1997. Fifty-one patients with a past history of female genital mutilation who were attending the hospital for antenatal or gynaecological care consented to participate in the study. We found that 77.6% of women identified as having had female genital mutilation had undergone infibulation. More than 85% of the women in our study reported a complication of the procedure. The major complications were dyspareunia, apareunia and urinary tract infections; 29.4% of these women required surgery to facilitate intercourse. In our study group there was no difference in Caesarean section rates between the women who had previously delivered in Australia compared with those who had delivered in Africa. Women who have had a female genital mutilation procedure have specific needs for their care which present challenges to both their general practitioners and obstetrician/gynaecologists. These women have significant complications related to their procedure including social and psychosexual problems

				which require sympathetic management.
1999	Morris, R.I.	Female genital mutilation: perspectives, risks, and complications.	Urol Nurs. 1999 Mar;19(1):13-9.	Female genital mutilation, traditionally known as female circumcision, is a surgically unnecessary modification of the female genitalia, practiced in nations in Africa, the Arab Peninsula, among some communities in Asia, and among immigrants and refugees from these areas who have settled in other areas. The practice is known across socio-economic classes and among many different ethnic and cultural groups, including Christians, Muslims, Jews, and followers of indigenous African religions. As people from these areas immigrate to North America, health care professionals need to understand the important aspects of this growing problem, including management of complications, cultural attitudes, and sensitivities.
1999	Nkrumah, J.	Unuttered screams: the psychological effects of female genital mutilation	In: Ferguson, B. and Pittaway, E. eds. Nobody wants to talk about it: refugee women's mental health. Paramatta, NSW: Transcultural Mental Health Centre, 1999, p54-73, figures	The practice of female genital mutilations (FGM) is examined in this chapter which provides a World Health Organisation definition of FGM and discusses the following issues: global distribution; effects of FGM on women affected including physical health, long term health effects and psychological effects; the experience of girls; FGM and social control; revealing long term psychological effects of FGM; FGM and migration; and triggers of psychological effects. A chart on how FGM is sustained at grassroots level is provided.

1999	No authors listed	Excision: the new prohibition that divides the society. Press review: Senegal	Pop Sahel. 1999 Dec;(28):7.	ARTICLE IN FRENCH PIP: Approximately 700,000 women in Senegal have suffered female genital mutilation (FGM). Now, following a vote upon legislation banning FGM, public opinion in the country over the practice is more divided than ever. The practitioners of FGM are not taking the law seriously, while politicians hesitate to openly condemn the practice, which still occurs widely in rural zones. Most of the 140 parliamentarians do not believe that laws alone can successfully end FGM in Senegal. Some deputies and feminists believe that several years of sensitization on the issue will be needed to effectively reduce the frequency with which FGM is practiced. Only optimists believe FGM will disappear on its own. The debate threatens to resurface in some areas during the year 2000 presidential election. One deputy from the governing party, originally from southern Senegal, states that he dares not tell his constituency that the president himself created the anti-FGM legislation, especially when locally elected leaders finance villages inverted question mark FGM-related celebrations. According to a scholar of the Koran, FGM is an Islamic practice, but it is not taught in the Koran. FGM is therefore a cultural practice borne from individual choice. In Kolda, 650 km south of Dakar, the practitioners of such mutilation argue that they would rather be imprisoned than abandon the practice they consider to be an immutable component of their cultural history.
1999	No authors listed	Female genital cutting. Evidence from the Demographic and Health Surveys.	Afr Popul Dev Bull. 1999 Jun-Jul;:26-7.	PIP: This article reports on the prevalence of female genital mutilation (FGM) in the Central African Republic (CAR), Cote d'Ivoire, Egypt, Eritrea, Mali, Tanzania and Yemen. Evidences from the Demographic and Health Surveys indicate that FGM is widely practiced in these countries. About 9 out of 10 women have had at least some part of their external genitalia removed in Egypt, Eritrea, Mali, and northern Sudan, while in Cote d'Ivoire and the CAR the practice is less common. A comparison of prevalence levels among age groups in women aged 15-49 years revealed little or no decline in FGM; however, the CAR displayed a slight, but continuous, decline in prevalence across age groups. Furthermore, educational level and religion were found to affect the prevalence rate. Also, the 1996 clinical study in Egypt found that more than 70% of the study population had at least part or all of their clitoris and labia minora excised. In Eritrea and Sudan, many women undergo infibulation, the most hazardous and extensive form of female genital cutting, which almost entirely closes off the vaginal opening. The study also showed that women who had undergone the operation had experienced adverse health effects like hemorrhage. Widespread and enduring support for FGM among women was noted in Egypt, Mali, and Sudan; only Eritrea appeared to have a critical mass of opposition to the procedure among the adult population, which suggests an openness to change.

1999	No authors listed	FGM: Senegalese women protected by law.	Afr Health. 1999 May;21(4):40.	PIP: This article reports on the prohibition of the practice of female genital mutilation (FGM) among Senegalese women as ordered by the Senegalese parliament. People who defy the law by ordering or performing the operation, which is often carried out using unsterile or rusty instruments and without anesthetic, will be imprisoned for 5 years. Enforcing the prohibition may be problematic; however, the government was anxious to avoid upsetting cultural sensitivities within the country inverted question marks borders. UNICEF and other UN agencies have approved the prohibition in the hope of ending this cruel and unacceptable practice that violates the right of all girls to free, safe, and healthy lives.
1999	No authors listed	An evaluation of the impact of community health field stations in Burkina Faso.	Afr Popul Dev Bull. 1999 Jun-Jul;:28.	The UERD (Unite d'Enseignement et de Recherche en Demographie) carries out an ongoing research project that aims to evaluate community-based strategies in the provision of reproductive health services in the Bazega community health field station in Burkina Faso. UERD evaluates the effectiveness of two different strategies: 1) the improvement of Health Center based FP services and 2) the recruitment and training of agents selected from the local community (community-based service agents, or CBS agents). 18 months after the interventions began UERD made an evaluation of its impact on the general population based on a quasi-experimental research design and a detailed protocol. The results indicate a significant increase in contraceptive prevalence (from 3.6% to 8%) in the zone of CBS intervention over the course of the period. However, the prevalence levels remain weak. The growth in contraceptive prevalence was not determined to be the result of an increased demand brought about by the CBS agents, but instead by improving accessibility due to the proximity of the supply. The research sample comprised 1600 randomly selected compounds (2000 women and 1500 men), which allows for another evaluation in the year 2000. It was designed to permit research in other areas of reproductive health such as HIV/AIDS and STDs, FGM, abortion, etc. full text
1999	No authors listed	Student's Knowledge of and Attitude about Female Circumcision in Egypt	New England Journal of Medicine, vol 341, pagg. 1552-1553	

1999	Obermeyer, C.M.	Female genital surgeries: The known, the unknown, and the unknowable.	(1999). Medical Anthropology Quarterly (New Series) 13(1): Mar.	
1999	Obermeyer, C.M. & Reynolds, R.	Roundtable on cutting women's genitals. Female genital surgeries, reproductive health, and sexuality: a review of the evidence.	(1999). Reproductive Health Matters 7(13):112–120.	
1999	Petersen MM.	Changing tradition -- a Danish approach to female genital mutilation	Entre Nous Cph Den. 1999 Winter;(45):7-8	PIP: This article reviews the video film "Let us talk" and the book "Preventing FGM", the Danish response to the challenge of FGM (female genital mutilation). The video film, produced in Somali in 1998, presents different Somali views on the harmfulness of FGM. Also included are the opinions of Somali men, a religious leader and professionals in the fields of psychology and medicine. The main points against FGM cited in the video include the physical and mental impact of FGM, religious aspects of FGM, and violation of human rights. This is meant to raise consciousness, induce discussions and sway common opinion on the subject. Meanwhile, the book published by the Danish National Board of Health in 1999 aims at the professionals working in the public sector. It deals with the prevention of FGM and supplies the reader with important background information, statistics and diagrams. Guidelines on how to address specific situations involving FGM are offered.

1999	Wagner M	Episiotomy: a form of genital mutilation	The Lancet, vol. 353, pag. 1977-78	
1999	Wassef, N. & Mansour, A	Investigating masculinities and female genital mutilation in Egypt.	(1999). National NGO Centre for Population and Development, Cairo.	
1999	WHO World Health Organization.	Female genital mutilation (information kit).	Geneva, World Health Organization, 1999 (WHO/CHS/WMH/ 99.11).	

1999	WHO World Health Organization.	Female genital mutilation. Programmes to date: What works and what doesn't.	Geneva, World Health Organization, 1999 (WHO/CHS/WMH/ 99.5).	
1998	Akpoterabor CE.	Female circumcision [letter]	Afr Health. 1998 Jan;20(2):5.	The letter on unsafe male circumcision by Dr. H. Gretahun (Africa Health, March 1997) brings into very clear focus the whole issue of genital mutilation. Circumcision, whether male or female, does not per se amount to genital mutilation unless performed unsafely. Female circumcision involves only reducing the rudimentary penis, the clitoris, in order to tuck it neatly and beautifully under the labia majora. When the operation involves slicing off the labia, it ceases to be circumcision. Any scar tissue formed, both in size and location, is never enough to interfere with childbirth, otherwise the Black race would have been extinct millennia ago. Orgasm is not impeded in any way or else the female population of the planet would have been 80% frigid. If an uncircumcised female exhibits greater excitability, it is to be expected; even the constant friction between the clitoris and the underpart sets off some amount of auto-arousal. African female anti-circumcision activists should stop to consider the real issues and recognize the ulterior motives of the Western world, where even males are not circumcised. They should worry more about AIDS, which the West created as a weapon against its Communist opponents using Africans as laboratory animals. Africans should be demanding compensation and free distribution of all available drugs and not condoms.
1998	American Academy Pediatrics. Committee on Bioethics	Female Genital Mutilation	Pediatrics, vol. 102, pagg.153-156	

1998	Bayly, C M	Female genital mutilation: responding to health needs.	Medical Journal of Australia v.169 no.9 Nov 1998: 455-456	Public debate about female genital mutilation (FGM) has focused on extreme forms of this practice and on legislation intended to prevent it. However, little attention has been paid to the actual health needs of those women and girls who have already experienced this procedure. This editorial states that affected women require a culturally sensitive approach to health issues related to these practices. Before coming to Australia, women who have been affected would have seen themselves as normal, but would now have to re evaluate their experiences. It is important that medical practitioners respond helpfully to the problems of women who have undergone FGM, provide accurate health information and respect cultural identification while discouraging any harmful practices.
1998	Blickstein I.	Female genital mutilation	Harefuah. 1998 Mar 15;134(6):455-6.	ARTICLE IN HEBREW
1998	Chelala C	An alternative way to stop female genital mutilation	The Lancet, Vol 352, July 11pag. 126	

1998	Colombo D	Bambine a rischio. Le cifre italiane	Unimondo one world http://www.unimondo.org/aidos/1998/1_019.html	
1998	Cvjeticanin, V.	Legislating against female genital mutilation: the ACT experience	Australian Family Lawyer v.12 no.3 Autumn 1998: 20-23	Written from the perspective of health promotion and community education, this article looks at the legal and health aspects of the practice of female genital mutilation. It focuses on basic legal, health and sociological issues regarding the practice in the Australian Capital Territory (ACT) and aims to present the relevant information in a comprehensive manner, with the understanding that any practitioner working on the issue, particularly lawyers in criminal law, family law and immigration law fields, will need to do further reading on the topic. Female genital mutilation is defined, the ACT program is described, and the ACT legislation is outlined.
1998	Davis AJ.	Female genital mutilation: some ethical questions.	Med Law. 1998;17(2):143-8.	This paper provides some basic information about female genital mutilation (FGM) as a social problem and as a health problem. It includes selected actions taken over the last 45 years by the United Nations regarding FGM. The focus here is on the ethics of individuals and institutions, such as the World Health Organization, attempting to intervene in traditional cultural practices like FGM. This discussion raises some questions about ethical universals and ethical relativism with regards to FGM and the attempts to change or eradicate this practice.

1998	Dawson MT	A case of cultural misunderstanding	Australian Family Physician, vol. 27, n. 8, pagg. 669-670	
1998	Forjuoh SN	Violence against children and adolescents : International Perspectives	Pediatric Clinics of North America, vol. 45, n. 2, pagg. 415-426	
1998	Fourcroy, J.L.	The three feminine sorrows.	(1998). Hospital Practice, July 15.	

1998	Fox E.	Female genital mutilation protocol for clinic staff.	Womens Health Newsl. 1998 Mar;(36):6.	PIP: This article offers a brief protocol for providing health care to the survivors of female genital mutilation. The suggestions begin with the reminder that women rarely mention that they have undergone female genital mutilation. Health care workers should, therefore, ask women directly but sensitively if they have been cut and if they have any problems or concerns related to their genitalia. It may not be possible to obtain swabs from the correct anatomical site in women who are infibulated, so treatment of some cases will be presumptive. All infibulated women, especially those who are pregnant or planning a pregnancy, should be offered deinfibulation. Women with structural abnormalities that may be amenable to correction should be referred to a surgeon. Women with psychosexual problems should be referred to an appropriate physician or therapist. A box contained in this article notes that Waris Dirir, a Somali nomad who was forced to undergo female genital mutilation at age five and later became an international supermodel, has been appointed a special ambassador for the UN campaign against female genital mutilation.
1998	Gibeau AM.	Female genital mutilation: when a cultural practice generates clinical and ethical dilemmas.	J Obstet Gynecol Neonatal Nurs. 1998 Jan-Feb;27(1):85-91.	Female genital mutilation (FGM) is of growing concern to health care providers in the United States and Canada as more women from countries where the procedure is practiced emigrate to North America. An introduction to the demographics of FGM, including prevalence rates, is a necessary antecedent for understanding the cultural rationales for this widespread practice. Considering the health consequences of this practice promotes questions about legal and ethical aspects of care as North Americans approach FGM from their own individual cultural frameworks. PIP: Female genital mutilation (FGM) is a widespread practice which affects millions of women. As women have migrated from countries in which FGM is practiced to the US, Canada, and western Europe, and present themselves to physicians with FGM-related morbidity, the levels of awareness and concern internationally about FGM as both a cultural practice and a human rights issue have grown over the past decade. There are, however, large gaps in the existing knowledge about FGM. Few studies have been conducted about its specific practices and no accurate statistics exist about its prevalence. The author describes FGM, including current information on its prevalence and classifications, while a review of the short- and long-term sequelae situates FGM in context as a health care issue. Background about FGM as a cultural practice is provided. National and international policy are then described with regard to current efforts to eradicate FGM, including legal initiatives proposed and legislated in the US. Ethical dilemmas on FGM and their possible resolutions are reviewed.

1998	Hosken, F.P.	Female genital mutilation: strategies for eradication.	Womens Health Newsl. 1998 Mar;(36):2, 4-5.	PIP: Female genital mutilation (FGM) is a term applied to genital cutting that can vary from a nick on the clitoris to total excision of all external genital tissue and closure of the vulva. FGM is practiced in many African countries, in some parts of the Arab peninsula and Persian Gulf, in some groups in Indonesia and Malaysia, and among immigrants in Western countries. The practice has been outlawed in the most European countries and in the US. The US legislation also requires all African countries receiving US aid to begin education programs to eradicate FGM mutilation. The first international recommendations to abolish FGM were made in 1979, and the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was formed in 1984. The IAC, which gained worldwide support at the 1985 UN Conference for women, has affiliated committees in 26 African countries. The IAC supports its affiliates by offering training, networking opportunities, and resources and by holding a major conference every 3 years. The fourth IAC conference, in 1997 in Dakar, attracted about 90 delegates, including two women from Japan and one from the US. The IAC is working to eradicate all forms of traditionally condoned violence against women and girls, including FGM, child marriage, food taboos, and force feeding. Efforts to reach rural populations rely on distribution of childbirth picture books that explain the biological facts of reproduction and then describe the effects of FGM on women's health. These include immediate complications (including death), long-term complications, pregnancy-associated problems, and psychosexual and psychological problems.
1998	Mazzetti M	Mutilazioni genitali femminili in Italia. Un dramma a più soggetti	ISMU Salute Gennaio 1998 pagg. 4-5	

1998	No authors listed	Consequences of genital mutilation	Womens Health Newsl. 1998 Mar;(36):5.	PIP: Female genital mutilation is associated with immediate, long-term, pregnancy-related, and psychosexual complications. Immediate complications can cause death and include severe pain, shock, hemorrhage, tetanus or sepsis, urine retention, ulceration of the genital region, and injury to adjacent tissues. Long-term complications include formation of cysts, abscesses, and keloid scars, damage to the urethra resulting in incontinence, painful sexual intercourse, sexual dysfunction, recurrent urinary tract infections, chronic pelvic inflammatory disease, and infertility. During child birth, survivors of female genital mutilation may require Cesarean section or suffer obstructed labor leading to fetal death and/or vesico-vaginal fistulae and large perineal tears. The psychological consequences of female genital mutilation may involve loss of trust and confidence in care-givers, feelings of incompleteness, anxiety, depression, chronic irritability, and sexual problems. In many women, flashbacks of the infibulation process are triggered by touch. Deinfibulation must be accompanied by adequate pain relief, but the use of local or epidural anesthesia is not appropriate.
1998	No authors listed	The reasons given for FGM: culture and tradition.	Womens Health Newsl. 1998 Mar;(36):7.	PIP: Many practitioners of female genital mutilation believe that the procedure is dictated by tradition and is necessary to ensure marriage because men refuse to marry intact women. It is sometimes stated that the purpose of female genital mutilation is to control women's sexuality, and, in some settings, intact women are considered dishonorable prostitutes. It is also widely believed that the clitoris connotes maleness and the prepuce of the penis connotes femaleness. Those who hold these beliefs, therefore, insist that both be removed before a person is accepted as an adult. It is additionally claimed that female genitalia are ugly and dirty and must be removed to enhance beauty and cleanliness. Female genital mutilation is perpetrated because it gives men power over women as a group. While no religion specifically requires female genital mutilation, patriarchal religions create the cultural milieu that allows this practice to continue
1998	No authors listed	Female genital mutilation. American Academy of Pediatrics. Committee on Bioethics	Pediatrics. 1998 Jul;102(1 Pt 1):153-6.	The traditional custom of ritual cutting and alteration of the genitalia of female infants, girls, and adolescents, referred to as female genital mutilation (FGM), persists primarily in Africa and among certain communities in the Middle East and Asia. Immigrants in the United States from areas where FGM is endemic may have daughters who have undergone a ritual genital procedure or may request that such a procedure be performed by a physician. The American Academy of Pediatrics (AAP) believes that pediatricians and pediatric surgical specialists should be aware that this practice has serious, life-threatening health risks for children and women. The AAP opposes all forms of FGM, counsels its members not to perform such ritual procedures, and encourages the development of community educational programs for immigrant populations.

