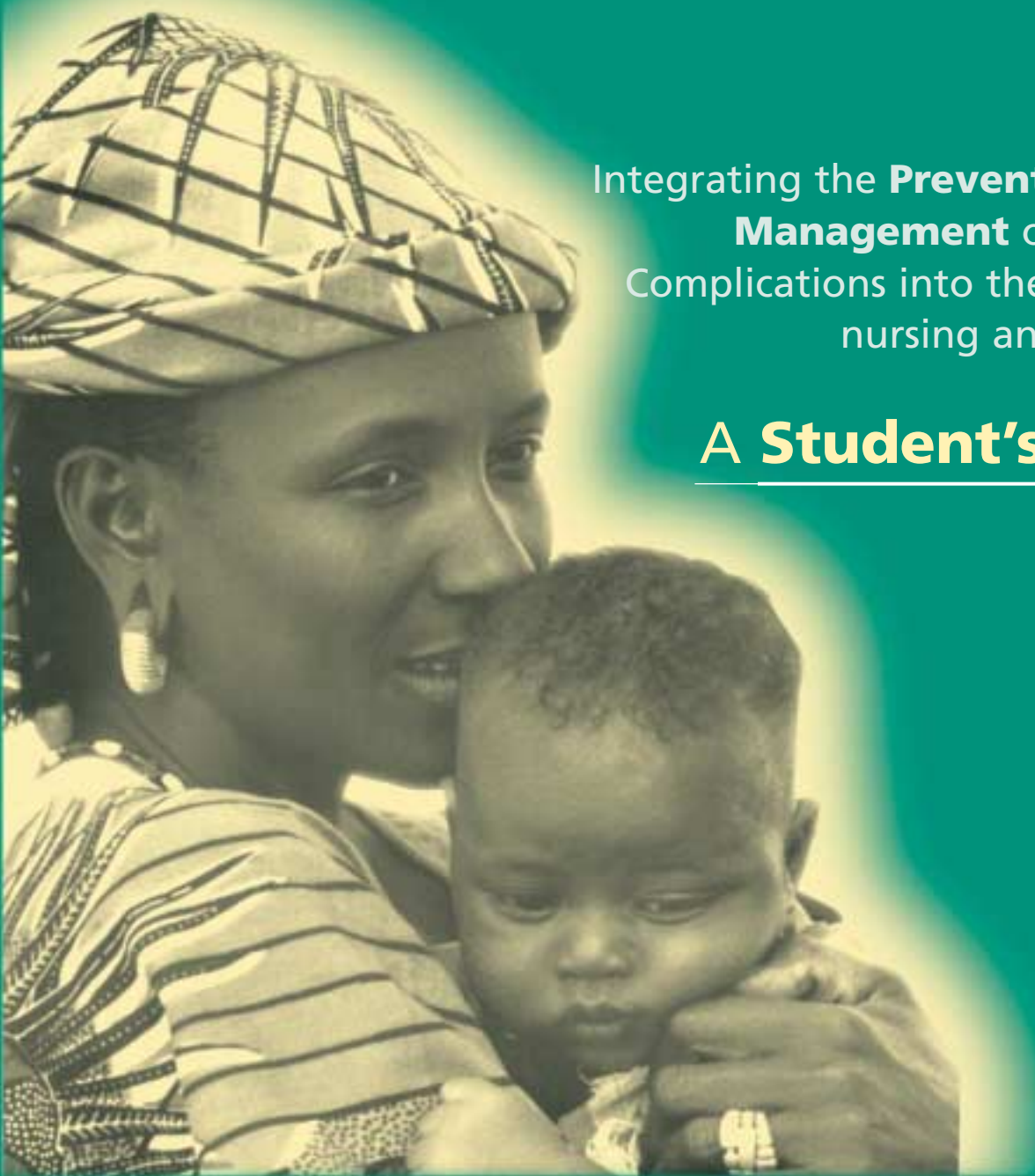


Female Genital Mutilation

Integrating the **Prevention** and the
Management of the Health
Complications into the curricula of
nursing and midwifery.

A Student's Manual



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“Tradition! Tradition!” © Efua Dorkenoo, FORWARD (1992)

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FOREWORD

An estimated 100 to 140 million girls and women in the world today have undergone some form of female genital mutilation, and 2 million girls are at risk from the practice each year. The great majority of affected women live in sub-Saharan Africa, but the practice is also known in parts of the Middle East and Asia. Today, women with FGM are increasingly found in Europe, Australia, New Zealand, Canada and the United States of America, largely as a result of migration from countries where FGM is a cultural tradition.

FGM covers a range of procedures, but in the great majority of cases it involves the excision of the clitoris and the labia minora. At its most extreme, the procedure entails the excision of almost all the external genitalia and the stitching up of the vulva to leave only a tiny opening. Whatever form it takes, FGM is a violation of the human rights of girls and women; and it is a grave threat to their health.

The complications of FGM – physical, psychological, and sexual – require skilled and sensitive management by health care workers, yet FGM is rarely mentioned, let

alone covered in detail, in the training curricula of nurses, midwives and other health professionals. WHO is committed to filling these gaps in professional education by producing a range of training materials to build the capacity of health personnel to prevent and to manage the health complications of FGM.

These materials are dedicated to all the girls and women who suffer – very often in silence – the personal violation and pain of FGM, and to those committed to their care and the relief of their suffering. Though much has been achieved over the past two decades in lifting the veil of secrecy surrounding FGM, there is still an enormous amount to be done to provide quality services to those affected, and to prevent other little girls and women from adding to their numbers. It is hoped that bringing FGM into mainstream education for health professionals will increase the pressure for elimination of the practice, while at the same time throwing out a lifeline to those who have felt isolated with their problems for so long.



Dr Tomris Türmen

Executive Director

Family and Community Health

World Health Organization, Geneva

INTRODUCTION

This manual has been prepared for use by students in response to needs expressed in a proposal on female genital mutilation (FGM) in which nurses and midwives expressed the need to acquire knowledge and skills to prevent FGM, and to be able to manage girls and women with FGM complications.

The manual provides students with strategies for involving individuals, families, communities, and political leaders in the prevention of FGM. It prepares students to manage clients with FGM during pregnancy, childbirth, and the postpartum period, by providing a step by step guide to assessment, counselling, referral, and the opening of type III FGM.

Who is the manual for?

The manual is intended for use primarily by nurses and midwives during basic, post-basic or in-service training. It may also be of use in the education and training of medical students, clinical officers, public health officers, and other health care providers.

How is the manual organized?

The manual consists of four modules. These are as follows:

Module 1:

Provides the foundation for the course. It introduces students to the practices involved in female genital mutilation, and explains how these are influenced by tradition.

Module 2:

Prepares students for working with communities to prevent FGM. The module looks at the different strategies for involving males, females, youth, and community leaders in prevention activities.

Module 3:

Gives nurses and midwives the skills necessary to identify the complications of FGM and to manage girls and women who present with such complications.

Module 4:

Prepares midwives and those involved in caring for women during pregnancy, labour, delivery and the postpartum period. The module provides skills in counselling, opening up of type III FGM, and the management of other complications due to FGM.

Each module starts with an introduction to the issues covered; it then describes the general objectives of the module, the essential skills to be acquired, and provides information on the reference materials to be used.

Each module is divided into separate sessions, or lessons. Learning resources, including videos, books, pamphlets etc. are identified, and a full list appears in the appendix. These are however only intended as guidance – students are advised to make use of whatever resources are available locally.

Learning activities

Because FGM is an extremely sensitive subject, it is important that students have the opportunity to share their own experiences, ideas, beliefs and cultural values as much as possible. Besides being an effective method of learning, this helps to reduce anxieties. The sessions in this manual are therefore designed to be participatory. The main teaching and learning activities are:

The lecture –

This is a brief talk, used by teachers to introduce a session or topic, provide new information or summarize

ideas given by students after a group discussion or assignment. However, such talks by teachers will be kept to a minimum to allow greater time for students to participate and share their own ideas.

Small group discussions –

Students divide into groups of six to eight to discuss an issue and come up with a common viewpoint. Students will be given an assignment and time to complete it. They will be required to present their views to the entire class.

Buzz group discussions –

These are brief discussions between two or three students, designed mainly to encourage participation. Students should turn to their neighbours to discuss a given subject for a short time before sharing their thoughts and ideas with the class.

Plenary, or large group discussions –

These are sessions in which the teacher engages the entire class in brain-storming on an issue, or in discussing feedback from small group work.

The summary –

At the end of each session, the classes will be asked to summarize what has been learnt, to see how this matches up to the original objectives. This process will give students the opportunity to seek clarification on anything they have not understood, and to raise further questions on issues covered in the session, if they so wish.

Case studies –

Students may be given the opportunity to share real-life case studies from the community or clinic with others in the classroom. Where this is not feasible, fictional cases will be used for classroom discussion.

Scenarios and situation analysis –

Students will be given case histories, scenarios or situations to analyse. They will be expected to decide how such cases or situations should be managed and to be able to justify their decisions. Students will work singly or in groups on these assignments, but an important part of the exercise will be sharing their analysis with the class.

Role play and drama –

Students may be given a range of roles to play in mini dramas in order to give them insights into different people's situations and points of view regarding FGM. Sometimes these roles will be allocated by the teacher, at other times, students will work together with the teacher on translating stories or actual case studies into dramas that they can act out.

Story telling –

This activity will be used to explore attitudes and values. The modules include stories that illustrate many different aspects of FGM, which the teacher or student can tell to the class.

Simulation games and exercises –

These are make-believe situations in which students are asked to perform a procedure. They are an effective means of learning skills. In each module there is an indication of where simulation games and exercises may be used.

Demonstration and return demonstration –

This is a very important part of the learning process. Teachers will demonstrate essential skills to students, after requesting them to observe carefully. Selected students will then be asked to demonstrate what they have observed (return demonstration). This is the time for clarification of any uncertainties, and

student are encourage to ask questions. They will then be given an opportunity to practice the skills in the clinical setting.

Field trips –

These are visits organized by the teacher to communities, youth centres or schools, where students can observe different situations relevant to their training. Guidelines for the field experience will be provided and students will be given projects to write up and present individually or as a group in class.

Clinical practice –

In order for students to learn clinical skills, they will be assigned to a clinic where relevant skills are practiced. They will be supervised by both their teachers and the clinic staff. Objectives for clinical practice and the skills to be learned will be prepared by the teacher.

Assignments –

In each module there are opportunities for students to undertake assignments, either individually or in groups, so that they may practise using their knowledge and skills, and to make sure they understand the work. Feedback is an essential part of every assignment.

Evaluation

In order to evaluate what students have learnt, there is a pre-test exercise at the beginning of each module, and a post-test exercise at the end. However, evaluation would be a continuous process, and the teacher would organize time for questions and answers, for quizzes and peer assessment, at regular intervals, to check the understanding of students.



MODULE 1: INTRODUCTION TO FEMALE GENITAL MUTILATION

This module is intended to equip students with basic information about female genital mutilation, its health consequences and the cultural traditions that underpin it. It will also look at the ethical, legal and human rights implications of FGM.

General objectives

On completion of the module, students should be able to:

- Give a descriptive definition of FGM.
- Recall the WHO classification of FGM.
- Give the theories behind the origins of FGM.
- Identify the reasons given by communities for practising FGM.
- Describe the range of procedures carried out in a particular country.
- Describe the effects of FGM on the health of girls and woman in the community.

Essential competencies

Students are expected to acquire the following skills from this module:

- knowledge and understanding of the WHO classification of FGM
- knowledge of the prevalence of FGM worldwide and nationally
- knowledge of what is involved in FGM – how the procedure is performed, by whom, to whom, at what ages, under what conditions, and for what reasons
- knowledge of the full range of complications associated with FGM among clients of different ages:
 - physical complications
 - psychosocial complications

- sexual complications
- obstetric complications.

Reference materials

- *Female Genital Mutilation. A Joint WHO/UNICEF/UNFPA Statement.* Geneva, World Health Organization, 1997.
- *A Systematic review of the complications of female genital mutilation including sequelae in childbirth.* WHO/FCH/ WMH/00.2 Geneva (2000).
- *Regional plan of action to accelerate the elimination of female genital mutilation in Africa.* WHO Regional Office for Africa, Brazzaville, 1996 (AFR/WAH/97.1).
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- *Female Genital Mutilation: A Handbook for Frontline Workers.* Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.5 Rev.1).
- *Female Genital Mutilation. Report of a WHO Technical Working Group,* Geneva, 17-19 July 1995. Geneva, World Health Organization, 1996. (WHO/FRH/WHD/96.10)
- *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996)

Regional and national references such as:

- WHO regional strategy for reproductive health.
- National plans of action on the elimination of FGM practice.

The Sessions

Session 1:

Analysing and influencing traditions.

Session 2:

Description and background of FGM.

Session 3:

Complications of FGM.

Session 4:

Professional ethics and legal implications of FGM.

Session 5:

Human rights and FGM.



Session 1: Analysing and influencing traditions

Session objectives

By the end of the session students are expected to:

1. Have a broad understanding of the meaning of “tradition”.
2. Be able to identify traditions which are prevalent in the community.
3. Be able to identify good and bad traditions.
4. Have constructive ideas for how to bring about change.

Key reference

- Dorkenoo, E. *Tradition! Tradition! A story of Mother Earth*. published by FORWARD Ltd., London, 1992.

Introduction

Female genital mutilation (FGM) is a term now generally accepted for the traditional practices that entail injury or removal of part or all of the external genitalia of girls and women. It does not include genital surgery performed for medically prescribed reasons. Prior to the adoption of “female genital mutilation”, the practices were referred to as female circumcision, a term still in common use and preferred by the majority of people in communities where it is practiced.

Defining tradition

Traditions are the customs, beliefs and values of a community which govern and influence people’s behaviour. Traditions constitute learned habits which are passed on from generation to generation. Traditions are often guided by taboos and they are not easy to change. People adhere to these patterns of behaviour, believing that they are the right things to do.

Examining tradition

Traditions can be beneficial, harmful or neutral – i.e. neither beneficial nor harmful. For example:

BENEFCIAL	HARMFUL	NEUTRAL
<ul style="list-style-type: none"> – Breast feeding – Women relieved of work after delivery – Special care and nutritious diet for a newly delivered mother – Puberty rites (without FGM) which prepare adolescents for womanhood 	<ul style="list-style-type: none"> – Lack of autonomy for women in seeking medical care (decision made only by men) – Food taboos for pregnant women and children – Early marriage and early child bearing for girls – Force feeding for babies – Son preference – Priority of access for men and boys in the family to good food (mothers and daughters eat last) – Tribal marks – Female genital mutilation 	<ul style="list-style-type: none"> – Wearing talisman – Putting a piece of thread on the babies’ anterior fontanel to cure hiccups – Wearing charms to keep evil spirits away.

Thinking about harmful tradition

Tradition! Tradition! A Story of Mother Earth, by Efua Dorkenoo, published by FORWARD Ltd., London, 1992.

Once upon a time, there was a kingdom in a faraway country known as the Land of Myrrh. There lived a proud people of great cultural heritage, enriched by deep-rooted and much-treasured traditions. It was tradition, for instance, that the women of Myrrh were one-legged. But one-legged as they might be, a more elegant and self-possessed species of womankind can hardly be imagined.

They had charming flirtatious ways, and an extraordinary gift for beautiful poetry. At the same time they were not without ambitions, and they possessed just the right measure of astuteness necessary to achieve them. And when the occasion demanded it, they could be very aggressive.

One day, the Great Creator sent Mother Earth to the Land of Myrrh to see how the people were getting along. You see, there had been a very bad drought, people were hungry, and naturally the Great Creator was concerned.



And so Mother Earth, disguised as an old woman, visited the Land of Myrrh. She was surprised to notice,

upon her arrival, that the women considered it not only normal, but fashionable, to walk on one leg!

So Mother Earth set about trying to discover the reasons for the strange phenomenon of the one-legged women. This, however, was no easy task. The people she asked gave somewhat confusing answers as to why women were unable to keep their two legs.

Some people told her that if one of the legs of a little girl was not cut off, it would grow and grow, and before you knew where you were, it would become as big as a tree!



Others told her that a woman with both legs was unable to bear a child.

Yet others explained that a woman needed protection from herself; and somehow having one leg cut off helped to ensure this. Mother Earth asked: "In what way?" But she did not receive a satisfactory answer.

However, when she persisted with her question, Mother Earth was told that with two legs a woman would run away and become a prostitute, but with one she would have difficulty!

Some people turned to the religious texts for an answer to Mother Earth's question, and they convinced themselves that it was the Great Creator who had decreed that women would behave better with just one leg.

But there was one very old woman in the Land of Myrrh who could remember how this habit of cutting one leg off every little girl had started. And she told Mother Earth the following story:

“A long time ago”, said the old woman, “in fact three thousand years ago, in the reign of Moussa, the Land of Myrrh was enjoying a period of plenty and there were great festivities.

“Each year, colourful, exotic dance festivals were held to select the person who would be Ruler of the Land. In those days men and women competed equally and the best dancer would be crowned the Ruler of Myrrh.

“For five successive years, Moussa won all the competitions hands down. But in the sixth year, it seemed that the throne was going to be snatched from him. A beautiful woman had appeared on the scene, and it was clear she could dance far better than Moussa.

“Moussa got very worried,” the old woman continued. “He decided something had to be done! In desperation he passed a decree that all women should have one leg cut off. This seemed to solve his problem, for dancing on one leg unsuccessfully put women out of the competition. So Moussa was able to continue his reign for another 20 years.”

This, then, was the old woman’s recollection of how the phenomenon of the one-legged women began. But to generations of the people of Myrrh it was simply tradition, handed down by their ancestors. What is more, it had become the responsibility of women themselves to see to it that all girl children adhered to this tradition!

Mother Earth was fascinated by the story. But she wanted to know whether the old woman thought it was a good practice.

The old woman stood pondering for a while, and then she replied: “I have known of many traditions, some good, some bad – as for this one, I am not sure”.

Then Mother Earth remarked: “But just from looking at you I thought you felt comfortable.”

“Oh no,” said the old woman. “We have so many difficulties carrying out our daily chores with one leg! But everybody was frightened, and dared not discuss this issue.

They all put on a brave face and professed it to be a wonderful tradition!

“Some said you could only be beautiful with one leg! Others claimed you could only be clean with one leg! Many claimed a woman could only be pure with one leg!!!



“And after a while, some women would say: ‘Why should we let the young women off the hook? We have suffered so much being one-legged. Now it is time for young girls to play their part in keeping the tradition going’”

By this time, Mother Earth was curious to know what the men had to say about all this. Was it possible that fathers would be blindly following such a tradition? Surely not!

But the truth, she discovered, was that men could not afford to disapprove of tradition – even bad tradition. They believed it would destroy family honour and dignity, and affect their status in the community. “And after all”, they argued, “who would pay a good bride price for a daughter with two legs?”

Then Mother Earth asked: “But what about the children?” She could imagine them screaming with

fear and pain. Yes, she was told, children would always be children. There were those who screamed and shouted and had to be forced to have the operation for their own good. Most of them, though, wanted to be like their friends and part of the crowd.

Then Mother Earth thought that perhaps the rulers of the land might take a lead in stopping this bad tradition. But alas even they were not prepared to do so! They were afraid of challenging such a deep-rooted tradition.

Meanwhile, the food situation in this drought-stricken land was getting worse and worse. Walking on crutches, the women found it difficult to work the land and to travel far and wide to find richer pastures and foliage for the animals.

But as the situation became more dire, Mother Earth noticed that the people of Myrrh were beginning to question. A few men and women were coming together to discuss what they could do to stop this bad tradition. They had realised the time had come to challenge it, if future generations were to survive these hard times.

As they talked among themselves, they discovered a multitude of myths surrounding the tradition. And as time went on, they gathered strength to challenge the myths and began to plan.



But alas all this time there had been a spy amongst them. Unknown to them, she had betrayed

their plans to the rulers. In return, the rulers had promised that her family would never go hungry.

And so the guards came and took away the ring-leaders. And that was the end of the effort of the people of Myrrh to come together to stop this evil tradition.

And so, children, little girls continue to be mutilated to this day. In fact, it has been going on for so long now that people just take it for granted. They have stopped questioning their tradition!

But come along, children. We have a game of survival to play, and for this we need both our legs. So come along!



Summary interpretation of the story

- Cutting off the leg is comparable with FGM.
- Mother Earth represents all of us with our individual and collective responsibility for the actions of society.
- Mother Earth's exploration of the tradition depended on her ability to relate effectively to the community
 - she asked questions
 - she was non-judgmental
 - she listened empathetically
 - she reflected carefully
 - she used a positive approach.
- Mother Earth motivated people in the community to think again about the tradition.
- At the end, where Mother Earth invites children hearing the story to play a game of survival, indicates that the new generation needs to be educated and motivated to change harmful traditions.

Some constructive approaches to changing a harmful tradition

- Awareness-raising in communities of problems associated with the tradition.
- Community involvement to eliminate the practice.
- Education of health care workers to provide knowledge and understanding of the practice.
- Mobilization of youth, women, elders and leaders to work to eliminate the practice.
- Introduction of by-laws against FGM practice at community level.



Session 2: Description and background of FGM

Session objectives

By the end of this session the students should be able to:

1. Describe the structure and functions of the normal female external genitalia.
2. Recognize FGM in a girl or woman.
3. Give a descriptive definition of FGM.
4. Describe the range of procedures and the conditions in which FGM is carried out in their communities.
5. Recall the WHO classification of FGM.
6. Give the theories behind the origins of FGM.
7. Identify the reasons given by communities for performing FGM.
8. Give estimates of the prevalence of FGM in the countries where it is practiced.

