

BRIEFING
PAPER

IPPF's suite of policy resources includes factsheets, briefing papers and discussion papers that provide evidence-based information, analysis and guidance on key issues related to sexual and reproductive health and rights.

Female genital mutilation (FGM)

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What is female genital mutilation?

Female genital mutilation (FGM) is "the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons."¹

There are four different types of FGM:

- i. The partial or total removal of the clitoris and/or the area surrounding and protecting the clitoris.
- ii. The partial or total removal of the clitoris and the removal of the labia. This is the most common type of FGM and accounts for up to 80 per cent of cases.
- iii. The third type involves the narrowing of the vaginal orifice by

creating a covering seal through the cutting and apposition of the labia. This may be done with or without the removal of all or part of the clitoris. This type of FGM – often called infibulation – constitutes 15 per cent of all procedures.

- iv. The final type involves all other harmful procedures done to female genitalia for non-medical purposes, including pricking, piercing, incision, burning, branding and scraping.²

Traditionally, the procedure is carried out by women with no medical training. Anesthetics and antiseptic treatment are not often used and the practice may be carried out using basic tools such as scissors, knives, scalpels, pieces of glass and razor blades. Iodine or a mixture of herbs is often placed on the wound to tighten

the skin in and around the vagina and stop the bleeding. In recent years, the procedure has been medicalized in some regions and it is carried out in health care facilities by trained health care personnel.

The age at which female genital mutilation is carried out varies from one region to another. It is carried out on infants just a few days old, children, adolescents and, occasionally, on mature women. In some cultures that practise FGM, women are re-infibulated (re-stitched) following childbirth.

IPPF and female genital mutilation

IPPF views female genital mutilation (FGM) as a harmful practice that negates IPPF's vision of a world in which all women, men and young people have access to the information and services they need; a world in which sexuality is recognized as a natural and precious aspect of life and as a fundamental human right; a world in which choices are fully respected and where stigma and discrimination have no place.

FGM is a crime against the human rights of women. By denying women and girls equal sexual expression and pleasure, it reinforces the subordination and victimization of girls and women, and is directly linked to poor sexual and reproductive health. FGM raises the question of basic rights of women and girls, such as equality of opportunity, full citizenship and the right to health, including sexual and reproductive choice. FGM is an act of violence that, while often justified by tradition, culture or religion, serves only to support patriarchal dominance and structures within society and undermines the role of women. FGM ignores a woman's or girl's right to privacy and bodily integrity, and directly contradicts the principle of non-discrimination.

Female genital mutilation is a direct violation of a number of sexual rights, which have been identified in Sexual Rights: An IPPF Declaration. These include: article one – the right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender; article three – the rights to life, liberty, security of the person and bodily integrity; article five – the right to personal autonomy and recognition before the law; article seven – the right to health and to the benefits of scientific progress; and article ten – the right to accountability and redress.³ FGM as a violation of human rights is discussed in detail below.

IPPF is driven to achieve its vision through sustained efforts to eliminate FGM. It does this work in close partnership with stakeholders including other service providers and advocates, international organizations, donors, governments, non-governmental organizations and the women, men and young people that we serve.

Origins of FGM and common justifications

Evidence from Egyptian mummies suggests that a form of FGM was routinely practised some 5000 years ago.⁴ In ancient Rome, metal rings were passed through the labia of female slaves to prevent them from procreating. The United Kingdom in the 19th century allowed the surgical removal of the clitoris as an accepted technique for the management of epilepsy, sterilization and masturbation.⁵ In Africa and the Middle East, FGM is thought to have taken root centuries ago. Yet even in those regions, there are some countries where the practice began relatively recently.

Reasons that have been offered to justify FGM are complex and vary according to tribal roots and ethnic traditions. Explanations regarding the utility and purpose of FGM are usually

entrenched in social, economic, cultural and political structures, and the procedure is often accepted without question. Some social justifications that are held by groups that defend the practice include:

- Preservation of virginity and ensuring fidelity
- Identification with cultural heritage
- To mark the transition of girls into womanhood
- Social integration and acceptance, particularly for marriage and family honour
- Hygiene and cleanliness
- Enhancing fertility and infant survival
- Increasing sexual pleasure for the male (the husband)
- Religion