1998	Ortiz ET	Female genital mutilation and public health: lessons from the British experience.	Health Care Women Int. 1998 Mar-Apr;19(2):119-29.	The author addresses the public health policy challenge posed by the increasing numbers of immigrant girls and women in the United States affected by female genital mutilation (FGM), a traditional ritual health practice in which part or all of the external genital structures are removed from females, usually during childhood. The practice is common today in 26 African nations and affects 100 to 126 million women and girls worldwide. The significant lifelong negative health impact of FGM has been documented. Recent developments in British domestic health and social policy are reviewed to provide insights. The definition of FGM, prevalence, health impact, and history of the practice are presented. Implications for the development of health and social services policies and programs in the United States are drawn.
1998	Schiander Gray C	A case history based assessment of female genital mutilation in Sudan	Evaluation and Programming Planning 21 429-436	
1998	Toubia, N. & Izett, S.	Female Genital Mutilation: An Overview	(1998). Geneva: World Health Organization.	

1998	WHO World Health Organization.	Female genital mutilation: An Overview.	Geneva, World Health Organization, 1998.	
1997	Abd el Hadi A	A step forward for opponents of female genital mutilation in Egypt.	Lancet. 1997 Jan 11;349(9045):129-30.	PIP: In July 1996, Egypt's Minister of Health reversed a 1994 ruling of his predecessor that allowed public hospitals to perform female genital mutilation (FGM). 1994 also saw the establishment of a Task Force Against Female Genital Mutilation, which launched a national campaign to reverse this ruling. This campaign included taking the previous Health Minister to court and legally challenging a religious leader who stated that Muslim women should be mutilated . Activists also countered official statistics placing the prevalence of FGM at 50%. A 1995 National Health Survey of 14,000 ever-married women 14-59 years old revealed that 97% had undergone the procedure. These findings were supported by a validation study of 1400 women which showed that 94% were affected. Activists are hopeful because contradictory medical and religious messages are being resolved in favor of banning the procedure, and the media has begun to report deaths from FGM. Challenges remain, however, including a suit filed in court by a group of professors of obstetrics and gynecology who claim that prohibiting the procedure in a clinical setting will result in clandestine operations that endanger women's health. The Egyptian Medical Syndicate, which endorsed the 1994 ruling, has remained silent about the current decree.
1997	Adinma J.I.	Current status of female circumcision among Nigerian Igbos.	West Africa Journal of Medicine 1997 - 16(4): 227–231	

1997	Althaus, FA.	Female circumcision: rite of passage or violation of rights?	International Family Planning Perspectives, Vol 23, No 3, 1997. pp 130-133.	
1997	Azadeh H.	Female circumcision genital mutilation and childbirth--a mother and child tragedy.	Br J Theatre Nurs. 1997 Oct;7(7):5-8, 10.	
1997	Bashir LM.	Female genital mutilation: balancing intolerance of the practice with tolerance of culture.	J Womens Health. 1997 Feb;6(1):11-4.	

1997	Berg K.	Female genital mutilation: implications for social work.	Soc Work. 1997 Fall;65(3):16-26.	PIP: This article examines the different aspects of female genital mutilation (FGM) which is more commonly known as "female circumcision." It also discusses the Women-at-Risk Program in Canada, mental health issues, and Canadian laws and bans on this practice. Implications of FGM for the social work are also addressed. FGM is a global issue, occurring across different cultures and ethnic groups. It is estimated that between 85 and 14 million women have been mutilated worldwide. There are three forms of FGM: circumcision, excision, and infibulation. Despite the many serious risks arising from these procedures, the practice still continues for reasons that are often based on myths, tradition, and beliefs that religion requires it. Females can suffer from severe consequences of FGM. Various fields, which address health needs, however, failed to recognize the physical and psychological impact of the practice, and have not effectively trained health workers to confront this issue. Putting an end to FGM requires a global action from professionals in mental health, social work, medicine and nursing to challenge laws and lobby for new policies; advocate for the human rights of women and children; negotiate for changes in the health care system to address the needs of women have been mutilated; and create educational literature, thus, increasing awareness on FGM.
1997	Black JA	Female Genital Mutilation: a contemporary issue, and a Victorian obsession	Journal of the Royal Society of Medicine vol. 80; pagg. 402-405	
1997	Boland, R and Rahman, A.	Promoting reproductive rights: a global mandate.	New York: Center for Reproductive Law and Policy, 1997. 48p	

1997	Caldwell, JC, Orubuloye, IO and Caldwell, P.	Male and female circumcision in Africa from a regional to a specific Nigerian examination	Social Science and Medicine, Vol 44, No 8, 1997. pp 1181-1193.	
1997	Carr, D.	Female genital cutting.	Calverton: Macro International, 1997. 96p.	
1997	Chalkley K.	Female genital mutilation: new laws, programs try to end practice.	Popul Today. 1997 Oct;25(10):4-5.	PIP: A new US law criminalizes female genital mutilation (FGM) and requires notification of this fact to immigrants from Africa and the Middle East. In addition, US representative to international financial institutions are directed to oppose issuance of foreign aid to countries that lack established educational programs to eradicate FGM. FGM involves a range of procedures characterized by the amount of tissue removed and may be carried out in infants, adolescents, or new mothers. Complications include death, debilitating illness, and increased risk during child birth. FGM is firmly entrenched in countries in sub-Saharan Africa and parts of the Arab peninsula and extends to a few groups in Asia and immigrant populations in developed countries. Most women in an Egyptian study had undergone FGM and justified the practice as a way of reducing sexual desire and, thus, preserving premarital virginity. Many women also consider FGM a religious requirement, but this claim is unsubstantiated. Successful eradication campaigns in Kenya have preserved the social and coming-of-age ritual aspects of the practice while rejecting the physical mutilation, and efforts in Nigeria have focuses on health education. A New York-based group working to eradicate FGM has criticized the new US law because it requires education of affected communities without allocating the necessary funding. The group charges that the new law needs revision to remove criminal liability from family members who may object to a proposed FGM

				procedure but fail to report or stop it.
1997	Craft N	Life span: conception to adolescence	~~BMJ, vol. 315, pag. 12227-12230~~	
1997	Diasio N	Immigrazione, cultura e salute	Argomenti di medicina delle migrazioni pagg. 169-203 (*vol. esaurito*)	

1997	Ebong, RD.	Female circumcision and its health implications: a study of the Uruan Local Government Area of Akwa Ibom State, Nigeria.	Journal of the Royal Society of Health, Vol 117, No 2, 1997. pp 95-99.	
1997	El Bashir, H.	The future prospects of FGM in central Sudan: field testimonies.	Unpublished paper, 1997. 15p.	
1997	Elchalal, U et al.	Ritualistic female genital mutilation: current status and future outlook.	Obstetrical and Gynecological Survey, Vol 52, No 10, 1997. pp 643-651.	

1997	Equality Now.	The Gambia: government censorship of the campaign to stop female genital mutilation (FGM).	Equality Now: Women's Action, Vol 13, No 1, 1997. pp 1-2.	
1997	Eyega Z, Conneely E.	Facts and fiction regarding female circumcision/female genital mutilation: a pilot study in New York City	J Am Med Womens Assoc. 1997 Fall;52(4):174-8, 187.	Little information on the practice of female circumcision/female genital mutilation (FC/FGM) in the West is currently available. Recent legislative efforts have largely ignored the main public health issue: the needs of girls and women living with circumcision in a new country that condemns the practice and where health care providers are not trained in the management of its complications. We report here on a needs assessment designed to determine the extent of FC/FGM in African immigrant communities in New York City, the health and social service needs of African immigrant women, and the training and information needs of their providers. Obstetrics/ gynecology providers in 8 of New York's 11 public hospitals and 10 maternal infant care/family planning (MIC/FP) clinics were surveyed, along with 20 women from FGM-practicing countries. Quality services for women living with circumcision can be fostered if care is provided in a sensitive and culturally appropriate manner, with thorough training and education of health care providers on the physical and mental health consequences and clinical management of FC/FGM, along with counseling guidelines, interdepartmental linkages, referrals and integrated service delivery, and the provision of translators and information in African languages.
1997	Farooqui, O	Female circumcision - a fair cut for women?.	The British Journal of Family Planning, Vol 23, 1997. pp 96-100.	

1997	Finocchiaro On. Ministro Angela	Mutiliazioni Genitali Feminili - Giornata di studio sulle conseguenze sanitarie - Istituto Superiore di Sanità, Aula Pocchiari - Roma 18 Novembre 1997		
1997	Fox, E., de Ruiter, A.& Bingham J.	Female genital mutilation in a genitourinary medicine clinic: a case note review.	(1997). International Journal of STD & AIDS 8(10): 659–660	
1997	Fox, EF, de Ruiter, A and Bingham, JS.	Female genital mutilation.	International Journal of STD and AIDS, Vol 8, No 10, 1997. pp 599-601.	

1997	Fraser A.	Female genital mutilation and Baker Brown.	J R Soc Med. 1997 Oct;90(10):586-7.	
1997	Hamilton J	UN condemns female circumcision	BMJ, vol. 314, pag. 1148	
1997	Jones WK, Smith J, Kieke B Jr, Wilcox L.	Female genital mutilation. Female circumcision. Who is at risk in the U.S.?	Public Health Rep. 1997 Sep-Oct;112(5):368-77.	Female genital mutilation/female circumcision (FGM/FC) refers to a group of traditional practices that involve partial or total removal of the external female genitalia or other injury to the female genital organs for cultural, religious, or other non-therapeutic reasons. These practices are usually performed by a nonmedical practitioner in the home or other nonclinical setting. Complications occurring immediately after the practice as well as those encountered months and years afterward can result in disability or premature death. In 1996 Congress directed the Department of Health and Human Services to develop estimates of the prevalence of women and girls with or at risk for FGM/FC in the United States. This paper reports those estimates, as derived by the Centers for Disease Control and Prevention, which showed that in 1990 there were an estimated 168,000 girls and women living in the United States with or at risk for FGM/FC

1997	Kandela P	Court ruling means that Egypt embraces female circumcision again	The Lancet, vol. 350 pag. 41	
1997	Kelley T.	Token "circumcision" is too painful.	Sun. 1997 Jan 6;:2A.	PIP: It is a cultural tradition in many African countries for women to undergo female circumcision, or female genital mutilation (FGM). FGM is intended to ensure that women remain virgins until they are married and remain faithful to their husbands. About 3000 recent immigrants from Somalia live in Seattle. An activist in the community says that Somalis believe only circumcised women to be complete and that the immigrants, if possible, plan to send their daughters back to Somalia for FGM if they cannot secure the procedure in the US. A group of physicians at Harborview Medical Center, a public hospital in Seattle, recently proposed what they hoped would be a way of appeasing girls' parents' desire to adhere to the tradition of FGM, while sparing girls the loss of their external genitalia and the adverse sequelae related to FGM. The idea was to perform a symbolic blood-letting upon girls brought in for FGM, thus discouraging some African parents from sending their daughters back to Africa for the actual procedure. While the procedure would draw a drop of blood, there would be neither scarring nor removal of genital tissue. However, when the proposal became public, doctors and hospital and state administrators received letters of complaint condemning what the writers perceived to be the doctors' advocacy of FGM. In the wake of such controversy, Harborview announced that it will perform no form of FGM. Harborview Medical Center is the only medical center in the US to have addressed the issue of FGM.
1997	Key FL	Female circumcision/female genital mutilation in the United States: legislation and its implications for health providers.	J Am Med Womens Assoc. 1997 Fall;52(4):179-80, 187.	Criminal laws prohibiting female circumcision/female genital mutilation (FC/FGM) have recently been passed in the US Congress and in several state legislatures. The full effect of criminalization on prevention and on the overall well-being of immigrant groups from FC/FGM-practicing countries is currently unknown and will ultimately depend on, among other things, the precise interpretation of the laws by courts and local authorities. Meanwhile, the content of these laws prompt questions about their intended and inadvertent effects on FC/FGM, including: What acts are criminalized under these laws? Will criminalization prevent them? Do the laws have the potential to do more harm than good? The appropriateness of prosecuting FC/FGM under existing child protection statutes is also raised.

1997	Kun KE	Female Genital Mutilation: the potential for increased risk of HIV infection	International Journal of Gynecology & Obstetrics, vol. 59, pagg. 153-155	
1997	Kun, KE.	Female genital mutilation: the potential for increased risk of HIV infection.	International Journal of Gynecology and Obstetrics, Vol 59, 1997. pp 153-155.	
1997	Miller Bashir L	Female Genital Mutilation: balancing intolerance of the practice with tolerance of culture	Journal of the Women's Health, vol. 6, n. 1, pagg. 11-14	

1997	No authors listed	New York governor signs ban on female genital mutilation	Reprod Freedom News. 1997 Oct 3;6(16):6.	On September 29, 1997, mixed-record Governor George Pataki (R) signed a bill that bans female genial mutilation (FGM) from being performed on minor females and establishes a campaign to educate the communities that traditionally use FGM about the "health risks and emotional trauma inflicted by such practices." The measure, AB 3379, which is scheduled to take effect 45 days after the signing date, passed the Assembly on July 2 by 145-0 and was approved in the Senate by 55-0. AB 3379 would only allow such a procedure to be used by a licensed medical practitioner if it is "necessary to the health of the person on whom it is performed" or it is performed "for medical purposes" associated with labor or childbirth. Individuals accused of performing FGM would be charged with a class E felony, which is punishable by up to 1 year in prison. full text
1997	No authors listed	Egyptian court overturns ban on genital mutilation	Reprod Freedom News. 1997 Jul 4;6(12):12.	PIP: The ban on female genital mutilation (FGM) performed by health professionals in Egypt was overturned by a June 24 [1997] ruling of Judge Abdul Aziz Hamade of a mid-level administrative court in Cairo. The judge determined that the ministerial decree, which had been implemented last July by Health Minister Ismail Sallam, inappropriately restricted the practice of doctors. According to news reports, the court cited research purporting to show that failure to perform FGM harmed children, as well as quotes from Mohammed, which FGM advocates said endorsed the procedure under Islamic law. Although the court overturned the ministerial decree, it did acknowledge that Parliament could outlaw the practice; however, human rights groups believe the practice is too popular for Parliament to do so. The suit against the ban had been filed by Sheik Youssef al-Badry, a conservative Islamic cleric, and Munir Fawzi, a Cairo gynecologist. In May, Egypt's highest court had recommended to the mid-level court that FGM should be legal. The decision does not effect a ban on the performance of surgery by those without a medical license, including barbers and midwives. It is estimated that 80% of girls in Egypt undergo FGM. Egypt's highest Sunni Moslem authority contests the endorsement of FGM under Islamic law
1997	No authors listed	Ritualistic Female Genital Mutilation: Current Status and Future Outlook	Obstetrical and Gynecologicl Survey vol.52, n.10, pagg. 643-651	

1997	No authors listed	Female genital mutilation: A joint WHO/UNICEF/UNFPA Statement	WHO	
1997	No authors listed	Azienda Ospedaliera S. Camillo - Forlanini: organizzazione di una struttura di riferimento per le donne portatrici di M.G.F.		
1997	No authors listed	Female Genital Mutilation	World Health Forum, vol. 18, pag. 374	

1997	No authors listed	Female genital mutilation as grounds for refugee determination.	INSCAN, Vol 11, No 1, 1997. p 5, 15	
1997	Odoi, A, Brody, SP and Elkins, TE.	Female genital mutilation in rural Ghana, West Africa.	International Journal of Gynecology and Obstetrics, Vol 56, 1997. pp 179-180.	
1997	Omer-Hashi K, Entwistle MR.	Female genital mutilation	Can J Public Health. 1997 Mar-Apr;88(2):137.	

1997	RACOG - The Royal Australian College of Obstetricians and Gynaecologists	Female Genital Mutilation - A pamphlet for health professionals	© The Royal Australian College of Obstetricians and Gynaecologists 1997	
1997	RACOG - The Royal Australian College of Obstetricians and Gynaecologists	Female genital mutilation - Information for Australian health professionals	© The Royal Australian College of Obstetricians and Gynaecologists 1997	
1997	Schenker JG	Ethical issues relating to reproduction control and women's health	International Journal of Gynecology & Obstetrics, vol. 58, pagg. 167-176	

1997	Walley, C.	Searching for voices: Feminism, anthropology, and the global debate over female genital operations.	(1997). Cultural Anthropology 12(3): 405-438.	
1997	WHO World Health Organization.	Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation Report of a WHO Technical Consultation Geneva, 15-17 October 1997	WHO/FCH/GWH/01.2 WHO/RHR/01.13 Distribution: General	
1997	WHO World Health Organization.	Regional plan of action to accelerate the elimination of female genital mutilation in Africa.	Brazzaville, Congo: WHO Regional Office for Africa, 1997. 47p.	