Key references

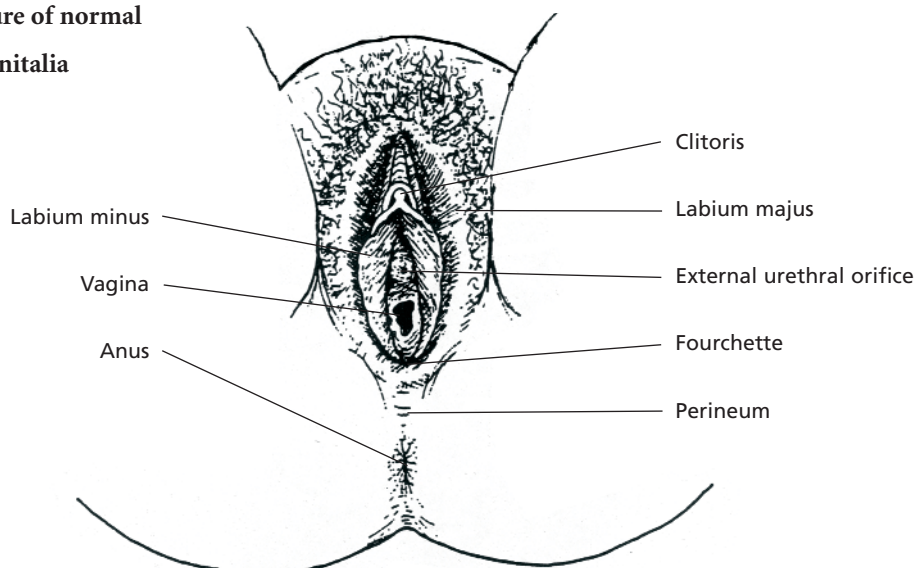
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- *Female Genital Mutilation. An overview.* Geneva, World Health Organization, Geneva, 1998.

- *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996)

Learning activities

- Students are required individually to learn the anatomy and physiology of the female external genitalia.
- As an exercise, student will be required to label a diagram of external female genitalia.

Figure 1.1: Structure of normal external female genitalia



STRUCTURE**FUNCTION**

Skene's and Bartholin's glands	Lubrication of the vagina
Vaginal orifice	Allows escape of the menstrual flow, sexual intercourse and delivery of the baby
Urethral meatus	Allows emptying of the bladder within a few minutes
Clitoris	Assists women to achieve sexual satisfaction
Perineum	Supports the pelvic organs and separates vagina from anus
Labia minora	Protects structures and orifices
Labia majora	Protects the inner structures and orifices

Definition of female genital mutilation

Female genital mutilation (FGM) constitutes all procedures which involve the partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or any other non-therapeutic reasons (WHO, 1995). Prior to the adoption of the term FGM, the practices were referred to as “female circumcision”.

The procedures of FGM

(see Figures 1.2 to 1.6)

FGM is carried out using special knives, scissors, razors, or pieces of glass. On rare occasions sharp stones have been reported to be used (e.g. in eastern Sudan), and cauterization (burning) is practised in some parts of Ethiopia. Finger nails have been used to pluck out the clitoris of babies in some areas in the Gambia. The instruments may be re-used without being cleaned.

The operation is usually performed by an elderly woman of the village specially designated this task, who may also be a traditional birth attendant (TBA). Anaesthesia is rarely used and the girl is held down by a

number of women, frequently including her own relatives. The procedure may take 15 to 20 minutes, depending on the skill of the operator, the extent of excision and the amount of resistance put up by the girl. The wound is dabbed with anything from alcohol or lemon juice to ash, herb mixtures, porridge or cow dung, and the girl's legs may be bound together until healing is completed.

In some areas (e.g. parts of Congo and mainland Tanzania), FGM entails the pulling of the labia minora and/or clitoris over a period of about 2 to 3 weeks. The procedure is usually started by an elderly woman designated this task, who places sticks of a special type to hold the stretched genital parts so that they do not revert back to their original size. The girl is instructed to pull her genitalia every day, to stretch them further, and to add additional sticks from time to time to hold the stretched parts. Usually no more than four sticks are used, as further pulling and stretching would make the genitals unexceptionally long.

FGM includes the following operations: (see the following pages).

Figure 1.2: Normal female external genitalia and female external genitalia with the tip of the clitoris excised (Type I)

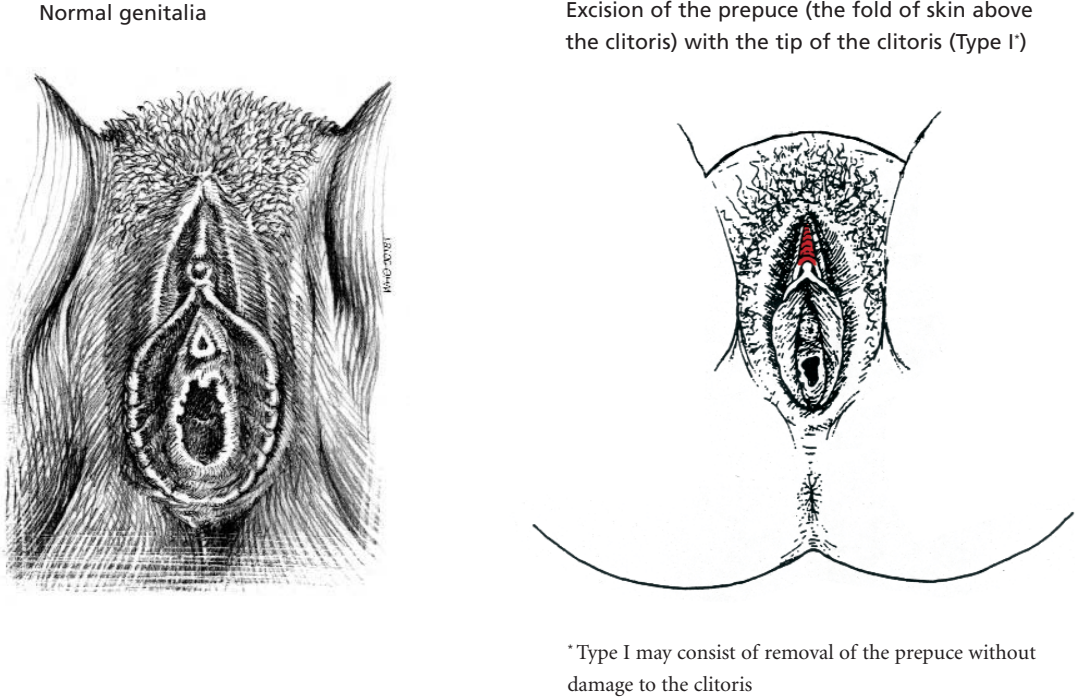


Figure 1.3: Normal female external genitalia and female external genitalia with excision of prepuce and clitoris (Type I)

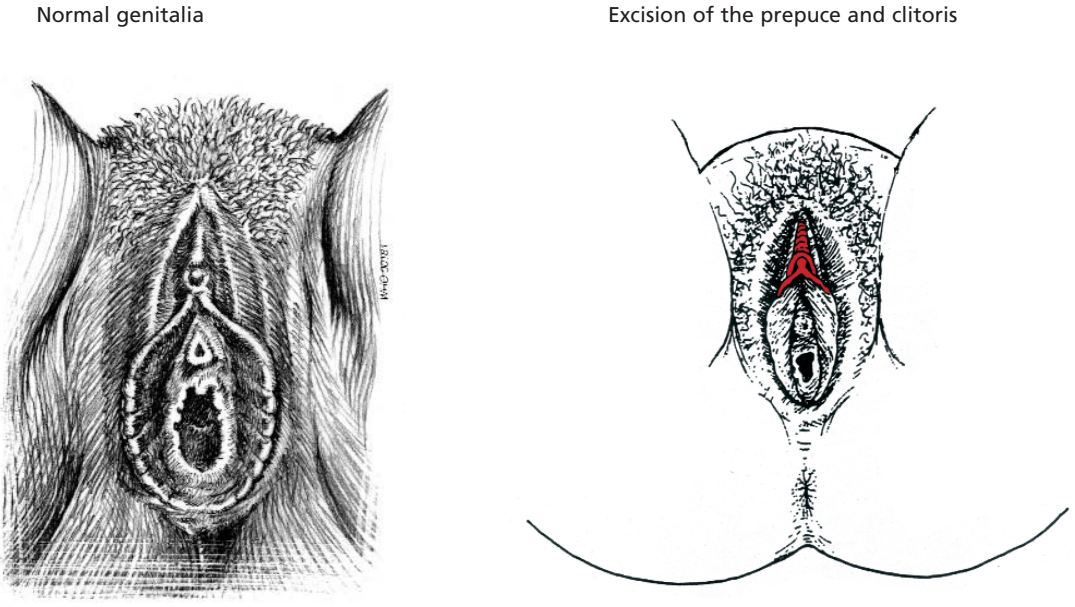
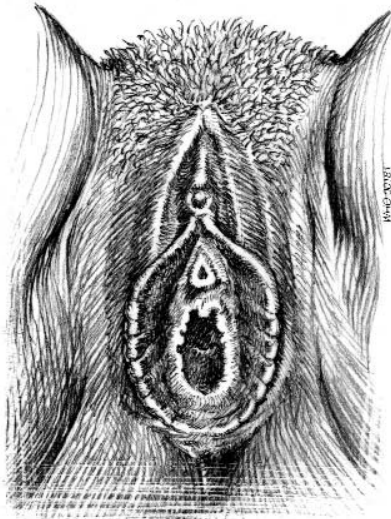


Figure 1. 4: Normal female external genitalia and genitalia with excision of the prepuce, clitoris and labia minora (Type II)

Normal genitalia



Excision of prepuce, clitoris and labia minora

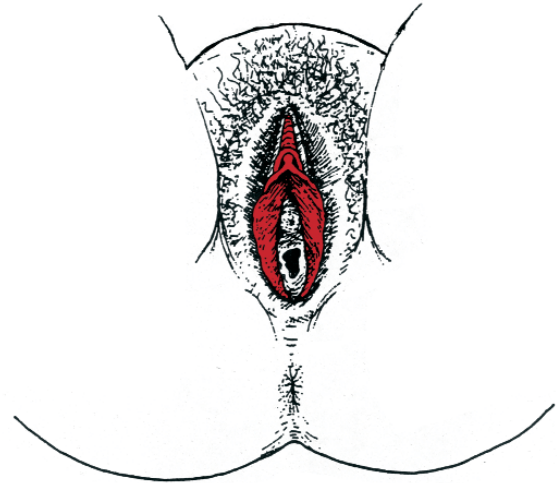
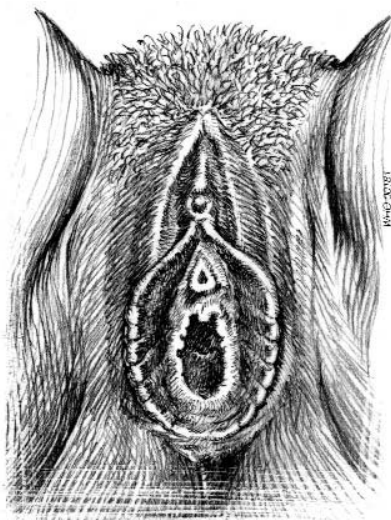


Figure 1.5: Normal female external genitalia and infibulated genitalia (Type III)

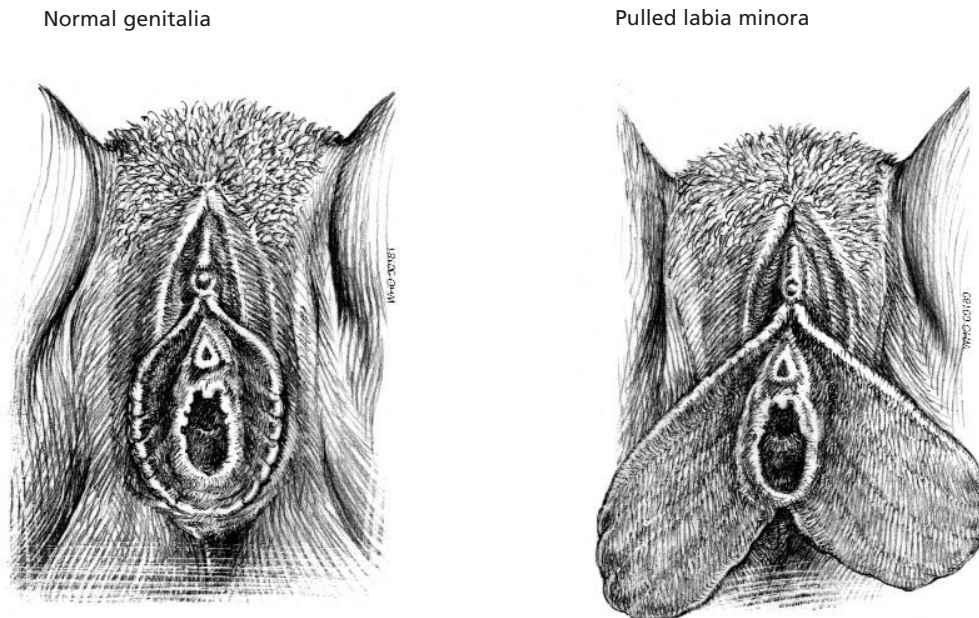
Normal genitalia



Infibulated genitalia



Figure 1.6: Normal female external genitalia and pulled labia minora (Type IV)



World Health Organization classifications of FGM (1995)

- Type I:** Excision of the prepuce with or without excision of part or all of the clitoris.
- Type II:** Excision of the clitoris with partial or total excision of the labia minora.
- Type III:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- Type IV:** Unclassified: Includes pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping of the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding, into the vagina or

for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above.

The age at which FGM is performed

(see Figures 1.7 to 1.12)

The age at which girls are undergo FGM varies widely, depending on the ethnic group or geographical location. The timing of FGM procedure is often flexible even within communities, either because it is not tied to any particular ceremony, or because people's belief in its ceremonial significance has died away. The procedure may be carried out on infant girls, during childhood or adolescence, at the time of marriage, at a woman's first pregnancy, or even whilst in labour.

Figure 1.7: It is performed on babies



Figure 1.9: It is performed on adolescents



Figure 1.8: It is performed on children



Figure 1.10: It is performed on adult women at marriage



Figure 1.11: It is performed on pregnant women

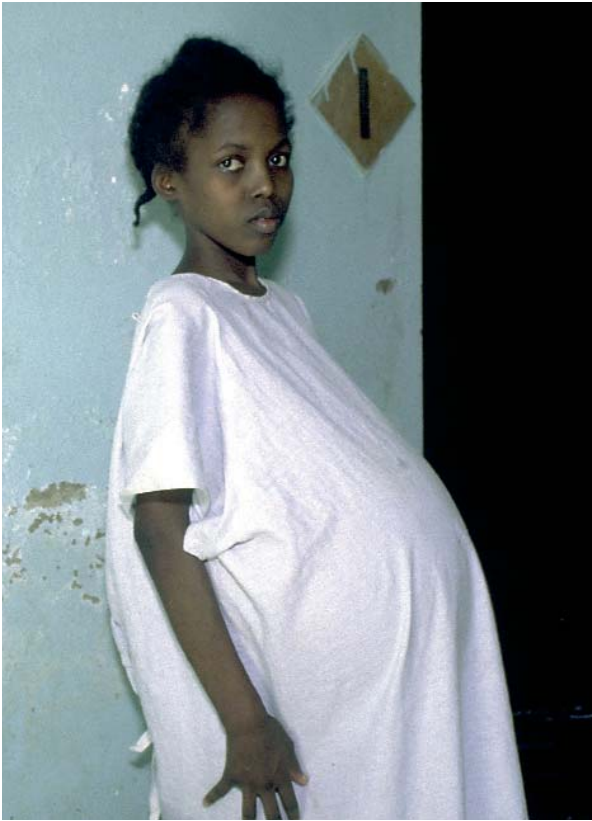


Figure 1.12: It is performed during labour and delivery



The origins of female genital mutilation

- It is not known when or where the tradition of female genital mutilation originated.
- Some people believe the practice started in ancient Egypt.
- Some believe it started during the slave trade when black slave women entered ancient Arab societies.
- Some believe FGM began with the arrival of Islam in some parts of sub-Saharan Africa.
- Others believe it started independently in sub-Saharan Africa, prior to the arrival of Islam, notably among warrior-like peoples.
- Some believe the practice developed independently among certain ethnic groups in sub-Saharan Africa as part of puberty rites.

Who practises FGM?

FGM is practised by followers of different religions – including Muslims, Christians (Catholics, Protestants and Copts), and Animists – as well as by non-believers in the countries concerned.

Reasons for performing FGM

There are a variety of reasons why female genital mutilation continues to be practiced. The reasons given by practising communities are grouped as follows:

- **Socio-cultural reasons.**
- **Hygienic and aesthetic reasons.**
- **Spiritual and religious reasons.**
- **Psycho-sexual reasons.**

Socio-cultural reasons

- Some communities believe that unless a girl's clitoris is removed, she will not become a mature woman, or even a full member of the human race. She will have no right to associate with others of her age group, or her ancestors.

- Some communities believe that a woman's external genitalia have the power to blind anyone attending to her in childbirth; to cause the death of her infant or else physical deformity or madness; or to cause the death of her husband.
- Female genital mutilation is believed to ensure a girl's virginity. Virginity is a pre-requisite for marriage, which is necessary to maintain a family's honour and to secure the family line.
- The societies practising FGM, are patriarchal and largely patrilineal. Women's access to land and security is through marriage, and only excised women are considered suitable for marriage.
- In some communities, FGM is the rite of passage into womanhood and is accompanied by ceremonies to mark the occasion when the girl becomes a mature woman.
- In communities that practise FGM, girls are generally subjected to powerful social pressure from their peers and family members to undergo the procedure. They are threatened with rejection by the group or family if they do not follow tradition.
- Typically, the traditional excisor is a powerful and well respected member of the community, and FGM is her source of income. She therefore has a personal interest in keeping the tradition alive.

Hygienic and aesthetic reasons

- In FGM practising communities, it is believed that a woman's external genitalia are ugly and dirty, and will continue to grow ever bigger if they are not cut away. Removing these structures makes a girl hygienically clean.
- FGM is believed to make a girl beautiful.

Spiritual and religious reasons

- Some communities believe that removing the external genitalia is necessary to make a girl spiritually clean and is therefore required by religion.

- In Muslim societies which practise FGM, people believe that it is required by the Koran. However FGM is not mentioned in the Koran.

It is important to note that neither the Bible nor the Koran subscribe to the practice of FGM, although it is frequently carried out by communities – especially Muslim communities – in the genuine belief that it is part of their religion.

Psycho-sexual reasons

- The unexcised girl is believed to have an over-active and uncontrollable sex drive so that she is likely to lose her virginity prematurely, to disgrace her family and damage her chances of marriage, and to become a menace to all men and to her community as a whole. The belief is that the uncut clitoris will grow big and pressure on this organ will arouse intense desire.
- It is also believed that the tight vaginal orifice of an infibulated woman, or a woman who has had chemicals placed in the vagina in order to narrow it, will enhance male sexual pleasure, in turn preventing divorce or unfaithfulness.
- In some communities it is believed that excising a woman who fails to conceive will solve the problem of infertility.

Who are the excisors?

- In cultures where FGM is the custom, the operation is performed by traditional excisors, commonly elderly women in the community specially designated this task. FGM is sometimes performed by traditional birth attendance and village barbers.

“Medicalization” of FGM

FGM is increasingly being performed in hospitals and in health clinics by health professionals using anaesthetics and antiseptics. The justification is that it reduces the pain and the risks to the victim’s health because the operation is performed hygienically. Health professionals who perform FGM claim that medicalization is the first step towards prevention of the practice, and that if they refuse to carry out an operation, the client will simply have it performed by a traditional excisor in unhygienic conditions and without pain relief.

FGM, whether carried out in a hospital or any other modern setting, is willful damage to healthy organs for non-therapeutic reasons. It violates the injunction to “do no harm”, and is unethical by any standards.

The Prevalence of FGM

It is estimated that 100 – 140 million girls and women have undergone some form of female genital mutilation and that at least 2 million girls per year are at risk of mutilation. Most girls and women who have undergone genital mutilation live in 28 African countries although some live in the Middle East and Asia (see Table 1). It has also been reported to be practiced in India by the Daudi Bohra Muslims. Due to migration of people who follow this tradition, FGM is today seen in Europe, Australia, Canada, and the United States of America.

Table 1. Estimated prevalence of female genital mutilation

Please note: Information about the prevalence of FGM comes from sources of variable quality. This summary has organized the information according to the reliability of estimates.

Most reliable estimates: national surveys*

Country	Prevalence (%)	Year
Burkina Faso	72	1998/99
Central African Rep.	43	1994/95
Côte d'Ivoire	43	1994
Egypt	97	1995
Eritrea	95	1995
Guinea	99	1999
Kenya	38	1998
Mali	94	1995/96
Niger	5	1998
Nigeria	25	1999
Somalia	98-100	1982-93
Sudan	89	1989/90
Tanzania	18	1996
Togo	12	1996
Yemen	23	1997

*Source for all above estimates, with the exception of Somalia and Togo: National Demographic and Health Surveys (DHS); available from Macro International Inc. (<http://www.measuredhs.int>), Calverton, Maryland, USA.

For Somalia, the estimate comes from a 1983 national survey by the Ministry of Health, *Fertility and Family Planning in Urban Somalia*, 1983, Ministry of Health, Mogadishu and Westinghouse. The survey found a prevalence of 96%. Five other surveys, carried out between 1982 and 1993 on diverse populations found prevalence of 99-100%. Details about these sources can be found in reference #3 below.

For Togo, the source is a national survey carried out by the Unité de Recherche Démographique (URD) in 1996 (the reference of the unpublished report is Agounke E, Janssens M, Vignikin K, *Prévalence et facteurs socio-économiques de l'excision au Togo, rapport provisoire, Lomé*, June 1996). Results are given in Locoh T. 1998. "Pratiques, opinions et attitudes en matière d'excision en Afrique". *Population* 6: 1227-1240.

Year refers to the year of the survey, except for Somalia, where years refer to the publication date of the MOH report. Note that some DHS reports are dated a year after the survey itself.