While religious justifications across Christian, Jewish, Muslim and certain indigenous African groups are often used, it must be noted that none of the holy scriptures of Christianity, Judaism or Islam advocate for FGM.^{6,7} El-Saadawi, author of *The Hidden Face of Eve: Women in the Arab World*, writes:

Religion, if authentic in the principles it stands for, aims at truth, equality, justice, love and a healthy wholesome life for all people, whether men or women. There can be no true religion that aims at disease, mutilation of the bodies of female children, and amputation of an essential part of their reproductive organs.⁸

A complex interaction of socio-cultural factors exerts pressure on mothers and families not to break the custom of passing the tradition of FGM from generation to generation. Even when parents know the harm that FGM will cause to their child, they feel pressured to keep with tradition as the individual harm (often considered limited and of short duration) is seen as less damaging than the ostracism and social stigma a girl may face within the community if she does not undergo FGM. In communities where FGM is the norm, a girl that has not

undergone FGM may have no chance at social acceptance or marriage. As such, she may pose a lifelong burden to her parents and the choices that are open to her to pursue her aspirations and/or to form her own family will be limited.

In some areas where FGM is practised, it has been integrated into the health care arena. This medicalization of the practice is likely a result of the emphasis that campaigners have placed on the negative health implications of FGM. This has occurred in several countries, including Egypt, Ethiopia, Kenya, Nigeria and Senegal. Medicalization of the procedure is particularly common in Egypt, where up to three quarters of FGM procedures are performed by trained medical personnel. Even in rural Upper Egypt, where FGM is performed more commonly by traditional health attendants, the majority are still carried out by health care providers.⁹ While it may reduce the physical health impact, the medicalization of FGM ignores the human rights violations that are inherent in the procedure as well as the social and mental health consequences. Because it may appear to be a positive development, the medicalization of FGM hinders the campaign to end the practice.

IPPF endorses the joint statement of WHO and other United Nations agencies that FGM is an unjustifiable and harmful practice which must be eliminated,¹⁰ and recognizes that an understanding of the above justifications is critical to any work designed to eliminate the harmful practice. In particular, researchers should explore how socio-cultural beliefs about female sexuality, sexual morality and femininity affect women's support of FGM.

Consequences: Poor health, emotional suffering and lost opportunities throughout life

The immediate and long-term health consequences of FGM vary according to the type and severity of the procedure performed. Even if no complications arise, once tissue is removed it can never be replaced, resulting in life-long physical change. Complications are common as many of the procedures are performed by untrained practitioners or family members, without anaesthesia, and using non-surgical and unsterilized implements including razors, knives or broken glass.

Immediate complications include shock, severe pain and haemorrhage, which can lead to death. Swelling can make urination and defecation painful. Healing can take up to eight weeks, or longer, depending on the severity of the procedure. Infections are very common and can lead to fatal septicaemia, tetanus or gangrene.

Long-term or delayed complications can occur at any time in the life of a woman who has been mutilated. These complications include severe pain and tenderness over the scar tissue, which can make sexual intercourse painful, even when the vaginal opening is large enough to allow penetration. Penetration attempts through a narrowed vaginal opening (infibulation, or type three) is extremely painful and may lead to tearing of the skin and internal bleeding, both of which require medical intervention. Painful intercourse and excessive scarring can adversely affect sexual sensitivity and pleasure, and can negatively impact a girl's psychological and psychosexual development.

Recurring infections can cause chronic pelvic and back pain. FGM increases the risk of urinary tract infections which can affect the bladder and kidneys, and may lead to fatal complications. FGM may also result in incontinence, sexual dysfunction and infertility. Irritation and inflammation may result in retention of urine and menstrual blood. Women who have undergone FGM are at higher risk of complications during childbirth, such as obstructed labour, perineal tears, the need for a caesarean section or haemorrhage after giving birth.

Adverse physical consequences are only part of the damage that a girl or woman may suffer as a result of being mutilated. A wide variety of psychological and psychosomatic disorders have been attributed to the practice, including depression and symptoms of impaired cognition that include sleeplessness, recurring nightmares, loss of appetite, weight loss or excessive weight gain, and panic attacks.¹¹ The extent of psychological trauma can be difficult to ascertain as the effects are often subtle and may not be easily diagnosed.