1997	WHO World Health Organization.	UN agencies call for end to female genital mutilation.	Geneva: WHO, 1997. 2p. (Press Release WHO/29)	
1997	Williams, L and Sobieszczyk, T.	Attitudes surrounding the continuation of female circumcision in the Sudan: passing the tradition to the next generation.	Journal of Marriage and the Family, Vol 59, No 4, 1997. pp 966-981.	
1997	Wittich AC, Salminen ER.	Genital mutilation of young girls traditionally practiced in militarily significant regions of the world.	Mil Med. 1997 Oct;162(10):677-9.	Very few physicians practicing in the United States have experience in treating female patients who have undergone mutilation of the external genitalia, incorrectly termed female circumcision. This procedure, known as infibulation, consists of removing the clitoris, prepuce, and portions of the labia of young girls, usually younger than 7 years of age. Infibulation has been practiced by lay midwives for centuries in the Horn of Africa and in other African and Middle Eastern countries. This paper discusses infibulation, the techniques, and the recommended medical and obstetric management of patients subjected to genital mutilation. With increased immigration to the United States by Africans and Middle Easterners, and with readily increasing military medical deployments, primary care physicians and specialists can expect to be confronted with patients who have undergone this disfiguring procedure during their youth.

1997	World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA).	Female genital mutilation: a joint WHO/UNICEF/UNFPA statement.	Geneva: WHO, 1997. 20p.	
1996	Adamson, F.	Female genital mutilation: a counselling guide for professionals.	London: Foundation for Women's Health (FORWARD), 1996. 10p.	
1996	Ahmed S.	Leaving the female body intact.	Nurs N Z. 1996 May;2(4):20-1.	More than 80 million women in Africa and around the world have been damaged by the practice of female genital mutilation. As Somali refugees are accepted into New Zealand and others immigrate from African countries where the practice is still prevalent, health professionals need to be aware of what legal, ethical and cultural considerations are involved

1996	Al-Sabbagh, ML.	Islamic ruling on male and female circumcision.	Alexandria: WHO, Regional Office for the Eastern Mediterranean(EMRO), 1996. 42p. (The right path to health: health education through religion; no. 8)	
1996	Andersson K, Staugard F.	Prevention of female genital mutilation in Sweden	Nord Med. 1996 Dec;111(10):358-60	ARTICLE IN SWEDISH A three-year pilot study of female genital mutilation has been carried out at Gothenburg. There is increasing awareness of this issue, and discussions have started between immigrants and health-care professionals. By means of further information and education it is hoped to improve care of the victims, and in the long-term to eliminate a pernicious tradition. It is estimated tha there are approximately 115 million victims of female genital mutilation in Africa alone. As a result of emigration, about 5000 young women from areas where it is practised are now to be found in Europe, and 16,000 in Sweden.
1996	Black JA, Debelle GD.	Female Genital Mutilation	BMJ. 1996 Feb 10;312(7027):377-8.	

1996	Dabbagh L	Socio-Cultural Research and Female Genital Mutilation	from a paper presented at a UNFPA workshop on "Socio-cultural factors affecting demographic Behavior and Implications for the Formulation and Execution of Population Policies and Programs", Amman, 16-18 April 1996	
1996	Denmark, Ministry of Foreign Affairs.	Guidelines on the prevention of female genital mutilation, 2nd revised edition.	Copenhagen: Ministry of Foreign Affairs, 1996. 45p.	
1996	Dorkenoo E.	Combating female genital mutilation: an agenda for the next decade	World Health Stat Q. 1996;49(2):142-7.	Female genital mutilation (FGM)-sometimes locally referred to as "female circumcision"-is a deeply rooted traditional practice that adversely affects the health of girls and women. At present it is estimated that over 120 million girls and women have undergone some form of genital mutilation and that 2 million girls per year are at risk. Most of the girls and women affected live in 28 African countries where the prevalence of female genital mutilation is estimated to range from 5% to 98%. The elimination of female genital mutilation will not only improve women's and children's health; it will also promote gender equity and women's empowerment in the communities where the practice persists. To achieve change will require more planning, and more sustained programmes for its elimination. The political will of governments is essential in order to eliminate this harmful traditional practice and concerted efforts from all concerned are required. PIP: It is estimated that more than 120 million females have undergone female genital mutilation (FGM) and that 2 million more girls are at risk of mutilation each year. In response to this enormous health problem, the World Health Organization

				(WHO) convened a Technical Working Group Meeting on the subject in July 1995. The working group defined FGM as "the removal of part or all of the external female genitalia and/or injury to the female genital organs for cultural or other nontherapeutic reasons." The working group also provided four classifications for different types of FGM. FGM is usually performed by traditional practitioners (the WHO is opposed to the medicalization of this procedure) on girls and young women of any age (but the average age is decreasing). The origins of FGM are unknown, and a variety of reasons are forwarded in its defense. The health complications are known, however, and include the immediate complications of hemorrhage, severe pain, fractured bones, possible HIV transmission, and shock; longterm complications such as keloid scar formation, painful intercourse, chronic infection, and problems in pregnancy and childbirth; and psychological problems associated with sexual dysfunction caused by painful intercourse, the loss of trust in care-givers, and depression. Human rights instruments exist that oblige states to eliminate such harmful procedures, but gaps exist in information about types and prevalence of FGM. Because FGM involves human rights and health issues, a multidisciplinary approach will be necessary for its eradication. An action agenda calls for adoption of clear national policies, establishment of interagency coalitions, research, community outreach, and training of health workers.
1996	Eliah, E.	Reaching for a healthier future: Uganda's Sabiny people.	Populi, Vol 23, No 1, 1996. pp 12-16	
1996	El-Zanaty, F., Hussein, E.M., Shawky, G.A., Way, A.A. & Kishor, S.	Egypt Demographic and Health Survey 1995.	(1996). Calverton,MD: MacroInternational, Inc.	

1996	Gadallah, A., Zarzour, A.H. El-Gibaly, O.M. Abd El-Aty, M.A. & Monazea, I.M.	Knowledge, Attitude, and Practice of Women Teachers on Female Circumcision in Assiut Governorate, Final Report	(1996). Paper presented at Rainbo Workshop on Female Genital Mutilation, November, Cairo.	
1996	Khaled, K and Vause, S.	Genital mutilation: a continued abuse.	British Journal of Obstetrics and Gynaecology, Vol 103, No 1, 1996. pp 86-87.	
1996	Khattab, H.	Women's perceptions of sexuality in rural Giza.	Giza: Population Council Regional Office for West Asia and North Africa, 1996. 54p. (Monographs in Reproductive Health No 1)	

1996	Knott, L.	Female circumcision in Britain.	Maternal and Child Health, May 1996. pp 127-129.	
1996	Lane, SD and Rubinstein, RA.	Judging the other. Responding to traditional female genital surgeries.	Hastings Center Report, Vol 26, No 3, 1996. pp 31-40	
1996	Leonard, L.	Female circumcision in southern Chad: Origins, meaning, and current practice.	Social Science and Medicine, Vol 43, No 2, 1996. pp 255-263.	

1996	Mabry, M and Hecht, D.	Fighting for their rites: a local reaction to attacks on female circumcision.	Newsweek, 14 October 1996. p 57	
1996	Macready N.	Female genital mutilation outlawed in United States.	BMJ. 1996 Nov 2;313(7065):1103.	PIP: Effective March 29, 1997, under new Congressional legislation, female genital mutilation (FGM) will be outlawed in the United States. Federal authorities will be required to inform new immigrants from countries where FGM is prevalent that parents who arrange FGM for their daughters and those who perform it will face prison sentences of up to five years. US representatives to the World Bank and other international financial institutions will be required to oppose aid to countries that have not established educational programs to end the practice. FGM is most common in Africa; it is estimated that 99% of women in Somalia and Djibouti, 90% of women in Ethiopia, and 85% of women in Sudan have undergone it. More than 127 million African women have been mutilated, and each year 2 million girls, usually between 4 and 12 years old, undergo the ordeal. In the US, 168,000 girls either are at risk of being mutilated or have been already. Almost half of them live in urban areas with large immigrant populations, including New York; Washington, D.C.; Los Angeles; Houston; Chicago; Philadelphia; Atlanta; Oakland, California; Newark, New Jersey; Dallas; and Boston. Fourteen states have, or are considering, bills against the practice.
1996	Morris R.	The culture of female circumcision.	ANS Adv Nurs Sci. 1996 Dec;19(2):43-53.	The issue of female circumcision takes on special significance as more women migrate to the United States from countries where the practice has religious and traditional underpinnings. Female circumcision is a problem unfamiliar to most Western health care practitioners. This article describes an ethnographic study of the types of female circumcision, the reasons for and against the practice, the health implications of this practice, and cultural attitudes of circumcised women both in Western Africa and as migrant refugees living in the United States. Ethical dilemmas in dealing with this practice and implications for nurses and health care providers are discussed. PIP: In San Diego, California, health-care providers to a rapidly growing community of 3000-4000 Somali refugees have been confronted with female genital mutilation (FGM) for the first time. In order to help Western practitioners devise ways to deal with this phenomenon, this article describes the history of FGM, the various types of mutilation, attitudes towards the procedure,

				early attempts to abolish it, reasons why the practice is continued, and reasons why it should be ended. The article then describes the results of an ethnographic study of the procedure using data gathered in Liberia and Kenya and the results of a needs assessment among Somali refugees in San Diego. In Kenya, the Kpelle tribe conducts the Sande Bush School every few years. This school removes all the young girls from the villages for 6-12 weeks' training, which includes the secret ritual of FGM. Not all of the girls survive this ordeal. In order to reduce the incidence of mortality, a local hospital sent physicians and nurses into the bush to perform the least destructive type of mutilation in a mobile van. In Kenya, respondents favored the least destructive type of circumcision and adamantly supported the practice. The Somali refugees in the US are undergoing stress adjusting to economic difficulties that make it necessary for women to work outside of the home and make large families prohibitively expensive. All of the interviewed women had the most severe type of infibulation performed, with many of the mutilations taking place in hospitals when they were 5-10 years old. Most of the women believed the practice was mandated by Islam and were distressed by the refusal of US medical personnel to perform FGM. While health care providers need to understand the cultural forces that support FGM, there is no doubt that it would be unethical as well as illegal to perform the procedure. Cultural diversity must be accepted while cultural change is promoted.
1996	Mostafa, H.	The unkindest cut of all.	Egypt Today, Vol 17, No 12, 1996. pp 102-107.	

1996	Nelson T	Violence against women.	World Watch. 1996 Jul-Aug;9(4):33-8.	PIP: This essay opens its discussion of violence against women by referring to the 1994 television broadcast of a 10-year-old Egyptian girl undergoing female genital mutilation (FGM) without benefit of infection control measures or anesthesia at the hands of a local barber. After presenting a brief description of FGM, its various justifications, and its impacts on its victims, the official Egyptian policy is described as ambiguous, and the broadcast is shown to have caused influential religious leaders and medical personnel to defend FGM and, thus, led to postponement of a bill to outlaw FGM. The next section of the essay shows that Egypt's response to FGM reflects the international debate on all forms of violence against women emerging from and reinforcing the social relationships that give men power over women. These forms of violence include domestic violence in almost all societies; the dowry-related, bride-burning homicides that claim 5000-12,000 lives each year in India; son preference that leads to abortion of female fetuses and female infanticide; and crimes such as rape, sexual abuse, and forced prostitution. The essay continues with a look at the costs of violence hidden in the damage to women that increases health care costs substantially and reduces economic productivity. Violence towards women, which occurs throughout the world and can prevent women from participating in public life or from controlling their fertility, is a male tool to inhibit women from gaining autonomy outside the home. The essay concludes that victims of violence are beginning to break the silence that surrounded these deeds and are seeking legislative protection. Laws may not result in real-life changes, but the movement to eliminate FGM may prove to be the first success in women's efforts to achieve human rights. An example is the important precedent being set in the US by a woman seeking asylum to avoid facing an arranged marriage and FGM in her native Togo.
1996	No authors listed	Egyptian government broadens ban on female genital mutilation	Sex Wkly Plus. 1996;(Sample No):19.	PIP: An estimated 70-90% of girls in Egypt are subjected to female genital mutilation (FGM) before reaching puberty. Many Egyptians believe the practice to be ordained by Islam. Whether this is true, however, remains an issue of debate among Muslim scholars. Some Egyptian Christians also secure FGM for their girls. Egyptian law prohibits anyone without medical training from performing FGM, and any physician or health worker who causes permanent damage to a girl may face 3-10 years of hard labor. However, the law is frequently ignored, especially in rural areas, where village barbers and midwives perform the operations. In October 1995, Egyptian state hospitals were banned from performing FGM. Egypt has since broadened its ban to bar all health care workers in both state-run hospitals and private clinics from performing the procedure. No health care worker affiliated with the Ministry of Health is therefore allowed to perform FGM. Almost all Egyptian doctors are affiliated with the Ministry. While this recent move by the Health Minister is laudable, it remains to be seen whether he can enforce it. The

				secretary-general of the Egyptian Organization for Human Rights has urged parliament to enact legislation criminalizing FGM.
1996	No authors listed	Female genital mutilation: reverence and revulsion around the world.	Sex Wkly Plus. 1996;(Sample No):20.	PIP: As many as 120 million females worldwide have undergone genital mutilation, most often when they were 4-10 years old. Female genital mutilation (FGM) is considered a right of passage in parts of Africa, the Middle East, and Southeast Asia and is performed to make women marriageable. FGM can range from a nick across the clitoris to infibulation, which involves complete removal of the clitoris, the inner labia, and most of the labia majora as well as fastening together the vulva except for a small opening. In Somalia, where FGM is almost universal, 89% of the women undergo infibulation. The harmful effects of FGM include a doubled risk of maternal death and increased risk of stillbirth. Efforts have been mounted to eradicate the practice in the self-declared independent Republic of Somaliland. It has been recommended that the public be taught that FGM is contrary to Islamic law and, thus, is sinful.
1996	No authors listed	U.S. grants political asylum to woman who fled female genital mutilation	Reprod Freedom News. 1996 Jun 28;5(11):8.	PIP: Fauziya Kasinga fled to the US from Togo in 1994 at the age of 17 years after an aunt forced her to marry a 45-year-old man with three wives. From the time of her arrival to the US in December 1994 to April 24, 1996, Kasinga was detained at two correctional facilities awaiting a decision by the US Board of Immigration Appeals (BIA) on her request for political asylum. That asylum was granted in a 11-1 decision issued on June 13 on the grounds of Kasinga's fear of being forced to undergo female genital mutilation (FGM) if sent back to Togo. This is the first time that the BIA has ruled that FGM can be grounds for asylum. 50% of women in Togo are estimated to have undergone FGM. The BIA decided that the young woman met the criteria for receiving refuge because she is a member of a particular social group, the unmutilated women of the Tchamba-Kunsuntu tribe who face but oppose FGM, which has a well-founded fear of persecution which is country wide. Moreover, Kasinga's husband has influence with the police in Togo, a rather small country. This decision not only sets precedent with regard to FGM, but also is the first gender-based asylum claim to be considered since the Immigration and Naturalization Service revised its guidelines in May 1995 to cover such persecution.

1996	No authors listed	Egyptian FGM policy fails to prevent girl's death	Reprod Freedom News. 1996 Sep 6;5(14):8.	PIP: The form of female genital mutilation (FGM) predominantly practiced throughout Egypt consists of the surgical removal of the clitoris and often the inner labia. The practice reduces the level of a woman's sexual sensation and causes pain, psychological trauma, and the risk of infection and hemorrhage. An estimated 80% of Egyptian girls undergo the procedure. Egypt's Ministry of Health in 1994 decided to permit only doctors in government hospitals to perform FGM. This policy was adopted in an effort to make safer what was considered to be an inevitable practice. However, the policy was revoked in October 1995 after women's rights and health advocates criticized it as a government endorsement of FGM. An 11-year-old Nile Delta girl died July 12, 1996, as a result of FGM. The Health Ministry subsequently banned all registered health professionals from performing FGM. Two months later, on August 24, a 14-year-old girl died from hemorrhaging shortly after undergoing FGM. These recent deaths challenge the effectiveness of Egypt's new attempts to prevent FGM. Barbers and midwives in Egypt perform thousands of mutilations annually. While they are theoretically subject to criminal penalties for performing surgery without a license, the laws are rarely enforced. Furthermore, despite existing regulations, no provision in the Egyptian penal code criminalizes FGM.
1996	No authors listed	Fighting FGM in Dodoma, Tanzania	Newsl Womens Glob Netw Reprod Rights. 1996 Jul-Dec;(55-56):31-2.	PIP: This paper reports the aims of the Training and Information Program of Inter-Africa Committee (IAC) to eradicate the practice of female genital mutilation (FGM) in Dodoma, Tanzania. Dodoma is one of the 25 regions chosen for this pilot project because of the high prevalence of FGM, its proximity to Dar-es-Salam, and relative access to local transportation. The campaign was based on the active participation of concerned communities. Two coordinators were identified in 1993 who started to make a series of visits to the surrounding villages to discuss the situation of FGM with the local authorities and explain the objectives of IAC. Each village was requested to nominate one candidate as a Village Facilitator. 32 participants attended the first workshop that was organized by the IAC. Furthermore, the media collaborated with weekly radio programs and information that was provided to the Tanzania Midwifery School and to the primary school teachers. In 1995, the IAC in Dodoma had gained recognition among wider circles and had collaborated with the Ministry of Health in the training of traditional birth attendants and in creating awareness about FGM. The initiative sparked a very strong interest among other villagers in the area. The IAC-Dodoma team had plans to extending its services to other regions in 1997.

1996	No authors listed	Ferite a vita. Dossier	Negrizia novembre 1996 pagg. 31-48	
1996	No authors listed	A nurse wins her battle to ban FGM	Am J Nurs. 1996 Dec;96(12):69, 71.	
1996	No authors listed	Soraya Mire: battling FGM through forgiveness and education.	Together, January-March 1996. pp 12-15	

1996	Rich, S and Joyce, S.	Eradicating female genital mutilation: lessons for donors.	Washington: Wallace Global Fund, 1996. 12p.	
1996	Robertson, C.	Grassroots in Kenya: women, genital mutilation, and collective action, 1920-1990.	Signs: Journal of Women in Culture and Society, Vol 21, No 3, 1996. pp 615-642.	
1996	Robertson, C.	Grassroots in Kenya: Women, genital mutilation, and collective action, 1920-1990.	(1996). Signs 21(3): spring.	