Other estimates

Country	Prevalence (%)	Year	Source
Benin	50	1993	National Committee study, unpublished, cited in ^{1,2}
Chad	60	1991	UNICEF sponsored study, unpublished, cited in ^{1,2}
Ethiopia	85	1885; 1990	Ministry of Health study sponsored by UNICEF; Inter-African Committee study; cited in ²
Gambia	80	1985	Study, cited in ^{1,2}
Ghana	30 [*]	1986; 1987	Two studies cited in ^{1,2} on different regions, divergent findings
Liberia	60 ^{**}	1984	Unpublished study, cited in ^{1,2}
Senegal	20	1990	National study cited in ^{1,2}
Sierra Leone	90	1987	Koso-Thomas O. <i>The circumcision of women: a strategy for eradication</i> . London, Zed Press, 1987.

For published studies, year refers to year of publication. For unpublished studies, it is not always clear whether year refers to year of the report or year of the survey. Where no year is indicated, the information is not available.

¹ Toubia N. 1993. "Female Genital Mutilation: A Call for Global Action" (<http://www.rainbo.org>). (Some figures are updated in the 1996 Arabic version of the document.)

² World Health Organization. 1998. "Female Genital Mutilation. An Overview".

³ Makhlof Obermeyer C. 1999. "Female Genital Surgeries: The Known, the Unknown and the Unknowable". *Anthropology Quarterly*; 13(1): 79-106.

^{*} One study found prevalence ranging from 75 to 100% among ethnic groups in the north; another study in the south found FGM only among migrants; the 30% comes from reference #1.

^{**} A limited survey found that all but three groups practice FGM, and estimated prevalence at between 50-70%; the 60% comes from reference #1.

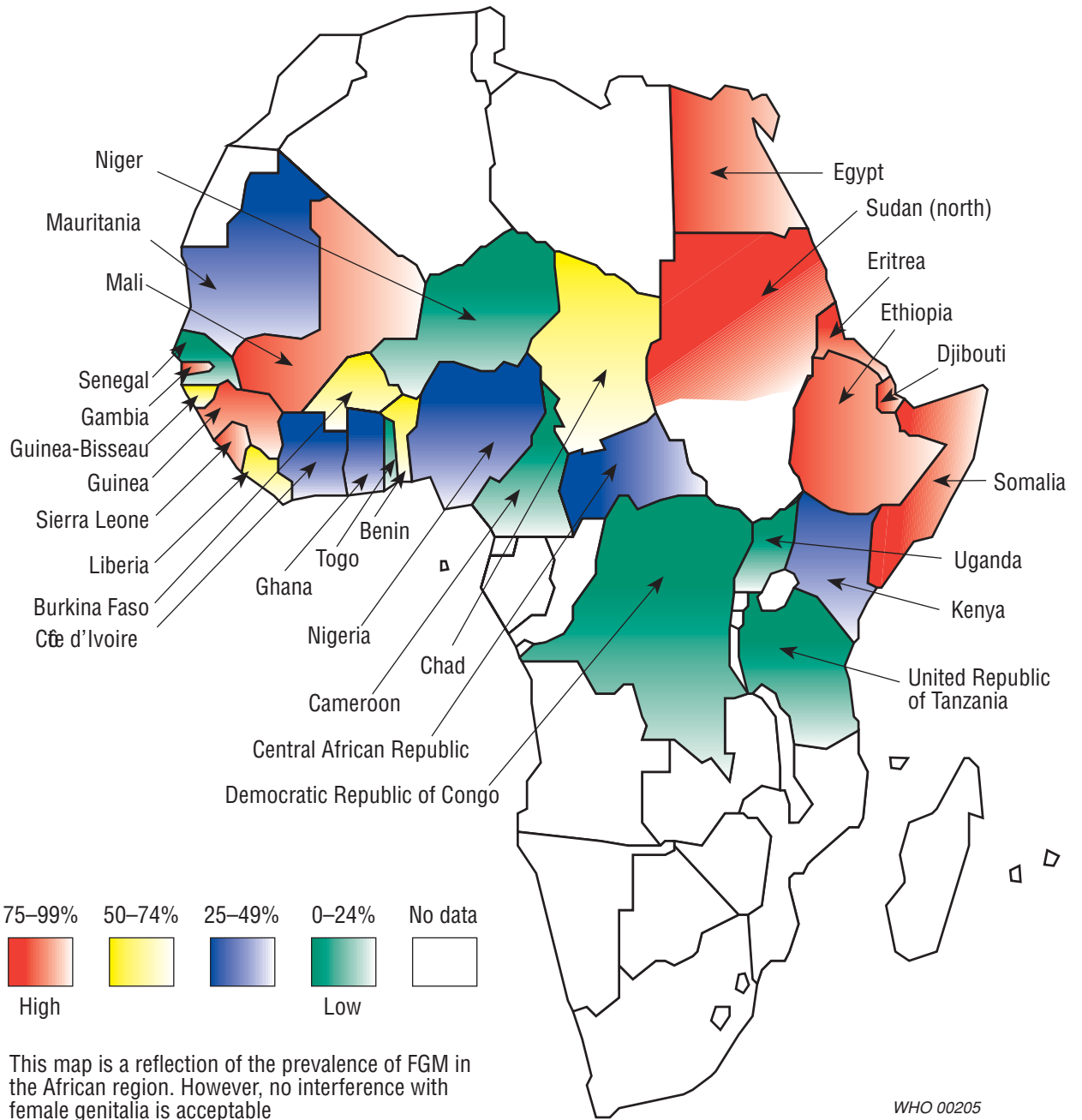
Questionable estimates***

Country	Prevalence (%)
Cameroon	20
Democratic Republic of the Congo	5
Djibouti	98
Guinea-Bissau	50
Mauritania****	25
Uganda	5

***These estimates are based on anecdotal evidence. They are cited in references #1 and 2 above.

****A national survey has been carried out by the DHS and the report is forthcoming.

Figure 2: Estimated prevalence of FGM among female population in African countries



Session 3: Complications of FGM

Session objectives

By the end of the session the students should be able to:

1. Describe the immediate and the long-term physical complications of FGM.
2. Recognise the psychosocial and sexual complications of FGM.
3. Document FGM complications.

Reference materials

- *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).
- *Female Genital Mutilation: A Handbook for Frontline Workers*. Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.5 Rev.1).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives*. WHO/FCH/GWH/01.5. WHO, Geneva (2001)

Introduction

The range of health complications associated with FGM is wide and some are severely disabling (see WHO *Systematic Review of the Health Complications of FGM* under the key references). However, it is important to note that the evidence on the frequency of the health complications is very scanty. Lack of information conceals the extent of FGM and hinders the effort to plan for the health needs of affected communities and to eliminate the practice. At the clinical level, good documentation is necessary for the efficient management of cases, and for providing quality health care and follow up for clients with FGM. As an important note, nurses and midwives should record the presence of FGM, the type and the relevant complication as a matter of routine in the clinical records of health service clients as required by the policy of the health institution.

Physical complications of FGM

The immediate

physical complications include:

- **Severe pain** due to the operation being performed with crude instruments and without anaesthetic. The range of complications associated with FGM is wide. In medical settings where local anaesthetic is available, it is difficult to administer anaesthetic as the clitoris is a highly vascular organ with a dense concentration of nerve endings. Multiple painful injections are required to anaesthetize the area completely.
- **Injury to the adjacent tissue of urethra, vagina, perineum and rectum** can result from the use of crude instruments, or because the operator is ignorant of the anatomy and physiology of the female external genitalia, has poor eyesight or a careless technique, or may be operating in poor light. Such injury is especially likely if the girl is struggling because of pain and fear. Damage to the urethra can result in incontinence.
- **Haemorrhage**. Excision of the clitoris involves cutting the clitoral artery which has a strong flow and high pressure. Packing, tying or stitching to stop bleeding may not be effective and this can lead to haemorrhage. Secondary haemorrhage may occur after the first week as a result of sloughing of the clot over the artery due to infection. Cutting of the labia causes further damage to blood vessels and Bartholin glands. Haemorrhage is the most common and life-

threatening complication of female genital mutilation. Extensive acute haemorrhage or protracted bleeding can lead to anaemia or haemorrhagic shock and in some cases death.

- **Shock.** Immediately after the procedure, the girl may go into shock as a result of the sudden loss of blood (haemorrhagic shock) and experience severe pain and trauma (neurogenic shock), which can be fatal.
- **Acute urine retention** can result from swelling and inflammation around the wound, the girl's fear of the pain of passing urine on the raw wound, or injury to the urethra. Retention is very common; it may last for hours or days, but is usually reversible. This condition often leads to urinary tract infection.
- **Fracture or dislocation.** Fractures of the clavicle, femur or humerus, or dislocation of the hip joint can occur if heavy pressure is applied to restrain the struggling girl during the operation. It is common for several adults to hold a girl down during the mutilation.
- **Infection** is very common as a result of unhygienic conditions; use of unsterilized instruments; the application of substances such as herbs or ashes to the wound, which provide an excellent growth medium for bacteria; binding of the legs following type III female genital mutilation (infibulation), which prevents wound drainage; or contamination of the wound with urine and/or faeces. Infections may prevent the wound healing, and may result in an abscess, fever, ascending urinary tract infection, pelvic infection, tetanus, gangrene or septicaemia. Severe infections can be fatal. Group mutilations, in which the same unclean instruments are used on each girl successively may pose a risk of transmission of blood borne diseases such as HIV and hepatitis B, although there have been no confirmed cases of such transmission to date.
- **Failure to heal.** The wounds may fail to heal

quickly because of infection, irritation from urine or rubbing when walking, or an underlying condition such as anaemia or malnutrition. This can lead to a purulent, weeping wound or to a chronic infected ulcer.

Long-term

Physical complications may include:

- **Difficulty in passing urine** can occur as a result of damage to the urethral opening or scarring of the meatus.
- **Recurrent urinary tract infection.** Infection near the urethra can result in ascending urinary tract infections. This is particularly common following type III mutilation, when the normal flow of urine is deflected and the perineum remains constantly wet and susceptible to bacterial growth. Stasis of urine resulting from difficulty in micturition can lead to bladder infections. Both types of infection can spread to the ureters and kidneys. If not treated, kidney stones and other kidney damage may result.
- **Pelvic infections** are common in infibulated women. They are painful and may be accompanied by a discharge. Infections may spread to the uterus, fallopian tubes and ovaries, and may become chronic.
- **Infertility** can result if pelvic infection causes irreparable damage to the reproductive organs.
- **Keloid scar.** Slow and incomplete healing of the wound and post operative infection can lead to the production of excess connective tissue in the scar (keloids). This may obstruct the vaginal orifice, leading to dysmenorrhoea (painful menstrual period). Following infibulation, scarring can be so extensive that it prevents penile penetration and may cause sexual and psychological problems.
- **Abscess.** Deep infection resulting from faulty healing or an embedded stitch can cause an

abscess, which may require surgical incision.

- **Cysts and abscesses on the vulva.** Implantation dermoid cysts are the commonest complication of infibulation. They vary in size, sometimes growing as big as a football, and occasionally becoming infected. They are extremely painful and inhibit sexual intercourse.
- **Clitoral neuroma.** A painful neuroma can develop as a result of the clitoral nerve being trapped in a stitch or in the scar tissue of the healed wound, leading to hypersensitivity and dyspareunia.
- **Difficulties in menstruation** can occur as a result of partial or total occlusion of the vaginal opening. Such difficulties include dysmenorrhoea and haematocolpos (accumulation of menstrual blood in the vagina). Haematocolpos may appear as a bluish bulging membrane in the vaginal orifice and can prevent penetrative sexual intercourse. It can also cause distension of the abdomen which, together with the lack of menstrual flow, may give rise to suspicions of pregnancy, with potentially serious social implications.
- **Calculus formation in the vagina.** This can occur as a result of the accumulation of menstrual debris and urinary deposits in the vagina or in the space behind the bridge of scar tissue formed after infibulation.
- **Fistulae** (holes or false passages) between the bladder and the vagina (vesico-vaginal) or between the rectum and vagina (recto-vaginal), can develop as a result of injury to the soft tissues during mutilation, opening up infibulation or re-suturing an infibulation, sexual intercourse or obstructed labour. Urinary or faecal incontinence can be lifelong and have serious social consequences.
- **Dyspareunia** (painful sexual intercourse). This is a consequence of many forms of female genital mutilation because of scarring, the reduced vaginal opening and complications such as infection.

Vaginal penetration may be difficult or even impossible and re-cutting may be necessary.

Vaginismus may result from injury to the vulval area and repeated vigorous sexual intercourse; the vaginal opening closes by reflex action, causing considerable pain and soreness.

- **Sexual dysfunction** may affect both partners because of pain and difficulty in vaginal penetration, and reduced sexual sensitivity following clitoridectomy.
- **Problems in childbirth** are common, particularly following severe forms of mutilation, because the tough scar tissue that forms causes partial or total occlusion of the vaginal opening. Difficulties in performing an examination during labour can lead to incorrect monitoring of the stage of labour and fetal presentation. Prolonged and obstructed labour can lead to tearing of the perineum, haemorrhage, fistula formation, and uterine inertia, rupture or prolapse. These complication can cause harm to the neonate (including stillbirth) and maternal death. In the event of miscarriage, the fetus may be retained in the uterus or birth canal.

Psychosocial complications of FGM

Genital mutilation is commonly performed when girls are young and uninformed and is often preceded by acts of deception, intimidation, coercion, and violence by parents, relatives and friends that the girl has trusted. Girls are generally conscious when the painful operation is undertaken as no anaesthetic or other medication is used. They have to be physically restrained because they struggle. In some instances they are forced to watch the mutilation of other girls. This can lead to psychosocial problems. Examples are as follows:

- For some girls, mutilation is an occasion marked by fear, submission, inhibition and the suppression

of feelings. The experience is a vivid “landmark” in their mental development, the memory of which never leaves them.

- Some women have sometimes reported that they suffer pain during sexual intercourse and menstruation that is almost as bad as the initial experience of genital mutilation. They suffer in silence. In Sudan an official day off from work every month is given to women to deal with the menstrual problems.
- Some girls and women are ready to express the humiliation, inhibition and fear that have become part of their lives as a result of enduring genital mutilation. Others find it difficult or impossible to talk about their personal experience, but their obvious anxiety and sometimes tearfulness reflect the depth of their emotional pain.
- Girls may suffer feelings of betrayal, bitterness and anger at being subjected to such an ordeal, even if they receive support from their families immediately following the procedure. This may cause a crisis of confidence and trust in family and friends that may have long term implications. It may affect the relationship between the girl and her parents, and may also affect her ability to form intimate relationships in the future, even perhaps with her own children.
- For some girls and women, the experience of genital mutilation and its effect on them psychologically are comparable to the experience of rape.
- The experience of genital mutilation has been associated with a range of mental and psychosomatic disorders. For example, girls have reported disturbances in their eating and sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, difficulties in concentration and

learning, and other symptoms of post-traumatic stress. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders. Many women suffer in silence, unable to express their pain and fear.

- Girls who have not been excised may be socially stigmatized, rejected by their communities, and unable to marry locally, which may also cause psychological trauma.

Sexual complications of FGM

Sexual problems as a result of FGM can affect both partners in a marriage, from fear of the first sexual intercourse onwards, and create great anxiety.

- Excised women may suffer painful sexual intercourse (dyspareunia) because of scarring, narrow vaginal opening, or obstruction of the vagina due to elongation of labia minora, and complications such as infection.
- Vaginal penetration for women with a tight introitus may be difficult or even impossible without tearing or re-cutting the scar. This may lead to loss of self-esteem and sexual dysfunction.
- Vaginismus may result from injury to the vulval area and repeated vigorous sexual intercourse.
- Inhibition of coitus because of fear of pain may damage the marital relationship and even lead to divorce.

Session 4: Professional ethics and legal implications of FGM

Session objectives

By the end of this session students should be able to:

1. Discuss professional ethics in relation to FGM practice.
2. Discuss the legal implications of FGM.

Learning activities

- Students are required to read the national code of conduct for nurses and midwives and those of international bodies like ICN and ICM.
- As a group exercise, students will be given case studies to read, analyze and respond to the following question:
 - What ethical principles and dilemmas are addressed in the case studies?
 - What actions would you have taken and why?
 - What recommendations should have been given?

Meaning of Professional Ethics

Professional ethics are moral statements or principles which guide professional behaviour. Ethics are not bound to law. For example, nursing ethics include maintaining confidentiality, showing respect for clients as individuals regardless of their cultural background, socioeconomic status or religion.

The ethical implications of FGM

Nurses, midwives and other health personnel are reported to be performing FGM in both health institutions and private facilities. Aside from the economic aspect, the justification given for “medicalization” of the practice is that there is less risk to health if the operation is performed in a hygienic environment, with anaesthetics and infection control.

Furthermore, medicalization offers the opportunity to encourage the less drastic forms of mutilation as a first step toward the elimination of the practice. But whether the procedure is performed in a hospital or in the bush, the fact remains that FGM is the deliberate damage of healthy organs for no medical or scientific reasons.

Performing FGM is a violation of the ethical principles “do no harm” and “do not kill”.

WHO has expressed its unequivocal opposition to the “medicalization” of female genital mutilation, advising that under no circumstances should it be performed by health professionals or in health institutions.

Professional bodies such as the International Confederation of Midwives (ICM), the International Council of Nurses (ICN) and the Federation of Gynecologist and Obstetricians have all declared their opposition to the medicalization of FGM, and have advised that it should never, under any circumstances, be performed in health establishments or by health professionals.

Legal implications of FGM

- The enactment of a law to protect girls and women from FGM makes it clear what is wrong and what is right.
- Having a law in place gives the police, community committees, and health professionals the legitimacy to intervene in cases of FGM.
- Passing laws is not enough on its own to protect girls and women from FGM. There is a danger that the fear of prosecution will inhibit people from seeking help for complications; thus laws must go hand in hand with community education to raise awareness of the harmful effects of FGM and to change attitudes on FGM.
- A law against FGM will only be meaningful if it is put into practice. There are a number of countries which have laws against FGM: some implement them and some do not.

Laws or decrees against practice of FGM

- The following countries have specific laws and decrees against FGM: Burkina Faso, Central Africa Republic, Djibouti, Egypt, Ghana, Côte D' Ivoire, Senegal and Sudan.

- In other countries, national laws make provisions for protection against injury, even if FGM is not specified.
- Laws and decrees have a variety of provisions that can be used to regulate or ban the practice of FGM. They may, for example:
 - Prohibit all forms of FGM (Burkina Faso, Guinea, Côte D' Ivoire, and Djibouti) or only the more drastic types (Sudan).
 - Provide for imprisonment and/or fines for both those who perform the procedure and those who request, incite, or promote excision by providing money, goods, or moral support (Burkina Faso, Côte D' Ivoire, Ghana, Djibouti).
 - Forbid the practice of excision either in hospitals or public or private clinics, except for medical indications and with concurrence of a senior obstetrician. (Egyptian Ministerial decree). The decree also forbids excision from being performed by non-physicians.
 - Prohibit injury that impairs the function of the body (Penal Code, Egypt), cruel and inhuman treatment (Penal Code Guinea), and assault and grievous bodily harm (Penal Code Mali).



Session 5: Human rights and FGM

Session objectives

By the end of this session students should be able to:

1. Learn about how FGM practice violates human rights.
2. Identify international conventions and declarations for the promotion and protection of the health of the child and the woman, including from FGM.

Introduction

Female genital mutilation is a human rights issue because the practice violates the rights of women and children. International human rights conventions oblige Member States of the United Nations to respect and ensure the protection and promotion of human rights, including the rights to non-discrimination, to integrity of the person, and to the highest attainable standard of physical and mental health.

How FGM violates human rights

- The evidence that FGM damages the health of girls and women is well documented. Thus the practice infringes their right to the highest attainable standard of physical, sexual and mental health of women and girls.
- Individuals and organizations working against the practice of FGM bear witness to the fact that the practice is:
 - associated with gender inequalities
 - a form of discrimination against girls and women
 - a form of torture, cruel, inhuman and degrading treatment of girls and women
 - an abuse of the physical, psychological and sexual health of girls and women.

International conventions and declarations relevant to FGM

A number of conventions and declarations provide for the promotion and protection of the health of the child and the woman; some specifically provide for the elimination of FGM. These are as follows:

- **The Universal Declaration of Human Rights (1948)** proclaims the right of all human beings to live in conditions that enable them to enjoy good health and health care.
- **The International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights (1966)** condemns discrimination on the grounds of sex and recognized the universal right of all persons to the highest attainable standard of physical and mental health.
- **The Convention on the Elimination of All Forms of Discrimination against Women (1979)** can be interpreted as obliging States to take action against female genital mutilation which is:
 - to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women (Art. 2.f)
 - to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices, and customary and all other practices which are

based on the idea of the inferiority or superiority of either of the sexes or on stereotypes for men and women (Art. 5.a).

- **The Convention on the Rights of the Child (1990)** protects the right to equality irrespective of sex (Art. 2), to freedom from all forms of mental and physical violence and maltreatment (Art.19.1), to the highest attainable levels of health.
- **The Vienna Declaration and the Programme of Action of the World Conference on Human Rights (1993)**, expanded the international human rights agenda to include gender-based violations which include female genital mutilation.
- **The Declaration on Violence against Women (1993)** states that violence against women must be understood to include physical and psychological violence occurring within the family, including female genital mutilation and other traditional practices harmful to women.
- **The Programme of Action of the International Conference on Population and Development (ICPD, 1994)** included a recommendation on female genital mutilation which commit governments and communities to: “urgently take steps to stop the practice of female genital mutilation and to protect women and girls from all such similar unnecessary and dangerous practices”.
- **The Platform of Action of the Fourth World Conference on Women (1995)** included a section on the girl-child and urged governments, international organizations and non governmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including female genital mutilation.

The regulatory bodies of nurses and midwives and FGM

Each country has a regulatory body for nurses and midwives. In some countries this is a Nurses and

Midwives Council or Board; in other countries it is the Medical Council. Whatever the existing structure, this body has the legal mandate to take appropriate action against a professional nurse or midwife who acts against the standards set for professional conduct.