Loss of opportunity is a frequently neglected consequence of the medical and psychological problems ascribed to FGM. FGM and its implications can have a significant impact on a girl's education, resulting in absenteeism, poor concentration, low academic performance and loss of interest.¹² Lost opportunities in education, employment, health and social activity, and the consequences of these lost opportunities, endure long after the mutilation has been carried out, affecting girls and women throughout their lives.

Extent of the problem

WHO estimates that between 100 and 140 million girls and women worldwide are living with the consequences of FGM today.¹³ Every year about three million girls and women, the majority under 15 years of age, undergo the procedure.¹⁴

FGM predominately occurs in 28 countries in Africa and the Middle East; they span a belt running from Senegal on the west coast of Africa to Ethiopia and Somalia in the east, where Egypt juts to the north and Kenya and United Republic of Tanzania extend to the South. Of these 28 countries, nearly half of all FGM occurs in Egypt or Ethiopia. Recent survey data for 18 of these 28 countries show the prevalence of FGM to range from five to 97 per cent of the female population.¹⁵ Some countries on the Red Sea coast, such as Yemen, are known to practise FGM and incidents are also reported in Jordan, Oman, the Palestinian territories (Gaza) and in certain Kurdish communities in Iraq. The practice has been reported among groups in India, Indonesia and Malaysia. Increasing numbers of girls and women who have been subjected to the procedure are seen in Australia, Canada, Europe and the USA, generally among immigrants from countries where FGM is widely practised. It is widely recognized that female genital mutilation is practised by specific ethnic groups, rather than by whole countries, as communities that practise FGM cross national boundaries.

FGM is a violation of women's rights, children's rights, human rights

FGM violates a series of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to bodily integrity, the right to life (in cases where the procedure results in death), and the right to the highest attainable standard of physical and mental health. Given that children are frequently subject to the procedure, FGM also violates the rights of the child. The Convention on the Rights of the Child makes explicit reference to harmful traditional practices, and calls upon all countries to take effective and appropriate measures to abolish them. The eradication of FGM is supported by a number of conventions, and international, regional and national agreements. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (also known as the 'Maputo Protocol') urges governments to combat all forms of discrimination against women, particularly harmful practices that endanger the health and general well-being of women, through legislative and regulatory measures. It asks nations to "commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices."¹⁶ Attempts to eliminate FGM implies compliance with agreements signed in the forums of the United Nations including UNFPA, UNIFEM, WHO and UNICEF, European Union, Inter-African Commission on Traditional Practices and the African Union, among others. Action plans and financial resources – agreed internationally, but particularly

by those 28 countries where FGM is most prevalent – are needed to make progress in ending the practice.

Progress in the campaign to end FGM

For over 50 years, many international and national, governmental and non-governmental, organizations and agencies have established programmes to eliminate FGM. Due to their efforts, many international legal instruments and national legislations now include clauses prohibiting the practice. However, the practice remains highly prevalent in 28 countries across Africa and the Middle East, despite the fact that half of these nations have introduced legislation forbidding FGM. Only four of these countries have brought forward prosecutions.¹⁷ This highlights the need for more than just legislative action.

Recommendations and statements on the elimination of FGM

IMAP statement on the elimination of FGM

In October 2007, IPPF's International Medical Advisory Panel (IMAP) issued a statement on the elimination of FGM. The IMAP statement makes recommendations to IPPF Member Associations on activities they should undertake to eliminate FGM.

As a starting point, Member Associations should conduct research to obtain all available information on the prevalence, dynamics and characteristics of FGM in their own countries. Then, within their specific social and cultural contexts, Member Associations should review their current activities, familiarize themselves with the available

resources to eliminate FGM, and develop strategies to eliminate the practice. IMAP emphasizes that sustained action is necessary to ensure long-term impact.

IMAP specifically advises Member Associations to: train service providers in human rights and the harms of FGM; encourage government and law-enforcing bodies to clarify and enforce existing laws against FGM; and collaborate with governments, NGOs and religious and community leaders to raise awareness of the negative impact of FGM and to dispel relevant justifications or myths about the procedure.

In countries where FGM is practised within immigrant communities, Member Associations should mobilize immigrant communities to be active participants in behaviour change activities, including through the delivery of accurate information and education. Member Associations should involve women in their efforts, in particular female health workers and women community leaders. Men should also be involved in behaviour change activities, as their buy-in and support is equally important to bring about an end to the practice. Member Associations should implement broader reproductive health programmes that include discussions of FGM and promote activities to end the practice, and they should train service providers to use every opportunity to counsel women and their partners on the issue.