1996	Sayed GH, Abd el-Aty MA, Fadel KA.	The practice of female genital mutilation in upper Egypt.	Int J Gynaecol Obstet. 1996 Dec;55(3):285-91.	OBJECTIVE: To study the prevalence of and reasons for female genital mutilation in an Egyptian village population. METHODS: A survey of all 819 households in an Upper Egyptian village near Assiut was conducted in 1992. The mothers of 1,732 girls under 20 years of age were interviewed to obtain information about their daughters. When possible, fathers and grandparents were also interviewed. RESULTS: Respectively, 62%, 36.6% and 1.1% were girls who had undergone female genital mutilation (FGM), were to undergo the procedure and were not to have the operation. A total of 67% of the fathers of girls who had undergone FGM and 92% of their mothers were illiterate. FGM was performed most often when girls were 5-9 years old. Almost all procedures (97.5%) were performed by dayas; 1.3% were performed by barbers. A razor was used in 80.7% of the cases, and a knife in 18.5%; in less than 1% (0.7%) of the procedures were medical instruments used. The most prevalent reason for FGM was that it followed customs and traditions (77%). Serious bleeding (5.7%) and pain (3%) were the most commonly reported complications of the procedure. CONCLUSIONS: The study raises a number of questions about the experience of FGM by young girls, the reasons for maintaining this practice and the kinds of interventions which might be effective in eliminating it.
1996	Sayed, G.H., Abd El-Aty, M.A. & Fadel, K.A.	The practice of female genital mutilation in Upper Egypt.	(1996). International Journal of Gynecology and Obstetrics 55: 285-291.	
1996	Sayed, GH, Abd El-Aty, MA and Fadel, KA.	The practice of female genital mutilation in Upper Egypt.	International Journal of Gynecology and Obstetrics, Vol 55, 1996. pp 285-291.	

1996	Seif El Dawla, A.	Women's rights in Egypt.	Women Against Fundamentalism Journal, No 8, 1996. pp 25-28.	
1996	The Population Council (Asia and Near East Operations Research and Technical Assistance Project).	Clinic-based investigation of the typology and self-reporting of FGM in Egypt: Final Report.	Cairo, The Population Council 1996.	
1996	WHO World Health Organization.	Female Genital Mutilation: Information kit.	(1996). Geneva: World Health Organization.	

1996	WHO World Health Organization.	Regional plan of action to accelerate the elimination of female genital mutilation.	Brazzaville, World Health Organization Regional Office for Africa, 1996 (AFR/WAH/97.1).	
1996	WHO World Health Organization.	Islamic ruling on male and female circumcision.	Alexandria, World Health Organization Regional Office for the Eastern Mediterranean, 1996	
1996	Wright J.	Female genital mutilation: an overview.	J Adv Nurs. 1996 Aug;24(2):251-9.	The literature on female genital mutilation (also known as female circumcision) within a feminist theoretical context is discussed. Issues of culture, politics and religion in the literature will be examined in relation to feminist thought and the paper will also assess the effects of female genital mutilation on women's health and status within developing societies. Parallels with other similar practices in developed and developing countries will be drawn and policy strategies discussed.

1995	Asali, A et al.	Ritual female genital surgery among Bedouin in Israel.	Archives of Sexual Behavior, Vol 24, No 5, 1995. pp 571-575.	
1995	Babalola, S and Adebajo, C.	Evaluation report of female circumcision eradication project in Nigeria.	Unpublished paper, 1995. 28p	
1995	Bayoudh, F et al.	Etude d'une coutume en Somalie: la circoncision des filles . [Study of a custom in Somalia: female circumcision].	Medecine Tropicale, Vol 55, No 3, 1995. pp 238-242.	

1995	Bedri NM.	Grandmothers' influence on mother and child health.	Ahfad J. 1995 Jun;12(1):74-86.	PIP: This study is based on interviews with grandmothers during July-September 1992-93 in Sudan. The study shows that grandmothers play a significant role in health education and child care within families in the Sudan. Grandmothers, who are not aware of the changes in knowledge, also promote harmful traditions. The authors recommend that health education be directed to elderly women and grandmothers in order to change beliefs and practices that continue to be harmful to children and mothers. Grandmothers were found to give sound advice on child birth, such as movement during labor, breast feeding immediately after birth, and birth intervals of 2-4 years. Grandmothers also gave sound advice on good nutritional practices during pregnancy and use of fermented cereals as weaning foods. Grandmothers recommended use of fenugreek for lactating mothers and use of mint and haharaib for stomach upsets, remedies that are beneficial. Babul is useful after an episiotomy for its antibacterial effects. Harmful advice includes recircumcision after delivery, short birth intervals, and avoidance of contraception. Female genital mutilation (FGM) is a major practice that exposes girls and mothers to a greater risk of mortality during childbirth and pregnancy. The sample of grandmothers agreed on the importance of sex education for a girl before marriage. Unfortunately, 57% of grandmothers recommended 14 years as a suitable age for marriage. Grandmothers generally believed wrongly that riding bicycles, drinking coffee, and wearing trousers by girls would increase their sexual desires. Grandmothers explained menstruation to granddaughters and offered home-made remedies for cramps. 45% believed that there were no disadvantages to FGM and recommended FGM at ages 2-5 years. Most viewed fevers as a danger that required a doctor's care. Advice varied among grandmothers according to socioeconomic class.
1995	Black J A, Debelle G D	Female Genital Mutilation in Britain	BMJ, vol. 310, pagg. 1590-1594	

1995	Council on Scientific Affairs, American Medical Association	Female Genital Mutilation	JAMA, vol. 274, pagg. 1714-1716	
1995	Dorkenoo E.	Cutting the rose: Female genital mutilation, the practice and its prevention.	London, Minority Rights Publications 1995	
1995	Effiom C, Bille S.	FGM in Cameroon.	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1995 Apr;(17):16.	PIP: In 1994, group discussions and individual interviews with 468 women and young girls were held in Cameroon's Extreme North Province, South West Province, and capital area to obtain data on female genital mutilation practices. Precise incidence data on this practice could not be obtained due to the refusal of hospitals and health centers to complete questionnaires. However, interviews suggested the incidence of this practice is about 40% in the South West Province and substantially higher in the Extreme North. All Moslem women, but only 63% of Christians, had undergone this procedure. Only 1.3% of procedures were performed in hospitals; the remainder were performed by traditional practitioners. Although circumcised women reported hemorrhage and infection as complications of the procedure, they minimized its health consequences. Most respondents reported they followed the practice out of respect for tradition. Young women were more receptive to abandonment of female genital mutilation than their older counterparts; however, most women expressed concerns about the potential loss o circumcision-associated rituals such as the decoration of their houses and the Monekim dance. Opinion makers were equally divided in their attitudes and generally unaware that several international agencies have condemned female circumcision.

1995	Erian, M.M.S. & Goh, J.T.W.	Female circumcision. Australian and New Zealand	(1995). Journal of Obstetrics and Gynaecology 35(1): 83-5.	
1995	Ericksen, K.P.	Female circumcision among Egyptian women.	(1995). Women's Health: Research on Gender, Behavior, and Policy 1(4): 309–328.	
1995	Gallard, C.	Female genital mutilation in France.	British Medical Journal, Vol 310, 1995. pp1592-1593	

1995	Gamble A.	Stopping female genital mutilation. An update.	Freedom Rev. 1995 Sep-Oct;26(5):22-3.	PIP: There is widespread consensus among many individuals, countries, and organizations that female genital mutilation (FGM) is a human rights abuse. France, Britain, Sweden, and Switzerland have passed legislation forbidding medical personnel from performing FGM, eighteen African countries have made official statements against FGM, and FGM was an issue in the 1993 World Health Assembly, the 1993 World Human Rights Conference, and the 1994 International Conference on Population and Development. True change, however, depends upon a transformation in the informal economic, social, and political structures which perpetuate women's dependency upon marriage and men. The Research Action Information Network for the Bodily Integrity of Women (RAINBOW) and the Development Law and Policy Unit of the Columbia University School of Public Health introduced the Global Action Against FGM (GAAFGM) Project in June 1994. The project is designed to integrate action against FGM into existing health and human rights programs and to pool available resources against FGM. GAAFGM has also coordinated an interagency working group comprised of international agencies, in-country grassroots organizations, and women's groups, which met for the first time in November 1994. The project should provide considerable information and leadership on the issue. On another front, participants in the most recent preparatory meeting for the upcoming Beijing Conference noted the existence of a strong recognition that FGM is a problem upon which the international community should act. The author notes recent litigation brought by the Egyptian Organization for Human Rights against the grand sheik of Al-Azhar University for issuing a fatwa declaring female circumcision an Islamic duty. In addition, a Ghanaian may be granted refugee status in Canada on the basis of her efforts to avoid mutilation if deported to her country of origin.
1995	Goodman E.	There ought to be a law against this type of abuse.	Sun. 1995 Oct 20;:19A.	PIP: Female genital mutilation occurs in parts of the world where ritual overwhelms reason and where women's sexuality is regarded as dangerous. Some 100-130 million women worldwide have been mutilated, with high prevalence in countries like Somalia, Ethiopia, and Egypt. Now female genital mutilation has been imported with international migrants to the US. While legislators first refused to believe that such abuse could be happening in the US, the evidence began mounting through accounts from school teachers, physicians, and immigrants themselves. The practice has been outlawed in much of Europe where women have been prosecuted for child abuse, but as of 1995, only three US states had made it a felony. US response has been muted by ignorance, by a perverse respect for cultural differences, and by a bizarre belief that female genital mutilation is comparable to male circumcision. Congress is considering two bills that would make it illegal to perform female genital mutilation on a child in the US and could provide funding to determine the prevalence of the problem.

				Representative Patricia Schroder, a co-sponsor of the legislation, also hopes to amend immigrant legislation to require that all new immigrants be informed that they can not import this practice to the US. The US must take a stand against female genital mutilation on its own shores and throughout the world.
1995	Haile Selassie A.	International Conference on Population and Development, Cairo 5-13 September 1994 -- IAC presence	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1995 Apr;(17):19.	PIP: During the International Conference on Population and Development (ICPD) in Cairo in September 1994, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) exhibited posters, leaflets, brochures, T-shirts, and handkerchiefs, and distributed 2000 leaflets on IAC programs. On September 7, IAC staff showed videos on female genital mutilation (FGM) in Ethiopia and Uganda in the NGO Forum; this was followed by discussions with the 100 attending participants. On the same day, the IAC president made a statement in the Plenary Hall of the ICPD concerning the discrimination and gender bias faced by African women due to certain traditions and value systems. She proposed adopting legislation to raise the age of marriage; intensification of public education and information; mobilization of the media; and organization of educational programs for health workers, traditional birth attendants (TBAs), and policymakers. A special session on harmful traditional practices in Egypt was presented on September 12. The IAC executive secretary strongly opposed the medicalization of FGM.
1995	Hanley, M.G. & Ojeda, V.J.	Epidermal inclusion cysts of the clitoris as a complication of female circumcision and pharaonic infibulation.	(1995). Central African Journal of Medicine 41(1): 22-24.	

1995	Hashi KO	Female Genital Mutilation: cultural and health issues and their implications for sexuality counselling in Canada	The Canadian Journal of Human Sexuality, vol.4, n.2 pagg. 137-47	
1995	Hassan A.	Sudanese women's struggle to eliminate harmful practices.	Plan Parent Chall. 1995;(2):17-8, 21-2.	PIP: Female genital mutilation (FGM) is widely accepted in the Sudan regardless of educational level. Findings from the 1989-90 Sudan Demographic and Health Survey indicate that a large majority of both men and women approved of the procedure. 73% of men preferred the less harmful "Sunna" type, and 18% preferred infibulation. 4% preferred an intermediate type. Another study found that all the polygynous men with both types of wives preferred non-excised or "Sunna" circumcised women as more sexually responsive and participatory. FGM is part of a continuation of a patriarchal repression of female sexuality. The belief is held among African societies that excision of the clitoris protects a woman from her sexuality by keeping her from temptation, suspicion, and disgrace. FGM occurs mainly in societies that have an absolute and clear requisite of female chastity for marriage. The Islamic view is ambivalent and variable by geographic region. Some physicians defend FGM on "scientific" grounds. The general principle of Islamic education as stated by Shiekh Mahmoud Shaltout of Cairo is that neither "Sunna" nor excision of the clitoris is mandatory. FGM is celebrated as a rite of passage. The practice is disappearing due to education and eradication campaigns. Although unexcised women are considered unclean, the FGM procedure actually interferes with menstruation and escape of urine and results in discomfort and infection. An obstacle to stopping FGM is the fee paid to traditional birth attendants, nurses, and midwives, whose self-interest is to defend the practice. Groups working to eradicate the practice include the Inter-African Committee (since 1984) and the Sudan National Committee on Harmful Traditional Practices (since 1985). Campaigns involve education and promotion of alternative employment for birth attendants and midwives. An impact assessment in Sudan in 1994 found that FGM is now publicly discussed, the influence of elders is declining, and the practice is viewed among the most educated as anti-modern. There is a trend toward use of the less harmful "Sunna" method or else a new "false circumcision," where only plaster is placed around the clitoris.

1995	Hosken F.	Female genital mutilation; Estimate: total number of girls and women mutilated in Africa.	Lexington MA, Women's International Network News 1995	
1995	Kiragu K	Female genital mutilation: a reproductive health concern.	Popul Rep J. 1995 Oct;(41 Suppl):1-4.	PIP: The practice of female genital mutilation (FGM) is thought to be 2000 years old and continues today in many areas of Africa, the Mid-East, and Asia. An estimated 100-132 million women have undergone the procedure, and 2 million more are subjected to it each year during infancy, childhood, or adolescence. The World Health Organization has defined four categories of FGM. Type 1 entails removal of the prepuce and, sometimes, all or part of the clitoris. In type 2, the clitoris is removed along with all or part of the labia minora. Type 3 (infibulation) involves removal of the clitoris, some or all of the labia minora, and the sealing of the labia majora with only a small opening remaining for the flow of urine and blood. Type 4 is a general category that includes other operations on the external genitalia as well as procedures done to the vagina. The FGM procedure itself can lead to shock, death, and infection. Long-term physical effects of infibulation include difficulty in urinating, in having sexual intercourse, and in delivering a baby. The psychological and psychosexual consequences of FGM remain to be identified. FGM is still practiced because it affords status to women in certain cultures. Efforts to eradicate the practice have been made by international agencies, governments,and grassroots community advocates. Public education as well as legislative action are important tactics as are working to educate health care providers and providing alternatives to FGM as well as alternative employment opportunities to FGM practitioners. In Western countries, anti-FGM efforts are centered on women in immigrant and refugee communities. Research efforts are underway in order to provide an understanding of FGM that will allow the design of effective eradication strategies. Community input will be vital in designing and conducting such campaigns.

1995	Koso-Thomas O.	Sierra Leone. Secret societies leaders are engaged in the fight against FGM.	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1995 Apr; (17):13.	PIP: Both the Sierra Leone Association on the Welfare of Women and the Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children have targeted the Sowies--leaders of the Secret Societies of Women--for education on the dangers of female genital mutilation. The Sowies, believed to have power to invoke ancestral spirits and knowledgeable in the art of using medicinal herbs, are also traditional birth attendants who perform female circumcision. Initially, Sowies were resistant to participate in any program organized by a group whose members were not initiated into the Secret Societies. However, contact with the head of Western Sierra Leone Sowies facilitated presentation of an educational program on the health hazards of female genital mutilation. This head subsequently attended the 1990 IAC Regional Conference where she heard testimonies from former circumcisers who had found new occupations. On her return, she designed a project to provide skills acquisition to 20 Sowies who would agree to "lay down the knife" and educate 6000 Secret Societies initiates on the dangers of female circumcision. Interest was so great that 38 Sowies were enrolled in a two-week training in soap making, bread making, cloth dying, organization and management of petty trading business, marketing and sales, simple business management, accounting, and savings.
1995	Kowser H	Female Genital Mutilation: overview and obstretrical care	The Canadian Journal of Ob/Gyn & Women's Health Care vol. 5, n.6 pagg. 538-43	
1995	Lalonde A	Clinical management of Female Genital Mutilation must be handled with understanding, compassion	CMAJ. 1995 Mar 15;152(6):949-50.	Canadian obstetricians, gynecologists and family practitioners are not allowed to perform female genital mutilation (FGM), but because of immigration patterns it is still a reality for them. Dr. Andre Lalonde, an Ottawa obstetrician-gynecologist who serves as executive vice-president of the Society of Obstetricians and Gynaecologists of Canada, offers some practical suggestions from his own experience for physicians unaccustomed to seeing patients who have experienced FGM.

1995	Larsen, U.	Differentials in infertility in Cameroon and Nigeria.	(1995). Population Studies 49(2):329–346.	
1995	Maggi A.			
1995	McCafferey M, Jankowsska A, Gordon H.	Management of female genital mutilation: the Northwick Park Hospital experience.	Br J Obstet Gynaecol. 1995 Oct;102(10):787-90.	OBJECTIVE: To outline the problems associated with female genital mutilation and to highlight the need for deinfibulation before delivery. DESIGN: A review of women attending a newly established African Well Woman Clinic. Age at infibulation, gravidity of clinic attenders and adequacy of introitus for management of labour were assessed. SETTING: Northwick Park Hospital, Harrow, Middlesex. SUBJECTS: Fifty women attending a newly established African Well Woman Clinic, of whom 13 were nulliparous, 14 were primigravid and 23 were multigravid. RESULTS: The average age at which infibulation had occurred was 6.7 years. At the time of clinic attendance the mean age of pregnant and nonpregnant patients was 26 and 23.3 years, respectively. Of the 14 primigravid patients, only 50% had an adequate introitus to allow management of the first and second stages of labour. Five had deinfibulation performed antenatally or at delivery. Ninety-three percent of the primigravid patients and 74% of the multigravid patients had a vaginal delivery. CONCLUSIONS: We believe that the Northwick Park Hospital management policy for infibulated women closely mirrors the cultural practices in Somalia. The policy also improves obstetric management of infibulated patients. Twenty-six percent of referrals were of nonpregnant women, and this practice is to be encouraged.