The International Confederation of Midwives (ICM) and the International Council of Nurses (ICN) are the international regulatory bodies in all matters concerning professional midwifery and nursing respectively. Both the ICM and the ICN have policies against the practice of FGM.

- Female genital organs are vital to the sexual response of women, and cutting or removal of even a few millimetres of highly sensitive tissue results in substantial damage. The experience of mutilation has a lasting impact psychologically, and memory of the pain and trauma remains with girls and women throughout their lives.
- Two of the most important ethical principles of health professionals are:
 - to do no harm, and
 - to preserve healthy functioning body organs at all costs unless they carry a life threatening disease.
- FGM entails the cutting of healthy functioning body organs simply to comply with traditional ritual, and with no medical justification. **It is usually performed on children who have no awareness or power of consent.** Furthermore, the consent of parents or guardians is not valid when the act performed is damaging, rather than beneficial, to the child.
- It is also unethical for a health professional to damage a healthy organ in the name of culture. The argument put forward by health professionals that an operation performed by a skilled person in hygienic conditions poses less risk to health and is therefore less damaging is not valid. Any health professional taking such action would be guilty of misconduct

and liable to disciplinary action being taken against him/her by the regulatory bodies for health professionals. Such action can vary from a warning to removal from the professional register, and denial of a license to practice. Health professionals can also be prosecuted under national laws against FGM.



MODULE 2: COMMUNITY INVOLVEMENT IN THE PREVENTION OF FEMALE GENITAL MUTILATION

This module is intended to prepare nurses and midwives for reaching out to communities for the prevention of FGM. The module consists of knowledge and skills relevant to this task, as well as strategies for involving different community groups, e.g. women, men, youth and children and community leaders.

General objectives

On completion of the module, students should be able to:

- Describe the relationship between beliefs, values, attitudes and the practice of FGM within specific groups of people.
- Recognize the ethical and legal implications of managing girls and women with FGM complications.
- Identify local, national and international organizations working to eliminate the practice of FGM (see list of national groups working against FGM in the reference document *Programmes to Date: What Works and What Doesn't*).
- Work with individuals, families and communities in the prevention of FGM.

Essential competencies

Students are expected to acquire the following skills from this module:

- an understanding of the values, beliefs and attitudes that underpin the practice of FGM and how these are formed
- an understanding of the rules and standards governing professional practice and behaviour in caring for women with FGM
- an understanding of, and ability to apply, ethical,

human rights and legal concepts to FGM prevention and care

- a knowledge of local, national and international organizations working against FGM
- an understanding of the differences between professional regulatory and legal bodies in relation to management of FGM
- an ability to identify key community groups/leaders who will be influential agents for change in FGM prevention
- an ability to develop effective and appropriate strategies in working with groups to bring about change
- an ability to apply information, education and communication (IEC) and advocacy skills when working with communities on the prevention of FGM.

Reference materials

The following materials are recommended for student's additional reading

- *Towards the healthy women counselling guide: Ideas from the gender and health research group*. TDR, WHO, Geneva.
- *Female Genital Mutilation. A Joint WHO/UNICEF/UNFPA Statement*. Geneva, World Health Organization, 1997.
- *Female Genital Mutilation. An Overview*. Geneva, World Health Organization, 1998.
- *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).

- *Female Genital Mutilation. Programmes to Date: What Works and What Doesn't. A Review.* Geneva, World Health Organization, 1999 (WHO/CHS/WMH/99.5).
- *Female Genital Mutilation. A Handbook for Frontline Workers.* Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.5 Rev.1).
- *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.* Geneva, World Health Organization, 2001 (WHO/FCH/GWH 01.2).

Students are also advised to read more on the following subjects:

- WHO regional strategy for reproductive health.
- Regional plans of action on the elimination of FGM practice.
- National plans of action on the elimination of FGM practice.
- Effective communication.
- Effective advocacy: mass media, campaigns and lobbying.

The Sessions

Session 1:

Beliefs, values and attitudes.

Session 2:

Traditional beliefs, values and attitudes towards FGM.

Session 3:

Strategies for involving individuals, families and communities in the prevention of FGM.

Session 4:

Strategies for involving political and government leaders in the prevention of FGM.

Learning exercises

This module gives students the opportunity, through various exercises, to explore and clarify their own beliefs, values and attitudes, and to appreciate the differences between their values and those of others. Students will also get an opportunity to visit communities to observe the interaction of people in real situations.

The exercises are:

- Value clarification exercises and games.
- Case studies exploring legal, ethical and human rights issues.

Session 1: Beliefs, values and attitudes

Session objectives

By the end of the session students should be able to:

1. Explain what is meant by beliefs, values and attitudes.
2. Discuss the origins of beliefs, values and attitudes.
3. Examine their own beliefs, values and attitudes.

Learning activities

- Value clarification exercises and games.

People are a complex mix of unique characteristics, which include physical characteristics as well as various beliefs, values and attitudes. Traditions are guided by beliefs, and the practice of traditions is based on values and attitudes.

Meaning of beliefs

The dictionary defines a **belief** as a conviction, a principle or an idea accepted as true or real, even without positive proof.

There are many belief systems – including religious beliefs, cultural beliefs, group and individual beliefs.

Examples of beliefs:

- the existence of God.
- the uvula causes coughing and retards the growth of children.
- if the clitoris touches the baby at birth the baby will die.
- if a pregnant woman eats eggs she will deliver a baby with no hair.
- an unexcised woman will have an overactive sex drive.

Meaning of values

The dictionary defines **values** as the moral principles and beliefs or accepted standards of a person or social group. Our values are the criteria

against which we make decisions. We inherit many of our values from our families, but they are also influenced by religion, culture, friends, education, and personal experiences as we go through life.

Meaning of attitudes

The dictionary defines **attitude** as a mental view or disposition. Attitudes are largely based on our personal values and perceptions.

Origins of beliefs, values and attitudes

Beliefs, values and attitudes are formed and developed under a multitude of influences – our parents, families, society, culture, traditions, religion, peer groups, the media (TV, music, videos, magazines, advertisements), school, climate, environment, technology, politics, the economy, personal experiences, friends, and personal needs. They are also influenced by our age and gender.

The development of a value system

A **value system** is a hierarchical set of beliefs and principles which influence an individual or group's outlook on life (**attitude**) and guide their behaviour. A value system is not rigid, but will be subject to change over time, and in the light of new insights, information and experiences.

Steps in the development of a value system

Step 1: Knowing how one should behave, or what is expected of one.

This is the cognitive component.

Step 2: Feeling emotionally about it.

This is the affective component.

Step 3: Taking appropriate action.

This is the behavioural component.

Exploring personal beliefs, values and attitudes

Exercises

The aim of these exercises is to enable students to explore their own values, and to look at them in relation to the different values of other people. The following table clarifies the objectives of each exercise, which is then described in detail below.

EXERCISE	OBJECTIVE
Walking survey	To create awareness that different people look at things differently, and that this is alright
Clarifying personal values	To raise awareness of how we make assumptions about other people's beliefs, values and attitudes, and that our assumptions are not always correct
Name tag and patterns exercises	To assist students to identify their own values, and to appreciate that our values influence the way we deal with clients and communities
Ranking values	To emphasise the fact that our values influence our practice in the way we address FGM issues, and that different ways of doing things may be equally good. We can learn from each other.

“Walking Survey” exercise

This is a group exercise

- Two signs are posted on the wall:
 - Agree.
 - Disagree.
- Read statements from a worksheet below then move to the sign “Agree” or “Disagree” that reflects your opinion.
- Repeat this process with all the statements.
- Representatives from each opinion group will then be asked to explain the reasons behind their choices.
- After the exercise answer the following questions:
 - What was the most striking experience for you when you did this exercise, both as regards to your own reaction to the questions, and that of others in the class?
 - Were you surprised with the responses of your peers?
 - How did you feel when your opinions differed from those of the other students?

LIST OF VALUE STATEMENTS ON FGM

1. FGM improves fertility.
2. FGM prevents maternal and infant mortality.
3. FGM prevents promiscuity.
4. FGM helps the genitalia to be clean.
5. FGM prevents the genitalia from growing.
6. FGM is an essential part of culture.
7. FGM is performed to please husbands.
8. FGM causes health, mental and sexual problems for girls and women.
9. Type 1 FGM does not lead to any complications; it is therefore acceptable.
10. Performing FGM in a hospital environment is more hygienic and less painful for the client.
11. Type IV FGM is harmless; people should be allowed to continue.
12. FGM is not a health issue.
13. FGM is a violation of human rights.
14. FGM is a religious obligation.

Value clarification

Value clarification is a process that helps one identify the values that guide one's actions by examining how one feels about a range of different behaviours, thoughts, and objects.

Value clarification is an important exercise since individuals are largely unaware of the motives underlying their behaviour and choices.

Each person develops a unique set of values and attitudes that guides them through life and gives them their cultural identity. By understanding our own values and how they were formed, we as health care providers can appreciate and respect the experiences that shape the values and belief systems of the communities with which we work.

The process of valuing

Before being able to clarify one's values, one must understand how the process of valuing occurs in individuals. Behaviour scientists suggest the following steps:

1. One chooses the value freely and individually.
2. One chooses the value from among a range of alternatives.
3. One carefully considers the consequences of the choice.
4. One cherishes or prizes the value chosen.
5. One incorporates the value into behaviour so that it becomes a standard.

Exercise

This exercise is performed by pairs of students

- Students will be asked to pair up, and the partners to sit facing each other but not speaking.
- Each student will be asked to do the following in turn:
 - List three activities they think their partner would be most interested in doing after the session.
 - Rank these activities in order of importance to the partner.
 - List three activities they themselves would be most interested in doing after the session.

- Each student will be asked to read out the list she has made on behalf of her partner.
- Then the partner will be asked to read out the list she has made for herself. This process will continue until everyone has shared his or her lists.

You may or may not find that the list you have made of your partner's interests is correct. The process of hearing someone else identify your interests may also elicit a range of feelings. You may, for instance, feel judged or misjudged.

If you had difficulty identifying a fellow student's real interests, think how much more likely you are to be mistaken in identifying the needs and problems of clients about whom you may know very little. Or in identifying the needs of a community of which you are not a member.

This activity will have demonstrated how difficult it is to make correct assumptions about someone else's interests. It underlines the fact that there has to be dialogue; as well, one should keep an open mind to really understand the beliefs and values of other people.

Name tag exercise

Instructions to students:

1. Take a piece of paper and write your name in the middle of it. In each of the four corners of the page, write your responses to these four questions:
 - What two things would you like your colleagues to say about you?
 - What is the single most important thing you do (or would like to do) to make your relationship with clients positive?
 - What do you do on a daily basis that shows that you value your health?
 - What are the three values you believe in most strongly?
2. In the space around your name, write at least six adjectives that you feel best describe you.

- _____ Teaching community about the need to eliminate FGM.
- _____ Being honest in answering clients questions.
- _____ Seeing that community acts on professionals advise.
- _____ Helping to decrease a client's anxiety in relation to FGM complications.
- _____ Making sure that community is involved in decision-making regarding FGM.
- _____ Following legal mandates regarding the practice of FGM.
- _____ Maintaining professional ethics all the time when dealing with clients who have undergone FGM.
- _____ Being in the forefront of efforts to eliminate FGM.

2. Examine the way in which you have ranked these options, and answer the following questions:
- What values can you identify based on your responses in this exercise?
 - How do these values emerge in your behaviour?

Our attitudes, values and beliefs greatly influence the service we provide to clients and to the community regarding FGM. If we try to impose our own attitudes and values on others, it is unlikely we will be effective in our efforts to eliminate FGM .

Our attitudes, beliefs and values are influenced by our cultural beliefs, social background, age, gender, education and other factors in life. We must not impose them on individual clients or communities.

Better understanding of our own values as well as those of our clients will help us, as health professionals, to provide care that is relevant, of high quality, and acceptable to individual clients and communities.

It is worth remembering that:

- Even in a group of people from similar backgrounds, with similar educational levels and professions, there is likely to be a wide range of attitudes and values.
- If health workers can recognize their own biases and understand the roots of their own beliefs, they are more likely to be successful in working with communities.
- Listening to the community and to clients will give health workers a better idea of how best to communicate with them about the dangers of FGM.
- The best ways to find out what someone's real interest are is to talk directly with that person.

We may think that we “see” somebody clearly but this is often not the case. No two people perceive things in exactly the same way.

- Values and attitudes are deeply rooted in the experiences of our lives, and it is not easy to change them. However, it is important to examine our values and attitudes and to make conscious decisions about these which we believe are worth hanging on to, and those which we feel may no longer be valid.
- Only when there is dialogue and openness are people likely to question their beliefs and values and be prepared to change.

Session 2: Traditional beliefs, values and attitudes towards FGM

Session objectives

By the end of this session students should be able to:

1. Discuss how beliefs, values and attitudes influence the practice of FGM.
2. Describe the process of assisting individuals, families and communities to clarify their beliefs, values and attitudes towards the practice of FGM.
3. Describe the process of behaviour change.

Key references

- *Tradition! Tradition! A story of Mother Earth*, by E. Dorkenoo. Published by FORWARD Ltd., London, 1992.
- *The right path to health: Health education through religion. Islamic ruling and female circumcision*. WHO, regional office for Eastern Mediterranean (1996)
- *Female Genital Mutilation: A Handbook for Frontline Workers*. Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.5 Rev.1).

Introduction

As stated earlier, FGM is a deeply rooted tradition. Preceding sessions have enabled students to understand the concept of tradition. This session will give students an opportunity to apply this knowledge when working with individuals, families, and communities for the prevention of FGM.

Beliefs, values and attitudes that support FGM

The practice of FGM is supported by traditional beliefs, values and attitudes. In some communities it is valued as a rite of passage into womanhood (e.g. Kenya and Sierra Leone). Others value it as a means of preserving a girl's virginity until marriage, (e.g. Sudan, Egypt and Somalia). In each community where FGM is practised, it is an important part of the culturally

defined gender identity, which explains why many mothers and grandmothers defend the practice: they consider it a fundamental part of their own womanhood and believe it is essential to their daughters' acceptance into their society. In most of these communities FGM is a pre-requisite to marriage, and marriage is vital to a woman's social and economic survival.

Clarifying health provider's own values

- As a pre-requisite for assisting others to understand their beliefs, values and attitudes in relation to FGM, it is essential for nurses and midwives to understand their own feelings towards the practice.
- By understanding their own values, health professionals can better appreciate and respect the experiences that have shaped the values and belief systems of communities that practice FGM.

Assisting individuals, families and communities to clarify their beliefs, values and attitudes in relation to FGM

- The first step in assisting people to clarify their attitudes towards FGM is to find out from them the reasons why they support it, and what happens to those who do not go through it.

- After they have shared their views, the nurse/midwife can then give information and education on the anatomy and physiology of the female reproductive system; the effects of FGM on women's physical, psychological, sexual and reproductive health, and the possible consequences for childbirth.
- The nurse/midwife should give groups an opportunity to discuss their own experiences of such health problems. She should then relate these problems to the practice of FGM (Often, women who have experienced such problems have not associated them with genital mutilation, but attributed them to God's will or witchcraft).
- The nurse/midwife should help people to identify good practice and dangerous practice, and to understand the implications of FGM on the health of girls and women.

Assisting in the process of change

If people are already at the point of questioning their tradition and desiring change, the health professional should let them decide for themselves how best to stop the practice, and what would be culturally appropriate. For example, communities that value FGM as a rite of passage into adulthood might wish to find other ways of marking or celebrating a girl's transition to adulthood.

In order to assist in this process, the nurse/midwife should:

- Identify influential people in the community who may be able to act as change agents.
- Support community members in the process of devising their own, culturally appropriate strategies for change, and in implementing those strategies and monitoring their own performance.
- Give support at all stages of the process and acknowledge positive actions.

Behavioural scientists have demonstrated that in changing any behaviour, an individual goes through a series of steps (see Figure 3 on page 46).

These are as follows:

1. Awareness.
2. Seeking information.
3. Processing the information and "personalizing" it – i.e. accepting its value for oneself.
4. Examining options.
5. Reaching a decision.
6. Trying out the behaviour. Receiving positive feedback or "reinforcement".
7. Sharing the experience with others.

According to this model, someone making the decision to reject FGM – whether that person is a mother, grandparent, father, husband, aunt, teacher, older sister, or a girl herself – will go through a process that starts with realising that rejection of FGM is an option. This will be followed by the person finding such a choice desirable; reaching the decision to reject FGM; figuring out how to put this decision into practice; doing so and seeing what happens; and then receiving positive feedback from others that encourages the person to continue with their stand against FGM. The final stage is when the person feels confident enough in their decision to "go public" with it – i.e. share their reasoning and experience with others, thus encouraging them to follow the example. This is called the "multiplier effect". At every step, and whoever the person is, there is the risk of failure, and individuals must struggle with the personal and wider repercussions of the choice they have made.

Community observation visit

A visit to a community will be organized so that students can attend a community meeting as observers. After the visit they will be required to compile a report for presentation in class.

Figure 3:

STAGES OF BEHAVIOUR ADOPTION

Sharing
information
/multiplier

Receiving positive reinforcement

Trying new behavior

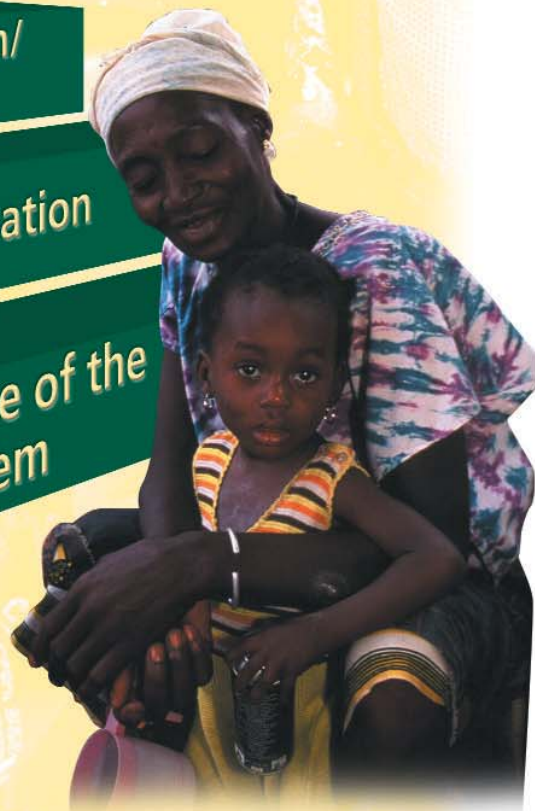
Reaching a decision

Examining options

Processing information/
personalizing

Seeking information

Being aware of the
problem



Student guideline for the community observation visit

Purpose of the visit:

- To observe the interaction between people in a community meeting.
- To identify the traditional beliefs, values and attitudes demonstrated during the meeting.
- To observe how decisions are made.

Questions to guide the observation:

- What was the structure of the meeting? For example, who was present, and who led the meeting?

- What subjects were discussed?
- Who introduced the subjects for discussion?
- Who participated?
- What traditional beliefs, values and attitudes were displayed during the meeting?
- What decisions were made?
- How were they made?
- By whom?



Session 3: Strategies for involving individuals, families and communities in the prevention of FGM

Session objectives

By the end of this session students should be able to:

1. Identify strategies for involving individuals, families and communities in the prevention of FGM.
2. Understand the theory behind communication for behaviour change (CBC).
3. Know how to conduct discussions with various target audiences.

Key references

- *Female Genital Mutilation: A Handbook for Frontline Workers*. WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).
- *Female Genital Mutilation. Programmes to Date: What Works and What Doesn't. A Review*. Geneva, World Health Organization, 1999 (WHO/CHS/WMH/99.5).
- *WHO Film: Female Genital Mutilation - "The Road to Change"*. WHO, Geneva (2000).

Introduction

Involving individuals, families and communities in the prevention of FGM means working with them towards changing their beliefs, values and attitudes towards the practice. The objective is to allow people to reach their own conclusion that change is necessary and thus have a sense of ownership of this decision.

Strategies for involving individuals, families and communities in FGM prevention

The primary objective is to encourage ownership of any decision reached by an individual, a family, a group, or the entire community, to change behaviour regarding FGM.

Health professionals are respected and listened to by individuals, families and communities and have a major role to play in promoting education against FGM. Some are already members of non governmental

groups working to bring about change in their communities on the practice.

You can assist individuals, families and communities in the process of changing their behaviour and practice as regards FGM by:

- integrating education and counselling against FGM into day to day nursing and midwifery practice
- identifying influential leaders and other key individuals and groups within the community with whom you can collaborate and could be used as change agents
- visiting individual people or groups in the community, as appropriate
- establishing small focus groups for discussions. These discussions should be interactive and participatory, allowing the people themselves to do most of the talking
- assisting the people to think through the practice of FGM and its effects on health and on human rights
- identifying resources within the community that could be used in the prevention programme
- suggesting strategies for changing practice, e.g. a culturally acceptable alternative ceremony to mark the rite of passage (Kenya) and teaching women problem solving skills (Tostan, Senegal)
- supporting individuals and families to cope with the problems of FGM and with adjusting to change.

Because of the personal and cultural sensitivity of the subject, it is important that discussions be carefully planned and appropriately conducted. As a general rule, discussions should be held with individuals alone unless and until people are ready to discuss the issue more openly – in family or peer groups, or even with their spouses, for example. Separate discussions should be held with the different target audiences – e.g. youth, men, community elders, women, religious leaders.

Strategies for involving men in the prevention of FGM

- Identify appropriate forums for meeting the target group, e.g. men's organizations, social groups, and make contact with relevant people.
- Use community leaders and other influential people as an entry point.
- Give clear information about the health effects and human rights implications of the practice, and identify and discuss misconceptions.
- Use film shows or posters, as appropriate,
- Encourage everyone to participate in the discussions.
- Assist the men with developing their own strategies for prevention

Strategies for involving women

- Identify appropriate forums for meetings with target group, and make contact with relevant people.
- Give clear information about the health effects and human rights implications of the practice, and identify and discuss misconceptions.
- Use a participatory approach in discussions.
- Address women's lack of power and self-esteem by teaching self-awareness, assertiveness, and problem-solving skills.