In countries where FGM is widely practised, IMAP strongly recommends that Member Associations include FGM-related programming as an integrated part of a comprehensive mix of services. Specifically, Member Associations should train health professionals to provide counselling and care for the physical and psychological complications of FGM, or they should refer clients for specialist care. Counselling for mutilated women (and their partners) should highlight the sexual

and reproductive complications commonly associated with FGM, which they may encounter, before these girls and women have sex for the first time and before they become pregnant. IMAP also advises Member Associations to provide information regarding the risks of childbirth for women who have undergone FGM, and to encourage pregnant women who have undergone FGM to deliver their babies in clinical settings where any complications could be properly managed. Lastly, Member Associations should ensure that a referral system is in place if counselling and care services for girls and women who have undergone FGM are not available at the service delivery point.

All women, including those who have been mutilated, must have access to sexual and reproductive health services, including testing, contraception and education. IMAP advises that all data relating to the prevalence and health consequences of FGM victims should be collected and used in advocacy to support change.

World Health Assembly

The 61st World Health Assembly issued a statement on female genital mutilation in May 2008. The Assembly stated that the outcome documents from a number of international events together form an essential framework for advancing the rights of women and girls and eliminating female genital mutilation. The outcome documents identified by the World Health Assembly are the:

- Beijing Declaration and Platform for Action of the Fourth World Conference on Women (Beijing, 1995)
- the Programme of Action of the International Conference on Population and Development (Cairo, 1994) and their five- and ten-year reviews
- the United Nations Millennium Declaration 2000

- the commitments, relevant to the girl child, made at the United Nations General Assembly special session on children (2002)
- the United Nations General Assembly resolution 60/1 on the 2005 World Summit Outcome

Through the statement on FGM, the World Health Assembly calls on all member states to:

- (1) accelerate actions towards the elimination of female genital mutilation, including education and information necessary for full understanding of the gender, health and human rights dimensions of female genital mutilation;
- (2) to enact and enforce legislation to protect girls and women from all forms of violence, particularly female genital mutilation, and ensure implementation of laws prohibiting female genital mutilation by any person, including medical professionals;
- (3) to support and enhance community-based efforts to eliminate the practice of female genital mutilation, particularly ensuring men's and local leaders' participation in the process to eliminate the practice;
- (4) to work with all sectors of government, international agencies and nongovernmental organizations in support of the abandonment of the practice as a major contribution to attainment of the Millennium Development Goals on promoting gender equality and empowerment of women, reducing child mortality, and improving maternal health;
- (5) to formulate and promote guidelines for the care, particularly during childbirth, of girls and women who have undergone female genital mutilation;

(6) to develop or reinforce social and psychological support services and care and to take measures to improve health, including sexual and reproductive health, in order to assist women and girls who are subjected to this violence.

The full statement is available on the World Health Organization's website at: www.who.int/gb/ebwaha/pdf_files/A61/A61_R16-en.pdf

The World Health Organization's response to FGM

The World Health Organization (WHO) has released several statements condemning the practice of FGM and it continues to campaign for an end to the practice. WHO has reviewed programmes on the eradication of FGM and has published a review on what works and what does not. It has also published a guide to the management of pregnancy, childbirth and the postpartum period in the presence of FGM; a set of training manuals for nurses and midwives, teachers and students; a systematic review of the health implications of FGM; the results of a study in six African countries on FGM and obstetric outcome; and a progress newsletter on the practice. These are available through WHO's website at www.who.int/reproductive-health/fgm

Future directions

While the elimination of FGM continues to be a difficult challenge, progress is occurring. One encouraging trend seen consistently in countries where FGM is practised, for which data are available, is that women aged 15-19 years are less likely to have been subjected to FGM than women aged 20 years and older.¹⁸ Efforts to eradicate FGM must continue and new strategies must be developed in order to end this devastating practice.

Legal approaches to reducing incidents of FGM

While advocating for laws restricting or outlawing FGM may be effective in reducing prevalence of the practice, care must be taken to ensure that legislation does not drive FGM underground or encourage cross-border movement of women from a country where the procedure is illegal to a neighbouring country where it is allowed. Even though anti-FGM laws have some disadvantages, activist and grassroots non-governmental organizations generally agree that a law provides a back up to their work by empowering them with legal support and, ostensibly, the support of their governments.