1995	McCaffrey, M.	Female genital mutilation: consequences for reproductive and sexual health.	Sex Marital Ther. 1995 Apr;10(2):189-200.	PIP: An estimated 80 million women worldwide have been subjected to female genital mutilation and 2 million new procedures are performed each year. The procedure, generally performed at home by medically untrained persons, has severe long-term physical and psychological consequences. At Northwick Park Hospital in the UK, genitally mutilated immigrants from countries such as Somalia and Sudan have presented health care personnel with immense challenges. Routine gynecologic and obstetric procedures cannot be performed when access to the vagina is inadequate, and there is often a need for psychosexual counseling. To address the unique needs of these women, the Hospital established an African Well Woman Clinic that was attended by 50 women (including 14 primigravidae and 23 multigravidae) in its first six months of operation. Women are offered de-infibulation, ideally before becoming pregnant, and infibulated women are not resutured after delivery. Tact and cultural sensitivity on the part of all medical personnel are essential to reduce feelings of shame. Although most attendees at the Northwick Park Hospital program state they do not intend to infibulate their female children, they are at risk of pressure from family when they visit their homeland. Ongoing counseling, education, and support are necessary to break the cycle of female genital mutilation.
1995	McWest C.	Empowering women: interventions. Nigeria: new law to end FGM.	Afr Link. 1995 Apr;:12.	In March 1994, a Nigerian woman fighting to spare her young daughters from circumcision was saved from deportation from the US by a judge who called the practice cruel, painful and dangerous. Female Circumcision or Genital Mutilation has been a custom in male-dominated African societies to prevent promiscuity among women, reduce their sex urge and enhance their fertility and fecundity. The mutilation ranges from clitoridectomy (cuts in the clitoris) to infibulation (removal of the labia and sewing up most of the vagina). These practices that operated traditionally or in hospitals, are condemned in most parts of the world. In 1993, the WHO vowed to fight female circumcision, which has claimed the life of tens of thousands of women and subjected, and still subjects millions of others to suffering. In Nigeria, the Military Government is due to sign a new law that will end the practice. Indeed, parents who circumcise their daughters could face seven years imprisonment. This law is from legislation that is designed to improve health care for children in Nigeria. full text

1995	Meniru GI, Meniru MO, Ezeh UO.	Female genital mutilation. Should be abolished	BMJ. 1995 Oct 21;311(7012):1088.	
1995	Mohamud, A and Ng'ang'a, L.	Female genital mutilation in Kenya: mobilizing the health professionals toward its elimination from Nyamira district, Nairobi, August 12-31, 1995.	Arlington, Virginia: Partnership for Child Health care, BASICS, 1995. 70p.	
1995	Nguelebe, E.	L'excision .	In: Enquete demographique et de sante, Republique Centrafricaine, 1994-95, edited by Robert Ndamobissi et al, Calverton, MD: Macro International, 1995. pp 201-206.	

1995	No authors listed	1995 World Conference on Women. African Regional Preparatory Conference, November 94, Dakar.	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1995 Apr;(17):18.	PIP: During the African Regional Preparatory Conference, held in Dakar in November 1994, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) organized a workshop on "Traditional Practices and Beliefs as a Violation of the Human Rights of the Woman and the Girl Child" in collaboration with the Organisation of African Unity (OAU) and the UN Economic Commission for Africa (ECA). Eight panelists shared their country experiences and made proposals for eradicating harmful traditional practices. A film was shown, and Mrs. Marianne Sidibe, president of the Senegalese IAC National Committee, gave a vivid description of female genital mutilation (FGM). Proposals made during the workshop include 1) a follow-up workshop in Beijing; 2) inclusion of IAC concerns in the Platform of Action; 3) integration of IAC concerns into the national health programs of African nations with allocated budgets for implementation; 4) strengthening of interagency collaboration with governments; 5) adoption of legislation prohibiting harmful traditional practices such as FGM; 6) a minimum legal age for marriage of 18 years; 7) inclusion of information on traditional practices and gender sensitivity in primary and high school curricula; 8) involvement of youth in the campaign against harmful traditional practices; 9) regular evaluation of IAC activities; and 10) education of parents concerning gender equality. The African Platform for Action adopted by the conference considers FGM a form of violence against women.
1995	No authors listed	Egypt: conflicting decree on FGM	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1995 Apr;(17):17.	PIP: Presentation at the 1994 World Population Conference of a film depicting the actual performance, by a barber, of female genital mutilation on a young Egyptian girl produced international outrage and pressure on the Egyptian Government to ban this traditional practice. In October 1994, the Minister of Health--who stated during the conference that female circumcision should be banned and those who practice it punished--convened a meeting of physicians, religious leaders, legal experts, and representatives of nongovernmental organizations. The group issued a statement that condemned female genital mutilation on religious and medical grounds. However, the Minister of Health designated several hospitals where, one day a week, female circumcision could be performed if medical counseling to convince the parents to abandon the procedure was unsuccessful. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children has established a task force to design strategies for the eradication of female genital mutilation in Egypt, without any intermediate measures to medicalize the procedure.

1995	No authors listed	Ghana -- legislation against FGM.	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1995 Apr;(17):9.	PIP: The First Lady of Ghana, Her Excellency Nana Konadu Ageyman Rawlings, a supporter of GAWW (the IAC affiliate), has been a primary advocate of legislation that protects women and children from harmful traditional practices, including female genital mutilation (FGM). GAWW, after lobbying the government and working with the Law Reform Commission, succeeded in having the Criminal Code, 1960 (Act 29) amended to include the practice of FGM. Extensive research at the national and district levels on the long- and short-term hazards of the practice led to the adoption of Article 39 of the Constitution which abolishes all injurious traditional practices; this is in conformity with the Convention on the Rights of the Child to which Ghana is a party. Although the amendment makes FGM a crime punishable by three years imprisonment, the educational campaign begun by GAWW needs to be intensified in collaboration with government offices if this deeply ingrained practice is to be stopped.
1995	No authors listed	Liberia-IAC has been reactivated	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1995 Apr;(17):12.	The former national committee of Liberia ceased activities at the outbreak of civil unrest, but as soon as the situation allowed, a group of former committee members and new volunteers held meetings starting in March 1993. However, it is not until 1994 that activities started again in earnest. Thanks to UNICEF, a potential committee leader was invited to the IAC Regional Conference in April 1994, Addis Ababa. There, Miss Patricia Marbey met with other members of the IAC network, notably from neighboring countries, which share similar problems concerning traditional practices. Soon after her return she reorganized the committee. Elections were in August 1994 under the auspices of UNICEF. Officers were elected to key posts for a two-year term renewable only once. The name of the new committee was changed for Liberia IAC National Committee, or IAC-LI for short. Even before it was formally reorganized, IAC-Liberia was called into action to represent a girl who had been forcibly initiated. This affair provided the necessary impetus for the committee to start a sensitization campaign toward the eradication of FGM in and around the capital. full text
1995	No authors listed	Mutilazioni genitali femminili: proposte per un cambiamento	Quaderno n. 2 - conseguenze sulla salute fisica e psichica pagg. 1-27	

1995	No authors listed	Female Genital Mutilation	BMJ, vol. 311, pagg. 1088-1089	
1995	No authors listed	Protest against Egypt's efforts to medicalise female genital mutilation.	Women's Health Project News, February 1995. pp 19-20.	
1995	Omuodo DO	Initiatives. Uganda: female genital mutilation among the Sabiny	Afr Link. 1995 Oct;:14-5.	PIP: As a result of a shortage of youth specific reproductive health care services, the Ugandan youth are faced with many sexual and reproductive health problems. In addition to high rates of unwanted pregnancies, induced abortions, sexually transmitted diseases, and drug misuse, are the harmful cultural and traditional practices such as female genital mutilation (FGM) and early and forced marriages. Working to address the social, reproductive and sexual health, general health and responsible self development needs of young people, the Family Planning Association of Uganda (FPAU) has developed and implemented awareness, educational and community based interventions. As the leading nongovernmental organization in Uganda, FPAU was incorporated by the government as major participant in the preparation of its first National Population Policy. The policy urges the development and implementation of family life education and advocates for sensitization of the general public needs, rights, and responsibilities of the youth. Before the inauguration of the National Population policy, the FPAU was already gearing up to address the concern with regard to FGM among the Sabiny community of Kapchorwa District in Uganda

1995	Parker, M.	Rethinking female circumcision.	Africa, Vol 65, No 4, 1995. pp 506-523	
1995	Peters, J, editor and Wolper, A, editor.	Women's rights human rights: international feminist perspectives.	London: Routledge, 1995. 372p.	
1995	Post, MT.	Female genital mutilation and the risk of HIV.	Washington, DC: Academy for Educational Development, Support for Analysis and Research in Africa, 1995. 28p.	

1995	Roberton NR.	Female genital mutilation	Arch Dis Child. 1995 Jan;72(1):98-9.	
1995	Roberton NRC	Female Genital Mutilation	Archives of Disease in Childhood, vol. 72, pagg. 98-99	
1995	The American College of Obstetricians and Gynecologists (ACOG).	Female genital mutilation: ACOG committee opinion	International Journal of Gynecology and Obstetrics, Vol 49, 1995. p 209.	

1995	Toubia, N.	Female genital mutilation: a call for global action.	New York, Women's Ink, Rainbo, 1995. 48p.	
1995	Walder, R.	Why the problem continues in Britain.	British Medical Journal, Vol 310, 1995. pp 1593-1594	
1995	Walker, L.R. & Morgan, M.C.	Female circumcision: A report of four adolescents.	(1995). Journal of Adolescent Health 17: 128-132.	

1995	Walker, LR and Morgan, MC.	Female circumcision: a report of four adolescents.	Journal of Adolescent Health, Vol 17, No 2, 1995. pp 128-132.	
1995	WHO World Health Organization.	WHO continues its battle against female genital mutilation.	Geneva: WHO, 1995. 2 p. (WHO Feature No 186)	
1995	WHO World Health Organization.	Female Genital Mutilation Report of a WHO Technicla Working Group. Geneva, 17-19 July 1995	Geneva: WHO, 1995.	

1994	Akers, S.	Female genital mutilation - cultural or criminal?	Journal of Child Law, Vol 6, No 1, 1994. pp 27-31	
1994	Aldeeb Abu-Sahlieh S.A.	To mutilate in the name of Jehovah or Allah: Legitimisation of male and female circumcision	Medicine and Law 1994; 13(7-8): 575-622.	
1994	Canadian Advisory Council on the Status of Women / Conseil consultatif canadien sur la situation de la femme	Female Genital Mutilation	Canadian Advisory Council on the Status of Women / Conseil consultatif canadien sur la situation de la femme	

1994	Clement M	Mutilation in Canada?	Toronto Sun 3 Ottobre	
1994	Dorkenoo, E.	Cutting the rose: female genital mutilation: the practice and its prevention.	London: Minority Rights Group, 1994. 196p.	
1994	Dorozynski, A.	French court rules in female circumcision case.	British Medical Journal, Vol 309, 1994. pp 831-832.	

1994	Forty-seventh World Health Assembly	Maternal and Child helath and family planning: traditional practices harmful to the health of women and children		
1994	Heise, LL, Pitanguy, J and Germain, A.	Violence against women: the hidden health burden.	Washington, DC: World Bank, 1994. 72p. (World Bank Discussion papers No. 255)	
1994	James S.	Reconciling international human rights and cultural relativism: The case of female circumcision.	Bioethics 1994; 8(1): 1-26.	

1994	Johnson KE, Rodgers S.	When cultural practices are health risks: the dilemma of female circumcision.	Holist Nurs Pract. 1994 Jan;8(2):70-8.	The circumcision of young women and girls is widespread in African countries as well as in other parts of the world and clearly places them at risk for serious health consequences. Plans to eradicate the practice must recognize the cultural underpinnings that have maintained it. This article discusses the types of female circumcision and the concomitant short- and long-term health risks. The cultural aspects and origins of the procedure are described and a simple model of risk-taking based on control, information, and time is used to explain the complexity of issues that may be involved in the decision of women to consent to the procedure. PIP: This article, which provides basic information about female genital mutilation (FGM) and its cultural relevance and offers a risk-taking model that helps explain the complexity of issues involved in the decision to continue the practice, opens with a section that describes the three main types of FGM, its prevalence and the geographic region where it is practiced, the age of the victims, immediate and long-term complications, and the increased risk of HIV transmission association with the procedure. The article then draws three variables from risk theory on business decision-making (control, information, and time) to explain individual decision-making that may place a person at risk of an untoward outcome. In this model, control is dependent upon information and time, information is dependent upon time, and time is the foundation. After detailing the significance of each of these variables, the article considers the cultural context of FGM, reviews the arguments of the proponents of the procedure, suggests reasons why it is continued, and identifies the primary commonalities of practicing cultures. Finally, the article integrates some of this cultural information into the proposed model and proposes that women may achieve more control over their decisions about perpetrating FGM if they have increased access to resources such as education, economic opportunities, training in self-reliance, and support groups. Time should be used effectively to provide individuals with the information they need to gain control and make appropriate decisions about FGM.
1994	Jordan, J.A.	Female genital mutilation (female circumcision).	(1994). British Journal of Obstetrics and Gynaecology 101(2): 94-95.	

1994	Jordan, JA.	Female genital mutilation (female circumcision).	British Journal of Obstetrics and Gynaecology, Vol 101, No 2, 1994. pp 94-95.	
1994	Kere, LA and Tapsoba, I.	Charity will not liberate women: female genital mutilation in Burkina Faso.	In Private decisions, public debate: women, reproduction and population, edited by Judith Mirsky et al, London: Panos Publications, 1994. pp 43-56.	
1994	Khalifa, NK.	Reasons behind practicing recircumcision among educated Sudanese women.	AHFAD Journal: Women and Change, Vol 11, No 2, 1994. pp 16-32.	

1994	Kowser H	Commentary: Female Genital Mutilation: Perspectives from a Somalian Midwife	Birth vol.21, n.4 pagg. 224-26	
1994	Larsen, U.	Sterility in sub-Saharan Africa,	(1994). Population Studies, 48(3): 459–475	
1994	Lewis, I.M.	Blood and Bone: The call of kinship in Somali Society.	(1994). Lawrenceville, NJ: The Read Sea Press.	

1994	Mawad, N.M. & Hassanein, O.M.	Female circumcision: three years' experience of common complications in patients treated in Khartoum teaching hospitals.	(1994). Journal of Obstetrics and Gynaecology 14(1): 40-44	
1994	McCleary PH	Female genital mutilation and childbirth: a case report.	Birth. 1994 Dec;21(4):221-3.	Over 80 million women in more than 30 countries have undergone female genitalmutilation, also called female circumcision, according to World Health Organization estimates. Over the past decade 70,000 Somalians have become residents in Canada, 50,000 of whom live in Toronto, Ontario. Many of the women are of childbearing age, and 99.5 percent of women in Somalia are reported to have been genitally mutilated. Canadian medical organizations have published position statements prohibiting the practice. This case report describes the pregnancy and childbirth of a Somalian woman with the infibulation type of procedure. When perinatal health professionals are aware of and sensitive to the cultural and medical implications and sequelae of female genital mutilation, they will give better care to affected women.
1994	Muigana, M.	Kenya: female circumcision.	In: Conveying concerns: women write on reproductive health, compiled by Population Reference Bureau, Washington, DC: PRB, 1994. p 11.	

1994	Nelson D.	What's wrong with female circumcision?	Cape Breton Post. 1994 Mar 16;:[1] p	PIP: Why should the multicultural society of Canada outlaw female genital mutilation (FGM) as proposed by federal Justice Minister Allan Rock or allow avoidance of the procedure to be a legitimate reason for gaining refugee status? Is this anti-FGM position simply an ethnocentric stance that would be called racism in other circumstances? Canadian objections to FGM can not arise from objections about mutilation of a child's sexual organs because male circumcision is legal in Canada, although it, too, is medically questionable. Perhaps Rock is being patriarchal in reserving his concern for females. In Somali culture, women determine the nature and extent of FGM, so Rock may simply be exhibiting his inability to understand other cultures. On the other hand, it is politically incorrect for Canadian government workers to criticize other cultures, and immigrants are assured that their values and beliefs will be accommodated in Canada. Thus, polygamy among Somali immigrants is ignored. The question is why should FGM be a major exception and invoke efforts at repression instead of a respect for diversity.
1994	No authors listed	Ban horrific ritual, Cairo summit urges.	Tor Star. 1994 Sep 11;:[1] p	PIP: The story is told of an 8-year-old girl who was subjected to female genital mutilation (FGM) while on school break in her mother's hometown in central Sudan. The girl was taken into a room with 10 women and told to remove her underwear. While pinned down, screaming, and resisting, the girl's clitoris and labia minora were excised and she was subsequently sewn up. The International Conference on Population and Development to be held in Cairo will encourage countries to ban such ritual FGM as an abuse and health hazard to girls and young women. The final report of the 9-day UN conference advocates abolishing FGM as an important goal in efforts to empower women worldwide. This girl, now a woman in her early 30s, is 1 of about 114 million women around the world who have undergone FGM. The excision of the external female genitalia and subsequent sewing shut of the aperture, except for a small hole for urination and menstruation, is done to girls aged 6-9 years, usually without anesthetic, to suppress sexual urges and ensure chastity before marriage.
1994	No authors listed	Recomendations to the Government of Canada on Female Genital Mutilation - Presented by the Canadian Advisory Council on the Satus o Women	Canadian Advisory Council on the Status of Women / Conseil consultatif canadien sur la situation de la femme	

1994	No authors listed	The female eunuchs.	West Africa, No 4010, 1994. pp 1382-1386	
1994	No authors listed	Tradition of harm.	Populi, Vol 21, No 5, 1994. pp 4-5.	
1994	Omer-Hashi K.M.	Commentary: Female genital mutilation, perspectives from a Somalian midwife.	BIRTH 1994; 21(4): 224-226.	