Strategies for involving youth

- Identify appropriate forums for meeting with young people, e.g. youth clubs, schools, colleges, and make contact with relevant people.
- Identify appropriate forums for meeting young girls separately, in order to address sensitive issues of direct relevance to them, including teaching basic life skills.
- Give clear information about the health effects and human rights implications of the practice, and identify misconceptions.
- Use a participatory approach.
- Advocate for the issue of FGM to be addressed in school health programmes, and included in the curricula of schools.
- Provide special support to girls who have already undergone FGM.
- Establish peer education (i.e. youth to youth) programmes.

Communication for behaviour change (CBC) is different from communicating simply to impart information, and for this interpersonal skills are specially effective. Interpersonal communication is a process whereby two or more people discuss an issue together to try to reach mutual understanding.

Communicating with target groups

In communicating with the various audiences it is important to:

- **Assess and decide on appropriate ways of communicating.** For example:
 - One-to-one discussions.
 - Group discussions, e.g. with all members of a family; or a youth group.
 - Mass campaign meetings.

- Use of mass media e.g. radio, television, magazines, newspapers, journals.
- Use of drama, dance, song, storytelling.
- **Know your audience** – this means identifying the target group e.g. individuals, family members, women or youth or men’s groups, community leaders; and knowing their background, education level, language, age etc.
- **Find out about the practice of FGM locally.** Ask the individual or group the following:
 - what type of FGM is performed locally?
 - what are the reasons for practising FGM?
 - what problems or complications do people experience during or after the procedure and how are they handled?
 - who performs FGM?
 - what happens to girls/women who do not comply with this tradition?
- **Know your material** – have the information and materials well prepared and readily available.
- **Make contact with appropriate people** to set up meetings – e.g. community and religious leaders; health authorities etc.
- **Create and maintain trusting relationships:**
 - In communicating for behaviour change it is very important to establish a rapport with the target audience.
 - Creating a trusting relationship necessitates showing respect for people’s beliefs and values regarding FGM.
 - Greet people in a culturally accepted manner.
 - Always introduce yourself and others accompanying you.
 - Make sure people are comfortable with you and with the setting before opening a dialogue with them.
- Address people by their names and/or titles according to the accepted norm.
- **Present clear and appropriate information.** This means:
 - Assessing the level of knowledge about FGM in the target audience.
 - Introducing the topic, and the objective of the discussion.
 - Speaking slowly and clearly, using simple but accurate terms. Most people prefer the term “circumcision” to “mutilation” when speaking in English, as the idea that they are “mutilated”, or that their parents or society are “mutilators” can be offensive. The best way to refer to the procedure is to use local terminology.
 - Using posters and pictures to illustrate a point as appropriate, since some people may be illiterate.
 - Selecting the most important messages to be delivered, as too much information may confuse people.
 - Giving out adequate information for reading e.g. posters, leaflets.
 - Ensuring people have understood the most important information.
 - Giving ample time for people to ask questions and clarify points.
 - Informing people where they can find more information if they wish.
 - Inviting individuals with personal questions or those who need counselling to come and discuss things privately.

Session 4: Strategies for involving political and government leaders in the prevention of FGM

Session objectives

By the end of this session students should be able to:

1. Describe the role of local and national governments in the prevention of FGM.
2. Describe the role of international organisations in the prevention of FGM.
3. Identify political and community leaders who can help in the prevention of FGM.
4. Identify and use strategies for involving political and government leaders in the prevention of FGM.

Introduction

The involvement of political and government leaders in the effort to eliminate FGM is very important as they are the major opinion-leaders and decision-makers in society, and are responsible for policy and law making.

Over the last decade, many organizations and individuals have become involved in community-based activities aimed at the elimination of female genital mutilation. These efforts have raised awareness of FGM worldwide and brought the issue to the attention of influential people at all levels of society in the FGM-practising nations, from village leaders to national government ministers. Elimination of the practice depends on the concerted effort of everyone with an interest in protecting the health of women and girls.

The role of governments, national and local organizations in FGM prevention

In countries where FGM is practised:

- some national governments have made a clear and public commitment to eliminate female genital mutilation through laws, professional regulations and programmes, and by signing international declarations that condemn the practice
- some national governments have begun developing policies and plans of action for eliminating the

practise, including setting targets for elimination and developing national-level and district-level indicators for monitoring and evaluating programmes

- there is a move, in some countries where FGM is practiced, towards integrating efforts to prevent female genital mutilation into mainstream health and education's programmes, and towards building partnerships with non-governmental groups and communities in order to bring about change
- the launching, in March 1997, of the WHO African Region's "Plan of Action to Accelerate Elimination of Female Genital Mutilation in Africa" for speeding up efforts to eliminate female genital mutilation has given a boost to national government commitment.

Involving political leaders in the prevention of FGM

- Identify influential people in local and national politics and civic structures: These might include:
 - parliamentarians, who can be encouraged to advocate for laws and policies on FGM
 - women's leaders, youth leaders, heads of professional associations (such as lawyers, physicians, nurses, midwives) who can be encouraged to create pressure groups to lobby government.

- Make contact with relevant people and organise seminars or workshops to inform people of the issues surrounding FGM, e.g. its health consequences, human rights implications.
- Lobby influential people in all relevant forums (e.g. political gatherings, professional conferences) to encourage them to pass laws, develop policies, and become actively involved in efforts to eliminate FGM.

The greater the opposition to FGM among the general public, the more likely governments are to take action to end the practice.

Tips for effective communication

- Clarify your own attitudes towards FGM.
- Know your subject – have the facts clear in your mind as well as the messages you wish to communicate.
- Speak clearly, with confidence and conviction.
- Emphasize and repeat important points.
- Use participatory approach.
- Make the person/people you are addressing believe they are specially important in this campaign and have the power to make a difference.
- Suggest a plan of action and agree on a follow-up date to discuss progress.
- Have determination, patience and never give in to despair, no matter how slow the progress maybe.

Advocacy

Advocacy means speaking up, or making a case, in favour of a specific cause in order to win support for it.

The most important strategies in advocacy are:

- **building coalitions** with people, e.g. NGOs or institutions with similar interest

- **effective use of mass media**
- **working with communities** directly affected.
- **Building coalitions.** Partnership with others active in the same field has several advantages. It allows for the sharing of experience and expertise, and the pooling of resources. Besides, there is strength in numbers. However, working with other groups is a delicate exercise with potential for conflict. It requires patience and sensitivity towards each other's views.

For coalition building, you should:

- identify other individuals or groups interested in stopping the practice of FGM within your community
- fix up a meeting with the leaders to find about their activities – e.g. how they work, who they work with, and what their objectives are – and give information about your organization's activities
- set up collaborative activities.

International organizations working to eliminate FGM include:

- The United Nations Agencies WHO, UNICEF, UNFPA and UNIFEM.
- Inter Africa Committee on Traditional Practices (IAC), FORWARD, RAINBO, PATH, EQUALITY NOW, Amnesty International (A.I.).
- International Federation of Gynecologists and Obstetricians (FIGO).
- International Confederation of Midwives (ICM).
- Medical Women's International Association.
- Africa Midwives Research Network (AMRN).

- **Working with mass media.** Articles published in newspapers or stories broadcast on radio and television spread the message far and wide. Thus building partnerships with media organizations is a valuable exercise. The first task of such a

partnership is to educate relevant people in the media about FGM. Other forms of mass media, such as drama, song, and poster and leaflet campaigns, can also be used to disseminate information, and can be targeted at specific audiences, e.g. youth, women, if desired.

- When working with the media, writing skills may be necessary. Messages should be clear, concise and convincing, and delivered in such a way that they catch the attention of the reader, listener or viewer. Messages should be tested for their effect before being delivered to a wide audience.
- **Working with communities.** Change will only occur when people who practise FGM are convinced of the need for the eliminating it. Therefore working with communities to raise awareness of the issues and educating and informing them is a vital part of any advocacy programme.

Steps in the advocacy process

- *Information gathering and analysis.* Before launching an advocacy programme it is necessary to collect reliable on FGM, including the extent of the practice locally and nationally, who performs it, the rationale for the practice, the age at which excision is performed, and what is known of the health and social consequences. Detailed background information is essential in formulating appropriate messages for the advocacy campaign.
- *Identification of target audiences, and key individuals, for advocacy.*

- *The setting of objectives for each component of the advocacy programme.*
- *The development of an action plan,* identifying the target audiences, the activities to be carried out, their objectives, and who will be responsible for what.
- *Monitoring and evaluation.* The advocacy program must be monitored using clearly developed indicators and objectives.

Lobbying

Lobbying means applying pressure to try to influence people's opinions and actions. It is frequently a slow, painstaking process, requiring great patience and persistence on the part of the lobbyist.

For successful lobbying you should:

- Identify decision-makers and other influential people, and make contact with them. People can be reached through their wives or husbands, relatives, friends, secretaries, or colleagues, where necessary.
- Make sure you are clear about what needs to be done and what role they could play.
- Organize a meeting with them, and use tactics and skills described above to convince them of your case.
- Suitable forums for lobbying include, for example:
 - parliamentary and other political meetings
 - religious gatherings
 - relevant international conferences .

Basic requirements for elimination of FGM

The elimination of FGM is a painstaking process that requires long-term commitment and the laying of a foundation that will support successful behaviour change. That foundation includes:

- strong and capable anti-FGM programmes at the national, regional and local levels
- a committed government that supports FGM elimination with policies, laws and resources
- making FGM a mainstream issue – integrating FGM prevention into all relevant government and non-government programmes, e.g. health, family

planning, education, social services, human rights, religious programmes etc.

- health care providers at all levels who are trained to recognize and manage the complications of FGM and to prevent the practice
- good coordination among governmental and non-governmental agencies
- advocacy that encourages a supportive policy and legal environment for the elimination of FGM, increased support for programmes, and public education
- empowerment of women.



MODULE 3: MANAGEMENT OF GIRLS AND WOMEN WITH FGM COMPLICATIONS

This module is intended to prepare nurses and midwives to identify and to manage the physical, psychosocial, and sexual complications that are consequences of female genital mutilation.

General objectives

On completion of the module, students should be able to:

- Recognize complications due to FGM.
- Manage women with physical, psychosocial and sexual complications due to FGM.
- Demonstrate skills in counselling.
- Demonstrate skills in opening up type III FGM.
- Refer clients for further management when the complications are beyond their competence.

Essential competencies

Students are expected to acquire the following skills from this module:

- ability to carry out an interview with a girl or woman with FGM
- ability to perform physical assessment and identify complications resulting from FGM
- ability to conduct a pelvic examination to determine the type of FGM and physical complications
- ability to adapt family planning methods to ensure effective family planning care to a woman who has undergone FGM
- ability to recognize and provide appropriate information, counselling, support, treatment and/or referral for further management of physical, sexual and psychosocial complications of FGM
- ability to manage the opening up of an infibulated girl or woman, including:

- recognizing that this is necessary;
- making a referral, as appropriate
- providing pre-operative care and counselling
- performing the procedure where appropriate
- managing post-operative care.

Reference materials

The following materials are recommended for student's additional reading

- *Female Genital Mutilation. A Joint WHO/UNICEF/UNFPA Statement.* Geneva, World Health Organization, 1997.
- *Female Genital Mutilation. An Overview.* Geneva, World Health Organization, 1998.
- *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).
- *Female Genital Mutilation. A Handbook for Frontline Workers.* Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.5 Rev.1).
- *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. Geneva, World Health Organization, 2001 (WHO/FCH/GWH 01.2)/
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives.* WHO/FCH/GWH/01.5. WHO, Geneva (2001)
- Toubia, N.A. *A practical manual for health care providers caring for women with circumcision.* RAINBO Publication, New York, 1999.

The Sessions

Session 1:

Assessment to identify physical complications of FGM.

Session 2:

Management of clients with physical complications of FGM.

Session 3:

Using counselling skills.

Session 4:

Identifying psychosocial and sexual problems.

Session 5:

Management of psychosocial and sexual problems.

Session 6:

Demonstrating referral skills.

Session 7:

Family planning use in the presence of FGM.

Session 8:

The procedure of opening up type III FGM.



Session 1: Assessment to identify physical complications of FGM

Session objectives

By the end of this session, students should be able to:

1. Carry out an interview with a client with FGM complications.
2. Carry out a physical examination to identify the type of FGM performed and any complications present.

Key references

- *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).
- *Female Genital Mutilation. A Handbook for Frontline Workers*. Geneva, World Health Organization, 2000 (WHO/FCH/WMH/00.5 Rev.1).
- Toubia, N.A. *A practical manual for health care providers caring for women with circumcision*. RAINBO Publication, New York, 1999.

Introduction

Assessment is a procedure carried out by a service provider to identify any deviations from the normal in the status of the client. Assessment is done using the following senses: seeing, hearing, touching, and smelling. In clients with FGM, assessment of the condition entails:

- interviewing the client by asking relevant questions (**history taking**)
- inspecting the genitalia for appearance (**clinical examination**).

Creating a trusting relationship

For the purposes of history taking and clinical examination, it is crucial that you establish a trusting relationship with clients. This means:

- Showing *empathy* – i.e. using interpersonal skills to create a rapport with client.

- Maintaining *confidentiality*.
- Showing *respect*.
- Having *patience*.

Taking a history

Success in history taking will depend largely on good use of interpersonal communication skills to create a trusting relationship. Women who have undergone FGM will most likely come to a health facility for other health reasons than FGM. The health care personnel has to address the health problems presented. However, there will be need to be alert to the fact that the woman may have undergone FGM. They will have to find out by asking direct or indirect questions.

The procedure is as follows:

- Greet the client in the culturally accepted manner. Ask her to sit comfortably near and facing you. Introduce yourself, and address the client by her name.
- Begin by asking general questions, such as: “How are you? How is the family? Do you have any information you would like to share with me?”
- When the patient is relaxed and seems ready to talk about personal matters, ask her tactfully about any operations she has had, including FGM. Use terminology which is familiar to the client. Ask her if she would like to share any information about the operation and any problems she may have due to FGM; and reassure her that you are comfortable

dealing with her condition and that it is not a barrier to her getting services.

- Let the client express her feelings and give you the information she wants to share. If she starts crying, be patient and give support. Listen carefully and empathize with her. Show concern to the client and let her know you can help her.
- Encourage the client to talk by using facilitation skills, such as nodding, saying “ah, ah”, and making eye contact when you look at her. Clients may be very slow in sharing information about excision; be patient and do not force her to speak. If the client is not ready to share information yet, make an appointment with her for another visit.
- Once it has been established that the woman has undergone FGM, this information and the subsequent clinical examination should be handled with professionalism and discretion.
- The information (the type and the complication observed) should be recorded as required by the policy of the health institution .

The clinical examination

Important note

Examining the genitalia of a woman who has undergone FGM can be very embarrassing for the client. Explaining the procedure slowly, with patience and empathy, respect and confidentiality, will help to build trust. This should be remembered in any situation where examination of genitalia is needed, because one might not have had a detailed discussion with a woman beforehand to know if she had FGM.

In some places, consent from the partner

or husband may be necessary before examining the genitalia of a woman.

The client should be made to feel confident that she is in safe hands, will not be judged and will not be made an object of curiosity or put on display. Women have reported that one of the most traumatic experiences they have had was during a pelvic examination by a health provider unfamiliar with the practice, they were found to be excised; and when the health provider called in the rest of the staff to look at her “mutilated” genitals.

Preparation for a clinical examination includes:

- Preparation of client – i.e. explain the procedure carefully and fully, and get her consent, or that of her partner if applicable:
- Preparation of equipment – it is essential to use sterile equipment and materials.
- The procedure is as follows:
 - Explain procedure to client in detail and check that she has understood.
 - Ask client’s consent to examine her. If there is another member of the health staff present, explain the reason for his/her presence to the client and ask her permission for the person to be present. The client has the right to refuse and this must be respected. The nurse/midwife should emphasize that care is not conditional on the woman’s consent to allow others to attend the examination.
 - Ensure privacy and confidentiality.
 - Instruct the client to take off her underwear and help her to lie down on the examination couch with her legs apart and flexed.

- Expose the necessary area for inspection and examination. Cover the client until you are ready for the examination.
- Wash your hands thoroughly and put on gloves.
- Expose the genitalia. Inspect the external genitalia to identify type of FGM, and to check for ulcers, infection, abscesses, or any abnormal swelling.
- Tactfully ask the client about her experiences of urination, menstruation, and sexual intercourse, if relevant.
- Most of the time there is no need to introduce fingers into the vagina, as most of the complications can be detected by inspection of the external genitalia. But if it is necessary, follow the following steps:
 - Try to introduce the tip of the index finger slowly, then introduce the whole finger very slowly if the introitus allows. If there is room for more than one finger, introduce the second finger very slowly and observe the client's reaction, as this may cause pain.
 - Respect client's reactions.
 - In cases of type III FGM (infibulation) the introitus may be very tight and may not allow the introduction of even the tip of a finger. In such cases, you should not attempt to introduce any fingers.
 - After completing the procedure, thank the client for her cooperation.
 - In cases where you have introduced fingers, look for abnormal vaginal discharge before taking off gloves.
 - Take off gloves and wash your hands.
 - Help the client to a sitting position; assist her with dressing, if appropriate, and seat her comfortably for next step of the procedure.
 - Record your findings and share these with the client.
 - All equipment used should be put to soak in disinfectant for half an hour before sterilization (See WHO International precautions on prevention of hospital infections).



Session 2: Management of clients with physical complications of FGM

Session objectives

By the end of this session, students should be able to:

1. Manage girls and women with physical complication due to FGM.
2. Refer girls and women for further management to the next level of care.

Introduction

Managing physical complications varies from giving simple support, to giving counselling, or to surgical interventions. During her assessment of the client, the nurse/midwife should identify what kind of care is appropriate for her.

Managing immediate and short term complications

Bleeding

Bleeding commonly occurs during or immediately following FGM. The management of bleeding associated with excision is the same as the management of bleeding in any other circumstances. The procedure is as follows:

- Inspect the site of the bleeding.
- Clean the area.
- Apply pressure at the site to stop the bleeding by packing with sterile gauze or pad.
- Assess the seriousness of the bleeding and the condition of the girl or woman.
- If client is in shock (see instructions under **shock**).
- If necessary replace fluid lost. If you are managing the client at a primary level facility, give I.V. fluids, monitor and transfer her immediately to a secondary level facility for blood transfusion if necessary.
- If you are seeing her at a secondary level facility where blood transfusion is not available but is

required because of severe bleeding, transfer her to a tertiary level facility immediately.

- It may be the policy of the health institution to prescribe Vitamin K, especially in the case of babies. If so, take action as required by the policy.
- A traditional compound (e.g. containing ash, herbs, soil, cowdung) may have been applied to the wound, and this can lead to tetanus or other infection. Therefore, you should give tetanus vaccine and antibiotics in accordance with national guidelines.
- If the problem is not serious, clean the site with antiseptic and advise client or attendants to keep it dry. Follow up client to monitor progress by making an appointment for her to return so that you can check her progress.

Severe pain and injury to tissues

Usually pain is immediate, and can be so severe that it causes shock. The management of pain associated with FGM is the same as pain management under any other circumstances. The procedure is as follows:

- Assess the severity of pain and injury.
- Give strong analgesic and treat injury.
- Clean site with antiseptic and advise the client or her attendants to keep it dry.
- If the client is in shock (see instructions under **shock**).
- If there is no relief from pain, refer client for medical attention.

- If injury is very extensive refer client for surgical intervention.

Shock

Shock can occur as a result of severe bleeding and/or pain. The management of shock associated with FGM is the same as the management of shock under any other circumstances. The procedure is as follows:

- Assess the severity of shock by checking vital signs.
- Treat for shock by raising the client's extremities above the level of her head to allow blood to drain to the vital centres in the brain.
- Cover the client to keep her warm.
- If she is having difficulty breathing, administer oxygen.
- Have a resuscitation tray near by.
- Give I.V. fluids to replace lost fluid.
- Check vital signs and record every quarter of an hour (15 minutes).
- If client's condition does not improve, refer her for medical attention.

Infection and septicaemia

Infection may occur as a result of unhygienic surroundings and dirty instruments used to carry out FGM. The management of this condition is as follows:

- Inspect the vulva carefully for signs of an infected wound, and to check for anything that might be contributing to the infection, such as obstruction of urine.
- Take a vaginal swab and a urine sample to test for the presence of infection and to identify the organisms involved. Any obstruction found should be removed
- If the wound is infected, it should be cleaned and left dry. The Client should be treated with antibiotic and analgesic
- Follow up client after 7 days to assess the progress.
- If infection persists refer the client for medical attention.

Urine retention

Urine retention may be the result of injury, pains and fear of passing urine, or occlusion of the urethra during infibulation. Management of this condition is as follows:

- Carry out an assessment to determine cause.
- Use appropriate nursing skills and techniques to encourage the client to pass urine, such as turning on a water tap.
- If she is unable to pass urine because of pain and fear, give her strong analgesics.
- Give the client personal encouragement and support.
- If inability to pass urine is due to infibulation, open up the infibulation (see procedure for opening up type III FGM) after counselling the client, or her attendant if the client is a child.
- If retention is due to injury of the urethra, refer for surgical intervention under anaesthetic.

Anaemia

Anaemia can be due to bleeding or infection or it can be due to malaria, especially in children.

Management of this condition is as follows:

- Assess the severity of anaemia and send blood for Hb and grouping.
- If anaemia is mild, give folic acid and iron tablets and advise on nutritious diet.
- In cases of malaria treat appropriately.
- If anaemia is severe, refer for medical attention.

Managing long-term physical complications

Keloid formation

A keloid may form in the scar tissue and may cause obstruction to the introitus. Management of this condition is as follows:

- Inspect client's genitalia to assess size of keloid.
- If the keloid is small, advise the woman to leave it undisturbed, and reassure her that it will not cause harm.