In countries that enforce laws restricting FGM, it is difficult to find the right balance between enforcement, community education and dialogue.

Education

While the law is important, education is key to the elimination of FGM.

Public education in the broadest sense is vital in producing behaviour change, and is essential to the success of the campaign to end FGM. Education about FGM prevention should be encouraged in schools. Reproduction and FGM related problems should be integrated into science; biology and hygiene lessons; personal, social and gender education;

and religious teachings. Nurses, midwives and doctors, when they are themselves fully aware of FGM and its implications, can facilitate and aid teachers with such education.

Medical education is important both during initial training and in ongoing professional development, as many nurses and midwives are ill-prepared to deal with FGM at the level of prevention, management and counselling. FGM should be included as a specific topic in nursing and midwifery curricula in all countries where FGM is a problem, including migrant populations, so that health providers are sensitive to the needs of clients who have undergone the procedure. Doctors also need adequate information. For example, in Egypt, human sexuality and the functions of the female external genitalia is not taught in medical schools or any other schools or colleges.¹⁹ In countries where FGM is highly medicalized, doctors and nurses are complicit. In these circumstances, relevant professional bodies should implement ethical guidelines and impose penalties on practitioners who violate them. Education on FGM for traditional birth attendants is also essential, especially in resource-poor settings where pregnant women have little or no access to formal health care. Their training should also be periodically re-assessed. Training, updating and supervision currently vary from area to area. Demand and need for training and education should be reviewed in different areas, taking into consideration the prevalence of FGM within the community and with regard to existing health care resources.

FGM practitioners must also be educated about the consequences of their actions and the violation of fundamental human rights that is inherent in the mutilation they inflict. During and after this education is provided, information and resources should be provided to practitioners about other income-generating

activities and jobs so that they can more easily choose not to continue the practice.

Collaboration with public, private and non-governmental stakeholders

In order to develop strong educational strategies, there is a need for collaboration between government bodies, private sector, non-governmental organizations and research institutions, including biomedical and social science researchers who have linkages to relevant communities.

Governments that have made FGM illegal must be held accountable to enforce the law, including developing and developed countries. Civil society has a duty to monitor the implementation of laws and policies that support the eradication of FGM.

Other approaches

Other important strategies to eradicate FGM include: finding alternative sources of income for FGM practitioners; economic and social empowerment for women; the promotion of alternative rites of passage; group discussions and media campaigns aimed at raising awareness; promoting the abandonment of FGM as part of a 'development package' that includes a reduction of poverty and of inequities and inequalities between the sexes; and an increase in access to education and health services. The development of innovative strategies and the scaling up and duplication of proven techniques to reduce FGM could prove enormously valuable in reducing the prevalence of FGM worldwide.

A note on terminology

Female genital mutilation is known by a number of names, including female genital cutting and female circumcision – both of which are not acceptable terms. Neither of these names reflect the true horror and impact of the procedure on the girls and women who are subjected to it.

Additionally, 'female genital cutting' over-simplifies the procedure and it does not encompass the range of methods that may be used to alter female genital tissue. 'Female circumcision' is misleading because it may incorrectly align the procedure with male circumcision, which is a relatively harmless process that has been linked to positive health outcomes.

Some groups argue that female genital mutilation is an inappropriate term as some audiences may infer that the intent to mutilate, which is inherent in the procedure, extends to the cultures and contexts (in which this practice is prevalent) as a whole. Usage of this term has been labeled culturally insensitive, representing a broader sentiment and expression against such cultures and places, including the people that are native to them, where the procedure is carried out. These are incorrect inferences that must be corrected to the greatest extent possible.

Female genital mutilation is the most accurate description of the procedure and thus, this is the term used by IPPF. We anticipate that by using the term 'female genital mutilation' we will broaden and deepen awareness of the procedure and its implications.

Gita Sen says, "The argument of cultural diversity has been effectively used as a screen to justify and perpetuate even the grossest violation of women's humanity."²⁰ Women from developing countries are themselves demanding an end to FGM. They are demanding their human rights.

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IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF aims to improve the quality of life of individuals by campaigning for sexual and reproductive health and rights through advocacy and services, especially for poor and vulnerable people.

Published in December 2008 by
International Planned
Parenthood Federation

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