1994	Ryan M.M.	Female circumcision and related practices survey.	Royal Australian College of Obstetricians and Gynaecologists Bulletin, September 1994; p.11-12.	
1994	Schroeder, P.	Female genital mutilation - a form of child abuse.	The New England Journal of Medicine, Vol 331, No 11, 1994. pp 739-740.	
1994	Toubia N	Female genital mutilation and the responsibility of reproductive health professionals.	Int J Gynaecol Obstet. 1994 Aug;46(2):127-35.	

1994	Toubia, N.	Female circumcision as a public health issue.	N Engl J Med. 1994 Sep 15;331(11):712-6.	PIP: Female circumcision is practiced in 26 African countries, and it is estimated that at least 100 million women are circumcised. The mildest form is clitoridectomy and the more severe type is infibulation. Girls are commonly circumcised between the ages of 4 and 10 years. Since the operator is usually a nonprofessional without surgical experience, complications are common: hemorrhage and severe pain that can even result in shock and death. The most common long-term complication is the formation of dermoid cysts in the line of the scar. Childbirth adds other risks for infibulated women and vesicovaginal fistula is often the result. The attendant urinary incontinence leads to ostracism of these women. In sum, female circumcision is a major contributor to childhood and maternal mortality and morbidity in communities with poor health services. The physical complications add to the psychological trauma: many infibulated women have a syndrome of chronic anxiety and depression arising from their condition, intractable dysmenorrhea, and the fear of infertility. The psychological sequelae of immigrant women who live in societies where such practice is condemned is even worse and may need professional counseling to address their sexual identity and cultural identification. Tightly infibulated women require clinical intervention for deinfibulation in order to preclude serious maternal and fetal complications during childbirth. Reinfibulation is medically harmful and even though some women request it, health professionals who comply are ethically reprehensible. In Sweden a 1982 law makes all forms of female circumcision illegal, as does a law that was passed in the United Kingdom in 1985. In France several cases were brought against parents under child abuse laws for circumcising or attempting to circumcise their French-born daughters. In the United States a 1993 bill drafted by the Congressional Women's Caucus would make the practice illegal and fund a program to assist immigrant communities to deal with the problem.
1994	Toubia, N.	Female genital mutilation and the responsibility of reproductive health professionals.	International Journal of Gynecology and Obstetrics, Vol 46, No 2, 1994. pp 127-135.	

1994	Toubia, N.	Female circumcision as a public health issue.	(1994). New England Journal of Medicine 331(11): 712–717.	
1994	WHO World Health Organization.	Female genital mutilation: information kit.	Geneva: WHO, 1994.	
1993	Arbesman, M., Kahler, L. & Buck, G.M.	Assessment of the impact of female circumcision on the gynecological, genitourinary and obstetrical health problems of 30 women from Somalia: Literature review and case series	Women and Health, Vol 20, No 3, 1993. pp 27-42.	

1993	Baker CA, Gilson GJ, Vill MD, Curet LB	Female circumcision: obstetric issues.	Am J Obstet Gynecol. 1993 Dec;169(6):1616-8.	Female circumcision is a problem unfamiliar to most Western obstetrician-gynecologists. We present a case illustrative of the unique management problems posed by these patients during labor. A method of releasing the anterior vulvar scar tissue to allow vaginal delivery is described. Sensitivity and a nonjudgmental approach as to what is culturally appropriate care for these women are of paramount importance. PIP: Although female circumcision is a health condition unfamiliar to most Western obstetrician-gynecologists, immigrants from parts of the world where this procedure is routinely practiced may be encountered. Such women pose unique management problems during labor and delivery. Presented is the case of a 36-year-old Sudanese woman who had undergone pharaonic circumcision, with substantial vulvar scarring, as a young girl in her country of origin. After emigration to the US, she had 2 Cesarean section deliveries. When she presented to the University of New Mexico with a 3rd pregnancy, she requested vaginal birth (to overcome the stigma of moral weakness her family associated with cesarean section) and a female obstetrician familiar with female circumcision. The patient had spontaneous membrane rupture at 39 weeks' gestation. Epidural anesthesia was necessary to examine the patient without severe discomfort. The external genitalia were missing the labia minora, and the clitoral area and external urinary meatus were obscured by bands of scar tissue that had to be cut. The major obstetric problem associated with this profile is prolongation of the 2nd stage of labor due to scar or soft tissue dystocia and the consequent need for deinfibulation. Women who labor unattended with an obstructed introitus are at risk of vesicovaginal and rectovaginal fistulas, laceration of scar tissue with hemorrhage, and fetal asphyxia or death. Incision of the fibrous tissue in this patient allowed sufficient widening of the introitus for expulsion of the fetal head. Delivery was uneventful and occurred after 19 hours. Although some women may desire reinfibulation, this patient sought less discomfort in future vaginal examinations, so the vulvar scars were not reapproximated. The raw surfaces were oversewn loosely after delivery.
1993	Calder, BL, Brown, YM and Rae, DI.	Female circumcision/genital mutilation: culturally sensitive care	Health Care for Women International, Vol 14, No 3, 1993. pp 227-238	

1993	Darkenoo E.	6000 girls at risk every day. Female genital mutilation, although illegal, is still widely practiced.	Womens Health Newsl. 1993 Nov;(20):10-1.	PIP: 6000 girls face the risk of genital mutilation daily. More than 100 million women worldwide have already undergone genital mutilation. It increases the risk of death during childbirth and of fetal death. Female genital mutilation (FGM) is forced on 1-day-to 18-year-old females (95% of all FGM cases). Most genitally mutilated females live in more than 20 countries in Africa, in some countries in the Middle East, and in a few countries in Asia. The governments do not condone FGM, however. The 1990 African Charter on the Rights and Welfare of the Child calls on governments to abolish harmful traditional, social, and cultural practices. Migration has brought affected girls and women to Europe, Canada, the US, and Australia. About 1000 girls in these countries are at risk of genital mutilation. 10 social work departments in the UK have had to intervene in cases of suspected FGM. Another 18 departments think that it may be practiced in their communities. FGM predates Islam, and the Koran doe not refer to it; so, contrary to popular belief, FGM is not a religious requirement for Muslims. The underlying reason for FGM is the suppression and control of female sexuality. It is indeed one of the more extreme forms of female oppression. The UN Draft Convention on Violence against Women addresses FGM. Other international legal instruments are the UN Convention to Eliminate All Forms of Discrimination Against Women and the UN Children's Convention. The European parliament calls on member countries to move against FGM. In 1985, the UK outlawed FGM. Minority black and marginalized women and girls are at greatest risk of FGM in the UK. All local UK authorities should have an antiracist and multicultural policy protecting girls from FGM and provide services addressing the special health needs of genitally mutilated women.
1993	Dyer, O.	Gynaecologist struck off over female circumcision.	British Medical Journal (Clinical Research Edition), Vol 307, No 6917, 1993. pp 1441-1442.	

1993	Forty-sixth World Health Assembly	Maternal and Child helath and family planning for health		
1993	Gallagher, A.	The United Nations, human rights and traditional practices affecting the health of women and children.	Development, No 4, 1993. pp 44-48.	
1993	Gilbert D	For the sake of purity (and control). Female genital mutilation.	Links. 1993 Winter;9(5):6-8, 30.	PIP: In 1973 approximately 1 million girls will be victimized by female genital mutilation (FGM), widely practiced in more than 20 African nations from Mauritania to the Ivory Coast in the west, to Egypt and North Tanzania in the east, as well as in Oman, Bahrain, North and South Yemen, and the United Arab Emirates. FGM takes place among the Moslem populations of the Philippines, Indonesia, and Malaysia and the Jewish Falashas in Ethiopia. FGM is practiced on babies just a few days old to girls right before marriage or young women pregnant with their first child. The most extreme mutilation is called infibulation. In Somalia, almost 100% of the women are infibulated, and so are more than 80% of the women in north and central Sudan. In Ethiopia/Eritrea, Mali, and Sierra Leone, 90% of the women have undergone some form of genital mutilation. The rate reaches 70% in Burkina Faso; 60% in Kenya, Gambia, and the Ivory Coast; and 50% in Senegal, Egypt, Guinea Bissau, and Nigeria. The mutilation often results in accumulation of menstrual blood and pelvic inflammatory disease often leading to infertility. Between 20% and 25% of infertility in Sudan has been attributed to female genital mutilation. The practice of FGM has existed for centuries, and some claim it originated in the Nile Valley during the Pharaonic era. On the other hand, Muslim countries like Iraq, Syria, and Tunisia do not practice FGM. The London Black Women's Health Action Project set up an educational network to prevent

				mutilations and to dispel the myth of religion about FGM. FORWARD convened the First Study Conference on Genital Mutilation of Girls in Europe in 1992 and deemed FGM a form of child abuse. Local campaigns in Africa, Asia, and the Arab world educate against FGM. The Inter-Africa Committee on Traditional Practices Affecting the Health of Women and Children, based in Addis Ababa, Ethiopia, has offices in more than 20 African nations to sensitize the public about the harmful effects of FGM. In Nigeria, the National Association of Nigerian Nurses and Midwives presents plays in the local markets about the complications of FGM.
1993	Hicks, E.K.	Infibulation: Female Mutilation in Islamic Northeastern Africa.	New Brunswick: Transaction Publishers, 1993. 298p.	
1993	Hosken, F.P.	The Hosken Report: genital and sexual mutilation of females	4th rev.ed. Lexington, MA: Women's International Network News, 1993. 428p.	

1993	Hussein, A.	Female genital mutilation: the road to success in Egypt.	Planned Parenthood Challenges, No 2, 1993. pp 40-42.	
1993	Inhorn, M.C. & Buss, K.A.	Infertility, infection, and iatrogenesis in Egypt: The anthropological epidemiology of blocked tubes.	(1993). Medical Anthropology 15: 217–244.	
1993	Ladjali, M, Rattray, TW and Walder, RJW.	Female genital mutilation: both the problem and the solutions rest with women.	British Medical Journal, Vol 307, No 6902, 1993. p 460.	

1993	Mouvement Francais pour le Planning Familial (MFPF).	Mutilations sexuelles feminines en France [Female genital mutilation in france].	Paris: MFPF, 1993. 73p.	
1993	No authors listed	What is excision?	Voix Femme. 1993 Oct;(2):18	ARTICLE IN FRENCH PIP: The terms inverted question markfemale circumcision inverted question mark and inverted question markexcision inverted question mark are used to designate traditional practices or initiation ceremonies in which girls make the symbolic transition into womanhood and adult society. The first type of female genital mutilation (FGM), circumcision, involves removing only the clitoral hood and leaving the remaining external genitalia intact. The second form, excision, involves removing the clitoris and the adjacent genital, such as the labia minora, without harming the labia majora or making any other alterations. Infibulation refers to the excision of all external genitalia and closure of the vaginal entry. There are therefore 3 types of surgical FGM. Immediate adverse consequences include violent pain, hemorrhage, lesions to neighboring organs, urine retention, acute infections, tetanus, and septicemia. Later or long-term consequences include scarring, cysts and abscesses of the vulva, pelvic infection, sterility, dysmenorrhea, difficulty urinating, marital and delivery complications, psychological problems, and an increased risk of contracting HIV. There is no valid medical, health, or sanitary reason to perpetuate FGM
1993	No authors listed	The UNHCR works with the IAC in the eradication of FGM among Somali refugees / returnees in Ethiopia	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1993 Dec;(15):8.	PIP: The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children has joined with the UN High Commission for Refugees to develop a training program for midwives and nurses in order to eradicate female genital mutilation from the population of Somali refugees in Ethiopia. The training program was devised after it was found that the refugees were practicing infibulation, the most radical form of female genital mutilation. 52 midwives and 6 nurses have been trained in 3 sensitization programs which featured the history, geographical distribution, and types of female genital mutilation. After a fourth scheduled program, impact evaluation will take place. Informal interviews show that the information passed on by the midwives is gradually being assimilated by members of both sexes who are beginning to speak out in condemnation of infibulation.

1993	No authors listed	WHO policy on FGM / HTPs; an interview with Mark A. Belsey.	Newsl Inter Afr Comm Tradit Pract Affect Health Women Child. 1993 Dec;(15):5-7.	PIP: The World Health Organization (WHO) became interested in female genital mutilation in the 1960s at the request of the Sudanese government. During the 1970s and 1980s, 2 regional offices collaborated with WHO to hold seminars on harmful traditional practices. The WHO has been limited in its ability to work in this field by the nature of its organization. Thus, it is very happy to be able to work with the Inter-African Committee (IAC) on Traditional Practices Affecting the Health of Women and Children because the IAC can work with national NGOs which in turn can work with national governments. The IAC, in fact, laid the groundwork for the World Health Assembly resolution (WHA 46.18) which allows the WHO regions to approach all governments in a proactive sense with a plan of action (currently being developed) to contribute to the elimination of all harmful traditional practices This may allow humanity to reach a stage in 20 years where female genital mutilation, while not totally eradicated, will not be increasing. Then, the next generation will be free of this procedure which, especially in combination with child marriage, is a danger to the physical health of girls and young women. The WHO believes that child marriage may even be more dangerous than female genital mutilation because of the disharmony between reproductive maturity and physical maturity which allows a girl to become pregnant before her pelvis has matured. The growth of this immature pelvis may be stopped permanently by an early pregnancy and, therefore, make all subsequent child-bearing difficult. Among the traditional practices harmful to women, these 2 are the ones which require the most immediate action.
1993	Ntiri, DW.	Circumcision and health among rural women of southern Somalia as part of a family life survey.	Health Care for Women International, Vol 14, No 3, 1993. pp 215-226.	

1993	Omer-Hashi KH	Female genital mutilation: overview and obstetrical care	Can J Ob Gyn Womens Health Care. 1993;5(6):538-42.	PIP: According to 1991 census data, 72,285 East Africans are residing in Canada. Many female immigrants underwent female genital mutilation (FGM) in their countries of origin. This article, prepared by a Somalian midwife and health educator, describes FGM and its implications for obstetric-gynecologic care in Canada. Canadian obstetricians, especially males, must be sensitive to the cultural backgrounds of women who present with FGM and keep in mind that these women are reluctant to expose their genitals. Fear that they will be denied the right to natural childbirth prevents many women with FGM from presenting to a hospital. Medical mismanagement of women with FGM during childbirth can result in complications such as urine retention, perineal tears, and infection. Although infibulation after childbirth is customary for women with FGM, physicians in Ontario are authorized only to repair the surgically incised area. The Council of the College of Physicians and Surgeons of Ontario has designated performance of FGM by a Canadian physician as professional misconduct. Several organizations in Ontario are available to serve as resources for obstetricians who care for women with FGM. The Toronto Birth Control and Venereal Disease Information Center offers classes on childbirth and sexuality and contraception counseling to women with FGM
1993	Sanankoua F.	What is excision? Dr. Sanankoua's point of view	Voix Femme. 1993 Oct;(2):19.	ARTICLE IN FRENCH PIP: 80 million women worldwide have undergone female genital mutilation (FGM). In Mali, 83% of the country inverted question marks women are mutilated. Such mutilation is part of ceremonies initiating young girls into the world of adulthood. The first type of FGM involves removing a part of the clitoris, the second form of FGM involves excising the clitoris and labia minora, and the third type involves excising the clitoris, labia minora, and a large part of the labia majora. Immediate adverse consequences include violent pain, hemorrhage, lesions to neighboring organs, urine retention, acute infections, tetanus, and septicemia. Later or long-term consequences include scarring, cysts and abscesses of the vulva, pelvic infection, sterility, dysmenorrhea, difficulty urinating, marital and delivery complications, psychological problems, and an increased risk of contracting HIV.
1993	Sundby J, Austveg B.	Genital mutilation of women. A new challenge for the health service	Tidsskr Nor Laegeforen. 1993 Sep 10;113(21):2704-7.	ARTICLE IN NORWEGIAN Female circumcision, or genital mutilation is practised around the world. Because of war, conflicts and poverty, many women from cultures involving this practice now enter European communities. Some of them demand circumcision for their children. Genital mutilation of women has serious health effects, and in our societies there is a strong demand for its eradication. The cultural reasons for genital mutilation are varied, but it is not a compulsory part of theIslamic faith. Health workers in Norway may lack knowledge on how to handle these women when they meet them in their daily work. Sometimes unnecessary interventions are performed, sometimes ignorance may cause traumatic experiences for both patient and doctor. This article describes some of the social

				and cultural background for continued exposure to female mutilation, the health effects and some suggestions for interventions.
1993	Toubia, N.	Female genital mutilation: A Call for Global Action	(1993). New York: Women, Ink	
1993	Walker A, Pratibha P.	Warrior Marks.	London, Jonathan Cape 1993.	

1993	Walker A.	A legacy of betrayal: confronting the evil tradition of female genital mutilation.	Ms., November/December 1993. pp 55-57	
1992	Brighouse R	Ritual female circumcision and its effects on female sexual function	The Canadian Journal of Human Sexuality, vol.1, n.1 pagg. 3- 10	
1992	Dirie, MA and Lindmark, G.	The risk of medical complications after female circumcision	East African Medical Journal, Vol 69, No 9, 1992. pp 479-482	

1992	Dorkenoo, E and Elworthy, S.	Female genital mutilation: proposals for change.	London: Minority Rights Group, 1992. 43p. (Minority Rights Group International Report)	
1992	Foundation for Women's Health Research and Development (FORWARD).	The first study conference on genital mutilation of girls in Europe, London, 6-8 July 1992: London declaration.	London: Forward, 1992. 2p.	
1992	Hedley R, Dorkenoo E.	Child protection and female genital mutilation: Advice for health education and social work professional.	Foundation for Women's Health Research and Development (FORWARD), London 1992.	