- If the keloid is large, causing difficulties during intercourse, or possible obstruction during delivery, the woman should be referred to a specialist experienced in removing keloid scars.
- The presence or appearance of a keloid may cause excessive distress to a woman, in which case you should consider referring her for surgery for psychological reasons.

Cysts

Dermoid (or inclusion) cysts caused by a fold of skin becoming embedded in the scar, or sebaceous cysts caused by a blockage of the sebaceous gland duct, are common complications of all forms of FGM. A woman may present with these early on when they are the size of a pea, or after they have grown to the size of a tennis ball or even a grapefruit. Management of cysts is as follows:

- Inspect the site to assess the size and type of cyst.
- Small and non-infected cysts may be left alone after counselling client to accept the condition.

Alternatively the client may be referred to have them removed under local or regional anaesthesia.

- However, before interfering with a small cyst it is important to find out if the procedure could result in further damage and scarring of existing sensitive tissue. If such a risk exists, the woman should be fully informed and should be allowed to choose for herself whether to proceed with removal with full understanding of the risk involved.
- In the case of a large or infected cyst, the client must be referred for excision or marsupialization. The procedure is usually performed under general anaesthesia. During the procedure, great care should be taken to avoid further damage to sensitive tissue or injury to the blood or nerve supply of the area.

Clitoral neuroma

The clitoral nerve may be trapped in the fibrous tissue of the scar following clitoridectomy. This may result in an extremely sharp pain over the fibrous swelling anteriorly. With such a condition, intercourse, or even the friction of underpants, will cause pain.

Management of the condition is as follows:

- Check for the presence of a neuroma. A neuroma cannot usually be seen, but can be detected by carefully touching the area around the clitoral scar with a delicate object and asking the client if she feels any pain. Under general anaesthetic the neuroma can be felt as a small pebble under the mucosa.
- Advise the woman to wear loose pants and give her something to apply to the area, for example lidocaine cream.
- If the symptoms are severe, refer the client for surgical excision of the neuroma. This is not commonly required, and the woman should be carefully counselled before such a step is taken since the symptoms may be psychosomatic – the result of the traumatic experience of excision, or the fear of sexual intercourse.

Vulval abscesses

A vulval abscess may develop as a result of deep infection due to faulty healing or an embedded stitch.

Management is as follows:

- Inspect the site to assess the extent of the problem.
- Dress the abscess with a local application to relieve pain and to localize the swelling.
- Refer for surgical intervention, which may involve incision and drainage of the abscess under general anaesthesia, or administration of antibiotics as indicated by swab culture.

Urinary tract infection (UTI)

Urinary tract infections are a common symptom of women who have undergone type III FGM. This can

be due to obstruction of the urine in infibulated women or the presence of urinary stones or previous injury to the urethra. Management is as follows:

- Inspect the vulva carefully to establish the cause of infection.
- If infibulation is the cause, counsel the woman or her attendant on the need to open up the infibulation.
- Carry out urine analysis to identify specific infection for appropriate antibiotics.
- Give antibiotics and urinary antiseptics.
- Advise the patient to take plenty of water.
- If UTI is recurrent, refer client for medical attention.

Chronic pelvic infection

This condition may be the result of obstruction of the vaginal secretions due to occlusion of the vaginal orifice in infibulated women, or due to the presence of vaginal stones or vaginal stenosis. Management is as follows:

- Identify type of FGM and likely cause of problem.
- If the client has type III FGM, counsel her and/or her attendants on the need to open up the infibulation, and seek their informed consent.
- Take vaginal swab for culture and sensitivity.
- Give antibiotics that are appropriate and available locally, e.g. tetracycline 500mg 6 hourly for 10 days, or doxycycline 100mg twice daily for 10 days.
- If the infection is fungal, flagyl may be prescribed.
- If the client has a husband or partner, treat him also for the same infection.
- If symptoms persist, refer client for medical intervention.
- If the cause of the infection is obstruction due to stones or injury, refer client for surgical intervention.

Infertility

Usually infertility is a complication of pelvic infection and can be primary or secondary infertility. In rare cases it is due to failure of penetration because of a very tight vaginal opening. Management is as follows:

- Take a history and inspect the genitalia to identify the problem.
- If infertility is the result of failure to penetrate, counsel the client and her partner on the need for surgical opening up.
- Otherwise, refer client to a gynaecologist for further management.

Fistulae and incontinence

Vesico-vaginal (VVF) or recto-vaginal (RVF) fistulae, resulting in incontinence, occur as a result of injury to the external urethral meatus, or obstructed labour. Management of these conditions is as follows:

- Assess the child or woman to identify cause of incontinence and type of FGM.
- Ascertain the severity and level of fistula by dye test.
- In cases of stress incontinence, counsel the client and start a programme of exercises to strengthen the pelvic muscles, or refer client to a urologist for treatment.
- Clients with VVF or RVF must be referred for specialist repair.
- If client has infection give antibiotics as appropriate.

Vaginal obstruction

Partial or total obstruction of the vagina may occur as a result of infibulation, vaginal stenosis, or the presence of a vaginal haematoma. The condition may be accompanied by haematocolpos (accumulation of trapped menstrual blood). Unmarried girls may be suspected of being pregnant because the amenorrhoea and swelling of the abdomen. There are reported cases

where young girls have been punished for this condition. Management is as follows:

- Assess the client to identify the problem and type of FGM.
- If the client has been infibulated, counsel on the need for opening up.
- If the client has haematocolpos or stones or stenosis, refer her for surgical intervention under general anaesthetic. In cases of vaginal stenosis, surgical intervention may involve dilatation.

Menstrual disorders

Many excised women report severe dysmenorrhoea with or without menstrual regularity. Possible causes of this problem are an increase in pelvic congestion due to infection or other unknown causes, or anxiety over the state of the genitals, sexuality or fertility. Management is as follows:

- Try to establish the cause of dysmenorrhoea by taking a history and performing a clinical examination of the client's genitalia.
- Counsel the client to find out how she feels and support her in dealing with the situation.
- Give antispasmodic drugs to relieve pain.

- If dysmenorrhoea is due to the accumulation of menstrual flow as a result of infibulation, counsel the client on the need for opening up.
- If the condition is severe refer to a gynaecologist for further management.

Ulcers

Vulval ulcers may develop as a result of the formation of urea crystals in urine trapped under the scar tissue. Management of this condition is as follows:

- Counsel the client on the need for opening up her infibulation, and advise her that her vulva should be kept open thereafter.
- Perform the procedure after getting her informed consent.
- Apply antibiotics locally with or without 1-% hydrocortisone cream.
- If the ulcer is chronic and fails to heal, refer client for surgical excision of the tough fibrous walls.

Documentation of FGM

- Always record FGM type and complications presented.



Session 3: Using counselling skills

Session objectives

By the end of this session students should:

1. Understand the basic principles of counselling.
2. Understand the qualities and skills required for effective counselling.
3. Be able to demonstrate the use of counselling skills with clients.

Introduction

Counselling is defined as helping someone to explore a problem so that they cope more effectively. As mentioned earlier, counselling is an important element in the management of FGM complications. Counselling of a girl or woman with FGM complications should be strictly confidential. If the client has a partner, he should be counselled separately if necessary, until the right moment arrives for them to be counselled as a couple. The aim of counselling is to help a client, a couple, or a family come to terms with, or solve a problem they have.

During counselling sessions it is important to build a trusting relationship with clients, so that they feel safe in discussing their concerns with you as the counsellor. Important factors for achieving this are:

- **Privacy and confidentiality** – make sure that counselling is carried out in a room where nobody can come in without permission, and where the discussion cannot be overheard by other people.
- **Patience** – you should be relaxed and not pressed for time.
- **A carefully considered seating plan** – counsellor and client should be on the same level, and seated close to each other, with no barriers between them so that the counsellor can lean towards the client to demonstrate attentiveness and support during the discussion.
- **Eye contact** – it is important to look at the client directly and to observe her carefully so that you become aware of her mannerisms and body language (body cues), as these may tell a different story from her words (Remember the saying: “actions speak louder than words”). You should not look her straight in the eye all the time, but observe the whole person and her actions.
- **Attentive listening** – observe the client’s tone of voice as well as what she is saying as this may tell you more than her words. You should allow the client to do most of the talking, but try to paraphrase what she has said from time to time to check that you understand her correctly.
- **Showing concern** (empathizing) – try to put yourself in the client’s position and show that you care.
- **Appropriate facial expressions** – you should be aware of your facial expression and ensure it is appropriate to what is being said. Smile when you greet the client, but if she cried during the session your facial expression should show sympathy and concern.
- **Respect** – you should always show respect for your clients as dignified human beings with their own religious and cultural beliefs.
- **A non-judgmental attitude** – it is very important for you not to be judgmental. As counsellors, you need to be aware of your own biases and prejudices so that they do not interfere with the counselling process.

Preparation for counselling session

- Find a suitable setting – this should be a room where you will not be disturbed by other people, which can be locked if necessary, and where privacy and confidentiality can be assured.
- Prepare the place – there should be comfortable seating.
- Confirm the appointment with your client, and make sure that you both have allowed adequate time for the discussion.

The counselling session

- Welcome the client (and her partner/husband if appropriate) and invite her to sit down.
- Greet her and introduce yourself in the culturally appropriate manner.
- Ask client her name and ask if you can help her with anything.
- Let the client talk and encourage her by nodding or saying “ah” from time to time.
- Give client information about the services available in your clinic or ward or centre and the staff who will care for her.
- Let client explain her concerns; be patient as she may find it hard to express her experiences and feelings.
- Listen carefully and observe non-verbal cues (e.g. body language; tone of voice) to enhance your understanding of the client’s situation.
- Paraphrase the client’s information from time to time to check that you have heard her correctly and avoid misunderstanding.
- Show concern throughout the session by being attentive and making eye contact from time to time.
- Empathize with client when she is describing a disturbing experience, which may make her weep.
- Explain to client how you can help
- If the purpose of counselling is to raise with the client the need for opening up her infibulated

vulva after type III FGM, give her detailed information about the procedure, and advise her that her genitalia will be changed by the operation. Give her information about her after care (see information on opening up type III FGM).

- If counselling is for psychosocial or sexual problems, ask questions as appropriate to draw out as much information from the client as possible about her problems. Advise her that there are various ways of conducting sexual relationships; teach her appropriate techniques by which both she and her partner may be aroused. If she expresses a wish for her partner to be involved in the discussion, draw him into the counselling session also. It is known that FGM does not necessarily lead to inability of a woman to achieve orgasm or enjoy sex. Therefore sexual problems may be due to fear of pain, rather than to any physical malfunction. However, if sexual intercourse is not possible as a result of infibulation or extensive scarring the issue of opening up the tight introitus should be addressed during counselling.
- Assist the client, and her partner where appropriate, to make an informed decision on the steps to be taken to solve the problem.
- Assist them to act on their decision by giving advice on how to proceed.
- Give client an appointment for another counselling or follow-up session to prepare for the next step.
- If the problem persists refer to a specialist.

Please note:

A client’s problem may not be resolved in a single counselling session. Several sessions may be required for her to resolve a relationship problem and reach optimal psychological well-being. You should be prepared to spend as much time as is necessary for this process.

Role Play

Students should practice counselling using role-play to explore the following situations, as either a counsellor or a client:

1. Counselling a client with a vesico-vaginal fistula (VVF).
2. Counselling a client with vulval keloids.
3. Counselling a client with haematocolpos (obstructed menstrual flow).
4. Counselling a client for infertility.
5. Counselling a client who is experiencing dyspareunia (difficulty with sexual intercourse).
6. Counselling a client who is having problems passing urine.
7. Counselling a client who is very depressed.



Session 4: Identifying psychosocial and sexual complications of FGM

Session objectives

By the end of this session students should be able to:

1. Assess girls and women with psychosocial problems associated with FGM.
2. Identify psychosocial complications associated with FGM.

Key references

- *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).
- *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. Geneva, World Health Organization, 2001 (WHO/FCH/GWH 01.2).

Introduction

“Psychosocial” refers to the psychological and social aspects of human experience – i.e. how a person feels about her or his relationships with others in society. As we have seen, FGM can affect self-confidence and self-esteem and cause problems in relationships: these would mostly be classified as psychosocial or sexual problems.

Psychosocial and sexual problems are identified by interviewing clients using interpersonal communication, observation and listening skills. It is not easy for a client to talk about a sexual problem as it is a sensitive issue. Moreover, in areas where FGM is practised, sex is a taboo – something which is not talked about. Therefore, a woman will rarely speak directly about a psychosocial problem, but will tend to present with some physical complaint. It is essential for

the nurse/midwife to pick up non-verbal cues of psychosocial problems, by observing body language and listening carefully to the tone of voice, which may give more meaning to what the client is saying and feeling. Sometimes a client may just cry, which tells a lot about how distressed she is. She should be given comfort and a shoulder to cry on.

Identifying psychosocial and sexual problems

The procedure for identifying psychosocial and sexual problems is as follows:

- Take the client into a room where privacy and confidentiality are assured and ask her if she has time to talk to you.
- If she has time, ensure that she is comfortable and seated near to you. Counselling should never be hurried: if either of you is pressed for time it may be better to make an appointment for another mutually convenient time.
- Make it clear with body language and the way you are sitting that you are ready to listen to her concerns, and that she should feel free to share anything she wishes with you. Encourage her to talk using facilitation skills such as eye contact, nodding your head, saying “ah, ah”, and listening attentively while also observing non-verbal cues.
- When the client has opened up to you, ask her about her eating and sleeping patterns. Ask about

menstrual patterns and sexual relationships in a very tactful manner, as these questions may embarrass the client and result in communication breakdown.

- Use “open-ended” questions – i.e. questions that require more than a simple ‘yes’ or ‘no’ answer, and thus offer the client the chance to explain things in some detail.
 - Use observation skills continuously to pick up non-verbal cues, and tell the client what you have observed to give her the chance to tell you more about the situation.
 - Listen carefully and empathetically (showing concern).
 - Use all your senses to try to understand the client’s world. It may not be easy the first time you meet her, but arrange for subsequent visits to explore more.
 - Support the client throughout the interview to give her psychological strength.
 - Assess the client’s intellectual status – that is her ability to understand information and comprehend a situation.
- Remember that, throughout the counselling session, the emphasis should be on:
 - Privacy and confidentiality.
 - Patience.
 - Creating a trusting relationship.
 - Remaining non-judgmental.
 - Understanding of non-verbal cues.
 - Using facilitation skills.
 - Record your findings and share these with clients wherever appropriate.

Each girl or women should be treated as a unique individual with unique needs and problems. Counselling and care should be tailored to individual needs and problems, not carried out according to a formula devised for some imagined, stereotypical client.



Session 5: Management of girls or women with psychosocial and sexual problems associated with FGM

Session objectives

By the end of this session students should be able to:

1. Manage girls and women with psychosocial and sexual problems associated with FGM.

Introduction

In some instances girls and women from FGM-practising communities visit a clinic complaining of a wide variety of physical problems for which no sign can be found when they are examined. Their complaints are, in fact, “psychosomatic” – that is, they are psychological problems which the client experiences, or disguises, as physical discomfort. Anxiety about their genitals or about sexual relationships may manifest themselves in psychosomatic symptoms. Often the girl or woman is unaware that her symptoms are based on psychological anxieties. But in some cases the woman is aware of the fact that the symptoms she is presenting are not the real cause of her problems, but she is too shy to discuss them directly and attends the clinic hoping the health care provider will be able to read between the lines.

Key elements in managing psychosocial and sexual complications

The key elements in managing psychosocial and sexual complications are:

- **Identification** of the problem by interviewing the client (history taking).
- **Counselling** to help her identify the real problem and accept it (girls should be referred for counselling by their peers).
- **Referral** of clients who are severely disturbed for more specialised care.

Counselling is the principle tool used in managing psychosocial and sexual problem. Counselling of a girl or woman should be strictly confidential. If the client has a partner, he should be counselled separately if necessary, until the right moment arrives for them to be counselled as a couple. The aim of counselling is to help a client, a couple, or a family come to terms with, or solve a problem they have.

Managing psychosocial problems

Psychosocial problems include: chronic anxiety, and feelings of fear, humiliation, betrayal, stress, loss of self-esteem, depression, phobias, and panic attacks. These may manifest as psychosomatic symptoms such as nightmares, sleeping and eating disorders, disturbances of mood and cognition, loss of appetite, excessive weight loss or gain, and negative body image. The procedure for managing such symptoms is as follows:

- Assess client to identify the exact problem (take a detailed history).
- Counsel client, and partner where appropriate
- If the client has type III FGM, counsel her as to the need for opening up.
- If she has other types of FGM, counsel her until she is relieved of her symptoms.

- If symptoms are severe, refer client for further management.

Managing sexual problems

Painful intercourse (dyspareunia).

The procedure for managing this condition is as follows:

- Interview client to identify the real problem.
- Assess client to identify the type of FGM.
- If opening up the introitus is indicated, counsel the client and her husband/partner about the need for this and obtain their informed consent. Follow the procedure for opening up and repair (see session 8 on page 76).
- Where opening up is not indicated, encourage foreplay to stimulate maximum arousal, and the use of lubricating jelly.
- Open up the infibulation after obtaining client's consent. Follow the procedure for opening up and repair described later in this manual.
- Give antibiotics and analgesics.
- Follow-up client to monitor progress.
- Counsel the client and her husband about the

importance of discussing sexual matters.

- Invite them to come back whenever they have problems.
- Advise the couple of the changes to expect as a result of opening up operation – e.g. changes with urine flow and with sexual intercourse.

Other sexual problems

An example is failure or difficulty in penetration by husband/partner. The procedure for managing such problems is as follows:

- Assess the type of FGM.
- Interview the client to find out what the problem is.
- Counsel the client and her husband/partner together.
- Obtain informed consent for opening up of introitus.
- Follow the opening up procedure described later in this manual.

Documentation of FGM

- Record FGM type and complications presented.



Session 6: Demonstrating referral skills

Session objectives

By the end of this session students should be able to:

1. Identify conditions, which require further management such as fistulae, depression, infertility.
2. Identify appropriate referral centres for specific problems.

Introduction

Referral is necessary when a client presents with a problem that is beyond the competence of the care provider. However, referral is not a simple matter, it is a skill. If clients are not well informed about where to go and why referral is necessary, the process may fail and the patient remain untreated. The nurse/midwife must know what services are available and which ones are appropriate for the different conditions.

FGM complications which may require referral

- Severe bleeding.
- Calculus.
- VVF or RVE.
- Dermoid cyst.
- Clitoral neuroma.
- Depression.
- Infertility.
- Obstructed labour.

When referral is necessary

Referral is necessary under any of the following circumstances:

- when the management of a complication is beyond the competence of the nurse or midwife such as in:
 - Severe bleeding requiring blood transfusion.
 - Calculus.
 - VVF or RVE.

- Dermoid cyst.
- Infertility.
- Depression.
- Obstructed labour.
- the health facility does not have the equipment or skills necessary for diagnosis or treatment.

Referral is a skill. If the client is not well informed about the reasons for the referral she may refuse to go. Besides, FGM is a sensitive issue; for a client who has developed confidence and trust in a particular health care provider, transfer to another place where she will meet new people may be daunting.

Procedure for referral of clients

The referral procedure is as follows:

- Usually you will have identified the need for referral while taking a history or performing a physical examination.
- Inform the client sensitively that she has a problem which needs further management.
- Give her the facts and reasons for referral.
- Check that she has understood what you have said. Involve others, such as her husband/partner, who will accompany her to the referral facility.
- Give them detailed information about what to

expect and what to do at the referral point.

- Give the referral letter to the client or her attendants and give them detailed instructions about who to hand it on to at the referral point.
- Ask client to return for follow-up and monitoring of progress after she has received specialist treatment at the higher level facility.
- Ask client to repeat the important information she has been given, to check that she has understood.
- Wish her good luck and tell her you will see her when she comes back from the referral point.

The referral note

The referral note must include the following information:

- client's demographic data, e.g. age, marital status, etc.
- summary of health history
- clinical findings
- care given thus far
- reason for referral.

Practical training

Students will practice all the skills covered in module three in a clinical setting.



Session 7: Use of family planning in the presence of FGM

Session objectives

By the end of this session students should be able to:

1. Identify the type of FGM the girl or woman has experienced.
2. Identify the type of family planning method appropriate for a given situation.

Introduction

Family planning is as appropriate for girls and women with FGM as it is for any other client. As with other clients, the medical eligibility criteria set by WHO in 1996 should be used to determine the most suitable contraceptive methods for these women. Women who have been infibulated may have difficulties in using a method which has to be inserted vaginally, or an intra-uterine device (IUD). Since women with FGM of any type are prone to infections of the genital tract, IUDs should only be used after careful consideration. When advising a client with FGM on family planning, make sure history taking is carried out with sensitivity, and reassure the woman that you are comfortable with her condition and that there will be a family planning method that will suit her needs. It is important to carry out a genital examination to identify type of FGM and to check that there are no problems that need attention, especially infection.

Constraints

The following problems may be encountered by women with FGM seeking family planning:

- it may be difficult for the family planning adviser to perform a vaginal examination
- it may be difficult to use a family planning method that has to be inserted vaginally
- a client with FGM may encounter discrimination; she may be denied choice in family planning methods
- women with FGM may hesitate to seek advice on family planning due to embarrassment about the appearance of the vulva.

The table on page 75 indicates which types of family planning method are suitable for use with the different types of FGM, as well as those which are not suitable.

Table 2: Family Planning Method and Type of FGM

Contraceptive Method	Type I FGM	Type II FGM	Type III FGM (Infibulation)	Type IV FGM
Oral pills	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria	can use, follow, WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria
Injectable (DMPA)	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria
Intra - Uterine Devices (IUDs): Cu and LNG - 20	can use, follow WHO Medical Eligibility Criteria, but clients commonly suffer from infection, so it is important to exclude infections	can use after assessment of the introitus as too much scarring can prevent easy introduction of IUD. Also check infections. Follow WHO, Medical Eligibility Criteria	cannot use, as the introitus is very tight. If this is the only option, advise opening up of infibulation	can use, follow WHO, Medical Eligibility Criteria. During introduction care should be taken of the elongated labia minora and/or clitoris. Risk of infection.
Barrier methods: - Female condom - Spermicides (tablets and foam) - Diaphragm - Cervical cap	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria	It may be very difficult to use as the introitus is very small and in most cases does not allow even a fingertip. But if this is the only option, advise opening up of infibulation	can use, follow WHO, Medical Eligibility Criteria
Norplant Implants (NOR)	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria	can use, follow WHO, Medical Eligibility Criteria
Natural methods				
- Symptothermal method	can use with training	can use with training	can use with training	can use with training
- The basal body temperature method	Can use with training	Can use with training	can use with training	Can use with training
- The calendar method	can use with training	can use with training	can use with training	can use with training
- Cervical mucus method (Billings Ovulation Method)	can use with training, but exclude infection	can use with training, but exclude infection	cannot use because it is difficult to test the cervical mucus as in most cases the secretions are trapped by the infibulation	can use with training, but exclude infections
- Lactational amenorrhoea method (LAM)	can use with training, follow WHO, Medical Eligibility Criteria	can use with training, follow WHO, Medical Eligibility Criteria	can use with training, follow WHO, Medical Eligibility Criteria	can use with training, follow WHO, Medical Eligibility Criteria

Session 8: The procedure for opening up type III FGM (infibulation)

Session objectives

By the end of this session students should be able to:

1. Identify type III FGM.
2. Assess whether there is a need for opening up the infibulation.
3. Demonstrate the skills on opening up type III FGM.

Introduction

There are many situations in which opening up an infibulation will be necessary. However, such a procedure must only be done after the client has been thoroughly counselled. If the woman is married it is important to counsel the husband in separate sessions. Husbands need psychosexual counselling to assist them in dealing with the changes in sexual intercourse. The couple can be counselled together when it is necessary or appropriate to have them both in the same session.

Indication for the opening up procedure

Opening up an infibulation is indicated in many cases. These include the following:

- Urinary retention (common in children).
- Re-current urinary tract infection and or kidney infections.
- Severe genital tract infection.
- Haematocolpos (especially in adolescents).
- Severe menstrual problems.
- Difficulty in penetration during sexual intercourse.
- Incomplete abortion.
- Termination of pregnancy.
- Childbirth.
- Gynaecological problems of the genital tract.
- Gynaecological diseases in elderly requiring manual or speculum examination or treatment vaginally.

- For the use of certain contraceptive methods for family planning.
- For certain religious/purification purposes.

Preparation of the client

In order to prepare the client (and her husband/partner or attendants where appropriate), the following procedure should be followed:

- Teach her about the genitalia – make her aware of the difference between normal and infibulated genitalia.
- Provide information about complications associated with infibulated genitalia.
- Inform her of the legal status of FGM in their country.
- Give full and clear information about the procedure and make sure she has understood.
- Also inform her that the sides will be sutured separately, and not re-sutured together to create a small opening.
- Inform her of the physical changes that will result from the procedure. This information must be given to her partner also, if she is married, because the procedure will result in changes in: urination, menstrual flow, sexual intercourse.
- If the family refuses to give consent for an adolescent or the woman to be opened up (because of fear of rejection by family and community members), the provision of a medical certificate may help to alleviate these concerns.

- Counsel the client on the procedure. Several sessions may be needed to prepare her psychologically for the procedure. Her partner and/or guardians should also be counselled where appropriate.
- Make it clear to the woman (and others as appropriate) why it is advisable that she has the procedure. Sometimes a woman may be in two minds about being opened up – i.e. she may want it on one level, but be fearful of the consequences on another level.
- Counselling should aim to help her reach an informed decision about which she is confident.
- Reassure the client about privacy and confidentiality.
- If the client is an immigrant who speaks a different language from the health staff, make sure the interpreter is appropriate and is acceptable to her.
- Discuss pain relief options.
- Make sure you complete the required records and documentation accurately.

Preparation of equipment and materials

Prepare a tray with antiseptic swabs, a pair of straight scissors, a dilator, two artery forceps, a gallipot with sterile swabs, sterile gloves, a 5ml. syringe and needles, local anaesthetic, catgut, lubricant, sterile towel/cloth or mackintosh, antiseptic solution, a receptacle for used instruments, soap water for hand washing

The procedure

- Make the client comfortable in bed or on a couch.
- Remember to use all the interpersonal skills (facilitation skills).
- Introduce yourself to client if you have not already done so.
- Go over again what you have already discussed

with her about the opening up.

- Emphasize that the main reason for the problems she has suffered is the infibulation and that opening the infibulation will relieve these problems.
- Ensure total privacy and confidentiality.
- Wash hands, put on gloves, expose the genitalia and clean the perineal area with antiseptic swabs.
- Introduce index finger or forceps or dilator slowly and gently into the opening to lift the scar skin (see figures 4.1 & 4.2).

Figure 4.1: Introducing finger(s) under the scar

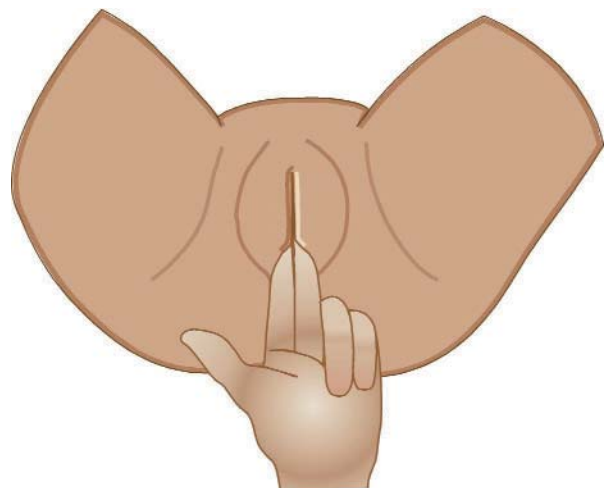
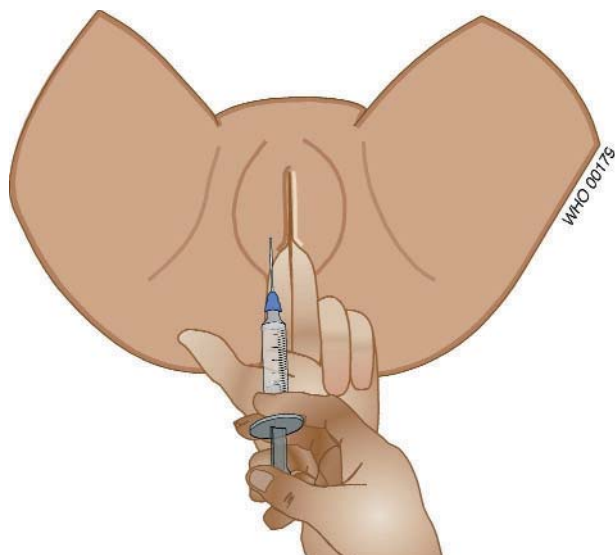


Figure 4.2: Introducing a dilator under the scar



Infiltrate 2–3 mls of local anaesthetic into the area where the cut will be made, along the scar and in both sides of the scar (see figure 4.3).

Figure 4.3: Infiltrating the scar area with local anaesthetic



- With your finger or dilator inside the scar, introduce the scissors and cut the scar alongside the finger or fingers to avoid injury to the adjacent tissues (or to the baby, if the procedure is done during labour).
- The cut should be made along the mid-line of the scar towards the pubis (see figure 4.4).
- Take care that you do not cause injury to the structures along the scar. It is common with type III FGM to find the structures below the scar intact, e.g. clitoris and labia minora.
- Incise the mid-line to expose the urethral opening. (see figure 4.5) Do not incise beyond the urethra. Extending the incision forward may cause haemorrhage, which is difficult to control. A cut of about 5–7 cm towards the urethra is usually appropriate. Generally speaking there is little bleeding for the relatively avascular scar tissue.

Figure 4.4: Cutting open the scar

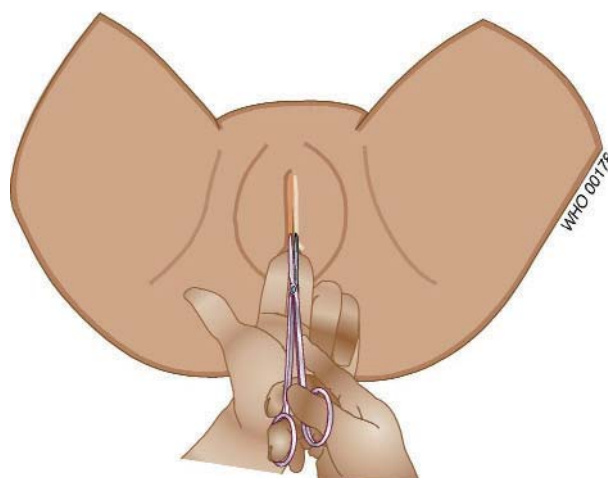


Figure 4.5: An opened infibulation



- Suture the raw edges separately using fine 3/0 plain catgut to secure haemostasis and prevent adhesion formation (see figure 4.6).
- Women should not be allowed to suffer pain as this may reinforce negative ideas about being opened up. Therefore, analgesia should be prescribed following the opening up procedure.
- Antibiotic may also be prescribed depending on the situation.

Figure 4.6: Sutured sides of the opened scar



Post operative care

Many women report increased sensitivity in the vulval area which was covered by the scar skin for 2 to 4 weeks following the procedure. They may also report discomfort about having wet genitals.

- Prepare the woman for these experiences by explaining to her that there will be changes in appearance, and that she is likely to have increased sensitivity for a while.
- Reassure her that the sensitivity will disappear after a while and that she will get used to the feeling of wet genitals.
- Suggest that she takes Sitz baths (warm water containing salt) three times a day followed by

gentle drying of the area and application of a soothing cream that should can be prescribed for the first 1-2 weeks.

- Advise her and her husband when to resume sexual intercourse. Typically this will be after 4 to 6 weeks. This may require counselling over several sessions. Advice and counselling regarding sexual matters require great sensitivity, and should be carefully tailored according to the needs of the client and her family and to what is culturally appropriate.
- Advise on the importance of personal hygiene.
- Make a follow-up appointment to monitor healing progress and to deal with any other issue that may have arisen concerning the genitals or sexual relationship.
- Home visiting is ideal because the client and her family need further support and counselling in order to cope successfully with the many changes following the opening up. Male partners in particular need psychosexual counselling to help them understand and accept the changes in sexual intercourse and to ensure they do not try to persuade the woman to be re-infibulated.
- In cases where the client is referred to community services for follow-up, the nurse/midwife who performed the procedure must provide clear information to the health care provider who will be responsible for follow-up to ensure there is no lapse in support.

Module 4: Management of women with FGM during pregnancy, labour, delivery and the postpartum period

Module 4 is also an intervention module. This module is intended to prepare midwives and those caring for women during pregnancy, labour, delivery and the postpartum period to be able to manage women with FGM and identify problems. The module gives guidance on counselling, opening up a type III FGM, and management of other complications associated with FGM.

General objectives

On completion of the module, students should be able to:

- Recognize obstetric complications due to FGM.
- Manage women with FGM complications during pregnancy, labour, delivery, and after delivery.
- Demonstrate skills in opening up tight a introitus and type III FGM during pregnancy and in labour.
- Demonstrate skills in counselling.
- Refer clients for further management when complications are beyond their competence.

Essential competencies

Students are expected to acquire the following skills from this module:

- ability to identify special complications that may occur as a consequence FGM during:
 - pregnancy
 - labour
 - delivery, and
 - the postpartum period.

Reference materials

- *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).
- *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. Geneva, World Health Organization, 2001 (WHO/FCH/GWH 01.2).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives*. WHO/FCH/GWH/01.5. WHO, Geneva (2001)
- Toubia, N.A. *A Practical Manual for Health Care Providers Caring for Women with Circumcision*. RAINBO Publication,. New York, 1999.

The Sessions

Session 1:

Assessment and management of women with complications due to FGM during pregnancy.

Session 2:

Obstetric complications due to FGM during labour and delivery.

Session 3:

Assessment and management of women with FGM complications during labour and delivery.

Session 4:

Management of women with FGM during the postpartum period.

Session 1: Assessment and management of women with complications due to FGM during pregnancy

Session objectives

By the end of this session students should be able to:

1. Identify the type of FGM and assess how it may affect the woman during pregnancy.
2. Identify complications due to FGM during pregnancy.
3. Manage women with type I type II and IV FGM during pregnancy.
4. Manage women with type III FGM.

Introduction

In FGM-practising communities, women coming to a clinic may present with many types of FGM. FGM-associated complications during pregnancy can be identified through history taking and during pelvic examinations.

Problems associated with FGM during pregnancy

- A tight introitus may make vaginal examinations difficult, e.g. during assessment for antepartum haemorrhage, management of incomplete abortion, etc.
- Urinary infections, may interfere with the normal progress of the pregnancy.
- Chronic pelvic infections, may interfere with normal progress of the pregnancy and may cause abortion.
- Vulval abscesses may cause pain and discomfort to the woman.
- Dermoid cysts, and keloids may cause discomfort and perhaps obstruction during delivery.
- Psychosocial and sexual problems may arise as a result of FGM.

Assessing problems associated with FGM

Problems can be identified during history taking and examination of a woman with FGM during pregnancy.

- During assessment, it is very important to create a trusting relationship with the client by:
 - using interpersonal communication skills
 - ensuring privacy and confidentiality
 - showing respect and patience.
- During assessment, check for the presence of conditions that are likely to cause problems during labour and delivery, e.g.:
 - tight introitus
 - infections
 - abscess
 - cysts, keloids and other growths.
- All complications identified in women with FGM should be recorded including the type of FGM.

It is important to remember the following:

- Women with FGM often suffer great anxiety at visiting a clinic when they are pregnant because of their genital mutilation. They may be fearful of being seen by a health care worker who is unfamiliar with FGM and who may advise unnecessary interventions, such as Caesarean section. Women with FGM should be made to feel welcome and respected in these clinics. You should

reassure them that you are comfortable with their condition and that they will get the services they need without being subjected to unnecessary interventions.

- Service providers working with immigrant communities may be unfamiliar with their cultural background. They should be aware of the need to be sensitive and respectful towards the cultural beliefs, values and attitudes of the women. They must ensure that their own values and attitudes do not interfere with the care they give to the client.
- If an interpreter is being used, she should be acceptable to the client and should be impartial, otherwise there is the risk that her own beliefs and values will bias the interpretation of what is being said.
- During assessment, it is very important to create a trusting relationship with the client by:
 - using interpersonal communication skills
 - ensuring privacy and confidentiality
 - showing respect and patience.
- During assessment, check for the presence of conditions that are likely to interfere with vaginal examinations or treatment, or cause problems during labour and delivery. These may include:
 - tight introitus
 - infections
 - abscess
 - cysts, keloids and other growths.
- Record the type of FGM and the complications identified

It is important for the health care workers to be knowledgeable about types of FGM so that they do not ask the clients embarrassing questions.

Management of women with type I, II and IV FGM during pregnancy

- Women with FGM require sensitive antenatal care. Type I, II and IV FGM can produce severe vulval and vaginal scarring which may cause obstruction during assessment and delivery. Infection and inflammation occurring at the time FGM was performed may result in vulval adhesions which narrow or completely occlude the vaginal orifice. Insertion of herbs or other substances may also cause severe scarring and stenosis.
- Where type I, II, and IV FGM have not resulted in any particular complications, the woman will not require special management or treatment during pregnancy. Reassure the woman that she is not at risk because of her condition and invite her to ask any questions about her excision or any other issues relating to her pregnancy. Find time to counsel her about sexual relationship and to give her support. Provide more information by giving leaflets on FGM. During follow-up visits, ask the woman if she needs any special help but do not ask about her excision unless she wants to discuss it.
- Pregnancy provides a good opportunity to give women education and information on:
 - basic health
 - normal and excised genitals
 - childbirth and postnatal care.
- Be aware that many women approach pregnancy and delivery with great fear of the possibility of dying. Special support and counselling is therefore required during this periods.

Women with vaginal infections

- Where infections are serious, send a vaginal swab for diagnosis, if laboratory facilities are available.
- Give antibiotics according to policy.

- Contact partner and give same treatment.
- Counsel woman and partner about the problem, and monitor the situation closely.

Women with abscess

- Give antibiotics and advice on vulval hygiene.
- Give client a follow-up appointment in order to monitor progress.
- If the abscess is very big and needs surgical intervention, refer for further management and advise client to have a hospital delivery.
- Monitor her progress closely.

Women with cysts and keloids

- Make referral of client to deliver in a hospital where there are facilities for Caesarean section if required.

Management of women with type III FGM during pregnancy

- Perform assessment to confirm type III FGM. Remember that there is great need for sensitivity during history taking and pelvic examination. It is not necessary to perform a vaginal examination to confirm infibulation, as this condition can be identified by visual inspection.
- In some communities type III FGM may not be the prevalent form of FGM and only a minority of women may be affected. Where type III FGM is common, the vulval area should be inspected at the first antenatal visit as a matter of routine.
- Women with tight introitus (i.e. opening of 1 cm. or less) are at special risk of major perineal damage during labour. As a general rule, if the urinary meatus is visible, (i.e. if there is no barrier from the urinary meatus downwards), or if two fingers can be introduced into the vagina without discomfort, the mutilation is unlikely to cause major physical problems at delivery. If the woman

has been pregnant before, her previous experiences during delivery will help to indicate whether she is likely to have problems this time.

- Because of the need to seek sensitive information, it is important to create a rapport with the client and to gain her confidence and trust. You should obtain her consent before conducting a genital examination.
- Making a record of the appearance of the vulva may help to avoid unnecessary examinations in future.
- Give client factual information about the effects of type III FGM on pregnancy and delivery. Give her information on the anatomy and physiology of the female reproductive system.
- Counsel the client and her husband (and/or other family members where appropriate) on the importance of opening up her infibulation before delivery. Discuss with them the importance of not re-suturing after delivery. Give the client and her husband detailed information about the changes that will occur in such functions as urination and sexual intercourse.

Once the woman has been opened up it may be possible for her to deliver with the perineum intact, episiotomy should only be carried out if necessary and not as routine.

- Ideally, opening up should be performed during the second trimester. Opening up between the 20th and 28th weeks of pregnancy will allow time for healing before labour starts. It is not a good idea to perform the opening up in the first trimester. The reason is that during this trimester there is a higher risk of spontaneous abortion. If the woman happens to have a spontaneous abortion after the opening up surgery the woman may blame the surgery for her abortion and word may spread in the community that the opening up procedure is a dangerous one.

- Follow the procedure for opening up as described earlier in this manual.
- Instruct the client on the importance of vulval hygiene, and the need to keep her vulva clean and dry.
- Advise client and her husband/partner on when it would be safe to resume sexual activity. They should be advised to wait for proper healing to take place – generally 4-6 weeks after the procedure.
- Make an appointment for a follow-up visit after one week in order to monitor healing process.
- Information about the opening up procedure must be clearly recorded on the antenatal records.
- Once the woman has been opened up, it may be possible for her to deliver with the perineum intact. Episiotomy should only be performed if it is necessary, and not as a matter of routine.
- Opening up during pregnancy has advantages besides preparing for delivery. It means that:
 - clean samples of urine can be obtained
 - vaginal infections, premature rupture of membranes and antepartum bleeding can be easily investigated if they occur.
- Women who refuse to be opened up during pregnancy should be informed about the dangers associated with infibulation during delivery and should be referred to be delivered in hospital.

The antenatal period provides an opportunity for health workers to educate women (and other family members where possible) about the health consequences of FGM. The objectives should be to discourage women from subjecting their own daughters or granddaughters to FGM, as well as to discourage the women themselves from demanding re-suturing after delivery. Counselling of the women and their husbands will help to dispel some of the myths and misunderstandings about the need for “tightness” to enhance the man’s sexual pleasure. And it will provide an opportunity to explain the dangers of repeated surgery to open up the vulva at every birth and to re-stitch it again after every delivery .

Session 2: Obstetric complications due to FGM during labour and delivery

Session objectives

By the end of this session students should be able to:

1. Understand the complications which may occur during labour and delivery as a result of FGM.

Key references

- *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)
- *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. Geneva, World Health Organization, 2001 (WHO/FCH/GWH 01.2).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives*. WHO/FCH/GWH/01.5. WHO, Geneva (2001)
- Toubia, N.A. *A Practical Manual for Health Care Providers Caring for Women with Circumcision*. RAINBO Publication, New York, 1999.

Case Study

Mrs. Piego is a 20-year-old primigravid who comes to the labour ward with a family member complaining of contractions for the last five hours. From her antenatal records you note that she is full-term and also that she has type III FGM. It is your responsibility to admit her and conduct a complete assessment

of her condition and to monitor her labour. You need to develop a care plan for Mrs. Piego that takes account the importance of reducing the risk of complications during labour and delivery associated with type III FGM.

Analyze the case study and determine what complications you might expect for Mrs. Piego and her newborn under the circumstances. Analyze the causes of these complications.

Possible FGM-associated complications during labour and delivery include:

- Reduced vaginal opening, which will present a direct mechanical barrier to delivery and interfere with other procedures required for both assessment and management during labour. A tight introitus may, for example, prevent vaginal examination, and result in mistakes being made in assessing the degree of cervical dilatation, and in monitoring the stage of labour and fetal presentation.
- Labour may be obstructed as a result of scarring of the external genitalia which prevents normal stretching of the perineum to allow passage of the baby.
- Prolonged second stage due to scarring of the perineum and a tight vaginal opening.
- Tears during delivery due to rigidity of the

perineum as a result of scarring of the tissues around the introitus.

- Development of obstetric fistulae as a result of prolonged labour, during which the foetal head presses against the bladder or rectum.
- Death e.g. as a result of rupture of the uterus due to obstructed labour.
- Need for Caesarean section because infibulation has not been opened up during pregnancy.

Possible effects on newborn include:

- Asphyxia due to prolonged labour.
- Neonatal brain damage due to obstructed labour.
- Birth injuries due to difficult delivery.
- Death as a result of delivery complications.