1992	Khattab H.A.	The Silent Endurance. Social Conditions of Women's Reproductive Health in Rural Egypt.	(1992). Amman, Jordan, UNICEF, Regional Office of the Middle East and North Africa, [12], 59 p.	
1992	McSwiney, M.M. & Saunders, P.R.	Female circumcision: A risk factor in postpartum haemorrhage.	(1992). Journal of Postgraduate Medicine 38(3): 136-137.	
1992	No authors listed	Two years of work.	Aidos News. 1992 Jul;(Spec No):1	PIP: Despite a number of obstacles encountered during 1990 and 1991, AIDoS increased its level of involvement in field projects and the campaign against female genital mutilation (FGM) in Africa, continued its collaboration with several UN agencies, and increased its work in the area of women and the environment. Since the first issue of AIDoS News, published more than 2 years ago in English, was so helpful in initiating and maintaining contacts with women's organizations around the world, efforts will be made to keep publishing the bulletin annually, and to circulate it to a larger audience. The shift of available resources toward Eastern Europe during 1990/91 had severe adverse effects upon the countries of the Third World, while the Gulf War stilted international cooperation. Moreover, Italian development cooperation is undergoing organizational and staff restructuring. In this context, AIDoS has nonetheless achieved greater government recognition and is now involved in establishing a documentation center and information system for the integration of women in development at the Ministry of Community Development, Women's Affairs and Children in Tanzania. Recent AIDoS activities are briefly discussed.

1992	No authors listed	The eradication of female genital mutilation.	Aidos News. 1992 Jul;(Spec No):4-5.	PIP: Female genital mutilation (FGM) refers to a traditional practice involving the excision of external female genitalia. Taking place in several regions in Africa and practiced in 25 countries, FGM has serious adverse consequences upon women's health. FGM is often conducted upon young girls under unsanitary conditions and with only the most basic surgical tools. Death can result from hemorrhage and infection. Once the girl who has undergone FGM develops into a woman and begins to conceive and bear children, the almost fully closed vaginal opening impedes the natural flow of fluids from the vagina and bladder, making childbirth particularly difficult. Moreover, women who have undergone FGM are at increased risk of contracting HIV. The World Health Organization estimates that up to 80 million women and children undergo FGM. FGM has received growing attention in recent years, with action being taken at the national and international levels by governments and nongovernmental organizations to eradicate the practice. AIDoS has been involved in FGM eradication efforts for the past several years, expanding its involvement in 1990/91 in the campaign to eradicate FGM in Africa. The campaign to eradicate FGM in Africa and the Inter-African Committee are discussed,
1992	No authors listed	Female circumcision, excision and infibulation	College Notices - The College of Physicians and Surgeons of Ontario, n. 25	
1992	Ozumba, B. C.	Acquired gynetresia in Eastern Africa.	(1992). International Journal of Gynecology and Obstetrics 37(2): 105–109.	

1992	Schuler, M editor.	Freedom from violence: women's strategies from around the world..	New York: United Nations Development Fund for Women (UNIFEM), 1992. 354p.	
1992	Smith, Jacqueline.	Visions and discussions on genital mutilation of girls: an international survey.	Amsterdam : Defence for Children International, Section The Netherlands, 1992. 216p.	

1992	Van der Veer G.	Counselling and therapy with refugees. Psychological problems of victims of war, torture and repression.	Chichester, John Wiley and Sons. 1992.	
1992	Van der Kwaak A.	Female circumcision and gender identity: a questionable alliance?	Social Science and Medicine 1992; 35(6): 777-787	
1992	van Roosmalen, J., Reynerse, M. M. & Wiebenga,J. E.	AIDS and women's health care in developing countries.	(1992). Tropical and Geographical Medicine 44(3):284–285.	

1991	Armstrong, S.	Female circumcision: fighting a cruel tradition.	New Scientist, 2 February 1991. pp 42-47	
1991	Boddy, J.	Body politics: Continuing the anticircumcision crusade	Medical Anthropology Quarterly 1991; 10(5): 15-17. p16.	
1991	Dirie, M.A. & Lindmark, G.	A hospital study of the complications of female circumcision.	(1991). Tropical Doctor 21:146-148.	

1991	Dirie, MA and Lindmark, G.	Female circumcision in Somalia and women's motives.	Acta Obstetricia et Gynecologica Scandinavica, Vol 70, No 7-8, 1991. pp 581-585.	
1991	Dolphyne, FA.	The emancipation of women: an African perspective.	Accra: Ghana Universities Press, 1991. 107p.	
1991	Gordon, D.	Female circumcision and genital operations in Egypt and the Sudan: A dilemma for medical anthropology.	(1991). Medical Anthropology Quarterly New Series 5(1): 3–28.	

1991	IPPF International Planned Parenthood Federation	Female genital mutilation (IPPF's Medical Advisory Panel (IMAP) statement).	London: IPPF, Vol 25, No 5, 1991. p 2. (Available in English, French and Spanish)	
1991	IPPF International Planned Parenthood Federation	Together building a space for women.	London: IPPF, 1991. 8p. (Available in English, French and Arabic)	
1991	Kenyon, SM.	Five women of Sennar: culture and change in Central Sudan.	Oxford: Clarendon Press, 1991. 262p.	

1991	Kheir, E.H., Kumar, S. & Cross, AR..	Female Circumcision: Attitudes and Practices in Sudan.	In Demographic and Health Surveys World Conference, 5-7 August 1991, Washington, DC, Vol 111, Columbia, Maryland: IRD/Macro International, 1991. pp 1697-1717.	
1991	Lane, S.D. & Meleis, A.I.	Roles, work, health perceptions and health resources of women: a study in an Egyptian delta hamlet	1991). Social Science and Medicine 33(10):1197-1208.	
1991	Mbunda, D.	Traditional sex education in Tanzania: a study of 12 ethnic groups	New York: Margaret Sanger Center, Planned Parenthood of New York City, 1991. 76p.	

1991	Mottin Sylla, MH.	Excision au Senegal.	Dakar: Environmental Development Action in the Third World (ENDA), 1991. 125p. (Serie Etudes et Recherches No.137)	
1991	No authors listed	IPPF's new Initiative on Female Genital Mmutilation	IPPF International Planned Parenthood Federation	
1991	No authors listed	Statement on Female Genital Mutilation	IPPF International Planned Parenthood Federation	

1991	Sudan, Ministry of Economic and National Planning	Sudan demographic and health survey 1989/1990.	Columbia, Maryland: IRD/Macro Systems, 1991. 180p.	
1991	Weil-Curiel, L.	La loi et l'excision feminine pratiquee en France parmi les immigrants	Nouvelles Feministes Internationales, Vol 86, No 1, 1991. p 10.	
1990	Andersson-Brolin, L.	How to eradicate circumcision of girls?: a study of efforts in Egypt, Kenya and Mali.	Stockholm: Radda-Barnen, 1990. 79p	

1990	Aryee, D.	Traditional practices which adversely affect the health of women and children in Africa: a strategy for change.	Leeds: Leeds University, 1990. 129p	
1990	Hawkins, C.	Countering female circumcision in Britain.	People, Vol 17, No 4, 1990. pp 12-13.	
1990	Katumba, R.	Kenyan elders defend circumcision.	Development Forum, September/October 1990. p 17.	

1990	Kouyate, H.	Les mutilations sexuelles.	Vie & Sante, No 4, 1990. pp 3-6	
1990	Ladjali, M and Toubia, N.	Female circumcision: desperately seeking a space for women.	IPPF Medical Bulletin, Vol 24, No 2, April, 1990. pp 1-2.	
1990	Nakalema R.	Moi bans female circumcision	New Afr. 1990 Jun;:47.	PIP: A recent survey by the Inter-African Committee for Traditional Practices ffecting the Health of Women and Children found that 75-85 million women in Africa have undergone some form of female genital mutilation (FGM). FGM has long been practiced in Kenya. The ethnic groups which practice it, including the Kikuyu, Kamba, Kisii, Kalenjin, Maasai, and people of Somali origin, have a death rate of 170/1000 of their female populations. Approximately half of these deaths are the result of FGM, a practice which also contributes to the poor health of mutilated women. The adverse health consequences of FGM have led Kenya's President Daniel arap Moi to ban the practice in his country. In announcing the ban, President Moi advised Kenyans to discontinue cultural practices and customs which have no place in modern society and which will otherwise retard development. A number of prominent Kenyans have come forth in support of Moi's move.

1989	Brennan, K.	The influence of cultural relativism on international human rights law: female circumcision as a case study.	Law and Inequality, Vol 7, 1989. pp 367-398.	
1989	Brown I	Female Circumcision	The Canadian Nurse / L'infirmière canadienne pagg. 19-22	
1989	De Silva, S.	Obstetric sequelae of female circumcision.	(1989). European Journal of Obstetrics Gynecology, and Reproductive Biology 32: 233–240.	

1989	Foundation for Women's Health Research and Development (FORWARD).	Whole issue on subject of female genital mutilation	Sisterlinks, Vol 2, No 2, 1989. pp 2-9.	
1989	Gailliard, F.	Dossier: non aux mutilations sexuelles.	Croissance des jeunes nations, No 320, 1989. pp 15-22	
1989	Graham, E.	Female mutilation: unsettled issues.	Spare Rib, April 1989. pp 44-45	

1989	Hezekiah, J. & Wafula, F.	Major health problems of women in a Kenyan village.	(1989). Health Care for Women International 10:15-25.	
1989	Hosken, F.P.	Somalia campaigns to eradicate infibulation.	People, Vol 16, No 3, 1989. pp 31-33.	
1989	Ladjali, M.	A new challenge for Africa: to reduce maternal mortality by half over the next decade	IPPF Medical Bulletin, Vol 23, No 2, 1989. pp 3-4.	

1989	Larsen, U.	A Comparative Study of the Levels and the Differentials of Sterility in Cameroon, Kenya, and Sudan.	(1989). In Ron Lesthaeghe, ed. Reproduction and Social Organization in Sub-Saharan Africa. Berkeley: University of California Press.	
1989	Lightfoot-Klein, H.	Prisoners of ritual: an odyssey into female genital circumcision in Africa.	New York: Harrington Park Press, 1989. 306p.	
1989	Lightfoot-Klein, H.	Rites of purification and their effects: Some psychological aspects of female genital circumcision and infibulation (Pharaonic Circumcision) in an Afro-Arab Islamic society (Sudan).	Journal of Psychology and Human Sexuality 1989; 2(2): 79-91.	

1989	Lightfoot-Klein, H.	The sexual experience and marital adjustment of genitally circumcised and infibulated females in the Sudan.	The Journal of Sex Research, Vol 26, No 3, 1989. pp 375-392.	
1989	Ras-Work, B.	Female circumcision.	In: Maternal and child care in developing countries: assessment, promotion, implementation, edited by E. Kessel and AK Awan, Switzerland: Ott Publishers, 1989. pp 24-27.	
1988	Gruenbaum, E.	Reproductive ritual and social reproduction: Female circumcision and the subordination of women in Sudan.	In (1988). N. O'Neill and J. O'Brian (eds.), Economy and Class in Sudan. Aldershot: Averbury, England.	

1988	Kheir, AH et al.	Female circumcision: a strategy for eradication.	In Population and development in the Sudan, edited by AA Saghayroun et al, Khartoum: National population Committee, 1988. pp 101-109	
1988	Slack, A.T.	Female circumcision: A critical appraisal.	(1988). Human Rights Quarterly 10: 437–486	
1988	Slack, AT.	Female circumcision: a critical appraisal.	Human Rights Quarterly, Vol 10, 1988. pp 437-48.	

1987	Graham, E and Adamson, F.	Female circumcision and consciousness raising: a manual for educators and group facilitators.	London: Foundation for Women's Health (FORWARD), 1987. 56p	
1987	Hardy, D.B.	Cultural practices contributing to the transmission of Human Immunodeficiency Virus in Africa.	(1987). Review of Infectious Diseases 9(6): 1109–1119.	
1987	Inter-African Committee on Traditional Practices Affecting the Health of Women and Children.	Report on the regional seminar on traditional practices affecting the health of women and children in Africa, 6-10 April 1987, Addis Ababa, Ethiopia.	Geneva: Inter-African Committee, 1987. 182p.	

1987	Koso-Thomas, O.	The Circumcision of Women: A Strategy for Eradication.	London: Zed Books, 1987. 109p.	
1987	Ras-Work, B.	Call to ban female circumcision.	People, Vol 14, No 4, 1987. pp 26-27.	
1986	Belsey, M.A. & Ware, H.	Epidemiological, social, and psychological aspects of infertility.	(1986). In Vaclav Insler and Bruno Lunenfeld (eds.), Infertility: Male and Female. Edinburgh: Churchill Livingston.	

1986	Mammo, A. & Morgan, S. P.	Childlessness in rural Ethiopia.	(1986). Population and Development Review 12(3): 533–546.	
1986	No authors listed	A traditional practice that threatens health - female circumcision	WHO Chronicle, vol. 40 pagg. 31-36	
1986	Sami, I.R.	Female circumcision with special reference to the Sudan.	(1986). Annals of Tropical Medicine 6:99-115.	

1986	United Nations Economic and Social Council, Commission on Human Rights.	Report of the Working Group on Traditional Practices Affecting the Health of Women and Children	New York: UN, 1986. 41p. (E/CN.4/1986/42)	
1986	WHO World Health Organization.	A traditional practice that threatens health: female circumcision.	WHO Chronicle, Vol 40, No 1, 1986. pp 31-36.	
1985	Berardi, J., Teillet, J., Godard, J., Laloux, V. Allane, P. & Franjou, M.H.	Consequences obstetricales de l'excision feminine.	(1985). Journal de Gynecologie, Obstetrique et Biologie de la Reproduction 14(6): 743-746.	

1985	Boulware-Miller, K.	Female circumcision: challenges to the practice as a human rights violation.	Harvard Women's Law Journal, Vol 8, 1985. pp 155-177	
1985	Cutner LP	Female Genital Mutilation	Obstetrical and Gynecologicl Survey vol. 40, n.7, pagg. 437-43	
1985	Diallo, B.	The dream of domination.	World Health, April 1985. pp 26-28	

1985	Gallo, PG.	Female circumcision in Somalia: some psychosocial aspects.	Genus, Vol 41, No 1-2, 1985. pp 133-147.	
1985	Michaels, E.	Female circumcision: a personal account.	British Journal of Sexual Medicine, December 1985. p 168.	
1985	No authors listed	Excision and infibulation: a painful practice.	Midwives Chron. 1985 Feb;98(1165):46.	

1985	Odebiyi, AI.	Child-rearing practices among nursing mothers in Ile-Ife, Nigeria.	Child: care, health and development, Vol 11, No 5, 1985. pp 325-335.	
1985	Ras-Work, B.	Traditional practices affecting the health of women and children: female circumcision and its effects on health.	Nursing News (ICN), No 44, 1985. pp 13-22.	
1985	Shaw, E.	Female circumcision: Perceptions of clients and caregivers.	(1985). Journal of American College Health 33(5): 193–197	

1985	Toubia, N.	The social and political implications of female circumcision: the case of the Sudan.	In: Women and family in the Middle East: new voices of change, edited by EW Fernea, Texas: University of Texas Press, 1985. pp 148-159.	
1985	Toubia, N.	The social and political implications of female circumcision: The case of Sudan.	In (1985). Elizabeth Warnock Fernea, ed. Women and the Family in the Middle East: New Voices of Change. Austin: University of Texas Press.	
1985	Union Nationale des Femmes du Mali (UNFM).	Seminaire national: a caractere sous-regional sur l'excision, l'avortement, les filles-meres, et l'infanticide: rapport final	Bamako, 21-25 Janvier 1985. 132p.	

1984	Badri, AE.	Female circumcision in the Sudan.	Paper presented at the Conference on Reproductive Health Management in sub-Saharan Africa, Freetown, Sierra Leone, November 5-9, 1984. 1984. 26p	
1984	Bongaarts, J., Frank, O. & Lesthaeghe, R.	The proximate determinants of fertility in sub-Saharan Africa,	(1984). Population and Development Review 10(3): 511–538.	
1984	France, Ministere des Droits de la Femme.	Les mutilations sexuelles en France.	Paris: Ministere des Droits de la Femme, 1984. 231p.	

1984	McFall, J.A. & McFall, M.H.	Disease and Fertility.	(1984). NY: Academic Press.	
1984	McFalls, JA and McFalls, MH.	Female circumcision.	In Disease and fertility, Orlando, Florida: Academic Press, 1984. 455-463.	
1984	McLean, S.	Sexual mutilation of women.	Socialist Affairs, No 3, 1984. pp 56-60.	

1984	Senegal, Ministry of Publich Health.	Report on a seminar on traditional practices affecting the health of women and children in Africa	Senegal: Ministry of Public health, 1984. 253p.	
1983	Baasher, S, Baasher, T and Cook, R.	Traditional practices for women and young children in the Eastern Mediterranean: recent developments.	In: Advances in international maternal and child health, Vol 3, edited by DB Jelliffe and EFP Jelliffe, Oxford: Oxford University Press, 1983. pp 63-89.	
1983	Bourrel, P.	Complications des coutumes et mutilations rituelles chez l'Africain.	Contraception-fertilite-sexualite, Vol 11, No 12, 1983. pp 1351-1358.	

1983	Cloudsey, A.	Women of Omdurman: Life, Love and the Cult of Virginity.	(1983). London: Ethnographica.	
1983	Frank, O.	Infertility in sub-Saharan Africa: Estimates and implications,	(1983). Population and Development Review 9(1): 137–144	
1983	Nelson, J.	Female excision in Africa: "I see very positive things coming".	UNICEF Ideas Forum, No 15, 1983/4. pp 25-26.	