Session 3: Assessment and management of women with FGM during labour and delivery

Session objectives

By the end of this session students should be able to:

1. Use assessment skills in order to identify and manage complications during labour and delivery caused by FGM.

Introduction

In most cases, a woman who comes to the labour ward will have received antenatal care. However there will be some who have not attended an antenatal clinic, and their first contact with a health care provider will be when they arrive at the labour ward. Whatever the circumstances, the woman must be reassured that her condition will be managed and that nurses and midwives are ready to offer any service she needs.

Assessment during labour

The procedure for assessment of a woman with FGM arriving at the labour ward is as follows:

- Take a history of labour and perform a physical examination as you would for any woman in labour.
- Examine the genitalia with special care to assess the tightness of the introitus, and whether or not it will allow for normal vaginal delivery. If there is a problem, such as extensive scarring or keloid, the woman must be informed of the action to be taken to enable delivery.

Physical examination

The procedure for a physical examination entails the following:

- Head to toe assessment.
- Abdominal examination, inspection, palpation and auscultation.
- Palpation of the bladder (also, ensure that bladder is emptied regularly).

- Examination of the genitalia to identify type of FGM (follow the procedure and principles of genital examination in women with FGM described earlier in this manual)

If introitus is tight:

- explain to the woman the problems associated with having a tight opening during labour and delivery
- inform her that an episiotomy will need to be performed during delivery to increase the opening, and explain carefully what is involved.

Monitoring progress of labour

- If there is a problem with assessment, such as a tight introitus making vaginal examination impossible, the scar can be opened along the midline. The incision should be made at the height of a contraction, and usually after the administration of a local anaesthetic. Generally speaking, there is little bleeding from the relatively avascular scar tissue, and suturing of the cut can be delayed until after delivery. If the situation allows, labour can be assessed using other parameters such as contractions, descent and fetal heart rates.
- Observe the woman closely and monitor her vital signs hourly.
- Give clear and simple information to the client about what she should expect during delivery.
- Record all observations in the partograph.

Assessment of the introitus during labour

- It is important to inspect the introitus carefully during second stage of labour to assess whether it is going to be able to stretch sufficiently during delivery of the baby.
- Prepare the client psychologically for this procedure by telling her what you are going to do and why such an assessment is needed.
- Ask her permission to examine her genitalia.
- Prepare equipment: a tray with antiseptic, sterile swab and gloves.
- Prepare the client by putting her into a lithotomy position; expose only the necessary parts of the body – do not expose unnecessarily.
- Wash hands with soap and water; put on gloves.
- Clean the external genitalia with antiseptic swab.
- Instruct the client to relax by taking a deep breath while you are introducing a finger into the introitus.
- Try slowly and carefully to introduce first one finger into the vagina to measure the tightness of the introitus. If it allows one finger, try to move the finger upward and downward, and left to right. If there is space for a second finger, try to widen the two fingers and check the resistance.
- If it is impossible to introduce a finger, or even the tip of a finger, the introitus is extremely tight – equivalent to type III FGM.
- If it is possible to introduce a finger but if it is impossible to stretch the opening at all because of resistance due to scar tissue, it will be necessary to then to open up the introitus by performing an episiotomy.
- If there is need for an episiotomy, inform the client and perform the procedure following the guidelines described previously in the manual.

Management of woman with tight introitus in cases of types I, II and IV FGM during labour

Management of women with FGM during labour is the same as for any other women, except where FGM has caused vaginal stenosis and inelasticity of the perineal muscle. In such cases, there may be a need for an episiotomy.

- Generally speaking, women with type I FGM are able to deliver vaginally without episiotomy unless there is extensive scarring causing inelasticity of the perineum.
- If FGM has caused a tight introitus, there is a need to increase the vaginal opening by performing an episiotomy.
- Usually a tight introitus will have been identified during first stage of labour, and the woman prepared for the performance of episiotomy at that time.
- If, however, the woman has arrived at the ward already in second stage of labour, explain to her the need to increase the opening by performing an episiotomy, and inform her of when and how this will be done (As already described, this should be at the height of a contraction, under local anesthesia, using special episiotomy scissors).

Management of women with type III FGM during labour

- If the woman attended antenatal clinic, the infibulation may have been opened during the antenatal period.
- In cases where the infibulation has not been opened during pregnancy, the woman should be informed during the first stage of labour of the need for this procedure.
- The client should be told that her vulva will be opened up during delivery to allow the passage of the baby. She should also be informed that the

sides of the infibulated vulva will be sutured separately and not re-sutured to a small opening, and told why. And she should be informed that the procedure will result in changes in the pattern of urination and menstrual flow, and also in sexual intercourse.

- The vulva should be opened up during the second stage of labour, at the height of a contraction to minimize pain.
- The cut should be made along the midline scar towards the pubis, taking care not to cause injury to the baby or structures along the scar. As stated earlier, it is common with type III FGM to find the structures below the scar intact, e.g. clitoris and labia minor.
- Follow the opening up procedure described on page 76. In some cases, where the scar has caused extensive inelasticity of the skin around the vagina, an episiotomy may be needed in addition to the opening up of the infibulation.
- Usually after cutting you deliver the baby slowly.
- After delivery of the baby and the placenta, and after the immediate needs of the baby have been taken care of, the entire cutting and any tears must be sutured.
- If there is not sufficient time to discuss the procedure in detail with the woman – if, for example, she arrives at the labour ward already in

the second stage – make sure everything is discussed with her after delivery. At this point the woman should be counselled about the procedure, and the importance of not re-suturing to create a small opening impressed upon her. This counselling will require great patience as the woman will be used to having a closed vulva as this is all she has experienced in life. The changes brought about by opening her up will need to be explained carefully and with sensitivity. She should be reassured that she will get used to changes in time.

- Reassure the woman that you are ready to discuss the situation with her husband/partner and/or anyone else she wishes. They may need to be counselled also. They should be informed of the procedure of opening up, the importance of keeping the genitalia open, and the health consequences of closing them again.
- Post-operative care for an infibulated woman opened up during labour is the same as for any other women whose infibulation has been opened up. Inform the woman of the need for good personal hygiene, and suggest she takes sitz baths to prevent infection. Dressings of sugar and paste have been proved to be effective in treating the wound.

Session 4: Management of women with FGM during the postpartum period

Session objectives

By the end of this session students should be able to:

1. Identify problems due to FGM during the postpartum period.
2. Manage women with FGM during the postpartum period.

Key references

- *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)
- *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*. Geneva, World Health Organization, 2001 (WHO/FCH/GWH 01.2).
- *Female Genital Mutilation: The Prevention and the Management of the Health Complications: Policy Guidelines for nurses and midwives*. WHO/FCH/GWH/01.5. WHO, Geneva (2001)

Introduction

It is in the period immediate following delivery that major problems may occur. These include extensive lacerations and haemorrhage from tears. If an incision has been incorrectly performed, tears may involve urethra and bladder anteriorly and rectum posteriorly. Later in the puerperium, sutured lacerations may become infected and break down. In cases of type III FGM and if the infibulation has not been opened, both mother and baby may suffer severe injuries, e.g. VVF and RVF in the case of the mother; and asphyxiation, stillbirth or severe brain injuries in the case of the baby. Therefore it is vital that a woman with FGM and her baby be properly assessed after delivery.

Immediate assessment of mother and baby

Immediately after delivery, the mother should be assessed as follows:

- Check if uterus has contracted. If it has not, massage the uterus to contract, check the bladder and empty if necessary; or administer oxytocic drugs.
- If you have delivered the woman, change gloves to another sterile pair.
- Check for tears on the vulva and inside the birth canal.
- Clean the vulval area to enable you to look into the external genitalia.
- Use speculum and good light to check for tears in the vaginal wall and on the cervix.
- Introduce the speculum very slowly as this may cause pain to the woman.
- Look along the inside of the vaginal wall and at the cervix.
- If there is bleeding or tears, take appropriate action immediately.

Immediately after delivery, the baby should be assessed as follows:

- Apply the Apgar test.
- If the baby is asphyxiated, resuscitate it. But if the condition is severe, send for medical attention appropriately.

Subsequent assessment of mother and baby

- Assess the mother's genitalia for bleeding and any sign of infection, and check that any tears, episiotomies or the edges of an opened up type III FGM are healing properly.
- Assess contraction of the uterus and bleeding; check for the normal involution of the uterus.
- Assess the mother's mental state (psychological and emotional).
- Assess the baby according to normal routine – e.g. check site of umbilicus for healing or bleeding; check its progress with breastfeeding.

Complications after delivery

Complications to look out for following delivery include:

- Excessive primary bleeding due to injury of the arteries and veins as a result of tears.
- Secondary bleeding as a result of wound infection.
- Infection which may lead to septicaemia.
- Urine retention if repair was not done correctly.
- Injury to adjacent tissues due to tears, if the delivery was not managed correctly. This may result in:
 - Incontinence of urine and/or faeces.
 - Vesico-vaginal fistula (VVF).
 - Sexual problems if repair was not done properly.
- Asphyxia neonatorum due to obstructed labour, this may result in brain damage to the baby.

Management of a woman with FGM after delivery

Management of women with FGM during the postpartum period is the same as for any other women. However, these women will need more psychological care in cases where the vulva has been opened up and not closed to restore the genitalia to the condition they were in before pregnancy and delivery. Such women will have to learn to accept

dramatic changes to the vulva from what they have known all their lives. The opened vulva will be different in both appearance and function from the infibulated vulva.

Women may request that they be re-sutured after delivery. In countries where there are laws against closing up an opened infibulation, it is relatively simple to deal with the situation, since the nurse/midwife can say the law does not allow the re-suturing. But in countries where there are no such laws, a request for re-suturing can cause a real dilemma for the nurse/midwife. In such a situation the nurse/midwife should follow the guideline of the health facility or her institution. Whatever the legal status of FGM and re-suturing, counselling and education over this issue are extremely important, and every effort should be made to discourage the practice of reinfibulation.

Immediate care

In cases of haemorrhage:

- Suture any tears and episiotomies immediately. Also, suture the sides of an opened infibulation (see procedure described earlier).
- If uterus does not contract, expel any clots, massage the uterus to aid contraction and administer oxytocic drug if necessary.
- Keep the patient warm.
- If post-partum haemorrhage is severe, call for medical assistance.

In cases of Neonatal asphyxia:

- Resuscitate the new-born and send for medical attention if severe

Postpartum follow-up

- Women with type I, II and IV with no complications after delivery should be advised like any other woman.

- Assure client that you are available to answer any queries she might have about her own care or that of the baby, or concerns about sexual matters.
- Perform the usual postpartum care for the mother and the baby.
- Women with type III FGM need the same kind of postnatal care as other women, but they will need additional information, counselling and support to help them adapt to the changes following de-infibulation, and to discourage them from seeking re-closure after discharge from the health unit. Discuss with her the feeling of wetness and increased sensitivity in her opened vulva, which she might not have experienced before. Advise her to wear loose underwear to reduce discomfort caused by friction.
- Provide psychosexual counselling to the husband separately to make him aware of the importance of not closing the opened up infibulation, and to help him deal with sexual changes.
- A women with any type of FGM who delivers a baby girl should be counselled about the consequences of allowing her daughter to be excised. The husband and other family members who are influential in decisions about FGM, e.g. mothers and mothers-in-law, should also be counselled about the same issues.
- Like any other woman in the postpartum period, those with FGM should be advised about the importance of personal hygiene, good nutrition, adequate rest, and about care of the new-born including breast feeding. They should also be given family planning advice and counselling like any other newly delivered mother.
- Always make sure you record information on FGM types and the complications.



APPENDIX 1: CASE STUDIES

CASE 1

Adela is a 27 years old woman from Nigeria. She sells yams in a village market. She has been married for four years but has had no child. She goes to a Pentecostal church where she has made friends with one of the prayer sisters, Dua, who is a midwife working in one of the private clinics. One day Adela asked her friend if she would fast and pray for her because life was becoming miserable with her failure to become pregnant. Her friend agreed, but also took the time and opportunity to talk to her about the problem.

Adela told her friend that she was a virgin when she married, and she thinks that is why her husband loves her even though she is still childless. However, she wants to have children because her mother in law has been asking her husband about it. She also thinks that although her husband does not seem bothered at present, that may change since no African man could be happy for long with a wife who does not produce children.

When asked about her childhood, Adela revealed that she was excised when she was eight years old. Following the procedure she was very sick for over a month. She had fever and the wound was sore and smelly. She remembers the room where she was being nursed smelling so bad that she was embarrassed when people came to see her. She said that her mother had given her traditional medicine to drink and to apply to her genitalia, but she did not improve. She was taken to hospital when her condition was very serious and everybody thought she was going to die.

Dua advised her friend to visit a doctor for investigations, and made an appointment for Adela to see one of the gynaecologists in the clinic where she was working. The investigations at the clinic revealed

that Adela's fallopian tubes were completely blocked, and the doctor told her it was due to infection. Her problem was therefore primary infertility. The doctor said they could try to clear the obstruction in the fallopian tubes with surgery. But Adela and her husband have so far not been able to raise the money necessary for the operation.

CASE 2

Yemeni is a 32 year old male midwifery tutor in a medical school in Ethiopia. His wife works as a clerk in the hospital where he teaches. They have one daughter who is 3 years old. They both come from an area where traditionally every baby girl has her clitoris excised during her first month of life. Before he got married, Yemeni had the chance to attend a workshop on female genital mutilation, which sensitised him and made him realise that the tradition is harmful.

He decided not to allow his daughter to be excised. He had educated his wife and she supported the idea of not excising their daughter. But the family lives with Yemeni's mother who wants her grand daughter to be excised. She complains constantly that the girl is becoming more and more naughty because she is not excised. "It is time you decided to excise this girl, look at how she behaves. Who is going to marry her?" Or she says to Yemeni's wife "I cannot sit here and at look you violate our tradition. This girl belongs to our clan; she must be excised; it is our culture". Yemeni keeps on talking to his mother about the harmful effects of female genital mutilation, and he has made it clear to her that under no circumstances will he excise the little girl. He says it is hard to keep challenging his mother but he will persist.

CASE 3

Asma is a 30 year old housewife. At the age of 6 she was infibulated. She still remembers the pain and brutality of the procedure. She was married at the age of 16, and says the pain she experienced when her husband penetrated her made her terrified of him for a long time because she thought he was so brutal. Intercourse continued to be painful for the first 6 months of her marriage, and she has never enjoyed sex but accepts it as an obligation in marriage.

Asma has four children, one of whom is a 2 month old girl. At each delivery she is opened to allow the passage of the baby, and then re-stitched after the birth. Her husband insists that she should have a tight vagina. Asma is currently debating with herself whether or not to have her daughter infibulated. She feels that if it is done, then it should be less extensive than her own type of FGM, because she does not like to think of her daughter experiencing the agony she has been through.

CASE 4

Meda is a 35 years old university lecturer who decided that her two daughters would not be excised as she and her sisters had been. Meda's daughters were born while she and her husband were studying abroad. When the family returned home Meda's mother and mother-in-law asked her if the girls had been excised. Meda said they had not, and explained to the older women that she and her husband had agreed the girls would not be mutilated.

Meda went back to work, but she was unable to find a maid to look after the children while she was out of the house. Since her mother-in-law lives in the same town, she decided to leave the girls with her during the week and to fetch them on Friday evenings to take them home for the weekends. One Friday evening when she went to fetch the girls, she was surprised not to find them playing outside as usual.

Her mother-in-law explained that they could not come out because they were not well. Meda thought perhaps they just had a fever. But as she entered the room, the girls cried out: "Mum it hurts!" It did not occur to her immediately that the girls had been genitally mutilated, but then her mother-in-law announced proudly: "I have excised my grand-daughters; I have done what is right for them".

CASE 5

Agnes is a village woman who was excised when she was a child. She does not remember how old she was at the time, only that she grew up with this scar. She was married at age 17 and realized four months after her marriage that she was pregnant.

Agnes decided to deliver at home, and her husband called a well-known and experienced traditional birth attendant when labour started. She was in labour for two days, and finally gave birth to a stillborn baby. Agnes was badly torn during the delivery and had to be taken to hospital to have the tears stitched. She also bled profusely and was transfused with one unit of blood.

However, the tear was so extensive that Agnes developed a vesico-vaginal fistula (VVF), which she had repaired eight months after delivery. Unfortunately the operation was unsuccessful, and she is to have another operation to try to repair the fistula, which she hopes very much will be successful. While she is undergoing treatment, she is living with her parents again. But she says her husband, who is a farmer, is very supportive and visits her regularly.

CASE 6

Ella is a 19 year old woman married to a soldier. She has a 2 year old daughter who was infibulated 7 days after birth. The child has been admitted to hospital several times because of urinary tract infections. During discussions, Ella reveals that she

also was mutilated when she was a child, and that she has lived with the pain all her life. She explains that she was opened during delivery and stitched up again afterwards to create a small opening. She did not want her daughter to undergo the procedure, but says there was no way she could persuade her mother-in-law to accept the idea that the little girl should not be excised.

Ella's country is now at war and her husband is at the frontline. A week after he left for the front, his mother inspected Ella's genitalia and then called a traditional birth attendant who stitched her up to create an even smaller opening to ensure that she remains chaste (i.e. does not have intercourse) until her husband returns from the war front.



APPENDIX 2:

LEARNING RESOURCES

Films and videos

- A compilation of videos on Female Genital Mutilation. UNHCR Programme and Technical Support Section. P. O. Box 2500, CH-1211 Geneva. The video is approximately 70 minutes and comprises the following films:
 - **Scarred for Life.** (25 minutes), produced by ABC, a special programme called Day One. This film compliments the topics in the introduction to FGM.
 - **A Dangerous Practice.** (12 minutes), produced by UK news programme. This film particularly addresses issues of human rights.
 - **Welcome to Womanhood.** (15 minutes) produced by Charlotte Metcalf. This is a Report of the ‘Reach’ Project in Kapchorwa Uganda. ‘Reach’ is a project which was started by the United Nations Population Fund to work with Sabyin people to stop the life threatening practice of female circumcision. The film looks at traditional beliefs, values and attitudes, and is specially relevant in discussions about involving men in the prevention of FGM.
 - **Infibulation: The Worst type of Female Genital Mutilation.** (12 minutes). This film (produced by the IAC) shows the act of infibulation. It can be very disturbing and some students may break down in tears. They should be given support by their teachers and encouraged to support each other. This film is specially useful in teaching about the different types of FGM, or in efforts to change people’s beliefs and attitudes towards FGM.
- **From Awareness to Action: Eradication of Female Genital Mutilation in Somalia. Eradicating Female Genital Mutilation in Somali Refugee Camps in Eastern Ethiopia.** UNHCR Liaison Office. P.O. Box 1076 Addis Ababa., Ethiopia.

The film is especially relevant to the lessons in Module Two, on community involvement in the prevention of FGM.
- **WHO Film: Female Genital Mutilation - “The Road to Change”.** WHO, Geneva (2000).

This film discusses the origins of the practice. It describes the different types of female genital mutilation, and the efforts made to eliminate the practice in various countries. It is especially relevant to the lessons in Modules One and Two.

Printed materials from WHO

- *Female Genital Mutilation. A joint WHO/UNICEF/ UNFPA Statement.* WHO. Geneva (1997).
- *Female Genital Mutilation.* An overview. WHO, Geneva (1998).
- *A systematic review of the health complications of Female Genital Mutilation including sequelae in childbirth.* WHO/FCH/WMH/00.2. Geneva (2000).
- *Female Genital Mutilation. Programmes to date: what works and what doesn’t. A review.* WHO/CHS/ WMH/99.5. Geneva (1999).
- *Female Genital Mutilation. A Handbook for frontline workers.* WHO/FCH/WMH/00.5 Rev.1. WHO, Geneva (2000).
- *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, Geneva (2000).

- *Summary of international and regional human rights texts relevant to the prevention of violence against women.* WHO/GCWH/WMH/99.3. Geneva (1999).
- *Counselling skills training in adolescent sexuality and reproductive health: A facilitator's guide.* WHO/ADH/93.3. Geneva (1993).
- R.J. Cook. *Women's Health and Human Rights.* Geneva, World Health Organization, 1994.
- *Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa.* World Health Organization Regional Office for Africa, Brazzaville, 1997.
- *The right path to health: Health education through religion. Islamic ruling and female circumcision.* WHO, regional office for Eastern Mediterranean (1996)
- Smith, J. (1995). *Visions and discussions on genital mutilation of girls: An international survey.* Published by Defense for Children International, Netherlands,
- Johns Hopkins Population Information Program (1997). *The Essentials of Contraceptives Technology: A Handbook for Clinic Staff.* Publisher of Population Reports. WHO, Geneva.
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- International Services for Human Rights. *Women's Rights in The United Nations: A Manual on how the United Nations Human Rights Mechanism can Protect Women's Rights, 1995.* (P.O. Box 16 1211 Geneva 20).
- Toubia, N.A. *A Practical Manual for Health Care Providers Caring for Women with Circumcision.* RAINBO Publication, New York, 1999

Books and booklets

- *Tradition! Tradition! A story of Mother Earth,* by Dorkenoo, E. published by FORWARD Ltd. London, 1992.
- *Yimmer's story.* Published by The National committee on Traditional Practices in Ethiopia, 1995.
- *Alia's story.* Published by The National committee on Traditional Practices in Ethiopia, 1995.
- *Fatoumata's story.* Published by Turin centre regional programme. AIC/AIDOS/ILO (1995).
- *Female Genital Mutilation: The Unspoken Issue.* Published by The Royal College of Nursing, London, 1994.
- Dorkenoo, E. (1994). *Cutting the Rose. Female Genital Mutilation: The practice and its prevention.* Minority Rights Publications, London.

Human rights charters

- The Universal Declaration of Human Rights (1948).
- The Convention on the Rights of the Child (1989).
- The Convention on the Elimination of All Forms of Discrimination Against Women (1979).
- The African Charter on Human and Peoples' Rights (1981).

WHO documents on FGM are available on the web site www.who.int/frh-whd

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