1983	No authors listed	President Moi acts against female circumcision.	People, Vol 10, No 1, 1983. pp 40-41	
1983	Thiam, A.	Women's fight for the abolition of sexual mutilation.	Unesco Features, No 812, 1983. pp 18-25.	
1982	Abdalla, R.H.D.	Sisters in Affliction: Circumcision and Infibulation of Women in Africa.	London: Zed Press 1982	

1982	Agugua, N.E.N. & Egwuatu, V.E.	Female circumcision: Management of urinary complication.	Journal of Tropical Pediatrics 1982 - 28: 248–252	
1982	Assaad, F.	The sexual mutilation of women.	World Health Forum, Vol 3, No 4, 1982. pp 391-394.	
1982	Boddy, J.	Womb as oasis: The symbolic context of pharaonic circumcision in rural northern Sudan,	(1982). American Ethnologist 9(4): 682–98.	

1982	El Dareer, A.	Woman, why do you weep? circumcision and its consequences.	London: Zed Press, 1982. 130p.	
1982	Githieya, M.	Abolition, not civilisation.	Africa Now, September 1982. pp 104-105.	
1982	Hosken, F.P.	The Hosken Report: Genital and Sexual Mutilation of Females,	(1982). Third Revised Edition, Lexington, MA: Women's International Network News	

1982	Rushwan, H.	Female circumcision: present position and future outlook.	Singapore Journal of Obstetrics and Gynaecology, Vol 13, No 1, 1982. pp 3-6.	
1982	WHO World Health Organization.	Traditional practices affecting the health of women and children.	World Health Organization (WHO), Regional Office for South-East Asia. Alexandria, Egypt: WHO, 1982. 362p.	
1981	Adelaja OA.	Final report on position of female circumcision in Nigeria.	WIN News. 1981 Summer;7(3):41.	PIP: Survey data reveal that female genital mutilation (FGM) is being practiced in most Nigerian states, usually on babies and young girls but occasionally during wedding preparations or 7 months into the first pregnancy. Among the few tribes that mutilate women after marriage, husbands carry out the deed. Usually, FGM is performed on a group of girls, but it can also be performed on one girl in her home. The mutilator, who is paid a token fee, uses a knife or a razor. Post-mutilation treatment includes application of a variety of traditional methods. The most usual immediate complication is bleeding but other complications include tearing, septicemia, fistula development, stenosis, delayed second-stage labor, tetanus, urinary obstruction, and dyspareunia. Reasons cited for FGM include tradition, the belief that FGM curbs female promiscuity, and the belief that a baby whose head touches a clitoris during delivery will die. A prominent 1981 newspaper article on the subject reported the view of a physician that the practice ought to be eradicated and the view of a mutilator that it is not likely to be stopped.

1981	Anti-Slavery Society for the Protection of Human Rights.	Appeal for support of the work against female circumcision.	Brixton: Anti-Slavery Society, 1981. 8p.	
1981	Assaad, MB.	A communication gap regarding female circumcision.	In: Health needs of the world's poor women, edited by Blair, PW, Washington, DC: Equity Policy Center, 1981. pp 9-11.	
1981	Egwuatu, VE and Agugua, NEN.	Complications of female circumcision in Nigerian Igbos.	British Journal of Obstetrics and Gynaecology, Vol 88, No 11, 1981. pp 1090-1093	

1981	Henin, R.A.	Fertility, infertility, and sub-fertility in Eastern Africa.	(1981). International Union for the Scientific Study of Population Conference Proceedings, Manila. (pp. 667-697) Liege	
1981	Hosken, F.P.	Female genital mutilation in the world today: A global review.	(1981). International Journal of Health Services 11(3): 415–430.	
1981	Lyons, H.	Anthropologists, moralities, and relativities: The problem of genital mutilations.	(1981). Canadian Review of Sociology and Anthropology 18(4): 499–518.	

1981	Mahran, M.	Medical dangers of female circumcision.	IPPF Medical Bulletin, Vol 15, No 2, 1981. pp 1-3.	
1981	No authors listed	The battle against female circumcision	New Afr. 1981 Sep;:42.	PIP: Most of Nigeria's estimated 50 million females have suffered female genital mutilation (FGM). Those who have escaped FGM either belong to nonmutilating tribes, are members of enlightened families, or have been overlooked for some reason. Nigerian girls who undergo FGM are told that the pain the suffer will be eased when they marry, but they are not told that this will likely occur because sexual intercourse will widen their vaginal opening or else it will be surgically widened. Many who submit their children to this mutilation have no clear idea about why it is called for except to claim that it protects a family's honor by proving virginity. A Yoruba scholar claims that FGM is used in that tribe to reduce a woman's sexual desires so that she will not engage in intercourse during the 18 months she breast feeds her baby (it is believed that sperm migrates to the mother's milk and can make the baby ill). Yoruba husbands have no curb on their sexual pleasure and may marry as many wives as they can afford. Yorubas mutilate girls when they are 2-8 years old. Ibos, on the other hand, mutilate young women when they are preparing for marriage as part of an initiation ceremony. Abohs mutilate women during their first pregnancy in the belief that this aids the safe delivery of the child by protecting it from contact with the "lethal" clitoris during delivery. While some argue for maintaining FGM because it is an African tradition, other harmful customs, such as facial scarification, have been eliminated

1981	Paige, KE et al.	The politics of reproductive ritual.	Berkeley, California: University of California Press, 1981. 380p.	
1981	Passmore Sanderson, L.	Against the Mutilation of Women: The struggle to end unnecessary suffering.	(1981). London: Ithaca Press.	
1981	Sanderson, LP	Against the mutilation of women: the struggle against unnecessary suffering.	London: Ithaca Press, 1981. 117p.	

1981	Sheehan, E.	Victorian clitoridectomy: Isaac Baker Brown and his harmless operative procedure.	Medical Anthropology Newsletter, Vol 12, No 4, 1981. pp 9-15.	
1981	Taban, A.	Circumcision in Sudan.	African Women, No 35, 1981. p 17.	
1980	Assaad, MB.	Female circumcision in Egypt: social implications, current research and prospects for change	Studies in Family Planning, Vol 11, No 1, 1980. pp 3-16.	

1980	Aziz, F.A.	Gynecologic and obstetric complications of female circumcision	Int J Gynaecol Obstet. 1980 May-Jun;17(6):560-3.	Although female circumcision is a mutilating operation and has been illegal in the Sudan since 1945, it is an old tradition and is still performed on about two thirds of Sudanese women. The three types of female circumcision are described and the gynecologic and obstetric complications experienced by 7505 circumcised women are discussed.
1980	El-Saadawi, N and Hetata, S.	The hidden face of Eve: women in the Arab world.	London: Zed Press, 1980. 212p.	
1980	Haile, D.	Law and the status of women in Ethiopia.	Addis Ababa, Ethiopia: UNECWA, 1980. 51p.	

1980	Harrell-Bond, B.	Women's attitudes to circumcision dispute.	West Africa, No No 3296, 1980. pp 1844-1847.	
1980	Hosken, F.P.	Female sexual mutilation: the facts and proposals for action.	Lexington, Mass: Women's International Network News, 1980. 102p.	
1980	Iregbulem, LM.	Post-circumcision vulval adhesions in Nigerians.	British Journal of Plastic Surgery, Vol 33, 1980. 83-86.	

1980	Lecoultre, D, Leyland, G and Hughes, J.	Mutilation.	People, Vol 7, No 1, 1980. p 2	
1980	McLean, S.	Female circumcision, excision and infibulation: the facts and proposals for change.	London: Minority Rights Group, 1980. 20p.	
1980	Morgan, R and Steinem, G.	The international crime of genital mutilation.	Ms, March 1980. pp 65-67, 98-100.	

1980	Rushwan, H.	Etiologic factors in pelvic inflammatory disease in Sudanese women.	American Journal of Obstetrics and Gynecology, Vol 138, No 7, Part 2, 1980. pp 877-879.	
1980	Rushwan, H.	Etiologic factors in pelvic inflammatory disease in Sudanese women.	(1980). American Journal of Obstetrics and Gynecology 138: 877–879.	
1980	University of Khartoum, Faculty of Medicine.	Epidemiological study of female circumcision in the Sudan. Form 1 Questionnaire on female circumcision.	Khartoum: Khartoum University Press, 1980. 22p	

1980	University of Khartoum, Faculty of Medicine.	Epidemiological study of female circumcision in the Sudan. Form 2 Questionnaire on female circumcision	Khartoum: Khartoum University Press, 1980. 10p	
1979	Baasher, T	Psychological aspects of female circumcision in Traditional Practices Affecting the Health of Women and Children.	(1979). Alexandria, Egypt: World Health Organization.	
1979	Belsey, M.A.	Biological factors other than nutrition and lactation which may influence natural fertility: Additional notes with particular reference to sub-Saharan Africa.	(1979). In Henri Leridon and Jane Menken (eds.), Natural Fertility. Liege: Ordina Editions.	

1979	Brisset, C.	Excision condemned [At the Meeting on Traditional Practices affecting the Health of Women, Khartoum, Sudan, February 10-15, 1979].	People, Vol 6, No 2, 1979. p 40.	
1979	Cairo Family Planning Association.	Report of the seminar on bodily mutilation of young females, Cairo, Egypt, October 14-15, 1979.	Cairo: Family Planning Association, 1979. 120p.	
1979	Cook, R.	Damage to physical health from pharonic circumcision (infibulation) of females: A review of the medical literature.	In (1979). Traditional Practices Affecting the Health of Women and Children. Alexandria, Egypt: World Health Organization.	

1979	Franjou, M-H.	Eradicating harmful traditional practices.	People, Vol 6, No 1, 1979. p 28.	
1979	Groult, B.	Les mutilations sexuelles	F Magazine, No 14, 1979. pp 50-59.	
1979	Ibrahim, H.	The Shaiqiya: The Cultural and Social Change of a Northern Sudanese Riverain People.	(1979). Wiesbaden, Germany: Franz Steiner Verlag GMBH.	

1979	Taba, AH.	Female circumcision.	World Health, May 1979. pp 8-13.	
1979	WHO World Health Organization.	Traditional practices affecting the health of women and children: female circumcision, childhood marriage, nutritional taboos etc. Report of a seminar	World Health Organization (WHO), Regional Office for the Eastern Mediterranean., Khartoum, 10-15 February 1979. 1979. 170p.	
1978	Epelboin, S.	L'excision: tradition mutilante ou valeur culturelle?	Paper presented at Congres International des Femmes de Carriere Juridique, Dakar, Senegal, 10-16 Juillet 1978 = 1978. 15p.	

1978	Hosken F.	Women and health: female circumcision.	WIN News. 1978 Autumn;4(4):39-44.	PIP: Documented cases of female circumcision are reported for Malaysia, Indonesia, East and West Africa. Infibulation is reported for East and West Africa. A specific village listing is provided. Female circumcision as practised in African villages is designed to reduce sexual enjoyment. Those girls who refuse the operation are often ostracized. Sunna circumcision, the cutting of the prepuce of the clitoris, is performed with razor blades and knives by old women. In some areas cuts in the vagina are made to make childbearing easier. The result is the opposite. Moslems perform infibulation (fastening the labia majora together) to insure virginity and paternity. In Kenya defenders of the practise of clitoridectomy say its opposers are viewing the situation emotionally from a Western perspective. Changes are typically resisted by men, especially if they are perceived as being determined by outsiders.
1978	Hosken, F.P.	The epidemiology of female genital mutilations.	Tropical Doctor, Vol 8, July 1978. pp 150-155.	
1977	El Din, M.A.-A.G.	The economic value of children in rural sudan.	In John C. Caldwell (ed.), The Persistence of High Fertility, vol. 2.(pp. 617-658). Canberra: The Australian National University. (1977).	

1977	Lowenstein, LF.	Attitudes and attitude differences to female genital mutilation in the Sudan: is there a change on the horizon?.	Social Science and Medicine, Vol 12, No 5A, 1977. pp 417-421.	
1977	Silberstein, A.J.	Circoncision feminine en Côte D'Ivoire.	(1977). Annales de Societé Belge de Médicine Tropicale 57(3): 129–135	
1977	Silberstein, AJ.	Circoncision feminiine en Cote D'Ivoire. [Female circumcision in the Ivory Coast].	Annales de la Societe belge de Medicine Tropicale, Vol 57, No 3, 1977. pp 129-135.	

1976	Gulick, J.	The Middle East: An Anthropological Perspective.	(1976). Pacific Palisades, CA: Goodyear Publishing Co.	
1976	Hosken, F.P.	Genital mutilation of women in Africa.	Pasadena: California Institute of Technology, 1976. 21p. (Munger Africana Library Notes No 36)	
1976	Hosken, F.P.	Female circumcision and fertility in Africa.	Women and Health, Vol 1, No 6, 1976. pp 3-11.	

1975	Bitho, MS et al.	Les accidents de la circoncision et de l'excision en milieu african.	Bulletin de la Societe Medicale d'Afrique Noire de Langue Francaise, Vol 20, No 3, 1975. pp 249-255	
1975	Hayes, R.O.	Female genital mutilation, fertility control, women's roles, and the patrilineage in modern Sudan: A functional analysis.	(1975). American Ethnologist 2(4): 617–633.	
1975	Verzin, J.A.	Sequelae of female circumcision.	(1975). Tropical Doctor 5: 163–169.	

1975	Verzin, JA.	Sequelae of female circumcision.	Tropical Doctor, Vol 5, 1975. pp 163-169.	
1970	Daw, E.	Female circumcision and infibulation complicating delivery	The Practitioner (UK), Vol 204, April 1970. pp 559-563	
1970	Kennedy, J.G.	Circumcision and excision in Egyptian Nubia.	(1970). Journal of the Royal Anthropological Institute 5(2): 175–191.	

1970	Lenzi, E.	Damage caused by infibulation and infertility.	(1970). Acta European Fertility 2: 47–58.	
1969	Nichol, G.	The clitoris martyr.	World Medicine, 6 May 1969. pp 59-65.	
1968	Hudson CN.	African problems in English obstetrics.	Midwives Chron. 1968 Sep;81(968):314-5.	

1967	Shandall, A.	Circumcision and infibulation of females.	(1967). Sudan Medical Journal 5: 178–212.	
1967	Shandall, AA.	Circumcision and infibulation of females: a general consideration of the problem and a clinical study of the complications in Sudanese women.	Sudan Medical Journal, Vol 5, No 4, 1967. pp 178-212.	
1966	Huber A.	Female circumcision and infibulation in Ethiopia	Acta Trop. 1966;23(1):87-91.	ARTICLE IN GERMAN PIP: The practices of female circumcision and infibulation in Ethiopia are discussed. Circumcision consists of excision of the clitoris, in some cases including the labia minorae. The operation is performed by a skilled woman anywhere from shortly after birth to the time of marriage, depending on the tribe. This custom is practiced throughout Ethiopia and has also been reported in other African countries, in Indonesia, Australia, and in some South American countries. In Africa it is not limited to Moslem tribes; tribes of all religions practice the custom. The reason for this practice is ostensibly to reduce the libido of the female and promote sexual purity. Infibulation is also practiced in Ethiopia. This operation is limited to the north and northeast regions of Africa. The labia are cut with a knife to make them bleed and then sewn together, after which the girl is kept immobile. A small opening is left for the excretion of body fluids. This operation is performed during childhood by a skilled woman, usually in conjunction with circumcision. At the time of marriage, defibulation is performed by a skilled woman. The defibulation operation can cause heavy bleeding and infections, especially genital infections, which can multiply quickly and unnoticed in the tissues created by the infibulation. This practice is performed to insure female virginity.

1966	Meuwissen, J. H. J. M.	Human infertility in West Africa.	(1966). Tropical and Geographic Medicine 18: 147–152.	
1966	Mustafa, AZ.	Female circumcision and infibulation in the Sudan.	Journal of Obstetrics and Gynaecology of the British Commonwealth, Vol 73, 1966. pp 302-306	
1965	Kenyatta, J.	Initiation of boys and girls.	In Facing Mount Kenya, edited by J Kenyatta, New York: Vintage Books, 1965. pp 130-154	

1964	Barclay, H.B.	Buurri Al Lamaab: A Suburban Village in the Sudan.	(1964). Ithaca, NY: Cornell University Press	
1964	Dewhurst, C. & Michelson, A.	Infibulation complicating pregnancy.	(1964). British Medical Journal 2: 1442.	
1964	Widstrand, C.	Female infibulation	(1964). Studia Ethnographica Upsaliensia 10(Varia I):95–124	

1954	Ammar, H.	Growing Up in an Egyptian Village: Silwa, Province of Assam.	(1954). London:Routledge and Kegan Paul.	
1950	Laycock, H.T.	Surgical aspects of female circumcision in Somaliland.	(1950). The East African Medical Journal 27: 445–450.	
1946	Montagu MF.	Ritual mutilation among primitive peoples	CIBA Symp. 1946 Oct;8(7):421-36.	PIP: Circumcision, or the circular abscission of the foreskin, is a medical practice which has been performed over a wide area of the world. Only the Indo-Germanic peoples, the Mongols, and the Finno-Ugrian-speaking peoples did not ever practice circumcision. The original reason for this practice varies and is generally lost in history. The practice was almost universally performed at or before puberty. The method of performance and reasons, where known, in various parts of the world are discussed. The operation was often of fundamental importance in establishing the social position, rights, and duties of members of the community. Only the Jews are believed to have originated the practice as an hygienic measure. Practices similar to circumcison among males were incision and subincision. Common to all of the mutilatory practices was the evocation of bleeding. A type of circumcision was also practiced on girls at puberty. Incision, artificial defloration and infibulation are in the same category of mutilatory operations.

1938	Worsley, A	Infibulation and female circumcision: A study of a little-known custom	(1938). Journal of Obstetrics and Gynaecology of the British Empire 45: 686–91.	
1937	de Villeneuve, A.	Étude sur une coutume Somalie: Les femmes cousues.	(1937). Journal de la Societé des Africanistes 6: 15–32.	